

U.S. DEVELOPMENTS

The *Evanston* Opinion: What's New, if Anything?

BY SHARIS ARNOLD POZEN

AS THE FEDERAL TRADE COMMISSION prepared to issue its Opinion in the *Evanston/Highland Park* hospital merger case, several questions were circulating among antitrust practitioners who followed the case closely: Would the Commission uphold the Administrative Law Judge's finding that the merger violated Section 7 of the Clayton Act? If so, would the Commission order divestiture of the acquired hospital, given that the merger had been consummated for over seven years? And in the process, would the Commission clarify the ALJ's analysis and provide further refinement of the antitrust analysis of hospital mergers, as was envisioned by former FTC Chairman Timothy J. Muris when he initiated the retrospective review of consummated hospital mergers back in 2002?¹

In a straightforward and thorough Opinion authored by Chairman Deborah P. Majoras, the Commission provided answers to these questions. But they were not necessarily the answers some expected.

For the most part, the Commission's merger analysis was based on well-established precedent. The Commission, however, departed from precedent in two important ways. First, the Commission departed from precedent in its approach to geographic market definition. In its Opinion, the Commission adopted complaint counsel's view that the relevant geographic market should not be defined by the traditional methods—by measuring the distances between and among area hospitals, comparing the services provided by the area hospitals, and thoroughly analyzing patient flow data to

determine whether the hospitals drew patients from the same or from different areas.

Instead, the Commission Opinion relied on the fact that the hospitals had raised prices “substantially and immediately” following the merger, and concluded that the geographic market included only the three hospitals now combined as a result of the merger. In essence, the Commission Opinion looked to evidence of competitive effects to define the geographic market at issue. The question remains whether this approach can be used when considering unconsummated mergers prospectively, or whether this approach may be used only when consummated mergers are reviewed after the fact, and only when there is a finding of supracompetitive pricing following the merger.

Second, while the Commission found that the merger violated Section 7, it did not order divestiture. Instead, it ordered a non-structural remedy that requires the merged hospitals to negotiate future contracts separately.

Background

In August 2002, then-FTC Chairman Muris announced the creation of the Merger Litigation Task Force.² Its stated purpose was to target completed (and previously unchallenged) hospital mergers for retrospective review. Chairman Muris stated that this retrospective inquiry was intended to enable the Commission to “update prior assumptions about the consequences of particular transactions and the nature of competitive forces in health care” based on “real-world information.”³ It was reported that the FTC reviewed a number of consummated mergers as part of this effort, and that at least four were under serious consideration for challenge.⁴

In the end, the FTC issued one Administrative Complaint seeking to “unwind” the acquisition of Highland Park Hospital (Highland Park) by *Evanston Northwestern Healthcare Corp.* (ENH), a relatively small hospital system operating in the Chicago suburbs that was comprised of two hospitals, *Evanston* and *Glenbrook*.

These three hospitals are located in an affluent suburb of Chicago and form a geographic triangle, with Lake Michigan as its eastern boundary. *Evanston* is a 400-bed facility, *Glenbrook* is a 125-bed facility, and *Highland Park* is a 125–200-bed facility. While *Glenbrook* offers only somewhat limited primary and secondary services, *Evanston* and *Highland Park* offer a full range of primary and secondary services, with *Evanston* also offering tertiary services. Several other nearby hospitals (including *Advocate Lutheran General*, *Rush North Shore*, and *Northwestern Memorial* hospitals) all closely resemble *Evanston* in the number of beds and in the services offered. In addition, according to the Commission Opinion, at least “nine hospitals [] are closer to *Evanston*, *Glenbrook*, or *Highland Park* than they are to each other.”⁵ These nearby hospitals include the three tertiary care institutions listed above.

The FTC reviewed the merger before it was consummated, as part of its Hart-Scott-Rodino premerger review process,

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and allowed it to proceed. ENH had been operating as an integrated hospital system for over four years prior to challenge by the FTC.

Once the Complaint was issued, the case proceeded through the FTC's administrative litigation process, which took over three-and-a-half years. Discovery began in February 2004, and proceeded for over twelve months. The trial before the ALJ was held over several weeks. In October 2005, the ALJ issued his Initial Decision,⁶ finding that the merger violated Section 7 of the Clayton Act, and ordered the divestiture of Highland Park. The ALJ's Decision was appealed by ENH to the Commission, which issued its Opinion on August 6, 2007.

Traditional Analysis

As with mergers in other industries, the traditional approach to analyzing hospital mergers has involved defining the relevant markets and determining whether anticompetitive effects are likely to result from the merger in those markets. In the majority of past hospital merger cases, the relevant product market has been defined to include "general acute inpatient hospital services."⁷ Such services have been viewed as a discrete set of hospital functions for which other services are not reasonably interchangeable.

A central focus in hospital merger cases has involved defining the relevant geographic market. Geographic market analysis has traditionally relied upon quantitative and empirical analyses of where patients can turn in the event of an anticompetitive price increase, along with the testimony of market participants and the merging parties' contemporaneous business documents.⁸ One important piece of empirical evidence in hospital merger analysis has been patient origin and flow data—meaning data collected by hospitals and insurance companies that reflect where hospital patients live and how far they have traveled to obtain hospital services.

In addition, several courts have applied the Elzinga-Hogarty test⁹ to patient flow data to determine the strength of candidate geographic markets.¹⁰ If, for example, the E-H test shows a significant portion of patients "flow" outside of or migrate into a candidate geographic market to obtain hospital services, courts have determined that the relevant geographic market should include those more distant hospitals.

Once the relevant markets have been established, as with other industries, the courts and the antitrust agencies have turned to analyzing possible anticompetitive effects. The Merger Guidelines recognize two theories of "potential adverse competitive effects of mergers": coordinated effects and unilateral effects. The theory of coordinated effects is concerned with the possibility that the merger may encourage or facilitate a "[c]oordinated interaction . . . by a group of firms," through either "tacit or express collusion," to raise prices or restrict output.¹¹ Unilateral effects analysis is concerned with the monopolistic power of the merged entity and its ability "unilaterally" to elevate price and suppress output.¹² This may result when the merging parties are each other's next best

substitute, so that the merger eliminates the pricing constraint that each merging party presented for the other. Both theories have been used to analyze hospital mergers, with unilateral effects theory used more often due to the heterogeneity of hospital services.¹³

In addition, as with other industries, the efficiencies likely to result from the hospital merger are measured and evaluated, along with the parties' defenses. And the traditional remedy in hospital merger cases, as with most mergers, is divestiture of either the acquired assets or the overlapping assets of the acquiring party.

The Commission Opinion

In its Opinion, the Commission unanimously affirmed the ALJ's Decision that the acquisition of Highland Park by ENH violated Section 7. The Commission Opinion held that the merger enabled ENH to exercise market power in the traditional market for "general acute care hospital services" and thereby raise prices to supracompetitive levels. In doing so, the FTC found that the merged hospitals were each others' closest substitutes.¹⁴

Interestingly, Commissioner J. Thomas Rosch, in his concurring opinion, viewed the question of whether the merged hospitals were each other's next best substitutes somewhat differently. He saw the hospitals as competing with one another not only as separate, individual hospitals, but also as key providers in health care networks created by health insurance companies. Commissioner Rosch argued that the merger eliminated competition between Evanston and Highland Park to be included in such networks to serve area patients.¹⁵ This analysis of competition among networks in hospital mergers appears to be somewhat similar to the arguments the court rejected in the Long Island Jewish hospital merger.¹⁶ There, the Department of Justice argued that the merging hospitals were competing "anchors" for insurance companies' networks, making the effect of the merger more pronounced.

The Commission Opinion next turned to the parties' econometric evidence regarding post-merger pricing. ENH's experts found that prices had increased between 9 to 10 percent following the merger, and complaint counsel's expert found that prices had increased between 11 to 18 percent.¹⁷ The Commission concluded that the post-merger price increases demonstrated that ENH had market power as a result of the acquisition.¹⁸ The Commission reasoned:

[T]he merging parties' contemporaneous business assessment about the transaction's competitive effects, complaint counsel's and respondent's econometric analyses of ENH's post-merger prices, and portions of the merging parties' and MCOs' testimony—demonstrate on the whole that it is very likely that the merger enabled the combined firm to exercise market power.¹⁹

Evidence of price increases not only established anticompetitive effects, it was also used by the Commission to establish the relevant geographic market. In doing this, as discussed in further detail below, the Commission departed

from traditional analysis of geographic markets in hospital mergers.

The Commission Opinion went on to reject ENH's defenses, which included the theory that any price increases that followed the merger were actually the result of learning through the due diligence process that Evanston was charging below-market prices before the merger. In other words, ENH suggested that the Commission's analysis of the post-merger price increase was flawed because it was applied to a lower than competitive price. ENH called its defense "learning-about-demand." In the Commission Opinion, this defense was referred to as a "reverse version of the *Cellophane* fallacy."²⁰ The Commission Opinion rejected this defense on factual grounds. The Commission stated that ENH's contemporaneous business documents and premerger negotiation strategies did not support this defense. In addition, the Commission Opinion suggested that: "while not unambiguous, the weight of the evidence suggests that th[e] gap [between Evanston's premerger prices and those charged by Highland Park] did not exist."²¹

Finally, the Commission rejected ENH's argument that quality improvements that resulted from the merger justified the higher prices charged post-merger. Instead, the Commission Opinion held that most of the quality improvements cited by ENH were not merger-specific, stating that the parties, in the Commission's view, had either begun most of these efforts prior to merging or could have done them regardless of the merger.²²

Rather than ordering ENH to divest Highland Park, which would have been the traditional remedy in these circumstances, the Commission ordered ENH to cause each of its three constituent hospitals to negotiate separately with insurance companies. To justify this remedy, as discussed below, the Commission relied on the same post-merger quality improvements that it had earlier found not to be merger-specific.

Geographic Market and Competitive Effects Conflated.

As indicated above, the Commission Opinion's analysis of the geographic market at issue departed from the traditional one. The Complaint defined the geographic market at issue as the area "directly proximate to the three ENH hospitals."²³ The ALJ, however, defined the geographic market to include not only the areas surrounding the three merged hospitals, but also the areas around four other nearby hospitals, concluding that "it is highly probable that the four non-ENH hospitals in the geographic market would have the ability to constrain prices at ENH, either now or in the future."²⁴

In rejecting the ALJ's relevant geographic market, the Commission pointed out the inconsistency between these findings and the ALJ's conclusion that the merger enabled ENH to exercise market power. A finding that several similar nearby hospitals were constraining prices could only lead to a conclusion that the merged hospitals could not exercise market power, and yet the ALJ had concluded that the merger had in fact resulted in price increases.

Rather than ordering ENH to divest Highland Park, which would have been the traditional remedy in these circumstances, the Commission ordered ENH to cause each of its three constituent hospitals to negotiate separately with insurance companies.

Then, instead of turning to the traditional means for determining geographic market noted above—patient flow data and other information on patient travel times and usage of the merging hospitals as compared to surrounding hospitals—the Commission stated: "if complaint counsel has proven that the significant higher-than-predicted post-merger price increases resulted from market power gained through the merger, then complaint counsel has correctly defined the geographic market as the triangle formed by the three ENH hospitals."²⁵

In other words, the Commission Opinion conflated the geographic market analysis with the competitive effect analyses of the merger, and suggested that when actual competitive effects of a merger can be shown, the relevant geographic market can be presumed, even if the result is a very narrow market area consisting of only the merged hospitals. Given that, as noted above, the hospitals at issue in this case were in an urban area served by many nearby hospitals, this finding is interesting, to say the least.

The idea that relevant product markets may be defined using effects evidence is not new. In *FTC v. Staples, Inc.*,²⁶ the court used evidence of anticompetitive effect to define a narrow relevant product market—the sale of consumable office supplies through the superstore channel. Through pricing evidence, the FTC established that while consumable office supplies were also sold by independent stationery stores and certain other large retailers, the sale of such products through the superstore channel was differentiated and constituted a relevant market. In essence, the FTC was able to show that the office-supply superstores priced against one another, and did not take into account prices charged at other types of office supplies retailers.

In contrast, in the *Evanston* case, the Commission used post-merger price increases to establish the geographic market, which seems less indicative of whether hospitals in a given area compete with one another. Patients and their insurance companies evaluate alternative sources for hospital services based upon a number of factors, including the services offered, location, quality and reputation, whether preferred physicians admit to the hospital, and rates, to some extent. Relying on post-merger price effects to determine geographic market boundaries instead of relying on such evidence seems to be bootstrapping—once a significant price increase was found to have occurred and the parties' explanations for it were rejected, the Commission Opinion presumed it could have only occurred because other area hospi-

tals were not constraining the merged parties, despite the fact that those hospitals are nearby and offered similar services.

Patient flow analysis and the E-H test, which have traditionally been relied upon heavily to define geographic markets in hospital mergers, was rejected by the Commission. As the ALJ observed in his Decision, even health insurance companies in the area used patient flow data to define their service areas and to determine where patients actually could and did go for hospital services.²⁷ Again, the Commission pointed to the evidence of a price effect post-merger as “almost certain to produce a more reliable determination of the geographic market than is analysis of patient flow data.”²⁸

Complaint counsel called Professor Kenneth Elzinga as a witness on this issue, and the Commission Opinion relied on Professor Elzinga’s conclusion that using patient flow analysis was “uninformative” about whether it would be profitable for merging hospitals to raise prices.²⁹ The Commission Opinion pointed to Professor Elzinga’s “silent majority fallacy” and the “payor problem,” both of which, according to the Commission Opinion, undermine the reliability of patient travel patterns between and among hospitals.³⁰ This finding will likely have a lasting effect on the extent to which the Elzinga-Hogarty test will be used in the geographic market analysis of future hospitals mergers.

One question that remains is whether the Commission Opinion’s analysis of geographic market can be applied to mergers considered during the Hart-Scott-Rodino review period, prior to their consummation. Here, where the transaction was challenged post-merger, the Commission found much more certain evidence of what it believed to be anti-competitive effects from the merger in the form of price increases. Moreover, the Commission was in a much better position to assess ENH’s defenses. It had the benefit of the passage of time to review all of the relevant issues related to these defenses, including the contemporaneous business documents surrounding price negotiations, the impact of the quality improvements, as well as the ability to hear from the market participants on such issues. As the old adage goes, “hindsight is 20/20.”

Using this analysis when evaluating mergers before they are consummated, however, where the competitive effects analysis is limited to speculation about the merging firm’s likely behavior post-merger, would seem to be much more difficult. Thus, it could be argued that this new approach employed in the Commission Opinion will have little bearing on pre-consummation hospital merger analysis in the future.

The Remedy

In fashioning its remedy, the Commission essentially adopted ENH’s proposed remedy. ENH had suggested that if the Commission found liability, it should not order divestiture, as the ALJ had done, but instead require each of the merged hospitals to negotiate and maintain separate contracts with

health insurance plans (referred to in the FTC’s and ALJ’s opinions as “managed care organizations” or “MCOs”). The Commission stated:

While not ideal, this remedy will allow MCOs to negotiate separately again for these competing hospitals, thus re-injecting competition between them for the business of MCOs. Further, ENH should be able to implement the required modifications to its contract negotiating procedures in a very short time. In contrast, divesting Highland Park after seven years of integration would be a complex, lengthy, and expensive process.³¹

While the Commission acknowledged that this was not “ideal,” the real question is whether it was practicable at all. For example, negotiations between health insurance companies and hospitals are often contentious and can include stalemates that lead to threatened or actual terminations. The Commission’s guidance on how ENH is to implement this process did not seem to contemplate such stand-offs. And given that the FTC will be monitoring Order compliance, having the Commission operate somewhat as a party to negotiations is also not necessarily “ideal” for ENH, the insurance companies, or the Commission.

The Commission went on in its Opinion to justify its departure from the long-held precedent that structural remedies are preferred for Section 7 violations. It stated that

our rationale for not requiring a divestiture in this case is likely to have little applicability to our consideration of the proper remedy in further challenge to an unconsummated merger, including a hospital merger. . . .

Nor will our reasoning here necessarily apply to consideration of the appropriate remedy in a future challenge to a consummated merger, including a consummated hospital merger.³²

The fact that the Commission accepted ENH’s solution begs the question of whether this remedy had been proposed and rejected previously, and if so, why it was accepted at this point in the litigation. Thus, in imposing this non-structural remedy, the Commission left many unanswered questions.

In outlining its remedy, the Commission required ENH to work with it to implement the remedy, which ENH did in its “Submission in Explanation and Support of its Proposed Final Order.”³³ ENH proposed an order that included details on the negotiating teams, a dispute resolution process, and a proposal for a third-party trustee to monitor the negotiations.³⁴ Given that this process is underway, the time for ENH to appeal the FTC’s Opinion has not run.

Conclusion

While seven years have ensued between the consummation of the merger and the Commission Opinion, including over three years of administrative litigation, the Commission Opinion seems to reflect many of the same legal principles that what were well-accepted and in use prior to its challenge. Thus, Chairman Muris’s goal in launching retrospective reviews of hospital mergers may not have been fully realized.

At least two exceptions stand out as changes that practitioners need to take into account when counseling hospital clients—the Commission’s approach to geographic market analysis and its remedy. Yet, the question remains whether this analysis and the remedy are the result of a unique opportunity to look back, seven years after consummation of the merger, and assess the effects of the merger.

Other areas may also be of interest to practitioners. First, the Commission Opinion represents a comprehensive rejection of the E-H test in hospital mergers. Though the use of this test had been largely abandoned as a means for determining geographic markets, practitioners should be even less likely to present E-H test results in court or before the antitrust agencies. The use of patient flow and origin data, utilized not through the E-H test, but as a means of conducting critical loss analysis and determining whether hospitals are serving patients from the same or from different areas, remains an open question that the Commission Opinion did not address.

Second, hospitals and their counsel should not take for granted that nearby hospitals will be viewed as constraining forces when evaluating potential mergers. Potential merging hospitals will also have to consider Commissioner Rosch’s analysis of provider network formation when considering the likely unilateral effects of a merger and take into account their positions in such.

These developments, along with the geographic market analysis and remedy, are what is “new” post-*Evanston*. ■

¹ 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 19–20 (Nov. 7, 2002). Note that the FTC has not yet published its findings from the Retrospective Study it launched in 2002.

² See Press Release, Fed. Trade Comm’n, Federal Trade Commission Announces Formation of Merger Litigation Task Force (Aug. 28, 2002), available at <http://www.ftc.gov/opa/2002/08/mergerlitigation.htm>.

³ Muris, *supra* note 1.

⁴ See Mark Taylor, *Merger Probes Should Be Done in a Few Months*, MODERN HEALTHCARE, Apr. 21, 2003.

⁵ *Evanston Nw. Healthcare Corp.*, FTC Docket No. 9315, slip op. at 13 (Aug. 6, 2007), available at <http://www.ftc.gov/os/adjpro/d9315/070806opinion.pdf>. [hereinafter Commission Opinion].

⁶ *Evanston Nw. Healthcare Corp.*, FTC Docket No. 9315 (Oct. 20, 2005), available at <http://www.ftc.gov/os/adjpro/d9315/051021idtextversion.pdf> [hereinafter ALJ Decision].

⁷ See, e.g., *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995); *FTC v. Univ. Health, Inc.*, 938 F. 2d 1206, 1211–12 (11th Cir. 1991); *United States v. Rockford Mem’l Corp.*, 898 F. 2d 1278, 1284 (7th Cir. 1990); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 138–40 (E.D.N.Y. 1997); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290–91 (W.D. Mich. 1996), *aff’d*, 121 F.3d 708 (6th Cir. 1997) (unpublished table decision); *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1119 (N.D. Cal. 2001).

⁸ See *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1052 (8th Cir. 1999); *Butterworth Health Corp.*, 946 F. Supp. at 1291.

⁹ See Kenneth G. Elzinga & Thomas F. Hogarty, *The Problem of Geographic Market Delineation in Antimerger Suits*, 18 ANTITRUST BULL. 45 (1973);

Kenneth G. Elzinga & Thomas F. Hogarty, *The Problem of Geographic Market Delineation Revised: the Case of Coal*, 23 ANTITRUST BULL. 1 (1978).

¹⁰ See, e.g., *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1072 (N.D. Cal. 2002), *aff’d*, 217 F.3d 846 (9th Cir. 2000) (unpublished table decision); *FTC v. Tenet Healthcare Corp.*, 17 F. Supp. 2d 937 (E.D. Mo. 1998), *rev’d on other grounds*, 186 F. 3d 1045 (8th Cir. 1999); *Freeman Hosp.*, 69 F.3d at 264–65; *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 978 (N.D. Iowa 1995), *vacated as moot*, 107 F. 3d 632 (8th Cir. 1997).

¹¹ U.S. Dep’t of Justice & Fed. Trade Comm’n, Horizontal Merger Guidelines, § 2.1 (1992, revised 1997), available at <http://www.ftc.gov/bc/docs/horizmer.htm>.

¹² *Id.* § 2.

¹³ See, e.g., *Long Island Jewish Medical Center*, 983 F. Supp. at 138–40 (court rejected DOJ alleged unilateral effects resulting from the merger).

¹⁴ In doing so, the Commission Opinion acknowledged that health insurance company testimony was inconsistent on whether the two merging hospitals were in fact the other’s closest competitor. For example, the Commission Opinion stated that “some of the MCO testimony partially supports complaint counsel’s assertion that Evanston and Highland Park were close substitutes for some MCOs.” But “[s]tanding alone . . . the MCO testimony was not precise enough to allow the Commission to draw firm conclusions.” Commission Opinion, *supra* note 5, at 58.

¹⁵ Rosch Concurring Opinion at 3, available at <http://www.ftc.gov/os/adjpro/d9315/070806rosch.pdf>.

¹⁶ *Long Island Jewish Medical Center*, 983 F. Supp. at 138–40.

¹⁷ The Commission Opinion acknowledged that the largest health insurance company in the Chicago area, Blue Cross of Illinois, did not incur such prices increases. Commission Opinion, *supra* note 5, at 65. However, the Commission Opinion provided no explanation of how it took this into account.

¹⁸ *Id.* at 58.

¹⁹ *Id.* at 74.

²⁰ Commission Opinion, *supra* note 5, at 67; See *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377 (1956) (holding that existence of market power was improperly assessed by using as a baseline the existing supra-competitive price of a food wrap, rather than examining the profitability of a price increase from the baseline of a competitive price for the product).

²¹ Commission Opinion, *supra* note 5, at 69.

²² *Id.* at 70–72.

²³ *Evanston Nw. Healthcare Corp.*, FTC Docket No. 9315 (Feb. 10, 2004) (complaint), available at <http://www.ftc.gov/os/caselist/0110234/040210emhcomplaint.pdf>.

²⁴ ALJ Decision, *supra* note 6, at 156, available at <http://www.ftc.gov/os/adjpro/d9315/051021idtextversion.pdf>.

²⁵ Commission Opinion, *supra* note 5, at 63–64.

²⁶ 970 F. Supp. 1066, 1076 (D.D.C. 1997).

²⁷ See ALJ Decision, *supra* note 6, at 151. (“Patient flow data is used by managed care organizations and by hospitals themselves to determine service areas and core service areas. Patient flow data . . . shows which hospitals patients actually utilize for services.”).

²⁸ Commission Opinion, *supra* note 5, at 78.

²⁹ *Id.* at 77.

³⁰ See *id.* at 76, discussing the “silent majority fallacy” as the false assumption that patients who travel to a distant hospital to obtain care significantly constrain the prices that the closer hospital charges to patients who will not travel to other hospitals. And “payor problem” is that patients who travel among different hospitals may not necessarily be doing so in response to a price increase. Instead it may have more to do with their health insurance.

³¹ *Id.* at 90.

³² *Id.*

³³ *Evanston Nw. Healthcare Corp.*, FTC Docket No. 9315 (Sept. 17, 2007), available at <http://www.ftc.gov/os/adjpro/d9315/070917submissionin explanation.pdf>

³⁴ *Id.*