

FTC v. Evanston Northwestern: A Change from Traditional Hospital Merger Analysis?

BY BARRY C. HARRIS AND DAVID A. ARGUE

ON NOVEMBER 7, 2002, then-FTC Chairman Timothy J. Muris delivered the Keynote Address to the Northwestern School of Law's Seventh Annual Competition in Health Care Forum.¹ In his address, Chairman Muris observed that after seven straight losses by the Federal Trade Commission and the Department of Justice in federal court it was obvious that the government's template for trying these cases no longer worked. He announced that the Commission had established a new merger litigation task force that would be screening merger-case targets, selecting the best cases and developing new strategies for trying them. Chairman Muris also explained that the Commission was in the midst of a retrospective study of consummated hospital mergers designed to evaluate the effects of hospital mergers in several cities and that the Commission would be considering whether administrative litigation is appropriate if the studies were to indicate that a merger was anticompetitive.

In February 2004, Complaint Counsel for the FTC filed the only complaint resulting from the retrospective study, alleging that the January 2000 merger of Highland Park Hospital with Evanston Hospital and Glenbrook Hospital to form Evanston Northwestern Healthcare Corporation (ENH) substantially lessened competition. On October 20, 2005, Chief Administrative Law (ALJ) Judge Stephen J. McGuire issued an Initial Decision finding that, "Complaint Counsel proved that the Challenged merger has substantially lessened competition in the product market of general acute inpatient services [sold to managed care organizations] and in the geographic market of the seven hospitals described above."² In explaining his decision, the ALJ wrote:

This opinion follows the traditional Clayton 7 approach in assessing whether there is a reasonable probability that the

merger is likely to result in anticompetitive effects in a relevant market. First, the relevant product market and geographic market are determined. Then, the Court analyzes whether anticompetitive effects are probable, using both market concentration statistics and post-acquisition evidence. Finally, Respondent's procompetitive justifications and affirmative defense are assessed.

Despite these claims, the decision neither follows a traditional Clayton 7 approach nor is consistent with the standards outlined in the DOJ/FTC Horizontal Merger Guidelines.³ While the analysis in the decision does identify a product market and an associated geographic market and calculates concentration measures associated with the market, the decision's findings on how competition is harmed and how market power is exercised are inconsistent with its findings on the relevant antitrust market.

Several commentators (including some of the panelists participating in a recent ABA CLE session on the decision) have discussed whether the Evanston decision represents a major change in hospital merger analysis. In particular, commentators have focused on a finding of a relevant product market of general acute care inpatient services *sold to managed care organizations* and the reliance on direct effects evidence to conclude that ENH unilaterally exercised market power after the merger.⁴

Our reading of the decision, however, is that it does not represent a new approach to hospital merger analysis. There are several bases for our belief. First, the use of direct effects evidence typically is limited to consummated mergers, and in recent years both federal antitrust agencies have based challenges of consummated mergers on post-merger pricing.⁵ Second, the focus on sales of hospital services to managed care organizations is consistent in principle with the Merger Guidelines' focus on demand-side considerations in identifying antitrust markets. Third, this product market is conceptually identical to the product market alleged by the Department of Justice in its 1997 challenge of the Long Island Jewish Medical Center/North Shore Health System merger. In that case, the DOJ alleged a product market of anchor hospitals that compete for inclusion in managed care plans' networks. The DOJ further alleged, as Complaint Counsel did in

Barry Harris is Chairman, and David Argue is Corporate Vice President, of Economists Incorporated. Each has testified about market definition in hospital cases before the FTC/DOJ Health Care and Competition Law Hearings. Dr. Harris testified for defendants in the Dubuque and Poplar Bluff hospital merger cases. He is former Deputy Assistant Attorney General, Antitrust Division, U.S. Department of Justice.

Evanston, that reasonable choices available to managed care plans in this product market are limited to the merging parties.⁶

We believe, however, that the *Evanston* decision is not a good indicator of future merger analysis for two primary reasons. First, the decision does not necessarily represent the views of either the Commission or FTC staff.⁷ Second, the reasoning and logic in the decision's analysis is problematic and inconsistent enough that it is unlikely to provide a reliable framework for future policy. The most fundamental of these problems, a problem that permeates both the decision's market definition analysis and its direct effects analysis, relates to the finding that ENH unilaterally exercised market power by raising its rates in 2002 and 2003 at each of its three hospitals. This finding is at odds with other findings in the decision that ENH competed in a market with four other nearby hospitals and that non-ENH hospitals are closer competitors to individual ENH hospitals than the merging ENH hospitals are to each other. That is, the decision's finding of direct anticompetitive effects from the merger is based on unilateral action by ENH, but the decision identifies a market structure inconsistent with unilateral effects.

We also believe that the decision will not guide future merger policy because it fails to identify the specific hospital services necessary for inclusion in the stated product market and it does not conduct a traditional Guidelines profitability analysis with regard to the antitrust market.⁸

In this article, we review and critique the logic employed in the decision. We specifically address the implications of so-called two-stage competition, the relevance of patient flow data, and the use of price data to ascertain whether the merger allowed or increased the exercise of market power. We conclude that even if the decision's product market (and its logical complement, two-stage competition) are employed, a Guidelines' profitability analysis of this product market raises the same types of questions concerning patient preferences considered in most previous hospital merger cases, and that patient flow data are particularly useful in identifying hospitals available to managed care plans for inclusion in a network. We also find, based on the decision and other publicly available materials, that neither the parties to the merger nor the ALJ applied the appropriate tests with regard to post-merger prices, relying instead on traditional tests of statistical significance. Simply stated, statistically higher prices (or faster growing prices) are necessary but not sufficient to infer the creation of market power from a merger.

Principles of a Guidelines Analysis

The introduction to the Merger Guidelines explains that the Guidelines outline the present merger enforcement policy of the Department of Justice and the FTC and that they describe the analytical framework and specific standards normally used by these agencies in analyzing mergers.⁹ While there may be some disagreement about details and specific numerical standards, there is general agreement that the ana-

lytical framework described in the Guidelines is well grounded in sound economics.

The Guidelines identify two general mechanisms through which a merger can harm competition: coordinated effects and unilateral effects. It is critical that a claim of competitive harm identify which mechanism would be used and confirm that the conditions necessary for the use of that mechanism actually exist. As we discuss in detail below, the decision does not identify an internally consistent mechanism of harm. The decision's finding of a multi-hospital market suggests that market power might be exercised by ENH jointly with its competitors. The joint exercise of market power would result in all prices increasing, which is inconsistent with the decision's focus in its direct effects findings on ENH's prices alone. The alternative mechanism for harm, unilateral effects, focuses on the prices of the merging parties. Unilateral effects, however, generally requires that the merging parties sell products that are each other's closest competitor. As we discuss below, the decision finds that the merging hospitals are not especially close competitors.

Another key component of a Guidelines analysis is a test for the profitability of an above-competitive price increase. The Guidelines paradigm focuses on whether a price increase would result in a sufficient loss of sales to make the increase unprofitable. If a large enough amount of substitution were to occur, the provisional market must be defined too narrowly, and other suppliers would need to be included. Absent this profitability test—and the *Evanston* decision does not include such a test for the market it describes—the analysis does not meet the Guidelines standard.

Product Market

The decision concludes that the relevant product market is general acute care inpatient services sold to managed care organizations, including primary, secondary, and tertiary inpatient services.¹⁰ The decision's product market has a significant impact on the focus and methodology of its overall analysis. To see why, it is important to understand that this product market has two limiting characteristics: (1) hospital services are limited to inpatient acute care services and (2) sales of hospital services are limited to sales to managed care organizations. This product market is the same product market alleged by the FTC staff.¹¹

Under the Guidelines, market definition derives from demand-side considerations (i.e., buyers' willingness to switch products). That is, a properly defined product market would generally be limited to a specific service and its substitutes. For example, obstetrics services do not compete with heart surgery services. Supply-side factors are incorporated into a Guidelines analysis in the identification of firms that are considered to participate in the market and through an analysis of entry and repositioning. Consequently, individual hospital services may each be an antitrust product market because it may be possible to raise rates charged for each of these individual services.

One possible exception to the general notion that product markets be comprised of individual hospital services may occur if health insurers typically contract with hospitals for a specific cluster of services. The use of a cluster market of inpatient acute care hospital services has a long history in antitrust merger analysis. Despite this long history, there are clear problems and certain limitations associated with using such a market.¹² The cluster market approach leaves open the issue of identifying the cluster of hospital services that health insurers require a single hospital to provide. If a specific cluster of services must be provided at a single hospital, then it is appropriate to consider only those hospitals that offer the set of services. If, as is much more likely, health insurers do not require that these services be provided at a single hospital, then the analysis reverts to product markets determined by individual hospital services.¹³ Curiously, the *Evanston* decision makes only some cursory findings about the services provided by the merging parties and fails to make any findings about the set of services a hospital must provide to be included in the relevant product market.

Rather than conducting an analysis of services offered, the decision relied on what is called two-stage competition to support its product market.¹⁴ Two-stage competition theory posits that hospitals first compete on price to be included in a managed care plan's network, then, in the second stage, hospitals compete with other network hospitals for patients, ostensibly through non-price factors. Importantly, the decision states that “[i]n this case, the government challenges the merger because of its probable effect on price, i.e., on first stage managed care competition. Accordingly, it is the *first stage managed care market that is of critical concern to the antitrust analysis*, and it is the review of this market which will determine whether Respondent has market power to raise its prices to anticompetitive levels.”¹⁵

The decision's focus on the first stage of two-stage competition raises the question of how this type of competition should be considered in a Guidelines analysis. The Guidelines process of market delineation focuses on whether a price increase would be profitable, but the decision addresses neither the mechanism through which hospitals translate any market power in this first-stage market into higher profits nor whether such an attempt to exercise market power would actually be profitable. The decision observes that because of the focus on first-stage competition, “a key issue in determining the geographic market in this case is identifying which hospitals managed care organizations need to have in their hospital networks in order to establish viable, competitive networks.”¹⁶ Thus the decision indicates that the mechanism by which market power would be exercised first involves the inclusion or exclusion of hospitals from managed care plans' networks.

Hospitals, however, do not generally receive any compensation for being included in a health insurer's network. Rather, they are compensated only when a health insurance enrollee is treated at the hospital, which means that any

exercise of market power requires the hospital to raise its rates for its patients and the specific services patients receive.¹⁷ Consequently, a Guidelines analysis of the decision's proposed market should include an assessment of the profitability of a hospital's attempted price increase in the context of its possible exclusion from managed care plans' networks. The likelihood of a hospital's exclusion from a network, however, depends on how many of the hospital's patients consider other hospitals to be good substitutes.

The need to consider patient choice in evaluating first-stage competition is illustrated by a stylized example. Consider two different circumstances in which two hospitals are perceived as being needed for inclusion in managed care networks. In the first circumstance, the two hospitals are identical in every way and patients using these hospitals have no close substitutes. Clearly, a merger between these two hospitals would harm competition whether first-stage or second-stage competition is considered.

In the second circumstance, the hospitals are similar but not identical, where 20 percent of the hospitals' patients have no close substitute to the two hospitals. The remaining 80 percent of their patients, however, have good substitutes. Health insurers might perceive a need to include one of the hospitals in their networks in order to serve the 20 percent of patients without a good substitute. Whether an attempt by the hospitals to exercise market power by raising rates will be successful depends on how many of the 80 percent of patients with alternative hospitals actually decide to use a substitute. If a sufficient portion of these patients switches to alternative hospitals, the attempt to exercise market power will be unprofitable because market power is exercised through higher rates, and the hospitals' profitability depends on patients actually using the merging hospitals. Whether a specific patient will switch hospitals depends on the circumstances facing that patient, including the specific hospital services to be received, the patient's residential location and the proximity of hospitals to that location, and the relative costs to the patient of using these alternate hospitals. These factors, of course, are the same factors considered in previous hospital merger cases.¹⁸

What, then, are the logical consequences of the decision's findings? If, as the decision indicates, the ultimate patient is not affected by price in choosing a hospital, what is the mechanism through which the hospitals constrained each others' pricing prior to the merger?

We believe, contrary to the decision's findings, proper consideration of these questions produces an analysis similar, if not identical, to analyses traditionally employed in hospital merger cases.¹⁹ A Guidelines analysis of two-stage competition must consider that managed care plans care about hospital prices because higher hospital prices mean higher costs and possibly lower profits for the plan. The managed care plan bears these increased costs for each of its enrollees who uses a higher-cost hospital whether or not that enrollee “needs” to use the higher-cost hospital. A profit-maximizing

managed care plan decides whether to include a high-cost hospital in its network by comparing the profits lost from any enrollees who would change to a different health insurer in order to continue to access the high-cost hospital to the costs it would save by excluding the high-cost hospital. Consequently, a managed care plan's decision about whether to include a high-cost hospital in its network depends critically on the share of its enrollees using the high-cost hospital that would switch insurers if the high-cost hospital were removed from the network.²⁰

To see this concept more clearly, consider the case in which a managed care plan typically has 100 enrollees using the ENH hospitals before the merger and in which 20 enrollees view the merging hospitals as closest competitors and would change insurers if the ENH hospitals were not in the network. The remaining 80 enrollees, by contrast, would remain with the insurer even if the ENH hospitals were not available. Suppose, for example, the ENH merger raised the cost of serving these enrollees by \$1,000 per enrollee. By dropping the ENH hospitals, the managed care plan loses the profits associated with the 20 enrollees who switch insurers in order to access the ENH hospitals. Dropping the ENH hospitals from its network, however, also saves the managed care plan \$1,000 on each enrollee who remains with the insurer and switches to another hospital. Consequently, the decision to keep or drop the ENH hospitals from the network depends on the balance between (a) the profit associated with the 20 enrollees who "need" the ENH hospitals and would switch insurers to keep that access and (b) and the costs associated with the enrollees who would keep the insurer and simply switch hospitals. Ultimately, the hospital's attempt to raise its rates depends on how many patients it would lose as a result of these types of decisions by managed care plans.

The assessment of patient switching behavior is informed in part by patient flow data. These data have been one of the mainstays of most geographic market analyses for hospital services, but the *Evanston* decision specifically excludes them. The decision finds that "patient flow data is relevant to second-stage competition for patients, but provides no useful information about first-stage competition for managed care contracts."²¹ If employing a complete Guidelines analysis for first-stage competition requires consideration of individual patient options, then patient flow data are relevant to first-stage competition because they are informative about second-stage competition.

Our illustrative example is, of course, very much simplified. A full analysis might consider many complications, such as the employer's role in selecting insurance options for its employees.²² Nonetheless, we believe that this example provides some insight into how the Commission is likely to analyze two-stage competition. While the Commission may follow the decision and focus on two-stage competition and on managed care plans as purchasers of hospital services, we believe that for the Commission to maintain the Guidelines

standard, it will require a complete Guidelines analysis including consideration of how network composition affects managed care plans' profitability.

Geographic Market

The contradiction between the decision's findings about geographic market and its analysis of direct effects ultimately limits the decision's likely impact on the nature of future hospital merger analysis. The geographic market identified in the decision includes the three merging hospitals plus Lake Forest, Advocate Lutheran General, Rush North Shore, and St. Francis.²³ The decision also reaches some important conclusions about the significance of the four non-merging hospitals included in the market. It states:²⁴

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, and could be utilized by managed care organizations to create alternate hospital networks. These hospitals comprise the "area of effective competition" (*Philadelphia Nat'l Bank*, 374 U.S. at 359) to ENH and provide suitable alternatives for managed care organizations in building and marketing their health plan networks in the geographic market.

If accurate, these findings indicate that the merger did not provide ENH with the means to exercise market power unilaterally, and, consequently that the decision's focus on prices at ENH rather than prices at all hospitals in this market is misplaced.²⁵

It is logically possible that ENH could exercise market power unilaterally in the market identified in the decision if (contrary to the above findings) the merging hospitals had been each others' closest competitors. A quick review of patient flow data, the use of which the decision rejected, further indicates that the merging hospitals are unlikely to be each other's closest competitor.²⁶ Patient flow data are particularly informative in evaluating the facilities necessary to construct a network. Indeed, managed care plans employ patient flow data for this use. Ironically, the principal criticism of the traditional use of patient flow data is that the data may not be a good indicator of patients' future decisions about hospitals. But any such limitations are attenuated when the data are used to address the composition of a network in the first stage of two-stage competition.

Data from the Illinois Hospital Association for commercially insured patients for 1999 were reviewed.²⁷ We considered initially the set of zip codes that collectively provided Evanston/Glenbrook with 90 percent of its pre-merger patients. Evanston/Glenbrook's share of patients from this group of zip codes is only 13.8 percent, while Highland Park's share is only 3.8 percent. That is, in 1999, over 80% percent of patients residing within the Evanston/Glenbrook service area used non-merging hospitals.²⁸ We next considered for each zip code which hospitals are used by patients residing within the Evanston/Glenbrook service area. Significant use of non-merging hospitals is found for residents of every zip

code in the service area. Moreover, Highland Park is not a particularly close competitor to Evanston/Glenbrook. As a brief illustration, consider the ten zip codes that provided Evanston/Glenbrook with its greatest number of patients before the merger (more than 55 percent of its total patients). Highland Park's share of discharges of residents of each of these ten zip codes was only 0.9%, 2.7%, 1.0%, 10.2%, 2.3%, 1.3%, 1.1%, 4.8%, 1.0%, and 0.2%. By contrast, the share of discharges of residents of these zip codes from non-merging hospitals was 25.8%, 48.3%, 41.1%, 43.6%, 35.7%, 73.2%, 66.1%, 38.0%, 68.7%, and 82.5%.

There is nothing special about the shares for these ten zip codes. Similar shares are evident throughout the area served by Evanston/Glenbrook. These data strongly suggest that several other hospitals served the same patients as the merging hospitals and, consequently, that Highland Park and Evanston/Glenbrook were not uniquely close pre-merger competitors of each other.

An important conceptual point related to consideration of patient flow data is that it is not necessary for non-merging hospitals to be perfect substitutes for the merging hospitals to prevent the merging hospitals from exercising market power. All that is necessary to prevent the exercise of market power is for a sufficient number of patients to use alternate hospitals in the event an attempt were made to exercise market power. The profitability of a hospital attempting to exercise market power is not affected differently if patients using alternatives go to a single hospital or go to several hospitals.

The results from the patient flow data raise an additional point concerning a basic Guidelines analysis. The decision found a relevant market consisting of seven hospitals, based on identifying hospitals that compete with the merging hospitals. The Guidelines explain, however, that while the market can be no smaller than this group of hospitals, it may be larger depending on the ability of the seven hospitals in the market to profitably raise their rates. Consequently, it is necessary to repeat the market analysis for the expanded group of locations.²⁹ This additional step is important because, if the non-merging hospitals in the decision's market face significant competition from hospitals outside this market, then the non-merging hospitals in the market will not find it profitable to participate in an attempt to exercise market power.

Patient flow data are also useful in calculating market share. The decision indicates that the merger resulted in a post-merger HHI based on each hospital's inpatient net revenues of 2739 with an increase of 384.³⁰ Similarly, it finds that the merger increased ENH's share from 35 percent to 40 percent. It is unclear what the hospitals' overall net revenues have to do with the ability to serve a specific service area or exercise market power. To the extent that shares matter for differentiated products or unilateral effects, it probably makes more sense to base these shares on the extent to which each hospital serves specific service areas because any market power will be exercised over the patients in these service areas. Using the number of hospital discharges of patients residing in the

service area of the three ENH hospitals, Evanston/Glenbrook had a 12.1 percent share and Highland Park had a 3.6 percent share.³¹ That is, for the area served by the three merging hospitals, more than 84 percent of patients use other hospitals.

If, by contrast, shares had been based on discharges of patients from the service area of the seven hospitals in the Decision's relevant market, the Evanston/Glenbrook pre-merger share is 10.5 percent and the Highland Park share is 3.1 percent. The overall share of the seven hospitals in their own service area is only 32 percent. These shares are not usually associated with the ability to exercise market power.³²

These alternative market share calculations further illustrate the fundamental contradiction between the decision's findings concerning geographic market and unilateral direct effects, a contradiction that makes the decision an unreliable framework for future analysis.

Direct Effects

The decision concludes that direct effects evidence shows that ENH unilaterally achieved significant price increases after the merger relative to other hospitals; explanations other than the merger for these price increases are ruled out.³³ In addressing direct effects, the decision considers documentary and testimony evidence, as well as empirical pricing evidence.³⁴ In this article, we focus on the use of post-merger pricing evidence. The decision's analysis uses data from four different sources.³⁵ While the period of analysis varied depending on the data source and the control group used, the general period of analysis was 1998 through 2002. Regression analysis was used to account for variations over time and across hospitals for factors, such as patient mix, customer mix, and teaching intensity.³⁶

While the results varied somewhat across samples and control groups, the statistical analyses' overall findings indicate that the price increase at ENH was greater than the average price increase at other hospitals and that the difference was generally statistically significant. Several conceptual problems underlie this analysis. One problem is related to the use of statistical tests that compare ENH's post-merger rates to the average rates of groups of other hospitals. A second problem is related to identifying reasons other than the merger that may account for the price increases. These problems are not narrow and technical but rather present issues that must be addressed generally if direct effects analysis is used to evaluate mergers.

The decision's overall conclusion of unilateral competitive harm implies that price increases at ENH should exceed price increases at other hospitals after accounting for other factors that affect hospital rates. This prediction, however, is not the same as a finding that ENH prices are statistically different from average prices for a group of many hospitals. What, for example, would be the conclusion if ENH were one of five hospitals that had rate increases significantly different than the average, but nothing occurred during the sample period to provide the other four hospitals with an

increased ability to exercise market power? If this example is accurate, and the decision does not discuss whether there are other hospitals with statistically significant higher price increases, then there must be explanations not identified by the statistical analysis for price increases. Stated slightly differently, how is it determined that the underlying cause of the price increase at ENH differs from the underlying causes associated with the price increases at the other hospitals where market power did not increase? The decision's finding of statistical significance is a necessary but not sufficient basis on which to base a finding of increased market power.

The strength of the decision's conclusion that the exercise of market power is the only explanation for ENH's price increases depends on whether the empirical analysis can rule out all plausible explanations for the difference in price increases other than market power. Thus, the empirical analysis must include a comprehensive list of possible alternative explanations. The decision acknowledges that "it is not possible to test for all possible explanations of a price increase" so only "reasonable explanations" need to be considered.³⁷ The actual econometric analysis appears to include only three explanatory variables: changes in patient mix, changes in customer mix, and changes in teaching intensity. The other five explanations were "directly rule[d] out" as being theoretically inconsistent with differences in price increases between ENH and the control group hospitals.³⁸

The test statistics that derive from these empirical analyses typically identify how much of the variation in the dependent variable (e.g., price) is explained by the explanatory variables (e.g., patient mix, customer mix, teaching intensity). The decision does not provide any information about the explanatory power of Complaint Counsel's regressions. If the regressions fail to have sufficient explanatory power, important variables must have been omitted, and alternative explanations besides the exercise of market power might be viable.

An additional consideration that conflicts with the analysis in the decision concerns the lack of an above-average price increase to Blue Cross Blue Shield of Illinois. Experts for both Complaint Counsel and ENH found that ENH's prices to Blue Cross did not increase faster than the prices Blue Cross received from the control group hospitals. In other words, ENH evidently failed to exercise its alleged newly acquired market power against Blue Cross. The decision dismisses the significance of Blue Cross's rates on the grounds that Blue Cross "accounts for approximately twenty percent of ENH's business" which gave Blue Cross "a very strong bargaining position against ENH."³⁹

The decision offers no explanation why a 20 percent share of ENH's business enables Blue Cross to resist an attempted price increase. If accurate, a claim that Blue Cross has a strong bargaining position relative to ENH would mean that Blue Cross has the ability to shift patients to non-ENH hospitals. If Blue Cross has the ability to shift patients (either by omitting ENH from its network or providing financial incen-

tives for in-network diversion of patients), then a question is raised concerning why other payors do not have that ability as well. The loss of a patient by ENH from other payors is likely to be as costly to ENH as would the loss of a Blue Cross patient.

Some of these econometric problems might be avoided if a longer sample period is used for the empirical tests. An analysis based on a sample that includes data only from two years prior to the merger to two years after the merger can easily fail to distinguish a merger-related price increase from a price increase unrelated to the merger. For example, if Evanston/Glenbrook made minor pricing adjustments each year, making major pricing adjustments only every third year, then the four-year sample used in this case could misidentify the cause of the price increase if the major pricing adjustments occurred after the merger.⁴⁰ It is particularly important when statistical tests are based on a limited time period that the tests' results be consistent with the theory of the case and with the market structure in which the hospitals compete. The lack of such consistency further diminishes the decision's influence on future policy.

Conclusion

Our overall conclusion is that while the *Evanston* decision provides a different focus than most previous hospital merger cases, it is unlikely to indicate a significant change in future hospital-merger analysis. We reach this conclusion because of problems in the decision and because the analysis that results when these problems are rectified looks quite similar to traditional hospital merger analysis. ■

¹ Timothy J. Muris, Chairman, FTC, Everything Old Is New Again: Health Care and Competition in the 21st Century, Prepared Remarks of Timothy J. Muris Before the Seventh Annual Competition in Health Care Forum (Nov. 7, 2002), available at <http://www.ftc.gov/speeches/muris/murishealthcarespeech0211>.

² Evanston Northwestern Healthcare Corp., FTC Docket No. 9315, Initial Decision (Oct. 20, 2005), available at <http://www.ftc.gov/os/adjpro/d9315/051021idtextversion.pdf> [*Evanston* Decision].

³ U.S. Dep't of Justice & Federal Trade Comm'n, Horizontal Merger Guidelines (1992, revised 1997), available at <http://www.ftc.gov/bc/docs/horizmer.htm> [Guidelines].

⁴ For an overview of hospital merger enforcement, see Toby G. Singer, *Developments in Hospital Merger Litigation: FTC Administrative Proceedings and the Evanston Northwestern Case*, *supra* this issue, at 29.

⁵ See *United States v. Dairy Farmers of Am.*, 426 F.3d 850 (6th Cir. 2005); *Chicago Bridge and Iron Co.*, FTC Docket No. 9300, Final Order at 4 (Jan. 6, 2005). Pre-merger pricing was used to estimate direct effects in *FTC v. Staples, Inc.*, 970 F. Supp. 1066 (D.D.C. 1997).

⁶ *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121 (E.D.N.Y. 1997).

⁷ An overview of the FTC staff's views is presented in Theresa E. Weir, *An Overview and Roadmap to the Key Issues in "The Evanston Case"*, *ANTITRUST HEALTHCARE CHRONICLE* (ABA Section of Antitrust Law Newsl.), Oct. 2005.

⁸ In denying the government's request for a permanent injunction in *Long Island Jewish Medical Center*, the district court relied on the existence of numerous

other nearby hospitals offering the same specific services as the merging hospitals.

⁹ The Guidelines' framework and standards are also routinely used by the courts. See, e.g., *United States v. SunGard Data Sys., Inc.*, 172 F. Supp. 2d 172, 182 (D.D.C. 2001); *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 (8th Cir. 1999); *FTC v. Swedish Match*, 131 F. Supp. 2d 151 (D.D.C. 2000); *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109 (D.D.C. 2004); *Staples*, 970 F. Supp. 1066.

¹⁰ *Evanston* Decision at 27; Findings of Fact ¶¶ 191–192. Curiously, the decision finds that Highland Park generally did not provide tertiary services before the merger. *Id.* Findings of Fact ¶ 202.

¹¹ *Evanston Northwestern Healthcare Corp.*, FTC Docket No. 9315, Complaint ¶ 16 (Feb. 10, 2004), available at <http://www.ftc.gov/os/caselist/0110234/040210emhcomplaint.pdf>. *Evanston*, Complaint Counsel's Post-Trial Brief at 52–53 (May 27, 2005), available at <http://www.ftc.gov/os/adjpro/d9315/050527ccposttrialbrief.pdf>.

¹² The proper product market should be limited to services offered by both the acquired and the acquiring hospitals plus services for which repositioning would not be difficult. It may, however, make sense for organizational and analytical convenience to lump inpatient acute care services into some cluster of services when repositioning is generally easy.

¹³ Economies of scale or scope may make it most efficient to supply individual services in a single hospital. The existence of economies of scale or scope does not, however, determine which services need to be provided. Unless a defined set of services are necessarily sold as a group, it is still possible for a hospital to target price increases to certain services. Absent repositioning, a hospital that does not offer the targeted services does not provide a competitive constraint on pricing of those services. This process is essentially the same process the agencies follow when considering petroleum products made in multi-product refineries.

¹⁴ *Evanston* Decision at 135–36.

¹⁵ *Id.* at 136 (emphasis added).

¹⁶ *Id.* at 139. The decision further concludes that “patient flow data and service areas are not reliable in determining substitutability in first stage (price) competition for managed care contracts and are not considered in determining the geographic market.” *Id.* at 139. Rather, consideration is given to factors such as market-participant views, geographic proximity, travel times, and physician admitting patterns. *Id.* at 140.

¹⁷ In principle, a hospital with market power in this first-stage competition could exercise that market power through a two-part tariff. For example, the hospital could maintain competitive rates for admitted patients while charging a managed care plan a fixed fee for being included in its network. We have never observed such a pricing scheme.

¹⁸ While addressing a related issue, the *Evanston* decision finds that, “the ultimate patient is not affected by price because the patient’s contribution, or co-payment, is generally the same regardless of which hospital in the market is selected” and “managed care organizations’ inability to selectively contract or steer patients to more distant hospitals to avoid ENH’s price increases is powerful evidence that . . . patients want a local hospital in their managed care plan.” *Id.* at 136, 138.

¹⁹ For purposes of this discussion, it is assumed (contrary to our beliefs) that managed care plans lack the ability to influence patient choice of hospitals.

²⁰ For a discussion of the incentives facing managed care plans under two-stage competition, see Gregory Vistnes, *Hospitals, Mergers and Two-Stage Competition*, 67 ANTITRUST L.J. 671 (2000). Dr. Vistnes testified about two-stage competition for the Department of Justice in the *Long Island Jewish Medical Center* case. See also Robert Town & Gregory Vistnes, *Hospital Competition in HMO Networks*, 20 J. HEALTH ECON. 733 (2002).

²¹ *Evanston* Decision at 139. This finding, however, contradicts the decision’s other finding that the ultimate patient’s choice is not affected by price.

²² This analysis is nothing more than a Critical Loss analysis applied to the specific market identified in the decision. Related to such an analysis is the finding in the decision that a “silent majority” of people will not travel in response to a change in hospital prices, and those people can be subject to an anti-competitive price increase. *Id.* at 139. As with any product, this so-called

silent majority can only be targeted if they account for most patients using the merged hospitals or if there were a way to charge them higher prices than other patients using these hospitals. We do not know of a mechanism that would allow such price discrimination.

²³ *Id.* at 1; Findings of Fact ¶¶ 262–292.

²⁴ *Evanston* Decision at 144. These conclusions are supported through a host of Findings of Fact, which are generally found at ¶¶ 230–292.

²⁵ As we discuss later, this failure to focus on the correct price test is critical.

²⁶ The decision discusses the Elzinga-Hogarty test and the use of patient flow data. *Evanston* Decision at 138–40. We agree that the Elzinga-Hogarty test is not an appropriate methodology for identifying hospital markets.

²⁷ Data for 1999 were chosen because it was the last year before the merger, so there is no *Cellophane*-type issue. (See *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377 (1956). The so-called *Cellophane* fallacy pertains to the Court’s use of prevailing prices in determining that cellophane had a high cross-elasticity with other packaging materials. Because a profit-maximizing monopolist would price where demand is elastic, this finding of high cross-elasticity may reflect the exercise of existing market power.) Analyses were conducted for several mixes of hospital services, including separate analyses for all patients and patients classified as DRG 391 (Normal Newborns). The group of all patients was reviewed because it parallels the all-or-nothing choice implicit in first-stage competition. DRG 391 was reviewed because it is a good proxy for localized services. For purposes of this article, only the results for all patients are discussed, but the results are qualitatively the same for DRG 391.

²⁸ Seven non-merging hospitals discharged more patients from the *Evanston*/Glenbrook service area than did Highland Park.

²⁹ Guidelines § 1.21.

³⁰ *Evanston* Decision at 151.

³¹ It is appropriate to base these shares on the service area of the three ENH hospitals combined because the same rates were set at the three hospitals.

³² As discussed previously, patient flow data provide a great deal of information on the issue of which hospitals are good substitutes in a network. With patient flow data, it is possible to identify hospitals that are actually used by residents of each residential zip code served by the merging hospitals. This inquiry may be limited to patients with commercial insurance or focus on specific hospital services. Consequently, groups of hospitals can be identified that collectively provide the same services as the merging hospitals to the same set of patients and likely could serve as substitutes in a managed care network. The decision, nevertheless, rejects the use of patient origin data, finding that, “[b]ecause patients do not set the price of hospital services, their willingness to travel tells us nothing about their sensitivity to price changes by the merging hospitals. In other words, patient flow data is relevant to second stage competition for patients, but provides no useful information about first stage competition for managed care contracts.” *Evanston* Decision at 139.

³³ *Id.* at 1–2.

³⁴ Most of the detail of this analysis is redacted in the decision. Consequently, this discussion necessarily is based on only partial knowledge of the analysis.

³⁵ *Id.* at 166. The ENH price increases were compared to three control groups of hospitals: (1) all general acute care hospitals in the Chicago PMSA; (2) all general acute care hospitals in the Chicago PMSA that were not involved in a merger between 1996 and 2002; and (3) all general acute care hospitals in the Chicago PMSA that were involved in some teaching activity during the study period of the price analysis.

³⁶ *Id.* at 68; Findings of Fact ¶¶ 518–519.

³⁷ *Evanston* Decision at 88.

³⁸ *Id.* at 74, 86.

³⁹ *Id.* at 167.

⁴⁰ The statistical tests only indicate that ENH had larger rate increases after 2000. The tests do not provide a reason for the higher increases. The decision, however, references documents that suggest a merger-related price increase.