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CASE 4

Revisiting a Merger: *FTC v. Evanston Northwestern Healthcare* (2007)

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INTRODUCTION

On February 10, 2004, the Federal Trade Commission (FTC) issued a three-count complaint that challenged the January 1, 2000, merger of Evanston Northwestern Healthcare Corporation (Evanston, or ENH) and Highland Park Hospital (HPH) under Section 7 of the Clayton Act. Count I of the complaint alleged that the Evanston merger violated the Clayton Act in specified relevant product and geographic markets. Count II alleged the same anticompetitive behavior, but did not allege a specific product or geographic market. Under this count the FTC argued that it is not necessary to prove a relevant market because evidence of significantly higher post-merger prices demonstrated that the Evanston merger substantially lessened competition.¹ Count III alleged that the group of physicians who were associated with the hospitals had engaged in price fixing on behalf of its employed and affiliated physicians. Since the third count raised different issues and was settled by a consent agreement, it will not be discussed here.

At the time of the merger Evanston owned two hospitals—its 400-bed teaching hospital in Evanston, Illinois, and a 125-bed community hospital in nearby Glenview, Illinois. The acquired 150 to 200-bed community hospital is also located in the affluent suburbs north of Chicago: Highland Park. The three hospitals form a geographic triangle, and there are no other hospitals within this triangle, although there are many other hospitals that are

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¹ The Commission did not rule on Count II. "Having found that the evidence is sufficient to define the product and geographic markets, and that complaint counsel has prevailed under Count I, we consider it unnecessary to decide whether the law permits establishing a violation of Section 7 without defining a relevant market."

located closer to one of the three hospitals of the merged entity (ENH) than the three are to each other.

This case is particularly interesting on multiple fronts. First, after a decade of unsuccessful hospital merger challenges the government finally won one. From the mid-to-late 1990s the FTC, Department of Justice (DOJ), and California's Attorney General were unsuccessful in seven straight challenges to hospital mergers.² The Evanston case turned things around. In 2005 an administrative law judge (ALJ) ruled in the government's favor. More specifically, he ruled that the Evanston merger gave the merged entity the ability to increase prices through the exercise of market power and that these anticompetitive effects were not offset by merger-specific efficiencies.³ This decision was upheld by the full Commission on appeal in 2007.⁴

The government's success in the Evanston case can be explained, in part, by its success in focusing the spotlight on how competition in markets for hospital services has evolved as more individuals obtained their health insurance and/or care through managed care organizations, such as health maintenance organizations and preferred provider organizations. This new understanding about hospital market competition is especially important in the determination of the relevant geographic market for hospital services.

The second reason that this case is particularly interesting is that the FTC challenged the Evanston merger retrospectively, rather than prospectively.⁵ Usually the federal antitrust agencies challenge a merger after it has been proposed but before it has been consummated.⁶ These prospective challenges are based on predictions about whether the proposed merger is likely to lessen competition. Proxies for future market power, such as changes in market share and concentration in a well-defined market, are used to predict the likely impact of the merger on competition.

In contrast the challenge to the Evanston merger was retrospective. The merger occurred in 2000, and the challenge was issued four years later. Rather than having to rely on proxies for future market power, the FTC had two years of pre-merger data on prices and at least two years of post-merger data on the prices that were paid by five of the largest health insurers in the Chicago area.

² See, e.g., Haas-Wilson (2003) for a discussion of antitrust enforcement in markets for hospital services, physician services, and health-care financing.

³ *In the Matter of Evanston Northwestern Healthcare Corporation*, Dkt. No. 9315, Initial Decision (October 20, 2005) [hereinafter the Initial Decision].

⁴ *In Re Evanston Northwest Healthcare Corp.*, F.T.C. No. 9315, at 5 (August 6, 2007) [hereinafter *The Opinion of the Commission*].

⁵ Prior to the merger, Evanston and Highland Park Hospital were members of the Northwestern Healthcare Network, which was a network that was formed pursuant to a 1989 affiliation agreement. Accordingly, the hospitals had already received Hart-Scott-Rodino clearance and did not have to file again. The 2000 merger was not a reportable transaction.

⁶ Approximately one-fifth of the FTC's merger challenges are retrospective. Since 2009 the FTC has challenged nine consummated mergers (Rosch 2012).

Some of these data were collected as part of the FTC's Hospital Merger Retrospectives Project. The goal of this project was to study consummated hospital mergers and gain a better understand of the competitive effects of hospital mergers.⁷ In order not to interfere with hospital mergers that are either neutral or competitively beneficial (raise quality or lower costs), the FTC hoped to learn to identify those mergers that are competitively harmful (increase prices without offsetting efficiencies). The data that were collected as part of this project (and additional data that were provided by health insurers and the Illinois Department of Public Health⁸) allowed the FTC to measure directly the competitive effects of the merger. The FTC was able to address the issues of whether the merging parties obtained or enhanced market power, and if so, whether they had exercised that market power.

Third, the case raised the issue of the relationship between geographic market definition and empirical estimates of competitive effects of mergers. In prospective challenges to mergers the government agencies must rely on predictions about the potential for demand substitution to implement their hypothetical monopoly test. In retrospective challenges to mergers, however, the government may not have to rely on predictions about the likely reaction of consumers to price increases. If pre- and post-merger data are available, the government has actual evidence on consumers' reactions to post-merger price changes.

Importantly for future hospital merger enforcement, the geographic market that was based on direct measurement of competitive effects was considerably smaller than the geographic markets of the previous seven cases that the federal and state governments had lost.

Fourth, the case cast serious doubt on an argument that is often made by the nonprofit hospitals that are proposing to merge: Hospitals that are organized as nonprofit organizations are not likely to exercise market power. The Evanston case clearly demonstrated that nonprofit status does not prevent the exercise of market power. Just as is true of for-profit firms, the management at ENH faced financial incentives (award of bonuses and salary increases for growth in revenue and income) to exercise its market power, and they did so.

BACKGROUND

Hospital and other health care services differ from "standard" goods and services in an important way: Uncertainty about the future occurrence of

⁷ See, e.g., Tenn (2011) and Thompson (2011) for a discussion of the results of the study of the 1999 Sutter-Summit hospital merger in Berkeley-Oakland, California, and the study of the 1998 merger of two hospitals in Wilmington, North Carolina, respectively.

⁸ The Illinois Department of Public Health's Universal Dataset includes all inpatient hospital discharges in the state of Illinois.

disease and injury leads many individuals to purchase health insurance from third-party payers. As a result, hospitals and patients rarely negotiate directly over the prices of hospital services, and patients rarely pay directly to hospitals for the full costs of their care.⁹

Before the 1990s most insured individuals had indemnity insurance that gave them insured access to all hospitals. Third-party payers often reimbursed hospitals based on their full charges. Under this regime competition among hospitals was “patient driven.”¹⁰ Patients in conjunction with their physicians could select any hospital, and thus hospitals competed for patients, not for inclusion in third-party payers’ networks.

With the growth of managed care in the 1990s the locus of competition in markets for hospital services changed from patient-driven to “payer-driven competition.”¹¹ Third-party payers sell health plans (which are usually described as being provided by health maintenance organizations [HMOs] or “preferred provider organizations” [PPOs]), and these plans provide insurance coverage (or more generous coverage) only for a select group of hospitals that are included in the plans’ provider networks. Under this regime hospitals first compete to be included in third-party payers’ provider networks in order to gain access to their enrollees. This process in which third-party payers simultaneously select hospitals for inclusion in their plans’ networks and negotiate contract terms is called “selective contracting.” Hospitals are reimbursed for the care that they provide based on negotiated prices, rather than their list prices or “charges”.

Selective contracting has been viewed as the first-stage of a two-stage competitive process.¹² In stage one each hospital competes based on price and quality to be included in the provider networks of third-party payers. The negotiations between hospitals and payers determine the prices that are paid to hospitals. In stage two in-network hospitals compete for the network’s patients. Because patients face little or no variation in out-of-pocket costs across in-network hospitals, these hospitals compete on the basis of nonprice variables, such as reputation, quality, and amenities.

The prices that are paid to a specific hospital are determined by bilateral negotiations between that hospital and the third-party payer.¹³ Third-party payers may pay different prices for the same service to different

⁹ Because the out-of-pocket prices that are paid by insured patients (deductibles and copayments) are a small fraction of actual hospital prices, insured patients’ demand for hospital services tends to be less elastic.

¹⁰ Dranove, Shanley, and White (1993).

¹¹ *Ibid.*

¹² Vistnes (2000).

¹³ One can understand the relationship between third-party payers and hospitals based on bargaining models. See, e.g., Capps *et al.* (2003).

hospitals.¹⁴ Similarly, for the same service hospitals may be paid different prices by different payers.

A key determinant of a third-party payer’s ability to negotiate lower hospital prices is its ability to shift enrollees from the hospital with which it is currently negotiating to other hospitals. If there is a substitute hospital(s), a third-party payer may be in a stronger bargaining position and, thus, may be better able to negotiate lower hospital prices by threatening to exclude a particular hospital from its network. This is a credible threat when a third-party payer can encourage its enrollees to obtain their hospital care at a substitute hospital(s). When third-party payers are in strong bargaining positions, they may be able to negotiate lower hospital prices: lower per diems (an all-inclusive price for a day of hospital services), lower case rates (a fixed price for an episode of care),¹⁵ or higher discounts-off charges (a payment based upon an agreed-upon discount off the hospital’s charges).¹⁶

A hospital’s bargaining position depends on its incremental value to a health plan’s network.¹⁷ Hospitals are differentiated by their geographic locations, reputations, teaching programs, range of services, religious affiliations, and other factors. Accordingly, a hospital’s value to a health plan’s network, and thus its bargaining position, depends on two factors: The first factor is the heterogeneous preferences of the health plans’ enrollees. For example, some enrollees may value highly the insured parties’ access to hospitals near their homes, while others may value highly the insured parties’ access to hospitals that are affiliated with medical schools.

The second factor that determines a particular hospital’s bargaining position is the extent to which other hospitals are good substitutes for it. For example, if some enrollees of a health plan highly value the insured parties’ access to hospitals near their homes and for these enrollees there is only one hospital within 10–15 miles of their homes, that hospital may attain “must-have” status because it has no good substitutes from those enrollees’ perspectives. A hospital attains “must-have” status when third-party payers recognize that, without that particular hospital in their networks, their health plans will be at a competitive disadvantage in the market for health care enrollees.

¹⁴ A study by the Center for Studying Health System Change (2010) found wide variation in the prices that are paid by commercial third-party payers for hospital services. For example, in Los Angeles hospitals at the 25th percentile were paid 84 percent of the Medicare reimbursement rate, while hospitals at the 75th percentile were paid 168 percent of Medicare. The highest payment to a single hospital in Los Angeles was 418 percent of the Medicare rate. Similarly, in San Francisco hospitals at the 25th percentile were paid 136 percent of Medicare, while hospitals at the 75th percentile were paid 252 percent. The highest payment to a single hospital in San Francisco was 484 percent of Medicare.

¹⁵ Case rates are often used for obstetric care, such as a normal delivery.

¹⁶ Interestingly, these charges are set unilaterally by the hospital without interaction/negotiation with buyers.

¹⁷ See Town and Vistnes (2001).

Payers are in a weak bargaining position with a “must-have” hospital because withdrawal of this hospital from the network decreases individuals’ willingness to pay for insured access to the remaining hospitals in a health plan’s network. When a hospital has no close substitutes, it may be able to negotiate significantly higher prices.¹⁸ Hospitals may increase their actual prices in multiple ways, including changing their pricing strategies (for example, a switch from negotiated per diems and case rates to a strategy of discounts-off charges), raising their charges, negotiating lower discounts-off charges, and negotiating higher per diems and case rates.

Further, concentrated markets for hospital services have been shown to be associated with higher hospital prices.¹⁹

THE FTC’S ENFORCEMENT OF THE ANTITRUST LAWS

The FTC is composed of five Commissioners (the Commission) who are appointed by the President and confirmed by the Senate and a large staff of attorneys and economists.

The FTC challenges mergers by issuing an Administrative Complaint and having a trial before an administrative law judge (ALJ). When the Commission wants to challenge a merger that has been proposed but not consummated, it will first go into federal district court to seek a preliminary injunction (PI) to block the merger until the administrative proceedings are completed. District courts typically rule on a PI request within a few months. Either the prospective merging parties or the FTC can appeal the decision of the district court to an appeals court.

The administrative proceedings include a period of discovery, a trial, and possibly an appeal by the losing side to the full Commission. After the Commission rules, if the defendants lose before the Commission, they can then appeal to a federal court of appeals. The administrative proceeding can take well over a year. Because it takes so long to resolve the administrative complaint, if the merging parties lose at the PI stage, including any appeal, they will usually abandon the merger. If the Commission loses at the PI stage, it will often abandon its administrative case. There are two reasons for this: First, the ruling on the PI might indicate the FTC’s case was weaker than it believed. Second, if the Commission loses at the PI stage, the parties are free to merge, and subsequently splitting them up may be impractical or impossible.

The FTC has the power to challenge completed mergers, as it did after the merger of Evanston and HPH. Since a PI was not available to prevent

¹⁸ Empirical support for this hypothesis is found in a study by the Massachusetts Attorney General (2010).

¹⁹ Town and Vogt (2006) and Gaynor and Town (2012) review the empirical literature.

the merger, the Commission went directly to an administrative procedure to attempt to undo the merger.

The FTC staff acted as “Complaint Counsel” and issued the three-count complaint that specified the charges against ENH (the “Respondents”). Rather than settling and signing a consent agreement, ENH elected to contest the charges. Accordingly, the complaint was adjudicated before an ALJ. After the hearing the ALJ issued his “initial decision,” and ENH appealed this decision to the Commission. These decisions of the ALJ and the Commission are discussed later in the chapter.

MARKET DEFINITION

The 1992 *Horizontal Merger Guidelines*²⁰ describe the analytical techniques and enforcement policies of the FTC and DOJ with respect to horizontal mergers between competitors at the time of the challenge to the Evanston merger.²¹ Accordingly, the government defined the product and geographic markets using the hypothetical monopoly test.²²

The Product Market

Hospitals provide a wide variety of primary and secondary acute-care inpatient services that are not substitutes for one another. For example, a patient with appendicitis would most likely not consider treatment for pneumonia to be a good substitute for an appendectomy. Although demand substitutability between many hospital services is generally quite limited, it would be impractical to analyze competitive effects in this large number of product markets. Accordingly, there is a precedent for defining hospitals’ product markets as very broad clusters of services. This approach was appropriate in the evaluation of the Evanston merger because these distinct inpatient services were provided under similar competitive conditions.

Most general acute-care hospitals sell at least two clusters of services: outpatient services and general acute-care inpatient services. General acute-care inpatient services are the host of diagnostic and treatment services that are necessary to meet the surgical, medical, and other needs of inpatients (patients who require a stay of 24 hours or more). These services include, for example, 24-hour nursing care, intensive-care units, and sophisticated

²⁰ U.S. Department of Justice & Federal Trade Commission. 1992 *Horizontal Merger Guidelines* (revised April 8, 1997), 4 Fed. Trade Reg. Rep. (CCH) 13,104, at 20,569.

²¹ The most recent *Horizontal Merger Guidelines* were issued on August 19, 2010, and still use the hypothetical monopolist test to define markets. The 2010 *Guidelines* for the first time address the subject of consummated mergers.

²² See the Introduction to Part I of this book for a discussion of this test and the current *Horizontal Merger Guidelines*.

technologies. Outpatient services are those services, such as hospital-based outpatient facilities, that are necessary to meet the medical and surgical needs of patients who spend fewer than 24 hours at the hospital.

ENH took the position that the relevant product market included the clusters of services that are used to produce both inpatient and outpatient services. Specifically, they claimed that outpatient services should be included in the product market because third-party payers contract with general acute-care hospitals for both inpatient and outpatient services. ENH provided evidence (testimony of third-party payers) that when third-party payers evaluate the financial impact of their contracts with hospitals, they consider the total cost, including both inpatient and outpatient services.

Complaint Counsel, however, argued for a narrower product market that included only the cluster of general acute-care inpatient services that are sold to commercial third-party payers.²³ It has been generally accepted by the courts that general acute-care inpatient services constitute the appropriate product market in hospital merger challenges.²⁴ Accordingly, Complaint Counsel used general acute-care inpatient services as a starting point to apply the hypothetical monopolist test.

The government argued that its empirical analyses (which are discussed in the section on competitive effects) demonstrated that ENH had (post-merger) successfully imposed a small but significant and nontransitory increase in price (SSNIP) for general acute-care inpatient services that are sold to commercial third-party payers. Thus, in the view of the FTC, no additional products needed to be added to the candidate product market. Interestingly, ENH's empirical analyses that used its broader product market, including both inpatient and outpatient services, demonstrated that ENH's average post-merger prices increased by 11 to 12 percent, relative to comparable hospitals. In other words, ENH's own estimates showed that, even in the broader product market, ENH was able successfully to impose a SSNIP. ENH's expert economist estimated larger relative post-merger price increases using the broader product market definition (11 to 12 percent) than he did for inpatient services alone (9 to 10 percent).²⁵

From an economic perspective the narrower product market definition makes sense. In the design of their benefit packages, third-party payers do not consider outpatient services to be a substitute for inpatient services. If a

²³ Public third-party payers contract with general acute-care hospitals to provide their enrollees with the insured's access to hospital services; however, the FTC excluded the services that are sold to public payers because the prices that are paid by these public payers are set by regulation, rather than by market forces. The largest public third-party payers are Medicare (the federal government's program of health insurance for the elderly) and Medicaid (the federal-state programs of health insurance for low-income individuals and families).

²⁴ See, e.g., *California v. Sutter Health System*, 130 F.Supp.2d 1109, 1119 (N.D. Cal. 2001), *United States v. Mercy Health Services*, 902 F.Supp. 968, 976 (N.D. Iowa 1995); *FTC v. Freeman Hospital*, 69 F.3d 260, 268 (8th Cir. 1995).

²⁵ The Opinion of the Commission at 57.

hypothetical monopolist raised its prices for inpatient services, third-party payers would not substitute outpatient services for inpatient services. A health plan that included the insured's access to outpatient services, but not to inpatient services, would not meet the market test.²⁶ Accordingly, hospitals may be able successfully to impose a SSNIP for general acute care services sold to commercial third party payers. Thus based on the *Horizontal Merger Guidelines'* methodology, general acute-care inpatient services sold to commercial third party payers are a relevant product market.

The Geographic Market

Geographic market definition played an important role in many of the government's unsuccessful challenges to hospital mergers in the 1990s. These losses can be explained, in part, by the methodologies used for defining geographic markets, such as the Elzinga-Hogarty (E-H) test.²⁷ Since then new methods that are based more closely on the *Horizontal Merger Guidelines* have been developed. The significance of this issue and its role in the Evanston case can be clarified by outlining the E-H model and these alternative tests.

As initially developed, the E-H test defined geographic markets on the basis of actual shipments of products or the distance that a product moved from the location at which it was produced to the location at which it was consumed. More recently the test has also been applied to the movement of consumers to the producer.

In challenges to hospital mergers the E-H test uses hospital discharge data, which include information on patients' chosen hospitals and the zip codes of their residences. An area is a relevant geographic market if both (1) a small percentage of patients from outside the area are treated by hospitals within the area, and (2) a small percentage of patients residing in the area are treated at hospitals outside the area.

In other words, the E-H test defines geographic markets for hospital services from the perspective of patients, rather than third-party payers, and thus focuses on the second-stage of the two-stage competitive process. A result of this focus on patients is that the E-H test tends to define large geographic markets that include more hospitals, each with a lower market share and a concomitant lower probability of the merger's lessening competition. However, as discussed earlier and agreed upon by the FTC and ENH, price is determined in the first-stage, and thus geographic market definition should focus on the first-stage where third-party payers are the buyers.

²⁶ In selecting their health plans, individuals demand the insured's access to inpatient services. Individuals do not know in advance (at the time that they are selecting their health plan) whether they will suffer a life-threatening illness and require inpatient hospital services and thus would not select a plan with insured access to only outpatient services.

²⁷ See Elzinga and Hogarty (1973).

The problems that are associated with the E-H test based on historical patient flow data are well known.²⁸ For example, the E-H test may lead to overestimates of the geographic market for inpatient hospital services as a result of “the silent majority fallacy.” The E-H test draws market boundaries based on a small subset of patients who traveled to more distant hospitals before the merger (travelers). If the tastes and preferences of travelers and nontravelers are heterogeneous and/or travelers and nontravelers have different needs for locally-available and not-locally-available services, then evidence that a minority of patients traveled to more distant hospitals before the merger does not imply that a local hospital lacks the ability to raise its prices above competitive levels to the majority of nontravelers. Even Professor Elzinga (co-creator of the E-H test) testified that given the unique features of hospital markets, the results of the E-H test may be less reliable.²⁹

However, new methodologies that focus on the first-stage of the two-stage competitive process, such as the willingness-to-pay (WTP) model, have been developed and used to define geographic markets in post-Evanston prospective challenges to hospital mergers. The WTP model estimates the amount that consumers would be willing to pay for the insured’s access to a particular hospital or, in other words, the monetary value that they place on inclusion of that hospital in a third-party payer’s provider network.³⁰

This model facilitates identification of which hospitals are close substitutes for one another. If consumers’ WTP for hospital A is high, this suggests that the other hospitals in the provider network are not close substitutes for hospital A. If, on the other hand, hospital A and another hospital in the provider network are perfect substitutes (consumers are indifferent between the two), then a network without hospital A would be valued the same as one with hospital A, and consumers would have \$0 WTP for hospital A.

Accordingly, the WTP model can be used to implement the *Horizontal Merger Guidelines*’ hypothetical monopoly test to define geographic markets. This requires estimation of both the WTP for all hospitals in a candidate geographic market as a single unit (the hypothetical monopolist) and the WTP for each hospital separately in the candidate geographic market. The difference between these two is the additional WTP that is associated with the hypothetical monopolist. The additional WTP can be expressed as the predicted price increase. If this predicted price increase is greater than the SSNIP (a price increase of 5 to 10 percent), this suggests that the geographic market is well defined. A hypothetical monopolist would be able to raise its prices without too much substitution to more distant hospitals.

²⁸ See, e.g., Capps *et al.* (2001); Frech, Langenfeld, and McCluer (2004); and Elzinga and Swisher (2011).

²⁹ The Initial Decision at 30.

³⁰ Town and Vistnes (2001) and Capps, Dranove, and Satterthwaite (2003).

In the Evanston case Complaint Counsel used the methodology of the *Horizontal Merger Guidelines*—the hypothetical monopoly test—to define the geographic market. Using the geographic triangle that was formed by the three Evanston hospitals³¹ as its starting point, the government’s econometric evidence demonstrated that ENH successfully imposed a significant and nontransitory price increase. As discussed in the competitive effects section of this chapter, the FTC estimated an 11 to 18 percent higher post-merger price increase at ENH, relative to other local hospitals. Even the hospital’s economic expert found a 9 to 10 percent higher post-merger price increase at ENH, relative to other local hospitals.³² Despite ENH’s relatively large price increases, third-party payers were not able to substitute hospitals outside ENH’s geographic triangle in the formation of their networks, and thus the hospitals outside the triangle were not viable substitutes and thus were not constraints on ENH’s pricing, regardless of their proximity to ENH. Thus, the government argued that the geographic triangle that was formed by the three hospitals was a relevant geographic market based on the Guideline’s SSNIP test.

ENH’s expert economist argued for a broader geographic market that included at a minimum six additional hospitals. This argument was based primarily on the geographic proximity and driving times among these six additional hospitals and the merging hospitals, market participants’ views on competition, and patient flow data. Executives from third-party payers testified that multiple other hospitals competed with Evanston and HPH.³³ Similarly, the President of HPH testified that HPH considered Lake Forest Hospital, not Evanston, to be its closest competitor.³⁴ The CEO of Evanston testified that HPH was not a significant competitor of Evanston.³⁵ With respect to geographic proximity, ENH provided evidence that Evanston and HPH are 13.7 miles and 27 minutes from each other, while there are 18 hospitals that are closer to Evanston or HPH than Evanston and HPH are to each other.³⁶

In prospective challenges to hospital mergers the factors examined by ENH, such as travel times and opinions of hospital and third-party payers, often play a role in defining the geographic market. One of the reasons that the Evanston case is important is that it showed these factors can lead to overly expansive geographic markets for inpatient hospital services.

³¹ There are no other hospitals that are located within the triangle that is formed by these three hospitals.

³² The Opinion of the Commission at 38.

³³ The Initial Decision at 32.

³⁴ The Initial Decision at 33.

³⁵ The Initial Decision at 33.

³⁶ *In the Matter of Evanston Northwestern Healthcare Corporation*, Dkt. No. 9315, Respondent’s Appeal Brief (December 20, 2005) at 28–29.

COMPETITIVE EFFECTS

Methodology for Measuring Direct Effects

Complaint Counsel alleged that the Evanston merger substantially lessened competition through unilateral effects or the elimination of competition between the two hospitals.

Complaint Counsel's econometric analyses were designed to determine (1) whether the merged entity was paid more than the merging hospitals would have been paid if the merger had not occurred; and if the answer to the first question is yes, then (2) whether the price increases were due to an increase in market power that was associated with the merger.

With regard to the first question, the government began by distinguishing post-merger price changes from post-merger price levels. As supported by economic theory the government measured market power as post-merger price changes, rather than post-merger price levels. In markets where firms sell differentiated goods or services different price levels are neither necessary, nor sufficient, to conclude that a firm is exercising market power. For example, that hotel rooms sell for prices ranging from \$49 to \$1,000/night is not evidence that the higher-priced hotels have market power, but rather that the higher-priced hotels have successfully differentiated their products by location (e.g., ocean front), service (e.g., availability of room service), reputation, or some other factor. If however, one observes that Hotel A has increased its prices by 10–20 percent more than have its competitors (especially if this follows Hotel A's merger with Hotel B), this could be evidence of the exercise of market power.

As a first step the FTC used data that had been provided by ENH to calculate ENH's price³⁷ increases to 14 commercial third-party payers between fiscal year 1999 (prior to the merger) and fiscal year 2002 (after merger). These simple calculations showed that ENH negotiated greater than 100 percent price increases with two of the 14 payers and greater than 75 percent with another seven payers.

The next step was to determine whether ENH was able to negotiate higher post-merger prices than would have been possible absent the merger. This is necessary because factors other than enhanced market power could potentially explain the observed price increases at ENH following the merger.

Other possible explanations include: (1) exogenous factors that affected all hospitals in the Chicago area (such as exogenous changes in demand, hospital costs, and/or government regulations); (2) increases in case complexity at ENH (and thus costs at ENH), relative to other hospitals; (3) increases in the share of patients with public insurance (Medicare

³⁷ Two proxies for price—inpatient net revenue per case of inpatient care and inpatient net revenue per day of inpatient care—were used.

and Medicaid), relative to other hospitals; (4) increases in teaching intensity at ENH relative to other hospitals; (5) decreases in the price of outpatient services at ENH, relative to other hospitals; and (6) increases in the quality of care at ENH, relative to other hospitals. If the merged hospital increased its percentage of more complex and costly cases (for example, a greater percentage of open heart surgeries and a lower percentage of appendectomies), relative to control hospitals, then this could explain a finding of higher relative post-merger price increases at ENH. Similarly, if the percentage of patients with public insurance (Medicare and Medicaid) increased at the merged hospital relative to control hospitals and hospitals can "cost-shift" (charge higher prices to commercially insured patients to compensate for lower reimbursements for publicly insured patients), then this could explain a finding of higher relative post-merger price increases at ENH. Teaching hospitals tend to have higher costs than do nonteaching hospitals, so an increase in teaching intensity at the merged hospital relative to control hospitals could also explain a finding of higher relative post-merger price increases at ENH. Hospitals sell both inpatient and outpatient services. Third-party payers may be willing to agree to higher price increases for inpatient services in return for lower price increases for outpatient services.³⁸

Accordingly, the FTC compared the price increases at ENH to the price increases at other local hospitals. If other local hospitals experienced similar price increases, then the price increases at ENH were most likely due to exogenous factors that affected all hospitals, rather than the merger. A finding of price increases at ENH that were significantly larger than the increases at other local hospitals, however, suggests that the merger created and/or enhanced the merged entity's market power. The FTC used multiple control groups: (1) all non-federal general acute-care hospitals in the Chicago Primary Metropolitan Statistical Area (PMSA);³⁹ (2) nonfederal general acute-care hospitals in the Chicago PMSA that were not involved in mergers between 1996 and 2002;⁴⁰ (3) nonfederal general acute-care hospitals in the Chicago PMSA with teaching programs; and (4) nonfederal general acute-care hospitals in the Chicago PMSA with major teaching programs.⁴¹

³⁸ To rule out lower price increases for outpatient services at ENH following the merger, relative to other hospitals, Complaint Counsel compared the post-merger price increases for outpatient services at ENH to those at other local hospitals. The results showed that ENH's post-merger price increases for outpatient services were either no different or significantly greater than the post-merger increases for other hospitals for all third-party payers and all control groups.

³⁹ The only hospitals that were excluded from this control group were federal facilities (e.g., VA hospitals), nonpediatric specialty hospitals (e.g. psychiatric hospitals), rehabilitation hospitals, and long-term care hospitals.

⁴⁰ A merger is defined as a change in ownership for a hospital in the Chicago PMSA in which the acquiring party owns one or more hospitals in the Chicago PMSA.

⁴¹ Teaching hospitals may have different cost structures than do nonteaching hospitals.

The FTC found relatively larger post-merger price increases at ENH compared to the four groups of control hospitals. These larger relative price increases are consistent with the merger's creating or enhancing ENH's market power; however, the FTC could not stop here. The question of ultimate interest is whether the relatively larger post-merger price increases were associated with the merger and the consequent exercise of market power, and thus anticompetitive. To answer this question the government had to provide evidence that these larger relative price increases at ENH were not the result of other factors, such as increases in the complexity of care, relative to other hospitals.

The FTC used the difference-in-differences (DID) empirical framework to measure the price effect of the Evanston merger and to rule out the other possible explanations for the relatively larger post-merger price increases at ENH.⁴² This method is the standard approach that is utilized to estimate the price effects of consummated mergers in retrospective challenges. This framework compares the pre-merger to post-merger change in ENH's prices to the changes in the prices of control hospitals (similar hospitals that were unaffected by the Evanston merger) over the same period of time. As was mentioned above, the FTC assembled groups of similar hospitals to control for exogenous, time-varying factors, such as changes in the demand for hospital services, changes in the costs of providing hospital services, and changes in regulations, that may have had an effect on hospital prices for reasons that were unrelated to the Evanston merger. These control groups provide an estimate of the merger's "counterfactual," or an estimate of what would have happened to prices at ENH if the merger had not taken place.

Accordingly, using a DID specification the FTC estimated using ordinary least squares regression the following econometric model:

$$Price_i = a_0 + b_1 Post_i + b_2 (Post_i)(D_h = ENH) + b_3 Case-mix_i + b_4 Public_h + b_5 Teach_h + b_6 Plan_i + b_7 D_h + b_8 T + e_i$$

where i indexes inpatient cases and h indexes hospitals.

$Price_i$ is the total reimbursement allowed by the third-party payer for each inpatient admission $_i$ (expressed in log form);⁴³

$Post_i$ is a dummy variable that equals 1 if admission $_i$ occurred after the merger;

$Case-mix_i$ is a measure of the complexity of or resource intensity that would be necessary to treat admission $_i$;

⁴² See, e.g., Vita and Sacher (2001) and Ashenfelter and Hosken (2010) for further discussion of the DID framework in retrospective merger challenges.

⁴³ The "allowed amount" is the total amount that the third-party payer and the patient owe the hospital.

$Public_h$ is the share of patients that were insured by Medicare and Medicaid at hospital $_h$ (expressed in log form);

$Teach_h$ is medical students per bed at hospital $_h$ (expressed in log form);

$Plan_i$ is the vector of dummy variables that indicate the patient's plan (HMO, PPO, or indemnity);

D_h is the vector of hospital dummy variables;

T is the vector of year dummy variables.

The regression coefficients provide estimates of the effects of each of these right-hand-side variables on the variable of interest ($Price_i$), holding the other right-hand-side variables constant.⁴⁴ The factors held constant were the mix of patients, the mix of third-party payers, and the teaching intensity at the merged and control hospitals. In other words, the empirical results allowed the government to rule out the following three potential explanations for the relatively higher post-merger prices at ENH: (1) ENH treated relatively sicker patients and thus incurred relatively higher costs after the merger; (2) ENH increased its teaching intensity relative to other hospitals; and (3) ENH increased its share of publicly-insured patients relative to other hospitals.

The Data

The primary data set included five years (1998–2002) of insurance claims data that were provided by five of the largest third-party payers in the Chicago area, representing more than 50 percent of insured enrollees in the area.⁴⁵ These data included information on each patient's diagnoses, dates of service, and the "amount allowed." The amount allowed is the total amount that the hospital is entitled to collect under its contract with the third-party payer as well as any amounts owed by the patient for co-insurance, co-payment, and deductible. Based on these data the FTC calculated the actual transaction price of hospital services per case or episode of inpatient care. There were 4,260,561 observations that were drawn from the sample of all general acute care hospitals in the Chicago PMSA.⁴⁶

⁴⁴ Ordinary least squares regression was used to estimate the model. To address the issue of cross-hospital heteroskedasticity and within-hospital autocorrelation the standard errors were estimated using clustered-robust estimates of variance. For a discussion of ordinary least squares, see Green (2011).

⁴⁵ A second set of regressions used data from the Illinois Department of Public Health's "Universal Dataset" on inpatient data from all hospitals in Illinois. The results of these regressions were consistent with those reported in the text and in Table 4–1.

⁴⁶ In addition, regressions were run using smaller samples that were limited to the more restricted categories of Chicago PMSA hospitals that were mentioned in the text as control groups. The results of these regressions were consistent with those reported in Table 4–1.

Estimates of the Competitive Effects

The estimated coefficient of primary interest is b_2 , which approximately measures the difference between the price change at the merging hospitals and the average price change across the control hospitals, holding constant the other factors.⁴⁷ One factor held constant was the complexity of, and thus the cost to treat, each inpatient admission into a hospital (case-mix). The government measured case-mix in at least six ways. The results reported in Table 4-1 show the relative price increases at ENH holding constant case-mix measured in two of these six ways:⁴⁸ The first measure was based on the "Diagnostic Related Group" (DRG) classification system, which consisted of roughly 500 groups of diagnoses that are used by the federal government to determine reimbursements for Medicare patients. These groups are constructed so that, within each group, the resources required to treat patients are similar. Accordingly, the first measure of patient mix was the government's estimate of the costs of treating a case in each DRG relative to the cost of treating the average case, and this estimate is called the DRG weight.

The second measure of case-mix relied on a similar system that was developed by 3M Health Information Systems and includes approximately 300 groups of diagnoses called All Patient Refined DRGs (APRDRG).⁴⁹ Within each APRDRG, each case is ranked from one to four based on severity of illness, and thus resource use.

Depending on the control group and the measure of case-mix, the estimated relative price increases at ENH ranged from 21 to 35 percentage points for Payer A, 16 to 33 percentage points for Payer B, 47 to 79 percentage points for Payer D, and 11 to 28 percentage points for Payer E.⁵⁰ Only Payer C was able to negotiate similar price increases at ENH and other local hospitals. (The identities of the payers are protected by confidentiality agreements.)

These estimates show that four of the five largest third-party payers experienced large and statistically significant price increases at the merged hospital relative to control hospitals. The results are robust across the alternative control groups of hospitals and the alternative methods for controlling for the complexity of an inpatient admission.

⁴⁷ More specifically, $b_2 = (\text{the post-merger price at ENH} - \text{the pre-merger price at ENH}) - (\text{the average post-merger price at the control hospitals} - \text{the average pre-merger price at the control hospitals})$.

⁴⁸ The results in the table are drawn from five separate regressions for the five payers in which the two relative cost measures of DRGs are used to control for the complexity of an inpatient admission. Alternative complexity control measures yielded similar results. See Haas-Wilson and Garmon (2011) for further discussion.

⁴⁹ Also, measures of a patient's length of stay were tried.

⁵⁰ Table 4-1 shows a subset of the empirical results and, thus, does not include the full range of estimates.

TABLE 4-1
Estimated Post-Merger Percentage Price Increase by Control Group, Case-Mix, and Third-Party Payer

Case-Mix =	DRG Weights	APRDRG Weights
Control = Chicago PMSA Hospitals		
Payer A	22.3***	23.1***
Payer B	21.3***	17.2***
Payer C	0.4	-0.8
Payer D	58.6***	55.7***
Payer E	15.4***	11.0***
Control = Non-Merging Chicago PMSA Hospitals		
Payer A	33.1***	35.1***
Payer B	30.1***	26.5***
Payer C	5.5**	3.8*
Payer D	68.9***	64.9***
Payer E	28.0***	20.1***
Control = Chicago PMSA Teaching Hospitals		
Payer A	24.0***	24.9***
Payer B	20.2***	16.3***
Payer C	0.3	-0.8
Payer D	51.2***	50.1***
Payer E	13.9***	12.2***

Significance level: *** = 1%; ** = 5%; * = 10%.

Source: Haas-Wilson and Garmon (2011, p. 27).

As was mentioned above, even ENH's economic expert found post-merger price increases at ENH that exceeded the price increases at control hospitals.

EXPLANATIONS OF ENH'S RELATIVELY LARGER POST-MERGER PRICE INCREASES

The FTC's and ENH's similar estimates of post-merger price increases eliminated any potential dispute over whether after the merger ENH was able to negotiate significantly higher prices with third-party payers, relative to other local hospitals. ENH did not contest this.

Instead, the disagreement was over the cause of these relatively larger post-merger price increases. The government maintained that the relatively higher post-merger price increases at ENH were the result of ENH's gaining market power as a result of the merger. ENH maintained that the relatively higher post-merger prices at ENH were the result of multiple factors, including increases in the clinical quality of care at HPH and "learning about demand."

The FTC concluded that the substantially higher-than-predicted post-merger price increases at ENH were the result of ENH's exercising market power created by the merger. This conclusion was based on the competitive effects analyses that ruled out other explanations for the relatively larger post-merger price increases at ENH and on business documents. For example, one ENH document explained the Evanston merger as the answer to the "pricing pressures" from health plans: "Strengthen negotiation capability with managed care companies through merged entities. Commit with single signature/one voice to market place. Make 'indispensable' to market place."⁵¹ An HPH document saw the Evanston merger as a way to "push back" health plans and "get the rates back to where they ought to be" because "it would be real tough for any of the Fortune 40 companies in this area whose CEOs either use this place or that place to walk from Evanston, Highland Park, Glenbrook and 1700 of their doctors."⁵² After the merger ENH's CEO reported to the Board an additional \$24 million in higher revenue from renegotiated contracts with health plans and then concluded, "none of this could have been achieved by either Evanston or Highland Park alone. The 'fighting unit' of our three hospitals and 1,600 physicians was instrumental in achieving these ends."⁵³

ENH, on the other hand, offered alternative explanations for the larger relative price increases at ENH. Specifically, they maintained that the larger post-merger prices at ENH were due to procompetitive or competitively benign causes, such as improvements in quality and Evanston Hospital's "learning about demand."⁵⁴

The "learning about demand" argument went as follows: Coincident with the merger, Evanston learned (by reviewing HPH's contracts with third-party payers and hiring Bain Consulting for advice regarding contracting with third-party payers) that HPH was being reimbursed at more favorable rates on some contracts. Since some of the hospital services at Evanston were more complex than those at HPH, Evanston claimed that its pre-merger prices were below competitive prices. Further, for many years prior to the merger Evanston had not negotiated higher reimbursement rates

⁵¹ Complaint Counsel's Post Trial Brief in the Matter of Evanston Northwestern Healthcare Corp., Docket No. 9315 (June 5, 2006) at 6.

⁵² *Ibid* at 6.

⁵³ The Opinion of the Commission at 17.

⁵⁴ See Adams and Noether (2011).

with third-party payers. Thus ENH merely raised its prices to competitive levels. According to the learning-about-demand argument, ENH was able to increase its prices at a higher rate after the merger because ENH's pre-merger prices were below equilibrium prices.

Other defenses that were offered by ENH included: (1) HPH was in a deteriorating financial condition before the merger (for example, ENH maintained that HPH had operating losses of over \$3 million in 1999);⁵⁵ (2) HPH's improved post-merger financial strength made it a more potent competitor; (3) ENH's nonprofit status reduced the potential for anticompetitive harm (for example, ENH is deeply committed to the community and most of ENH's board members live in the community); and (4) from a geographic perspective Evanston and HPH were not close substitutes (for example, 18 hospitals are closer to Evanston or HPH than Evanston and HPH are to each other).⁵⁶

Economic research has not supported the notion that nonprofit hospitals will not exercise market power. With the exception of two studies by one set of authors, the results of five empirical studies by five different sets of authors suggest that nonprofit hospitals do exercise market power in less competitive markets.⁵⁷ This is especially important because in two challenges to hospital mergers, the notion that nonprofit hospitals (compared to for-profit hospitals) might be less likely to exercise market power influenced the courts' decisions.⁵⁸ In this case, however, the ALJ found that ENH's nonprofit status was "irrelevant" based on evidence, such as the board at ENH not monitoring the pricing decisions of hospital management and ENH's contracts "did not align managements' interests with consumers on the issue of price."⁵⁹

ENH contended that the merger resulted in quality improvements and new services at the acquired hospital and that these quality improvements enhanced HPH's ability to compete with other local hospitals. More specifically, before the merger HPH had systemic quality-of-care problems, such as no in-house evening obstetrics coverage and problems getting physicians to respond to emergency calls.⁶⁰ ENH corrected these and other quality problems by changing the governance structure, bringing the benefits of a teaching hospital, and spending \$120 million on renovations, new

⁵⁵ ENH did not claim that HPH was a failing firm.

⁵⁶ Post-Trial Brief of Respondent in the Matter of Evanston Northwestern Healthcare Corp., Docket No. 9315 (December 20, 2005).

⁵⁷ See Lynk (1995); Lynk and Neumann (1999); Simpson and Shin (1998); Dranove and Ludwick (1999); Keeler, Melnick, and Zwanziger (1999); Young and Desai (2000); and Vita and Sacher (2001).

⁵⁸ *FTC v. Freeman Hospital* No. 95-5015-CV-SW-1, 1995 WL 462226 (W.D. Mo., June 5, 1995); and *FTC v. Butterworth Health Corporation and Blodgett Memorial Medical Center* 1996-2 Trade Cases 71, 571; 1996 QL 570479 (W.D. Michigan, September 26, 1996).

⁵⁹ The Initial Decision at 193.

⁶⁰ Post-Trial Brief of Respondent at 4.

equipment, and improved staffing at HPH.⁶¹ Further, ENH built a cardiac catheterization lab in order to bring a new interventional cardiology program at HPH and opened a cancer care center at HPH.⁶²

To rule out the higher-quality argument the FTC analyzed pre- and post-merger quality at ENH and other local hospitals using the same difference-in-differences methodology that was employed for the price analysis.⁶³ Quality was measured principally by patient outcomes, such as inpatient mortality for surgical procedures and potentially avoidable complications and iatrogenic events.⁶⁴ Based, in part, on these analyses, the ALJ found “no evidence of improvements in overall quality of care relative to other hospitals.”⁶⁵ Similarly, the Commission concluded that ENH “failed to show that quality improved across the combined ENH system and relative to other hospitals.”⁶⁶ Further, there was evidence that suggested that any quality improvements at HPH were not merger-specific. Strategic planning documents from 1998 (two years prior to the merger) showed that HPH’s parent company planned to start a cardiovascular surgery program, start a comprehensive oncology program, enhance physician leadership, and make other service and quality improvements.

Counsel for ENH claimed that it could show empirically that the post-merger price increases at ENH were the result of “learning about demand,” rather than market power, by examining average pre- and post-merger price levels at ENH relative to a control group of six “academic” hospitals. Their argument was that if the FTC’s market power explanation for the relatively greater post-merger price increases at ENH was correct, then Evanston’s pre-merger price levels should be equal to the pre-merger prices at other academic hospitals and ENH’s post-merger prices should be higher than those at other academic hospitals. On the other hand, if “learning about demand” accounted for the relatively greater post-merger price increases at ENH, then one would expect to observe lower pre-merger prices and equal post-merger prices at ENH, relative to other academic hospitals.

ENH used regression analysis to compare ENH’s post-merger average price levels with the average price levels at the six hospitals that ENH claimed to be their most similar competitors. ENH estimated the average difference in prices between Evanston and the academic hospitals, controlling for differences in case-mix across hospitals, for each year. The results suggested that ENH’s average price (across the four third-party payers in the

⁶¹ Post-Trial Brief of Respondent at 4.

⁶² Post-Trial Brief of Respondent at 14.

⁶³ See, e.g., Romano and Balon (2011) for additional discussion of measuring quality changes in the Evanston merger.

⁶⁴ An iatrogenic event occurs when a patient acquires a new illness or injury because of the medical services provided.

⁶⁵ The Initial Decision at 173.

⁶⁶ The Opinion of the Commission at 83.

sample) did not exceed the average level at the six hospitals in the academic control group.

ENH’s test might have been valid if it had used a better control group of hospitals. The control group should include only those hospitals that were very similar to the merging hospitals before the merger (e.g., same quality of care, same number of beds, same breadth of services) and after the merger except for the ENH hospitals’ merger.⁶⁷ ENH, however, claimed it was comparable to a group of academic hospitals that included the most expensive teaching hospitals in Chicago. This claim was inconsistent with the evidence. In particular, four of the six control hospitals provided significantly more complex care than did ENH, such as severe burn care and transplants of the liver and kidney; all six of these hospitals offered a broader range of services than did ENH; four of the six hospitals had much higher teaching intensity than did ENH; and all of the control hospitals had more beds than did ENH.

With respect to the argument that the merger was necessary to strengthen HPH’s financial position, the ALJ wrote “The evidence demonstrates that Highland Park’s premerger financial condition was essentially sound.”⁶⁸

THE REMEDY

The Evanston merger was found to substantially lessen competition in violation of Section 7 of the Clayton Act. Accordingly, the ALJ was obligated to order effective relief, and the purpose of such relief is to “undo the probable anti-competitive effects of the unlawful merger, to restore competition to the state in which it existed at the time of the merger, or to the state in which it would be existing at the time the relief is ordered.”⁶⁹

Complaint Counsel argued that the appropriate relief was a structural remedy: full divestiture of HPH. ENH, not surprisingly, proposed two alternative remedies—imposition of a “prior notice” order that would obligate ENH to notify the FTC of any plans to acquire additional general acute care hospitals and a conduct remedy that would require Evanston and HPH to negotiate separately with third-party payers.

ENH claimed that divestiture of HPH would harm local consumers in multiple ways. First, divestiture would decrease the rate of quality improvements at HPH. Second, divestiture would eliminate cardiac surgery and interventional cardiology services at HPH, the benefits of the electronic

⁶⁷ Only in this special case might it be possible to distinguish between the market power and “learning about demand” explanations by comparing post-merger price levels. For a critique of the “learning about demand” defense in retrospective merger cases, see, e.g., Balan and Garmon (2008) and Garmon and Haas-Wilson (2011).

⁶⁸ The Initial Decision at 196.

⁶⁹ *Retail Credit Co.* 92 F.T.C. at 161.

medical record system, and the benefits that were associated with HPH's physicians having academic affiliation with Evanston.

The ALJ concluded that "... only full divestiture of Highland Park can be expected to effectively restore competition in the market."⁷⁰ The Commission disagreed with the ALJ on the appropriate remedy. In its 5-0 decision the Commission ruled that a conduct remedy was preferable to a structural remedy in this case, in part, because of the long time that lapsed between the merger and the conclusion of the litigation. The conduct remedy required ENH to establish separate and independent negotiating teams—one for Evanston and Glenbrook Hospitals, and another for Highland Park. In other words, the Commission allowed ENH to remain intact as long as the hospitals independently set prices.

The Commission's remedy was most likely to be ineffective in curbing ENH's anticompetitive conduct, and thus ineffective in restoring competition to the market. Even though the hospitals were required to negotiate separately with third-party payers, at the end of the day both Evanston and HPH report to the same hospital administrators and thus there was (and still is) ample opportunity for communication and coordination over prices. Further, even in the absence of coordination, there was little incentive for Evanston or HPH to negotiate competitive prices. If HPH insisted on high prices and consequently a third-party payer excluded HPH from its network, enrollees of the third-party payer would most likely seek hospital treatment at Evanston. The possibility of diversion of patients to other system hospitals reduced the likelihood that the Commission's remedy curbed anticompetitive behavior.

CHALLENGES TO HOSPITAL MERGERS AFTER EVANSTON

The strong evidence of ENH's exercise of market power following the merger renewed the FTC's commitment to hospital merger enforcement. Since *Evanston* the FTC has challenged four additional hospital mergers:

In May of 2008 the FTC and the Attorney General of Virginia challenged the proposed merger of a five-hospital system and an independent hospital. The FTC alleged that the merger would reduce competition for general acute-care inpatient services in northern Virginia. According to data in the complaint, the merger would reduce the number of competitors from six to five hospitals, and the merged hospital would control 73 percent of the hospital beds in northern Virginia.⁷¹ While this case did not go to trial, the merger was successfully blocked. Approximately one month after the

⁷⁰ *Ibid* at 206.

⁷¹ *In the Matter of Inova Health System Foundation and Prince William Health System, Inc.*, FTC Docket No. 9326. Complaint (May 9, 2008) at 6.

Complaint was issued the hospitals announced their decision to terminate their plans to merge, and the FTC dismissed the Complaint.⁷²

In January of 2011 the FTC and the Attorney General of Ohio challenged the consummated merger of a three-hospital system (ProMedica Health System) and a formally independent hospital (St. Luke's Hospital).⁷³ The FTC alleged that the acquisition threatened to substantially lessen competition in two product markets: the market for general acute-care inpatient services and the market for inpatient obstetrical services (services provided for labor and delivery of newborns) in Lucas County, Ohio. The FTC justified the more narrow product market on the basis that no other hospital services are a substitute for inpatient obstetric services and that there are unique competitive conditions in this market. The merger reduced the number of competitors in the broader market from four to three and increased the Herfindahl-Hirschman Index (HHI) from 3312 to 4391: an increase of 1079 points. In the market for inpatient obstetric services the merger reduced the number of competitors from three to two and increased the HHI from 5531 to 6854: an increase of 1323 points.⁷⁴ Under the 2010 *Merger Guidelines* a merger is presumed likely to create or enhance market power when the post-merger HHI is greater than 2500 and the merger increases the HHI by more than 200 points.

In the ProMedica case, unlike the Evanston case, the Commission held that the merger was likely to lessen competition and ordered divestiture.⁷⁵ The parties appealed the Commission's decision to the U.S. Court of Appeals for the Sixth Circuit in May of 2012, so the final chapter has not yet been written.

Just three months after the FTC filed the Complaint challenging the ProMedica merger, the FTC and the Attorney General of Georgia challenged the proposed joint operation (effective merger) of the only two hospitals in Albany, Georgia. The FTC wrote that the proposed joint operation would create "a virtual monopoly for inpatient general acute care services sold to commercial health plans."⁷⁶ Further the FTC alleged that the merging parties structured the deal in a particular way to shield it from antitrust scrutiny under the state-action doctrine. State-action immunity doctrine holds that activities that are approved and monitored by the state are exempt from federal antitrust laws. The Eleventh Circuit noted that the joint opera-

⁷² *In the Matter of Inova Health System Foundation and Prince William Health System Inc.*, FTC Docket No. 9326, Joint Motion to Dismiss Complaint (June 11, 2008).

⁷³ The merger occurred in August of 2010.

⁷⁴ *In the Matter of ProMedica Health Systems, Inc.*, Docket No. 9346. Complaint (January 6, 2011) at 6.

⁷⁵ *In the Matter of ProMedica Health Systems, Inc.*, Docket No. 9346. Opinion of the Commission (June 25, 2012).

⁷⁶ *In the Matter of Phoebe Putney Health System, Inc., Phoebe Putney Memorial Hospital, Inc., Phoebe North, Inc., HCA Inc., Palmyra Park Hospital, Inc., Hospital Authority of Albany-Dougherty County*, Docket No. 9348. Complaint (April 20, 2011) at 2.

tion of these two hospitals would substantially lessen competition or tend to create a monopoly, but ruled that this anticompetitive conduct is immunized by the state-action doctrine.⁷⁷ The FTC appealed to the Supreme Court, and in February 2013 Court ruled in favor of the FTC—i.e., that the joint operation of the hospitals was not shielded by the state-action doctrine—and remanded the case back to the lower court for further consideration.⁷⁸ Again, the final chapter has not yet been written.

In November of 2011 the FTC challenged the proposed merger of two hospitals in Rockford, Illinois. The FTC alleged that the merger would lessen competition in two product markets: the market for general acute-care inpatient hospital services that are sold to commercial third-party payers and the market for primary care physician services that are sold to commercial third-party payers. As a result of the merger both the number of general acute-care hospitals and the number of hospital-employed physician groups would fall from three to two in the Rockford area. Accordingly, the merged entity would gain bargaining leverage in its negotiations with third-party payers, and there would be a greater risk of coordination among the two remaining systems. As in the FTC's 2008 challenge, the hospitals decided to abandon their plan to merge, and the Commission dismissed the Complaint.

HEALTH CARE REFORM, ACCOUNTABLE CARE ORGANIZATIONS, AND ANTITRUST POLICY

Since the Evanston case there have been new developments with important implications for competition in markets for hospital (and physician) services. The Patient Protection and Affordable Care Act of 2010⁷⁹ (PPACA) seeks to lower health care costs and increase quality, in part, by encouraging health care providers to become accountable for patients and to form integrated health care delivery systems. More specifically, the PPACA encourages the establishment of Accountable Care Organizations (ACOs) and not only authorizes but also provides incentives for otherwise independent hospitals, physicians, and other health care providers to collaborate.

ACOs have the potential to be both pro-competitive and anticompetitive. They raise the usual issues that are associated with joint ventures among competitors, such as whether the ACO could facilitate the exercise of market power and whether the ACO could become a vehicle for

⁷⁷ *In the Matter of Phoebe Putney Health System, Inc. et al*, Appeal from the US District Court for the Middle District of Georgia (December 9, 2011).

⁷⁸ *FTC v. Phoebe Putney Health Systems, Inc.*, 133 s. ct. 1003 (2013).

⁷⁹ The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 through 124 Stat. (2010).

collusion.⁸⁰ Accordingly, the FTC and the DOJ issued an antitrust enforcement Policy Statement with respect to ACOs.⁸¹ The Policy Statement does not apply to mergers, but instead provides guidance to the otherwise independent providers that constitute the ACO. The Policy Statement creates an antitrust safety zone. ACOs that fall within this safety zone will not be challenged under the antitrust laws. To fall within the safety zone, the independent members of the ACO who provide the same service (for example, orthopedists all provide orthopedic physicians services) must have a combined market share of 30 percent or less. For ACOs that fall outside the safety zone, the Policy Statement provides guidance as to the types of practices that will be evaluated to determine whether an ACO is a legitimate joint venture or is illegal under the antitrust laws.

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⁸⁰ For additional discussion of the issues, see Scheffler, Shortell, and Wilensky (2012).

⁸¹ The Federal Trade Commission and Department of Justice "Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program." 76 Fed. Reg. 67,026 (October 28, 2011).

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