

## ARTICLES AND BOOKS

### *Summary of Evanston Initial Decision*

February 2006

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On October, 20, 2005, The Federal Trade Commission's ("FTC") Chief Administrative Law Judge, Stephen J. McGuire ("ALJ"), issued an Initial Decision finding that Evanston Northwestern Healthcare Corporation's ("Evanston") acquisition of Highland Park Hospital ("Highland Park") violated § 7 of the Clayton Act. The ALJ ordered Evanston to divest itself of Highland Park within 180 days of the ALJ Order becoming final.<sup>1</sup> As explained in more detail below, the ALJ found that Evanston and Highland entered into the transaction with the purpose and intent of raising prices to managed care organizations. Because of the greater market power that Evanston obtained as a result of the transaction, the ALJ found that the merged entity was able to raise prices significantly to managed care organizations.

Historically, the antitrust agencies (the FTC and the U.S. Department of Justice) have challenged hospital mergers prospectively, based on the anticipated effects of the merger. Following an unbroken string of government losses in prospective hospital merger cases since the mid-1990s, the FTC announced a new hospital merger retrospective review program in August of 2002, whereby the FTC would begin reviewing completed hospital mergers and acquisitions and would seek to dissolve any mergers that the FTC believed had produced anticompetitive effects. Not surprisingly, the announcement raised significant concern within the hospital industry. In the months that followed, rumors of several retrospective investigations, including the FTC's investigation of Evanston's acquisition of Highland Park, began to surface.<sup>2</sup> After many months of investigation, Evanston's acquisition of Highland Park became the FTC's first retrospective challenge of a completed hospital merger and, importantly, the first retrospective examination of the actual competitive effects of a hospital merger.

Although the ALJ's conclusions in this case are important, it is the ALJ's analysis of the relevant market, and the role of patient flow analysis and the Elzinga-Hogarty test in defining the relevant geographic market, that are potentially far-reaching in their impact. The ALJ's conclusions regarding the relevance of patient flow analysis and the Elzinga-Hogarty test are likely to have a significant impact on geographic market definition in hospital merger cases and other health care cases. The ALJ's Decision specifically declares patient flow analysis and the Elzinga-Hogarty

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<sup>1</sup> The ALJ also dismissed as moot, Count II of the Complaint in which the FTC had charged that the direct effects of the acquisition established the illegality of the acquisition without the need to establish a relevant market. Within a day, Evanston filed notice of its intent to appeal all aspects of the ALJ's decision to the FTC itself, and the FTC Staff (complaint counsel) subsequently also filed notice of its intent to appeal the dismissal of Count II along with certain findings of the ALJ.

<sup>2</sup> Because the FTC's investigations are non-public, very little information was available about the FTC's retrospective reviews, unless the hospitals involved confirmed the existence of an FTC investigation.

test irrelevant in defining the relevant geographic market in hospital merger cases. However, a careful reading of the Initial Decision reveals that while the ALJ explicitly rejected any relevance of patient flow analysis to determining hospital geographic markets, his discussion of managed care competition demonstrated the continued relevance of patient flow data, if used correctly. Although patient flow data and analyses have appeared to play a determinative role in many of the hospital merger cases decided over the last ten years, the correct use of patient flow analysis has always been, and will continue to be, as a useful, albeit preliminary, tool in understanding hospital markets and competition.

## **Background**

On February 10, 2004, the FTC announced that it had issued an administrative complaint against Evanston (the “Complaint”), charging that Evanston’s January, 2000 acquisition of Highland violated Section 7 of the Clayton Act. The FTC’s Complaint alleged that following the acquisition, the hospitals (Evanston Hospital, Glenbrook Hospital, and Highland – all of which are located in the Evanston, Illinois area) increased their prices to managed care plans significantly (from 15% to 190%); forced many managed care plans to change their reimbursement methods to discounts off hospital charges; substantially increased their costs; and engaged in a *per se* illegal price-fixing agreement among physicians employed by the hospitals and independent physicians on the hospitals’ medical staffs.<sup>3</sup> The Complaint also alleged that the relevant geographic market was an area covering “the densely populated suburban corridor that runs for about 15 miles north-south along the shore of Lake Michigan, and extends roughly ten miles west of the Lake.”

The trial (administrative hearing) began on February 10, 2005 – one year after the Complaint was filed – and lasted for 8 weeks. Over 1600 exhibits were admitted and forty-two witnesses testified in person. From May 20, 2005 to June 24, 2005, the parties filed post-hearing briefs, replies and findings of fact. The ALJ heard closing arguments on July 7, 2005 and rendered his Initial Decision on October 20, 2005.<sup>4</sup>

## **Summary of the ALJ’s Decision**

The ALJ’s Initial Decision highlights a number of important issues and legal principles that apply to all hospitals and health care companies. Some of the most significant antitrust principles involved in the Evanston case are: the applicability of antitrust laws to post-merger conduct; the realistic threat of divestiture as a remedy to anticompetitive mergers and acquisitions; the implications of achieving (or not achieving) economic unity under the Copperweld principle; and the proper role of patient flow data and analyses in hospital merger cases. It is this last point – the proper role of patient flow analysis – that is the focus of this paper. Although some aspects of the Initial Decision are similar to other hospital merger cases,

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<sup>3</sup> The FTC and Evanston settled the Count related to the physician price-fixing charges before the case went to trial.

<sup>4</sup> The ALJ’s ruling is officially termed an Initial Decision. The Initial Decision is an advisory decision that the FTC may adopt, modify, reject or ignore altogether. In other words, the FTC may adopt some or all of the ALJ’s decision, or start over from scratch and essentially repeat the entire trial if it so chooses. The ALJ’s decision is subject to review by the FTC on its own initiative, or at the request of either party (in this case Evanston or Complaint Counsel). Once the FTC renders its decision, assuming it is adverse to the hospitals, Evanston may appeal the FTC’s decision to a U.S. Circuit Court of Appeals, probably the 7<sup>th</sup> Circuit.

the ALJ's ruling (and the FTC's strategy) are different from earlier cases in some important respects.

The relevant product market was primary, secondary, and tertiary general acute care inpatient hospital services sold to managed care organizations. Although hospital merger cases have routinely focused on managed care as the area of greatest potential competitive effect, in the past the product market typically has included all of the hospital's inpatient acute care hospital services. By identifying hospital services sold to managed care organizations as a separate and relevant submarket, the ALJ effectively rendered the impact on managed care the only relevant issue, which provided the theoretical basis for ignoring (at least ostensibly), patient flow data and analyses, including the Elzinga-Hogarty test.

The ALJ determined that the relevant geographic market was a relatively small geographic area encompassing only seven (7) hospitals in the densely-populated northwestern suburbs of Chicago: Evanston, Glenbrook, Highland Park, Lake Forest, Advocate Lutheran General, Rush North Shore, and St. Francis hospitals. It is unlikely that such a narrow geographic market could be supported based on patient flow analysis alone. However, the evidence of the hospitals' intent, their ability to raise prices significantly following the merger, and the views of hospital personnel and managed care representatives regarding the lack of practical alternatives to the merged hospitals provided significant support for the finding of a narrow geographic market. Consequently, even though the evidence of price increases may not appear to be directly relevant to the question of whether or not patient flow analysis can or should be used to define a geographic market, understanding the competitive effects evidence in this case is important in understanding why the ALJ ignored patient flow data, and how patient flow data can, and should be used. Of course, the ALJ's analysis begs the question as to whether or not the ALJ was using the pricing effects and other evidence to define the geographic market, or was defining a geographic market that was consistent with the pricing and other evidence.

The ALJ found that Evanston consciously and intentionally entered into the transaction with the primary purpose of obtaining negotiating leverage so that the hospitals could extract higher reimbursement from managed care organizations. Evanston was able to extract significant price increases (relative to other hospitals) from managed care organizations because of the increased market power created by the transaction. The ALJ stated that Evanston's ability to raise prices following the merger provided substantial evidence that Evanston's acquisition of Highland was anticompetitive.

Although the Initial Decision contained considerable discussion of Evanston's price increases, it is important to understand that price increases alone, do not render a hospital merger illegal. The ALJ identified three (3) factual elements needed for post-merger prices to establish that a merger or acquisition has substantially reduced competition, or is likely to substantially reduce competition. First, there must be evidence that the hospitals raised prices significantly above competitive levels, and that they were able to maintain those price increases. Theoretically, if a merger allowed the hospitals to avoid reducing their prices (e.g., giving managed care greater discounts), the lack of a price reduction would be equivalent to a price increase. Determining whether or not prices increased significantly above competitive levels is a relative determination, which is the second factual element identified by the ALJ.

It is difficult to determine what the merged hospitals' prices would be absent the transaction. Therefore, comparing the price increases at the merging hospitals against the price increases at a valid set of control hospitals probably provides the best approximation of competitive prices. The ALJ ruled that the appropriate method for measuring the price increase is to compare the merged hospitals' price increases to price increases at comparable hospitals over the same time period. Evanston raised its prices to managed care 11% to 18% higher than other comparable hospitals in the area. In other words, if other hospitals raised their prices 10%, Evanston raised its prices 21% to 28%. Although the FTC's expert and the hospitals' expert disagreed on the composition of the appropriate "control group," the ALJ noted that even Evanston's expert determined that Evanston had raised prices 9% to 10% higher than other hospitals.

Higher relative prices alone, are not enough. The evidence must demonstrate that factors other than an increase in market power cannot account for, or explain, the price increases. While comparing the merged hospitals' price increases to price increases at comparable hospitals should have accounted for any market-wide factors affecting pricing, the ALJ specifically examined eight factors other than market power that could have affected the merged hospitals' pricing: changes in costs; changes in regulations; changes in consumer demand; changes in quality (the hospitals also argued quality improvements as an affirmative defense); changes in outpatient prices; changes in patient mix; changes in customer/payor mix; changes in teaching intensity. The ALJ found that none of these factors could adequately explain the price increases at Evanston.

The merged hospitals' ability to successfully implement such significant price increases provided strong evidence that the merger had given the hospitals substantially greater market power than they possessed prior to the merger, irrespective of any patient flow analysis. Indeed, the hospitals apparently recognized the limited size of the relevant geographic market and lack of alternatives to the merged hospitals. Highland Park's President stated in 1999 that "I think 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." Similar views about the lack of viable substitutes if Evanston and Highland Park merged were shared by managed care representatives. The ALJ found that in spite of the significant price increases imposed following the merger, "[Evanston] lost no managed care organization customers over the course of the 2000 negotiations," except for One Health for a short period of time.<sup>5</sup>

It is against this backdrop of very substantial evidence of pricing effects and lack of practical alternatives to the merged hospitals that the ALJ ruled that patient flow analyses, including Elzinga-Hogarty test, are not appropriate for defining geographic markets in hospital merger cases, and perhaps other hospital antitrust cases. The ALJ went on to state that "[p]rior cases have traditionally relied on the Elzinga-Hogarty test and patient flow data to establish the geographic market for hospital services."<sup>6</sup> The ALJ noted that "[b]oth parties acknowledge the string of government losses in hospital merger cases over the last decade. In many of those

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<sup>5</sup> Initial Decision, page 50, ¶ 372.

<sup>6</sup> Initial Decision, page 138.

cases, the government's failure to prove a relevant geographic market within which a hospital merger would have anticompetitive effects was determinative."<sup>7</sup>

As the ALJ explained, "first stage" competition is for inclusion in managed care panels. The managed care organizations are the consumers in this stage and hospitals compete to be in the networks of managed care organizations. This is important because the hospital-managed care relationship determines hospital prices. Patient flow data and the Elzinga-Hogarty test are not appropriate for determining substitutability (i.e., the market) in competition for inclusion in managed care contracts because the focus is on inclusion in the network, not where patients actually receive care.

In addition to the ALJ's rejection of the Elzinga-Hogarty test, Dr. Kenneth G. Elzinga, co-creator of the test that bears his name and the FTC's expert witness in the Evanston case, specifically rejected the use of the Elzinga-Hogarty test and patient flow analysis in hospital merger cases. He identified a number of problems with the use of patient flow analysis and Elzinga-Hogarty test in hospital merger cases. First, the Elzinga-Hogarty test was developed for use in cases involving undifferentiated products; i.e., where the product is the same irrespective of the source of the product. However, hospital services are differentiated; i.e., services of one hospital are not the same as services of another hospital.

The primary assumption upon which the Elzinga-Hogarty test is based is that purchase decisions affect price. Since patients do not set, or even pay, most of the price of hospital services, patient willingness to travel does not reflect sensitivity to price. Therefore, the assumption of a causal connection between purchase (use) decisions and price is unwarranted. Moreover, the test assumes that all patients are equally willing and able to travel the same distance for services. In other words, the test assumes that if a small minority of patients are willing to travel a certain distance, all patients are willing to travel the same distance.

Following substantial discussion of the flaws of patient origin analysis, the ALJ ruled 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. . . . Therefore, factors such as market participant views, geographic proximity, travel times and physician admitting patterns are considered in making the geographic market determination."<sup>8</sup> Although such factors are clearly relevant to geographic market definition, the ALJ's categorical rejection of the relevance of patient flow analyses was overly broad, perhaps intentionally so.

In most of the prospective hospital merger cases that the FTC or DOJ have brought and lost in the last ten years, the government lost because of their failure to prove a relevant geographic market. In earlier cases in the late 1980s and early 1990s, the FTC and DOJ had been relatively successful in defining narrow geographic markets, and then showing that the resulting concentration created a presumption of illegality. Consequently, a rather simplistic view of hospital merger analysis appears to have developed: narrow market, government wins; broad market, government loses. Although antitrust theory has always recognized that patient flow analysis is only a starting point in defining geographic markets, in practice, patient flow analyses

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<sup>7</sup> Initial Decision, page 137.

<sup>8</sup> Initial Decision, pages 139 – 140.

showing that some patients traveled into, or out of, a market often was used as evidence that the market was bigger than the government had alleged, and therefore, the government had failed to prove its market. Thus, in practice, patient flow analyses that exploit the assumption that all patients are willing to travel the same distance became a relatively quick way to defeat the government's market definition, and thereby its case. In other words, patient flow analysis has come to be used in a prescriptive, rather than descriptive way, by requiring patient flow data to conclusively prove a geographic market.

The ALJ's specific finding that patient flow analysis is not relevant in determining the geographic market in hospital merger cases appears to be a direct response to the prescriptive use of patient flow analysis discussed above. The ALJ's categorical rejection of patient flow data notwithstanding, other portions of the ALJ's decision demonstrate that patient flow data is relevant to defining geographic markets and understanding the nature and extent of competition in the market. It is likely that the ALJ recognized that his findings regarding managed care competition implicitly reaffirmed the relevance of patient flow analysis, and that his explicit rejection of any relevance of patient flow analysis was a pragmatic decision intended to break the pattern of over-and misplaced-reliance on patient flow data.

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