I. INTRODUCTION

On October 20, 2006, the Administrative Law Judge (“ALJ”) presiding over the Federal Trade Commission ("FTC") case In re Evanston Northwestern Healthcare Corp. 1 issued an initial decision which granted the FTC a preliminary victory in its new strategy of “looking back” at consummated hospital mergers. Post-merger challenges attempt to use actual, instead of theoretical, empirical evidence to establish that the combined entity used its market power to lessen competition in violation of antitrust laws. The ALJ’s decision, while currently in the process of several layers of appeals, is significant because it adopts much of the FTC’s argument in support of the post-merger challenge, and could potentially impact future hospital mergers regardless of the ultimate outcome of the litigation.

This article will lay out the framework of the decision and the analysis used by the ALJ in ruling for the FTC, and will offer some potential implications on future hospital mergers as result of the decision. Section II provides background information on the recent hospital merger challenges and the new strategy adopted by the FTC regarding post-merger reviews. Section III sets up the background of the merger of Evanston Hospital, Glenbrook Hospital, and Highland Park Hospital to form Evanston

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Northwestern Healthcare ("ENH"). Section IV gives an analysis of the ALJ’s initial decision, which relies on empirical and contemporaneous post-acquisition evidence in holding that ENH exercised its post-merger market power to increase prices. Section V provides the groundwork for the next steps in the ENH litigation as it moves through the appeals process. Finally, Section VI explores some potential implications including the use of internal documents to prove intent and the rationale used during negotiations for post-merger price increases.

II. RECENT HOSPITAL MERGER CHALLENGES AND A NEW FTC STRATEGY FOR POST-MERGER REVIEWS

Hospital mergers, like other transactions, are generally challenged prior to consummation pursuant to the Hart-Scott-Rodino Act pre-merger notification guidelines.\(^2\) Challenges by the FTC or DOJ to the proposed merger typically occur during the waiting period required by the statute. Since the mid-1990s, the FTC and DOJ have lost all seven of their pre-merger challenges in hospital merger cases, including the well publicized Poplar Bluff case which was initially successful, but was ultimately overturned by the Court of Appeals for the Eighth Circuit.\(^3\) Due to the string of defeats, the agencies decided to review their litigation strategy, including the use of post-merger challenges.

In August of 2002, the FTC and the DOJ announced a joint task force responsible for, “reinvigorating the Commission's hospital merger program, which includes a review of, and potential challenge to, consummated transactions that may have resulted in

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\(^3\) Molly McDonough, *Looking Back at Hospital Mergers, FTC Reviews Mergers for Possible Antitrust Violations*, 1 No. 44 A.B.A. J. E-REPORT 3 (Nov. 15, 2002); see generally *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 (8th Cir. 1999) (holding that FTC failed to show that it was likely to succeed at trial because the evidence showed residents were already using other hospitals, and the merger would enable the merged hospitals to provide services that would increase competition).
anticompetitive price increases. In examining potential cases, then FTC Chair Timothy Muris said they are attempting to base cases on, “real-world empirical evidence, instead of hunches, guesswork, and theoretical predictions.” Additionally, the number or hospital mergers and amounts involved were also on the rise. In 2004, the number of hospitals acquired or merged rose 136 percent, to 130 from 55 in 2003 and the highest since 2000, when 129 hospitals were involved in mergers. The amount of dollars involved in hospital mergers is also increasing, nearly quadrupling to $9.1 billion in 2004 from $2.3 billion in 2003. In choosing the 2000 ENH merger as the initial test case, the FTC specifically choose a larger merger (valued at over $200 million), in a concentrated market, and where there was several years of actual price changes to use as evidence of potentially anticompetitive behavior.

III. BACKGROUND OF THE ENH MERGER AND COMPLAINT BY THE FTC THAT ENH SUBSTANTIALLY LESSENED COMPETITION IN VIOLATION OF SECTION 7 OF THE CLAYTON ACT

The merger agreement between Evanston and Highland Park was consummated in January 1, 2000; however, the roots of the merger went back as far as 1994 when the CEOs of both hospitals agreed that the hospitals should collaborate and use their leverage to get the best pricing. The first attempt at merger was in 1996 when Evanston, Highland Park, and Northwest Community Hospital began discussions of a proposed

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5 McDonough, supra note 39.
6 Bruce Japsen, Analysis Shows Jump in Hospital Mergers, CHICAGO TRIBUNE, Feb. 10, 2005 (citing study according to Irving Levin Associates Inc., a New Canaan, Conn. based publisher of health-care information).
7 Bruce Japsen, Final Volleys over Evanston Healthcare Merger; Decision Pending, CHICAGO TRIBUNE, July 8, 2005.
merger of the three hospitals into a new entity that would have been called NH North. The combined entity sought to achieve market influence and indispensability through product differentiation and cost leadership. A consulting firm used in the negotiations identified two key tactics that should be used by NH North to gain incremental market share which were: “(1) improved/coordinated physician recruitment and development; and (2) developing and leveraging brand name.” Ultimately negotiations broke down and the merger did not materialize.10

Evanston and Highland Park previously had been founding members, along with two other local hospitals, of the Northwestern Healthcare Network in 1989. This network allowed the member hospitals to continue to operate as independent entities, but enabled them to collectively negotiate with managed care organizations on capitated contracts. In capitated contracts the managed care organization paid the providers a fixed dollar amount per month in order to place the financial risk on the providers. However, while capitated contracts were present in the marketplace, they did not become as major of a factor as the hospitals had anticipated. Since each hospital in the network sustained separate administrations, separate staffs, and complete financial independence11, there were no difficulties in dissolving the network in 1999 once the costs of maintaining the network outweighed the benefits received.12

The ultimate merger between Evanston and Highland Park began discussions in late 1998 or early 1999. A letter of intent to merger was signed effective July 1, 1999,

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9 Id. at 8.
10 Id. at 9.
11 Id. at 9-12.
12 Id. at 13.
and the parties entered into an Agreement and Plan of Merger on October 29, 1999.\textsuperscript{13} At the time of the merger ENH was comprised of Evanston Hospital, Glenbrook Hospital, ENH Medical Group, ENH Research Institute, and ENH Homecare Services.\textsuperscript{14} The main entities of Evanston Hospital and Glenbrook Hospital had 400 and 125-150 beds respectively, and were approximately 12.6 miles and 26 minutes apart.\textsuperscript{15} Both provided a wide variety of inpatient and outpatient services, but Glenbrook Hospital did not provide obstetrics services.\textsuperscript{16} Highland Park is located 13.7 miles and 27 minutes north of Evanston Hospital, and had approximately 150-200 beds and 562 physicians on staff in 1999.\textsuperscript{17} Prior to the merger, Highland Park offered a variety of services including: obstetrical services, diagnostic services, nursing facility, fertility center, psychiatric care, neurosurgery, radiation therapy, cardiology services, an oncology program, and a level II trauma center. Other entities included in the merger were the Highland Park Hospital Foundation, Lakeland Health Ventures, and a 50 percent stake in Highland Park Healthcare.

Since the merger all three ENH hospitals have operated as a single entity with all corporate activities being consolidated in Evanston.\textsuperscript{18} All corporate functions were eliminated from Highland Park including human resources, purchasing, payor contracting, business office, and information systems. ENH also instituted a single billing and office system which coordinated the registration, scheduling, and billing for all three hospitals. Additionally, the Healthcare Foundation of Highland Park was created on January 1, 2000, with the purpose of fostering support for ENH in the

\textsuperscript{13} Id. at 14.
\textsuperscript{14} Id. at 5.
\textsuperscript{15} Id. at 5-6.
\textsuperscript{16} Id. at 6.
Highland Park community and to partially compensate the community for the loss of control to ENH.\textsuperscript{19}

On February 10, 2004, the FTC filed its complaint challenging the merger asserting that the consummated merger had substantially lessened competition.\textsuperscript{20} The complaint contained three counts: count I alleged that the merger substantially lessened competition in the alleged relevant product and geographic market in violation of Section 7 of the Clayton Act; count II alternatively alleged that the merger substantially lessened competition, but did not allege a relevant product or geographic market; and count III which alleged that ENH Medical Group, Inc., violated Section 5 of the Federal Trade Commission Act and was resolved by a consent agreement on May 17, 2005.\textsuperscript{21} The trial began on February 10, 2005 and lasted eight weeks.\textsuperscript{22} The initial decision was filed on October 20, 2005.\textsuperscript{23}

IV. ALJ'S INITIAL DECISION HOLDING THAT ENH USED ITS POST-MERGER MARKET POWER TO INCREASE PRICES ABOVE PRE-MERGER PRICES AND COMPARISON HOSPITALS

The ALJ’s initial decision purports to follow the traditional Clayton Act approach of defining the relevant product and geographic market, and then analyzing whether anticompetitive effects are probable using market concentration statistics.\textsuperscript{24} However, the

\textsuperscript{17} \textit{Id.} at 7.
\textsuperscript{18} \textit{Id.} at 14.
\textsuperscript{19} \textit{Id.} at 15.
\textsuperscript{20} \textit{Id.} at 2.
\textsuperscript{21} Initial Decision, supra note 1, at 3; \textit{In re Evanston Northwestern Healthcare, Corp.}, F.T.C. Docket No. 9315, Agreement Containing Consent Order to Cease and Desist (Apr. 5, 2005) available at http://www.ftc.gov/os/adjpro/d9315/050405agreed9315.pdf.
\textsuperscript{22} Initial Decision, supra note 1, at 3.
\textsuperscript{23} \textit{Id.} at 225.
\textsuperscript{24} \textit{Id.} at 1.
ALJ had the benefit of post-acquisition evidence which allowed it to reach what some might consider a non-traditional outcome.

A. Relevant Product Market Defined as General Acute Care Impatient Services Sold to Managed Care Organizations

The ALJ determined that the relevant product market in this case was, “general acute care inpatient services sold to managed care organizations, which includes primary, secondary, and tertiary impatient services.” In making this determination, the ALJ accepted the product market proposed by counsel for the FTC, and rejected the inclusion of outpatient services as requested by ENH. Courts have typically refused to include outpatient services based on the rationale that other entities cannot provide most acute impatient care, thus hospitals have no competition for providing that type of specialized care. Since there is no ability to interchange inpatient care for outpatient care, managed care organizations do not have the ability to switch the type of service provided.

The ALJ also accepted evidence that prices for inpatient services are not dependant on prices for outpatient services. Evidence indicated that ENH, “set inpatient rates independent of its outpatient rates and without concern that patients would switch to outpatient services.” The ALJ further rejected the demand-side analysis theory presented by ENH which examines the products sold by the merging firms, and argues that when the products are purchased together they should be considered part of the relevant

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25 Id. at 135.
26 Initial Decision, supra note 1, at 133, see e.g FTC v. Freeman Hosp., 69 F.3d 260, 268 (8th Cir. 1995); FTC v. University Health, 938 F.2d 1206, 210-11 (11th Cir. 1991); United States v. Rockford Memorial Corp., 898 F.2d 1278, 1284 (7th Cir. 1990); FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1290-91 (WD. Mi. 1996); Long Island Jewish Med. Ctr., 983 F. Supp. at 139; In re Hospital Corp. of Am., 106 F.T.C. 361, 464-66 (Oct. 25, 1985), aff’d, Hospital Corp. of Am. v. FTC, 807 F.2d 1381 (7th Cir. 1986) (all courts refusing to expand the relevant product market to include outpatient services).
27 Initial Decision, supra note 1, at 133 (citing Hospital Corp. of Am. v. FTC, 807 F.2d at 1388).
product market. In doing so, the ALJ relied on the decision of the Court of Appeals for the Seventh Circuit in *United States v. Rockford Memorial* when it held that the common provider of a hospital does not make inpatient and outpatient services part of the same product market.

**B. Relevant Geographic Market Included Seven Local Hospitals Based on Market Participant View, Geographic Proximity, Travel Times, and Physician Admitting Patterns; But Not Patient Flow Data**

When determining the relevant geographic market, the ALJ settled on a market of seven hospitals in suburban Chicago: the three directly involved in the merger (Evanston, Glenbrook, and Highland Park), Lake Forest Hospital, Advocate Lutheran General, Rush North Shore, and St. Francis Hospital. Local hospitals are generally preferred when employers select managed care plans, and the ALJ felt it reasonable that managed care organizations could conceivably create a network excluding the three ENH hospitals if they included the next set of proximately close hospitals where customers could seek “practical alternative” acute care inpatient services. In making this determination, the ALJ typically must complete a dynamic, “forward looking” analysis, which considers potential competitive responses from hospitals, managed care organizations, and consumers (patients). In this case, post-merger evidence demonstrated that managed care organizations were unable to selectively contract or steer patients to other hospitals to avoid price increases by ENH because patients continued to want the local hospitals in their managed care plans.

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28 *Id.* at 134.
29 *Initial Decision,* supra note 1, at 134 (citing *Rockford Memorial Corp.*, 898 F.2d at 1280).
30 *Id.* at 149.
31 *Id.* at 137.
Most courts have traditionally focused on patient flow data as the statistical methodology for determining the geographic market. Patient flow data attempts to quantify where the individual patients live of each of the merging hospitals.\(^{32}\) This data is analyzed using a variant of the Elzinga-Hogarty (“E-H”) approach which looks at the level of imports and exports from a specific market. The rationale of the E-H approach is that if some customers are willing to cross market boundaries, additional people will follow if the price increases, thus rendering the monopolist’s price increase unprofitable. For hospital merger cases, the E-H approach relies on the little-in-from-outside (LIFO) statistic, and little-out-from-inside (LOFI) statistic. The LIFO statistic measures, “the percentage of patients living in the market who use market hospitals rather than hospital outside the market (i.e., patient out-flow).” Alternatively, the LOFI statistic measures, “the percentage of admissions at hospitals within the market stemming from patients living within the market rather than from patients living outside the market (i.e., patient inflow).” The combined statistics have generally been categorized as “strong” E-H markets (at least 90 percent), “weak” E-H markets (at least 75 percent), or “average” E-H markets (between 75 and 90 percent).

While neither party in the current case relied solely on the E-H approach, the ALJ did distinguish its usefulness in hospital merger cases.\(^{33}\) Specifically, the court accepted the testimony of Dr. Kenneth G. Elzinga that the test he helped develop was originally for the beer and coal industries, and is inappropriate when applied to hospital services.\(^{34}\)

\(^{33}\) Initial Decision, *supra* note 1, at 139.
\(^{34}\) Id. at 138.
Two specific problems with using the E-H approach in the hospital context were identified by Dr. Elzinga.35

First, is the “payor problem” which is due to the fact that managed care organizations directly pay for the hospital services, but their customers are the patients who use the services. Dr. Elzinga hypothesized that since the patients do not set the price of hospital services, there is no direct correlation between price increases and their willingness to travel to a further hospital to receive care. Therefore, patient flow data can only be useful in managed care competition for customers, and not about competition for managed care contracts with hospitals.

The second problem with patient flow data is that it incorrectly assumes that if some patients will travel further to other hospitals, then others also will if prices increase. This can create a broader geographic market than is appropriate since there is a “silent majority” of patients that will not travel further regardless of price increases. Patient flow data is still useful to managed care organizations and hospitals to determine service areas by helping identify which hospitals patients actually use; however, the ALJ rejected the use of the E-H approach and patient flow data in determining the relevant geographic market in this case.

After rejecting the traditional analysis, the ALJ turned other factors such as market participant views, geographic proximity, travel times, and physician admitting patterns to determine the relevant geographic market.36 Market participant views help to establish the assertion that patients require that a local hospital be included in their managed care plan. In this case, the ALJ accepted the premise that the customers in the

35 Id. at 139.
36 Id. at 140.
surrounding area of the three ENH hospitals would be less willing to travel further to receive care based on their more affluent economic status. The residents of this area are described as “senior executives and decision-makers” who not only make decisions about their own health services, but also are included in making the managed care decisions for their company’s employees. Dr. Elzinga agreed with this theory based on economic studies which have found that more affluent customers have a higher value of time and opportunity cost of traveling.

In addition to the views of the residents, the ALJ also considered the perception of managed care organizations who typically viewed Evanston and Highland Park as substitute hospitals for building a network that included a local hospital. Testimony by several managed care organizations supported the contention that Evanston and Highland Park were each other’s main competition and primary alternative when negotiating contracts. Lake Forest, Advocate Lutheran General, Rush North Shore, and St. Francis were the hospitals most cited by managed care organizations as those that competed with ENH due to their relative proximity. Contemporaneous documents produced by two of the managed care organizations also presented these hospitals as alternatives to ENH for customers in the area. Evanston and Highland Park themselves considered Lake Forest a primary competitor in the market based on testimony and documents.

Furthermore, geographic proximity and travel times are accepted as key components to determination of the relevant geographic market based on the desire of managed care organizations to meet the expectation for convenience of its customers. Citing a 2001 Lake Forrest customer survey, the ALJ accepted the proposition that a

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37 Id. at 141.
38 Id. at 142.
reasonable travel time would be, on average, “up to 16 minutes for emergency care and 35 minutes for an overnight hospital stay.” ENH’s own expert Dr. Monica G. Noether calculated the average driving distance of 5.75 miles between those hospitals included in the geographic market and either Evanston or Highland Park, with an average driving time of 13 minutes.39

Finally, physician admitting practices were briefly discussed as being a relevant factor in determining the relevant geographic market because the evidence showed that when the merger was announced, several physicians who had been admitting their patients to Highland Park began to shift “a lot” of them to Lake Forest. Managed care organizations would want networks which included Highland Park or Lake Forest for patients of physicians who can admit to either hospital. However, the ALJ determined that there was insufficient evidence regarding physician admitting practices for the other relevant hospitals.

C. ENH Determined to Have a Market Concentration with an HHI of 2739 and a Post-Merger Increase of 384

After determining the relevant product and geographic market, the court then conducted an analysis of the competitive effects of the merger by examining market concentration and evidence of post-merger price increases.40 The ALJ first acknowledged that service areas are not necessarily the same and the geographic market due to the reliance on patient flow data. Since the ALJ set the size of the geographic market between those requested by the parties, a post-merger HHI of 2739 was determined with an increase of 384.41 In setting the HHI above 2700, the ALJ relied

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39 Id. at 143.
40 Id. at 150.
41 Id. at 151.
primarily on ENH’s expert whose market share analysis was based on Medicare Cost Reports which included data on total net revenue for inpatient and outpatient services of each hospital. Because the HHI was significantly above 1800 level to be considered highly concentrated and the post-merger increase was substantially greater than 100, the ALJ followed the Horizontal Merger Guidelines in determining that there was a presumption that the merger would create or enhance market power.42 Additionally, the ALJ determined that ENH’s post-merger market share was thirty-five percent in 1999, and it grew to forty percent by 2002.43 Therefore, under traditional market concentration analysis, ENH operated in a highly concentrated market and the merger was likely to create or enhance ENH’s market power.

D. ENH Achieved Substantial Post-Merger Price Increases Based on Empirical and Contemporaneous Evidence Not Justified by the Learning About Demand or Improved Quality of Care Defenses

Beyond the conventional market concentration analysis, since this case was a look back at a consummated merger, the ALJ placed an additional burden on the FTC of providing evidence that the merger affected managed care prices.44 However, the evidence needed only to show probable, not actual, anticompetitive effects. In meeting its burden the FTC relied on contemporaneous and post-acquisition evidence which are generally accepted as pertinent when establishing the probable effects of a merger.45 The ALJ felt that the evidence established that ENH, “exercised its enhanced post-merger market power and obtained post-merger price increases substantially above its premerger

43 Initial Decision, supra note 1, at 152.
44 Id. at 152-153.
prices and significantly larger than price increases obtained by other comparison hospitals.\textsuperscript{46}

Pricing evidence was based primarily on the FTC’s expert, Dr. Deborah Haas-Wilson, who used four different data sources in her analysis, as opposed to just data provided by managed care organizations relied on by ENH.\textsuperscript{47} Since there is little case law to assist in analysis of post-merger price increases, the ALJ accepted the five percent increase threshold suggested by the Horizontal Merger Guidelines.\textsuperscript{48} Although the evidence was not determined to be conclusive and the FTC was not required to definitively prove it, the evidence suggested that ENH prices rose to a supra competitive level far in excess of the four other hospitals in the relevant geographic market.\textsuperscript{49} The ALJ made three conclusions based on this evidence: (1) ENH achieved substantial price increases post-merger, (2) empirical evidence shows that ENH’s prices rose relative to other hospitals, and (3) explanations other than market power were ruled out and rejected.

First, evidence that ENH achieved substantial price increases were supported by evidence of the intent of the merger.\textsuperscript{50} Both Evanston and Highland Park felt that merging would eliminate a competitor in the market and give the combined entity greater leverage in contact negotiations. In subsequent contract negotiations, ENH began using its market power through use of a single contract, adding on “premiums” to contract rates

\textsuperscript{45} Initial Decision, supra note 1, at 153, see \textit{e.g.} \textit{Purex Corp. v. Procter Gamble Co.}, 664 F.2d 1105, 1108 (9th Cir. 1981); \textit{United States v. Falstaff Brewing Corp.}, 383 F. Supp. 1020, 1025 (D.R.I. 1974); \textit{FTC v. Consolidated Foods Corp.}, 380 U.S. 592, 598 (1965).

\textsuperscript{46} Initial Decision, supra note 1, at 153.

\textsuperscript{47} \textit{Id.} at 154.

\textsuperscript{48} \textit{Id.}; 1992 Horizontal Merger Guidelines, supra note 42, at 15.

\textsuperscript{49} Initial Decision, supra note 1, at 155. Note that price increases of other hospitals are not available in public version of the initial decision and were considered by the ALJ \textit{in camera}.

\textsuperscript{50} \textit{Id.} at 156.
while also negotiating discounts, and consolidating the hospitals’ chargemasters.\textsuperscript{51} Tangible benefits received by these activities included, but were not limited to, an $18 million annualize economic impact of renegotiated contracts, and four chargemaster rate increases between 2002 and 2003. The chargemaster increases in particular were not publicized and ENH’s executive vice-president of finance suggested that they should be kept “as quiet as possible.”\textsuperscript{52} Managed care organizations testified that ENH was attempting to maximize the leverage of the merged hospitals to increase prices, independent of any improvements in quality of care or level of services. All throughout ENH was highlighting the price increases as a major achievement of the merger.\textsuperscript{53} Internal memoranda, reports, and statements of senior officers all indicated that ENH had successfully used its increased market share to renegotiate favorable contracts significantly above prices either hospital could have achieved independently.\textsuperscript{54}

Empirical evidence was also cited by the ALJ in support of the increase in prices. The control group that Dr. Haas-Wilson used to compare ENH included three groups: (1) general acute care hospitals in the Chicago Primary Metropolitan Statistical Area (“Chicago PMSA Hospitals”), (2) Chicago PMSA Hospitals not involved in a merger between 1996-2002, and (3) Chicago PMSA Hospitals involved in medical teaching. The ALJ accepted Dr. Haas-Wilson’s analysis that, except for Blue Cross Blue Shield, ENH’s price increases for all other managed care organizations were higher than those of the

\textsuperscript{51} Id. at 158.
\textsuperscript{52} Id. at 160.
\textsuperscript{53} Id. at 159.
\textsuperscript{54} Id. at 165 (quoting ENH’s CEO as stating in June 2000 that the merger accomplished managed care contract savings of a, “$12 million improvement on the Hospital side and $8 million to physicians’ practices to date,” and an internal memorandum of Highland Park CEO that, “Neither Evanston nor Highland Park alone could achieve these results”).
control group. Since Blue Cross Blue Shield accounted for twenty percent of ENH’s business, the managed care organization was able to limit price increases. Even including Blue Cross Blue Shield, the empirical evidence indicated that ENH’s price increases exceed the control groups by eleven to eighteen percent which was clearly above the five percent threshold set by the ALJ.

Finally, the ALJ rejected ENH’s two primary explanations for the price increases, “learning about demand and improved quality of care.” The learning about demand argument was based on a review of Highland Park’s contract rates which uncovered that some were outdated or below mark rates. Despite Evanston being a teaching hospital, increased rates were not justified for Highland Park since it was not a teaching hospital. ENH was also not able to, “point to any contemporaneous documents which reflect that ENH’s learning about Highland Park’s rates taught ENH about other hospitals’ pricing or that its ‘fair market value’ would be comparable to advanced teaching hospitals rather than community hospitals.” Additionally, empirical analysis of rates indicated that Evanston had higher pre-merger rates than Highland Park in three out of four managed care contracts examined.

Post-merger improvements made at Highland Park were the basis of a “quality of care” argument in order to justify increased prices. The relevancy of quality of care to

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55 Id. at 167.
56 Id. at 168.
57 Id. at 169.
58 Id. at 170.
59 Id. at 171 (noting that Evanston itself was not considered a “top-tier, major academic center,” and Highland Park only had six residents and merging with Evanston does not transform it into a “teaching hospital” which deserved higher rates).
60 Id. at 172.
61 Id. at 173.
62 Id. at 175.
anticompetitive effects has not clearly been defined by the courts.\textsuperscript{63} ENH argued that quality of care should be analyzed as a pro-competitive justification, as opposed to an affirmative defense or efficiency, therefore the ALJ relied on the anticompetitive evidence previously discussed to outweigh any benefits received from quality of care.\textsuperscript{64} When price increases were being negotiated, the quality improvements to Highland Park were never advertised to justify the increases.\textsuperscript{65} The ALJ found no evidence that the quality of care improved relative to other hospitals in the relevant geographic market.\textsuperscript{66} None of the areas of improvement were considered to be merger specific, and most likely would have been undertaken individually by Highland Park given adequate funding.\textsuperscript{67}

E. Divestiture Determined to be the Appropriate Remedy Based on the Ability to Continue to Provide Adequate Care Despite Having to Replace Some Infrastructure

The ALJ determined that ENH failed to, “meet its burden by identifying any hardship which would entitle it to an exception to the divestiture rule,” or provide, “any alternative remedies to divestiture [which] would effectively ‘redress the violation’ found herein.” First, the ALJ rejected ENH’s proposal of a “prior notice” order requiring it to notify the FTC over the next five years if it intends to make any additional acquisitions within the relevant geographic market because it did not require any present action to address the market conditions.\textsuperscript{68} Also found unpersuasive was the proposal by ENH to

\textsuperscript{63} Id. at 175-176 (discussing the district court’s holding in Rockford Memorial, 898 F.2d at 1286, that quality of care improvements were irrelevant in a § 7 of the Clayton Act inquiry, but accepting that the 1992 Horizontal Merger Guidelines recognize quality as relevant in efficiency analysis).
\textsuperscript{64} Id. at 177. For a more complete analysis of the use of efficiency as an argument in antitrust litigation, see Malcolm B. Coate, Efficiencies in Merger Analysis: An Institutionalist View, 13 S. CT. ECON. REV. 189, 193 (2005) (evaluating the use of three part efficiency test pursuant to the 1992 Horizontal Merger Guidelines).
\textsuperscript{65} Id. at 178 (noting that a single solitary press release about the quality improvements was not enough to be determinative).
\textsuperscript{66} Id. at 182.
\textsuperscript{67} Id. Evidence demonstrated that Highland Park planned to spend $100 million on improvements as compared to $120 million actually spent post-merger by ENH.
\textsuperscript{68} Id. at 203-204.
require Evanston and Highland Park to negotiate and maintain separate managed care contracts because it would not effectively restore the pre-merger competitive landscape.\textsuperscript{69} Ultimately, the ALJ felt that Highland Park had the ability to continue to provide adequate care post-divestiture despite having to replace some of the infrastructure changes inherited as a result of the merger.\textsuperscript{70} Thus, divestiture of Highland Park was ordered to go into effect one hundred eighty (180) days from the date the Order becomes final.\textsuperscript{71}

V. NEXT STEPS IN THE ENH LITIGATION INCLUDE REVIEW BY THE FULL FTC PANEL AND FEDERAL COURT OF APPEALS

On October 26, 2005, ENH filed their Notice of Appeal pursuant to FTC Rule of Practice § 3.52(a).\textsuperscript{72} ENH is appealing the entirety of decision which will now be reviewed by the full five-member FTC panel. If the panel upholds the ALJ’s initial decision, ENH may still appeal to the federal courts, likely the Court of Appeals for the Seventh Circuit.\textsuperscript{73} Additionally, amicus briefs have been approved to be submitted by The Advisory Board Company, the American Hospital Association, the Business Roundtable, the City of Highland Park, and the Joint Commission on Accreditation of Health Care Organizations.\textsuperscript{74} The American Hospital Association has been particularly outspoken about their displeasure in the outcome of the case, offering the assessment that, “after more than a decade of losing every single hospital merger case before a

\textsuperscript{69} Id. at 205.
\textsuperscript{70} Id. (noting that losses from divestiture included: improvements already achieved, electronic medical records system, academic affiliation and clinical integration, and cardiac surgery services).
\textsuperscript{71} Id. at 215.
\textsuperscript{72} 16. C.F.R. § 3.52(a).
\textsuperscript{73} 5 U.S.C. § 704 “Agency action made reviewable by statute and final agency action for which there is no other adequate remedy in a court are subject to judicial review.”
neutral federal judge, this time around the FTC has elected to stack the deck in its favor by hand - picking its own administrative law judge to oversee the case. It's like letting the home team pick the umpire. The result is never really in doubt."75

VI. POTENTIAL IMPLICATIONS ON FUTURE HOSPITAL MERGERS INCLUDE THE INCREASED USE OF INTERNAL DOCUMENTS AND THE RATIONALE USED DURING NEGOTIATIONS FOR PRICE INCREASES

Regardless of whether the ALJ’s initial decision is upheld, there are potential implications not only on additional consummated mergers that may also be subject to review, but also to future hospital mergers. Mark Neaman, president and CEO of Evanston Northwestern, noted that, “if [hospitals] think that five or six years later the FTC could come back to investigate after receiving a complaint from a payer who didn't like the outcome of a negotiation, they (the hospitals) might reconsider taking such a big risk." James Skogsbergh, president and CEO of the eight hospital Advocate Health Care system based in Oak Brook, IL, agreed that, “if this decision is upheld it will become even harder for us (hospitals) to exert any kind of leverage in the marketplace."

Alternatively, Paul Ginsburg, president of the Center for Studying Health System Change, called the decision a “definitive win" for managed care organizations because it “puts hospitals on notice that their mergers can be challenged, which may influence their pricing."

In his departures from the traditional merger analysis, the ALJ highlighted some key issues that will continue to receive scrutiny. First, the rejection of patient flow data as a means of determining relevant geographic market could eliminate one of the oft-

75 Mark Taylor, Changing the Balance; In Ordering Evanston Northwestern to Divest a Hospital, the FTC Could Give Insurers More Power in Negotiating with Providers, MODERN HEALTHCARE, Oct. 24, 2005, at
criticized aspects of hospital merger analysis. However, the value of the data in pre-merger analysis is yet to be determined since there would not be any actual evidence as in consummated merger cases. Given the reliance of the ALJ on testimony from managed care organizations, their statements and credibility in determining anticompetitive behavior will likely be aggressively contested.

Internal documents should continue to have a bigger role in proving intent of anticompetitive behavior and actual success. The ALJ accepted both pre and post-merger documents and statements of hospital officials in order to establish intent. Even discoverable documents prepared by external consultants will play a role in the FTC proving anticompetitive behavior. Mark Horoschak, a former FTC official now in private practice, has recommended that since internal documents were used in the case, “what's instructive for hospital executives is to watch what you put in writing, particularly when describing changes in pricing policies. E-mails can come back to haunt you.”

Finally, the rejection of the “learning about demand” and “improved quality of care” defenses to price increases will likely cause merging hospitals to carefully lay out their rationale during negotiations when seeking price increases. Characteristics, such as being considered a teaching hospital, will not be carried over from one hospital to another purely as a result of the merger. If one of the hospitals has pricing below the other, simply using the combined entity’s leverage to increases prices overall may be evidence of anticompetitive behavior absent a sufficient rationale that is expressly conveyed during.

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negotiations. Merging hospitals should also consider post-merger improvements above and beyond those that would be required in the normal course of business in order to have empirical evidence of improved quality. During closing arguments, the ALJ said he was “deeply concerned” that ENH did not discuss specific ways it would improve the quality of care provided at Highland Park during negotiations with managed care organizations to justify the cost increases.78

Some specific suggestions and potential courses of action are already being recommended for future hospital mergers. First, merged hospitals cannot assume that the FTC will not investigate a consummated deal.79 Second, since the FTC learns about potential problems from local news and customer complaints, significant post-merger price increases may lead to complaints which could trigger an investigation unless the hospital is less aggressive in their contract negotiations. Third, if merged hospitals can integrate their operations to achieve actual efficiencies, then there may be less of a chance of a divestiture ruling since there would then be beneficial evidence of cost savings and improved quality of care. Most likely, the ALJ’s initial decision should lead to changes in behavior for hospital mergers regardless of the ultimate outcome.

VII. CONCLUSION

The ALJ’s initial decision, while a preliminary victory for the FTC, will continue to be hotly contested and closely watched as it moves through the appeals process. Regardless of its definitive resolution, the anticompetitive behavior analysis will likely be

78 Japsen, supra note 7.
the basis for additional post-merger challenges by the FTC, and will likely be taken into consideration during future hospital merger negotiations.

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79 Mark E. Nagle and Andre P. Barlow, *Scrutiny After the Fact; Practice Focus; Hospitals Should Take Care to Avoid Post-Merger Challenge from the FTC*, LEGAL TIMES, Mar. 14, 2005, at 28.