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November 2005

Theory No More: Federal Government Achieves Initial Success in Challenge of Already-Consummated Hospital Merger

As we reported in February of 2004, the federal government has experienced a notable lack of success in seeking to enjoin hospital mergers believed to be anticompetitive.[1] The government's string of losses may soon be coming to an end, however, as counsel for the Federal Trade Commission ("FTC" or "Commission") recently scored a preliminary victory in its challenge of an already-consummated merger of three Chicago-area hospitals. Although this victory will no doubt be the subject of a lengthy appeals process, the initial decision of FTC Administrative Law Judge Stephen J. McGuire will likely embolden federal antitrust enforcement efforts in an increasingly concentrated market for inpatient hospital services. As a result, providers should not only seek legal counsel with respect to future transactions, they also should seek counsel to assess potential antitrust liabilities created by past transactions.

First of all, it should be noted that Judge McGuire's 239-page decision[2] is exceedingly detailed, delving into many facets of antitrust law not conducive to a brief discussion such as that herein presented. The following merely highlights certain portions of the decision:

In January of 2000, Evanston Northwestern Healthcare Corporation ("ENH") and Lakeland Health Services, Inc. ("Lakeland") merged, forming a three-hospital network with 836 acute care beds in an area just north of Chicago. Following the merger, ENH negotiated prices with private payers on behalf of all three hospitals. After a lengthy investigation by the FTC, counsel for the Commission filed an administrative complaint challenging the merger on February 10, 2004. The complaint alleged that, among other things, ENH succeeded in raising prices unilaterally through the use of its newly acquired market power. For example, counsel for the FTC alleged that ENH imposed significant price increases for large private payers that included CIGNA, Aetna and Humana. Rather than risk losing the use of ENH's hospitals (and, by implication, the ability to compete effectively in the sale of health insurance to area employers), all but one of these private payers accepted large price increases.

Following an eight-week trial that saw the introduction of over 1,600 exhibits and testimony by forty-two witnesses, Judge McGuire issued an initial decision first made public on October 21, 2005. Unlike the government's typical hospital merger challenges, Judge McGuire noted that the government's case against ENH presented a "rare opportunity" to examine the actual effect of concentration on price in the hospital industry. Using historical evidence of ENH's pricing and conduct after the merger, which was established with the assistance of testimony by numerous large insurers, Judge McGuire concluded that the merger was likely to

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[1] *See, e.g., FTC v. Tenet Healthcare Corp.*, 186 F.3d 1045 (8th Cir. 1999); *FTC v. Freeman Hosp.*, 69 F.3d 260 (8th Cir. 1995); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121 (E.D.N.Y. 1997); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997) (per curiam) (unpublished table decision); *United States v. Mercy Health Servs.*, 902 F. Supp. 968 (N.D. Iowa 1995).

[2] *See In re Evanston Northwestern Healthcare Corp.*, available at http://www.ftc.gov/os/adjpro/d9315/051020initialdecision.pdf.

result in anticompetitive effects. According to Judge McGuire, ENH's acquisition resulted in "substantially lessened competition" and higher prices for insurers and health care consumers for general acute care inpatient services sold to managed care organizations ("MCOs").

In assessing the merger's effects on competition, Judge McGuire held that the relevant product market was general acute care inpatient services sold to MCOs and that the relevant geographic market was an area encompassing seven neighboring hospitals. Interestingly, because MCOs (unlike individual patients) purchase a range of services under one contract, the ALJ's analysis that outpatient services were not part of the product market is not an obvious conclusion, and might be worth more focus in other cases. Also, Judge McGuire expressly rejected the use of patient flow data to define the relevant geographic market. Such data had been successfully used by hospitals in the past to rebut government arguments regarding a merger's potential anticompetitive effects. Hospitals had argued that the relevant geographic market was based on the (typically large) area from which a hospital attracted its patients and where patients within that area went to receive health care. According to Judge McGuire, however, patient flow data was "inapplicable to geographic market definition for a differentiated product such as hospital service." Not only did such data fail to recognize that MCOs pay for hospital services on behalf of patients, patient flow data incorrectly assumed that if some patients were willing to travel to distant hospitals, others would travel as well in response to a change in hospital prices. In his opinion, basing geographic market definition on patient flow data would inherently overstate the size of the geographic market for hospital services.

Judge McGuire found that ENH exercised its market power to obtain price increases substantially larger than price increases obtained by other comparison hospitals. He also flatly rejected ENH's procompetitive justifications for the price increases. For example, ENH had put forward a "learning about demand" theory, arguing that ENH's post-merger price increases were the result of it discovering the true demand for hospital services in the market. Moreover, Judge McGuire found ENH's nonprofit status irrelevant to the question of whether the merger had anticompetitive effects.

In the end, Judge McGuire found that ENH's divestiture of one of the three hospitals would be the most effective and appropriate remedy to address the anticompetitive effects of the merger. The judge specifically rejected an alternative remedy that the hospitals engage in separate contracting. Divestiture to an FTC-approved buyer in an FTC-approved manner would therefore be required within 180 days after his order become final.

Noteworthy Issues and Questions

Hospitals that are considering mergers or network affiliations, or that have already taken such steps, should note at least the following key antitrust and litigation issues in addition to those discussed above:

1. Providers contemplating a merger or network alliance must be scrupulous in their discussions and documentation not to misstate the competitive significance of a proposed transaction. It may have been the case that the boards of the Evanston hospitals intended to create benefits for payers and patients that would support higher rates for the added value, but the "story" told by the documents that Judge McGuire cited extensively seems almost determinative of the outcome. Despite the decision's stated reliance on regression analysis as the primary evidence of competitive effects, it is difficult to escape the conclusion that "bad documents" written by trustees and executives regarding their desire to obtain leverage against MCOs and to end divisive competition inclined the judge towards his conclusion and may have affected his resolution of any ambiguous economic analysis.

2. The decision's treatment of efficiencies is troubling, both for merger analysis and for analysis of the competitive effects of hospital networks. The judge rejected all evidence of procompetitive effects flowing from efficiencies either because one or another of the hospitals "could have" accomplished them individually, a standard that is typically not acceptable when offered by merging parties as support for an efficiencies argument, or because they were not shown by medical literature to be useful, or because they were not improvements *relative to practices and outcomes in other hospitals*. Moreover, the ALJ adopted the goal of improved quality of care as a procompetitive justification only theoretically for purposes of the decision, citing a Seventh Circuit decision involving hospitals in a downstate Illinois market that held that creation of a tertiary care center by the merging hospitals was not justification for a merger that allegedly conferred market power in the provision of other acute care services.[3]

3. The decision uses rate change percentages measured against rate changes at other hospitals, rather than dollar rate increases, as evidence of anticompetitive effects. Though there seems to be a legitimate role for relative rate changes, this factor, coupled with the rejection of the efficiencies achieved by ENH, point to a view that hospitals may not lawfully merge in order to "catch up"

[3] *See United States v. Rockford Mem'l Hosp. Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990).

to competing hospitals without thorough and detailed procompetitive justifications that are tied specifically to the rate increases.

4. At the time of the merger, the largest payer in the market had a share of about 20%. In the current environment of ever-larger MCOs through acquisition, the ALJ's definition of the relevant market as general acute care services sold to MCOs may lead to more favorable outcomes in merger analysis as MCOs may be characterized as "power buyers."

Conclusion

Both parties have already appealed Judge McGuire's decision to the full Commission. Providers should nonetheless realize that Judge McGuire's decision likely portends a new era of federal antitrust enforcement in an increasingly concentrated market for inpatient hospital services. Not only should providers seek legal counsel as soon as they begin thinking about entering into a merger or network affiliation in which there is any meaningful overlap of services and territory, as shown by the *ENH* case, providers also should seek counsel with respect to already-consummated transactions that raise potential antitrust concerns.

Joseph E. Casson, 202.778.1111
jcasson@proskauer.com

Martha E. Gifford, 212.969.3490
mgifford@proskauer.com

James F. Segroves, 202.416.6871
jsegroves@proskauer.com