The Federal Trade Commission’s approach to relevant market definition in hospital merger analysis has changed significantly since the antitrust agencies began challenging hospital mergers in the mid-1980s. Most of the changes have applied to the geographic dimension of market definition. Coinciding with these developments has been a reversal of fortunes for the government in court. In the 1990s, the FTC, Antitrust Division of the Department of Justice and State of California collectively lost seven straight litigated challenges to hospital mergers.1

At that point there was a litigation pause. The FTC pursued a “retrospective” on past hospital mergers to assess whether any resulted in anticompetitive effects.2 The agency brought its next case in 2004 and introduced a new approach to market definition – focused on locations important to managed care contracting. Since that time, the FTC has won three federal court cases (two hospital mergers and one physician group merger)3 and other mergers were abandoned when an FTC lawsuit was filed or forthcoming. As this article is being written, two FTC hospital merger challenges are awaiting decisions in U.S. district courts.

Whether there is cause-and-effect between the evolution in hospital market definition and the government’s litigation record is beyond the scope of this article. But it is reasonable to observe that the government’s string of losses in the 1990s was largely connected to judicial findings about the relevant geographic market. Courts found geographic markets that usually were very large (typically encompassing many counties comprising the service area) and populated by many hospitals, and concluded that a price increase by the merged entity would cause enough patients to travel to alternative hospitals in the market to make the price increase unprofitable.

The FTC’s post-2004 successes coincide with a new paradigm for geographic market definition. The FTC still often pleads, as it did in the 1990s, markets aligned with hospital primary service areas. But the evidence it offers to support the market definition relates to hospital locations important for managed care contracting, not to patient flow patterns, and overlaps closely with the evidence it uses to argue a likelihood of unilateral anticompetitive effects. The FTC argues

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that the merging hospitals are located in a well-defined area in which a hypothetical monopolist could increase prices to commercial health plans (relevant market), and that the merged entity will unilaterally have the power to raise prices to commercial health plans (anticompetitive effects). Both arguments arise from assertions that patients prefer to receive care close to home, that commercial insurers strive to offer health plan networks that meet patient preferences, and that the merging parties are close substitutes in the view of most local consumers. From this, the FTC argues that it would be difficult to market a successful health plan network without at least one of the merging parties.

The evidence offered in support of these points, be it for reasons of market definition or competitive effects, is often largely contained in the same sets of documents, testimony and economic analyses. FTC economists regularly present diversion analysis, which estimates to which hospitals patients would likely switch were one of the merging hospitals excluded from the network. Estimates of substantial diversion to the other merging hospital are used to argue that the parties are close substitutes, increasing the likelihood of unilateral anticompetitive effects from the merger. Diversion ratios and other economic tools on which the FTC relies, such as willingness to pay models, were developed after the 1990s.

**Geographic Market Definition in the 1990s**

In several hospital merger cases the government lost in the 1990s, courts based their geographic market analysis on interpretations of patient origin data and applications of the Elzinga-Hogarty test and critical loss analysis (i.e., the method for applying the hypothetical monopolist test by, among other things, predicting how many patients would travel to more distant hospitals in response to a small price increase). Elzinga-Hogarty’s premise was that a hospital geographic market can be evidenced by inferences from patient travel patterns for hospital care.

Under this approach, the reasonableness of defining a certain region (say, the hospitals’ primary service area) as the geographic market depended on (i) the percentage of inpatients hospitalized inside the region who reside outside of it (in-migration), and (ii) the percentage of inpatients residing in the region who traveled to hospitals outside of it (out-migration). A candidate market generally was deemed more defensible the smaller were these percentages. The opposite was also the case: high in-migration and out-migration percentages suggested that the candidate market was too narrow. A proposed geographic market definition was deemed “strong” if fewer than 10 percent of the patients in the candidate market originated from outside its borders and left the area for hospital care. A “weak” market was characterized as one in which more than 10 percent but less than 25 percent of patients traveled in or out of the candidate market. The effect of this analysis of patient flow was that markets generally were defined broadly and included many hospitals.

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4. Willingness to pay models derive estimates of a hospital’s value to a health plan provider network and evaluate a merger’s competitive significance based on estimated diversion and on the change in the network’s value if marketed without the merging parties.

5. See supra note 1 (Sutter, Tenet, Butterworth, Mercy and Freeman cases).

6. See generally FTC and DOJ, Improving Health Care: A Dose of Competition, Ch. 4 (Competition Law: Hospitals) section II (Geographic Market Definition) (2004), available at
A main criticism of Elzinga-Hogarty was that it assumed without empirical evidence that current migration patterns by a minority of patients were informative on how the broader population would respond to a small but significant and non-transitory price increase by the merged entity. Termed the “silent majority,” those who did not travel outside the area under pre-merger market conditions should not, in the view of critics, be presumed likely to do so in meaningful numbers in response to a small price increase, absent additional evidence that was not provided in the court decisions.7

In a report issued in 2004, the FTC and DOJ attributed the 1990s losing streak directly to overly broad geographic markets resulting from the courts’ acceptance of defendants’ application of Elzinga-Hogarty and critical loss analysis.8 The agencies pointed to commentator views that “these cases reflect judicial acceptance of implausibly large geographic markets, judicial approval of mergers that would not be permitted in any other industry, and the lessening of competition in the hospital services market.”9

The New Era –2004 to Present

If one year most clearly marks the transition from old to new in terms of government market definition for hospital mergers, it would probably be 2004. That year, in addition to publishing with DOJ the report noted above, the FTC filed an administrative complaint alleging that a hospital merger that occurred four years earlier was a violation of Section 7 of the Clayton Act. The retrospective nature of the case, _In the Matter of Evanston Northwestern Healthcare Corporation_ (“Evanston”),10 was itself unusual, but the complaint stands out in two ways in particular.

First, in Count I, the FTC defined the geographic market as the “area directly proximate to the three ENH hospitals and contiguous geographic areas in northeast Cook County and southeast Lake County, Illinois.” The emphasis on hospital location, not just scope of service area, was new for the FTC, and hospital location remains a point of emphasis today. Evidence alleged in support of this market was that the merged entity could “profitably impose significant and non-transitory price increases upon private payers in their purchase of acute care hospital services at those hospitals.” It is now standard for the FTC to define hospital markets by the area in which a hypothetical monopolist could impose a price increase on commercial payers.11

Second, and relatedly, in Count II, the FTC’s _Evanston_ complaint did not allege any relevant market. Its underlying premise was that evidence proving anticompetitive effects (here, steep post-merger price increases) obviates the need to define any market. This approach veered away from cases over many decades holding that “determination of the relevant market is a necessary

7 Id.
8 Id. at Ch. 4, sec. II, p. 5.
9 Id. at p. 6.
11 DOJ previously alleged a geographic market based on the area in which a hypothetical monopolist could increase prices to health plans, in _U.S. v. Long Island Jewish Med. Ctr._, 983 F. Supp.121 (E.D.N.Y. 1997). The court ruled for defendants, in part by rejecting the government’s proposed product market (“anchor hospitals” for health care plans) and in part by rejecting its exclusion of Manhattan from the geographic market for tertiary care services.


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predicate to a finding of a Clayton Act violation.”12 The FTC ultimately (in 2007) decided the case against the hospitals based solely on Count I (which included a relevant market allegation), and did not rule on Count II.13 But the Evanston complaint set the foundation for what evolved into a new FTC approach that rejects Elzinga-Hogarty and treats hospital market definition as an analytical step closely linked to unilateral competitive effects analysis.

In the Evanston administrative trial, Professor Elzinga testified for complaint counsel. He explained that the market definition test he co-developed was meant for the coal and beer industries and is not appropriate for hospital mergers, for two reasons. One is the “silent majority fallacy” described above. The other he described as the “payer problem.” That is, because third-parties (insurers) cover all but the co-pay for services, it is not a reliable assumption that the minorities who travel for healthcare services do so for price reasons, and therefore that significantly more people would travel in response to and defeat of a price increase. The FTC said this testimony was “persuasive.”14

The FTC explained in its Evanston decision that in a differentiated product market like hospital services, market definition and unilateral competitive effects analysis are closely linked:

Because the focus of the analysis is on the unilateral loss of “localized” competition between the merging parties, there are substantial factual and analytical overlaps between the market definition process and competitive effects analysis in unilateral effects cases. Again, a market is the smallest possible group of competing products (or geographic area) over which a hypothetical monopolist that sells those products (or competes in that area) could profitably impose a SSNIP. Thus, if a merger enables the combined firm unilaterally to raise prices by a SSNIP for a non-transitory period due to the loss of competition between the merging parties, the merger plainly is anticompetitive, and the merging firms comprise a relevant antitrust market because the merged entity is considered to be a “monopolist” under the Guidelines.15

Finding that the merger enabled the post-merger price increases, the Commission accepted complaint counsel’s argument that the relevant geographic was “the geographic triangle in which the three [Evanston] hospitals are located.”16 That description is another way of saying, as the FTC did in the blocked quotation above, that “the merging firms comprise a relevant antitrust market.” The Evanston approach to market definition by the FTC continues to the present.

One of the latest examples of this is found in a case currently in litigation, FTC and State of Illinois v. Advocate Health Care Network, which involves an action to enjoin Advocate’s proposed acquisition of rival NorthShore University Health System – the same system that was the respondent in Evanston (now with a new name and a fourth hospital within its system).17

14 Id. at 77.
15 Id. at 60 (citation to 1992 FTC-DOJ Horizontal Merger Guidelines omitted).
16 Id. at 78.
The complaint alleges a geographic market that is no broader than the “North Shore Area,” which includes all four Northshore hospitals, two Advocate hospitals, and five other hospitals. This is a different geographic market from the one the FTC found in 2007 to apply to the consummated merger at issue in that case.

The FTC and Illinois refer to this market as “conservative,” arguing that a narrower market consisting only of defendants’ hospitals would, like the North Shore Area, satisfy the hypothetical monopolist test. They allege that “it would be very difficult” for payers to market a health plan successfully in the North Shore Area without the merged system; the other hospitals in the market, according to the agencies, are not “comparable alternatives.” They assert that a diversion analysis supports these conclusions.

Defendants dispute the government’s alleged geographic market as “gerrymandered and divorced from competitive realities,” pointing to, among other things, data allegedly showing that 27 percent of patients leave the North Shore Area to receive inpatient hospital services and that almost 50 percent of the patients treated in North Shore Area hospitals travel from outside that area. These are percentages that, if substantiated, would likely induce a broadening of the geographic market using the tests applied by the courts in the 1990s decisions that the government lost. Defendants also criticize the FTC’s definition of a different geographic market from the one found in the *Evanston*, and dispute that the merger would result in a unilateral anticompetitive effect.

As the time of this article, the parties are awaiting the court’s decision on the FTC’s motion for a preliminary injunction. So, too, are the parties in *FTC and Commonwealth of Pennsylvania v. Penn State Hershey Medical Center*, involving a challenge to Penn State Hershey’s proposed merger with PinnacleHealth System in the Harrisburg-Hershey area, in which geographic market is also a disputed issue.

**Conclusion**

Through adjudication and the abandonment of transactions that it was prepared to challenge, the FTC has had success shifting geographic market definition away from an interpretation of patient flows and migration statistics to an analysis of where commercial insurers need hospitals to market a health plan network successfully. A central premise of that analysis is that patients want to receive care close to home and payers, to be competitive, must respond to their members with plans that include local hospitals in the network.

If the FTC concludes through diversion analysis and other evidence that two merging local hospitals are close substitutes for a significant number of patients, then it may define a market

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18 *Id.* ¶¶ 30, 34, 37.
19 *Memorandum in Support of Plaintiffs’ Motion for a Preliminary Injunction*, FTC v. Advocate Health Care Network, No. 15-cv-11473 (N.D. Ill.) (Feb 26, 2016) (obtained via PACER).
20 Complaint, *supra* note 17, ¶¶ 6, 49.
21 *Id.* ¶ 48.
22 *Defendants’ Opposition to Plaintiffs Motion for Preliminary Injunction*, FTC v. Advocate Health Care Network, No. 15-cv-11473 (N.D. Ill.) (March 18, 2016) at 8-9 (obtained via PACER).
23 *Id.* at 19-27.
based only on those hospitals’ locations. Its reasoning is that if a unilateral price increase will likely result from the merger of these two close competitors, then that analysis is not materially different from the hypothetical monopolist test for defining markets. Even if the market includes additional hospitals, the unilateral effects analysis would still remain.

The evolution in market definition has not necessarily reached its final stage. The premise that patients largely choose hospitals close to home, even if assumed valid, is not necessarily a permanent market condition. Any number of factors could increasingly induce patients to respond “with their feet” to avoid hospitals that raise prices unjustifiably: rising cost pressures on patients and employers; greater transparency of price and quality information through accessible government, payer, hospital and others’ websites; narrow networks that offer lower members significantly lower out-of-pocket expenditures in exchange for fewer choices in provider panels; continued movement of services from the inpatient to outpatient settings.

These are just some factors that could expand the areas in which patients seek healthcare services rather than bear their portion of higher hospital prices that may hypothetically result from a future merger. This does not even take into account repositioning by more distant hospitals through expanded services or other strategic responses to compete for those patients for whom the merging hospitals are close to home. However hospital geographic market definition may evolve going forward, it is probably not in dispute that the subject will be the subject of sharp dispute in many cases for the foreseeable future.