



ANALYZING THE GEOGRAPHIC MARKET IN HOSPITAL MERGERS: TRAVEL PATTERNS TAKE A BACKSEAT TO PAYER RESPONSE



By Andrea Levine & Andy Hasty ¹

I. INTRODUCTION

In December, 2015, the Federal Trade Commission (“FTC”) filed complaints in federal district court seeking preliminary injunctions to halt two separate proposed hospital mergers pending the outcomes of the FTC’s administrative challenges.² The first action, filed in the Middle District of Pennsylvania, sought to block Penn State Hershey Medical Center from merging with PinnacleHealth System. The second complaint, filed in the Northern District of Illinois, challenged the proposed merger between Advocate Health Care Network and Northshore University HealthSystem. Six months later, both district court judges sided with the hospitals, finding that the FTC’s proffered geographic markets were too narrowly drawn, and handed the FTC its first set of losses in hospital merger challenges in nearly a decade.³ But, in the end, the FTC was vindicated on appeal when both the Third and Seventh Circuits reversed the

¹ Andrea Levine is an associate in Simpson Thacher & Bartlett LLP’s New York office, and Andrew Hasty is an associate in Simpson Thacher & Bartlett LLP’s Washington, DC office.

² In conjunction with its requests for preliminary injunctive relief, the FTC simultaneously filed administrative complaints alleging that the proposed mergers would violate the antitrust laws.

³ See *FTC v. Penn State Hershey Med. Ctr.*, No. 1:15-cv-2362, 2016 WL 2622372 (M.D. Pa. 2016), rev’d and remanded, 838 F.3d 327 (3d Cir. 2016) (“*Hershey P*”); *FTC v. Advocate Health Care Network*, No. 1:15-cv-11473, 2016 WL 3387163 (N.D. Ill. 2016), rev’d and remanded sub nom. *FTC v. Advocate Healthcare Network*, No. 16-2492, 2016 WL 6407247 (7th Cir. Oct. 31, 2016) (“*Advocate P*”).



lower court decisions.⁴ These cases highlight not only the importance of a properly defined geographic market in hospital mergers, but also courts' definitive shift away from relying on patient travel patterns in making this determination.

As many commentators have noted elsewhere, the FTC consistently lost hospital merger challenges in the 1990s due in large part to findings that the FTC's alleged relevant geographic markets were too narrow. That changed with the new millennium when the FTC conducted a thorough retrospective analysis of consummated hospital mergers, including joint hearings with the Department of Justice ("DOJ"), and concluded that its recent losses were due in part to the acceptance by courts of the Elzinga-Hogarty method for delineating the boundaries of geographic markets.⁵ The Elzinga-Hogarty approach requires analysis of both "little in from outside" and "little out from inside" to properly articulate the relevant geographic market.⁶ In hospital mergers, this approach looks to patient travel patterns into and out of the proposed geographic market for hospital services.⁷ The FTC relied on its findings from the retrospective—that the use of patient flow data results in implausibly broad geographic markets and that other analyses (e.g. competition among hospitals to be included in health plans' networks) and sources of information (e.g. strategic documents, commercial payer testimony) should be employed to define the relevant geographic market⁸ — in successfully challenging the consummated merger between Evanston Northwestern Healthcare Corporation ("ENH") and Highland Park Hospital ("Highland Park") before an administrative law judge ("ALJ").⁹ In *Evanston*, based in part on the expert testimony of Dr. Elzinga himself, the ALJ explicitly rejected the use of patient flow data and the Elzinga-Hogarty method to define the relevant geographic market for healthcare services.¹⁰

With the patient-in and patient-out Elzinga-Hogarty framework so discarded, the *Evanston* decision paved the way for a string of successful FTC challenges to proposed hospital mergers. But, while geographic markets in hospital mergers may have narrowed in the past 20 years, a close look at these matters reveals that patient travel patterns continued to play a role whenever the relevant geographic market was seriously contested by the parties. Now that two appeals courts have clearly rejected the Elzinga-Hogarty framework as

⁴ See *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327 (3d Cir. 2016) ("*Hershey IP*"); *FTC v. Advocate Health Care Network*, No. 15-cv-11476, -- F.3d --, 2016 WL 3387163 (N.D. Ill. 2016) ("*Advocate IP*").

⁵ See Press Release, FTC, FTC Chairman Announces Public Hearings on Health Care and Competition Law and Policy to Begin in February 2003 (Nov. 7, 2002), available at: <http://www.ftc.gov/opa/2002/11/murishealthcare.shtm>; FTC & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, at 4-10 (July 2004), available at: <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf> ("IMPROVING HEALTH CARE"); Julie Brill, Commissioner, FTC, Keynote Address at the 2014 Hal White Antitrust Conference: Competition in Health Care Markets (June 9, 2014), available at: https://www.ftc.gov/system/files/documents/public_statements/314861/140609halwhite.pdf.

⁶ See Kenneth Elzinga & Thomas Hogarty, *The Problem of Geographic Market Delineation in Antitrust Suits*, 18 ANTITRUST BULL. 45, 72-76 (1973).

⁷ IMPROVING HEALTH CARE, at 7.

⁸ *Id.* at 14-21.

⁹ Initial Decision, *In re Evanston Northwestern Healthcare Corp.*, F.T.C. Docket No. 9315 (Oct. 21, 2005).

¹⁰ *Id.* at 30.



inconsistent with the hypothetical monopolist test in the hospital merger context, practitioners will be wise to place greater emphasis on how payers are likely to respond to theoretical price increases than the distance patients are willing to travel for treatment.¹¹

II. GEOGRAPHIC MARKET IN RECENT HOSPITAL MERGERS

In both *Hershey* and *Advocate*, reliance on patient travel patterns was central to the district and appeals courts' decisions. Where the district courts rejected the FTC's geographic markets for being too narrowly drawn in light of demonstrated patient travel patterns, the appeals courts rejected the district courts' decisions as ignoring the commercial realities of the healthcare markets by focusing primarily on patient travel patterns.

A. *Hershey/Pinnacle*

In challenging the *Hershey/Pinnacle* merger, the FTC argued that the relevant geographic market was a four-county region roughly equivalent to the Harrisburg Metropolitan Statistical Area (Dauphin, Cumberland and Perry Counties) and Lebanon County because (i) patients who lived in this region primarily relied on the merging hospital systems for care; and (ii) the region's two main commercial health insurance payers both recognized the area as a distinct market.¹² The merging hospitals disagreed, arguing that the FTC's view was too narrow as it did not account for the actual travel preferences of the merging hospitals' patients, thousands of whom traveled from outside of the FTC's alleged geographic market to receive care at the defendants' hospitals.¹³ Specifically, defendants alleged that 43.5 percent of Hershey's patients resided, and more than half of Hershey's revenue was generated from, outside of the Harrisburg area.¹⁴ Finding defendants' evidence compelling, Judge Jones held that the FTC did not appropriately account for where the hospitals drew their business, incorrectly excluded from the market the 19 other hospitals within a 65 minute drive of Harrisburg, and therefore failed to establish its *prima facie* case under the Clayton Act.¹⁵

On appeal, the Third Circuit thoroughly rejected the district court's approach to defining the geographic market.¹⁶ In the Third Circuit's view, by relying exclusively on patient flow data, the district court ignored "two problems: the 'silent majority fallacy' and the 'payer

¹¹ The hypothetical monopolist test evaluates whether "a hypothetical monopolist could impose a small but significant non-transitory increase in price ("SSNIP") in the proposed market." *Hershey II*, 838 F.3d 327, 338 (3d Cir. 2016). If so, then the geographic market is properly defined. *Id.* But if enough consumers would respond to a SSNIP by purchasing the product from outside the proposed market, so as to make the SSNIP unprofitable, then the proposed market is too narrow. *Id.* In the context of hospital mergers, because payers rather than patients pay most hospital costs, the hypothetical monopolist test must look at the likely response of payers to a price increase. See *Advocate II*, 2016 WL 3387163, at *7.

¹² *Hershey I*, 2016 WL 2622372, at *3.

¹³ *Id.* at *4.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ See *Hershey II*, 838 F.3d at 339, 344 (characterizing the district court's position as "economically unsound and not reflective of the commercial reality of the healthcare market").



problem.”¹⁷ First, the Third Circuit held that reliance on patient flow data falsely assumes that “patients who travel to a distant hospital to obtain care significantly constrain the prices that the closer hospital charges to patients who will not travel to other hospitals.”¹⁸ As the Third Circuit reasoned, however, because “patient decisions are based mostly on non-price factors, such as location or quality of services,” the travel preferences of a few cannot reliably be attributed to those in the “silent majority.”¹⁹ Second, the Third Circuit found that the district court “completely neglected any mention of the insurers in the healthcare market,” which misunderstands the commercial realities of the healthcare market.²⁰ In short, the Third Circuit’s rejection of the district court’s approach made clear that proper application of the hypothetical monopolist test in hospital mergers looks to payers’ likely response to a price increase, not patients’.²¹

Further emphasizing the role of payer response, the Third Circuit proceeded to apply the hypothetical monopolist test and found that the FTC sufficiently established that “payors would accept a price increase rather than exclud[e] *all* of the hospitals in the Harrisburg area.”²² In so holding, the Third Circuit relied on payers’ testimony that they could not successfully market a network that did not include a large hospital in the Harrisburg area, and evidence of another payer’s unsuccessful attempt to sell a network with only a smaller hospital in the Harrisburg area but with large hospitals in two neighboring counties.²³ The court also considered payers’ testimony that “the Harrisburg area [was] a distinct market.”²⁴ Thus, the Third Circuit concluded that the FTC met its burden to properly define the relevant geographic market.²⁵

B. *Advocate/Northshore*

The Third Circuit’s reasoning was echoed in the Seventh Circuit shortly thereafter. In seeking to block the *Advocate/Northshore* merger, the FTC similarly relied on patients’ preference to receive general acute care services locally, arguing that the relevant geographic market was the “North Shore Area” — a region in the Chicago suburbs no broader than northern Cook County and southern Lake County.²⁶ The merging hospitals responded that the FTC’s geographic market contrasted sharply with the one it defined in *Evanston* when five FTC Commissioners specifically rejected a geographic market including both *Advocate* and

¹⁷ Id. at 340-41. The Third Circuit also held that the district court “erred in resting part of its analysis of the relevant geographic market on the private agreements between the Hospitals and the payors,” since private contracts are irrelevant to “whether a *hypothetical* monopolist could profitably impose a [small but significant non-transitory increase in price].” Id. at 343-44.

¹⁸ Id.

¹⁹ Id. at 341.

²⁰ Id. at 341-42. The Third Circuit described the healthcare market as being “represented by a two-stage model of competition” where “hospitals compete to be included in an insurance plan’s hospital network” and “to attract individual members of an insurer’s plan.” Id.

²¹ Id. at 342-45.

²² Id. at 345-46.

²³ Id.

²⁴ Id.

²⁵ Id.

²⁶ See Mem. In Supp. Of Pls.’ Mot. for a Prelim. Inj. at 13-17, *Advocate I*, ECF No. 170.



NorthShore, and argued that the FTC's decision to ignore the competitive effects of "destination" hospitals — i.e. hospitals for which patients will travel greater distances for care — was arbitrary and contradicted by patients' actual travel patterns.²⁷ Finding the evidence regarding patients' preferences "equivocal," Judge Alonso ultimately agreed with the merging hospitals that the FTC's geographic market was too narrow since it excluded destination and other hospitals without sufficient economic basis or other justification.²⁸

The Seventh Circuit reversed, making clear that exclusive reliance on patient travel patterns to define the geographic market in hospital merger challenges is now a relic of the past.²⁹ According to the Seventh Circuit, the district court's central problem was that it misunderstood the hypothetical monopolist test, "overlook[ing] the test's results and mist[aking] the test's iterations for logical circularity."³⁰ Specifically, in the Seventh Circuit's view, the district court erred when it criticized the FTC's expert for advancing a narrow geographic market without explaining why a broader market would provide incorrect results.³¹ The Seventh Circuit reasoned that such explanation is unnecessary because, "if a candidate market is too narrow, the [hypothetical monopolist] test will show as much, and further iterations will broaden the market until it is big enough." As the Seventh Circuit explained, "the hypothetical monopolist test is an iterative analysis."³² If payers could defeat the hypothetical monopolist's attempt to impose a SSNIP by looking to providers outside the region, then it is not a relevant geographic market for antitrust purposes and "the test should be rerun using a larger candidate region."³³ Like the Third Circuit, the Seventh Circuit also addressed the "silent majority fallacy" and the non-price factors that inform patient travel patterns: "[P]atients vary in their hospital preferences. Getting an appendectomy is not like buying a beer; one Pabst Blue Ribbon or Hoegaarden may be as good as another, no matter where they are bought. For surgery patients, who their surgeon will be matters, the hospital's reputation matters, and the hospital's location matters."³⁴

III. GEOGRAPHIC MARKETS IN HEALTHCARE MERGERS LEADING UP TO *HERSHEY* AND *ADVOCATE*

From 2005 until the recent decisions in *Hershey* and *Advocate*, the FTC collected a series of wins challenging healthcare mergers in federal and administrative court, beginning with *Evanston*. After a more than 10-year hospital merger losing streak, the FTC challenged the already consummated acquisition of Highland Park by ENH, relying on empirical pricing data to establish that the merger raised prices to commercial payers in the relevant geographic market — a narrow triangular area formed by drawing lines connecting the three ENH

²⁷ See Defs.' Opp. to Pls.' Mot. for a Prelim. Inj. at 6-13, *Advocate I*, ECF No. 210.

²⁸ *Advocate I*, 2016 WL 3387163, at *3-5.

²⁹ *Advocate II*, 2016 WL 6407247, at *1.

³⁰ *Id.* at *9.

³¹ *Id.*

³² *Id.* at *9.

³³ *Id.* at *5.

³⁴ *Id.* at *9-11.



hospitals.³⁵ While the ALJ rejected the FTC's narrowly drawn market, he also rejected the Elzinga-Hogarty test to determine the geographic market for hospital services, an approach that had historically led to very broad geographic market definitions and a series of losses by the federal antitrust authorities.³⁶ Relying in part on the empirical data showing actual and substantial post-merger price increases by ENH relative to other hospitals in the market, the ALJ ultimately found that the merger violated Section 7 of the Clayton Act and ordered ENH to divest all of the Highland Park assets acquired by ENH.³⁷

Following the *Evanston* decision, the FTC filed complaints in and prevailed on six subsequent hospital mergers challenged in the federal district courts.³⁸ These successes have sometimes been attributed to a change in the way the FTC approaches geographic market definition – arguing for courts to analyze health care mergers “through the lens of contract negotiations between health care providers and commercial health plans,” not patient travel patterns.³⁹ But a closer look reveals that, prior to its recent wins before the Third and Seventh Circuits, the FTC's successes rarely turned on the court's analysis of the relevant geographic market. For starters, in two of these cases the parties abandoned the merger before ever reaching the preliminary injunction hearing⁴⁰ and, in a third case, the parties stipulated to a preliminary injunction without a hearing on the merits of the FTC's substantive claims.⁴¹ In two additional cases, the court acknowledged that the merging hospitals did not seriously contest the geographic market proffered by the FTC.⁴² Moreover, in confirming that the relevant geographic market was Lucas County, as the FTC had alleged, the court in *ProMedica* relied in part on the FTC's expert's findings that “[o]nly 2.1% of Lucas County residents leave the county for [general acute care] services, and only 0.6% leave the

³⁵ Initial Decision at 137, *In re Evanston Northwestern Healthcare Corp.*, FTC Docket No. 9315 (Oct. 21, 2005).

³⁶ See, e.g. IMPROVING HEALTH CARE, at Ch. 4.

³⁷ Initial Decision at 1-2, *Evanston*, F.T.C. Docket No. 9315.

³⁸ *FTC v. Inova Health Sys. Found.*, No. 1:08-cv-460 (E.D. Va. 2008); *In re Reading Health Sys.*, F.T.C. Docket No. 9353 (2012); *FTC v. Phoebe Putney Health Sys., Inc.*, No. 1:11-cv-0058-WLS (M.D. Ga. 2013); *FTC v. OSF Healthcare Sys.*, No. 3:11-cv-50344 (N.D. Ill. 2012); *FTC v. ProMedica Health Sys.*, No. 3:11-cv-47 (N.D. Ohio 2011); *Saint Alphonsus Medical Ctr. – Nampa, Inc. v. St. Luke's Health System, Ltd.*, No. 1:12-cv-00560-BLW-REB (D. Idaho 2014).

³⁹ Mem. of Law in Supp. of Pls.' Mot. for Inj. Pending Appeal at 6, *Hershey I*, ECF No. 133-1.

⁴⁰ See Joint Stipulated Mot. for Order Dismissing Compl., *FTC v. Inova Health Sys. Found.*, No. 1:08-cv-460 CMH/JFA (E.D. Va. 2008); Order Dismissing Compl., *In re Reading Health Sys.*, F.T.C. Docket No. 9353 (Dec. 7, 2012) (parties abandoned before the FTC filed its complaint in federal court).

⁴¹ See Stipulated Preliminary Injunction Order, *FTC v. Phoebe Putney Health Sys., Inc.*, No. 1:11-cv-00058-WLS (M.D. Ga. 2013). *Phoebe Putney* was adjudicated in the federal courts to determine whether, as defendants alleged, state action immunity exempted the transaction from the antitrust laws. *FTC v. Phoebe Putney Health Sys. Inc.*, 793 F. Supp. 2d 1356 (M.D. Ga. 2011), aff'd, 663 F.3d 1396 (11th Cir. 2011), rev'd, 133 S. Ct. 1003 (2013). Following the Supreme Court's decision that state action immunity did not apply, the parties reached a consent agreement in the administrative proceeding, obviating the need for an adjudication on the merits. See Order Withdrawing Matter From Adjudication for the Purpose of Considering a Consent Proposal, *In re Phoebe Putney Health Sys., Inc.*, F.T.C. Docket No. 9348 (2015).

⁴² See Mem. Opinion and Order at 11, *FTC v. OSF Healthcare Sys.*, No. 3:11-cv-50344 (N.D. Ill. 2012) (“[D]efense counsel indicated at the hearing that defendants are not contesting the geographic market in this case.”); Findings of Fact and Conclusions of Law at 18, *FTC v. ProMedica Health Sys.*, No. 3:11-cv-47 (N.D. Ohio 2011) (“Indeed, Defendant has not seriously disputed that Lucas County is the relevant geographic market for GAC.”).



county for OB services.”⁴³

In fact, prior to the *Advocate/Northshore* and *Hershey/Pinnacle* merger challenges, there was only one post-*Evanston* hospital merger challenge where a court had to seriously evaluate and rule on the appropriate geographic market. In challenging St. Luke’s Health System, Ltd.’s (“St. Luke’s”) acquisition of Saltzer Medical Group, P.A. (“Saltzer”), the FTC alleged that a series of zip codes around Nampa, Idaho was the relevant geographic market⁴⁴ and that defendants’ much larger geographic market of at least “Canyon County plus the western portion of Ada County” was improper because it relied on the Elzinga-Hogarty test, whose application to healthcare mergers had (according to the FTC) “been thoroughly discredited.”⁴⁵ While the court in *St. Luke’s* adopted the FTC’s geographic market, it did so relying in part on the FTC’s own patient flow data, finding that “68% of Nampa residents get their primary care from providers who are located in Nampa” and “only 15% of Nampa residents obtain their primary care in Boise . . . near where they work.”⁴⁶ Moreover, the court made no mention of the FTC’s criticism of the Elzinga-Hogarty framework.

Thus, while the decision in *Evanston* rejected a strict reliance on patient flow data to define the relevant geographic market in hospital mergers, it appears that patient flow data continued to aid both the FTC and the courts in defining the proper geographic market, albeit also with the assistance of testimony and documents from market participants, including commercial insurance payers, on the competitive dynamics and the likely effects of a merger between the hospital defendants.⁴⁷

IV. THE PATH FORWARD FOR MERGING HOSPITALS

Several explanations have been offered as to why hospital mergers and, in particular, geographic market definitions, created such difficulties for the FTC, notwithstanding its

⁴³ Findings of Fact and Conclusions of Law at 16-17, *ProMedica Health Sys.*, No. 3:11-cv-47 (N.D. Ohio 2011), ECF No. 121. While the FTC has argued against reliance on patient flow data to delineate the relevant geographic market in hospital mergers, the FTC continues to put forth such evidence when the data is consistent with and supported by other non-empirical evidence of a narrow geographic market. See, e.g. Br. of FTC and the Commonwealth of Penn. at 10, *Hershey II* (arguing that defendants’ documents and testimony evidence “aggressive competition” between the merging parties, especially in the Harrisburg area, and that “[t]he evidence showed that 91% of Harrisburg area patients sought care at hospitals located in the four-county area, within a median travel time of 15 minutes”).

⁴⁴ See Compl. for Permanent Inj. at 11, *FTC v. St. Luke’s Health System, Ltd.*, No. 1:13-cv-00116-BLW (D. Idaho 2014), ECF No. 98 (Relying on “both quantitative and qualitative evidence, including Defendants’ own executives and St. Luke’s ordinary-course documents,” the FTC alleged that the “relevant geographic market . . . is no larger than the five zip codes that encompass Nampa and Caldwell, Idaho.”).

⁴⁵ Pls.’ Joint Pre-Trial Mem. at 9, 10, n.34, *Saint Alphonsus Medical Ctr. – Nampa, Inc. v. St. Luke’s Health System, Ltd.*, No. 1:12-cv-00560-BLW (D. Idaho 2014), ECF No. 203.

⁴⁶ Findings of Fact and Conclusions of Law at 15, *St. Luke’s*, No. 1:12-cv-00560-BLW (D. Idaho 2014), ECF No. 464 (internal citations omitted).

⁴⁷ See, e.g. *Advocate I*, 2016 WL 3387163, at *3-5 (rejecting the FTC’s expert’s exclusion of destination hospitals in the relevant geographic market, but also noting that evidence on whether patients prefer to receive care near their homes is “equivocal”).



successes in other contexts throughout the same timeframe.⁴⁸

In the hospital merger context, the presence and role of commercial payers often makes it difficult to pin down the boundaries of the relevant geographic market. Through a form of bilateral bargaining, commercial payers negotiate reimbursement rates directly with healthcare providers and then sell insurance plans to employers and consumers. The importance of a healthcare provider to a commercial payer's network often depends on the provider's location and an assumption that patients prefer to receive care close to home. But, as the merging hospitals in numerous cases have successfully argued, actual patient travel patterns can undercut this assumption. And, because commercial payers generally cover all of a patient's healthcare costs except for the patient's co-pay, patient travel patterns cannot be explained by pricing considerations. Thus, properly defining the relevant geographic market in any given case has traditionally required balancing a number of factors unique to hospital mergers.

Also complicating hospital merger challenges is the Patient Protection and Affordable Care Act ("Affordable Care Act")⁴⁹ and its general emphasis on reimbursement for the quality of care ("paying for performance") as opposed to the traditional fee-for-service structure ("paying for volume"). Indeed, this policy shift — encouraging integrated care for all of a patient's needs to improve patient outcomes — was acknowledged in *St. Luke's*, where the court recognized the acquisition of Saltzer by St. Luke's as a means to "practice integrated medicine to improve the quality of care," and going so far as to state that "St. Luke's is to be applauded for its efforts to improve the delivery of health care in the Treasure Valley."⁵⁰ While the court granted the FTC's request for a permanent injunction, it also noted that "[i]n a world that was not governed by the Clayton Act, the best result might be to approve the Acquisition and monitor its outcome to see if the predicted price increases actually occurred. In other words, the Acquisition could serve as a controlled experiment."⁵¹

More recently, the lower court in *Hershey* took a stronger stance on the paradox of promoting integrated care while seeking to block healthcare mergers that would allow hospitals to provide a more complete array of services to care for all of their patients' needs. Specifically, the district court stated that:

[w]e find it no small irony that the same federal government under which the FTC operates has created a climate that virtually compels institutions to seek alliances such as the Hospitals intend here. . . . It is better for the people they treat that such hospitals unite and survive rather than remain divided and wither.⁵²

On appeal, although the Third Circuit acknowledged that increased scale may increase the

⁴⁸ See, e.g. *FTC v. Staples, Inc.*, No. 15-cv-02115, -- F. Supp. 3d --, 2016 WL 2899222 (D.D.C. 2016); *FTC v. Sysco Corp.*, 113 F. Supp. 3d 1 (D.D.C. 2015).

⁴⁹ Patient Protection and Affordable Care Act, Pub. L. No. 11-48, 124 Stat. 119 (2010).

⁵⁰ Findings of Fact and Conclusions of Law at 3-4, 46, *St. Luke's*, No. 1:12-cv-00560-BLW (D. Idaho 2014), ECF No. 464.

⁵¹ *Id.* at 51.

⁵² *Hershey I*, 2016 WL 2622372, at *9.



hospitals' ability to engage in risk-based contracting in some ways, it ultimately found that the hospitals had not demonstrated that any such benefits would be passed on to consumers.⁵³

While these factors may explain why the use of patient travel patterns continued to play a role in geographic market definitions until recently, the Third and Seventh Circuits have made clear that such analyses are relevant only to the extent they inform how payers are likely to respond to the proposed merger. As such, instead of relying on patient travel patterns to argue for a broader geographic market, parties should seek to understand how payers would respond to a 5 percent price increase by a hypothetical monopolist healthcare provider in the alleged geographic market.⁵⁴ Relatedly, parties should also consider how non-price factors, such as convenience and quality of care, inform payers' understanding of what employers and other customers demand in their health plan.⁵⁵ Finally, as a way of further evaluating payers' likely responses, parties should review available healthcare data to determine where patients would seek care if their first choice hospital were to become unavailable.⁵⁶ While this data still looks to patient rather than payer preferences, diversion ratios better predict post-merger travel patterns and may therefore be afforded more weight than patient travel patterns.⁵⁷

V. CONCLUSION

Despite the decision in *Evanston*, a close look at the ensuing hospital merger challenges shows that patient flow data – and even some semblance of the Elzinga-Hogarty test – continued to inform geographic market analysis in hospital (and physician group) mergers until recently. But now that two appeals courts have issued opinions clearly rejecting the Elzinga-Hogarty framework and its reliance on patient travel patterns to define the geographic market in hospital mergers, practitioners should no longer rely on these previous decisions and should instead prepare to present as much evidence as to payers' likely response to a five percent price increase by the merging parties.

⁵³ *Hershey II*, 838 F.3d at 351 (“It is not clear from the record how this would be so beyond the mere assertion that it would save the Hospitals money and such savings would be passed on to consumers.”).

⁵⁴ See *Hershey II*, 838 F.3d at 344-45; *Advocate II*, 2016 WL 6407247, at *10.

⁵⁵ See *Advocate II*, 2016 WL 6407247, at *10.

⁵⁶ See *id.* at *10-11.

⁵⁷ *Id.*