Anti-competitive behavior by firms is not inherently evil. There are often public benefits to anti-competitive behavior, in addition to the harm it may cause. Although Microsoft’s bundling of the Internet Explorer browser with its Windows 95 operating system stifled competition in the market for web browsers, it helped ensure a de facto standard, and enabled the browser to function more seamlessly within the operating system. While this behavior was clearly harmful to Netscape, it would be far harder to argue that it was harmful to the consumer. In The United States v. Microsoft, the Federal Trade Commission (FTC) attempted to impose changes in the integration between Windows and Internet Explorer, and ultimately failed in doing so.1

At the time of writing, in April 2007, the Federal Trade Commission was engaged in another battle that was dubiously in the public’s interest. In the Matter of Evanston Northwestern Healthcare Corporation [ENH] and ENH Medical Group, Inc., the FTC made three allegations of anti-competitive behavior.2 The FTC alleged that ENH’s attempt to merge its two hospitals, Evanston Hospital and Glenbrook Hospital, with the nearby Highland Park Hospital, was in violation of Section 7 of the Clayton Act. In further violation of Section 7, it was alleged that ENH used its market power to create a sustained increase in prices. The FTC additionally alleged that ENH engaged in the price fixing of physician services by forcing health plans to negotiate hospital and physician prices in the same negotiation.3 In order to focus on the hospital merger, this paper will

not explore the allegation related to the bundling of hospital and physician services price negotiations.

While this case was originally decided against the interests of ENH, it was still in appeal as of April 2007. Highland Park Hospital continued to display a purple and white ENH sign outside of its entrance, despite the uncertainty of the future of the merger. Should Highland Park Hospital (HPH) be allowed to continue its operations as part of ENH, or should it be forced to sever its ties?

This question is difficult to answer, as it could arguably be in the public’s best interest for either outcome to occur. The FTC and payers have argued that merging with HPH has enabled ENH to substantially raise its prices. ENH, along with a variety of medical, hospital, and business organizations, as well as the City of Highland Park, has argued that the merger has substantially improved the quality of HPH, providing those in the Highland Park area with easier access to high-quality care. Thus, the question boils down to whether it is in the public’s best interest for HPH to offer better service, with the side-effect of decreased competition in the relevant market. While I will attempt to explore both sides of the case, I will try to demonstrate why I believe that HPH should remain a part of ENH. Having lived for seventeen years in homes equidistant from Evanston Hospital and Highland Park Hospital, I feel strongly that it would be feasible for a health plan to design coverage that does not include the ENH hospitals, if doing so were desired. Having patronized HPH both before and after the merger, I have witnessed the investments that ENH has made in the facility.
Had an Antitrust Violation Occurred?

According to J. J. Miles (1998), there are six steps to determining whether an antitrust violation has occurred. The steps suggested by Miles are:

1. Define the product market
2. Define the geographic market
3. Identify competitors with the same product, in the same geographic market
4. Calculate the pre-merger market shares of competitors and the Herfindahl-Hirschman Index
5. Calculate the post-merger market share of competitors and the Herfindahl-Hirschman Index, and determine the likely competitive effects of the merger
6. Consider any factors which might mitigate or enhance the anticompetitive effects

Thus, in order to tell whether a violation has occurred, we must first explore the product and geographic market of ENH. Using the market, as defined by ENH or the FTC, it is then possible to see how the merger affected market concentration, as determined by the Herfindahl-Hirschman Index (HHI). When the HHI of a market is high, firms within it have strong monopoly or oligopoly power, and can control prices. Alternatively, when the HHI of a market is low, the firms in the market are price-takers and the market is competitive. Needless to say, it is in the best interest of the hospitals for the HHI of the market for northern Illinois academic medicine to be high, and it is in the best interest of the insurers for the HHI to be low. However, there may be mitigating factors that affect whether it is in the best interest of consumers for ENH to be a financially-strong player with a large amount of market power.

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**Frequently Asked Question: What is the Herfindahl-Hirschman Index?**

The Herfindahl-Hirschman Index (HHI) is a measure of market concentration used to determine whether or not a market is anti-competitive. In order to calculate the HHI of a market, one must first determine the products sold in the market and the geographic limits of the market. Then, one must determine the output of all of the firms within the market.

\[
HHI = \sum_{i=1}^{n} 100 \times \frac{\text{firmOutput}_i}{\text{marketOutput}}
\]

A merger is likely to be viewed as anticompetitive if it raises the HHI by 50 more points, resulting in an HHI of over 1,800, or if it raises the HHI by 100 or more points, and results in an HHI of over 1,000. The fewer firms in the market, the higher the HHI.

**The Product Market**

Far fewer pages of the initial decision were devoted to determining the product market of ENH than were devoted to determining its geographic market. This is likely because the product market is far less debatable than the geographic market. (Three pages of the initial decision were spent discussing the product market, while eleven pages were spent discussing the geographic market.\(^5\)) The court defined the relevant product market as “general acute care inpatient services sold to managed care organizations.” The product offered by ENH was said to include primary, secondary, and tertiary services, but not quaternary services.\(^6\) Dr. Monica Noether, ENH’s economic expert, agreed that specialty hospitals which do not provide a full range of hospital services may be excluded.

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from the product market.\(^7\) (It is in ENH’s best interest to include as many types of care as possible in the product market, as the larger the amount of competition, the lower the HHI for the market, and the less likely it will be declared that an antitrust violation has occurred.)

Before the merger, HPH was a community hospital serving the needs of the local community. As its facilities were not recently renovated and it had no academic affiliation, people used the hospital to receive standard, maintenance treatments, rather than to receive cutting-edge medical care. After the merger, HPH was affiliated with Northwestern University’s Feinberg School of Medicine, like the other hospitals that were part of ENH.

The Geographic Market

The hospitals involved in the merger are all located in suburbs within northern Illinois, near the shore of Lake Michigan. The population has easy access to downtown Chicago, as a train runs through the region, providing regular service. Evanston borders Chicago, potentially allowing its population to use the city’s hospitals with little added effort. The population is not particularly dense, but it is rather affluent. According to Forbes, Glencoe, Kenilworth, and Winnetka had the United States’ 160\(^{th}\), 88\(^{th}\), and 168\(^{th}\) “most expensive ZIP Codes” respectively in 2006.\(^8\) As a result, most of the people living in the area have cars and can afford to take a cab to and from the city in the event that they are unable to drive themselves while receiving medical care.

Figure 1: Northern Illinois and the ENH Hospitals; Street Map (Left) and Satellite Map (Right)^9

<table>
<thead>
<tr>
<th>Community</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deerfield</td>
<td>18,420</td>
</tr>
<tr>
<td>Evanston</td>
<td>74,239</td>
</tr>
<tr>
<td>Glencoe</td>
<td>8,762</td>
</tr>
<tr>
<td>Glenview</td>
<td>41,847</td>
</tr>
<tr>
<td>Highland Park</td>
<td>31,365</td>
</tr>
<tr>
<td>Highwood</td>
<td>4,143</td>
</tr>
<tr>
<td>Kenilworth</td>
<td>2,494</td>
</tr>
<tr>
<td>Northbrook</td>
<td>33,435</td>
</tr>
<tr>
<td>Northfield</td>
<td>5,389</td>
</tr>
<tr>
<td>Wilmette</td>
<td>27,651</td>
</tr>
<tr>
<td>Winnetka</td>
<td>12,419</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>260,164</strong></td>
</tr>
</tbody>
</table>

Figure 2: Populations of Communities near the ENH Hospitals (2000 Census Data)^10

In Figure 2, the populations of the communities encompassed by the ENH hospitals are provided. Glenbrook Hospital is situated to geographically serve the communities of Glenview and Northbrook (Glenview + Northbrook = Glenbrook, a name used for many institutions in the area). Unsurprisingly, the hospitals are located in the

^10 Extracted from multiple entries on Wikipedia. Available at <http://en.wikipedia.org/wiki/*%2C_Illinois> where * is the name of the city.
communities with the highest populations in the area. The three ENH hospitals combined have 645 beds, which according to Cusack et al. (2006), is only a 3.4% share of the market.\(^\text{11}\)

The ENH hospitals are by no means the only hospitals available to people living in northern Illinois. In Cook County, DuPage County, and Lake County, there are a total of 19,493 staffed hospital beds. (Chicago, Evanston, Glenview, and Northbrook are all in Cook County, while Highland Park is in Lake County.) In Evanston, St. Francis Hospital provides 236 beds. In nearby Skokie, the Rush North Shore Medical Center provides 239 beds. Rush North Shore is academically affiliated with Rush University.\(^\text{12}\)

Beyond the ENH hospitals and Rush University’s three hospitals (which combined have 2,392 beds), there are several slightly more distant hospitals offering academic medicine. Northwestern University’s Feinberg School of Medicine is affiliated with Northwestern Memorial Hospital in addition to ENH. Northwestern Memorial Hospital contracts with payers separately from ENH, and has 744 beds. Other local academic offerings include the University of Chicago Hospitals, which have 585 beds, the Loyola University Medical Center, with 505 beds, and the University of Illinois Medical Center at Chicago, with 443 beds. There are also a slew of religious and for-profit hospitals in the region for those who do not desire academic medicine.\(^\text{13}\) Thus, in the event that an insurer was not willing to contract with ENH, there would be many other hospitals in the area with which it could contract.

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\(^\text{12}\) Ib. at 6.

\(^\text{13}\) Ib. at 6.
As is shown in the satellite map on the right side of Figure 1, northern Illinois is green and sparsely populated. Most of the residents commute from their homes to Chicago, as there are few opportunities for employment in the suburbs. Since the residents of the area are accustomed to commuting into the city, they can coordinate their commutes with their medical care if they desire. As many medical specialties only make appointments during the daytime, it may in fact be easier for much of the population of northern Illinois to receive medical care from Chicago hospitals than from suburban hospitals. Insurer contracting is unlikely to affect how patients choose hospitals in emergency situations, as ambulances typically take patients to the nearest adequate hospital.

It is rather ambiguous how wide a radius a geographic market can be defined as having. According to Gaynor and Vogt (2000), “Geographic markets have been found to be as small as a single county, with a single city as a relevant submarket (San Luis Obispo) to as large as 19 counties (Roanoke) or to include hospitals as far way as 100 from merging hospitals (Dubuque).” Thus, although the FTC successfully argued that patient flow data should not be used to determine geographic markets, as the patients are not the payers, there is past precedent for hospitals having wide geographic markets. The court felt that most “people will not travel in response to a change in hospital prices, and those people can be subject to an anticompetitive price increase.” Furthermore, it was stated that the affluent population situated between the ENH hospitals is less willing to travel due to the high opportunity cost of the time they spend traveling.

16 Ib. at 10.
Before the merger, several payers claim that they had used the threat of including ENH and not Highland Park (or vice-versa) in their plans in order to leverage lower prices. After the merger, this no longer was possible. However, it is not clear that the payers had no other options. According to the initial decision, “The Aetna representative testified that Evanston competed locally with Rush North Shore and St. Francis and that Highland Park competed locally primarily with Lake Forest.” Thus, it would have been possible for Aetna to have potentially excluded the merged ENH if financially necessary. This was the view of Evanston Hospital’s CEO, Mark Neaman, who testified that while Condell and Lake Forest were competitors of Evanston Hospital, Highland Park Hospital was not a major competitor. However, ENH has also made public statements that do not support the belief that in a competitive market, patients might be willing to travel to Chicago. According to the initial court decision, when Evanston submitted a proposal for extending its heart surgery program to include Highland Park, it stated:

Last, a concept that is often misunderstood by persons not living in suburban communities is that many suburban residents rarely travel from their general area of residence for shopping, business and health care services. For this reason, many of the anxiety and convenience-related issues related to a resistance to travel for care that are typically associated with smaller communities, also exist in the suburbs.

While this statement may have been made purely to encourage the approval of a proposal, it provides evidence contradictory to the assertion that Chicago hospitals serve as a viable alternative to the ENH hospitals.

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I personally believe that Chicago hospitals are a viable substitute for the ENH hospitals, and that people in northern Illinois would not be substantially inconvenienced by a health plan that did not include the ENH hospitals. While affluent adults highly value their time, they often generate their income in Chicago, enabling them to potentially plan their medical care around their work day. Elderly people, who are less likely to commute to Chicago on a regular basis, do not have as high an opportunity cost as those in the workforce. Thus, the elderly would not be very adversely affected by health plan design decisions favoring Chicago-based care. While children would have to depend on their workforce-age, likely affluent, parents to take them to Chicago-based hospitals, this is not likely to be a substantial inconvenience as children require far less non-emergency, hospital-based care than adults or the elderly.

**Effect of the Merger on the Herfindahl-Hirshman Index**

It is a simple statement of mathematical fact that any merger will raise the HHI. If Hospital A has market share A and Hospital B has market share B, and the two hospitals combine, the HHI of the market will increase by:

\[(A + B)^2 - A^2 - B^2 \geq 0\]

When the HHI of the market increases, firms have more leverage in setting their prices.

A merger is considered anticompetitive if it raises the HHI by over 50 points, to a level greater than 1,800. If two firms with 5% of market share merge into one firm with 10% of market share, the HHI increases exactly 50 points.

The court found the pre-merger HHI to be 2,355 and the post-merger HHI to be 2,739. Thus, the merger caused the HHI to increase by 384. Dr. Monica Noether, who
testified on behalf of ENH, had more favorable estimates of the HHI. She claimed that the pre-merger HHI was 1,697, and that the post-merger HHI was 1,919, indicating that the merger had increased the HHI by 222.20 While both estimates of the change in HHI imply that the merger was anticompetitive, Noether’s estimate makes the market appear far more competitive than the estimate used by the FTC.

### Negative Effects of the Merger

The FTC has alleged that the merger had two negative effects; it violated Section 7 of the Clayton Act and raised the Herfindahl-Hirschman Index to an anti-competitive level and it enabled ENH to extract substantial price increases from payers.21 All of the payers contracting with ENH, except Blue Cross, who protested, experienced substantial price increases in 2000 after the merger had taken place.

<table>
<thead>
<tr>
<th>MCO</th>
<th>Type</th>
<th>Hospital</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>All</td>
<td>ENH</td>
<td>15%</td>
</tr>
<tr>
<td>Blue Cross</td>
<td>All</td>
<td>ENH</td>
<td>Challenged and repealed</td>
</tr>
<tr>
<td>CIGNA</td>
<td>HMO</td>
<td>ENH</td>
<td>15-20%</td>
</tr>
<tr>
<td>CIGNA</td>
<td>PPO</td>
<td>ENH</td>
<td>30%</td>
</tr>
<tr>
<td>HFN, Inc.</td>
<td>EPO</td>
<td>EH / GH</td>
<td>25%</td>
</tr>
<tr>
<td>HFN, Inc.</td>
<td>EPO</td>
<td>HPH</td>
<td>21%</td>
</tr>
<tr>
<td>Humana</td>
<td>PPO</td>
<td>ENH</td>
<td>50-60%</td>
</tr>
<tr>
<td>Preferred Plan, Inc.</td>
<td>All</td>
<td>ENG</td>
<td>24%</td>
</tr>
<tr>
<td>Private Healthcare</td>
<td>All</td>
<td>EH / GH</td>
<td>40%</td>
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<tr>
<td>United</td>
<td>HMO</td>
<td>EH / GH</td>
<td>52%</td>
</tr>
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<td>PPO</td>
<td>HPH</td>
<td>38%</td>
</tr>
<tr>
<td>United</td>
<td>PPO</td>
<td>EH / GH</td>
<td>190%</td>
</tr>
<tr>
<td>United</td>
<td>PPO</td>
<td>HPH</td>
<td>15-20%</td>
</tr>
</tbody>
</table>

Figure 3: ENH's Price Increases in 200022

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21 The FTC’s third charge, that ENH engaged in price fixing by bundling physician services with hospital services when negotiating prices, is not fully related to the actual merger.

From the data presented in Figure 3, it is unambiguous that ENH raised its prices at its hospitals after the merger occurred. However, the mere fact that prices were raised does not indicate that anti-competitive activity occurred. According to Professor Deborah Haas-Watson, there are eight possible legitimate explanations for why price increases may have occurred:

1. Cost increases affecting all hospitals
2. Changes in regulations affecting all hospitals
3. Increases in consumer demand for hospital services
4. Increases in quality at ENH
5. Changes in the mix of patients
6. Changes in the mix of ENH customers
7. Increases in teaching intensity
8. Decreases in outpatient prices

Although Professor Haas-Watson dismissed all of the legitimate explanations for price increases, some might wish to argue against her findings. While Haas-Watson’s fourth explanation, increases in quality at ENH, would explain the price increases experienced at HPH, it does not explain the price increases experienced at the other ENH hospitals.

In its response to the FTC’s allegations, ENH claimed that it increased its prices because its pre-merger prices were below market levels. After Evanston and Glenbrook Hospital merged with Highland Park Hospital, all of the hospitals were able to share information about their contracts with insurers. ENH was surprised to learn that the prices paid by insurers to Evanston and Glenbrook were in general lower than those paid to Highland Park, despite the fact that Evanston and Glenbrook are academic hospitals, and Highland Park was a community hospital. Typically, academic hospitals charge higher prices than community hospitals, as there are extra costs associated with training residents and performing research. Upon discovering that Highland Park Hospital was

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receiving higher payments, ENH began to consider that it had been using below-market prices at its other hospitals. After converting HPH into an academic hospital and improving its services, ENH felt justified in raising its prices as well. Thus, the merger may have caused ENH to unilaterally raise its prices even if it were not in fact engaging in anti-competitive behavior.

**Are there any factors that mitigate the “harm” done by the merger?**

Using the criteria provided by Miles (1998), a merger may still be permissible if there are factors that mitigate the anticompetitive effects. Two arguments used in this case that may make the merger appeal more favorable are the argument that Highland Park Hospital was failing, and that the merger improved access and quality of care in Highland Park. Another issue that must be considered is what course of action is in the public’s best interest.

Cusack et al. felt rather strongly that people consuming healthcare were better served by a merged HPH than by a more competitive market. They stated, “The FTC failed to call a single consumer or patient of any of the Evanston Northwestern Healthcare hospitals to demonstrate the alleged injury to competition.”24 They felt that the judge relied too heavily on “the self-serving testimony of MCOs as ‘customers’ of ENH,” while ignoring the needs of the patients. As it is in the best interest of payers to claim that they are being overcharged, the complaints of MCOs do not demonstrate that an injustice has occurred. The preliminary witness list of the FTC featured MCO

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executives from Aetna, Blue Cross and Blue Shield of Illinois, Provider Networks, CIGNA, HFN, Humana, One Health, Private Health Care Systems, Preferred Plan, Unicare, and United Healthcare. There were additionally witnesses from several competing hospitals; Resurrection Healthcare, Lake Forest Hospital, St. Francis Hospital, Rush North Shore, and Northwestern Memorial Hospital. Also present were representatives from Abbott Laboratories, to testify about an employer’s experiences negotiating with ENH, and Towers Perrin, a professional services firm that had conducted a study on the merger. None of these parties has a vested interest in the quality of care improving at HPH. However, they all lose money if ENH gains market power or raises prices.

After the initial decision in favor of the FTC, several amicus curiae were filed on behalf of ENH. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO), a group representing “the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association and the American Medical Association,” was one of the supporters of the merger.25 JCAHO, however, has a vested interest in allowing the merger to occur, as physicians potentially benefit from the higher prices resulting from the merger. The American Hospital Association, “a national advocacy organization that represents and serves hospitals and health care networks of all types and sizes,” also filed in support of

ENH. While some of the organizations that filed the amicus curiae briefs had a self-serving interest in seeing that ENH was allowed to retain HPH, there were also briefs filed by fully neutral parties. The Business Roundtable, “an association of chief executive officers of leading U.S. corporations” and the Advisor Board Company, “a for-profit research organization that provides best practices research and analysis to the health care industry” both filed on behalf of ENH.

Perhaps most persuasively, the City of Highland Park filed on behalf of Highland Park Hospital. The lead author of the amicus curiae was John Edward Porter, a former member of the U.S. House of Representatives, who had represented Illinois’s 10th district (which includes Highland Park). Both Mr. Porter and the City of Highland Park represent the interests of the citizens in the area, not the interests of the payers or the providers. The neutrality of the parties involved makes these amicus curiae a particularly important representation of the needs of the consumer.

In supporting the merger, Porter et al. argued that divestiture could hurt the recruitment of physicians at HPH, and cause it to lose some of the physicians it had. This fear was tangible, as sixty HPH physicians had been given academic appointments by

ENH following the merger. The physicians might enjoy their academic status, and be reluctant to part with it (and with ENH) in the event that the hospital was divested.

Porter et al. also argued that if HPH were to merge with another hospital, it would be unlikely for that merger to be as successful as the merger with ENH. The City of Highland Park felt that the merger met and surpassed its goals from the perspective of the community, and recognized that it is rare when a hospital merger succeeds and does not reduce efficiency. Todd (1999) spoke to this fact by stating, “McKinsey’s study … found that most hospital mergers, to put it bluntly, have failed. They have failed to save money, failed to increase market share, and failed to garner higher reimbursements—in short, failed to deliver on their promises.”30 This was not the case at HPH. The claim of increased efficiency in the past has sometimes been adequate to justify a merger. According to Gaynor and Vogt (2000), “In hospital merger cases, courts have sometimes found the efficiency claims plausible.”31 Thus, increased efficiency may be legitimate grounds for a merger. According to Porter, it is unlikely that these benefits could have achieved by merging HPH with another hospital, as HPH sought a non-religious, non-profit partner with a similar culture, and only ENH seemed suitable.

The divestiture of HPH was viewed by Porter et al. as unlikely to restore competition, and as potentially harmful to the community. This was argued, as ENH has no vested interest in helping another acquirer rehabilitate the hospital. It was stated, “The eggs are so completely scrambled that successful divestiture is unlikely.” In order to achieve efficiencies, ENH dismantled all of the corporate functions occurring in Highland Park and transferred them to Evanston, in addition to consolidating the medical staffs.

After having now acted for several years as a single entity with a single Medicare identification number, billing system, and administrative office, it is unlikely that the hospitals will be easily separable. It is somewhat remarkable that ENH managed to achieve this level of integration, as Todd (1999) wrote, “In many cases, merging nonprofit hospitals, which naturally have a charitable orientation, shy away from making painful but necessary staffing and service cuts.” Thus, the very success of the merger added to the potential difficulty of divestiture.

Finally, many of the benefits resulting from the merger would likely be lost in the event of the divestiture of HPH. Although the parking garage and physical plant renovations installed by ENH would not disappear after a divestiture occurred, many of the other benefits accrued would be likely to vanish. The benefits of academic status will disappear if HPH ceases to be affiliated with Northwestern University. Also, the Kellogg Cancer Center can only exist with the support of the other ENH hospitals. Electronic medical records are uncommon in community hospitals, but HPH was one of the first to gain the benefit of them, as it was able to utilize ENH’s license for EPIC. If divestiture occurred, HPH would be left to decide whether to purchase its own license for EPIC, at great expense, to abandon electronic medical records, or to migrate to a new system. For all of these reasons, the quality of HPH would be reduced if it were to be divested from ENH.

Conclusion

It is my belief that Highland Park Hospital should be allowed to remain a part of Evanston Northwestern Healthcare. I am unconvinced by the arguments of the FTC, as much of the witness testimony that they provided was given by self-serving witnesses. The extensive support the merger has seen from neutral organizations and the community is strong evidence that it is likely in the public’s best interest.

I feel that the geographic market for inpatient care was incorrectly defined in this case. There are a broad range of hospitals in Chicago, which albeit inconvenient, are likely near the workplaces of the local workforce. Although children and the elderly are unlikely to frequently be near Chicago hospitals, the opportunity cost of the time spent by the elderly visiting hospitals for non-emergency care is low, and children require little non-emergency care in the first place. While people in the region may not be accustomed to utilizing non-ENH hospitals at present, if health plan designs excluded the hospitals, it is likely that behavior would rapidly change.

Evanston Northwestern Healthcare should be commended for making an investment in Highland Park Hospital, and should be allowed to reap the long-term rewards of its efforts. So long as the fate of HPH is unknown, ENH is unlikely to be willing to make further capital investments in HPH, reducing the potential quality of care available to the community. HPH was in poor physical condition before the merger, and could not afford to make the investments necessary to both increase its quality and profitability. ENH chose to primarily focus on adding services to HPH that were profit centers; an improved ambulatory care center, a cancer center, a cardiac catheterization lab, and a parking garage. These services are typically used on a non-emergency basis,
but benefit the community if they are located locally. If payers do not wish to include the ENH system, Highland Park cancer patients can continue to receive their treatments at a hospital other than HPH, as they did before the merger and upgrades. However, if payers wish to include HPH in their network, Highland Park cancer patients can experience a benefit that likely would never have been possible without the merger. Feldman & Wholey (2001) supported this belief when the cited Rubenstein, et al. (1995) as stating that “HMOs were willing to move patients among hospitals to get lower prices for tertiary care.” Thus, there is no reason to believe that health plans cannot thrive without providing access to the services of HPH.

Although it is clear that prices were raised by ENH after the merger, it is not clear that they were raised to above-market levels. Brooks et al. (1997) reported, ““We are able to demonstrate that the bargaining power of hospitals has diminished over time, which supports earlier empirical findings.” ENH may have raised prices at Evanston Hospital and Glenbrook Hospital after discovering with horror that it was charging less at its academic hospitals than was being charged at Highland Park Hospital, a community hospital. After upgrades and investments were made in Highland Park Hospital, it might have only seemed reasonable to increase prices there as well.

The fate of Highland Park Hospital has yet to be decided. Hopefully, this piece has helped demonstrate how it is in the community’s best interest for the hospital to remain in the nurturing hands of Evanston Northwestern Healthcare. Capitally-intensive projects, like the upgrades pursued by ENH, cannot be performed without the support of

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an entity with a large amount of cash reserves or a good bond rating. HPH is fortunate to have received the upgrades and support that it needed to be able to profitably deliver quality care to the northern Illinois community for years to come.