UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

In the matter of	)	
	)	Docket No. 9315
Evanston Northwestern Healthcare Corporation,	)	**Public Record**

POST-TRIAL BRIEF OF RESPONDENT EVANSTON NORTHWESTERN HEALTHCARE CORPORATION

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INTRODUCTION

This is the case that was supposed to reinvigorate federal antitrust enforcement directed toward hospital mergers. It is the case that was supposed to demonstrate that the FTC Staff can identify consummated mergers that have had anticompetitive effects. And it is the case in which Complaint Counsel planned to prove such anti-competitive effects with what it labels "direct evidence"-- rather than a market structure analysis -- with the hope of convincing the Court to ignore a half century of legal precedent requiring proof of a relevant market within which to evaluate those effects.

After a two-month trial -- featuring testimony from 41 witnesses and the admission of more than 1500 exhibits into evidence -- it is clear that this case is none of those things. Complaint Counsel failed to prove that the five-year old merger between Evanston Northwestern Healthcare Corp. ("ENH") and Highland Park Hospital ("HPH") (the "Merger") created market power resulting in anti-competitive price increases.[1] Experts for the parties agreed that evidence of a price increase coincident with a merger is not indicative of market power unless all competitively benign explanations for the price increase have been eliminated. Complaint Counsel failed to do this. To the contrary, the testimony, contemporaneous documents, and expert analyses showed that prices under long outdated contracts between Evanston Hospital and Managed Care Organizations ("MCOs")[2] only rose to competitive levels. These prices increased because Evanston Hospital learned at about the time of the Merger -- and with the help of outside consultants -- that it had underestimated the demand for its services. Such a phenomena

[1] "HPH" refers to Highland Park Hospital; "Evanston Hospital" refers to pre-Merger Evanston and Glenbrook Hospitals when referred to in the past tense, and Evanston Hospital alone when referred to in the present tense; and "ENH" refers to all three hospitals collectively after the Merger.

[2] The terms MCO and payor are interchangeable.

recognized in economic theory -- described as "learning about demand" -- is simply not the concern of antitrust.

Moreover, the evidence showed that the combination of Evanston Hospital with a financially strapped, community hospital, HPH, resulted in unprecedented improvements in the quality of healthcare services available at HPH in Lake County, Illinois. These quality improvements outweigh any purported anti-competitive effects from the Merger and, in any event, it is Complaint Counsel's burden to show otherwise. Testimony from numerous physicians, hospital administrators, a nurse, a pharmacist, and from Respondent's quality of care expert, Dr. Mark Chassin -- as well as ENH's investments of over $120 million in HPH since the Merger -- overwhelmingly show that ENH's improvements in the quality of HPH outweigh any purported anti-competitive effects from the Merger. This strong quality evidence is Complaint Counsel's worst nightmare. As one self-styled Special Counsel to the FTC recently wrote:

> "[O]ne senior antitrust official, speaking on condition of anonymity, candidly stated that if the agencies ever confronted a serious quality of care defense backed up by an empirical study, they 'really wouldn't know what to do with it.'"[3]

Two counts in the Complaint challenge the hospital merger. Count I alleges most of the traditional elements of a merger challenge under Section 7 of the Clayton Act -- relevant product market, relevant geographic market, and at least some variant of anti-competitive effects flowing from the Merger. As demonstrated below, Complaint Counsel has failed to meet its burden of persuasion on each of these necessary elements of its prima facie case.

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[3] D. Hyman, Five Reasons Why Health Care Quality Research Hasn't Affected Competition Law and Policy, 4 Int'l J. of Health Care Finance and Econ. 159,163 (2004)

In an effort to mask these failings of proof under traditional antitrust principles, Complaint Counsel urges this Court to adopt novel legal theories aimed at lightening its burdens. Count II of the Complaint, for example, seeks to establish a violation of Section 7 without pleading and proving a relevant product or geographic market based solely on so-called direct evidence of anti-competitive effects. This Court should reject Complaint Counsel's invitation to blaze such new ground with this and other imaginative , but legally unsupportable, theories given that:

- No court in a Section 7 merger case has ever permitted the government to avoid proof of a relevant market as a matter of law;
- No court in a merger case has ever held that the relevant geographic market consisted of only the merging hospitals -- particularly in the suburbs of a large metropolitan area;
- No court in a merger case has ever held that the government established "direct evidence" of anti-competitive effects in the face of viable alternative explanations for a price increase; and
- No court in a merger case has ever applied Complaint Counsel's theory of unilateral anti-competitive effects -- which differs from those in the Merger Guidelines -- where the facts show that other hospitals were closer substitutes to each of the merging firms than they were to one another.

There is no reason to depart from such well settled principles in this case.

SUMMARY OF ARGUMENT

Complaint Counsel has the burden of persuasion on each and every element of its Section 7 claims under both Counts I and II. Should this Court find for Respondent on *any one* of the dispositive issues set forth in Items 1 through 6 below, the Complaint should be dismissed in its entirety. If the Court finds for Respondent for the reasons set forth in Item 7 and/or Item 8, the court should dismiss the Complaint on Count I and/or Count II respectively.

1. Complaint Counsel did not disprove the existence of credible explanations for the price increases that are alternatives to market power. Accordingly, Complaint Counsel failed to carry its burden of proving anti-competitive effects. (Count I , II);
2. ENH's average prices only increased to competitive levels coincident with the Merger consistent with the learning about demand theory. In other words, Complaint Counsel failed to carry its burden of proving anti-competitive effects. (Count I, II);
3. Complaint Counsel failed to prove than any alleged anti-competitive effects of the Merger outweigh the evidence of substantial quality of care improvements ENH made in connection with the Merger. (Count I, II);
4. Complaint Counsel failed to carry its burden of proving anti-competitive effects because the price increases coincident with the merger may be explained by some combination of Items 1-3 above. (Count I, II);
5. ENH and HPH were "sister corporations" before the merger and therefore the same "person" under the Clayton Act. Therefore, the Merger was not subject to the jurisdiction of the Clayton Act. (Counts I, II);
6. Section 7 of the Clayton Act only prohibits transactions that are likely to "substantially "lessen competition" or "tend to create a monopoly." Regardless of what happened to pricing in 2000, Complaint Counsel failed to carry its burden to establish that the Merger is likely to have anti-competitive effect in the future today. (Counts I, II);
7. Complaint Counsel failed to prove that the relevant geographic market consists of only the three merging hospitals, a necessary element of a Section 7 claim. (Count I); and
8. Section 7 of the Clayton Act requires that Complaint Counsel allege and prove a relevant product and geographic market and, therefore, Count II which alleges no such relevant market, should be dismissed as a matter of law. (Count II).

In addition, there are a number of other factors which, while not themselves dispositive, would support a finding that the Merger did not violate Section 7 of the Clayton Act. In the event the Court did not find *any* of the facts above, it should consider the totality of the evidence for each count. Respondent's arguments are summarized below.

I. Complaint Counsel Failed to Prove Its Relevant Market

A. The Evidence Does Not Support Complaint Counsel's Product Market

Complaint Counsel failed to prove the product market alleged in the Complaint -- primary and secondary acute inpatient hospital services. The complaint specifically excluded more complex tertiary services -- such as "open heart surgery and transplants" -- as well as outpatient services offered at hospitals. *See* Compl. ¶ 16. The Complaint Counsel's own expert, however, agreed that tertiary services should be included in the relevant market in this case. Thus, the only dispute over the product market between the parties is whether it should include hospital-based outpatient services. The proper inclusion of these services in the relevant market is driven by Complaint Counsel's own chosen theory of the case -- that the "MCOs" are the relevant customers -- as well as the antitrust agencies' own Horizontal Merger Guidelines ("Merger Guidelines"). The undisputed evidence confirms that MCOs contract with hospitals for the entire bundle of inpatient and outpatient services that hospitals provide, often "trading off" the price of inpatient and outpatient services against one another to get a deal done. Thus, the correct product market must include both inpatient services -- primary, secondary, and tertiary -- as well as outpatient services.

B. Complaint Counsel's Gerrymandered Geographic Market Is Unsupported By The Evidence

Given that geographic market definition has been the downfall of the enforcement agencies in recent hospital merger cases, one may expect this to be the an area where Complaint Counsel would advance a conservative position consistent with the evidence in this case. It has not done so. Ignoring the case law, common sense and its own Merger Guidelines, Complaint Counsel attempts to gerrymander the market to include only the three hospitals involved in the Merger, and no others. In essence, Complaint Counsel's geographic market analysis is based

primarily on a circular argument. It assumes that ENH increased prices due to its enhanced market power -- an assumption it cannot prove -- and that therefore the market must not contain any competitors. The gerrymandered nature of Complaint Counsel's market is reflected in the awkward testimony of its own expert, who acknowledged that she could not identify with specificity the boundaries of the geographic market, but that it could include, in addition to the three ENH hospitals, such additional area as may take the market right up to -- but never include -- the next closest hospitals to each of the ENH campuses in any direction. That is not avoiding specificity; that is avoiding defining a market.

Complaint Counsel's purported geographic market is absurd. There are 18 hospitals closer to Evanston Hospital or HPH than Evanston Hospital or HPH are to each other. Representatives for the MCOs -- Complaint Counsel's own witnesses -- have testified that these geographic realities and employee preferences matter in assessing hospital competition. On the other hand, Respondent's economist, Dr. Noether, performed a comprehensive geographic market analysis and concluded that a highly conservative, minimum geographic market must include at least 9 hospitals, but may well include more. In addition, a number of more distant hospitals provide a competitive constraint on ENH. Dr. Noether looked at driving distances and times, actual patient travel patterns, physician admitting patterns, service area overlaps, third-party documents and a myriad of other sources to confirm her analysis which was consistent with the economic principles underlying the Guidelines. Complaint Counsel's market definition must fail.

C. Count II Should Be Rejected As A Matter of Law For Failing to Allege Any Relevant Market

Realizing the problems in its geographic market analysis, Complaint Counsel alleges in Count II of the Complaint that it need not prove a relevant market if it establishes direct evidence of anti-competitive effects. But once again, neither the law nor the facts support Complaint Counsel's claim. The Supreme Court and all lower federal courts have consistently held that the government must prove the relevant market in a merger case -- including in post-consummation merger cases.

II. Complaint Counsel Failed To Prove That The Merger Had Anti-Competitive Effects

A. The Post Merger Price Increases Were Not Anti-Competitive

Complaint Counsel failed to prove that the merger had anti-competitive effects. All of the economic experts who testified on this point -- both Respondent's and Complaint Counsel's -- stated that the fact that a firm increases its prices after a merger does not demonstrate that the firm has market power unless all viable competitively benign explanations for the price increase have been ruled out. Complaint Counsel's chief economic expert admitted that she did not even consider, let alone exclude, several credible alternative explanations for the price increase after the Merger. This fact alone, is enough to demonstrate that Complaint Counsel's pricing evidence did not prove an anti-competitive effect. Moreover, Complaint Counsel failed to establish the Merger is not likely to have an anti-competitive effect in the future, particularly given repositioning of competitors and increases in ENH quality since the Merger.

B. The Evidence is More Consistent With Respondent's Learning About Demand Theory Than With Complaint Counsel's Bargaining Theory

Although it is not Respondent's burden to do so, it has come forward with substantial, evidence from contemporary business records, an independent consultant, former ENH

employees, and hospital administrators demonstrating that Evanston Hospital learned many of its contracts with MCOs were outdated and under market in the fall of 1999. ENH used this new information it learned from HPH and from a consulting firm to better inform itself of the demand for its services, and to contract appropriately. Respondent's economists also testified about different empirical studies they did which all confirmed that learning about demand explained the price increase after the Merger. Under this theory, ENH's prices after the Merger were expected to increase from close to a community hospital average at which ENH was priced pre-merger toward the academic hospital average.

Ignoring several of the credible alternative explanations for the price increases, Complaint Counsel offers what it describes as "general bargaining theory" to explain them. The bargaining theory fails to explain the price changes in this case for at least three reasons. First, MCOs did not play Evanston Hospital and HPH off of each other before the Merger to get a better bargain. The evidence at trial -- MCO testimony, hospital documents and Dr. Noether's economic analysis -- confirmed that Evanston Hospital and HPH were not close substitutes before the Merger. Second, if the bargaining theory were correct, ENH should have been able to obtain some relative price increase from Blue Cross after the Merger. But ENH's prices to Blue Cross did not increase relative to other hospitals after the Merger. Finally, Complaint Counsel's economic expert testified that the theory would predict smaller price increases at larger MCOs and visa versa. But once again, the evidence from payors fails to support the theory. For example, United's increase, was larger than the price increases pertaining to both Aetna and Great West, the precise opposite of what Complaint Counsel's theory would predict.

On the other hand, these payor-by-payor outcomes are fully consistent with learning about demand. For example, because Evanston Hospital's pre-Merger rates with United were substantially lower than HPH's pre-Merger United rates, Evanston Hospital had more to learn about United's demand for its services than about Aetna's or Great West's demand where pre-merger price discrepancies were smaller. Under the learning about demand theory, United's prices should, and did, increase more than Aetna's or Great West's. Similarly, since Evanston Hospital historically paid careful attention to negotiations with Blue Cross and that Evanston Hospital's pre-merger contract rates with Blue Cross exceeded HPH's, its prices did not rise after the Merger.

C. The Relevant Post-Merger Price Increases Were Not Extraordinary

Finally, the relevant post-Merger price increases -- i.e., the ENH price increases when viewed in the context of price increases by competitor hospitals -- were only 9-12 percent overall. Complaint counsel's "payor-by-payor" and "plan-by-plan" price increases expressed in absolute terms are of little utility in assessing the competitive effect of the transaction. Moreover, even Respondent's assessment of the price increases is overstated because ENH's prices must be adjusted to account for the improvement in quality of the services being offered. As ENH has continued to improve the quality of its hospitals since the Merger -- and the evidence suggests that these improvements in key areas have been made at a rate exceeding other hospitals -- the reported prices increasingly overstate the true quality-adjusted prices for its services.

D. HPH's Declining Financial Condition Would Have Weakened Its Competitive Significance Absent The Merger

HPH was in a declining financial state in the years immediately proceeding the Merger. Documents and the testimony of accountants, financial advisors, and board members, who were familiar with HPH's financial state prior to the Merger, demonstrated that HPH could not maintain positive cash flows, while undertaking the quality and service improvements necessary to remain competitive on its own. Kenneth Kauffman -- an independent financial consultant hired by HPH Pre-Merger -- and Mr. Jones -- the Chief Financial Officer of Evanston Hospital -- both observed that as other area hospitals were rapidly expanding, HPH was immersed in a "deteriorating financial trend." HPH was not making money from operations on a year-to-year basis, and by 1999 its operating margin hovered near losses of over $3 million. Further, Respondent's expert economist, Dr. Noether -- who also holds a MBA -- performed an independent analysis and concluded that HPH's pre-Merger deteriorating condition further weakened its competitive significance going forward. In sharp contrast, Complaint Counsel offered only isolated quotes from select documents out of context and the testimony a former employee, Mark Newton, who was not responsible for HPH's finances when he was employed at the hospital. Newton left HPH soon after the Merger to assume a position at a competing hospital. Complaint Counsel offered no expert testimony or analysis of HPH's financial condition prior to the Merger.

III. The Extraordinary Quality Improvements Resulting From The Merger Outweigh Any Anti-Competitive Effects

Even if the Merger were found to have had some anti-competitive effect, Complaint Counsel still would have failed to prove that these effects outweighed the substantial quality improvements resulting from the Merger. Hospital quality is valued by prospective patients who

enroll in MCO networks -- and it is a basis on which hospitals compete. It was undisputed among the economic experts at trial that hospital quality should be considered in analyzing the competitive effects of a merger. The evidence in this case demonstrates that the quality of care at HPH has demonstrably improved as a direct result of the Merger with ENH. Numerous physicians, a pharmacist, a nurse and several administrators testified about the premerger quality problems at HPH and the concrete steps ENH took after the merger to address them. Further, Respondent's quality expert found that HPH's quality improved dramatically across 16 different service lines as a result of the merger, including quality assurance, cardiac surgery, obstetrics, emergency care, and electronic medical records, and many others. ENH has invested $120 million into HPH already, and is planning to invest substantial amounts more into HPH in the future. The evidence has also shown that, in HPH's weakened financial condition, it could not have made these quality improvements as fast, as well, or at all, without ENH.

IV. The Clayton Act Does Not Prohibit Mergers Between Sister Corporations Of the Same Network

The evidence in this case shows, that at the time of the Merger, Evanston Hospital and HPH were not two different "persons" as is required under Section 7 of the Clayton Act, but rather "sister corporations" wholly owned by the same parent. This analysis is consistent with the fact that the parties were deemed to be the same "person," and therefore not required to file a Premerger Report and Notification Form with the enforcement agencies. 15 U.S.C. § 18a(a). The jurisdictional requirement that there be two different "persons" involved in a transaction applies here. The FTC's own Pre-Merger Notification Office confirmed that no filing was required because a common parent was the sole member of both merging hospitals -- e.g. there were not two persons. Since Complaint Counsel failed to present any evidence at trial to dispute

that Evanston Hospital and HPH were "sister corporations" at the time of the Merger, Counts I and II should be dismissed on this basis alone.

V. Complaint Counsel's Proposed Remedy Would Harm, Not Benefit, The Public

Finally, although Respondent respectfully submits that the Court should never reach the issue of remedy, imposition of a structural remedy of divestiture threatens to undo the many quality improvements of the Merger. Divestiture would not fix a competitive problem because it would not undo the learning that Evanston Hospital has experienced. Instead, and if necessary, Respondent has offered alternatives to divestiture that would restore any competition allegedly lost through the Merger, while not immediately compromising the vast quality improvements that the Merger has brought to HPH and the community at large. Nevertheless, the alternatives would avoid the immediate harm to consumers from the unwinding of the quality improvements and lessen the risk that ENH's ability to make quality improvements in the long run would be inhibited.

ARGUMENT

I. COMPLAINT COUNSEL BEARS THE BURDEN OF PERSUASION AS TO EVERY ELEMENT OF ITS SECTION 7 CLAIM

Complaint Counsel alleges that the Merger between Highland Park Hospital and Evanston and Glenbrook Hospitals (the "Merger") violates Section 7 of the Clayton Act ("Section 7"). Section 7 provides in pertinent part:

> No person . . . shall acquire, directly or indirectly, the whole or any part of the stock or other share capital . . . of another person . . . where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.

15 U.S.C. § 18. An analysis of whether a transaction violates Section 7 "requires determinations of (1) the 'line of commerce' or product market in which to assess the transaction, (2) the 'section of the country' or geographic market in which to assess the transaction, and (3) the transaction's probable effect on competition in the product and geographic markets." *FTC v. Staples*, 970 F. Supp. 1066, 1072-73 (D.D.C. 1997); *see United States v. E.I. duPont de Nemours*, 353 U.S. 586, 593 (1957); U.S. Dep't of Justice & Fed. Trade Comm'n, *Merger Guidelines*. The elements of a Section 7 claim are identical where, as here, the claim relates to a merger or acquisition that has already been consummated, as discussed below.[4]

The government bears the burden of proving every element of its Section 7 challenge. *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 116-17 (D.D.C. 2004). In *United States v. Baker Hughes, Inc.*, the D.C. Circuit established a paradigm for applying this principle in merger litigation. First, the government must establish a presumption that the merger will substantially

[4] If anything, Complaint Counsel's ultimate burden is even higher with respect to a consummated merger, as acknowledged by the most recent former Chairman of the FTC: "I personally think that the FTC has to face a very high hurdle to bring a consummated merger case." Interview with Timothy Muris, *Global Competition Review* (December 21, 2004) (Attachment A).

lessen competition by producing evidence of undue concentration in a relevant geographic and product market. 908 F.2d 981, 982 (D.C. Cir. 1990). If the government establishes such a presumption, the burden of producing evidence to rebut this presumption shifts to the defendant. *Id.* Following the defendant's production of evidence, the burden of producing additional evidence of anti-competitive effect shifts to the government, and merges with the ultimate burden of persuasion, which remains with the government at all times. *Id.* at 983. This paradigm has been reiterated by the D.C. Circuit and adopted by numerous other federal courts and the Federal Trade Commission ("Commission") in reviewing mergers in recent years. *See e.g., FTC v. H.J. Heinz Co.*, 246 F.3d 708, 715 (D.C. Cir. 2001); *FTC v. University Health, Inc.*, 938 F.2d 1206, 1218 (11th Cir. 1991); *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1110 (N.D. Cal. 2004); *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 116 (D.D.C. 2004); *In re Chicago Bridge & Iron Co.*, Dkt. No. 9300, at 7-8 (Op. of FTC Comm'n January 6, 2005) (Attachment B); *In re Textron, Inc.*, No. 9226, 1994 WL 16010997, at *3 (FTC Consent Order May 6, 1994).

II. COMPLAINT COUNSEL DID NOT MEET ITS BURDEN OF PROVING THE REQUISITE RELEVANT MARKET

As demonstrated below, Complaint Counsel failed to establish a presumption that the Merger violates Section 7 and failed to rebut Respondent's evidence that the Merger will not harm competition. Accordingly, it has failed to carry its ultimate burden of persuasion and the Complaint should be dismissed.

The Complaint contains two distinct counts that the Merger violates Section 7. In Count I, Complaint Counsel alleges many of the necessary elements of a Section 7 violation, including a relevant product and geographic market. *See* Compl. ¶¶ 15-27. Recognizing that it lacked the

evidence to support a merger challenge under existing law, Complaint Counsel added a second count ("Count II"), alleging that the Merger violates Section 7 without any reference to a relevant product or geographic market. Although laden with inflammatory and irrelevant allegations about price increases in "absolute" terms, Complaint Counsel's real theory of Count II is that a relative increase in price coincident with a merger is "direct evidence" that the Merger produced anti-competitive effects. Complaint Counsel contends that this evidence allows it to state a claim without proving a relevant market, bypassing the requirements of the statute and decades of jurisprudence. Compl. Counsel Interrog. Answers at 33 (Attachment C) ("it is unnecessary to define a product or geographic market for the purposes of a claim under section 7 of the Clayton Act."); Compl. Counsel Pretrial Br. at 29-30.

As discussed below, Complaint Counsel cannot prevail under Count I because it failed to prove, *inter alia*, a relevant market within which the Merger will cause competitive harm. Count II fails because, as a matter of law, proof of a product and geographic market is necessary to establish a violation under Section 7 of the Clayton Act.

A. Complaint Counsel Failed To Prove A Relevant Market Within Which The Alleged Anti-Competitive Effects Will Occur

Complaint Counsel's putative product market is both internally inconsistent and contrary to the undisputed evidence in this case. Complaint Counsel alleged that the relevant product market includes all "general acute care inpatient hospital services" and explicitly excludes inpatient tertiary services as well as all outpatient services. Compl. ¶ 16.

(REDACTED)

(Respondent's Proposed Findings of Fact ¶¶ 382, 1087) (hereinafter

"FOF ¶ __"). Hence, the only remaining issue regarding the product market is whether hospital-based acute care outpatient services must be included.

1. Complaint Counsel Did Not Prove Its Relevant Product Market

A relevant product market consists of "products that have reasonable interchangeability for the purposes for which they are produced -- price, use and qualities considered." *E.I. du Pont de Nemours*, 351 U.S. at 404. In determining a relevant market, the actual market realities, such as customer preference or industry recognition of a product, are of key significance. *Eastman Kodak Co. v. Image Tech. Serv., Inc.*, 504 U.S. 451, 466-67 (1992); *Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962); *Bon-Ton Stores, Inc. v. May Dept. Stores Co.* 881 F. Supp. 860, 874 (W.D.N.Y. 1994); *see also General Indus. Corp. v. Hartz Mountain Corp.*, 810 F.2d 795, 805 (8th Cir. 1987) (in defining the relevant product market, "the reality of the marketplace must serve as the lodestar").

The Complaint in this case challenges only the effect of the Merger on one class of hospitals' direct "customers" -- MCOs.[5] Compl. ¶¶ 16, 29; Compl. Counsel's Revised Pretrial Br. at 30, 33; (FOF ¶ 377). For the purpose of analyzing this claim, the product market must be defined by the market realities faced by the MCOs and the hospitals. The overwhelming and uncontradicted evidence presented at trial by the MCO representatives themselves (who were Complaint Counsel's witnesses), confirms that the relevant product market here includes both inpatient and outpatient hospital services.

[5] It has been recognized that hospitals have other classes of customers as well, including Medicare/Medicaid, self-payors, employers and physicians. *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 134 (E.D.N.Y. 1997). The Complaint does not allege an anti-competitive effect with respect to these customers.

It is undisputed that payors contract with hospitals for the entire bundle of inpatient (including primary, secondary and tertiary) and outpatient services that hospitals provide, which they then combine and market as part of a network or health plan. (FOF ¶¶ 77, 369-375). For example,

(REDACTED) (FOF ¶ 370). Jane Ballangee from Private Healthcare Systems ("PHCS") also testified that when entering into a contract with a hospital, she contracts "for the entire set of services at a hospital." (FOF ¶ 370).

Similarly, it is understood that private payors often give concessions in inpatient services in exchange for gains in outpatient services, and *vice versa*. (FOF ¶ 371). Indeed, over the last couple of decades, the proportion of hospital services provided on an outpatient basis has increased substantially. (FOF ¶ 73). This shift is evidenced at ENH where 45% of its services were provided on an outpatient basis and gross revenue from outpatient services increased from 34% to 44% between 1997 and 2003. (FOF ¶ 74).

Defining the product market to include both inpatient and outpatient services conforms with the approach of the *Merger Guidelines*, which states that the relevant product market analysis "begin[s] with each product (narrowly defined) produced or sold by each merging firm . . ." *Merger Guidelines* § 1.11. Such a demand-side analysis begins with the product or service that the consumer actually purchases from the merging parties. As such, where the customer purchases several services together, it is those services taken as a whole that constitute the relevant product market, even when the services in the market are not substitutable in and of themselves. *See, e.g., Staples*, 970 F. Supp. at 1074, 1078 (market defined as consumable office supplies purchased from an office superstore because customer purchasing patterns confirmed a particular consumer demand for this set of goods as sold by office superstores); *JBL Enters., Inc.*

v. Jhirmack Enters., Inc., 698 F.2d 1011, 1016 (9th Cir. 1983) (product market consisted of lines of beauty supplies to beauty salons and professional outlets); *Bon-Ton Stores, Inc. v. May Dept. Stores Co.*, 881 F. Supp. 860, 875 (W.D.N.Y. 1994) (department stores constitute their own product market because they offer a collection of products to a different group of customers); *see also* Philip E. Areeda & Herbert Hovenkamp, *Antitrust Law* ¶ 565 (2d ed. 2002). Thus, the relevant product market in this case should include inpatient and outpatient services.

Although previous hospital merger cases have defined the product market as acute inpatient services, those cases are irrelevant in the present case, where the direct customers are the MCOs and not individual patients. Since Complaint Counsel has altered its view of the "real" customer, from individual patients to MCOs, it now must accept that inpatient and outpatient services together form the relevant product market. Complaint Counsel attempts to ignore the facts in order to create a narrow product market that suits its theory. Such a self-serving approach should be rejected, and Count I should be dismissed on this basis alone.

2. Complaint Counsel Did Not Prove Its Relevant Geographic Market

In recent years, court after court has denied the government relief in Section 7 hospital merger cases because of its failure to prove a relevant geographic market within which a hospital merger would have anti-competitive effects. Complaint Counsel has similarly failed here and its case should meet a similar end.

The Supreme Court describes the relevant geographic market as "the 'area of effective competition . . . in which the seller operates, and to which the purchaser can practicably turn for supplies.'" *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 359 (1963) (quoting *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1961)). A geographic market has been

defined as the area "in which the antitrust defendants face competition." *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995). While courts do not compel "scientific precision" in defining the geographic market, they do insist that any such market be "well-defined." *Id.* at 268; *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1120 (N.D. Cal. 2001). Consequently, "[t]he geographic market selected must, therefore, both 'correspond to the commercial realities' of the industry and be economically significant." *Brown Shoe*, 370 U.S. at 336-37. In order to capture the "commercial realities" of the market appropriately, the *Merger Guidelines* begin the process of defining the geographic market "with the location of each merging firm (or each plant of a multiplant firm) . . . [and] add[s] the location from which production is the next-best substitute for production at the merging firm's location." *Merger Guidelines* § 1.21.

Complaint Counsel's approach to the geographic market -- a moving target throughout this litigation -- is inconsistent with the law and the FTC's own *Merger Guidelines*, entirely unsupported by the facts and internally inconsistent. While vacillating on the geographic market definition throughout the case,[6]

(REDACTED)

(FOF ¶ 491). No court has ever defined the relevant market to include only the merging hospitals, and Complaint Counsel mustered no serious proof for such an extraordinarily narrow definition. To the

[6] Complaint Counsel along the way proposed several alternative gerrymandered geographic markets, none of which was supported by the facts. Complaint Counsel first proposed the following geographic market in the complaint: "[T]he densely populated corridor that runs for about 15 miles north-south along the shore of Lake Michigan, and extends roughly ten miles west of the Lake." Compl. ¶ 17. When asked to clarify this incomprehensible allegation, Complaint Counsel speculated that, hypothetically, the geographic market could be {

(REDACTED)

Compl. Counsel Interrog. Answers at 20 (Attachment C). Nevertheless, Complaint Counsel also asserted that the alleged geographic market encompasses only the three hospitals involved in the merger, and no others. *Id.* at 18-19. Dr. Haas-Wilson testified that the market could even include the area surrounding the three ENH hospital campuses that extends up to, but does not include, the hospital closest to each ENH hospital campus. (FOF ¶ 498).

contrary, the evidence at trial demonstrated that there are numerous hospitals that compete with Evanston Hospital and HPH, based on a variety of objective and subjective dimensions.

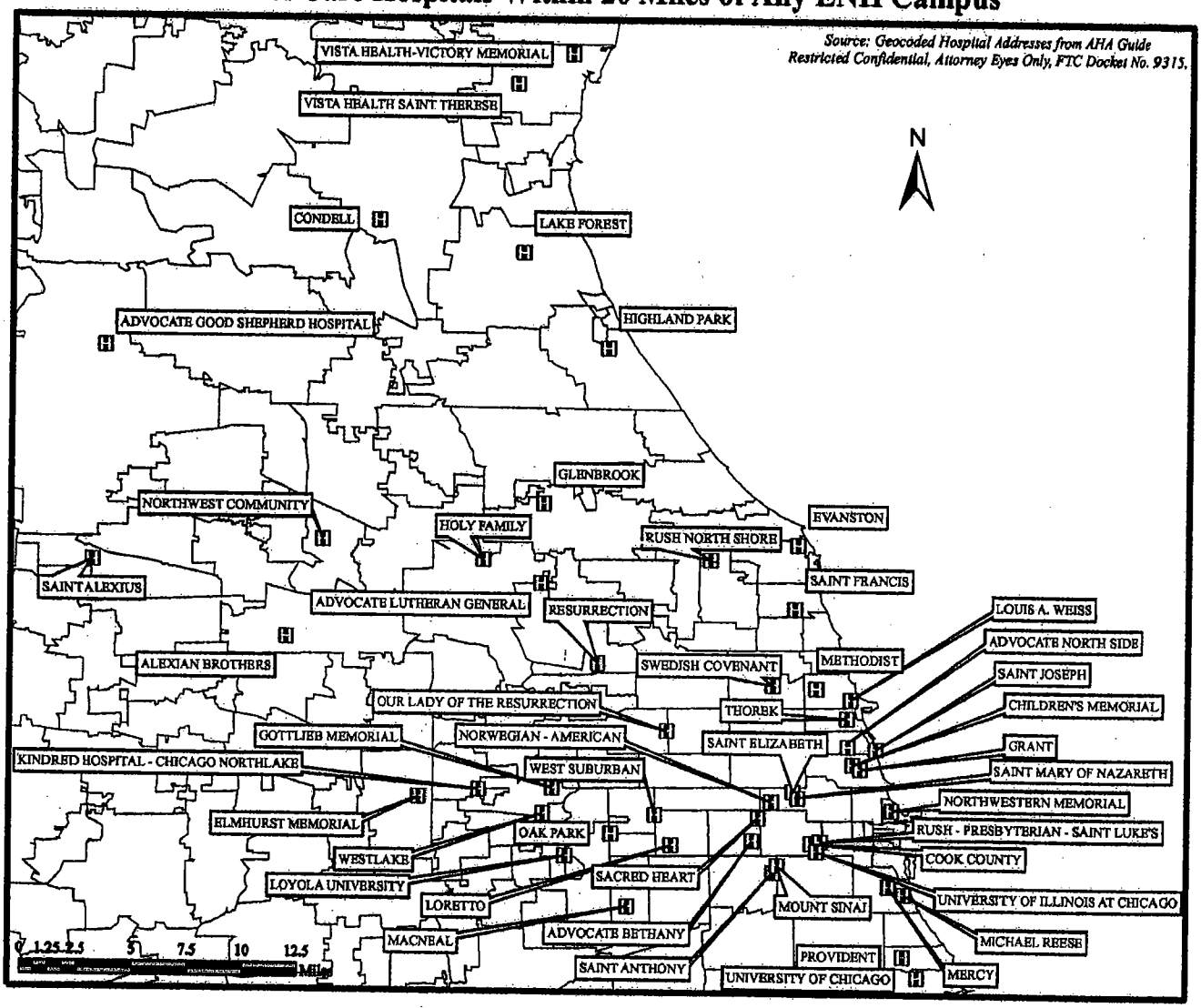
a. Numerous Hospitals Should Be Included In The Geographic Market

The commercial realities here demonstrate that there are a number of hospitals located near the ENH hospitals. (FOF ¶ 116). HPH and Evanston Hospital are 13.7 miles (27 minutes, driving time) away from each other. (FOF ¶ 388). In contrast, there are eighteen hospitals closer to Evanston Hospital or HPH than Evanston Hospital and HPH are to each other, including among others:

- Saint Francis Hospital (3 miles, 8 minutes from Evanston Hospital). (FOF ¶ 389(a)).
- Rush North Shore Medical Center (3.7 miles, 9 minutes from Evanston Hospital). (FOF ¶ 389(b)).
- Swedish Covenant Hospital (6.8 miles, 19 minutes from Evanston Hospital). (FOF ¶ 389(f)).
- Advocate Lutheran General Hospital (10.2 miles, 21 minutes from Evanston Hospital). (FOF ¶ 389(c)).
- Holy Family Medical Center (11.3 miles, 23 minutes from Evanston Hospital). (FOF ¶ 389(i)).
- Resurrection Medical Center (12.1 miles, 25 minutes from Evanston Hospital). (FOF ¶ 389(e)).
- Northwestern Memorial Hospital (13 miles, 26 minutes from Evanston Hospital). (FOF ¶ 390(a)).
- Lake Forest Hospital (6.1 miles and 13 minutes from HPH). (FOF ¶ 390(a)).
- Condell Medical Center (12.7 miles, 24 minutes from HPH). (FOF ¶ 390(b)).

As depicted in RX 1912-019 below, there are numerous hospitals in the Chicago area that are within 20 miles of any ENH campus.

Revised Exhibit 6:
Acute Care Hospitals Within 20 Miles of Any ENH Campus



See RX 1912-19, *in camera.*

In addition to accounting for the physical distance between locations, courts routinely find travel times relevant to geographic market definition -- which are affected by roads, traffic patterns and natural impediments such as rivers or mountains. *See, e.g., Sutter Health Sys.*, 130 F. Supp. 2d 1124, 1126 (travel time is relevant to a dynamic analysis of the geographic market);

J&S Oil, Inc. v. Irving Oil Corp., 63 F. Supp. 2d 62, 68 (D. Me. 1999) ("Simply put, the geographic market for retail gasoline depends on how far individuals are willing and able to travel to purchase the product."). Thus, the geographic market in hospital merger cases has typically been entire counties, or even multiple counties, even in urban and suburban areas.[7]

According to a 2001 Lake Forest Hospital customer survey report, consumers are willing to travel, on average, up to 16 minutes for emergency care, 28 minutes to a primary care physician for routine care, 31 minutes for outpatient services, and 35 minutes to a hospital for an overnight stay. (FOF ¶ 400). All of the 18 hospitals referenced above are located within 27 minutes or less of either Evanston Hospital or HPH, the driving time between Evanston Hospital and HPH. The same study determined that 25% of consumers in Lake County have left the county for medical services, and 28% of Lake County consumers travel to Chicago. (FOF ¶ 401).

The evidence at trial demonstrated that these geographic realities matter to competition. Payor testimony confirmed that the distance an employee must travel is a critical component for employers who are evaluating health care benefit plans. (FOF ¶¶ 385, 387). Because MCOs typically market their health care plans to employers, who are concerned about where their employees want to seek hospital care, MCOs themselves take into account patient preferences concerning hospital geography when building their networks. (FOF ¶¶ 156, 386, 391). Complaint Counsel's own experts, Drs. Elzinga and Haas-Wilson, confirmed that employers are

[7] *See, e.g., Long Island Jewish Med. Ctr.*, 983 F. Supp. at 141-42 (Queens and Nassau Counties); *Rockford Mem'l. Corp.*, 898 F.2d at 1284-85 (Winnebago County and pieces of several other counties); *Sutter Health Sys.*, 130 F. Supp. 2d at 1123 (geographic market at least as large as Inner East Bay and extends east into Contra Costa County to include several other zip codes); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1293 (W.D. Mich. 1996) ("geographic market for general acute care inpatient hospital services is the greater Kent County area" and "relevant geographic market for primary care inpatient hospital services as the immediate Grand Rapids area").

driven to provide a plan that is attractive to their employees, thus requiring MCOs to take patient preferences into consideration in constructing their hospital networks. (FOF ¶¶ 385-386). Consequently, to the extent that employees value convenience, there is a derived demand by MCOs for hospitals that are convenient to their enrollees. (FOF ¶ 391).

As found by Respondent's economic expert, Dr. Monica Noether, the relevant geographic market here should, at the very least, include the ENH hospitals, Rush North Shore, St. Francis, Advocate Lutheran General, Resurrection, Lake Forest Hospital and Condell. (FOF ¶ 488). Moreover, the evidence suggests that many hospitals outside Dr. Noether's minimum geographic market place a significant competitive constraint on ENH, such as Northwestern Memorial, Swedish Covenant and Holy Family. (FOF ¶ 489). Dr. Noether's minimum geographic market should be the most conservative market employed to analyze the competitive effects in this case.

Dr. Noether arrived at this conservative geographic market after identifying the hospitals that most competed with the merging hospitals based on: (1) geographic proximity, as measured by driving times; (2) patient travel patterns, as measured by 80% service areas;[8] (3) physician admitting patterns; and (4) market participant's views on competition. (FOF ¶¶ 392, 395, 406, 461, 474, 485). Dr. Noether considered these factors because they provide information about patients' hospital preferences which, as discussed above, influence managed care contracting choices. Specifically, geographic proximity and physician admitting patterns influence patient preferences. Patient travel patterns are one expression of these patient

[8] *FTC v. Tenet Health Corp.* 186 F.3d 1045, 1053-55 (8th Cir. 1999) (patient travel patterns are a relevant factor in defining geographic market and practical alternatives to the merged hospital); *Butterworth Health Corp.*, 946 F. Supp. 1285, 1292-93 (W.D. Mich. 1996) (relying on travel patterns to define geographic market and identify competitors); *see also J&S Oil, Inc.*, 63 F. Supp. 2d at 68 (stating that the relevant geographic market "depends on how far individuals were willing and able to travel to purchase the product").

preferences.[9] And market participants views on competition provide additional information about patient preferences and competition generally. (FOF ¶ 391). An examination of all of these various factors revealed that HPH and Evanston Hospital were not close competitors.

Dr. Noether's examination of driving times revealed that Rush North Shore (9 minutes), St. Francis (8 minutes), Holy Family (23 minutes), Resurrection Medical Center (25 minutes), Swedish Covenant (19 minutes), Louis A. Weiss (20 minutes), Northwestern Memorial (26 minutes) and Advocate Lutheran General (21 minutes) are all geographically closer to Evanston Hospital than HPH (27 minutes).[10] (FOF ¶¶ 389, 393). Similarly, Lake Forest Hospital (13 minutes), Rush North Shore (18 minutes) and Condell (24 minutes) are closer, in terms of driving time, to HPH than Evanston Hospital. (FOF ¶ 394).

As mentioned, MCOs regard patient travel patterns as an important factor to consider when building and marketing their networks. (FOF ¶¶ 385, 387). Dr. Noether's review of patient travel patterns, using the 80% service areas[11] of area hospitals, showed that Evanston Hospital had more overlap in its broad, thirty-two zip code service area with Northwestern Memorial, Rush North Shore, Advocate Lutheran General, St. Francis, Louis A. Weiss than with

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[9] In its pre-trial brief, Complaint Counsel attacked Dr. Noether's use of patient travel patterns as an attempt to use the so-called Elzinga-Hogarty test to define a geographic market, which Complaint Counsel contends is inappropriate in analyzing a hospital merger. Compl. Counsel's Revised Pretrial Br. at 34-35. This attack is unwarranted. First, Dr. Noether did not perform the Elzinga-Hogarty test and therefore in no way relied upon an Elzinga-Hogarty test in defining the geographic market. Second, as the case law points out, a proper geographic market must include those suppliers to whom consumers can turn in the event of an anti-competitive price increase. Because MCOs take patient preferences into account in building their provider networks, evidence of current patient preferences (FOF ¶¶ 385-387, 391), as reflected by patient travel patterns, is obviously a relevant factor to consider in a proper market definition analysis. Dr. Noether thus properly considered patient travel patterns (but not the Elzinga-Hogarty test) in defining the geographic market.

[10] Dr. Noether chose to use driving times rather than driving distances as a proxy for geographic proximity because driving times account for variations in road and/or traffic patterns, which can impact patient preferences. (FOF ¶ 392).

[11] Dr. Noether elected to use the 80% service area of area hospitals because this is an area typically considered by hospitals themselves in evaluating the geographic scope of competition. (FOF ¶¶ 400, 502-504).

HPH. (FOF ¶ 397). Similarly, there was at least as great an overlap between HPH's twenty zip code, 80% service area prior to the Merger with the 80% service areas of Advocate Lutheran General and Lake Forest Hospital, as there was between Evanston Hospital's 80% service area and HPH's 80% service area. (FOF ¶ 398). The fact that pre-Merger HPH and Evanston Hospital competed more for patients from the service area of other hospitals than they did for patients from each other's service area further confirms that inclusion in the relevant geographic market of other non-ENH hospitals is appropriate. Moreover, patients' willingness to travel pre-Merger, as reflected by these service area overlaps, is consistent with a geographic market that includes additional hospitals.

Physicians' patient admissions confirmed that the relevant geographic market here must include hospitals beyond ENH. (FOF ¶¶ 406-408). In particular, there was a substantial overlap of physicians who had privileges and admitted patients at both HPH and Lake Forest Hospital prior to the Merger. In fact, once the Merger was announced, a number of these physicians who had previously been very loyal to HPH shifted a significant volume of their admissions to Lake Forest Hospital. (FOF ¶ 408).

Finally, Dr. Noether found that market participants viewed, as expressed in hospital documents, payor testimony, and the testimony of ENH executives,[12] competition among the area hospitals as robust -- including more than the three ENH campuses -- confirming the objective evidence Dr. Noether examined. (FOF ¶¶ 485, 461, 474). The documentary evidence

[12] Perceptions of market participants, including the parties' competitors, also inform the geographic market analysis. *See Sutter Health Sys.*, 130 F. Supp. 2d at 1127 ("If hospitals located within the test market perceive a hospital located outside of the test market to be a significant competitor, the implication is that the hospital located outside of the test market may in fact constitute a practical alternative to which patients could turn if faced with an anti-competitive price increase.").

from area hospitals demonstrated that the ENH hospitals face competition from hospitals located over a wide geographic area. For example:

- St. Francis viewed Evanston Hospital as its strongest competitor to the North. (FOF ¶ 463).
- Rush North Shore considered its local market to include Evanston Hospital, St. Francis, Advocate Lutheran General, HPH, Lake Forest Hospital and Swedish Covenant. (FOF ¶ 464).
- Condell viewed hospitals such as Evanston Hospital, HPH, Lake Forest Hospital and Advocate Lutheran General as competitors in its primary service area. (FOF ¶ 466).
- Provena Saint Therese Medical Center viewed its major competitors as Condell, Lake Forest Hospital, Victory Memorial Hospital and HPH. (FOF ¶ 468).
- Lake Forest Hospital recognized HPH, Condell, St. Therese and Victory as other acute care hospitals that operate in its service area and in the 1990s viewed HPH as one if its major competitors for inpatient admissions in Lake County. (FOF ¶ 469).
- By late 1997, Lake Forest Hospital also recognized Evanston Hospital as a competitor. (FOF ¶ 470).
- **(REDACTED)**

(FOF ¶ 473).

Payor testimony also confirmed that the ENH hospitals compete with other hospitals near them. In fact, all five MCOs represented by witnesses at trial agreed that the ENH hospitals compete with a broad range of hospitals. For example:

- **(REDACTED)**

(FOF ¶ 455).

- **(REDACTED)**

(REDACTED)

(FOF ¶ 456).

- Unicare's representative, Lenore Holt-Darcy, testified that Unicare ensures that its "members have access to the hospital within *30 miles* of where they live and work so that [its plans] have *sufficient access*." (FOF ¶ 460) (emphasis added).

- **(REDACTED)**

(FOF ¶ 459).

- PHCS unambiguously told its members that in case of a termination with ENH "there are other contracted providers within the same geographical area as that of Highland Park Hospital and Evanston Northwestern Healthcare. These facilities are St. Francis Hospital, Evanston, Illinois; Lake Forest Hospital, Lake Forest, Illinois; Advocate Lutheran General Hospital, Park Ridge, Illinois; Rush North Shore Medical Center, Skokie, Illinois; Holy Family Medical Center, Des Plaines, Illinois." (FOF ¶ 457).

- Great West's witnesses who testified at trial, Patrick Neary and Kevin Dorsey, also agreed that ENH had "several" alternatives including Advocate Lutheran General, St. Francis, Lake Forest Hospital, Condell, Northwestern Memorial, St. Therese, and Victory Memorial Hospitals. (FOF ¶ 458).

In addition, current ENH executives and current and former HPH executives testified that both pre- and post-Merger the ENH hospitals faced competition from a broad range of Chicago area hospitals. HPH executives confirmed that, pre-Merger, Lake Forest Hospital, Condell, Rush North Shore, Advocate Lutheran General and Evanston Hospital all competed with HPH because of their "reasonably close" geography. (FOF ¶ 476). ENH executives currently view Advocate Lutheran General, Rush North Shore, St. Francis, Condell, Lake Forest Hospital, Northwestern Memorial, Rush-Presbyterian and University of Chicago as significant competitors. (FOF ¶ 477).

Unlike Complaint Counsel's result-oriented geographic market approach discussed below, Dr. Noether's approach to defining a relevant geographic market, and her resulting market definition, conforms to the economic principles underlying the *Merger Guidelines*. The *Merger Guidelines* begin the analysis by identifying the firms that are the "next-best substitute[s] for production at the merging firm's location" and continues to add such firms until the collection of firms in the geographic market, if viewed as a single entity, would profitably raise price above the competitive level. *Merger Guidelines* § 1.21. Dr. Noether thus included in the relevant market those hospitals that are geographically close to the ENH's hospitals and which offer services similar to those provided by ENH's hospitals. On the other hand, Complaint Counsel's proposed geographic market is wholly self-serving, contradicted by the evidence and determined by an illogical approach that does not conform to the principles underlying the *Merger Guidelines*.

b. Complaint Counsel's Geographic Market Definition Is Invalid

As articulated by its expert, Complaint Counsel's proposed geographic market can potentially range from the triangular area that immediately encompasses the ENH campuses up to the area encompassing the doorsteps of ENH's competitors, without actually including the competitors themselves. (FOF ¶¶ 497-498). As demonstrated above, however, based on a variety of objective and subjective dimensions, there are several hospitals that competed more closely with Evanston Hospital and HPH than Evanston Hospital and HPH did with each other. Complaint Counsel's geographic market definition, therefore, is unsupportable. Complaint Counsel's market definition fails for three additional reasons:

(REDACTED)

(FOF ¶ 492).[13]

(REDACTED)

[14] (FOF ¶ 495). Thus, she never identified the "next-best substitute" for each of ENH's locations. (FOF ¶ 968). To support her geographic market definition, Dr. Haas-Wilson would have to find that Evanston Hospital and HPH were each other's next-best geographic substitutes, which she did not do. (FOF ¶ 494). Such an approach, which assumes the answer to the question, fails the test of "rigorousness" that Complaint Counsel recognized is demanded by "the market definition analysis under the *Merger Guidelines*." (Complaint Counsel's Opening Statement, Tr. 57).

Second, Dr. Haas-Wilson's approach to market definition here is illogical. As explained by Professor Jonathan Baker, the former Director of the FTC's Bureau of Economics,

(REDACTED)

(FOF ¶ 495).

(REDACTED)

(FOF ¶ 496). In addition, Dr. Haas-Wilson's geographic definition fails to address the dynamics of the market. The geographic market must include all *potential* sources of supply to which

[13] In critiquing Complaint Counsel's geographic market definition, Dr. Noether found additional support for her conclusion that Dr. Haas-Wilson did not follow the *Merger Guidelines* in the deposition testimony under oath by another expert retained by Complaint Counsel in this litigation, Dr. Gregory Werden. Complaint Counsel ultimately decided not to call Dr. Werden to testify at trial. (FOF ¶ 493).

[14] The logical implication of Dr. Haas-Wilson's approach is that any firm which raises its prices would, by definition, be a monopolist.

customers could practicably turn in the event of an anti-competitive price increase.[15] If ENH's relative price increases (i.e., price increases relative to comparison hospitals) were not caused by market power, however, they were not anti-competitive. As a result, it was incumbent on Dr. Haas-Wilson to identify those hospitals to which MCOs could turn in the event of an anti-competitive price increase and she failed to perform this exercise.

Third, Complaint Counsel's geographic market definition is also internally inconsistent with its proposed product market definition. Complaint Counsel has repeatedly argued that MCOs are the primary customers, and yet in defining the product market Complaint Counsel focuses on the patient, including in the market only those services that best support its case (acute inpatient services). In focusing on patients, Complaint Counsel ignores the realities of the marketplace and the purchasing patterns of the MCOs, as discussed above. On the other hand, in defining the geographic market, Complaint Counsel purportedly focuses only on the MCO perspective. By including only the hospitals that Complaint Counsel contends must be included in an MCO network overlooks a number of successful, competing hospitals that are closer to Evanston Hospital and HPH than these two hospitals are to each other. In this way, Complaint Counsel attempts to hold on to a restrictive product market definition used in previous hospital cases, and yet avoid an unfavorable geographic market definition that has been the antitrust agencies' downfall in each of those same cases. *See e.g., Tenet Health Care Corp.*, 186 F.3d at

[15] *See Freeman Hosp.*, 69 F.3d at 271 ("[T]he FTC's expert testimony addressed only the question of where patients currently go, rather than where they could practicably go, for acute care inpatient services."); *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 140 ("The critical question is where can consumers of the product involved practically turn for alternative sources of the product should the merger be consummated and the merged hospitals' prices increase."); *Sutter Health Sys.*, 130 F. Supp. 2d at 1124 ("[T]he chief task in determining a geographic market is to identify the suppliers to whom consumers could practically turn if faced with *anticompetitive pricing*.") (emphasis added).

1045; *Sutter Health Sys.*, 130 F. Supp. 2d at 1109; *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 121; *Freeman Hospital*, 911 F. Supp. at 1213.

Under circumstances similar to those here -- a merger of two suburban metropolitan hospitals with MCOs identified as one of the hospitals' class of consumers -- one court rejected the government's proposed definition of the relevant product and geographic market which included only the merging hospitals. *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 140. As a result, Complaint Counsel's alleged market is, in fact, nothing more than "an awkward attempt to conform . . . [Complaint Counsel's] theory to the facts they allege." *Belfiore v. The N.Y. Times*, 826 F.2d 177, 180 (2d Cir. 1987). Because "[i]dentification of a relevant market is a 'necessary predicate' to a successful challenge under the Clayton Act," Complaint Counsel has "failed to meet its burden of proving a well-defined geographic market encompassing the practical alternative sources of acute inpatient services to which patients can turn if faced with an anti-competitive price increase." *Sutter Health Sys.*, 130 F. Supp. 2d at 1132. Accordingly, Count I should be dismissed.

B. Count II Should Be Dismissed Because Section 7 Requires Complaint Counsel To Define And Prove The Relevant Market

Perhaps recognizing the weakness in its proof of market definition in this case, Complaint Counsel pled an alternate count. Count II alleges that the Merger violates Section 7, but without any reference to a relevant product or geographic market. Complaint Counsel's attempt to lighten its burden in this case should fail because the language of Section 7 explicitly requires Complaint Counsel to prove that the Merger will substantially lessen competition *in a relevant market* before liability is imposed, prohibiting only acquisitions that harm competition "in any line of commerce or in any activity affecting commerce in any section of the country." 15

U.S.C. § 18 (emphasis added). According to the legislative history, Congress intentionally viewed a properly defined relevant market as a *necessary* element of a Section 7 Claim. *See, e.g.*, S. Rep. 81-1775, at 5 (1950) ("In determining the area of effective competition for a given product, it will be necessary to decide what comprises an appreciable segment of the *market*.") (emphasis added). Additionally, almost a half-century of merger jurisprudence confirms that Section 7 requires proof of a relevant product and geographic market.[16]

The Supreme Court has explained that a relevant market determination is necessary in order to provide a framework within which to analyze the alleged anti-competitive effects of the merger, even where the government brings a challenge years after the merger was consummated:

> Determination of the relevant market is a necessary predicate to a finding of a violation of the Clayton Act because the threatened monopoly must be one which will substantially lessen competition 'within the area of effective competition.' *Substantiality can be determined only in terms of the market affected.*

E.I. du Pont de Nemours & Co., 353 U.S. at 593 (1957) (emphasis added). This explains why the FTC's own *Merger Guidelines* require the delineation of the relevant product and geographic market before determining whether a particular merger raises competitive concerns:

> A merger is unlikely to create or enhance market power or to facilitate its exercise unless it significantly increases concentration and results *in a concentrated market, properly defined and measured. . . .*

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[16] *See United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 510 (1974) ("[D]elineation of proper geographic and product markets is a necessary precondition to assessment of the probabilities of a substantial effect on competition within them[.]"); *United States v. Marine Bancorporation*, 418 U.S. 602, 618 (1974) ("Determination of the relevant product market and geographic markets is 'a necessary predicate' to deciding whether a merger contravenes the Clayton Act.") (citations omitted); *Phil. Nat'l Bank*, 374 U.S. at 356 (considering the "probable competitive effects of [the] proposed merger" in the pertinent "'line of commerce' (relevant product or services market) and 'section of the country' (relevant geographic market)."); *Brown Shoe Co.*, 370 U.S. at 335 (holding that "the proper definition of the market is a 'necessary predicate' to an examination of the competition that may be affected by the horizontal aspects of the merger"); *E.I. duPont de Nemours*, 353 U.S. at 593 (same); *Tenet Health Care Corp.*, 186 F.3d at 1051; *FTC* v. *Cardinal Health* 12 F. Supp. 2d 34, 45 (D.D.C. 1998).

Merger Guidelines § 1.0 (emphasis added); *see also In the Matter of R.R. Donnelley & Sons Co.*, 120 FTC 36, 53-54 (1995); *Seeburg Corp. v. FTC*, 425 F.2d 124, 128-129 (6th Cir. 1970); *Gen. Dynamics Corp.*, 415 U.S. at 510.[17]

This Court's Order denying Respondent's Motion to Dismiss Count II is entirely consistent with the language of Section 7, the Supreme Court case law discussed above, and the *Merger Guidelines* -- all of which require Complaint Counsel to carry its burden of defining the relevant market. In denying Respondent's Motion to Dismiss, this Court noted that Complaint Counsel had alleged a relevant market in Count II: "the facts alleged in the Complaint, if taken as true, and the reasonable inferences there from when drawn in favor of Complaint Counsel, the non-moving party, sufficiently allege the relevant product and geographic markets." Order Denying Resp.'s Mot. to Dismiss Count II of Compl. at 5 (June 2, 2004). As indicated above, however, Complaint Counsel has since clarified its position that it is unnecessary to define a product or geographic market for the purposes of a claim under Section 7 of the Clayton Act. Compl. Counsel Interrog. Answers at 3. (Attachment C).

Complaint Counsel may not ignore this element of Section 7 analysis. Ultimately, a review of the cases involving unilateral effects,[18] consummated mergers and hospital mergers,[19] three salient features of this case, confirms that the relevant market must both be defined and

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[17] Indeed, earlier this year the Commission confirmed the use of traditional principles of merger analysis, including relevant market determination and an assessment of market share and concentration data, even in a challenge against a merger that was previously consummated, stating that: "[w]e are guided in our assessment of this merger by the case law and the *Merger Guidelines*, both of which set out the general framework for our analysis and provide instruction for the issues raised on appeal." *In the Matter of Chicago Bridge & Iron Co.*, Dkt. No. 9300, at 7 (Op. of Comm'n) (Jan. 6, 2005) ("*CB&I*") (Attachment B).

[18] *See, e.g., Oracle Corp.*, 331 F. Supp. 2d at 1110, 1123.

[19] *See, e.g., Freeman Hosp.*, 69 F.3d at 268 ("Without a well-defined relevant market, an examination of a transaction's competitive effects is without context or meaning."); *Cardinal Health, Inc.*, 12 F. Supp. 2d at 45 ("For this Court to consider the likely competitive effects of the transactions, it must first define the relevant product and geographic boundaries of the markets in question.").

proven. By failing to prove a relevant product or geographic market in this case, Complaint Counsel has not satisfied the elements necessary for finding Section 7 liability and both Counts I and II should be dismissed.

III. COMPLAINT COUNSEL DID NOT MEET ITS BURDEN OF PROVING THAT THE MERGER WILL CAUSE COMPETITIVE HARM

Under both Counts I and II, Complaint Counsel claims that the Merger caused competitive harm by increasing ENH's bargaining power with MCOs, based on the relative price increases that ENH negotiated with certain MCOs after the Merger.[20] Complaint Counsel failed to carry its burden of proving that the Merger caused competitive harm for several reasons.

First, the fact that a firm increased its prices does not demonstrate that it has market power unless all viable competitively benign explanations for the increase have been ruled out. As stated by Complaint Counsel's expert, Professor Elzinga, credible, benign reasons for the relative price increases "would allow you to move forward and conclude that the merger was not anti-competitive, whether you defined a relevant product market or geographic market or not." (FOF ¶ 522). Complaint Counsel has failed to rule out several viable alternative explanations.

Second, although not obligated to under *Baker Hughes*, ENH has convincingly demonstrated that its price increases are a result of its learning that its pre-Merger prices at Evanston Hospital were, on average, well below-market.

[20] Complaint Counsel's theory is not based on evidence that ENH increased its prices in absolute terms because many hospitals receive price increases when they re-negotiate their contracts. Rather, the relevant issue is whether ENH increased its prices relative to other area hospitals that serve as an appropriate basis for comparison.

Third, Complaint Counsel's hypothesis that the Merger provided ENH with greater "bargaining power" has been proven false.[21] Complaint Counsel cannot escape the fundamental truth that if two firms are not close substitutes, they cannot effectively be used to discipline each other in a bargaining situation. Evanston Hospital and HPH were clearly not close substitutes prior to the Merger and there is nothing about them that would enable a combination of the two to exert greater bargaining power.

Fourth, HPH's weakened financial condition, as well as ENH's commitment to serve the needs of the community, mitigate against any potential for competitive harm the Merger might otherwise allegedly cause. Accordingly, for all these reasons, Complaint Counsel is left without proof that the Merger caused competitive harm and without any viable theory that it would do so.

Finally, as discussed below in Section IV, even if Complaint Counsel had proven a prima facie case that the Merger violates Section 7, Respondent's showing that quality significantly improved as a result of the Merger required Complaint Counsel to demonstrate that these improvements were outweighed by the Merger's likely anti-competitive effects. It failed to meet that burden as well.

A. Mere Evidence Of Relative Price Increases Does Not Prove Competitive Harm

Complaint Counsel has not proven its prima facie case that the Merger will cause competitive harm. Section 7 prohibits acquisitions only where "the *effect* of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. § 18

[21] Dr. Haas-Wilson's "bargaining theory" posits that, after the Merger, ENH was able to raise prices unilaterally because an MCO *might* not be able to profitably market a health care network that excluded both HPH and Evanston Hospital. (FOF ¶¶ 984-988).

(emphasis added). Thus, Complaint Counsel is required to demonstrate that the purported anti-competitive effect was caused, and will likely continue to be caused, by the Merger.[22]

At trial, Complaint Counsel based its proof of competitive harm on evidence that ENH raised prices after the Merger. Standing alone, such evidence does not prove causation. As a matter of law, in order to utilize evidence of price increases to prove that a firm possesses market power, that evidence must be accompanied by proof that the price increased above a competitive level and can be sustained at that level over a period of time, or is associated with a reduction of output.[23] As a matter of economic theory, relative price increases may prove the existence of market power or provide evidence of competitive harm only after plausible, competitively neutral explanations for the increased prices have been eliminated. As demonstrated below, Complaint Counsel failed to prove any of the above. Accordingly, Complaint Counsel has not proven its prima facie case that the Merger will cause competitive harm in violation of Section 7.

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[22] Courts have dismissed Section 7 claims when plaintiffs have failed to tie the diminution in competition to the merger at issue. *See, e.g., Ricchetti v. Meister Brau, Inc.*, 431 F.2d 1211, 1215 (9th Cir. 1970) ("There must be a further showing that, as a result of the post merger acts, the merger has an effect on commerce which is proscribed within the meaning of all elements of Section 7."); *Smith-Victor Corp. v. Sylvania Elec. Prod., Inc.*, 242 F. Supp. 315, 320 (N.D. Ill. 1965) ("Section 7 requires more than allegations that there were mergers or acquisitions and a lessening of competition in a relevant line of commerce; it requires that the lessening of competition result from the mergers or acquisitions."). Moreover, the need to prove causation holds equally true for Section 7 claims against consummated mergers. *E.I. duPont de Nemours & Co.*, 353 U.S. at 607 (1957) (holding in a post-consummation challenge that "the test of a violation of § 7 is whether, at the time of suit, there is a reasonable probability that the acquisition is likely to result in the condemned restraints."); *Phil. Nat'l Bank*, 374 U.S. at 362.

[23] *See, e.g., Forsyth v. Humana, Inc.*, 114 F.3d 1467, 1476 (9th Cir. 1997) (proof of higher prices and profits, without a corresponding decrease in output, is not sufficient direct evidence to show market power); *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406, 1411-12 (7th Cir. 1995) ("[W]hen dealing with a heterogeneous product or service, such as the full range of medical care, a reasonable finder of fact cannot infer monopoly power just from higher prices..."); *see also Geneva Pharma. Tech. Corp. v. Barr Lab., Inc.*, 386 F.3d 485, 500 (2d Cir. 2004) (noting that pricing evidence is ambiguous with respect to monopoly power in the absence of analysis of firm's costs or evidence of restricted output); *Levine v. Cent. Fla. Med. Affiliates*, 72 F.3d 1538, 1552 (11th Cir. 1996) (evidence of rising fees is insufficient to show a detrimental effect on competition unless prices are above actual prices charged by competitors); *Rebel Oil Co. v. Atl. Richfield Co.*, 51 F.3d 1421, 1434 (9th Cir. 1995) (direct proof of market power consists of evidence showing restricted output and pricing above competitive levels); *Godix Equip. Export Corp. v. Caterpillar, Inc.*, 948 F. Supp. 1570, 1582 (S.D. Fla. 1996) (evidence of price increases, without showing that pricing exceeds competitive price levels within the market, is insufficient to show market power); *In the Matter of Schering-Plough Corp.*, Dkt. No. 9297 at 116 (June 27, 2002) (FTC Initial

1. ENH's Relative Price Increases Were Not Accompanied By A Reduction In Output

As the Commission recognized in *CB&I*, a theory of competitive harm must show an "exercise of market power [which] results in lower output and higher prices and a corresponding transfer of wealth from buyers to sellers or a misallocation of resources." *CB&I* at 6-7. (Attachment B). Indeed, Complaint Counsel's expert, Dr. Elzinga, explained that a merger is only anti-competitive if it causes prices to increase *and* output to fall. (FOF ¶ 320). Complaint Counsel, however, has not even attempted to argue that ENH's relative price increases were accompanied by a corresponding decrease in output of hospital services. That failure, in and of itself, renders meaningless its evidence of relative price increases.

Moreover, the evidence at trial established that output at ENH actually increased. For instance, following the Merger, ENH began expanding its facilities, including adding a cardiac catheterization lab and surgery room, parking facilities, an Ambulatory Care Center ("ACC"), as well as renovating the psychiatric ward, patient rooms, lobby areas, and the emergency department ("ED"). (FOF ¶¶ 1516, 1546, 1556, 1559-1560, 1579, 1653). Similarly, ENH upgraded its equipment after the Merger, including the addition of Epic, Pyxis, PACS, radiology equipment, pathology lab equipment, cardiac surgery equipment, and physical plant equipment. (FOF ¶¶ 1560, 1725, 1828, 1972, 2099, 2135). After the Merger, HPH also offered new services and programs including, cardiac surgery and interventional cardiology procedures, the Kellogg Cancer Care Center, an improved Fast Track system, double coverage in the ED, nighttime Obstetrics/Gynecology coverage, an intensivist program, and third shift pharmacists. (FOF ¶¶ 21, 649, 1276, 1653, 1672, 1764, 1866, 1956). As Dr. Noether explained, evidence of an

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Decision) *overruled on other grounds, In the Matter of Schering-Plough Corp. et al,* Dkt. No. 9297 (Op. of FTC Comm'n) (Dec. 18, 2003) ("Pricing evidence alone is not sufficient to prove monopoly power.").

increase in both price and output is consistent with an increase in quality and inconsistent with an increase in market power as a result of the Merger. (FOF ¶ 1164). Complaint Counsel's theory must therefore be rejected.

2. Complaint Counsel Did Not Eliminate Plausible, Competitively Neutral Explanations For ENH's Post-Merger Relative Price Increases

Every expert who testified at trial agrees that, as a matter of economic theory, price increases cannot prove market power unless all competitively benign causes for those price increases have been ruled out. (FOF ¶¶ 315, 519-520). Complaint Counsel itself has acknowledged that its alleged proof of anti-competitive effects holds true only if "the direct evidence demonstrates that these undisputed relative price increases were not attributable to other factors" and "could only be attributable to market power." Compl. Counsel Pretrial Brief at 30. Complaint Counsel failed to prove that the Merger will cause competitive harm because it failed to prove that the price increases "could only be attributable to market power."

In analyzing the relative price increases, **{Dr. Haas-Wilson used a difference-in-**

(REDACTED)

(FOF ¶ 1054).

(REDACTED)

(FOF ¶ 1032).

(REDACTED)

(REDACTED) (FOF ¶ 1057)

(REDACTED) (FOF ¶ 1053).

Dr. Haas-Wilson affirmatively identified nine viable (and competitively benign) alternative explanations for ENH's relative price increases: cost changes across all hospitals; changes in patient mix; changes in customer mix; changes in teaching intensity; changes in information; changes in regulations; changes in quality; decreases in outpatient prices; and increases in demand. (FOF ¶¶ 523(a)-(c), 523(g)-(k), 523(m)). Although Dr. Haas-Wilson admitted that ENH experienced changes in patient mix, changes in customer mix and changes in teaching intensity at rates different than her control group of hospitals, she purported to control for the effect of these changes using multivariable regression analysis. (FOF ¶ 1056).

Complaint Counsel's expert further admitted that there are a variety of competitively neutral factors that could have affected prices at ENH around the time of the Merger that she did not consider in her analysis at all, including: success of advertising and marketing programs; addition of nicer amenities; idiosyncratic cost changes; idiosyncratic demand changes; and payor-specific factors such as recent payor mergers or the sale of staff model practices to hospitals. (FOF ¶¶ 523(d), 523(e), 523(l), 523(n), 523(p), 1023). Furthermore, its expert admitted that there are factors that can generally impact the outcome of the bargain between MCOs and hospitals, that do not reflect market power, including: what other hospitals are already included in the MCO's provider network; the personalities of the negotiators; the size of the MCO; patient loyalty to the MCO; and the amount of information available to a hospital or MCO about market conditions. (FOF ¶¶ 526, 1021-1022). As discussed more fully below,

however, Dr. Haas-Wilson did not effectively rule out many of the potential, competitively neutral explanations for the relative price increases because she failed to consider fully all of the evidence and failed to control adequately for factors that lead to these explanations.

By failing to measure the impact of the changes in any of these factors effectively or rule out viable, competitively benign explanations, and by admitting that proof of a price increase is only indicative of competitive harm when all such explanations have been ruled out, Complaint Counsel's own expert has demonstrated the fatal flaw in Complaint Counsel's prima facie case. (FOF ¶¶ 315-317, 519-520). Although entitled to do so, ENH did not rest at trial on Complaint Counsel's failures, but introduced convincing evidence that alternative explanations accounted for the price increases, as discussed below.[24]

B. The Relative Price Increases Resulted From ENH "Learning About Demand," Not Its Acquisition Of Market Power

Complaint Counsel's failure to demonstrate that competitively neutral explanations were not the cause of ENH's price increases was highlighted by its inability to disprove that "learning about demand" was not the cause for these price increases. ENH put forth convincing evidence that Evanston Hospital/ENH learned, coincident with the Merger, that it had been short-changing itself for years in its negotiations with MCOs. (FOF ¶ 734; *see also generally* FOF ¶¶ 577-964). As a result of learning about the demand for its services, and not because of any market power acquired as a result of the Merger, ENH was able to negotiate price increases that brought ENH's prices in-line with those charged by other comparison hospitals. Evanston Hospital's pre-Merger

[24] Dr. Haas-Wilson could not provide any measure by which to assess whether a particular explanation would be considered "viable." (FOF ¶ 525). In fact, Dr. Haas-Wilson would not even rule out an explanation that had only a 10% chance of explaining the price increases from being considered as "viable." (FOF ¶ 525). Thus, if the Court were to find at least a 10% probability that there exists alternative explanations for the relative price increases, Complaint Counsel -- by the admission of its own expert -- has failed to prove its case.

failure to obtain competitive contract rates is significant because the normal assumption in examining assertions of market power is that the price charged prior to the challenged conduct is at least the competitive price. *CF Indus. Inc. v. Surface Transp. Bd.*, 255 F.3d 816, 824 (D.C. Cir. 2001) (*citing* Areeda & Hovenkamp, *Antitrust Law* ¶ 5376). In a situation where that assumption does not apply, like here, an increase in prices is not indicative of market power because "a firm in a fully competitive market that is pricing below market levels would expect to earn greater revenues by raising its prices to meet its competitors." *CF Indus.*, 255 F.3d at 824 (citation omitted). Indeed, there is an extensive body of economic thought, dating back at least 40 years and recognized by at least one Nobel prize recipient, that addresses the market impact of asymmetric and incomplete information. (FOF ¶ 531). Complaint Counsel's own expert admitted that "learning about demand" is both a plausible economic theory and relative price increases resulting from it are not anti-competitive. (FOF ¶ 1063; *see also* FOF ¶ 523(k)).

1. The Evidence At Trial Demonstrated That, Coincident With The Merger, ENH Learned About The Demand For Its Services

For ten years prior to the Merger, Evanston Hospital had been represented in its negotiations with payors by Jack Sirabian, whose stated objective in negotiating managed care contracts was to be in every managed care network. (FOF ¶¶ 600, 605). As he testified, Sirabian sought to nurture relationships with the payors, rather than to get the best possible deal for Evanston Hospital. (FOF ¶¶ 606-607). Consequently, Sirabian consciously refused to negotiate aggressively, even to the point of allowing contracts to lapse and reimbursement rates to linger for years without re-evaluation. (FOF ¶¶ 607, 613-615). In the late 1990s, however, Evanston Hospital began to face increasing pressure to generate additional revenue. (FOF ¶¶ 106, 624; *see also generally* ¶¶ 624-645). The passage of the Balanced Budget Amendment in 1997 ("BBA") led to a $95 million reduction in operating revenue, over five years, for Evanston, Glenbrook and

Highland Park Hospitals. (FOF ¶¶ 110, 630-632). In addition, during the same time period, liability insurance costs "sky-rocketed." (FOF ¶ 637).

As a result of this financial pressure, Evanston Hospital began to look at its managed care contracts and contracting strategy more critically. Towards that end, in late 1999, Evanston Hospital engaged Bain and Company ("Bain") to advise it regarding managed care contracting. (FOF ¶ 670). During due diligence for the Merger, Bain was able to examine managed care contracts from both Evanston Hospital and HPH. (FOF ¶¶ 656, 672). Bain's analysis revealed that many of Evanston Hospital's contracts contained unfavorable terms, including contact rate prices that were lower than HPH's, even though Evanston Hospital was a prestigious academic hospital and HPH was a smaller community hospital experiencing quality issues.[25] (FOF ¶¶ 3(a)-3(b), 30, 32, 41-42, 47-49, 99-104, 679-681, 685-686, 689-691). Moreover, Bain informed Evanston Hospital that some of its contracts had even expired. (FOF ¶ 694). For example, Evanston Hospital's contracts with United (Metlife), United (Share), CIGNA PPO, and HMO IL/MCNP had all expired and Evanston Hospital was continuing to honor the old rates, in some cases dating back 5-6 years. (FOF ¶ 692). Bain also found that Evanston Hospital was not very thoughtful about building escalator clauses into its managed care contracts to protect against general costs increases, medical cost increases, and similar factors. (FOF ¶ 692).

(REDACTED)

(FOF ¶¶ 681, 884).

[25] Contracts between hospitals and MCOs include rates to be paid for all of the various distinct services the hospital provides. A typical contract may have a list of dozens of distinct services, each with their own "rate." Such "rates" are one measure of price. Another measure of price, a proxy of which is used in the various price change analyses, is the actual revenue (i.e. reimbursement) paid by the MCO to the hospital for services rendered. This "price" obviously depends on the length of the patient's stay, the types of services actually rendered, contracted rates and other contract terms.

Kim Ogden, a former Vice President at Bain, was responsible for Bain's managed care contract analysis project at Evanston Hospital. (FOF ¶ 671). Testifying by deposition, Ogden recalled that the Evanston Hospital executives were "horrified" when they reviewed the results of Bain's contract analysis. (FOF ¶ 695). Consistent with Ogden's recollection, Evanston Hospital's executives testified that they were "shocked" and "embarrassed" when Bain presented the findings of their analysis. (FOF ¶¶ 683, 703). Even the HPH executives were surprised that they had been able to obtain better rates on payor contracts than an academic medical center like Evanston Hospital. (FOF ¶ 669). In general, HPH had higher per diems than Evanston Hospital, and HPH generated more revenue per case on a case mix index ("CMI") adjusted basis and higher revenue per day on a CMI adjusted basis. (FOF ¶ 679). For example, Bain's analysis revealed that United was paying Evanston Hospital roughly half what United was paying HPH. (FOF ¶ 680). In addition, Bain estimated that PHCS's rates with HPH were 30-35% higher than Evanston Hospital's rates despite the fact that PHCS had equally heavy volume with both institutions. (FOF ¶¶ 685, 687). Bain also informed Evanston Hospital that its rates with Aetna for certain plans were lower than HPH's rates. (FOF ¶ 689).

Bain's discoveries were supported by HPH's internal analysis. *See generally* (FOF ¶¶ 656-666). Terry Chan, who had primary responsibility for contracting at HPH pre-Merger, conducted her own analysis of Evanston Hospital and HPH's pre-Merger contracts. (FOF ¶ 658). Ms. Chan found that in at least 18 contracts, including those with PHCS, Humana, Cigna, Aetna, United and One Health, where HPH had better rates than Evanston Hospital. (FOF ¶ 658). Ms. Chan also calculated that if HPH had been reimbursed using Evanston Hospital's rates it would have received nearly $8 million less in revenue for 2000. (FOF ¶¶ 663, 665).

That Evanston Hospital's rates were far below the marketplace was later confirmed by the reactions of the payors when ENH began to renegotiate its outdated contracts. (FOF ¶¶ 684, 754, 796, 857, 864). For example:

- United acknowledged that Evanston Hospital's rates had last been negotiated in 1994 and were significantly below-market. (FOF ¶ 684). United's representative in the post-Merger negotiation was "embarrassed" by the fact that HPH's rates were "so much higher than Evanston's." (FOF ¶ 684).

- **(REDACTED)** (FOF ¶ 754).

(REDACTED) (FOF ¶ 754).

- **(REDACTED)** (FOF ¶ 857).

(FOF ¶ 864). **(REDACTED)**

- Great West testified that "it had been several years since the contracts had been renegotiated and that it was appropriate to [] increase some of the rates." (FOF ¶ 796). Based on the time lag between renegotiations, Great West did not find ENH's initial post-Merger proposal "that shocking." (FOF ¶ 796).

(REDACTED) (FOF ¶ 710-712).

(REDACTED)

(FOF ¶¶ 712-725).

(REDACTED)

(REDACTED) [26] (FOF ¶ 996). Bain's strategies worked.

(REDACTED) [27]

(FOF ¶¶ 726-733).

(REDACTED)

(FOF ¶ 728).

2. The Expert Testimony Confirms That "Learning About Demand," And Not Market Power, Explains ENH's Post-Merger Relative Price Increases

Both the learning about demand and market power theories predict that ENH's prices will increase more than those of comparable hospitals during the same time period. Therefore, it is impossible to rule out either explanation without considering ENH's price levels relative to those

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[26] ¶¶ 996-997). **(REDACTED)** **(REDACTED)** (FOF ¶ 998). **(REDACTED)** (FOF ¶ 998). (FOF ¶ 998).

[27] **(REDACTED)** (FOF ¶ 1002). **(REDACTED)** 1002). (FOF ¶ **(REDACTED)**

of other hospitals. (FOF ¶¶ 532, 1057-1062). Indeed, whether ENH priced above a competitive level is the ultimate market power determination that must be made. *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 790 n.19 (1984) ("Market power is the ability to raise prices above those that would be charged in a competitive market."); *Levine,* 72 F.3d at 1552; *Godix*, 948 F. Supp. at 1582; *Rebel Oil,* 51 F.3d at 1434 (market power is the ability to increase prices above competitive levels and sustain them for an extended period); *Merger Guidelines* § 0.1 ("Market power to a seller is the ability profitably to maintain prices above competitive levels for a significant period of time.").

a. Contrary To Complaint Counsel's Inflated Figures, ENH's Relative Price Increases Were Only Approximately 10%

Correctly measuring the amount of ENH's price changes relative to comparison hospitals is important for two reasons. First, it serves as a benchmark to determine whether the price increases are substantial enough to even raise concerns about market power. Second, a correct estimate of the relative price increases sets an upper boundary on how much must be explained by non-market power explanations.

(REDACTED)

(FOF ¶¶ 1003-1004). These figures are far more modest than the hyperbolic estimates alleged in the Complaint or Dr. Haas-Wilson's estimates based on ENH -- only data. Those estimates reflect simple price increases, not *relative* price increases. (FOF ¶ 1026). Professor Baker looked at the actual reimbursement per case based on payor data and then examined this information across all payors in the market. (FOF ¶¶ 1008, 1011).

(REDACTED)

(FOF ¶ 1011).

(REDACTED)

(FOF ¶ 1003).

(REDACTED)

(FOF ¶ 1004). Not only are these relative price increase estimates far lower than those provided by Dr. Haas-Wilson, but they are inherently conservative. ENH's prices must be adjusted to account for the improvement in the quality of the services being offered. (FOF ¶ 1157). Evidence at trial established that ENH's quality improved proportionately faster than other area hospitals in critical areas. (FOF ¶¶ 2205-2216). As ENH has continued to improve the quality of its hospitals since the Merger, the observed prices increasingly overstate the true quality-adjusted prices for its services. (FOF ¶¶ 1156, 1158, 1161).

Complaint Counsel's expert calculated ENH's relative price changes based on two data sources (payor data and state data). These calculations suffer from a variety of analytical flaws. (FOF ¶¶ 1011, 1024-1045, 1103, 1105, 1116, 1146).

(REDACTED)

(FOF ¶¶ 1031-1045)

(REDACTED)

(FOF ¶¶ 1011, 1024-1027). *See* Comp. ¶ 16. Indeed, Complaint Counsel conspicuously avoided presenting evidence regarding the impact of the increases on the market as a whole. Third, data problems unique to both of these sources create the risk of a biased

result.[28] (FOF ¶¶ 1028-1030, 1103, 1105, 1116, 1146).

(REDACTED)

(FOF ¶ 1028). As a result, Complaint Counsel overstates the effects of the Merger. (FOF ¶ 1028).

b. The Empirical Evidence Confirms That ENH Raised Its Relative Prices Because It Learned About Its Demand

As discussed above, coincident with the Merger, ENH learned that it was pricing its services as if it were a community hospital, and not at the higher levels that an academic hospital commands. *See generally* (FOF ¶¶ 103, 650-669, 677-693).

(REDACTED)

(FOF ¶¶ 125, 143, 170, 528, 732). **{Under this**

(REDACTED) (FOF ¶ 1059).

(REDACTED)

(FOF ¶¶ 1085, 1150).

(REDACTED)

(FOF ¶ 1150). As Evanston Hospital stopped pricing its services

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28

, (FOF ¶¶ 1028-1030, 1097-1109).

(REDACTED) (FOF ¶¶ 1103, 1105, 1146).

, (FOF ¶¶ 1113, 1116).

at below-market, community hospital levels, and began to price its services at competitive, academic hospital levels, it stands to reason that it would initially have larger price increases relative to other area hospitals. (FOF ¶ 1060).

To evaluate learning about demand, Dr. Noether compared ENH's pre- and post-Merger prices to those of two control groups of hospitals - community hospitals and academic hospitals. (FOF ¶ 1065). Based on the record evidence regarding competition, Dr. Noether initially identified 18 hospitals to be included in her control groups. (FOF ¶ 1065). Dr. Noether then identified the academic hospitals within this group using three criteria: (1) size; [29] (2) teaching intensity; [30] and, (3) breadth of service.[31] (FOF ¶ 1066).

Using these factors, Dr. Noether identified six academic hospitals for inclusion in her academic hospital control group:

(REDACTED) [32]

The remaining twelve hospitals became Dr. Noether's community hospital control group. (FOF ¶ 1065). **(REDACTED)** [33]

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[29] Dr. Noether used the number of staffed beds to measure the size of the hospital. (FOF ¶ 1069). Dr. Noether used a cut-off of 300 beds to qualify for her academic control group. (FOF ¶ 1069).

[30] Dr. Noether used the number of residents per staffed bed to measure teaching intensity. (FOF ¶ 1070). Dr. Noether used a cut-off of 0.25 residents per staffed bed for a hospital to be a member of the academic control group, the same measure used by both MedPAC (an independent federal commission that advises Congress on issues affecting Medicare) and Solucient (a private organization that measures hospital quality) to identify major teaching hospitals. (FOF ¶¶ 559, 1070).

[31] Dr. Noether used the number of DRGs provided by the hospital to measure the breadth of service. Dr. Noether viewed breadth of service as an important attribute of academic hospitals because the range of services offered impacts the demand for hospital services. (FOF ¶ 1068). Dr. Noether used a cut-off of 370 DRGs for inclusion in her academic control group. (FOF ¶ 1068).

[32] To avoid the potential of bias, which could result if only one factor were relied upon, Dr. Noether required that hospitals meet all three criteria in order to be considered academic hospitals. (FOF ¶ 1067).

[33] **(REDACTED)** (FOF ¶¶ 1097-1101).

(REDACTED)

(FOF ¶ 1109).

(REDACTED)

(FOF ¶¶ 1110, 1113, 1114).

(REDACTED) (FOF ¶ 1111).

(REDACTED)

(FOF ¶ 1111).

(REDACTED) (FOF ¶ 1112).

(REDACTED) (FOF ¶¶ 1117-1136).

(REDACTED) (FOF ¶¶ 1117-1136).

34

(REDACTED) (FOF ¶ 1107).

(FOF ¶ 1108). **(REDACTED)**

(REDACTED) (FOF ¶ 1104).

(REDACTED) (FOF ¶ 530).

Additionally, an examination of the pattern of relative price increases to each particular payor demonstrates that Merger-enhanced market power cannot explain the price increase; instead, the facts support the learning about demand explanation.

(REDACTED)

(FOF ¶ 1050).

(REDACTED)

(REDACTED)

(FOF ¶¶ 125, 143, 170, 1051).

(REDACTED) (FOF ¶ 1052).

(REDACTED) (FOF ¶ 1052).

(REDACTED)

, (FOF ¶ 680). By contrast, Evanston Hospital's pre-Merger rate with Aetna was only somewhat lower than HPH's pre-Merger rate. (FOF ¶ 745).

(REDACTED)

(FOF ¶ 1136).

(REDACTED)

(FOF ¶¶ 680, 790-791).

(REDACTED) (FOF ¶ 1049).

(REDACTED)

(FOF ¶¶ 604, 1124). **(REDACTED)**

(FOF ¶ 1122).

(REDACTED)

(FOF ¶ 693). **(REDACTED)**

(REDACTED)

(REDACTED)

[35] (FOF ¶ 1138).

(REDACTED)

(FOF ¶ 1138).

(REDACTED)

[36] (FOF ¶ 1161).

(REDACTED)

[37] (FOF ¶ 1142).

(REDACTED)

[38] (FOF ¶ 1148).

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35 **(REDACTED)**

(FOF ¶ 1144).

36 **(REDACTED)**

(FOF ¶ 1145).

37 **(REDACTED)**

(FOF ¶ 1142).

38 **(REDACTED)**

(FOF ¶ 1149).

(REDACTED)

(FOF ¶¶ 1148-1149).

(REDACTED) (FOF ¶ 1155).

C. Complaint Counsel's Theory of Competitive Harm Cannot Be Supported

In this case, Complaint Counsel alleges a "unilateral effects" theory of competitive harm.[39] Under a unilateral effects theory, a merger may diminish competition where, as a result of the acquisition of market power, "merging firms may find it profitable to alter their behavior unilaterally following the acquisition by elevating price and suppressing output." *Merger Guidelines* at § 2.2. In order to properly support a theory of unilateral effects where the product sold is "differentiated," [40] Complaint Counsel must show that Evanston Hospital and HPH were close substitutes for each other, and sufficiently different from other hospitals in the area, such that the Merger enabled them to raise prices without losing sales to the other nearby hospitals. *Oracle Corp.*, 331 F. Supp. 2d at 1117-18. Complaint Counsel must also prove that significant barriers to entry and expansion would prevent other hospitals from "repositioning" their service offerings in response to any price increase out-of-line with market levels. *Oracle Corp.*, 331 F. Supp. 2d at 1118; *CB&I*, at 6 n.34 (Attachment B); *Merger Guidelines §§ 2.211-2.*[41]

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[39] This is distinct from a theory of competitive harm based on coordinated interaction, where a merger "enabl[es] the firms selling in the relevant market more likely, more successfully, or more completely to engage in coordinated interaction that harms consumers." *Merger Guidelines* § 2.1. Complaint Counsel is not claiming that the Merger resulted in anti-competitive effects through coordinated interaction. (FOF ¶ 517).

[40] Both parties agree that the services provided by the hospitals are "differentiated." (FOF ¶¶ 368, 535). A "differentiated product" is one where the "products sold by different participants in the market are not perfect substitutes for one another." *Merger Guidelines* § 2.21. Hospitals may sell similar services, yet the services offered by different hospitals are "differentiated" by quality, geography, as well as many other factors.

[41] According to the *Merger Guidelines*, not only must the merging parties be close substitutes (generally defined as consumers' first and second choice), but the parties must also have a combined 35% share of the relevant market.

In a desperate attempt to put forward support for a unilateral effects case, Dr. Haas-Wilson has offered a "bargaining theory," which posits that ENH was able to raise prices unilaterally because an MCO *might* not be able profitably to market a health care network that excluded both HPH and Evanston Hospital.[42] Like in any economic analysis of a merger among differentiated products, fundamental to a "bargaining power" theory is the fact that, prior to the Merger, the two firms were close substitutes. In this way, they were able to discipline each other competitively in a bargaining situation. In setting out the "bargaining theory" in this case, however, Dr. Haas-Wilson never identified Evanston Hospital and HPH as close substitutes or asserted that they were significantly different from other hospitals in the area. In fact, the evidence in this case shows the opposite -- that Evanston Hospital and HPH were each more similar to other hospitals than they were to each other. Furthermore, Complaint Counsel never showed the existence of significant barriers to entry and expansion, completely ignoring recent evidence of growth and expansion among competitor hospitals. Finally, Dr. Haas-Wilson never articulated the objective elements upon which her theory is based. She also never articulated *why* ENH would have such bargaining power. Instead, she leaves it for the Court and Respondent to guess at the theory's support in the face of solid evidence to the contrary.

Merger Guideline § 2.211. With a 30% market share in the most narrowly defined geographic market, this case does even rise to the level of being considered for an enforcement action. (FOF ¶¶ 508-514).

[42] It is instructive that Complaint Counsel never attempted to offer evidence to support a traditional prima facie case, such as evidence regarding market shares and concentration levels. Instead, it relied only on its bargaining theory and evidence of price increases.

(REDACTED)

See, e.g., Butterworth, 946 F. Supp. at 1294 (market shares of 47-65% and uncontested testimony showing post-merger HHI figures ranging from 2767 to 4521, with a delta of 1064 and 1889); *see also* (FOF ¶¶ 508-514).

1. Evanston Hospital And HPH Were Not Close Substitutes For Each Other Prior To The Merger

The evidence is undisputed that Evanston Hospital and HPH were not close substitutes for each prior to the Merger. (FOF ¶¶ 32, 41-42). Indeed, the evidence at trial confirmed that, prior to the Merger, payors did not "play" HPH off of Evanston Hospital, or *vice versa*, in contract negotiations. (FOF ¶¶ 974-983). **(REDACTED)**

(FOF ¶ 975). {A

(REDACTED)

(FOF ¶ 979).

(FOF ¶ 977).

(REDACTED) (FOF ¶ 978).

As discussed above, there are a number of competing hospitals that are closer to Evanston Hospital than HPH, or closer to HPH than Evanston Hospital. This is true with respect to the breadth, intensity and quality of services provided, as well as geographically. Complaint Counsel failed even to consider whether Evanston Hospital and HPH were close substitutes before the Merger.

(REDACTED)

(FOF ¶ 536). Each of these measures confirms that Evanston Hospital and HPH were not close substitutes for each other, and that the closest substitutes for Evanston Hospital were different from the closest substitutes for HPH. (FOF ¶¶ 538-539).

a. Breadth Of Service

Evanston Hospital's breadth of service was far greater pre-Merger than was HPH's. For instance, Evanston Hospital provided nearly double the number of DRGs than HPH provided, while also providing sophisticated tertiary services (such as open heart surgery) that HPH did not. (FOF ¶¶ 544, 549).

(REDACTED)

(FOF ¶¶ 545-546).

(REDACTED)

(FOF ¶ 547).

b. Size

In 1999, HPH had only 157 staffed beds while ENH had 411 staffed beds. (FOF ¶¶ 555, 557). **(REDACTED)**

(FOF ¶ 556).

(REDACTED) (FOF ¶ 557).

c. Teaching Intensity

Before the Merger, HPH was a local community hospital. (FOF ¶¶ 41, 44-46, 2319-2322). ENH, on the other hand, is, and before the Merger was, an integrated health care delivery system with a strong teaching component and an affiliation with Northwestern University's Medical School. (FOF ¶¶ 1, 3(a)-(b), 30). Thus, it follows that in terms of teaching intensity, as measured by number of residents per bed, Evanston Hospital and HPH were wholly dissimilar. Evanston Hospital had 0.33 residents per bed while HPH had no residents. (FOF ¶ 559).

(REDACTED)

(FOF ¶¶ 415, 418, 426, 559).

2. Competing Hospitals Can, And Are, Repositioning

In order for a merger to harm competition through unilateral effects, "repositioning by the non-merging firms must be unlikely. In other words, a plaintiff must demonstrate that the non-merging firms are unlikely to introduce products sufficiently similar to the products controlled by the merging firms to eliminate any significant market power created by the merger." *Oracle Corp.*, 331 F. Supp. 2d at 1118; *Merger Guidelines* § 2.212; *see also Rebel Oil,* 51 F.3d at 1441 (a firm cannot have market power where existing competitors are able to expand their offerings to undercut alleged supra-competitive pricing by the firm); Areeda & Hovenkamp, ¶ 501 at 90 (defining market power as the ability to raise price substantially above the competitive level *and* persist in doing so for a significant period without erosion by new entry or expansion).[43]

Complaint Counsel has not met its burden to show significant barriers to expansion such that rival hospitals would be unable to re-position themselves to compete with ENH. Not only are competitor hospitals able to expand their capacity and service offerings, they have been doing so aggressively. For example, Northwestern Memorial recently received approval to construct a new women's hospital on the Northside of Chicago. (FOF ¶¶ 2290-2291).

[43] Entry and expansion is relevant in all examinations of market power, including in merger cases, because market power "depends largely on the ability of existing firms to quickly increase their own output in response to a contraction by the defendant." *Rebel Oil* 51 F.3d at 1441; *Baker Hughes Inc.*, 908 F.2d at 987; *Ball Mem'l Hosp., Inc. v. Mut. Hosp. Ins., Inc.*, 784 F.2d 1325, 1335-36 (7th Cir. 1986) (noting that a firm's market share does not imply market power where competitors may enter or expand production); *see also Oahu Gas Serv., Inc. v. Pacific Res., Inc.*, 838 F.2d 360, 366-67 (9th Cir. 1988) (high market share does not imply monopoly power in a market with low entry barriers); *United States v. Microsoft*, 253 F.3d 34, 82 (D.C. Cir. 2001).

Northwestern Memorial, which already significantly constrains ENH's pricing and is a substantial competitive force in obstetrics in the Chicago area, will draw even more patients as a result of constructing a new hospital dedicated to obstetrics. (FOF ¶¶ 434, 2291). In addition, between 2002 and 2004 Condell, located just 12.7 miles northwest of HPH, was granted permits to expand its medical/surgical department by 20 beds (10 in 2002 and another 10 in 2004), its ICU department by 33% by adding 8 ICU beds, and its obstetrics department by 40%, which added 10 beds. (FOF ¶¶ 390(b), 2293-2296). During the same time period, Lake Forest Hospital, located just 6.1 miles northwest of HPH, also added 10 medical/surgical beds to its facility. (FOF ¶¶ 390(a), 2297). Furthermore, the regulatory environment for entry and expansion will ease significantly with the repeal of the Illinois Certificate of Need laws, scheduled for July 1, 2006. (FOF ¶¶ 2280-2282). Once the Certificate of Need statute expires, all regulatory barriers to entry and expansion will be removed. (FOF ¶ 2282). Such expansion/repositioning demonstrates that Complaint Counsel's version of a unilateral effects theory is simply inapplicable here.

3. Complaint Counsel Has Not Articulated The Principled Bases For Its Bargaining Power Theory

Besides contradicting the objective and undisputed evidence presented at trial, Dr. Haas-Wilson's "bargaining power" theory contains significant flaws. First, she has failed to identify or articulate what attribute Evanston Hospital and HPH commonly possess that allowed them to exercise this enhanced bargaining power once they merged. That failure is particularly egregious because the evidence at trial undeniably demonstrated that Evanston Hospital and HPH are not close competitors, whether in terms of geographic distance or the quality and type of services they offer. Moreover, a "bargaining power" theory is based on a payor contracting only with selective hospitals and using its bargaining power to steer patients to the contracted hospitals,

inducing price competition among them. (FOF ¶¶ 989-990). The evidence at trial, however, established that payors in Chicago rarely engage in selective contracting. (FOF ¶¶ 991-994).

Complaint Counsel has also never articulated the elements and conditions that form the basis of such a bargaining theory. By remaining silent concerning the objective components that form the basis of the theory, Complaint Counsel fails to give this Court a meaningful benchmark by which to assess the credibility of the theory.

Complaint Counsel's failure here is significant because a theory of competitive harm almost identical to Dr. Haas-Wilson's bargaining theory, in a case whose facts are very similar, has already been rejected by a federal court. *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 121. Like here, that case involved the merger of two neighboring hospitals in the suburbs of a major city (New York City) where the court found that MCOs were a consumer of hospitals services. Like Complaint Counsel here, the Department of Justice ("DOJ") in that case contended that the MCOs had to have at least one of the merging hospitals in their networks in order to market their health care plans successfully. *Id.* Unlike here, however, the DOJ articulated what attribute the hospitals shared that would allegedly give them increased market power -- namely, they were the only two nearby hospitals with enough cachet and reputation to serve as an "anchor" or "flagship" hospital in an MCO provider network. According to DOJ, having such a hospital was necessary in order to attract members. *Id.* at 137-38. The district court rejected DOJ's theory on the grounds that several comparable hospitals existed within reasonable proximity to the merging hospitals, including a number of highly regarded academic institutions. *Id.* at 138-40. Like in *Long Island Jewish Med. Ctr.*, there are numerous competing hospitals located near the ENH hospitals. Complaint Counsel's theory in this case should therefore meet a similar end.

D. HPH's Deteriorating Financial Condition And ENH's Community Mission Make It Unlikely That The Merger Would Cause Competitive Harm

Even if Complaint Counsel established a presumption that the Merger caused, and is likely to cause, competitive harm, that presumption is rebutted by HPH's weakened financial condition before the Merger and ENH's community mission.

1. Absent the Merger, HPH's Deteriorating Financial Condition Would Have Significantly Reduced Its Competitive Significance

The Supreme Court has held that an acquired firm with scarce future resources has far less competitive significance than its market share or present market status would otherwise indicate. *General Dynamics Corp.*, 415 U.S. at 503-4. As a result, the acquisition of a company whose future resources were "severely limited" would not cause a reduction in competition. *Id.* *General Dynamics* and its progeny demonstrate that a firm need not be destined for imminent failure in order for its weakened financial condition to be a relevant and significant factor in assessing the legality of a merger. *Id.; see also Baker Hughes Inc.,* 908 F.2d at 984-86 (identifying weakened market position as one factor used to rebut government's prima facie case); *Kaiser Aluminum & Chem. Corp. v. FTC,* 652 F.2d 1324, 1341 (7th Cir. 1981) (financial weakness of acquired firm is part of the relevant inquiry); *United States v. Int'l Harvester Co.*, 564 F.2d 769, 773-74 (7th Cir. 1977) (evidence of a weakened competitor is a "mandated" area of inquiry).

The weakened firm analysis was most recently invoked in *Arch Coal.* 329 F. Supp. 2d at 158. The Court in *Arch Coal* found no Section 7 violation in part because the acquired firm was a "relatively weak competitor" in the current market. *Id.* at 157. The acquired firm "face[d] high costs, ha[d] low reserves, ha[d] at best uncertain prospects for loans or new reserves, [was] in a weakened financial condition, and ha[d] no realistic prospects for other buyers." *Id.* The Court

concluded that the acquired firm's "past and future competitive significance in the [] market ha[d] been far overstated" in light of the acquired firm's "weak competitive status." *Id.* In the context of hospital mergers, the declining operating statistics of the acquired hospital has also been held to be one of the factors that weighed against any violation of the Clayton Act. *Freeman Hosp.*, 911 F. Supp. at 1225, 1227 (hospital's "continuing decline in patient volume, financial sustainability, and competitive significance" diminished in part the acquired firm's "significance as a competitive force.").

Similar to *Arch Coal* and *Freeman*, the facts established at trial showed that prior to merging with Evanston Hospital, HPH's financial condition was on a "downward spiral." (FOF ¶¶ 2307, 2322, 2336). HPH was losing money from operations, the hospital was supporting its bottom line with investment income, it was significantly over-leveraged with no ability to borrow additional funds, and lacked sufficient capital to make critical facility improvements. (FOF ¶¶ 2319-2330, 2347-2348, 2354-2364, 2376-2381). The financial and strategic analysis performed by HPH revealed that the hospital could not maintain its capital capacity, improve its quality, or improve its level of services on its own. (FOF ¶¶ 2307, 2315). As other area hospitals were rapidly expanding, HPH was immersed in a "deteriorating financial trend." (FOF ¶¶ 2336, 2383). Thus, in the late 1990s, HPH was not making money from operations on a year-to-year basis, and by 1999 its operating margin hovered near losses of over $3 million. (FOF ¶ 2320). HPH attempted to diminish the appearance of its financial losses by offsetting them with earnings from its investments, but when HPH's investment income is subtracted from its operating revenue, it shows that the hospital was achieving a "significant operating loss." (FOF ¶ 2347).

In addition to suffering large operating losses, HPH was "significantly over-leveraged" and lacked sufficient funds to make much needed capital expenditures. (FOF ¶¶ 2359, 2376, 2379, 2384). In 1998, HPH had a total of $120 million in long term debt. (FOF ¶ 2355). This severely limited its ability to borrow any additional funds in the future. (FOF ¶¶ 2355-2356). In contrast to HPH, Evanston Hospital had zero debt during this time period. (FOF ¶ 2355).

Absent the Merger, HPH's financial condition would have continued to deteriorate such that its ability to compete would have been significantly diminished. (FOF ¶¶ 2299, 2327, 2354, 2366, 2405, 2407, 2412). The HPH Board of Directors, in consultation with its financial advisors, elected to seek a merger partner primarily because they believed that HPH no longer had an ability to compete effectively. (FOF ¶¶ 2298-2299, 2308-2309). The HPH Board had observed HPH's finances steadily decline throughout the 1990s and was concerned about perpetuating the existence of the hospital. (FOF ¶ 2300). Rather than wait until HPH was an actual "failing firm," the HPH Board of Directors believed that they had a fiduciary obligation to the hospital and the community to merge the hospital into a "stronger healthcare company that could bring much stronger services over the long term to the Highland Park community." (FOF ¶¶ 2308-2309). The Merger with Evanston Hospital best met the criteria established by the HPH Board to increase the capital capacity, improve the quality, and retain local control of the hospital while securing the future for both the hospital and the community. (FOF ¶¶ 2306, 2314-2315, 2318).

Complaint Counsel seeks to portray HPH as a generally profitable institution flushed with cash reserves that was experiencing a slight downward trend, a picture that is simply inconsistent with the facts. In support of this, Complaint Counsel proffered the testimony of Mark Newton, a former employee who left HPH soon after the Merger to assume a position at a competitor

hospital. (FOF ¶ 2339). As explained by Ron Speath, the former CEO of HPH prior to the Merger and Newton's direct supervisor at the time, Newton was a Vice President of Business Affairs and not responsible for the finances of the hospital. (FOF ¶ 2339). As a result, Newton is unable to reliably comment on the financial condition of HPH prior to the Merger.

In contrast to Complaint Counsel, Respondent presented evidence regarding HPH's financial condition from live witnesses who were actually part of the financial teams at HPH and Evanston Hospital. Kenneth Kaufman, a preeminent independent financial consultant hired by HPH prior to the Merger, testified about HPH's declining financial condition. (FOF ¶ 2304). In addition, Harry Jones, the CFO of Evanston Hospital, testified about the negative financial findings of the due diligence process. (FOF ¶¶ 2339-2343). Further, Respondent's expert, Dr. Noether, performed an independent review and analysis of the financial condition of the hospitals and concluded, consistent with Spaeth, Kaufman, and Jones, that HPH was in a weakened competitive and financial condition at the time of the Merger. (FOF ¶¶ 2334, 2336, 2405). Complaint Counsel's expert, on the other hand, did not perform any analysis of HPH's financial condition. (FOF ¶ 2413).

HPH's weakened financial condition significantly undermined its competitive significance in the market on a going forward basis. The facts presented by Respondent at trial illustrated that it would have been impossible for HPH to use its limited amount of cash to simultaneously service its debt, make significant capital investments into the hospital, and offset increasing operating losses with investment income. (FOF ¶¶ 2367-2369, 2386, 2410-2411). The evidence regarding HPH's financial condition was presented by witnesses who were in the

best positions to accurately describe HPH's financial situation.[44] (FOF ¶¶ 2301-2305, 2339). The declining financial condition of HPH is one additional factor which contributes to the finding that the Merger did not "substantially . . . lessen competition" in violation of Section 7.

2. ENH's Not-for-Profit Mission Reduces The Potential For Competitive Harm

Although Complaint Counsel attempts to ignore the practical implications of ENH's not-for-profit status on its pricing decisions, courts have recognized that the not-for-profit status of hospitals may be taken into account in evaluating the alleged anti-competitive effect. *See, e.g., Long Island Jewish Med. Ctr.*, 983 F. Supp. at 146; *Butterworth Health Corp.*, 946 F. Supp. at 1296-97.

Similarly, Complaint Counsel's own expert, Dr. Simpson, agreed that not-for-profit hospitals may not act like a profit-maximizing firm and exploit market power. (FOF ¶¶ 2416-2417, 2421). Factors such as close ties to the community and dedication to its welfare distinguish the goals of a not-for-profit hospital from those of a for-profit corporation. (FOF ¶¶ 2419, 2422-2413). *See Long Island Jewish Med. Ctr.*, 983 F. Supp. at 146 (not-for-profit status of the merging parties is relevant to Section 7 analysis); *Butterworth,* 946 F. Supp. at 1296-97 (merger of not-for-profit hospitals does not have the same potential for anti-competitive effect as for-profit corporations); *United States v. Carilion Health Sys.*, 707 F. Supp. 840, 849 (W.D. Va. 1989), *aff'd without op.*, 892 F.2d 1042 (4th Cir. 1989) (recognizing that hospital's board was made up of the same community businessmen who pay for employees' health insurance and thus

[44] As Dr. Noether explained, a proper economic analysis of a merger's competitive effects compares the actual situation post-Merger to what would have existed had the Merger had not occurred. (FOF ¶ 2278). HPH's weakened financial condition is thus particularly significant here because of its competitors' repositioning and expansion. HPH, absent the Merger, would not have been able to match such expansion and its competitive significance would have therefore decreased even further.

had an incentive to keep hospital costs and rates low). A not-for-profit hospital that has members of the community on its board will be less motivated by achieving high profits than by providing quality healthcare to the community. (FOF ¶ 2422). Moreover, evidence that not-for-profit hospitals are not acting to maximize profits is apparent from the benefits they provide to the community, such as the provision of charity care or locating new services where they would best benefit the community, rather than where they would be the most profitable for the hospital. (FOF ¶¶ 2417-2420).

At trial, ENH established it has a deep commitment to the community. (FOF ¶¶ 2419-2420, 2429, 2431-2433, 2435-2438, 2440, 2442). Indeed, by design, the ENH Board consists largely of members of the community, providing an incentive to keep rates as low as possible. (FOF ¶¶ 2422-2423). Also, ENH provides many benefits to the community including charity care and new services. (FOF ¶ 15). In fact, ENH created a comprehensive adolescent psychiatry program at HPH and consolidated all such services there because that was better for the community, notwithstanding the fact it would have been more profitable to consolidate adult and adolescent psychiatric services at Evanston Hospital. (FOF ¶¶ 2418, 2172-2186). Complaint Counsel's own expert agreed that such conduct would be evidence of a hospital behaving in a manner that was not designed to maximize profits. (FOF ¶ 2417). ENH has specifically demonstrated its commitment to the Highland Park community through the creation of an independent foundation, the Healthcare Foundation of Highland Park. (FOF ¶¶ 262, 311-12, 314, 2429, 2434). Endowed with $60 million at the time of the Merger, this foundation provides grants to local organizations and monitors ENH's obligations to the Highland Park community.[45]

[45] Under the Merger Agreement, ENH committed to improve HPH and the service provided to the community. (FOF ¶ 259-262, 2432-2433). The Foundation, which is separate and independent of ENH, is tasked with monitoring ENH's compliance with these commitments and, if the Foundation finds that ENH is not fulfilling them, it has the power notify the Illinois Attorney General. (FOF ¶¶ 313, 2433-2437).

(FOF ¶¶ 313-14, 2430, 2433). Accordingly, ENH's not-for-profit status, its entire mission and community commitment, as well as its close ties to the community, all significantly reduce the potential for the Merger to produce competitive harm.

IV. QUALITY IMPROVEMENTS RESULTING FROM THE MERGER OUTWEIGH ANY PURPORTED ANTI-COMPETITIVE EFFECTS OF THE MERGER

Antitrust enforcement officials, case law and the economic experts in this case all agree that improvements in quality are an important element in the analysis of competitive effects. The evidence in this case overwhelmingly establishes that the quality of care at HPH has improved substantially as a direct result of the Merger with ENH. Thirteen different witnesses involved in the functioning of HPH testified at trial based on personal knowledge that the quality of healthcare at HPH has improved as a result of actions ENH took following the Merger.[46] Specifically, the witnesses included seven highly qualified physicians, a pharmacist, a nurse leader, and four hospital administrators. Most have knowledge of the state of care at HPH prior to the Merger. Five worked at HPH prior to the Merger and were intimately familiar with its quality. Five more conducted in-depth assessments shortly after the Merger, which required them to analyze in detail the quality of the care provided by HPH just prior to January 2000.

Further, Respondent's expert, Dr. Mark Chassin, also concluded that quality improved dramatically across sixteen service lines as a result of the Merger based upon a detailed and thorough investigation into the quality of healthcare delivered at HPH. (FOF ¶¶ 1196-1207, 1210, 1229). Independent third-party organizations responsible for monitoring hospital quality have recognized and confirmed HPH's improved post-Merger quality. A patient cannot come to HPH today without benefiting from some improvement ENH made at HPH. (FOF ¶ 2217). If

[46] Moreover, ENH continued to invest substantial amounts of money into improving the quality at HPH even after it had allegedly achieved market power and after the initiation of the FTC's investigation.

ENH were forced to divest HPH, most of these improvements would be lost to the Highland Park and neighboring communities.

Even had Complaint Counsel established a presumption that the Merger is likely to cause competitive harm, which it did not, evidence offered by Respondent that the Merger substantially improved the quality of care at HPH shifts the burden of producing further evidence back to Complaint Counsel. This burden merges with Complaint Counsel's ultimate burden of persuasion. *Baker Hughes*, 908 F.2d at 983. Complaint Counsel attempted to satisfy its burden on this issue with only one expert, who has never set foot on any ENH campus, and a former HPH marketing director who had no clinical experience or responsibility. As demonstrated below, Complaint Counsel failed to carry its ultimate burden of persuasion and, therefore, the Complaint should be dismissed.

A. Quality Improvements Are Relevant To The Competitive Effects Analysis Of The Merger

Enforcement officials at the FTC and DOJ have publicly agreed that quality, innovation and similar factors are an important part of analyzing the competitive effects of a transaction. As noted by then-Chairman Muris:

> Quality is obviously an important part of the competitive mix when purchasing health care, and competition law does not hinder the delivery of high quality care. The Commission is always willing to consider arguments about how a particular transaction or conduct will improve quality, and it will pay close attention to such arguments in weighing the competitive implications. Moreover, because quality is so important in health care, we should err on the side of conduct that promises to improve patient care.

"Everything Old is New Again: Health Care and Competition in the 21st Century," Prepared Remarks of Timothy J. Muris, then-Chairman, FTC at 18. Similarly, the recent head of the Antitrust Division at the Department of Justice, Anne Bingaman, stated that, "[i]nnovation,

whether in the form of improved product quality and variety or production efficiency that allows lower prices, is a powerful engine for enhancing consumer welfare." "Competition And Innovation: Bedrock Of The American Economy," Prepared Remarks of Anne Bingaman, Asst. Attorney General, DOJ, September 19, 1996.[47]

In bringing recent enforcement actions, governmental antitrust agencies have asserted that quality and innovation are relevant in Merger analysis. Among the allegations of anticompetitive harm in cases filed by the agencies during the past decade was that the challenged Mergers would cause a reduction in quality or innovation. *See* Proposed Final Judgment and Competitive Impact Statement, *United States v. Alcan Aluminum Corp.*, 69 FR 33406, 33407 (June 15, 2004); *United States v. Manitowoc Co., Inc.*, 2002 WL 32060288, at *9 (D.D.C. 2002); Analysis to Aid Public Comment, *In re Wesley-Jessen*, 61 FR 52799 (Oct. 8, 1996). The underlying assumption in these complaints is that these quality factors are linked to the competitive impact of a Merger. It logically follows that if a decrease in quality or innovation would be anticompetitive, then an increase in these same areas as a result of a Merger should be considered pro-competitive.

This conclusion is consistent with the D.C. Circuit's holding in *Baker Hughes* that: "The Supreme Court has adopted a totality-of-the-circumstances approach to [Section 7], weighing a variety of factors to determine the effects of particular transactions on competition." *Baker Hughes*, 908 F.2d at 984; *see also* CB&I at 7, n. 35. Courts and antitrust authorities have long recognized that factors such as improved quality and innovation are relevant to a competitive effects analysis. Even as far back as 1970, courts specifically acknowledged quality

[47] *See also* "Leap-Frog And Other Forms Of Innovation: Protecting The Future For High-Tech And Emerging Industries Through Merger Enforcement," Address of Constance Robinson, Director Of Operations And Merger Enforcement, Antitrust Division (DOJ), June 10, 1999 ("In evaluating a Merger, innovation questions arise in the

improvements as pro-competitive justifications that may outweigh the anticompetitive effect of a Merger. *See, e.g., United States v. Idaho First Nat'l Bank*, 1970 WL 511, at *11 (D. Idaho 1970) (holding improvements in banking services, such as improving the quality of present services and adding new services, may outweigh the potential anti-competitive effects of the Merger) (rejection of Clayton Act and Bank Merger Act challenge). In more recent joint venture and non-Merger cases, the Commission and courts have found that improvements in quality and innovation are relevant. For example, in the consent order approving a joint venture between GM and Toyota, the Commission noted that the opportunity for GM to learn Japanese manufacturing and management techniques was a "major pro-competitive benefit[.]" *In re General Motors Corp.*, 103 F.T.C. 374 (Statement of Chairman James C. Miller III).[48] In the case of *United States v. Brown University*, the Third Circuit held that the goals of enhancing the quality of the educational system and extending education to a more diverse range of students were pro-competitive effects that are properly considered in a rule of reason analysis. *Brown Univ.*, 5 F.3d 658, 674-75. Also, in a string of cases involving the NCAA, the courts, including the Supreme Court, have consistently credited as pro-competitive benefits the NCAA's purposes of preserving amateurism and promoting the integrity and quality of college sports. *See NCAA v. Board of Regents of the Univ. of Okla.w*, 468 U.S. 85, 101-102, 120 (1984) (considering the NCAA's purposes in the "maintenance of a revered tradition of amateurism" and "add[ing] richness and diversity to intercollegiate athletics" in analyzing output restraints under the rule of reason); *Banks v. NCAA*, 746 F. Supp. 850, 861-62 (N.D. Ind. 1990) (promoting integrity and

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definition of product market, the identification of firms participating in the relevant market, and the analysis of market concentration, entry, and competitive effects.").

[48] *See also In re Polygram Holding, Inc.*, Dkt. 9298 (Commission Decision) (July 24, 2003), where the Commission, in analyzing a restraint under Section 1 of the Sherman Act, noted that "[c]ognizable justifications ordinarily explain how the specific restrictions enable the defendants to increase output or improve product quality, service or innovation."

quality of college football acknowledged as a pro-competitive effect) (discussing other cases involving the NCAA).[49]

In the present case, economists on both sides agreed that the quality improvements ENH made to HPH should be taken into account in evaluating whether the transaction, on balance, had a positive or negative impact on competition. (FOF ¶¶ 323, 325, 329, 523(g)). Quality is important in the analysis of competitive effects because it is one of the dimensions in which hospitals compete. (FOF ¶ 325). Improvements to quality benefit both patients and MCOs, and represent an important factor in a patient's choice of hospitals, which affects how MCOs build networks. (FOF ¶ 325).

Quality of healthcare has both clinical and non-clinical aspects. (FOF ¶ 324). Clinical improvements are changes that increase the likelihood of desired health outcomes and are consistent with the state of current professional knowledge. (FOF ¶ 324). Non-clinical improvements enhance the patient's overall experience, such as increased service, amenities and convenience. (FOF ¶ 324). In choosing among hospitals, patients value both of these aspects of quality. (FOF ¶ 324). Accordingly, in evaluating the pro-competitive effects of the Merger, the Court should consider both clinical and non-clinical improvements. (FOF ¶ 324). The evidence in this case shows dramatic improvements in both clinical and non-clinical dimensions of healthcare at HPH as a result of the Merger. *See* Section IV.C., *infra*.

[49] The district court's holding in *United States v. Rockford Memorial Corp.* that quality should not be considered in a Merger analysis is inapposite. 717 F. Supp. 1251 (N.D. Ill. 1989). The statement in that case on which Complaint Counsel has focused is, by its own terms, limited to the "present § 7 inquiry." *Id.* at 1289. That decision was affirmed, but not on the basis of the Section 7 analysis. The Seventh Circuit, instead, found that the Merger violated Section 1 of the Sherman Act and did not rely on, or even mention, the district court's remarks on quality in the context of its Section 7 analysis. *United States v. Rockford Mem. Corp.*, 898 F.2d 1278 (7th Cir. 1990).

B. A Proper Framework Must Be Used To Measure Clinical Hospital Quality

To determine whether quality improved as a result of the Merger, it is important to understand what the definition of quality is within the field of healthcare quality assessment. Both Complaint Counsel and Respondent retained qualified experts in the field of healthcare quality assessment to testify at trial. Respondent's expert, Dr. Chassin, was also qualified as an expert in health services research, which allowed him to offer conclusions regarding his historical analysis of HPH's quality in this case. (FOF ¶ 1212).

The Institute of Medicine ("IOM"), a branch of the National Academy of Sciences, established a definition of health care quality that has become accepted: "Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." (FOF ¶ 1167); *see also* Lohr KN, ed. Medicare: A Strategy for Quality Assurance (Institute of Medicine, Washington, National Academy Press; 1990). Dr. Chassin, Respondent's expert witness, was a member of the IOM committee that authored the definition of quality and is one of a handful of experts in the field of quality to be elected to the IOM. (FOF ¶ 1168). This IOM definition of healthcare quality is used by both quality experts in this case in their respective fields. (FOF ¶ 1167).

The IOM definition signifies that quality is not the same as simply counting up good outcomes; it is about "increasing the likelihood" of good outcomes. (FOF ¶ 1169).[50] The IOM definition recognizes that many adverse health outcomes are often beyond the control of a

[50] Another dimension of quality is captured in the IOM definition. Quality requires consideration of both "individuals and populations." Therefore, examining individual episodes of care is necessary and appropriate. Equally important is appraising the extent to which populations receive effective care from which they could benefit. Thus, accessibility to effective healthcare services is an aspect of healthcare quality.

healthcare provider and can and do occur despite the best possible quality of care. (FOF ¶¶ 1169-70). Experts in the field of healthcare quality assessment accept that, under the IOM definition, assessments of quality require examination of the content or structure and process of care in addition to outcomes. Proper healthcare quality improvements may fall into any one of these three classes or measures. (FOF ¶ 1171).

Structural measures of quality may be thought of as assessments of the capacity to provide high-quality care. These measures assess the characteristics of physicians, nurses, institutions, or systems of care. Such characteristics include physical resources, equipment, training and expertise. Structural measures provide the conditions under which care is delivered. (FOF ¶ 1172). For example, after the Merger, the expansion of obstetrical coverage at HPH to include nighttime physician coverage is a structural quality improvement even in the absence of any other data. (FOF ¶ 1172). Further, the investment of $120 million in the physical plant and facilities of HPH and the construction of the new Ambulatory Care Center ("ACC") are changes at HPH that would be regarded as structural improvements. (FOF 1518, 1561, 5289).

Second, process measures of care refer to specific strategies and interventions to prevent, cure, or ameliorate disease. They include the use of diagnostic services, medication regimens, or surgical procedures. (FOF ¶ 1173). For example, the improvements in clinical care given to patients who presented at HPH with a heart attack are process quality improvements rendered as a result of the Merger. (FOF ¶¶ 1482-1504). Finally, outcome measures may be used to assess quality of care. Outcomes may be defined broadly and reflect what actually happens to patients as the result of care processes employed.

To properly assess the impact of improvements in all three accepted classes of measures, a comprehensive and multidisciplinary strategy to track the changes in structures, processes and outcomes is needed. (FOF ¶ 1196). For example, accepted methods of study in the field of healthcare quality include interviews, site visits, analyses of documentation and patient records, and proper quantitative and qualitative analysis. (FOF ¶¶ 1196, 1209). These methods have been accepted and utilized by the preeminent independent assessors in the field of healthcare quality such as the Joint Commission on Accreditation of Healthcare Organizations ("Joint Commission" or "JCAHO"),[51] state health departments, and professional regulatory organizations. Specifically, JCAHO, the New York State Health Department, and the American College of Obstetricians and Gynecologists ("ACOG") all utilize site visits and interviews when assessing healthcare quality. (FOF ¶¶ 1203, 1209). The evidence demonstrates that ENH made significant improvements in each of the structure, process and outcome measures.

C. Quality Of Care Improved At HPH As A Result Of The Merger

After the Merger, ENH addressed numerous changes that dramatically improved the quality of care at HPH. HPH's pre-Merger quality problems manifested themselves in at least four different areas: obstetrics and gynecology ("Ob/Gyn"), quality assurance, quality improvement, and nursing. (FOF ¶¶ 1227, 1233, 1344-46, 1416, 1464-68). HPH also had serious deficiencies in its physical plant that threatened patient safety. (FOF ¶¶ 1227, 1512-14).

After the Merger, ENH fixed all of HPH's quality problems and either significantly expanded and improved services already existing at ENH – such as oncology, radiology, emergency medicine, laboratory medicine/pathology, pharmacy and psychiatry – or introduced new services that previously were not offered at HPH – such as cardiac surgery, interventional

[51] The Joint Commission is the entity responsible for accrediting hospitals and certain other types of healthcare

cardiology, intensivist coverage and Epic. (FOF ¶¶ 1228-29, 1564). Many of these new and improved services typically were not available in community hospitals. (FOF ¶¶ 1759, 1762, 1781-82, 1788, 2119-20, 2215). All told, ENH made substantial quality improvements in at least: (1) Ob/Gyn; (2) quality assurance; (3) quality improvement; (4) nursing; (5) physical plant; (6) oncology; (7) radiology and radiation medicine; (8) emergency care; (9) laboratory medicine/pathology; (10) pharmacy; (11) psychiatry; (12) the skills of the physician staff, as a result of the medical integration with ENH and its academic programs; (13) cardiac surgery; (14) interventional cardiology; (15) intensive care; and (16) electronic medical records (Epic). (FOF ¶ 1229).

The vast majority of these improvements could not have been achieved without a Merger. (FOF ¶ 1228). HPH's leadership structure, culture, and financial situation precluded effective improvement efforts and created the risk of adverse health outcomes in key clinical areas. (FOF ¶¶ 1226-27). Accordingly, the relationship between HPH and ENH is critical to maintaining the quality improvements at HPH, and as discussed in more depth in Section VII, any divestiture of HPH would erode a number of those improvements in quality. (FOF ¶ 1232).

1. ENH Fixed HPH's Pre-Merger Problems In Ob/Gyn At HPH And Greatly Improved Those Services

At the time of the Merger, Ob/Gyn was the largest patient care area at HPH. (FOF ¶ 1250). More than a third of all hospital admissions to HPH before the Merger were for mothers delivering babies and their newborns. (FOF ¶ 1250). Yet, at the time of the Merger, HPH had major quality deficiencies in this department. (FOF ¶¶ 1233, 1249). Many of these problems were identified in 1998 by ACOG and corroborated by other sources of information.

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organizations in the United States. (FOF ¶ 1185).

(FOF ¶¶ 1251-1255). ENH remedied these deficiencies and further improved obstetric services at HPH post-Merger.

Prior to the Merger, HPH was plagued by inadequate coverage by obstetricians on labor and delivery, lack of effective obstetrical leadership, inadequate nursing skills and lack of nursing accountability, very poor physician-nurse teamwork, physicians performing inappropriate gynecologic surgery, and a very weak quality assurance program. (FOF ¶¶ 1249-50, 1251-53). The problems in HPH's pre-Merger labor and delivery unit created unsafe situations in an area of critical care and increased the risk of adverse health outcomes for mothers and babies in the labor and delivery unit. (FOF ¶¶ 1250, 1256-57, 1262, 1268).

After the Merger, ENH improved the quality of HPH's Ob/Gyn services across the board at an annual cost of more than $750,000. (FOF ¶¶ 1233-34). However, money alone would not have been sufficient to bring about the sweeping changes that ENH implemented to HPH's Ob/Gyn services. Under the leadership of the newly-appointed ENH Chair of Ob/Gyn, Dr. Richard Silver, ENH implemented in-house, nighttime obstetrician coverage at HPH, which made full-time physicians available on the labor and delivery floor during the nighttime hours to respond to patient emergencies. (FOF ¶¶ 1276-82, 1284-92). The addition of new department leadership also corrected quality assurance problems within Ob/Gyn and allowed HPH to effectively deal with several HPH problem physicians who had escaped effective discipline prior to the Merger. (FOF ¶¶ 1295-1300, 1442, 1446-57). ENH also put an end to inappropriate practice patterns in the labor and delivery unit, including inappropriate inductions, late trimester abortions, and gynecologic procedures in the Emergency Department ("ED"). (FOF ¶¶ 1269-75, 1301-03). These improvements – including a preoperative gynecologic surgical review program, new obstetric practice protocols, improved physician discipline, and physician and nurse

teamwork – are all quality improvements at HPH resulting from the Merger. (FOF ¶¶ 1293-97, 1304-20, 1333).

The improved quality of HPH's Ob/Gyn services is evident from ENH's patient outcomes post-Merger. This evidence indicates that ENH performs Cesarean section and operative vaginal delivery rates at lower rates than national benchmarks. In addition, ENH's neonatal mortality rates are equal to or lower than national benchmarks. (FOF ¶ 1331). Because both Cesarean section and operative vaginal deliveries are riskier procedures than normal vaginal birth, these data establish that ENH is appropriately selecting the method of labor and minimizing the number of expectant mothers who are exposed to greater delivery risks. (FOF ¶¶ 1321-29).

2. ENH Fixed HPH's Pre-Merger Quality Assurance Problems

A strong quality assurance program is important to quality of care in a hospital. (FOF ¶ 1414). Hospitals are responsible for operating quality assurance programs: (1) to identify and appropriately discipline poorly performing physicians; and (2) to carefully investigate adverse events and close calls to identify opportunities for improvement in hospital systems and policies for reducing the likelihood of those adverse events recurring. (FOF ¶ 1415). HPH's pre-Merger quality assurance program was inadequate in both respects. (FOF ¶¶ 1416, 1420). It had a very weak structure within each of the clinical departments for performing effective peer review and identifying problem physicians, and it lacked an adequate process to discipline those physicians. (FOF ¶ 1416). Shortly after the Merger, ENH made several improvements to HPH's quality assurance program that remedied these problems and further improved quality assurance at HPH. (FOF ¶ 1418). In so doing, ENH also reduced the risk of adverse outcomes to patients.

a. Adverse Event Case Reviews

Prior to the Merger, adverse events, including adverse drug events, were largely underreported at HPH. (FOF ¶¶ 1421-23). Additionally, HPH lacked an effective way of reporting medical errors. (FOF ¶¶ 1421-22). Even when adverse events were reported, however, HPH lacked a systematic approach for examining them and determining ways to prevent them from recurring. (FOF ¶¶ 1421-22). As a result, when adverse events were investigated, rather than identifying hospital processes or systems that needed fixing, HPH had a pattern of finding no opportunities for improvement. (FOF ¶ 1422). This pattern of ineffective adverse event case reviews was widespread throughout HPH. (FOF ¶ 1428).

Hospital governance plays a critical role in setting the tone for effective quality assurance. (FOF ¶ 1429). Effective peer review and quality assurance starts with the leadership at all levels. (FOF ¶ 1429). For peer review and quality assurance to work well, the Board of Trustees must have a role in hearing about, encouraging, and enforcing discipline. (FOF ¶ 1429). The hospital's leadership, the administrative leadership, and the nursing and physician leadership must play similar roles. (FOF ¶ 1429). Before the Merger, HPH had a hospital culture of keeping adverse event discussions away from the Board of Trustees. (FOF ¶¶ 1430-31). As a result, the Board rarely, if ever, was involved either in analyzing the adverse events or in helping to solve them and, therefore, failed to perform adequate oversight of the hospital's quality assurance programs. (FOF ¶ 1431).

After the Merger, ENH exported to HPH its organizational culture, which encouraged the reporting of hospital errors for learning purposes. (FOF ¶ 1444). Over time, this has resulted in a positive change at HPH in the reporting of errors. (FOF ¶ 1444). As early as June 2000, the

quality assurance committee meetings at HPH reflect HPH's new efforts to discuss and encourage the reporting of medical errors and close calls. (FOF ¶ 1445).

b. Physician Discipline

Before the Merger, HPH was a typical community hospital with a typical governance structure. (FOF ¶ 1432). Rather than having full-time department leaders, as was common in academic teaching hospitals, the department heads at pre-Merger HPH were private practitioners who were not compensated for their work. (FOF ¶¶ 1432-33). Moreover, instead of being appointed on the basis of their abilities, the department heads were elected by their peers and served two-year terms. (FOF ¶ 1433). As private practitioners, the department heads were often in direct competition with the very physicians whose conduct they were charged with monitoring. (FOF ¶ 1432). This inherent conflict of interest prevented the members of the quality assurance committee from effective peer review because, in part, they did not want to be responsible for someone losing their privileges and livelihood. (FOF ¶ 1432). The incentive to discipline fellow physicians was further reduced by the possibility that the disciplined physician might be elected as a department head the following year. (FOF ¶ 1433). Consequently, the department chairmen were reluctant to deal effectively with physician misconduct. (FOF ¶¶ 1296, 1433).

(REDACTED) (FOF ¶¶ 1297, 1441).[52]

After the Merger, ENH completely changed the structure of physician oversight at HPH by replacing the part-time and private practicing physician chairs with full-time clinical

chairmen, who are selected following a national search and employed by ENH. (FOF ¶¶ 1295, 1298, 1417-18, 1442-43). ENH also integrated the medical staffs in each department, making the clinical chairman responsible for the integrated departments and physicians at HPH. (FOF ¶¶ 1442-43). This was an important step in improving the system of physician discipline at HPH, and it improved the quality in the department of Ob/Gyn at HPH. (FOF ¶¶ 1448-57).

(REDACTED)

(FOF ¶¶ 1446-47).

c. Physician Re-Credentialing

After the Merger, ENH also introduced a periodic re-credentialing process in which HPH physicians underwent a review of their practices, and as a result, decisions were made about medical staff privileges. (FOF ¶¶ 1458-59). Several HPH physicians were not granted re-appointment during the periodic re-credentialing process because of their failures to respond while on call. (FOF ¶ 1458).

(REDACTED)

(FOF ¶ 1459).

3. ENH Fixed HPH's Pre-Merger Quality Improvement Problems

Quality improvement ("QI") consists of hospital programs directed toward improving the quality of service across a wide variety of measures. (FOF ¶ 1460). Hospitals must have QI programs that are directed to proactively using data-driven methods to improve their services over time. (FOF ¶ 1460). Prior to the Merger, HPH's quality improvement program was

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(REDACTED)

(FOF ¶¶ 1455-56).

inadequate to achieve meaningful quality improvement. ENH quickly resolved this issue after the Merger by exporting its superior QI programs to HPH. (FOF ¶ 1462).

HPH's pre-Merger QI program suffered from several weaknesses: (1) it included several indicators that were not valid quality measures and did not use data from sources outside HPH to determine where its performance was on the scale of good, bad or indifferent; (2) there was a lack of benchmarking and use of best demonstrated practices; (3) HPH used a care map process that was overly simplistic and deficient as a means of improving care; and (4) HPH's approach to improvement was extremely limited in that it did not use evidence from adverse event investigations or a multidisciplinary process and had very few indicators. (FOF ¶¶ 1464-66). To be effective, a QI program has to involve multidisciplinary approaches, which requires input from all different clinical perspectives, including physicians, nurses, pharmacists, and all of the other perspectives of care. (FOF ¶ 1461).

HPH also had an extremely limited process for attempting to proactively improve quality of care pre-Merger and, as a result, HPH failed to identify the places where care needed to be improved. (FOF ¶¶ 1466-67). In addition, there was evidence of wide variations in the application of practice standards in the treatment of certain diseases, resulting in variation in patient outcomes at HPH. (FOF ¶ 1466).

In the months immediately following the Merger, ENH rapidly exported its QI systems to HPH by involving a large cohort of physicians in quality improvement committees and activities. (FOF ¶¶ 1462, 1470). As a result of their involvement in the development of critical pathways and review of literature to determine up-to-date treatment plans, these HPH physicians upgraded their skills, which is a structural improvement in the quality of care at HPH. (FOF ¶ 1473).

Beginning in March 2000, ENH also began exporting its multidisciplinary critical pathways to HPH. (FOF ¶¶ 1476-78). ENH's critical pathways contain numerous process measures of quality designed to improve patient outcomes, and they employ a lot of best practices from other sources to generate a proactive approach to quality improvement. (FOF ¶ 1475). By August 2002, ENH had introduced a total of 33 new critical pathways to HPH.[53] (FOF ¶ 1478). Complaint Counsel's expert, Dr. Patrick Romano, concedes that the QI program at HPH improved after the Merger. (FOF ¶ 1462). These QI program improvements dramatically improved the quality of patient care at HPH. (FOF ¶ 1463).

The improvement in the care of heart attack patients at HPH post-Merger confirms the improvement in HPH's post-Merger QI program. (FOF ¶¶ 1482-86, 1488). One of the first critical pathways ENH exported to HPH after the Merger was the myocardial infarction critical pathway, which emphasized improving performance on aspirin and beta blockers. (FOF ¶ 1487). The administration of aspirin and beta blockers to heart attack patients has been proven in many dozens of research studies to save lives and reduce complications. (FOF ¶¶ 1486-86, 1489). The uses of these medications are thus critical process measures of the effectiveness of treating heart attack patients. (FOF ¶¶ 1485-86).

(REDACTED)

(FOF ¶¶ 1489-98, 1499-1504, 1509). Thus, ENH's exportation to HPH of a much more effective QI program after the Merger produced very rapid and very substantial quality improvements at HPH in highly valid process measures of care. (FOF ¶¶ 1509-11).

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[53] Data available from HPH's care maps – such as length of stay and cost per case – cannot be used with data from Evanston Hospital's critical pathways to compare changes in quality at HPH before and after the Merger because those variables are not particularly related to quality of care. (FOF ¶ 1481).

4. ENH Fixed HPH's Pre-Merger Nursing Problems

Nursing services are absolutely critical to patient care because of the increasing complexity and severity of illnesses of hospitalized patients. (FOF ¶ 1338). HPH, however, lacked several key elements of an effective nursing program prior to the Merger. (FOF ¶ 1344). ENH effectively addressed these issues after the Merger.

Prior to the Merger, HPH had trouble recruiting nurses. (FOF ¶ 1350). It had a 13-15% nurse vacancy rate, and it was forced to fill the vacancies with temporary nurses from agencies. (FOF ¶ 1350). Although HPH needed to recruit and hire new nurses, its declining financial condition restricted its ability to compete in the market with respect to nursing salaries and benefits packages. (FOF ¶ 1353). Shortly after the Merger, nursing problems were memorialized in an August 23, 2000, memorandum from Peggy King, Assistant Vice President, to Mary O'Brien, Senior Vice President. (FOF ¶ 1347). King identified concerns about passive nursing, a lack of critical thinking skills by nurses, the failure of nurses to practice autonomously, a punitive nursing atmosphere that inhibited accident investigation, a lack of nurse leadership support and nursing competency. (FOF ¶ 1347).

Further, HPH nurses lacked proper training. There were nurses without CPR certification and nurses who lacked cross-training, and there was no nurse orientation program or nurse training for delivering care to high-risk patients. (FOF ¶ 1362). Hospital leadership also did not support active involvement of nursing in multidisciplinary care. (FOF ¶ 1344). Finally, HPH had problems with nurse/physician relationships. (FOF ¶¶ 1368-84). Contemporaneous documentation from hospital administrators confirms the problems facing HPH nursing services just described. (FOF ¶ 1347).

After the Merger, ENH improved nursing services at HPH in several clear ways. First, ENH immediately provided several nurse pay increases to address high turnover and vacancy rates at HPH. (FOF ¶ 1389). Second, it implemented widespread additional training for nurses across the entire HPH, on regular floors and in the Intensive Care Unit ("ICU") and operating room ("OR"), which allowed the nurses to be more active and more effective clinical caregivers. (FOF ¶¶ 1397-1407). The opening of the cardiac surgery program also enhanced HPH nurse training and skills. (FOF ¶¶ 1402-03). As a result of these programs, HPH nurses improved their critical thinking and assessment skills and improved patient safety. (FOF ¶¶ 1406-07). Third, ENH greatly improved the teamwork between physicians and nurses, transforming the nursing service from a passive culture to a more active, professional culture where nurses were full partners with physicians in providing multidisciplinary, effective care. (FOF ¶¶ 1408-09).

The Merger was necessary to cure HPH's nursing problems. HPH lacked a culture – throughout the hospital, through administration, or through physician leadership – that promoted positive nurse/physician relationships. (FOF ¶ 1384). Solving these cultural issues required a change of the hospital systems, administration and physician leadership. (FOF ¶ 1384). Support for cultural change had to be pervasive throughout the organization. (FOF ¶ 1384). ENH installed full-time, paid department chairs who are responsible for managing physicians within their department and addressing nurse/physician relationships, among other issues. (FOF ¶ 1410). Without this cultural change that ENH brought to HPH, nursing services would not have improved. (FOF ¶ 2456).

5. ENH Fixed HPH's Pre-Merger Deficiencies In Its Physical Plant And Substantially Expanded Its Facilities

Since the Merger, ENH has poured millions of dollars into renovating the physical plant at HPH to correct numerous deficiencies that endangered the lives and safety of its patients. ENH has also invested millions of dollars in expanding HPH's old facilities and adding new ones that allow HPH to offer services it previously could not. (FOF ¶¶ 1515-17). All of these physical plant and facility upgrades are substantial improvements to the structure of care, which increases HPH's ability to deliver high-quality care and thereby increases the likelihood of desired outcomes. (FOF ¶ 1516).

Prior to the Merger, HPH had significant deficiencies in its physical facilities that limited HPH's capacity to render adequate care and ensure the health and safety of its patients. (FOF ¶¶ 1512-14). **(REDACTED)**

(FOF ¶¶ 1513, 1519-35). In addition, ENH's pre-Merger due diligence revealed a number of critical upgrades that posed a direct threat to patient safety, as well as additional items that could or would affect operations and could become code violations if they were not addressed. (FOF ¶¶ 1536-48). These physical plant deficiencies were far more serious than those that threatened HPH's ability to participate in the Medicare program and increased the risk of adverse events at HPH. (FOF ¶ 1514). ENH estimated the cost to remedy these deficiencies at $14-19 million. (FOF ¶ 1514).

Shortly after the Merger, to protect the welfare of the patients at HPH, ENH addressed HPH's critical and potentially critical deficiencies. (FOF ¶¶ 1515, 1549). ENH replaced the HPH patient care buildings' entire electrical distribution and ventilation systems, plumbing, and waste pipes; built a new central plant at HPH, including a new power plant that houses utilities

such as electrical generators, backup generators, boilers, and air ventilation equipment; and built redundant critical life safety systems to ensure patient safety in the event of a failure of the primary system. (FOF ¶¶ 1550-57).

ENH also built new facilities and purchased new equipment for HPH that improved the quality of ENH's existing services and expanded the types of services ENH could offer. These improvements included a new Ambulatory Care Center ("ACC") that houses radiation medicine, nuclear medicine, the Kellogg Cancer Care Center, and the breast imaging center; a new cardiac catheterization lab to support the interventional cardiology program; the renovation and expansion of the ED and psychiatry units; expansion of the radiology department; and the addition of modern equipment to a variety of areas. (FOF ¶¶ 1516, 1559-61). The cost of these improvements has been substantial. For example, the ACC cost $19.5 million plus an additional $5.3 million for new state-of-the-art equipment, while the new open heart surgery suite cost $1.3 million. (FOF ¶¶ 1558, 1561). ENH also spent over $2 million in upgrades to the operating room equipment. (FOF ¶¶ 1562-63). Moreover, ENH is continuing to remodel HPH's radiation department and HPH's medical/surgical units, and it has started construction of a new ICU. (FOF ¶ 1517).

Overall, ENH has spent $120 million on capital improvements at HPH, and it has committed to spend an additional $45 million at HPH in the future. (FOF ¶ 1518).

6. ENH Brought Multidisciplinary Academic Oncology Services To HPH

ENH substantially improved oncology services at HPH post-Merger by extending the Kellogg Cancer Care Center and offering oncology services, research trials, and new equipment typically not found in community hospitals. (FOF ¶ 1789). Many of these services are only

offered in academic teaching hospitals. As a result of the improvements made by ENH to oncology services at HPH post-Merger, the American College of Surgeons changed its designation of HPH's oncology program from a community oncology program to a teaching hospital cancer center. (FOF ¶¶ 1722-26).

Before the Merger, as was typical in community hospitals, necessary support services such as pharmacy services, psychology, and nutritionists were not coordinated in a central location, instead requiring sick patients to travel to multiple locations to receive these important services. (FOF ¶¶ 1723, 1731-33). Also as was typical in community hospitals, HPH did not have any specialty oncologists prior to the Merger, often requiring cancer patients at HPH to travel long distances for consultations. (FOF ¶¶ 1734-35, 1776). Such coordinated and specialty services are typically provided only at academic medical centers. (FOF ¶¶ 1771, 1778). For a patient with a chronic debilitating illness, however, it is far superior from a quality of life standpoint to get health care treatment at one location that is near home. (FOF ¶ 1776).

After the Merger, ENH made major improvements to the oncology program at HPH by exporting its multidisciplinary approach to HPH and introducing subspecialty oncologists to HPH. (FOF ¶¶ 1724, 1750, 1761, 1774). Most notably, ENH introduced the Kellogg Cancer Care Center, a multidisciplinary treatment center providing coordinated access to subspecialty oncologists and critical ancillary support staff. (FOF ¶¶ 1729-30, 1751-55, 1763-71, 1774). HPH patients are now cared for by a team consisting of the physician oncologist, nurse, pharmacist, psychologist, social worker, and nutritionist. (FOF ¶ 1756). The Kellogg Cancer Care Center at HPH has a broad range of sub-specialist oncologists, including sub-specialists in breast oncology, thoracic oncology, hematologic malignancies, melanoma, head and neck cancer, and sarcoma. (FOF ¶¶ 1774-77).

In addition, the Merger enabled HPH oncologists to participate in the medical oncology conferences and case consultations with Evanston Hospital's oncologists, thereby expanding the pool of physician resources available to assist with oncology consultations and assuring that the most up-to-date and modern thoughts and treatment are applied to each case. (FOF ¶¶ 1757-59, 1777). The Merger also allowed HPH to receive additional funding from the National Cancer Institute that gave HPH patients access to a broader range of treatment and prevention research trials and to offer sophisticated, state-of-the-art diagnostic and treatment equipment, such as a CT/Pet scanner. (FOF ¶¶ 1736-48, 1779-82, 1785-87). Further, complex procedures and treatments such as interventional radiology, thermal ablation, and endoscopic ultrasound are available to cancer patients at HPH today. (FOF ¶ 1788). All of these services and specialized equipment normally would not be found in a community hospital, but rather in an academic teaching hospital. (FOF ¶¶ 1759, 1762, 1781, 1787-88).

7. ENH Substantially Improved Radiology And Radiation Medicine Services At HPH

After the Merger, ENH made substantial investments in new radiology and radiation therapy equipment at HPH, extended significant new technology to HPH, and added greater access to specialists in radiology, all of which substantially improved the quality of radiology and radiation medicine at HPH. (FOF ¶¶ 2144-45).

At the time of the Merger, the radiation therapy equipment at HPH was antiquated, had limited radiation capacity, and needed to be replaced. (FOF ¶¶ 2129-30). The equipment problems were so bad that prior to the Merger, physicians sent their patients elsewhere for radiation therapy. (FOF ¶¶ 2131-32). Additionally, all of the radiologists at pre-Merger HPH were generalists. (FOF ¶ 2142).

After the Merger, from 2000 to 2004, ENH purchased $6.4 million of new radiology equipment for HPH. (FOF ¶¶ 2133-34). It also extended RADNET (at a cost of $2.1 million), its radiology imaging system that provides access to patient reports from anywhere in the ENH system, and PACS, its filmless radiology imaging system that allows images to be viewed instantly from anywhere there is internet access, to HPH. (FOF ¶¶ 2135-38). Further, ENH added additional radiologists (to reduce turnaround times) and access to specialists in several areas. (FOF ¶¶ 2140-43). Both the immediate access to radiology results and the addition of specialists improved the quality of radiology services and radiation medicine at HPH. (FOF ¶¶ 2138, 2143).

8. ENH Improved The Emergency Department At HPH

ENH made significant structural and process quality improvements to the HPH ED. (FOF ¶¶ 1866-67). Prior to the Merger, the HPH ED was a cramped, cluttered area with technology that was far from state-of-the-art. (FOF ¶¶ 1872-77, 1892). In addition, the ED was covered by only a single physician, which created potentially dangerous gaps in patient care when emergencies occurred in other areas of the hospital and the ED physician was required to respond. (FOF ¶¶ 1878-83).

ENH made five major quality improvements in the ED at HPH after the Merger, including: (1) expanding physician coverage; (2) renovating and expanding facilities; (3) improving nurse staffing by skilled nurses; (4) upgrading the Fast Track area; and (5) fully integrating HPH physicians into the ENH ED. (FOF ¶¶ 1891-1910, 1912, 1920, 1928). For example, HPH added a second ED physician to cover the 11:00 a.m. to 9:00 p.m. shift, historically the busiest hours in the HPH ED. (FOF ¶ 1914). This allowed HPH ED physicians to respond to emergencies outside the ED without leaving the ED uncovered, and, as a result, to

offer higher quality, more efficient care for patients in the ED. (FOF ¶¶ 1911-19). The double coverage cost ENH several million dollars. (FOF ¶ 1914). The full integration of HPH and ENH medical staffs constituted another considerable improvement in quality of care in HPH's ED. As a result, all HPH emergency physicians rotate throughout all ENH EDs, taking part in academic activities and continuous learning opportunities designed to maintain their clinical acuity. (FOF ¶¶ 1920-21).

Coincident with these major improvements and the expansion to the HPH ED, the volume of patients seen and treated at the ED has increased 11.5%, demonstrating that the added capacity was utilized by, and of benefit to, a significant number of HPH patients. (FOF ¶ 1895).

9. ENH Significantly Improved And Expanded Laboratory Services At HPH

Laboratory services are essential to quality healthcare. It is estimated that 70% of medical decisions are based on laboratory results. (FOF ¶ 1790). After the Merger, ENH substantially improved and expanded laboratory services at HPH.

Prior to the Merger, HPH had an immediate response lab ("HPH lab") that provided urgent test results, and it outsourced all other testing to Consolidated Medical Labs ("CML"). (FOF ¶¶ 1791-93). ENH found numerous problems with the HPH lab when it took over after the Merger, including old and inadequate equipment, unqualified personnel, poor environmental controls, poor water quality, and a lack of documentation for lab testing, quality control, and safety procedures. (FOF ¶¶ 1795, 1801-26). Some of the personnel working in the HPH lab even had criminal records. (FOF ¶ 1814). Moreover, neither the HPH lab or CML had specialists overseeing the laboratory testing. (FOF ¶ 1815).

Upon taking over the HPH lab on June 1, 2000, ENH fixed the problems with the HPH lab and converted it from a immediate response lab to a full service laboratory. This included constructing new histology and cytology laboratories on-site, installing over $1 million in state-of-the-art lab equipment, and introducing more stringent quality controls. (FOF ¶¶ 1795, 1827-41). These changes allowed HPH to perform more complex testing on-site, while at the same time reducing turnaround times. (FOF ¶¶ 1792, 1856-58, 1862). ENH also put subspecialists in different areas of pathology in charge of the HPH lab, began rotating pathologists among the ENH hospitals, and brought its academic focus to HPH. (FOF ¶¶ 1795, 1854-55, 1859-61). Further, ENH brought all of the microbiology, immunology, and lab testing to Evanston Hospital, which has nationally recognized specialists in each field. (FOF ¶¶ 1795, 1842-49). These post-Merger changes improved the quality of the HPH lab. (FOF ¶¶ 1796, 1827).

10. ENH Substantially Upgraded Pharmacy Services At HPH

After the Merger, ENH upgraded the pharmacy services available at HPH by improving HPH's drug dispensing and clinical pharmacy services, which had a direct impact on patient safety. (FOF ¶¶ 1950, 1954). ENH's pharmacy improvements included, among other things: (1) adding a pharmacist to staff the night shift at HPH's pharmacy, which previously was not staffed; and (2) implementing an automated drug distribution system called Pyxis, which improved the efficiency and safety of drug distribution. (FOF ¶¶ 1953, 1955-78). Pyxis is a substantial improvement over the pre-Merger HPH method of drug distribution, which was the traditional unit dose cart exchange system. (FOF ¶¶ 1954, 1964, 1966). These improvements cost ENH at least $775,000. (FOF ¶ 1950).

ENH also improved the organization and deployment of clinical pharmacy services after the Merger, making specialized pharmacists available to oncology patients, providing

pharmacists on multidisciplinary rounds in the ICU, and otherwise decentralizing the pharmacists to better assist with drug-related questions. (FOF ¶¶ 1979-1991). Finally, ENH substantially improved HPH's compliance with the Institute for Safe Medication Practice's medication safety recommendations, which is a dramatic, quantified improvement in the quality of medication safety. (FOF ¶¶ 1992-98).

11. ENH Improved And Expanded Adolescent Psychiatric Services At HPH

After the Merger, ENH improved and expanded adolescent psychiatric services at HPH. Prior to the Merger, HPH and Evanston Hospital each had separate inpatient adolescent psychiatric units that treated both adult and adolescent patients. (FOF ¶ 2172). The adolescent populations at each hospital, however, were not large enough for either hospital to offer the full complement of services for inpatient psychiatric care. (FOF ¶ 2175). Moreover, the adolescent psychiatric unit at HPH contained many hazards for both the patients and the staff. (FOF ¶ 2177). Additionally, psychiatric consultations in the HPH ED were not sought from specialists, but rather from either ED physicians or private practice psychiatrists. (FOF ¶ 2176).

After the Merger, ENH consolidated adolescent inpatient psychiatric services at HPH and adult inpatient services at Evanston Hospital. (FOF ¶ 2172). The additional patient volume allowed HPH to offer a broader variety of treatment options and specialized services for adolescent patients, including a crisis intervention team dedicated to providing psychological counseling and evaluation to ED patients. (FOF ¶¶ 2175-76, 2178-83). ENH also remodeled the adolescent psychiatric unit at HPH to address the safety issues that were present before the Merger. (FOF ¶¶ 2184-85). The cost of these facility and program enhancements (excluding

additional staffing costs) was $1.2 million. (FOF ¶ 2173). All of these post-Merger changes improved the quality of psychiatric services at HPH. (FOF ¶ 2186).

12. HPH And Its Physicians Benefit From The Integration And Affiliation With An Academic Teaching Hospital

Prior to the Merger, HPH was a community hospital that lacked any affiliation with an academic teaching hospital. (FOF ¶ 2166). Physicians, however, require a continuous influx of academic information to prevent their skills from stagnating and becoming impaired. (FOF ¶ 2147). By integrating the two medical staffs after the Merger, ENH brought an academic focus to HPH and raised the skill level of the physicians practicing at ENH, which is an important structural improvement in the quality of care. (FOF ¶¶ 2146-49).

Since the integration of the medical staffs post-Merger, physicians in several specialties regularly rotate through or practice at all three ENH hospitals, and HPH physicians have become more involved in teaching activities, participate in more educational conferences with specialists in multiple disciplines, and obtain more faculty appointments at Northwestern Medical School. (FOF ¶¶ 2146-47, 2150-64, 2167). The academic and teaching experience keeps physicians sharp by forcing them to keep up with medical literature and research answers to questions, and it provides them with a venue for the exchange of new ideas. (FOF ¶¶ 2148, 2155). The Merger also allowed HPH to gain an academic affiliation with Northwestern Medical School, which improved HPH's ability to attract higher quality residents. (FOF ¶¶ 2166-71). Accordingly, the clinical integration and academic focus ENH brought to HPH post-Merger improved the quality of care at ENH. (FOF ¶¶ 2148-49).

13. Following The Merger, ENH Opened A High-Quality Cardiac Surgery Program At HPH

Prior to the Merger, HPH lacked a cardiac surgery program. ENH introduced a new cardiac surgery program at HPH, making HPH the first hospital in Lake County, Illinois to perform cardiac bypass surgery. (FOF ¶ 1565). The new program required the construction of a state-of-the art operating room, which cost over $1 million dollars, as well as the hiring and training of cardiac surgical ancillary support staff. (FOF ¶¶ 1558, 1579). The cardiac surgery program at HPH achieved high-quality patient outcomes within the first years of operation and compared favorably to the best cardiac surgery programs in the country with respect to mortality for isolated bypass surgery. (FOF ¶¶ 1609-10, 1621). **(REDACTED)**

(FOF ¶ 1611). Dr. Romano concedes that cardiac surgery in the best hands typically generates a mortality rate of around 3%. (FOF ¶ 1615).

The practice of cardiac surgery at Evanston Hospital and HPH is also state-of-the-art with respect to complexity of surgical techniques, cases, and cutting edge research. (FOF ¶ 1592). For example, HPH and Evanston perform advanced research, utilize new stenting technology, and employ advanced surgical techniques, such as performing cardiac surgery without blood transfusions. (FOF ¶¶ 1642, 1699). All of these aspects of the ENH cardiac surgery program are so advanced that few hospitals in Chicago or elsewhere in the country are doing likewise. (FOF ¶¶ 1637-38, 1640-42).

The high-quality results for the HPH cardiac surgery program could only be achieved through the Merger, which allowed ENH to have full control of post-operative care and administrative decisions relating to the cardiac surgery program. HPH could not have achieved the same high quality results either through a joint venture or by a partnership with a more

distant hospital. (FOF ¶¶ 1628-29). Dr. Rosengart specifically testified that due to the lack of integration between ENH and the affiliated programs, Swedish Covenant Hospital and Weiss Hospital, the ENH cardiac surgery program did not extend its most advanced surgical techniques nor carry out research at these sites because it would not be safe. (FOF ¶¶ 1636-46). Moreover, outcomes are also better at HPH than the affiliated sites. The mortality rates, length of stay, and cost per case are all higher at Swedish Covenant Hospital and Weiss Hospital due to the lack of integration and control afforded through the joint venture relationships. (FOF ¶¶ 1643-44).

14. ENH Opened A Life-Saving Interventional Cardiology Program At HPH

Commensurate with establishing the new cardiac surgery program, ENH opened a new interventional cardiology program at HPH that allowed HPH to treat heart attack patients with life-saving procedures to clear blocked arteries on an emergent or elective basis. (FOF ¶¶ 1647-49). ENH also constructed a new, $2.5 million state-of-the art interventional catheterization laboratory. (FOF ¶ 1653).

Prior to the Merger, many patients with acute myocardial infarction (heart attack) were transferred out of HPH. (FOF ¶ 1651). **(REDACTED)**

(FOF ¶ 1656). The reduction in heart attack patients being transferred from HPH is a substantial quality improvement because there is a medical risk when transferring a patient in the middle of an acute heart attack. (FOF ¶ 1658). Furthermore,

(REDACTED)

(FOF ¶ 1659).

Other physicians and hospitals in the region have recognized the quality of HPH's interventional cardiology program. (FOF ¶ 1660).

(REDACTED)

(FOF ¶ 1660). Patient outcome data further confirms that HPH has implemented the interventional cardiology program in a high-quality manner, with HPH achieving a 0.6% mortality rate for elective interventional procedures that is very comparable to national benchmarks. (FOF ¶¶ 1661-64).

15. ENH Implemented An Intensivist Program At HPH

Following the Merger, ENH introduced an intensivist program at HPH to provide staffing by physicians specially trained in critical care medicine in HPH's ICU. (FOF ¶¶ 1672-75). Intensivists at HPH are charged with directing the care of all patients in the ICU, responding to patient emergencies throughout HPH, training ICU nurses, providing on-site care 12 hours each weekday, and being on-call during the night and weekend. (FOF ¶¶ 1691-1703, 1708-10).

(REDACTED) (FOF ¶ 1690). The program is a quality improvement because intensivists are known to reduce mortality and complications in the ICU. (FOF ¶¶ 1686-90, 1696, 1711-12). Indeed, Dr. Romano concedes that the implementation of the intensivist program at HPH was likely to improve patient outcomes, reduce mortality in the ICU, and lead to improvements in quality of care. (FOF ¶ 1713).

Intensivist programs are rare in community hospitals. (FOF ¶ 1721, 2215). In a survey published by the Leapfrog Group in 2005, only 6 out of 37 hospitals reporting to LeapFrog in Illinois had intensivist programs, and three of those six hospitals were the ENH hospitals. (FOF ¶¶ 1721, 2216). Rush North Shore, for example, declined to institute such a program because it

could not afford it. (FOF ¶ 1720). It is unlikely that HPH would have had an intensivist program if not for the Merger. (FOF ¶¶ 1714-21).

16. ENH Installed A State-of-the-Art Electronic Medical Records System At HPH

After the Merger, ENH successfully introduced Epic at HPH. Epic is an integrated electronic medical record system that includes Computerized Physician Order Entry ("CPOE") and Clinical Decision Support Systems ("CDSS"), which aid the physician in making better medical decisions. (FOF ¶¶ 2007, 2074, 2076, 2097, 2099). This constituted a quantum leap over the system HPH used prior to the Merger and a major improvement in quality of care. (FOF ¶¶ 2004, 2121-27). Indeed, Dr. Romano concedes that Epic is a major improvement in the structure of care at ENH that increases the likelihood of desired health outcomes when the physician uses the information in ways that improve care. (FOF ¶ 2004).

The benefits of electronic medical records have been recognized by numerous groups that study healthcare quality, including the IOM and Leapfrog. (FOF ¶¶ 2011-14). The availability of complete patient health information at the point of care delivery, together with CDSS, such as those for medication order entry, can prevent many errors and events from occurring. (FOF ¶¶ 1999). For these reasons, the Federal Government has established a national initiative to develop a universally accessible electronic healthcare record for all citizens within 10 years. (FOF ¶¶ 2000, 2015-16).

ENH's implementation of Epic at the ENH hospitals is entirely consistent with the Government's vision. Epic allows all caregivers at ENH to have access to clinical information about a patient, including hospital admissions, office visits, laboratory studies, imaging studies, and information generated by other caregivers, that is secure, current, complete, legible,

organized, and instantly accessible from anywhere the caregiver has internet access. (FOF ¶¶ 2003, 2008, 2060). It ties all of the ENH campuses and their inpatient and outpatient services together with a single electronic health repository. (FOF ¶ 2003).

(REDACTED)

(FOF ¶ 2003).

Without the Merger, HPH would not have had the use of this powerful tool. To date, ENH has spent $42 million on Epic, $14 million of which was to implement Epic at HPH, and has a staff of 75 people dedicated solely to maintaining Epic. (FOF ¶¶ 2006, 2052). Because of the expense and effort involved, no community hospital has deployed an enterprise grade electronic medical record system such as Epic. (FOF ¶¶ 2118-19). In fact, the majority of community hospitals today do not have an electronic medical record that includes CPOE systems. (FOF ¶¶ 2120, 2211). Indeed, Meditech, the system HPH used prior to the Merger did not allow for CPOE. (FOF ¶¶ 2121, 2124). Meditech, as deployed at HPH, was not paperless, could not be accessed remotely, and lacked ambulatory capability. (FOF ¶¶ 2123-25).

ENH's uniquely successful implementation of Epic has been nationally recognized by several sources, including the Federal Government, and other academic teaching hospitals in the Chicago area have sought to learn from ENH. (FOF ¶¶ 2110-17, 2208-10). Moreover, the depth and speed with which ENH was able to completely engage its three campuses, including both physicians and non-physicians, in the roll-out of Epic produced a much greater improvement in

quality in a much shorter period of time than most, if not all, other implementations of a full electronic medical record.[54] (FOF ¶ 2109).

D. Respondent's Expert Applied Accepted Methodology To Study Quality

Respondent's quality of care expert, Dr. Mark Chassin, concluded that the quality of healthcare delivered by HPH has improved dramatically across many different service lines as a direct result of the Merger. (FOF ¶ 1226). Dr. Chassin, the Chairman of the Department of Health Policy at the Mount Sinai School of Medicine in New York City and former Commissioner of the New York State Health Department, conducted a comprehensive and multi-faceted investigation into the quality of healthcare delivered at HPH and the changes made to the hospital by ENH after the Merger. (FOF ¶¶ 1196, 1213, 1221).

Dr. Chassin's assessment in this case was based on several fundamental principles of quality measurement and improvement that have gained broad acceptance and use in health care in the past decade. Dr. Chassin employed assessment methods that have been used and sanctioned by significant governmental, regulatory, and third-party healthcare quality organizations. (FOF ¶ 1196). Appropriate and sound application of these principles is essential to accurately assess the changes in the quality of care at HPH.

1. Dr. Chassin Employed A Multidisciplinary Approach

Dr. Chassin used a comprehensive and multidisciplinary strategy to measure the enhancements in structures, processes and outcomes at HPH as a result of the Merger. (FOF ¶ 1197). Dr. Chassin made two, two-day site-visits to both Evanston Hospital and HPH. (FOF ¶ 1203). He also interviewed more than 34 key physicians and administrators, reviewed

[54] If HPH had to implement Epic on its own, it would take three to five years to get up and running. *See* Section

contemporaneous documents, and applied standard quantitative and qualitative assessment methods over a range of different sorts of data sets. (FOF ¶¶ 1199, 1204). When possible, Dr. Chassin utilized different sources in his analysis, including interviews, document review, examination of data, and site visits, to determine whether there was consistency among all the sources of information he was considering and to see if those sources pointed in the same direction in terms of the quality assessment he was conducting. (FOF ¶ 1210). This broad range of sources led Dr. Chassin to conclude that quality improved in a number of areas, including Ob/Gyn and nursing. (FOF ¶ 1210).

Dr. Chassin's methods were consistent with those used in the field of healthcare quality analysis such as JCAHO, the New York State Health Department and ACOG. (FOF ¶¶ 1203, 1209). In contrast, Complaint Counsel's expert conceded at trial that he did not undertake a comprehensive analysis. (FOF ¶ 2219). Specifically, when conducting his assessment in this case, Dr. Romano admittedly made no site visit and failed to interview any relevant individuals. (FOF ¶¶ 1203, 1209).

2. Chassin Employed Valid Measures Of Quality

Dr. Chassin quantified in detail changes in quality along all three accepted classes of quality measures: structures, processes, and outcomes. However, simply characterizing an element of care as a structure, process or outcome does not make the quantification of that element an indicator of quality. In order for a measure to be properly used to evaluate healthcare quality it must be proven "valid." (FOF ¶ 1188). Dr. Chassin relied only on valid measures of quality.

VII.C.4.

Measures of quality derive their validity from how closely they are tied to essential features of the quality definition noted earlier. For structure and process measures to be valid they must bear a proven relationship to a desired health outcome. (FOF ¶¶ 1191-92). The stronger and more rigorous the evidence that establishes this relationship, the greater the validity of the measure. (FOF ¶¶ 1193-95). Conversely, in order for an outcome to be a valid measure of quality, that outcome must be closely tied to processes of care that we can modify to affect the outcome. (FOF ¶ 1190).

In order to effectively use outcome data, the raw material used to compile the outcomes must be sufficiently detailed and accurate. Dr. Chassin relied heavily on clinical data in forming his opinions. (FOF ¶ 2240). Clinical data are the detailed measures of severity of illness and physiologic functioning, and are collected during the course of providing care to patients. (FOF ¶ 2241). As a result, clinical data are the primary data used by hospitals and third-party organizations to monitor quality assessment and quality assurance. (FOF ¶ 2241).

Further, outcomes must be properly risk-adjusted in order to be utilized in quality analyses. Risk-adjustment is the process by which all other factors that influence patient outcomes that are independent of the treatment are taken into account. (FOF ¶ 1181). Without risk-adjustment, one cannot tell whether a hospital's care has contributed to improving the outcome because it would be impossible to tell if the outcomes were simply driven by the fact that some hospitals' populations are sicker than others. (FOF ¶ 1182).

3. Dr. Romano Relied On Flawed Data Not Suited To Measure Quality

In contrast to Dr. Chassin, Dr. Romano's assessments are based on invalid measures of quality that are not properly risk-adjusted and replete with a number of significant limitations

with respect to quality analyses. (FOF ¶ 2239). A significant portion of Dr. Romano's analysis in this case turns on his use of administrative data. (FOF ¶ 2221).

Administrative data are data collected by hospitals primarily for billing and reimbursement purposes, and not for the purpose of research or measuring quality. (FOF ¶¶ 2222). Even organizations such as the Agency for Healthcare Research and Quality ("AHRQ"), of which Dr. Romano is a contributor, that utilize administrative data, aver that this sort of data "should not be used as a definitive source of information on quality of health care." (FOF ¶ 2231).

(REDACTED) (FOF ¶ 2229). Further, administrative data suffer from variation and inaccuracy in coding, and they fail to account for the difference between co-morbid conditions and complications. (FOF ¶¶ 2236-37). Because of these crucial weaknesses, administrative data should not be used to risk-adjust outcome data for the purpose of judging quality in individual hospitals. (FOF ¶¶ 2232-33). All of these limitations of administrative data are important deficiencies when attempting to conduct proper quality of care analyses. (FOF ¶ 2238).

The failings in Dr. Romano's methodology do not end with his use of administrative data. The significant majority of outcome measures Dr. Romano relied on are themselves invalid irrespective of the data used to calculate them. Specifically, Dr. Romano utilized several different indicators that are promulgated by AHRQ, and are predicated entirely on administrative data. (FOF ¶ 2245). Dr. Romano used these measures to posit that quality of care did not improve at HPH. (FOF ¶ 2245). Of the more than 46 indicators AHRQ publishes, according to

its own published guidelines, only six are defined as valid regardless of the kind of data on which they are based. (FOF ¶ 2245).

While AHRQ's indicators may have limited utility in conducting a preliminary assessment of quality, they were not intended to be authoritative by their developers. (FOF ¶ 2246). In fact, AHRQ cautions that its indicators were designed, in part, to identify hospital areas for further analysis and, "[a]s a result, the [AHRQ] indicators were not intended as definitive measures of quality problems, but rather as screens for use in quality improvement. As screening tools, these indicators would serve as a first-round flag of potential quality problems, which should be investigated further by other methods ...." (FOF ¶ 2246).

Further, Dr. Romano's analysis of almost all of these AHRQ and JCAHO indicators failed to reveal a statistically significant increase or decline in quality at the level that he states is the accepted statistical threshold. (FOF ¶ 2247). A statistically significant finding at the traditionally-accepted threshold of .05 means that the chance of the difference we have observed being due to chance is less than 5%. (FOF ¶ 2247). Dr. Romano admits that 17 of the 18 AHRQ and Joint Commission indicators that he employed in this case are not statistically significant at the standard threshold. (FOF ¶ 2247). Accordingly, although Dr. Romano opined that he found no evidence of improvement, it is more accurate to say Dr. Romano's analyses of the AHRQ and JCAHO indicators were inconclusive.

Dr. Romano's use of data and choice of measures stands in stark contrast to Dr. Chassin's well-accepted approach. Dr. Chassin's comprehensive and methodologically sound approach to the study of changes in healthcare quality in this case offer a clearer and more accurate picture of the changes HPH has brought to its patients and community.

Even with the flaws in Dr. Romano's methodology, he does not dispute the fact that quality has improved at HPH since the Merger.[55]

(REDACTED)

(FOF ¶ 1231).

E. Independent Assessments Affirm Improvements In Quality Of Care At Both ENH And HPH

Several third-party organizations tasked with evaluating quality of care at hospitals around the country have confirmed Dr. Chassin's and Dr. Romano's findings of improved post-Merger quality at HPH. Organizations such as Solucient that utilize administrative data in the same fashion as Dr. Romano have determined that ENH and HPH provide healthcare services of the highest quality. (FOF ¶¶ 2189-2190). Assessments performed by other independent third-party organizations further confirm that quality improved at HPH after the Merger. (FOF ¶¶ 2189-2202).

According to analyses performed by Solucient, ENH is a healthcare provider of the highest caliber. (FOF ¶¶ 2189-2193). Solucient is an organization that provides consulting and healthcare data analysis to hospitals and other healthcare organizations. (FOF ¶ 2189). ENH has been the recipient of Solucient's Top 100 Hospital Award for 10 years in the major teaching hospital category, including in 2004. (FOF ¶ 2190). Out of 147 hospitals in the major teaching hospital category, only 15 are selected for the Top 100 award. (FOF ¶ 2190). Since 1999, ENH

[55] Dr. Chassin found no evidence to support Dr. Romano's hypothesis that quality at Evanston Hospital declined because resources were purportedly diverted from Evanston Hospital to HPH. (FOF ¶¶ 1198, 1506, 2203-04). In addition, Dr. Chassin found no independent evidence of declines in quality of care at Evanston Hospital as a result of the Merger. (FOF ¶ 2203).

has received, on multiple occasions, both the Top 15 Teaching Hospital Award and the Top 100 Hospital Award. (FOF ¶¶ 2192).

Moreover, the progression of Solucient ratings demonstrates improvement in care at HPH. (FOF ¶¶ 2189-2193). Solucient compares ENH's performance against the median performance of benchmarked hospitals for quality-related issues, such as risk-adjusted mortality, complications and patient safety. In addition, Solucient also looks at financial performance. (FOF ¶¶ 2189).[56] Solucient uses administrative data from MedPar, AHRQ, and its own hospital database in comparing hospitals within the Top 100 category. (FOF ¶ 2191).

(REDACTED) (FOF ¶ 2191). With respect to the risk-adjusted patient safety index, ENH has a favorable rating of 11.4%, which means that ENH outperformed the elite Top 100 Hospitals in its peer group hospitals by 11.4% for this category. (FOF ¶ 2191). Additionally, ENH's performance with respect to risk-adjusted mortality improved from -18.0% in the 2001 survey, to -0.38% in the 2004 Solucient Top 100 Hospital survey, a substantial decrease in risk-adjusted mortality during that period. (FOF ¶ 2191). While ENH's profitability score decreased during the same period, its quality-related scores for risk-adjusted mortality and patient safety index either improved or remained favorable. (FOF ¶ 2193). Thus, ENH's receipt of the Top 100 Hospital Award in 2004 reflected a favorable quality evaluation separate and apart from any financial considerations. (FOF ¶ 2193).

ENH has received numerous other independent regional and national accolades for its high-quality care. HealthGrades, a proprietary data analysis firm that sponsors a website that includes information about hospital and physician quality, has identified ENH as a Distinguished

[56] Dr. Romano agreed that ENH was ranked by Solucient in the Top 100 hospitals based, in part, upon a quality assessment. (FOF ¶ 2193).

Hospital for Clinical Excellence for some of the last several years. (FOF ¶ 2194). HealthGrades also identified ENH as a recipient of the Award for Gastrointestinal Care Excellence for 2005. (FOF ¶ 2195). In addition, in 2005, ENH received the Leapfrog Award for being the top hospital system in Illinois. (FOF ¶ 2196).

At a national level, ENH has been recognized for its high quality of care by entities besides Solucient. For example, a recent article in Consumers Digest named 50 exceptional hospitals in the United States. (FOF ¶¶ 2197, 2199). The 50 hospitals were ranked based on the Leapfrog survey, which is completed by hospitals and reflects their compliance with four important areas of care, called leaps. (FOF ¶¶ 2197-2199). These leaps included having an intensivist program, having a computerized physician order entry system, having certain volumes in procedures, and compliance with 27 performance indicators that are aggregated into the last leap. (FOF ¶ 2198). In the most recent Leapfrog Group survey, in 2004, only three hospitals in the state of Illinois were mentioned in the list of 50 exceptional hospitals. (FOF ¶¶ 2196, 2199). Those three hospitals were Evanston Hospital, Glenbrook Hospital and HPH. (FOF ¶ 2199). Finally, in recognition of its unique achievement in the successful implementation of a fully integrated electronic medical record (Epic) across all inpatient and ambulatory care areas, ENH received two prestigious awards in 2004: the KLAS and Davies Award. (FOF ¶¶ 2211-12, 2202, 2208). These external awards and recognition provide further independent and objective evidence of the high quality of care across all ENH hospitals.

F. No Fact Witness Called By Complaint Counsel Countered Any Showing Of Quality Improvement At HPH

To prove that pre-Merger HPH provided exceptional clinical quality to its patients and that the organization was poised to implement new and advanced clinical services, Complaint

Counsel proffered the testimony of only one fact witness: Mark Newton, a former Vice President of Planning and Marketing at HPH. (FOF ¶ 310). Newton, however, had no responsibility for clinical quality at HPH, nor was he responsible for the credentialing or discipline of HPH physicians or information technology. (FOF ¶ 310). As such, his testimony has little probative value with respect to the various quality problems at HPH prior to the Merger and its ability to improve absent the Merger.

Respondents, on the other hand, presented evidence from the actual medical specialists who worked within the clinical departments at HPH on a daily basis both before and after the Merger. Respondents provided testimony from Drs. Victor, Silver, Wagner, Harris, Dragon, Rosengart, and Ankin, as well as key hospital administrators, who described in detail the quality issues at HPH prior to the Merger and the clinical quality improvements that have been made by ENH since the Merger. *See* Section IV.C, *supra* and the findings cited therein. The testimony of medical specialists with firsthand knowledge should be given far greater weight than the claims of a former employee with no role in the area of clinical quality. Their testimony, along with that of Respondent's expert, Dr. Chassin, and evidence from independent third parties who measure healthcare quality, establishes that quality improved dramatically at HPH post-Merger. These life-saving and other patient care improvements far outweigh any anticompetitive effects of the Merger. Accordingly, Counts I and II should be dismissed.

V. COMPLAINT COUNSEL FAILED TO PROVE THAT THE MERGER WILL RESULT IN FUTURE COMPETITIVE HARM

Complaint Counsel alleged only that the Merger reduced competition in the past and its proof of competitive harm at trial focused solely on past, one-time price increases that ENH obtained coincident with the Merger. Compl. ¶¶ 27, 32. Complaint Counsel thus failed to prove

that the Merger will produce anti-competitive effects in the future, as Section 7 requires. In enacting Section 7, Congress was not duplicating the already existing antitrust laws, such as Section 1 and 2 of the Sherman Act, but specifically sought to protect against mergers which would likely have anti-competitive effects in the future, something the antitrust laws at the time did not cover. 15 U.S.C. § 18. Thus, the statute prohibits acquisitions the effect of which "*may be* substantially to lessen competition, or to tend *to create* a monopoly." *Id.* (emphases added). The legislative history of the statute explains that the purpose of the statute is "to arrest the creation of trusts, conspiracies, and monopolies *in their incipiency and before consummation*...." S. Rep. No. 698, 63d Cong., 2d Sess. 1 (emphasis added). During the Conference Consideration of the bill in 1914, Edwin Y. Webb (D., N.C.), who chaired the House Judiciary Committee and had served as floor manager for the bill in the House, explained the incipiency aspect of the law by likening it to arresting the building of a chain at the creation of the first link:

> A person who only builds one link in the chain is denounced here. ... The Sherman law takes care of restraints of trade and monopoly. This bill is intended to prevent those individual acts which, if multiplied and persisted in, may lead to a violation of the Sherman law.

51 Cong. Rec. at 16275. In 1980, the House Committee on the Judiciary reiterated Congress' intent that Section 7 be distinct from Section 2 of the Sherman act "by reaching . . . restraints of trade before they become full fledged monopolies subject to the proscriptions of Section 2 of the Sherman Act." H.R. Rep. No. 96-871, at 4 (1980).

The Supreme Court has further explained that "incipiency," as used in the Senate Report of the bill, means that "an acquisition may be said with reasonable probability to contain a threat that it may lead to a restraint of commerce or tend to create a monopoly of a line of commerce." *United States v. E.I. duPont de Nemours & Co.*, 353 U.S. 586, 597 (1957); *see also Ash Grove Cement Co. v. FTC*, 577 F.2d 1368, 1378 (9th Cir. 1978) ("Section 7 was adopted to arrest anti-

competitive effects of market concentration in their incipiency."). Since then, the Supreme Court has repeatedly demanded evidence of probable anti-competitive effects *in the future* in order to find a violation of Section 7. *See, e.g., United States v. Gen. Dynamics, Corp.*, 415 U.S. 486 (1974); *FTC v. Procter & Gamble Co.*, 386 U.S. 568, 577 (1967) ("The core question is whether a merger may substantially lessen competition, and necessarily requires a prediction of the merger's impact on competition, present *and future.*") (emphasis added); *Brown Shoe Co. v. United States*, 370 U.S. 294, 333 (1962) ("It is the probable effect of the merger *upon the future* as well as the present which the Clayton Act commands the courts and the Commission to examine.") (emphasis added). *See also FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1218 (11th Cir. 1991).

In *General Dynamics*, the Court found no Section 7 violation in part because the future competitive ability of the merged entity was significantly weaker than current market share statistics indicated. *Gen. Dynamics, Corp.*, 415 U.S. at 503. Acknowledging the Government's data regarding market share at the time, the Supreme Court explained that "the essential question remains whether the probability of such *future* impact exists at the time of trial." *Id.* at 505.

The Federal Trade Commission recently confirmed that a future competitive harm is required before imposing Section 7 liability. In its most recent post-consummation case analyzed under Section 7, the Commission's analysis in finding a violation was strictly forward looking, ultimately holding that entry was not sufficient to constrain the merged entity's pricing "in the foreseeable future," notwithstanding evidence that the merger had already caused past competitive harm. *CB&I*, at 9. (Attachment B).

Thus, the entire focus of Section 7 at its birth was to prevent a competitive harm from occurring henceforth; it was never meant to apply to combinations whose effect was solely in the past. Despite this, Complaint Counsel here urges this Court to base a violation on purported anti-competitive price increases in 2000, which provide no insight into the competitive future of the merged entity. Complaint Counsel offered no evidence at all that the one-time relative price increases ENH obtained from a few MCOs forms a link in a chain of probable future anti-competitive effects. *See* 51 Cong. Rec. at 16275; *Brown Shoe Co. v. United States*, 370 U.S. at 333; *United States v. Phil. Natn'l Bank*, 374 U.S. 321, 362 (1963) (Section 7 requires "a prediction of its impact upon competitive conditions in the future; this is what is meant when it is said that the amended § 7 was intended to arrest anti-competitive tendencies in their 'incipiency.'"). This is especially true given the continuing improvements in quality at ENH. As explained above, as quality increases at ENH, its quality-adjusted prices decrease. Accordingly, Counts I and II herein should be dismissed.

VI. AS A MATTER OF LAW, THE MERGER OF EVANSTON HOSPITAL AND HPH COULD NOT VIOLATE SECTION 7

Section 7 of the Clayton Act provides in pertinent part that "[n]o person . . . shall acquire, directly or indirectly, the whole or any part of the stock or other share capital . . . [or] the whole or any part of the assets of another person" when "the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. § 18 (2005). The Merger of Evanston Hospital and HPH did not involve two "persons" because at the time of the Merger they were sister corporations owned by the same parent. Complaint Counsel did not present evidence at trial to dispute this.

As more fully discussed in the Findings of Fact, neither Evanston Hospital nor HPH issues any "stock" or "shared capital," but instead has "membership" interests in accordance with the Illinois General Not-For-Profit Corporation Act of 1986, as amended. 805 Ill. Comp. Stat. Ann. § 105/101.01, *et seq.* (West 2005). (FOF ¶ 207). Since 1989, the Northwestern Healthcare Network ("NHN" or the "Network") had been the *sole* corporate member of both Evanston Hospital and HPH, pursuant to a Network Affiliation Agreement dated October 23, 1989. (FOF ¶¶ 198, 207). Accordingly, an integral element of Section 7 is missing in this case -- namely, the existence of two separate "persons" at the time of the Merger.

Moreover, because Evanston Hospital and HPH were sister corporations under the ownership of one entity, the Merger did not result in any "acquisition" that could subject the transaction to Section 7. This analysis is confirmed by the fact that the parties were not required to file a Report and Notification Form ("HSR Form") pursuant to the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended ("HSR Act"). The HSR Act provides that "no person shall acquire, directly or indirectly, any voting securities or assets of any other person, unless both persons (or in the case of a tender offer, the acquiring person) file notification. . . ." 15 U.S.C. § 18a(a) (2005). Prior to the Merger, the parties asked the staff of the FTC's Premerger Notification Office whether they would be required to file an HSR Form, given the fact that a common parent was the sole corporate member of both merging entities. The parties were advised by staff that "because the parent already holds all of the assets held by the entities it controls," they were not required to file an HSR Form, pursuant to 16 C.F.R. § 801.1(c)(8). *See* FTC Pre-Merger Notification Office Informal Staff Opinion No. 9908002 (August 10, 1999).[57] (FOF ¶¶ 298-300). Given that the transaction was not required to be reported under Section 7A

[57] Available at http://www.ftc.gov/bc/hsr/informal/opinions/9908002.htm.

of the Clayton Act because the assets were already deemed commonly owned, it is difficult to understand how the transaction could violate Section 7.

That the Merger of Evanston Hospital and HPH cannot violate Section 7 of the Clayton Act as a matter of law is a result consistent with -- but not dependent upon -- the Supreme Court's holding in *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984). There, the Supreme Court recognized that a parent and its *wholly-owned* subsidiary are not distinct entities that are capable of conspiring as a matter of law. *Id.* at 777. The Court's rationale in *Copperweld* and subsequent case law confirms that a parent and its wholly-owned subsidiary are deemed to have a unity of interests *as a matter of law*. *See American Chiropractic Ass'n v. Trigon Healthcare*, 367 F.3 212, 223 (4th Cir. 2004); *Siegel Transfer, Inc. v. Carrier Exp., Inc.*, 54 F.3d 1125, 1131-32 (3rd Cir. 1995). While lower court decisions have engaged in a fact-specific analysis to test this premise in the case of less than wholly-owned subsidiaries, the presumption in the case of the wholly-owned subsidiary is unqualified and does not depend on any analysis of the internal machinations of the relationships between the parent and its wholly-owned subsidiaries. Since *Copperweld*, courts have extended this logic to many other types of corporate affiliations, including two wholly owned subsidiaries of a common parent.[58] Courts

[58] *See, e.g., Freeman v. San Diego Ass'n of Realtors*, 322 F.3d 1133, 1147 (9th Cir. 2003) (holding *Copperweld's* "single-entity rule . . . applies to subsidiaries controlled by a common parent") (citations omitted); *Advanced Health-Care Servs., Inc. v. Radford Cmty. Hosp.*, 910 F.2d 139, 146 (4th Cir. 1990) ("Applying the Supreme Court's reasoning [in *Copperweld*], we conclude that two subsidiaries wholly owned by the same parent corporation are legally incapable of conspiring with one another for purposes of § 1 of the Sherman Act."); *Directory Sales Mgmt. Corp. v. Ohio Bell Tel. Co.*, 833 F.2d 606, 611 (6th Cir. 1987) ("*Copperweld* precludes a finding that two wholly-owned sibling corporations can combine for the purposes of section 1") (citations omitted); *Greenwood Utils. Comm'n v. Miss. Power Co.*, 751 F.2d 1484, 1496 n.8 (5th Cir. 1985) ("Given the unity of interest shared by a parent corporation and its wholly owned subsidiary . . . a combination of such entities was not a concentration of separate economic forces. . ."); *see also* Areeda & Hovenkamp, *Antitrust Law* ¶ 1464f at 215 n.31 ("post-*Copperweld* decisions are virtually unanimous" that "the *Copperweld* holding also denies conspiratorial capacity to sister corporations' dealings with each other"); ABA Section of Antitrust Law, *Antitrust Law Developments* 27 (5th ed. 2002) ("Most Courts have held that the *Copperweld* rule extends to conspiracies between sister corporations").

have also extended the logic of *Copperweld* to claims involving Robinson-Patman,[59] Section 3 of the Clayton Act,[60] as well as issues of standing.[61]

During Phase II of the Network's development, which started in 1993 and was the premise for HSR review and approval, NHN had the power to: review and approve member institutions' strategic plans; create a "macro" strategic plan for the entire network; review and approve member institutions' operating and capital budgets; appoint and remove member institutions' Boards of Directors and CEOs; direct asset transfers by member institutions to accomplish Network goals and objectives; and, negotiate with MCOs on behalf of member institutions. (FOF ¶ 208-212, 222-223). Although these powers were exercised with varying degrees of vigor, Gary Mecklenberg, the CEO of the Network for four years, did not recall any the Network member that was "not committed to the exercise of the reserved powers." (FOF ¶ 217). Moreover, even when the Network did not directly exercise its powers, there was significant discussion about individual hospital actions and decisions at the Network level. (FOF ¶ 217). Accordingly, Counts I and II should be dismissed on this ground alone.

VII. THE DIVESTITURE REMEDY SOUGHT BY COMPLAINT COUNSEL WOULD HARM CONSUMERS AND FAIL TO CURE THE ALLEGED ANTI-COMPETITIVE EFFECTS

This Court should never need to reach the issue of remedy because, as discussed above, Complaint Counsel has not met its burden of proving that the Merger violated Section 7. Nevertheless, Respondent has presented evidence that clearly shows that Complaint Counsel's request to undo the Merger -- which was consummated more than five years ago and resulted in

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[59] *See, e.g., Caribe BMW, Inc. v. Bayerisch Motoren Werke Aktiengesellschaft*, 19 F.3d 745, 749-51 (1st Cir. 1994).

[60] *Advanced Health-Care*, 910 F.2d at 152 (extending Supreme Court's analysis to § 3 Clayton Act claims).

[61] *In re Vitamins Antitrust Litig.*, No. 99-197, 2001 U.S. Dist. Lexis 8903, at *73, 325 (D.D.C. 2001).

an investment of more than $120 million to improve HPH's facility and quality of care -- would adversely impact patients, medical personnel, employees and the local community as a whole. As demonstrated below, therefore, the requested divestiture remedy is unwarranted regardless of the Court's holding on liability.

A. The Law Does Not Require That HPH Be Divested From ENH Even Assuming, For The Sake Of Argument, That The Merger Violated Section 7

Any consideration of Complaint Counsel's requested remedy must begin with the basic premise that "[d]ivestiture is itself an equitable remedy designed to protect the public interest." *E.I. du Pont de Nemours & Co.*, 366 U.S. at 326. As an equitable remedy, "[c]ourts are *not* authorized in civil proceedings to punish antitrust violators, and relief must not be punitive." *Id.* (emphasis added). Consequently, "even in a case of a judicial determination that an acquisition was in violation of Section 7, a claim of hardship attendant upon complete divestiture can be considered in determining the appropriate remedy for the redress of antitrust violations where something short of divestiture will effectively redress the violation." *United States v. Int'l Tel. & Tel. Corp.*, 349 F. Supp. 22, 31 (D. Conn. 1972); *see also Hecht Co. v. Bowles*, 321 U.S. 321, 329-330 (1944) (holding that the essence of equity jurisdiction is the tribunal's ability "to mould each decree to the necessities of the particular case").

B. Complaint Counsel Offered No Proof With Respect To Remedy

Divesture is a "drastic" remedy; it "cannot be had on assumptions." *United States v. Crowell, Collier & MacMillan, Inc.*, 361 F. Supp. 983, 991 (S.D.N.Y. 1973). Rather, "[t]here must be factual bases and economic theory as applied to such facts" to support such a remedy. *Id.* To obtain the equitable remedy of divestiture, therefore, Complaint Counsel must have proven, not merely assumed, that such a remedy would most effectively restore whatever competition purportedly was lost through the Merger. *E.I. du Pont de Nemours & Co.*, 366 U.S.

at 326 ("The key to the whole question of an antitrust remedy is of course the discovery of measures effective to restore competition."); *CB&I* at 94-95 ("[T]he relief must be directed to that which is 'necessary and appropriate in the public interest to eliminate the effects of the acquisition offensive to the statute.'").

Complaint Counsel has offered no evidence, including economic expert testimony, which demonstrates that divestiture would be the most effective remedy to restore competition allegedly lost through the Merger. For instance, during its case-in-chief, Complaint Counsel presented testimony of 6 MCO representatives, the alleged consumers in this case.[62] Compl. ¶ 16. Complaint Counsel, however, failed to ask any of these witnesses questions regarding the feasibility, desirability or effectiveness of its proposed remedy, nor did any of these witnesses volunteer a shred of evidence regarding this issue. Remarkably, even Complaint Counsel's chief economic expert witness, Dr. Haas-Wilson, testified plainly that she was offering no opinion on the proper remedy in this case:

> Q. And you're not offering any opinion in this case on what the appropriate remedy should be in the event there was any finding of liability, correct?
>
> A. That's correct.

(FOF ¶ 2542).[63] As Complaint Counsel has not offered any evidence that divestiture would most effectively restore whatever competition purportedly was lost through the Merger, divestiture as a remedy cannot stand.

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[62] Complaint Counsel did not present any testimony of competitors of ENH (other than one ex-employee of HPH who now is the CEO of Swedish Covenant), employers who purchase managed care networks from MCOs, or individual patients.

[63] Complaint Counsel's other economic experts, Dr. Kenneth Elzinga and Dr. John Simpson, also offered no opinion on the proper remedy in this case. In contrast, both of Respondent's economic experts testified that if liability was found, divestiture would not be the proper remedy. (FOF ¶ 2483).

C. Divestiture In This Case Would Not Protect The Public Interest

To the contrary, unwinding the Merger at this late juncture would raise serious community and patient welfare concerns given the substantial quality benefits flowing from the Merger, as discussed above. As Luke Froeb, Director of the Bureau of Economics for the FTC, stated, "[o]nce consummated, mergers are very costly to undo[.]" Luke Froeb, Steven Tschantz, & Philip Crooke, *Mergers Among Asymmetric Bidders: A Logit Second-Price Auction Model*, at 10, (May 11, 1999) available at http://www2.owen.vanderbuilt.edu/luke.froeb/papers/oral.pdf. The evidence here has shown that the Merger was entirely consistent with ENH's mission as a not-for-profit hospital of serving the healthcare needs of its community. During the past five years since the Merger, ENH has invested about $120 million to improve the quality of care offered by HPH, which was a weakening community hospital before the Merger. (FOF ¶ 1518). ENH plans to further invest over $45 million more into HPH. (FOF ¶ 1518). Divestiture would be a great cost to both HPH and the community, and when examining divestiture, "one needs to evaluate the benefits and costs associated with a remedy." (FOF ¶ 2542). There are five reasons why divestiture is not in the public interest.

1. Divestiture Will Harm The Community By Eliminating Improvements Already Achieved And Slowing The Rate Of Improvement In HPH's Quality Of Care In The Future

The divestiture of HPH likely would erode and threaten a number of quality improvements and services achieved as a result of the Merger, adversely affecting patients, physicians, and the community as a whole. (FOF ¶¶ 1232, 2483). The relationship between ENH and HPH is essential to maintaining these quality improvements at HPH. (FOF ¶ 2484).

2. The Benefits Of The Academic Focus ENH Brings To HPH Would Be Lost Upon Divestiture

Maintaining quality is a continuous process. (FOF ¶ 2484). Physicians, for example, must have access to a continuous influx of academic information, or their skills are impaired and begin to stagnate. (FOF ¶ 2147). The clinical integration with ENH, an academic teaching hospital, has led HPH physicians to become more involved in teaching activities at Evanston Hospital, participate in more educational conferences with specialists in multiple disciplines, and keep up with the latest developments in healthcare. (FOF ¶¶ 2146-47, 2154-59). If this integration were severed, not only would HPH physicians lose this vital access to an academic enterprise, but patients would suffer because the multidisciplinary patient-care conferences, that currently discuss specific ENH cases, would be reduced to merely general educational topics. Similarly, conferences involving separate institutions could not look in depth at individual patient cases. (FOF ¶ 2514-2515). Moreover, HPH's loss of its academic affiliation with Northwestern Medical School (through ENH) would impair its ability to recruit the highest quality doctors and administrators. (FOF ¶¶ 2531-2532). HPH would also lose access to clinical research that has become available to its academic affiliation. (FOF ¶¶ 2476-2478).

Clinical protocols also must be constantly updated and modified pursuant to current health knowledge. (FOF ¶ 2485). If they are not, the continued use of the protocols likely will decrease the quality of care that is provided. (FOF ¶ 2485). Through ENH, HPH has access to subspecialists with knowledge of clinical advancements and clinical protocols which are continually monitored and updated. (FOF ¶ 2486). If the Court were to sever HPH's tie with ENH through divestiture, HPH would lose this important access, and the quality of care at HPH would begin to atrophy. (FOF ¶ 2486).

3. The Loss Of ENH's Leadership Structure And Collaborative Culture Would Further Erode The Quality Improvements That Resulted From The Merger

Most of the post-Merger improvements, including significant improvements in quality assurance and nursing, could not have occurred without clinical integration of the medical staffs and ENH's collaborative culture. (FOF ¶¶ 1384, 2455-2457).

(REDACTED)

(FOF ¶ 2458). Reverting HPH's governance back to its pre-Merger structure would re-create a system where the hospital's ability to discipline physicians would again be severely limited, and its ability to maintain a collaborative environment for doctors and nurses to work together would be at risk. *See* (FOF ¶¶ 1384, 1429-1434). It also unlikely that HPH would be able to continue certain new programs, such as the preoperative gynecologic surgical review program, without ENH's leadership. (FOF ¶ 2522).

4. Divestiture Would Result In The Loss Of Several Important Services That Substantially Improve Patient Care And Patient Safety

Divestiture would also represent the end of other vital new services at HPH, including cardiac surgery and interventional cardiology. A high quality cardiac surgery program must meet certain minimum volume requirements. (FOF ¶ 2492). HPH currently meets these requirements only because it is completely integrated with Evanston Hospital's cardiac program. (FOF ¶ 2492). If this integration were severed, the low volume of cardiac surgery at a freestanding HPH would make it nearly impossible for HPH to maintain a stand-alone cardiac surgery program with any reasonable quality, nor would it be substantial enough to support full-time sub-specialists in cardiac surgery at HPH.[64] (FOF ¶¶ 2491-2493). Moreover, the loss of

[64] Even if HPH were somehow to maintain its cardiac surgery program post-divestiture, it would not have the same quality that it offers presently because of the lack of integration with ENH. (FOF ¶ 2519). The continuous interaction between members of the ENH and HPH cardiac surgery teams involves continuous participation in

HPH's cardiac surgery program would also result in the loss of its interventional cardiology program because the State of Illinois and the American College of Cardiology guidelines mandate that elective PCI procedures cannot be done without cardiac surgery backup in the hospital. (FOF ¶¶ 1668-1669, 2498).

The consequences to patients of the loss of these two vital services would be dramatic.

(REDACTED)

(FOF ¶ 1659). Without cardiac surgery and interventional cardiology, acute heart attack patients would no longer be able to receive these immediate life-saving services at HPH. (FOF ¶ 2504). Instead, critical patients would have to be transferred to other area hospitals, which entails substantial medical risk. (FOF ¶¶ 1658, 1707, 2404-2405, 2508-2510).

The loss of these two services also would have an adverse effect on the level of nursing at HPH. To maintain a high quality cardiac program such as that instituted by ENH at HPH, a hospital must employ an intensive nurse training program. (FOF ¶¶ 2218, 2500). All different levels of nurses who provide care to cardiac patients must constantly update their skills. (FOF ¶ 2501). Moreover, the skills gained by nurses who handle very sick and complicated cardiac surgery patients, such as ICU nurses, spill over to the care they provide to other patients. (FOF ¶¶ 1402, 2502-2503). If HPH no longer had a cardiac program, it would not have the same incentive for maintaining its intensive nurse training program.

Divestiture likely would also represent the end of Epic at HPH. ENH owns the license to use Epic, and that license is non-assignable. (FOF ¶ 2526). Accordingly, in the event of

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learning and developing new protocols and evidence-based methods of treating patients. (FOF ¶ 2520). Without this close relationship, the skills of the HPH surgeons would atrophy. (FOF ¶ 2521).

divestiture, HPH would have to purchase a separate license to use Epic. (FOF ¶ 2526). Moreover, HPH would have to rebuild all of the Epic workflows, purchase a data center, hire an information services department to manage and run Epic, and develop its own training division and its own support team. (FOF ¶¶ 2527-2528). Because of the substantial cost and effort involved, no freestanding community hospital has implemented an enterprise grade electronic medical record system such as Epic. (FOF ¶¶ 2118-2119). Furthermore, even if HPH could come up with the substantial resources required to license, build, and maintain Epic, because it lacks the necessary infrastructure to run Epic, it would still take HPH three to five years to get up and running with Epic. (FOF ¶ 2529).

Additionally, even if HPH were to implement Epic, both the ENH and HPH communities still would lose because patient information would no longer be shared by both institutions. Recognizing the important safety benefits of access to shared medical information, the Federal Government has established a national initiative to develop a universally accessible electronic healthcare record for all citizens within 10 years. (FOF ¶¶ 2000, 2015-2016). In the event of divestiture, however, HPH would no longer have access to the ENH Epic database, even if HPH were bought by another hospital that used Epic. (FOF ¶¶ 2526, 2530). Accordingly, the value of Epic to both the ENH and HPH communities would be greatly diminished by divestiture. (FOF ¶¶ 2523-2525).

For all of these reasons quality of care at HPH likely would deteriorate if ENH were required to dissolve the Merger and re-establish HPH as an independent hospital. (FOF ¶ 1232).

5. The Merger's Benefits Outweigh Any Benefits Accruing From A Divestiture

The elimination of the substantial benefits accruing from the Merger would substantially outweigh any increase in competition that would be achieved by a divestiture. First, the

evidence has shown that Evanston Hospital and HPH were not close competitors prior to the Merger and MCOs did not play the hospitals off of each other. (FOF ¶¶ 494, 563-587, 975-983). Given HPH's weak financial position, it also lacked the ability to invest the sums necessary to make improvements that would have been needed to make HPH a significant competitor in the long-run if it remained independent. (FOF ¶¶ 2405-2412). As a result, consumers would not benefit from such a divestiture, particularly if HPH's quality of care levels reverted to pre-Merger levels.

Second, as discussed above, Complaint Counsel did not prove that the Merger will have an anti-competitive effect in the future, as Section 7 requires, or that it is harming competition today. In addition, as quality improvements have been implemented throughout the past five years, ENH's "quality adjusted" prices have declined. (FOF ¶¶ 1157-1159). As Dr. Baker testified -- and no other expert witness disputed -- "quality improvements need to be considered in evaluating competitive effects because if quality gets better, the quality-adjusted price to the buyers declines." (FOF ¶¶ 1157-1159). If the quality-adjusted price declines, the buyers "are better off." (FOF ¶¶ 1157, 1160). As such, for argument sake, even if Complaint Counsel proved the Merger violated Section 7 in the time period immediately following the Merger, the quality improvements since the Merger have eviscerated any alleged anti-competitive effects, and divestiture would be both unnecessary and harmful.

Third, there is also no reason to expect that the requested divestiture would affect ENH's negotiated prices charged to private payors. As discussed above, ENH substantially underestimated the demand for its services before the Merger. (FOF ¶¶ 609, 677, 680-690, 701-703). As a result, it accepted rates from private payors that were considerably below levels of its academic and tertiary hospital competitors. (FOF ¶¶ 701-703). A divestiture would not cause

corporate amnesia -- that is, ENH would not "forget" the competitively neutral information it learned about private payors' willingness to pay for its services.

(REDACTED)

(FOF ¶¶ 2533-2534).

Fourth, because divestiture is an equitable remedy, it is appropriate for the Court to take into account the historical posture of the case in determining whether HPH must be divested. The parties were advised by the Staff of the Federal Trade Commission that they were not required to file an HSR Form, which would have given the government prophylactic notice of the Merger. (FOF ¶¶ 298-301, 2535-2537). Moreover, Complaint Counsel did not file the Complaint until more than four years after the Merger.

Even if Complaint Counsel established a minor reduction in competition due to the Merger -- which it did not -- it would be fundamentally unfair to force ENH to divest HPH, especially given the substantial investments that ENH poured into services and facilities offered at HPH that benefit the community. Many of these investments were planned, budgeted and made before the FTC began its investigation. Indeed, ENH's commitment to establish the open heart surgery program and Kellogg Cancer Center at HPH were written into the Merger agreement itself. (FOF ¶¶ 266, 2487). ENH's good faith commitment to the community was reaffirmed by its continued implementation of these planned improvements after commencement of the investigation and throughout this litigation.

Finally, although Complaint Counsel has requested that if liability is found the remedy should be "[d]ivestiture of Highland Park, and associated assets, in a manner that restores the hospital as a viable, independent competitor in the relevant market, with the ability to offer such

services as Highland Park was offering and planning to offer prior to its acquisition by ENH," it has failed to provide any evidence to establish that divestiture would be the proper remedy if liability were found, or how HPH would survive on its own after divestiture. Compl. at 11. The evidence clearly shows that HPH was struggling financially prior to the Merger, and was greatly improved in terms of quality after the Merger. (FOF ¶¶ 2446-2482). The investments that ENH made into improving HPH could not have been made by HPH on its own. (FOF ¶¶ 2446, 2450-2458). Thus, it would not be possible nor desirable to restore HPH to an independent entity. Moreover, Complaint Counsel provides no insight into the criteria that it would use to select a purchaser of the HPH assets. This omission is critical because HPH had considerable trouble finding a suitable acquirer before the Merger. (FOF ¶¶ 285-287). Further, it is unlikely that there are any purchasers that could maintain the quality levels achieved by ENH. As Dr. Chassin testified, such an entity would have to be in the same general geographic proximity to HPH, with a similar full-time medical management structure, with similarly high-quality programs, with a collaborative culture similar to ENH's, and with the financial capacity to invest in HPH at a level comparable to that demonstrated by ENH. (FOF ¶¶ 1447, 2452, 2456, 2458). None of the area hospitals possesses all of these characteristics.

D. There Are Alternative Remedies To Divestiture That Are More Appropriate Even Assuming, For The Sake Of Argument, That The Merger Violated Section 7

If the Court were to find a violation of Section 7, it has significant discretion in fashioning appropriate relief when other options are available. Indeed, the Commission itself has acknowledged this fact:

> It is. . . well settled that the normal remedy in cases where Section 7 violation is found is the divestiture of what was unlawfully acquired. . . . *This is not to say that divestiture is an automatic sanction, mechanically invoked in merger cases. In cases where several equally effective remedies are available short of a*

> *complete divestiture, a due regard should be given to the preservation of substantial efficiencies or important benefits to the consumer in the choice of an appropriate remedy.*

In the Matter of Retail Credit Comp., 92 FTC 1, 1978 FTC LEXIS 246, at *258-59 (July 7, 1978) (emphasis added). The Commission has held that divestiture, at times can be a "cure ... worse than the disease," and that in such cases, it would not be an appropriate remedy. *See In the Matter of Ekco Prods. Co.*, 65 FTC 1163, 1964 FTC LEXIS 115, at *127 (June 30, 1964) (Divestiture may be "impracticable or inadequate, or impose unjustifiable hardship -- which underscores the importance of the Commission's having a range of alternatives in its arsenal of remedies."). Here, where the Merger has led to substantial, important benefits to consumers, divestiture would destroy, rather than preserve, these benefits. (FOF ¶¶ 2449, 2472-2532). If the Court were to find a violation of Section 7, alternative remedies would be much more appropriate, to maintain the benefits to consumers, than divestiture.[65]

Divestiture is not necessary here since, if there was any violation of Section 7, it occurred immediately after the Merger, and was subsequently cured by the quality improvements made by ENH. Further, the repositioning of other competitor hospitals, and the expected removal of the Illinois CON laws has also made the market even more competitive. (FOF ¶¶ 2280-2282, 2289-2297). However, if the Court were inclined to fence-in ENH for any past violation of Section 7, a prior notification order would be a much more appropriate remedy than divestiture. A prior notification remedy would require ENH to notify the FTC, over the next five years, before any

[65] Complaint Counsel alleged in Count III of the initial complaint that "ENH also followed a strategy of negotiating hospital services and physician services (through ENH Medical Group) as a package deal, requiring private payors to accept the terms offered for both hospital and physician services, or face termination of both." Compl. ¶ 34. This concern arose from the fact that the ENH Medical Group added many HPH based physicians who were not ENH employees in connection with the Merger. The settlement on Count III prohibits ENH from negotiating on behalf of physicians who are not employees. In this respect, the settlement mitigates any competitive concern arising from the allegedly enhanced power that may be derived from negotiating for the larger group of physicians as a package with the hospital.

future acquisitions could be made of providers of general acute care inpatient hospital services in whatever area the Court concludes is the relevant geographic market. *See Proposed Order A* (Attachment D). The Commission has found that a prior notification clause is useful for acquisitions that would otherwise be unreportable. Notice and Request for Comments Regarding Statement of Policy Concerning Prior Approval and Prior Notice Provisions in Merger Cases, 60 Fed. Reg. 39,745-47 (Aug. 3, 1995); 4 Trade Reg. Rep. (CCH) ¶ 13,241. As this Merger was properly not reported under HSR, such a remedy would be reasonably related to the transaction by insuring that any other non-reportable acquisition of inpatient services in the relevant market that ENH may pursue in the future would be reviewed by Commission staff prior to consummation. Such a remedy would acknowledge any past violation of Section 7 but -- given the absence of evidence of any present or future likely anti-competitive effects -- would not interfere with present competitive market conditions nor require any action that would destroy the quality improvements that are benefiting consumers.

Even if the Court were to find an ongoing violation of Section 7 that will continue into the future, a narrowly crafted conduct remedy requiring Evanston Hospital and HPH to negotiate and maintain separate managed care contracts at the request of the MCOs would be more suitable than a divestiture. This remedy would redress any anti-competitive concerns without losing the quality improvements created by the Merger and other harm to consumers that would flow from tearing apart the ENH integrated health care delivery system. Complaint Counsel has argued throughout the trial that the Merger caused ENH to increase its bargaining power because the MCOs needed at least one of the hospitals in their networks to be viable. As discussed above, Respondent has shown clearly that MCOs did not play HPH off of Evanston Hospital, or vice versa, prior to the Merger. (FOF ¶¶ 975-983). However, if the Court were to find

otherwise, this alternative remedy should alleviate the concerns of Complaint Counsel. Such an approach could include some or all of the following features: (1) At the request of an MCO, ENH would agree to bid inpatient services as one group (Evanston Hospital, Glenbrook, and HPH), or as two separate groups, Evanston Hospital and Glenbrook as part of one group, and HPH as the other group; (2) If requested by a MCO, ENH would agree that contracting with one group would not be contingent on contracting with the other group; and/or (3) The MCOs could chose the specific pricing methodology (discount, case rate, per diem etc.) that ENH would bid for inpatient services. *See Proposed Order B* (Attachment E).

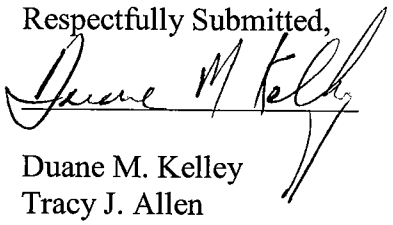
Other healthcare networks in the Chicago area, including Advocate, Resurrection, Provena, and Rush, all with multiple hospitals in their systems, have separate contracts for each hospital, although those hospital systems do not allow the MCOs to chose the specific pricing methodology to apply. (FOF ¶ 189). Thus, the remedy proposed by Respondent would place ENH in a stricter position than other healthcare systems in the Chicago area, while preserving the integrated structure that has led to vast quality improvements at HPH, and has benefited the community at large.

CONCLUSION

For the foregoing reasons, judgment should be entered in favor of Respondents and all counts of the Complaint should be dismissed with prejudice.

May 27, 2005

Respectfully Submitted,



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CERTIFICATE OF SERVICE

I hereby certify that on May 27, 2005, copies of the **Post-Trial Brief Of Respondent Evanston Northwestern Healthcare Corporation (Public Version) and Attachments To Post-Trial Brief Of Respondent Evanston Northwestern Healthcare Corporation (Public Version)** were served (unless otherwise indicated) by messenger on:

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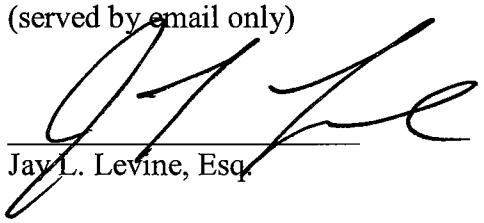

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