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**UNITED STATES OF AMERICA  
FEDERAL TRADE COMMISSION**

**In the Matter of**

***EVANSTON NORTHWESTERN HEALTHCARE CORP.***

**Docket No. 9315**

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**COMPLAINT COUNSEL'S PROPOSED FINDINGS OF FACT IN REPLY**

**(Public Version)**

**Volume I**

**(CCRFF 1-514)**

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Federal Trade Commission  
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COMPLAINT COUNSEL'S PROPOSED FINDINGS OF FACT IN REPLY

Pursuant to the Court's Order on Post Trial Briefs dated April 6, 2005, and its letter dated December 14, 2004, Complaint Counsel respectfully submit the following proposed findings replying to Respondent's May 20, 2005, proposed findings. (As required by Your Honor's April 6, 2005, order, we have included in our response Respondent's outline headings and single-spaced findings and have added a double-spaced reply to each of those findings.) We are filing separately our supporting reply brief.

## I. THE PARTIES

### A. Evanston Northwestern Healthcare

1. ENH is a not-for-profit, integrated health care delivery system that is affiliated with Northwestern University's Feinberg School of Medicine. (Neaman, Tr. 1281-82; RX 1004 at ENH GW 3501; RX 1425 at ENHE F22 1393). The ENH health care delivery system consists of, among other things, three hospitals, a physician multispecialty faculty group practice, a multimillion dollar research enterprise affiliated with Northwestern University and a charitable foundation. (Neaman, Tr. 1281-83).

#### Response to Finding No. 1:

This finding and other findings in Section I are misleading and incomplete because they fail to present an accurate picture of ENH and its role. ENH does not begin its findings of fact with a fair and even-handed description of the corporate entity. Rather, it describes itself as a "not-for-profit" health care delivery system (RFF 1),<sup>1</sup> as having as its "mission . . . 'to preserve and improve human life'" (RFF 2), as "nationally recognized as faithfully serving this mission" (RFF 3), as "a member of numerous hospital teaching organizations" (RFF 5), etc. Although these and later findings try to evoke an image of "St. Evanston," saving Highland Park from ruin, this is not an image shared by health plans. Whether or not Respondent did some good things, Respondent used the merger to exercise market power and increase prices for hospital care. (See, e.g., CCFF 373-745, 822-1337, 1346).

#### Intent

Respondent's findings 1-34 wrongly imply that ENH's non-profit status meant that it was not a profit-maximizing firm. Regardless of any purported "good intentions" that Respondent attempts to advance in its findings, the record shows that "non-profit

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<sup>1</sup> In this document "RFF [number]" refers to the finding of fact bearing that number in Respondent's May 20, 2005, proposed findings of fact, "CCFF [number]" refers to the finding of fact bearing that number in Complaint Counsel's May 20, 2005, proposed findings of fact, and "CCRFF [number]" refers to Complaint Counsel's reply finding of fact (*i.e.*, the Complaint Counsel response to the RFF of the same number) contained herein.

hospitals exercise market power” (Simpson, Tr. 1621), that the merging parties strategized to gain market power through the merger even before the merger took place (CCFF 1346-1362), and that, through various price increase mechanisms, the merged entity proceeded to exercise the market power that it had gained through the merger (CCFF 822-842, 848-880, 813-821, 881-903, 918-927, 942-958).

In any event, there is no requirement of proving an anticompetitive intent in a merger case. Furthermore, Respondent’s findings regarding ENH’s purportedly philanthropic intentions are misleading in implying that the merging parties’ motives with regard to the merger were all philanthropic. Even if, *arguendo*, the merging parties had one or more philanthropic motives, they were by no means the only motives. Highland Park Hospital strategic documents prepared around the time of the merger show the motivation of Highland Park senior management and board members with regard to the merger:

- To reap “the economic benefit” of “not do[ing] battle” with Evanston (CX 4 at 1)
- To “stop competing with each other” (CX 1879 at 3-4)
- To “push back on the managed care phenomenon” (CX 4 at 2)
- To be “a big enough concerted enough entity” (CX 4 at 2)
- To “get geographic leverage” (CX 4 at 9)
- To achieve “critical mass” in the North Shore (CX 4 at 9)
- To “exploit an area of the market in a meaningful way” (CX 3 at 1-2)
- To build “power to deal with managed care” (CX 3 at 2).

In short, Highland Park knew that “*it would be real tough for any of the Fortune 40 companies in this area whose CEOs use either this place or that place to walk from Evanston, Highland Park, Glenbrook, and 1700 of their doctors.*” (CX 4 at 1-2; Spaeth,

Tr. 2210-11 (emphasis added)).

Evanston's pre-merger strategic documents and testimony from ENH senior managers show that Evanston's goals through the merger were the same:

- “[T]o join forces and grow together rather than compete with each other” (CX 2 at 7)
- To “not compete with self” (CX 1 at 3)
- To “strengthen negotiation capability with managed care companies through merged entities” (CX 1 at 3)
- { [REDACTED] } (CX 1566 at 9; Neaman, Tr. 1138, *in camera*; RX 2015 at ENHL MO 003485)
- { [REDACTED] } (CX 1566 at 9; Neaman, Tr. 1138, *in camera*; RX 2015 at ENHL MO 003485)
- To make the merged entity “indispensable to marketplace” (CX 19 at 1)
- To get better prices and better terms on contracts with health plans (Neaman, Tr. 1036)
- To achieve “negotiating strength as a combined system of 3 hospitals.” (RX 704 at ENH HJ 001645).

#### Post-Merger Price Increases

ENH achieved all of these goals post-merger. ENH exercised market power, attained through the merger, to raise prices in various ways. For example, ENH: (1) moved health plans to one contract for all three ENH facilities, *i.e.*, the Evanston or Highland Park pre-merger contract, whichever had the higher rates (*see* CCFF 822-847); (2) added a *premium* to the higher of the Evanston or Highland Park contract rates (*see* CCFF 848-880); (3) moved health plans from a fixed price contract to a discount off charges contract or to a contract that contained more discount off charges provisions than the pre-merger contract (*see* CCFF 813-821); (4) adopted in 2000 the higher of the Evanston or Highland Park chargemaster list prices for the particular product or service



(see CCFF 881-903); and (5) repeatedly increased ENH's chagemaster list prices in the years following the merger (see CCFF 918-927, 942-958).

Significantly, for each mechanism that ENH used to exercise market power and raise prices, ENH extracted yet more price increases from health plans. ENH got:

- At least \$10 million "ongoing" in revenue enhancement just from converting all payer contracts to the most favorable rates (CX 23 at 2)
- At least \$18 million in additional annualized net revenue from the renegotiation with *only six named health plans and some small PPO contracts* (out of approximately 35-40 total contracts) (CX 5 at 5; Hillebrand, Tr. 1820; Sirabian, Tr. 5717. See CX 17 at 5-8)
- A projected \$100 million in increased gross revenue annually from adopting in 2000 the higher of the Evanston or Highland Park chagemaster list prices (CX 2237 at 1; CX 42 at 2; CX 2462 at 1; CX 2238 at 1; CX 2239 at 1; CX 2384 at 2)
- { [REDACTED]  
[REDACTED]  
[REDACTED] } (CX 45 at 8; RX 1687 at ENHL BW 027653, *in camera*).

None of these figures captures the full scope of the past and future harm of ENH's post-merger actions, because most of the mechanisms that ENH used to raise prices worked in conjunction with one another. For example, by shifting health plan contracts to discount off charges arrangements or adding discount off charges provisions to contracts, ENH guaranteed that it would be reimbursed under those contracts or provisions according to its chagemaster (whose prices were under ENH's exclusive control). (Newton, Tr. 366;

CCFF 799-800, 955-957). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Newton, Tr. 365-66; RX 1687 at ENHL BW 027653, *in camera*).

Dr. Haas-Wilson's pricing analysis showed that ENH's price increases were far greater than those of other Chicago hospitals post-merger. { [REDACTED]

[REDACTED]

[REDACTED] } (CX 6279 at

20, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (CX 6279 at 18-19, *in camera*; CX 6282 at 6, *in camera*).

It is the community (particularly workers) that bears the burden of paying the price increases imposed by this supposedly "community-minded" not-for-profit entity.

{ [REDACTED]

[REDACTED]

[REDACTED] } (Ballengee, Tr. 239, *in camera*;

Ballengee, Tr. 196-97; Mendonsa, Tr. 483-84; Mendonsa, Tr. 549, *in camera*; Dorsey, Tr.

1450).

#### Causation

The merger is responsible for price increases, including price increases from ENH's use of the five price increase mechanisms listed above. (*See* CX 17 at 2 ("None

of this could have been achieved by either Evanston or Highland Park alone”);

Hillebrand, Tr. 1704 (The question of whether Evanston should be put on the Highland Park chargemaster for a particular product or service or whether Highland Park should be put on the Evanston chargemaster for that product or service arose because of the merger.

The shift of all three hospitals to one of the two chargemasters for that product or service and the price increases resulting from the shift to the higher of the two chargemaster rates were both due to the merger), 1703-06, 1839-40 (The merger necessitated re-negotiation

of managed care contracts. ENH needed to move to one billing system and the same price at all three hospitals. A single chargemaster was developed.); RFF 309 (“Merger planning documents explained that the merged entity ‘[m]ust have same managed care contracts, pricing, technical/professional fees, etc. . . .’”); CX 30 at 1, 3; Neaman, Tr.

1031 (The question of whether Highland Park should be put on the Evanston pre-merger contract for a particular health plan or whether Evanston should be put on the Highland Park pre-merger contract for that health plan arose because of the merger. The shift of all three hospitals to one of the two pre-merger contracts for each health plan and the price increases resulting from the shift to the more favorable contract were both due to the merger), 1345-46; CCF 817-821, 930, *in camera* ( [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] ); CX 13 at 1 (“Neither Evanston nor Highland Park alone could achieve these results”)).

#### Self-Serving Statements

The self-serving testimony and documents cited by Respondent in support of its

St. Evanston argument should be given little weight. For example, RFF 1's support, all ENH documents and ENH employee testimony, comes from RX 1425, an award application prepared by ENH on behalf of ENH, ENH's "mission statement" as prepared by the board, and the self-serving testimony of Mr. Neaman.

2. ENH's mission "is to preserve and improve human life . . . through the provision of superior clinical care, academic excellence, and innovative research." (RX 1004 at ENH GW 3501).

**Response to Finding No. 2:**

Respondent's finding is part of its St. Evanston argument. The finding is irrelevant to the fact that Respondent used the merger to exercise market power and increase prices for hospital care. (See CCRFF 1).

3. Throughout the years, ENH has been nationally recognized as faithfully serving this mission.

(a) Since the mid 1990s, Evanston Hospital/ENH has been named ten times by Solucient both as a Top 15 Teaching Hospital and a Top 100 Hospital in the country. (Neaman, Tr. 1290-91; O'Brien, Tr. 3544-45; RX 1425 at ENHE F22 1393; RX 787 at ENH GW 4194). ENH was named a Top 15 Teaching Hospital and Top 100 Hospital by Solucient in 2004. (O'Brien, Tr. 3544).

(b) ENH has received the National Quality Award, which is given to a provider with a demonstrated outstanding program to improve the quality of healthcare delivery to its community. (Neaman, Tr. 1291).

(c) ENH has also received recognition from US News & World Report as one of "America's Best Hospitals." ENH specifically was recognized for its neurosciences, orthopedics and hormonal disorders programs. (Neaman, Tr. 1291).

(d) In 2004, ENH received the KLAS and Davies Awards, both given to the hospital with the top-ranked medical information system. (Neaman, Tr. 1291).

(e) In 2005, ENH received the Leapfrog Award for being the top hospital system in Illinois. (Neaman, Tr. 1291). Using the Leapfrog data, Consumers Digest named ENH one of 50 exceptional hospitals in the United States and the only such hospital in Illinois. (O'Brien, Tr. 3549-50).

**Response to Finding No. 3:**

Respondent's finding is part of its St. Evanston argument. The finding is irrelevant to the fact that Respondent used the merger to exercise market power and increase prices for hospital care. (See CCRFF 1). The quality-related distinctions cited in Respondent's finding are irrelevant also because there was no significant quality improvement at Highland Park Hospital due to the merger. (See CCFF 2032-2443).

{ [REDACTED] } (Romano, Tr. 3081-84, 3093, 3211-13, *in camera*. See CCFF 2061-2063, 2066-2067, 2074, 2078, 2080).

Moreover, the testimony cited in RFF 3 (c) supports only part of the claim. Mr. Neaman testified that ENH had received "the recognition by U.S. News & World Report," but did not say that it was named one of "America's Best Hospitals," nor did he state for which programs the hospital was recognized. (Neaman, Tr. 1291). The *U.S. News & World Report* article is not in evidence.

4. ENH is located in the northern suburbs of the Chicago, Illinois metropolitan area referred to as the "North Shore." (Holt-Darcy, Tr. 1425). The North Shore is a geographic area, primarily affluent, starting in northern Cook County and southern Lake County and extending through the towns of Kenilworth, Wilmette, Winnetka, Highland Park and Lake Forest, among others. (Holt-Darcy, Tr. 1425; Ballengee, Tr. 162-63). The communities within the North Shore that stretch from Evanston up to Highland Park are suburban, bedroom communities with single family homes and sizable plots of land, and a limited retail environment. (Hillebrand, Tr. 2030-31).

**Response to Finding No. 4:**

The finding is incomplete in its discussion of the area around the three ENH hospitals. The triangle created by Evanston, Glenbrook and Highland Park Hospitals, encompassing sections of northern Cook County and southern Lake County, "is very heavily populated, and it is very heavily populated by some of the most affluent communities in the Chicago area." (Foucre, Tr. 901-02; Holt-Darcy, Tr. 1426-27). The Combined Core Service Area of Evanston and Highland Park, which roughly corresponds

to the North Shore area, had a population of 363,000 at the time of the merger, with an average household income of \$122,975. (CX 360 at 12).

5. ENH is a member of numerous hospital teaching organizations – including the Northwestern University Medical Center, the Council on Teaching Hospitals and the Association of American Medical Colleges (“AAMC”). (Neaman, Tr. 1282-83).

**Response to Finding No. 5:**

The finding is misleading and mischaracterizes the testimony of Mr. Neaman, the sole source for the finding. When asked by Respondent’s counsel to identify the “teaching hospital associations” to which ENH belongs, Mr. Neaman listed three: the Northwestern University Medical Center, the Council on Teaching Hospitals and the Association of American Medical Colleges (“AAMC”). Nowhere in his testimony does Mr. Neaman imply that ENH belonged to “numerous” teaching hospital organizations. (Neaman, Tr. 1282-83).

6. Mark Neaman, who joined ENH in 1973, has served as its Chief Executive Officer (“CEO”) since 1992. (Neaman, Tr. 1278). Jeffrey Hillebrand, who joined ENH in 1974, has served as its Chief Operating Officer (“COO”) since 1998. (Hillebrand, Tr. 1827, 2009).



**Response to Finding No. 6:**

Complaint Counsel have no specific response.

**1. The Three ENH Hospitals**

7. ENH owns and operates three acute-care hospitals: Evanston Hospital, Glenbrook Hospital and, since the merger at issue on January 1, 2000 (the “Merger”), Highland Park Hospital (“HPH”). (Neaman, Tr. 954). These fully-integrated hospitals provide a broad array of primary, secondary and tertiary acute-care inpatient and outpatient services. (Neaman, Tr. 1291-93).

**Response to Finding No. 7:**

  
 } (Ballengee, Tr. 159; Holt-Darcy, Tr. 1507-08, *in camera*). Also, the cited source did not testify that outpatient

services include secondary and tertiary services and acute-care services. (See Neaman, Tr. 1291-93).

8. Evanston Hospital/ENH has been affiliated with Northwestern Medical School since at least 1930. (Neaman, Tr. 1282). Evanston Hospital strengthened its academic relationship with Northwestern University Medical School between 1992 and 1996. (RX 584 at ENH JH 2951-52; RX 132 at ENH JH 275). As a result, from the mid-1990's to the present day, the Evanston Hospital/ENH hospitals have been classified as teaching or academic hospitals by the Medicare Payment Advisory Commission ("MedPAC"), a federal government agency. (Neaman, Tr. 1283, 1286-87).

**Response to Finding No. 8:**

This finding is misleading and incomplete. Different industry participants have different ways of classifying hospitals. Some of the classifications used by industry participants include community hospital, teaching hospital, tertiary hospital, academic teaching hospital, and academic hospital. (Ballengee, Tr. 158-59 (community, tertiary, advanced teaching); Neary, Tr. 622 (academic teaching hospital); Chan, Tr. 746 (Evanston Hospital was a tertiary hospital)). There is no official designation as to which hospitals fall into which category. (Noether, Tr. 6155. See CCRFF 99 (discussing the various ways hospitals are classified)).

There is evidence, however, that the health plans that contracted with ENH did not believe it was comparable to "advanced" or "academic teaching" hospitals such as Northwestern Memorial Hospital, Rush-Presbyterian-St. Luke's or University of Chicago Hospital. Representatives from Private Health Care Systems ("PHCS"), One Health and United all drew distinctions between the level of services Evanston offers and those offered by these other providers. (See Ballengee, Tr. 189; Neary, Tr. 621-23; Dorsey, Tr. 1443-44; Foucre, Tr. 935-36).

9. { [REDACTED] } (Foucre, Tr. 1114, [REDACTED]; RX 1208 at UHCENH 3380, *in camera*; Ballengee, Tr. 212; Neaman, Tr. 1379).

**Response to Finding No. 9:**

Respondent's finding mischaracterizes the testimony, is incomplete and cites evidence that does not support its claim. First, it mischaracterizes the testimony of Ms.

Foucre. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Foucre, Tr. 1114, *in camera*).

Second, Respondent asserts that Ms. Ballengee acknowledged an affiliation between ENH and Northwestern Medical School, but Counsel neglects to mention that she specifically declined to call ENH an advanced teaching hospital. (Ballengee, Tr. 212, 189). Lastly, Mr. Neaman is not an employee of a managed care organization and thus cannot speak as an MCO in support of the claim Respondent makes in this finding.

10. Having an academic affiliation and being a teaching institution creates an environment which permits the presence of medical residents, and is attractive to young physicians and the very best physicians. (Neaman, Tr. 1289). From a marketing standpoint, consumers believe that academic teaching institutions provide care "a notch above" community hospitals and community-based physicians. (Neaman, Tr. 1289).

**Response to Finding No. 10:**

{ [REDACTED]

[REDACTED] } (Romano, Tr. 3124-25, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3118, *in*

*camera*).

11. All three ENH hospitals operate as if they were a single hospital entity. (Hillebrand, Tr. 1839-42). ENH has one Medicare identification number for all three hospitals. (Hillebrand, Tr. 1840-41). And all three hospitals share one professional staff. (Wagner, Tr. 3953). { [REDACTED]

[REDACTED] } (Hillebrand, Tr. 1839-40; Foucre, Tr. 890; Holt-Darcy, Tr. 1514, *in camera*).



**Response to Finding No. 11:**

The finding is misleading and incomplete. { [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED] } (CX 5902 at 1, 3, *in camera*. See CCRFF 308, *in camera*).

[REDACTED]

[REDACTED] } (Foucre, Tr. 890-92; Ballengee, Tr. 163-65; Dorsey, Tr.

1445-46; RX 1503, *in camera*; Holt-Darcy, Tr. 1528, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Foucre, Tr. 890-92; Ballengee, Tr. 163-65; Dorsey, Tr. 1446-47; RX 1503, *in camera*. See Holt-Darcy, Tr. 1528. See CCFF 908-917, *in camera*).

12. A single unified medical staff is in place for the ENH system, meaning physicians can admit patients to any of the three hospitals. (Hillebrand, Tr. 1840-41). Attending physicians are on faculty at Northwestern University's Feinberg School of Medicine. (Neaman, Tr. 1287).

**Response to Finding No. 12:**

Respondent's finding is misleading in implying that all of ENH's physicians are on faculty. Less than one-third of the physicians affiliated with ENH are on faculty. (Neaman, Tr. 1281-82,1287).

13. Close to half of ENH's hospital services are paid by the federal government. (Neaman, Tr. 1312). The rates and schedules at which hospitals are reimbursed by the government for providing goods and services to individuals covered by Medicare and Medicaid are publicly available and non-negotiable. (Neaman, Tr. 1312, 1317-18; Hillebrand, Tr. 1721).

**Response to Finding No. 13:**

Complaint Counsel have no specific response.

14. Approximately 45% of ENH's hospital services are paid by non-governmental entities providing medical insurance, including MCOs, based on negotiated rates. (Neaman, Tr. 1312).

**Response to Finding No. 14:**

Complaint Counsel have no specific response.

15. ENH's remaining 5% of hospital patients are uninsured and, therefore, pay for services out-of-pocket at prices set by the hospital, or receive free care from the hospital. (Neaman, Tr. 1312).

**Response to Finding No. 15:**

The citation does not support the 5% claim. Mr. Neaman stated that the remaining 10% of hospital patients are uninsured. (Neaman, Tr. 1312).

Furthermore, Respondent mischaracterizes the testimony of Mr. Neaman by sugarcoating his comments about the uninsured. Mr. Neaman characterizes these patients as people "who don't pay their bills," and whom Evanston "writes off as charity care." (Neaman, Tr. 1312).

**a. Evanston Hospital**

16. Evanston Hospital has more than 400 beds and is located in Evanston, Illinois. (Neaman, Tr. 1291). Evanston Hospital provides an extremely wide array of inpatient and outpatient services, from basic hospital services (such as obstetrics) to more intensive services (such as cardio-angiogenesis; Rosengart, Tr. 4496). (Neaman, Tr. 1291). { [REDACTED] } (Mendonsa, Tr. 565-66, in camera).

**Response to Finding No. 16:**

Respondent mischaracterizes the testimony of Mr. Mendonsa. { [REDACTED] }

565-66, *in camera*).

**b. Glenbrook Hospital**

17. Glenbrook Hospital is a medical-surgical hospital with approximately 125-150 beds that is located in Glenview, Illinois. (Neaman, Tr. 1292). Glenbrook Hospital was built by Evanston Hospital and opened in 1977. (Neaman, Tr. 1292; Hillebrand, Tr. 1827).

**Response to Finding No. 17:**

Respondent's finding is incomplete. So that the record is clear, Glenbrook Hospital was a community hospital pre-merger and retains its community hospital status today. (Holt-Darcy, Tr. 1507; Neaman, Tr. 1286; *See* CCFF 289).

18. Glenbrook Hospital provides a broad array of both inpatient and outpatient services, but it does not provide obstetrics services. (Neaman, Tr. 1292).

**Response to Finding No. 18:**

Complaint Counsel have no specific response.

19. Glenbrook Hospital has a Center of Excellence in orthopedics and does a significant amount of work in neurology, particularly movement disorders. (Neaman, Tr. 1292).

**Response to Finding No. 19:**

Complaint Counsel do not disagree.

**c. HPH**

20. HPH has approximately 200 beds and is located in Highland Park, Illinois. (Neaman, Tr. 1292). Since the Merger, HPH provides a significant amount of medical-surgical care. (Neaman, Tr. 1292). HPH's inpatient and outpatient services range from general obstetrics, but not high-risk obstetrics, to cardiac surgery. (Neaman, Tr. 1292-93).

**Response to Finding No. 20:**

The citation supports only part of the claim. Mr. Neaman stated that HPH has approximately 150-200 beds. (Neaman, Tr. 1292). Furthermore, HPH provided a significant amount of medical-surgical care even before the merger, and quality changes claimed by Respondent are exaggerated. (*See* CCFF 2149-2293). HPH was considered a

community hospital before the merger and remains a community hospital today. (See CCFF 289; Ballengee, Tr. 159).

21. As discussed in more depth below in Section VIII, HPH's services have changed dramatically both in breadth and depth since the Merger. (Neaman, Tr. 1293). In particular, ENH has enhanced substantially the quality and complexity of care at HPH as a result of the Merger in the following areas, among others: (1) obstetrical and gynecologic services; (2) nursing services; (3) quality assurance; (4) quality improvement; (5) physical plant renovations; (6) cardiac surgery; (7) interventional cardiology services; (8) intensive care unit services; (9) oncology services; (10) laboratory services; (11) emergency services; (12) pharmacy services; and (13) electronic medical records technology.

**Response to Finding No. 21:**

Various evidence supports the view that quality did not improve significantly at HPH and ENH after the merger. (See CCFF 2033-2293). Various evidence also supports the view that changes made to HPH after the merger were not merger specific. (See CCFF 2294-2443).

**2. ENH Faculty Practice Associates**

22. ENH Faculty Practice Associates is comprised of about 500 employed primary and specialty care physicians. (Neaman, Tr. 1287-88).

**Response to Finding No. 22:**

Complaint Counsel have no specific response.

23. The ENH Faculty Practice Associates does not include the approximately 1200 non-employed, private practice physicians who have admitting privileges at the three ENH hospitals. (Neaman, Tr. 1282).

**Response to Finding No. 23:**

Complaint Counsel have no specific response.

**3. ENH Research Institute**

24. The ENH Research Institute, founded in 1996, performs translational clinical research, meaning research that is taken from the bench to the bedside. (Neaman, Tr. 1289-90). The ENH Research Institute's translational research directly supports ENH's nucleus of clinical activities, such as oncology, cardiology, imaging, and patient outcomes. (Hillebrand, Tr. 2007).

**Response to Finding No. 24:**

Respondent slightly mischaracterizes the testimony of Mr. Hillebrand. He stated that the ENH Research Institute's translational research "is directly related to," not directly supports, ENH's nucleus of clinical activities. (Hillebrand, Tr. 2007).

25. The ENH Research Institute receives funding from the federal government, including the National Institutes for Health ("NIH"), the National Cancer Institute and the Department of Defense. (Hillebrand, Tr. 2007-08; Neaman, Tr. 1290). The Research Institute also receives small sums of money from corporations. (Hillebrand, Tr. 2008). The Research Institute competes for NIH grants with all other major research institutes in the United States. (Neaman, Tr. 1289-90).

**Response to Finding No. 25:**

Respondent mischaracterizes the testimony of Mr. Hillebrand. He did not state that the ENH Research Institute receives small sums from corporations; he merely stated that the "principal [*sic*] moneys" come from the National Institutes of Health. (Hillebrand, Tr. 2008).

26. In 2004, NIH restructured its clinical research initiatives, including the creation of the Patient Reported Outcome Measurement Information System ("PROMIS"), which is a top NIH priority for measuring the quality of healthcare. (Hillebrand, Tr. 2008). In 2004, and as part of the PROMIS initiative, the ENH Research Institute was named the National Coordinating Center for NIH's patient outcome studies. (Hillebrand, Tr. 2009).

**Response to Finding No. 26:**

Complaint Counsel have no specific response.

27. ENH has over \$100 million in NIH grants. (Neaman, Tr. 1290). In terms of NIH funding, ENH ranks twelfth nationally and first in Illinois. (Neaman, Tr. 1290).

**Response to Finding No. 27:**

Complaint Counsel have no specific response.

**4. ENH Foundation**

28. The ENH Foundation is the fund-raising arm of ENH. (Neaman, Tr. 1290). Ronald Spaeth (President of HPH before the Merger) has been the president of the ENH Foundation since February 2005. (Spaeth, Tr. 2236; Neaman, Tr. 1326).

**Response to Finding No. 28:**

Complaint Counsel do not disagree.

29. As the head of the ENH Foundation, Spaeth is responsible for growing “friends and funds” from ENH’s communities and to ensure that ENH has the support from these communities for the various healthcare programs the hospital provides. (Spaeth, Tr. 2237; Neaman, Tr. 1327). Spaeth and the Foundation seek support from ENH’s many grateful patients and others who have a history of supporting the hospital’s various research programs and facility extensions. (Spaeth, Tr. 2237).

**Response to Finding No. 29:**

Respondent’s finding, particularly the ENH employee’s claim that ENH has “many grateful patients,” is part of its, St. Evanston argument. The finding is irrelevant to the fact that Respondent used the merger to exercise market power and increase prices for hospital care. (See CCRFF 1).

**B. Evanston Hospital And HPH Before The Merger**

**1. Pre-Merger Evanston Hospital**

30. { [REDACTED] } (Mendonsa, Tr. 529, *in camera*; Holt-Darcy, Tr. 1505-06, *in camera*; RX 107 at GWL 859).

**Response to Finding No. 30:**

This proposed finding is misleading and incomplete. { [REDACTED] }  
[REDACTED]  
{ [REDACTED] } (Mendonsa, Tr. 529, *in camera*; Holt-Darcy, Tr. 1505-06, *in camera*; RX 107 at GWL 859). Prior to the merger, Evanston Hospital was considered a “community/tertiary” hospital, falling somewhere in between an academic and community healthcare provider. (Ballengee, Tr. 159; RX 2015 at ENHL MO 003489. See also CCRFF 8 (discussing the absence of a single classification system for hospitals and the payer testimony that ENH was not comparable to the “advanced” or “academic teaching” hospitals in the Chicago area)).

31. { [REDACTED] }

[REDACTED] } (Holt-Darcy, Tr. 1509, *in camera*). { [REDACTED]  
[REDACTED] } (Holt-Darcy, Tr. 1509-10, *in camera*). { [REDACTED]  
[REDACTED] } (Mendonsa, Tr. 529, *in camera*).

**Response to Finding No. 31:**

The proposed finding is misleading and mischaracterizes health plan testimony.

{ [REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED] } (Mendonsa, Tr. 518, 520, 530, *in camera*). Ms. Ballengee also testified that prior to the merger, when Evanston and Highland Park were separate entities, PHCS could use one hospital and not the other. “If, in fact, the negotiation and the rates were not going well at one hospital . . . , we had the alternative.” (Ballengee, Tr. 167. *See* Ballengee, Tr. 166-67 (PHCS “could choose between the two [hospitals] and work them against each other” because they were “competitors” prior to the merger.)).

{ [REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED] } (Holt-Darcy, Tr. 1518-19, *in camera*).

While certain hospitals may be important to certain employer groups, competitive pricing is of equal importance to employer groups. In fact, according to RFF 386, employers want to provide a plan that is attractive to their employees, “*subject to the constraints of cost.*” (RFF 386). Health plans testified that, when creating networks, the hospitals must be “price competitive” and give the “discounts” to allow health plans to competitively price their products. (Neary, Tr. 587; Mendonsa, Tr. 485, 491). After the

merger, Kraft representatives, in particular, were “pretty vocal about their . . . concern about the increasing trend” in ENH’s chargemaster rates. (Foucre, Tr. 908). They “question[ed] the current reimbursement structure that was at percentage of charges” and “supported [United’s] desire for more predictability on fixed rates.” (Foucre, Tr. 909).

Respondent’s use of the word “market” is ambiguous in the first sentence.

Respondent does not attempt to address the product market or geographic market in this finding or to make clear otherwise at to what “market” it is referring.

32. In comparison with HPH, { [REDACTED] } (Holt-Darcy, Tr. 1515, *in camera*). Evanston Hospital recruited high-quality physicians and staff with great success before the Merger. (CX 6304 at 11 (Livingston, Dep.)).

**Response to Finding No. 32:**

The proposed finding is misleading and incomplete. The quality of care at Highland Park Hospital up until the year 2000 was “very good, if not excellent.” (Newton, Tr. 376). The hospital was well-respected in the community and considered by many to be one of the “finest community hospitals in the country.” (Newton, Tr. 301. *See also* Spaeth, Tr. 2095). Prior to the merger, Highland Park Hospital sought to recruit the best physicians, to render the most effective experience for a patient, to have the best outcomes for its patients, and to have the highest quality at the hospital. (Spaeth, Tr. 2089). The medical staff at Highland Park Hospital before the merger was an excellent medical staff, consisting of a very good group of primary care physicians and a very excellent group of specialists, including medical oncologists. (Dragon, Tr. 4315).

33. Evanston Hospital once offered sophisticated services, such as solid organ transplants and specialized care for severe burns. For example, Evanston Hospital had a heart transplant program for 6-10 years, but discontinued it because it did not have sufficient volume to allow its physicians to perform a “first-class” job. (Neaman, Tr. 1295). Evanston Hospital also had a burn unit from 1972 until the late 1980s or early 1990s. (Hillebrand, Tr. 2010). But Evanston Hospital closed its burn unit because demand for such services has dropped dramatically due to the widespread adoption of smoke detectors in homes. (Hillebrand, Tr. 2010).



In February 2003, however, Evanston Hospital had burn treatment services as defined by the Illinois Health Facilities Planning Board. (D. Jones, Tr. at 1678-79). As of February 2005, ENH still treats burn patients, but no longer in a designated burn unit. (Hillebrand, Tr. 2010).

**Response to Finding No. 33:**

The finding is irrelevant. What services Evanston Hospital stopped offering years ago and well before the time of the merger is not relevant to any of the issues in this case.

Moreover, the finding is misleading. { [REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2702 (discussing DX 7058 at 1, *in camera*), *in camera*; Neaman, Tr. 1378).

34. In 1997, Evanston Hospital Corporation changed its name to Evanston Northwestern Healthcare because consumer surveys determined that the "Northwestern" and "Evanston" names were associated with high value. (Hillebrand, Tr. 1782). Adding "Northwestern" to Evanston's brand clarified the hospital's relationship with Northwestern Medical School and benefitted both the hospital and the university. (Spaeth, Tr. 2133).

**Response to Finding No. 34:**

Complaint Counsel have no specific response.

35. Pre-Merger HPH was a not-for-profit hospital and a subsidiary of Lakeland Health Services ("Lakeland"). (Newton, Tr. 472; RX 563 at ENH TH 1572). Lakeland contained four operating units: HPH, the HPH Foundation, Lakeland Health Ventures, Inc. and Groveland Health Services, Inc. (RX 563 at ENH TH 1572; RX 218 at ENHL TH 330).

**Response to Finding No. 35:**

Complaint Counsel have no specific response.

36. The HPH Foundation was HPH's fund-raising arm before the Merger. (Styer, Tr. 4954). The HPH Foundation was tasked with soliciting funds to support HPH from individuals and corporations in the general Highland Park community. (Styer, Tr. 4954-55, 5001). The HPH Foundation was dissolved immediately before, and in anticipation of, the Merger. (Styer, Tr. 4953).

**Response to Finding No. 36:**

Complaint Counsel have no specific response.

37. Lakeland Health Ventures, Inc. was a for-profit operating unit of Lakeland. (RX 563 at ENH TH 1572). Lakeland Health Ventures, Inc. operated Lakeland Primary Care Associates, physician practice management services, real estate ventures and numerous joint

ventures such as a fitness center and a mail order pharmacy. (RX 563 at ENH TH 1572).

**Response to Finding No. 37:**

Complaint Counsel have no specific response.

38. Groveland Health Services, Inc. provided healthcare services and products in a non-institutional setting. (RX 218 at ENH TH 330).

**Response to Finding No. 38:**

Complaint Counsel have no specific response.

39. HPH also owned 50% of Highland Park Healthcare, Inc., a physician-hospital organization ("PHO"). (RX 563 at ENH TH 1572). { [REDACTED] } (Chan, Tr. 789, *in camera*).

**Response to Finding No. 39:**

Complaint Counsel have no specific response.

40. Spaeth was HPH's president and CEO from 1983 up until the Merger. (Spaeth, Tr. 2235).

**Response to Finding No. 40:**

Complaint Counsel have no specific response.

**a. HPH Was A Community Hospital With Limited Services Before The Merger**

41. Before the Merger, HPH offered a "normal set" of general primary and secondary inpatient and outpatient services. (Spaeth, Tr. 2239; Neaman, Tr. 1306). Unlike Evanston Hospital, { [REDACTED] } (Holt-Darcy, Tr. 1506, *in camera*).

**Response to Finding No. 41:**

Respondent's finding is incomplete. Highland Park was a good hospital pre-merger and, pre-merger, was adding new clinical services and making improvements. (See CCFF 2295). Mr. Spaeth testified that HPH was recognized by patients before the merger as rendering more sophisticated medical care than the average community hospital. (Spaeth, Tr. 2095).

42. { [REDACTED] } (Spaeth, Tr. 2239; Chan, Tr. 746; Chan, Tr. 838, *in camera*).  
{ [REDACTED] } (Hillebrand, Tr. 1944, *in camera*).

**Response to Finding No. 42:**

Respondent's finding is incomplete and misleading. The categories of "academic" and "community" are ill-defined and ambiguous. (See CCRFF 99). In addition, Highland Park was in the process of developing certain tertiary offerings, including cardiac surgery, prior to the merger. (See CCFF 2353-2356). Indeed, HPH already had entered into a joint venture agreement with Evanston to provide cardiac surgery. (See CCFF 2357). Finally, Respondent's finding relating to obstetrics volume is irrelevant. Pre-merger, HPH also offered strong services in non-obstetrics departments, such as reproductive endocrinology and breast cancer. (See CCFF 2327-30). In any event, HPH did have a "very good" obstetrics program. (See CCFF 2331).

43. Before the Merger, many members of the Highland Park community tended to go to Northwestern Memorial Hospital ("Northwestern Memorial"), the University of Chicago, Loyola University Medical Center, Rush University Medical Center, or the Mayo Clinic because HPH could not fully satisfy their health care needs. (Spaeth, Tr. 2246). Before the Merger, HPH physicians tended to refer their patients away from HPH for a number of different healthcare services. (Spaeth, Tr. 2246). The Highland Park community viewed HPH as a "good community hospital, but if you were really sick, you went somewhere else." (Spaeth, Tr. 2243-44).

**Response to Finding No. 43:**

Respondent's finding is incomplete and misleading to the extent that it implies that HPH was not an excellent hospital that was developing a wider array of clinical services. Mr. Spaeth testified that HPH was recognized by patients before the merger as rendering more sophisticated medical care than the average community hospital. (Spaeth, Tr. 2095). The community of Highland Park and the other communities surrounding Highland Park Hospital respected the hospital and saw value in the facility. (Neaman, Tr.

1228-29; Newton, Tr. 301 (HPH was considered by many to be one of the “finest community hospitals in the country.”). HPH was offering leading edge and innovative programs before the merger (see CCFF 2324-2344), and was continually adding new clinical services and making improvements. (See CCFF 2345-2383).

**b. HPH Had Financial Problems Before The Merger**

44. As discussed in more depth in Section IX.B.4. below, HPH had serious financial problems before the Merger.

**Response to Finding No. 44:**

Respondent cites no support for this finding, contrary to the court’s April 6, 2005, Order on Post Trial Briefs stating that each proposed finding shall have a valid and correct cite to the record. In any event, HPH could have continued as a stand-alone competitor without the merger. (See CCFF 356-367). Finally, Complaint Counsel in their reply findings to Section IX.B.4 set forth reply findings demonstrating that HPH was not in serious financial trouble before the merger and was looking toward strong and sustained financial health.

45. HPH’s operating income steadily declined as the 1990s progressed. (CX 6305 at 2-3, 5 (Stearns, Dep.)). From 1996 to 1999, HPH was not making money from operations on a year-to-year basis. (Kaufman, Tr. 5811). In 1999, HPH had operating losses of over \$3 million, and its audited financials reported an \$11 million loss. (Spaeth, Tr. 2307; CX 1732 at 4; RX 609 at EY 236).

**Response to Finding No. 45:**

Respondent’s finding is incomplete, misleading and contradicted by the record evidence. Among other facts, HPH made money from operations for all years for which data are available in the record except for 1999. (See CCRFF 2319-2321). In 1999, the first year of operating losses, there were a number of non-recurring, one-time costs. In addition, the \$11 million loss included \$8 million in merger-related expenses. (See CCRFF 2320).

46. At the time of the Merger in 2000, HPH attempted to offset its operational losses with investment income, it had \$120 million in debt that exceeded its cash and investments by \$3 million, it required millions in "critical" facility improvements due to years of insufficient capital investments, and it lacked sufficient cash reserves to meet the competitive challenges of the Chicago marketplace. (Kaufman, Tr. 5806-07, 5811, 5814-16; H. Jones, Tr. 4097-99, 4119; RX 465 at FTC-KHA 2179; RX 569 at ENH JH 1215, 1225-26).

**Response to Finding No. 46:**

Respondent's finding is incomplete, misleading, and contradicted by the record evidence. Among other facts, Respondent fails to count \$100 million in assets within the "cash and investments" total referred to in RFF 46 that were spun off to form the post-merger Highland Park community foundation. (See CCRFF 2355). In addition, Highland Park had more than sufficient cash reserves to sustain itself, as well as a strategic plan in place such that the hospital did not need to dip into its cash reserves to make all its required facility improvements. (See CCRFF 2366-2370).

**c. HPH Had Quality Of Care Problems Before The Merger**

47. As discussed in more depth in Section VIII below, before the Merger, HPH had quality of care problems that were exacerbated by the hospital's financial problems.

**Response to Finding No. 47:**

Respondent cites no support for this finding. This is contrary to the judge's April 6, 2005, Order on Post Trial Briefs stating that each proposed finding shall have a valid and correct cite to the record. As discussed in more depth in response to Section VIII below, before the merger the quality of care at Highland Park Hospital HPH was "very good, if not excellent," (Newton, Tr. 376). { [REDACTED]

[REDACTED]}. (RX 412 at ENHL PK 017794, *in camera*. See, e.g., CCF 2294-2352).

Pre-merger, HPH routinely made capital investments to upgrade and improve its facilities. (Newton, Tr. 383-84). In 1999, HPH's long-range capital budget projected \$108 million in investments (Newton, Tr. 431), and HPH possessed the financial assets to

remain viable and make any needed improvements to its quality of care, (*See, e.g.*, CCF 302-355, 2440-2443).

48. The quality problems that existed at HPH before the Merger included, among others: (1) problems in the Obstetrics and Gynecology Department; (2) ineffective quality assurance programs; (3) a dysfunctional nursing culture; (4) weak quality improvement programs; (5) difficulties in getting private practicing physicians to respond to calls about patients; and (6) a series of deficiencies in the physical plant that affected patient safety. (Chassin, Tr. 5191-92).

**Response to Finding No. 48:**

See CCRFF 47 discussing the fact that HPH provided a high quality of care in the above-mentioned services before the merger. (*See also* CCRFF 1227; CCF 2166-2178 (nursing), 2188-2201 (obstetrics and gynecology), 2210-2226 (quality assurance), 2232-2244 (quality improvement), 2430-2432 (physical improvement)).

49. HPH's pre-Merger physical plant deficiencies so adversely affected the reliable operation of the hospital that they put the hospital's Medicare certification in jeopardy. (Chassin, Tr. 5286-87; RX 525 at ENH JH 11548).

**Response to Finding No. 49:**

Various evidence supports the view that the deficiencies were not significant and that HPH immediately began addressing the physical plant concerns while merger negotiations were ongoing and after the merger had been agreed to. (*See* CCRFF 1512).

## **II. DYNAMICS OF MANAGED CARE**

### **A. Overview: Interaction Among Relevant Players (Patients, Employers, Private Payors And Providers)**

50. Hospitals, like most health care providers, compete for their ultimate consumers, the patients, on both quality and price dimensions. (Noether, Tr. 6011).

#### **Response to Finding No. 50:**

Complaint Counsel have no specific response.

51. Included in "quality" are both service and clinical dimensions. (Noether, Tr. 6016). Patients can assess service dimensions directly (for example, convenience, promptness, courtesy of staff, physical aspects of the facility such as the availability of private rooms). (Noether, Tr. 6018-19). But they generally rely on their physicians for assistance to evaluate clinical dimensions. (Noether, Tr. 6018-19).

#### **Response to Finding No. 51:**

Complaint Counsel have no specific response.

52. Direct price competition for patients is often attenuated: patients generally pay only a portion of their bill and thus do not face (or react to) the entire amount of any change in price made by a hospital. (Haas-Wilson, Tr. 2464).

#### **Response to Finding No. 52:**

Complaint Counsel have no specific response.

53. Hospitals compete to be on the "preferred panel" of the health plans offered by MCOs. (Haas-Wilson, Tr. 2456-57). MCOs build provider networks to compete effectively with other MCOs for employer health plan contracts. (Haas-Wilson, Tr. 2456-57).

#### **Response to Finding No. 53:**

Complaint Counsel have no specific response.

54. Employers generally fall into one of two categories – self-insured and fully-insured. Self-insured employers are those that are responsible for the actual medical expenses of their employees but decide to pay MCOs to access and manage the network as well as to process claims. (Mendonsa, Tr. 480). Fully-insured employers are only liable for premiums, but not the actual healthcare dollars utilized by employees. (RX 1743 at 7).

#### **Response to Finding No. 54:**

Complaint Counsel have no specific response.

55. Employers want to limit the amount they spend on employee health benefits, and, as a result, price competition among MCOs is important. (Haas-Wilson, Tr. 2461). Therefore, MCOs are interested in obtaining the lowest rates possible from the providers they include in their networks, and this fosters price competition among hospitals (and other providers). (Haas-Wilson, Tr. 2457-58).

**Response to Finding No. 55:**

Complaint Counsel have no specific response.

56. Since employers must compete for qualified labor, they attempt to assure that their employees are reasonably satisfied with the health plan(s) that they offer. (Noether, Tr. 5936-37). Consequently, employers demand adequate provider networks that span the range of basic and specialty services that their employees may need, have good quality reputations, and are geographically convenient to employees and their families. (Noether, Tr. 5936-37).

**Response to Finding No. 56:**

Complaint Counsel note, for purposes of clarity, that an examination of the contracts listed in CX 5910, which are in evidence, shows that contracts vary as to the range of specialty services covered (i.e., a contract may not cover all the specialty services the employees may need).

57. All of these dimensions can be grouped into a category of attributes labeled “choice.” (RX 987 at FTC-LFH 229; Hillebrand, Tr. 1834; Mendonsa, Tr. 479). Different networks and plans may provide varying degrees of these dimensions for different prices so that employers make the price-choice tradeoffs that best meet their needs. (RX 1346 at BCBSI-ENH 5536).

**Response to Finding No. 57:**

Complaint Counsel have no specific response.

58. In recent years, consumers (i.e., patients/employees) have demanded broad provider networks with few restrictions from their managed care plans. (Hillebrand, Tr. 1761-62; RX 1189 at ENHL JL 14126; RX 1346 at BCBSI-ENH 5539). More tightly controlled, traditional Health Maintenance Organizations (“HMOs”) – which offer limited provider networks, have gatekeeper requirements and impose severe financial penalties for use of other providers or services not authorized by a primary care physician – have given way largely to more loosely structured Preferred Provider Organizations (“PPOs”) with large provider networks and few financial incentives. (RX 987 at FTC-LFH 229; Hillebrand, Tr. 1834; Mendonsa, Tr. 479).

**Response to Finding No. 58:**

Complaint Counsel have no specific response.



59. At the same time, the distinctions between HMOs and PPOs have blurred. (Noether, Tr. 5982). Many HMO plans offer substantial networks, and gatekeeper referrals are no longer always necessary. (Noether, Tr. 5982).

**Response to Finding No. 59:**

Complaint Counsel have no specific response.

60. Consequently, price competition among hospitals is generally attenuated. (Noether, Tr. 5980-81). For example, HMO networks in the Chicago metropolitan area market are broad. (Noether, Tr. 5982 (*explaining DX 7045*)).

**Response to Finding No. 60:**

Respondent's finding on price competition is contradicted by the record evidence. As demonstrated by the health plan representatives' testimony and other evidence, health plans in the Chicago area actively engaged in selective contracting. (*See testimony of PHCS, Aetna, One Health, Unicare, and United as discussed in CCFF 219-244*). For health plans, the price offered by the hospital was an important factor in deciding which hospitals to include in their networks. (*See CCFF 219-44*).

Selective contracting can occur even where there appear to be a large number of hospitals in a particular network. For example, PHCS contracted with about 75 of the 80-90 hospitals in the Chicago area. (Ballengee, Tr. 154). Nevertheless, PHCS excluded hospitals because their rates were too high compared to comparable hospitals. (Ballengee, Tr. 189-90).

61. { [REDACTED] } (RX 1393 at ENHL BW 3684, *in camera*). As a new effort to address this phenomenon, some MCOs have created "tiered" networks, which are broad networks in the aggregate that provide financial incentives for employees to use a limited subset of the network providers that have relatively lower negotiated rates. (RX 1346 at BCBSI-ENH 5536).

**Response to Finding No. 61:**

Complaint Counsel have no specific response.

62. Moreover, self-insured employer groups have vehicles available to them to control

costs. (Dorsey, Tr. 1471-72). A cafeteria plan, for example, could achieve cost savings. (Dorsey, Tr. 1471-72). In a cafeteria plan, employees pay a higher out-of-pocket fee to access a more expensive provider, and a lower out-of-pocket fee to access a less expensive provider. (Dorsey, Tr. 1471).

**Response to Finding No. 62:**

Complaint Counsel note, for purposes of clarity, that there are limits on the ability of self-insured employer groups to control their health care costs. (See CCFF 146).

**B. Types Of Managed Care Plans**

63. The purpose of a network is to provide employers and their employees with access to the facilities they want and a discount for using those hospitals. (Mendonsa, Tr. 485). Access means making sure that employees can get to the facilities to which they prefer to be admitted. (Mendonsa, Tr. 485). Such access generally is provided through one of the following managed care products.

**Response to Finding No. 63:**

Complaint Counsel have no specific response.

**1. HMO**

64. An HMO product provides prepaid health insurance coverage to members through a network of physicians, hospitals and other health care providers that contract with the HMO to furnish such services. (RX 1743 at 6). An HMO is generally an insured product, meaning that the insurance company takes the risk. (Neary, Tr. 585).

**Response to Finding No. 64:**

Complaint Counsel have no specific response, assuming that "between HMOs" in RFF 71 means "between HMOs and PPOs."

65. Traditionally, an HMO requires that a member's primary physician approve access to hospitals, specialty physicians and other health care providers. As a result, the HMO product is the most restricted form of managed care. (RX 1743 at 6). The primary physician is called a gatekeeper, who manages the relationship with the patient and will refer the patient to a selected panel of specialists. (Hillebrand, Tr. 1834). Pediatricians, family-medicine physicians, internists, and occasionally obstetricians act as the "gatekeeper." (Hillebrand, Dep. 1834).

**Response to Finding No. 65:**

Complaint Counsel have no specific response.

66. In an HMO network, there are significant economic incentives for the patient to

only go to in-network providers. (Hillebrand, Tr. 1759-60). HMO networks work on a fixed reimbursement methodology, and only provide benefits to patients if they go to in-network hospitals. (Hillebrand, Tr. 1759-60). HMO members receive no benefits for out-of-network usage. (Mendonsa, Tr. 477).

**Response to Finding No. 66:**

Complaint Counsel have no specific response.

67. { [REDACTED] } (Hillebrand, Tr. 1834; Mendonsa, Tr. 479; Holt-Darcy, Tr. 1543, *in camera*). Consumers have rejected closed-panel HMOs and increasingly have demanded “choice.” (RX 987 at FTC-LFH 229; Hillebrand, Tr. 1834; Mendonsa, Tr. 479). At most, Chicago had 25% HMO penetration, as compared to 50-60% in Los Angeles, New York and the District of Columbia. (Mendonsa, Tr. 479).

**Response to Finding No. 67:**

Complaint Counsel have no specific response.

**2. PPO**

68. A PPO includes some elements of managed health care, but typically includes more cost-sharing with the member, through co-payments and annual deductibles. (RX 1743 at 6). With a self-insured PPO product, the employer that contract with the insurance company is responsible ultimately for the payment of expenses beyond the co-payment and deductible. (Neary, Tr. 586).

**Response to Finding No. 68:**

Complaint Counsel have no specific response.

69. PPOs provide members more freedom to choose a hospital or physician. (RX 1743 at 6). In a PPO, the member is encouraged, through financial incentives, to use participating health care providers that have contracted with the PPO to provide services at more favorable rates. (RX 1743 at 6). If a member chooses not to use a participating health care provider, the member may be required to pay a greater portion of the provider’s fees. (RX 1743 at 6).

**Response to Finding No. 69:**

Complaint Counsel have no specific response.

70. A PPO plan offers employers the ability to have different co-pays, deductibles and other means to make employees partially accountable and responsible for paying for their own care. (Hillebrand, Tr. 1833-34).

**Response to Finding No. 70:**

Complaint Counsel have no specific response.

### 3. POS

71. A point of service product ("POS") tends to have a different configuration and generally involves a network smaller than a PPO network. (Ballengee, Tr. 142). POS plans are traditionally between HMOs in terms of freedom and price. (Ballengee, Tr. 142-3; Mendonsa, 479). For example, with a POS product, a member accesses a higher benefit level by utilizing a primary care physician. (Mendonsa, Tr. 478-79).

#### Response to Finding No. 71:

Complaint Counsel have no specific response, assuming that "between HMOs" in RFF 71 means, "between HMOs and PPOs."

### 4. Indemnity

72. In the 1980s, the predominant form of managed care insurance in Chicago was indemnity insurance. (Hillebrand, Tr. 1832). However, as of February 2005, indemnity insurance was virtually nonexistent in the Chicago market. (Hillebrand, Tr. 1832).

#### Response to Finding No. 72:

Complaint Counsel have no specific response.

### C. Role Of Outpatient Services

73. Inpatient services are those that require an overnight stay at the hospital. (Ballengee, Tr. 144). Over the last couple of decades, the proportion of hospital services that are delivered on an outpatient basis (*i.e.*, services that do not require an overnight stay) has increased substantially. (CX 6321 at 82; RX 267 at EY97 2050; Neaman, Tr. 1153).

#### Response to Finding No. 73:

Respondent's finding is misleading and incomplete because it implies that outpatient services are a substitute for inpatient services such that both are in the same relevant product market. The key inquiry is what products can health plans substitute into when faced with a hospital inpatient price increase. Health plans could not have in their networks outpatient-only providers and exclude higher-priced hospitals and still have a marketable plan. (Haas-Wilson, Tr. 2663). Mr. Hillebrand testified that any shift toward outpatient services from inpatient services is a factor of a change in medicine and other factors, rather than pricing. (Hillebrand, Tr. 1756). Both Mr. Neaman and Mr.

Hillebrand testified that changes in inpatient pricing have no impact on patients switching from inpatient services to outpatient services. (Neaman, Tr. 1210; Hillebrand, Tr. 1755-56. *See also* CCF 1635-44).

74. The shift toward outpatient care is evident at ENH itself. (Neaman, Tr. 1295-96). In the seven years from 1997-2003, ENH's percentage of gross revenue obtained from its outpatient care has increased. (RX 267 at EY97 2050; Neaman, Tr. 1153). ENH's percentage of outpatient services is approximately 45%. (Neaman, Tr. 1295-96).

**Response to Finding No. 74:**

Respondent's finding is misleading and incomplete because it implies that outpatient services are a substitute for inpatient services such that both are in the same relevant product market. Outpatient services are not a substitute for inpatient services.

(*See* CCRFF 73).

**D. Managed Care Contracting**

**1. Selective Contracting**

75. Typically, MCOs are able to obtain discounts from providers' list prices if the MCOs can credibly promise to steer patient volume toward the providers. (Dorsey, Tr. 1474-75). Such steerage can only occur if certain providers are "preferred" members of the plan's network. (Hillebrand, Tr. 1760-61). Patients are given financial incentives, through lower out-of-pocket expenditures, to use the preferred providers. (Hillebrand, Tr. 1759-60). [REDACTED] (RX 1393 at ENHL BW 3691, *in camera*).

**Response to Finding No. 75:**

Complaint Counsel have no specific response.

76. Such "selective contracting" has been one of the fundamental tools of managed care. (Noether, Tr. 5980-81). Selective contracting, however, has not historically played a major role in managed care in the Chicago area. (Noether, Tr. 5981).

**Response to Finding No. 76:**

The finding is incorrect. Respondent's finding on selective contracting is contradicted by the record evidence. As demonstrated by the health plan representatives' testimony and other evidence, health plans in the Chicago area actively engaged in

selective contracting. (See testimony of PHCS, Aetna, One Health, Unicare, and United as discussed in CCFE, 219-44). For health plans, the price offered by a hospital was an important factor in deciding which hospitals to include in their networks. (See CCFE 219-244).

More to the point, health plans' specific experiences related to the Evanston-Highland Park merger demonstrate the importance of competition between hospitals in the cost-effective formation of provider networks. The merger changed the alternatives available to the health plans, thereby affecting the outcome of the bargain between health plans and the merged entity. (Haas-Wilson, Tr. 2472). [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]  
(See, e.g., Ballengee, Tr. 167 (pre-merger pricing more competitive); Mendonsa, Tr. 568-69 ([REDACTED]  
[REDACTED]), *in camera*; Neary, Tr. 618-19 (One Health discovered that it was unable to market its network without ENH hospitals); Holt-Darcy, Tr. 1529 ([REDACTED]  
[REDACTED]), *in camera*; Foucre, Tr. 931-34 (United could not market a network without ENH). See also CCFE 261-83).

## 2. Scope Of MCO Contracts

77. [REDACTED]  
[REDACTED]  
[REDACTED] (Foucre, Tr. 1123, *in camera*; Ballengee, Tr. 200; Holt-Darcy, Tr. 1585, *in camera*). [REDACTED]  
[REDACTED]  
[REDACTED] (Mendonsa, Tr. 557, *in camera*; Ballengee, Tr. 200). [REDACTED]  
[REDACTED] (Foucre, Tr. 1122, *in camera*; Mendonsa, Tr. 556, *in*

camera; Holt-Darcy, Tr. 1585, *in camera*; Noether, Tr. 5906).

**Response to Finding No. 77:**

The finding is misleading to the extent that it suggests that the mere fact that services are purchased together has any significance under the Merger Guidelines in terms of defining a product. As discussed in CCRFF 369, the Merger Guidelines make clear that the definition of the relevant product market is determined by looking at the likely reaction of buyers to a price increase, including (among other things): (1) “evidence that buyers have shifted or have considered shifting purchases between products in response to relative changes in price or other competitive variables,” and (2) “evidence that sellers base business decisions on the prospect of buyer substitution between products in response to relative changes in price or other competitive variables.” (Merger Guidelines, § 1.11). (*See* CCRFF 369).

**3. Reimbursement Methodologies**

78. Hospitals use a variety of MCO contract reimbursement methodologies. (Hillebrand, Tr. 1833). { [REDACTED] } (RX 387 at H 2637, *in camera*; RX 1503 at 3651, 3656-67, 3684, *in camera*).

**Response to Finding No. 78:**

It is irrelevant that other hospitals may use a variety of MCO contract reimbursement methodologies, because ENH was pushing one methodology for post-merger contract renegotiations. Post-merger, ENH senior management strategized to “shif[t], whenever possible, to a discount from charges from a per diem.” (Newton, Tr. 366; Hillebrand, Tr. 1855. *See* Hillebrand, Tr. 1705-06 (Mr. Hillebrand’s “first negotiating step” with health plans in 2000 was to “move to discount off charges.”)).

{ [REDACTED] }

[REDACTED]

[REDACTED] } (CX 1373 at 14, *in camera*).

{ [REDACTED]

[REDACTED] } (Hillebrand, Tr. 1706. *See, e.g.,*

Hillebrand, Tr. 1893; Hillebrand, Tr. 1947, *in camera*; compare CX 5067 at 15, *in camera*, CX 5059 at 17, and CX 5065 at 17; Ballengee, Tr. 252, 255, *in camera*; compare CX 116 at 2, *in camera*, CX 117 at 1, *in camera*, and CX 5072 at 23, *in camera*; Holt-Darcy, Tr. 1536, 1539, 1563, *in camera*; CX 5075 at 17, *in camera*).

79. The rates negotiated by MCOs with hospitals are kept extremely confidential. For example, ENH did (and does) not know the rates a particular MCO has negotiated with ENH's competitor hospitals. (Neaman, Tr. 1344; Ballengee, Tr. 193-94).

**Response to Finding No. 79:**

The finding is incomplete. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Holt-Darcy, Tr. 1602, *in camera*). In any

event, ENH had some information, pre-merger on which hospitals were getting better rates. (Neaman, Tr. 1223).

**a. Discount-Off-Charges Contracts**

80. A discount-off-charges rate is a negotiated discount from a hospital's list price or chargemaster. (Chan, Tr. 667).

**Response to Finding No. 80:**

Complaint Counsel do not disagree.

81. Discount-off-charges rates may be preferred by a hospital because they offer less risk to a hospital. (Chan, Tr. 673). Payments from MCOs are received more timely under this reimbursement method, and fewer resources are spent "chasing underpayments" from MCOs. (RX 1266 at AE 15228).



**Response to Finding No. 81:**

It is irrelevant whether Advocate Health (the source of RX 1266) believes that “payments from health plans are received more timely under a discount off charges reimbursement method,” because ENH’s goal in shifting health plan contracts to discount off charges arrangements post-merger was to obtain better contract rates. (Newton, Tr. 366; Hillebrand, Tr. 1705-06, 1855. See CCRFF 78, CCFF 813-816). Respondent presented no documents or testimony in this matter to support a claim that ENH was trying to achieve more timely payments through discount off charges contracts.

82. { [REDACTED] } (Ballengee, Tr. 227, 270-71, *in camera*; RX 1503, *in camera*; Neary, Tr. 772, *in camera*; RX 257 at GWL 3987; RX 1187 at GWL 26, *in camera*; RX 1047 at 9). In fact, hospitals all over the country have requested, and are requesting, discount-off-charges MCO contracts. (RX 1615 at 4).

**Response to Finding No. 82:**

Complaint Counsel disagree with the implication that there was a trend in the Chicago area towards discount off charges contracts pre- or post-merger. In the years leading up to the merger, there was a movement by health plans towards fixed rate contracts. { [REDACTED] }

{ [REDACTED] } (See CCRFF 85).

83. When managed care contracting first began in the Chicago area, the most common payment methodology for inpatient and outpatient services was the discount-off-charges method. (Sirabian, Tr. 5703-04, 5725). { [REDACTED] } (Neary, Tr. 630; Dorsey, Tr. 1474; Mendonsa, Tr. 558, *in camera*; Holt-Darcy, Tr. 1572-73, *in camera*).

**Response to Finding No. 83:**

Respondent mischaracterizes the testimony of Mr. Neary, Mr. Dorsey, Mr. Mendonsa, and Ms. Holt-Darcy. { [REDACTED] }

[REDACTED] } (Neary, Tr. 630; Dorsey, Tr. 1474; Mendonsa, Tr. 558, *in camera*; Holt-Darcy, Tr. 1572-73, *in camera*). In fact, the record shows that per diem contracts remain the “predominant” method of reimbursement in the Chicago area for hospitals in 2005. (See CCRFF 85).

84. [REDACTED] } (RX 270 at ENH-RNSMC 312, *in camera*; RX 371 at CMC 17637; RX 233 at ALGH 1676, *in camera*; RX 244, *in camera*; RX 407, *in camera*; RX 275, at RHC 7799).

**Response to Finding No. 84:**

Complaint Counsel disagree with the implication that there was a trend towards discount off charges contracts pre- or post-merger. In the years leading up to the merger, there was a movement by health plans towards fixed rate contracts. [REDACTED]

[REDACTED] } (See CCRFF 85).

85. [REDACTED] } (Chan, Tr. 671; Chan, Tr. 852-853, *in camera*). [REDACTED] } (RX 663 at ENHL TC 16939; Chan, Tr. 852-53, *in camera*).

**Response to Finding No. 85:**

[REDACTED] } (CX 1099 at 10-11, 37-39, *in camera*. See also CX 5068 at 27-29 ([REDACTED] }), *in camera*; CX 5148 at 12 (United pre-merger contract with Highland Park)).

[REDACTED]

[REDACTED]

Complaint Counsel also disagree with this finding's implication that there was a trend towards discount off charges contracts pre- or post-merger.

[REDACTED]

[REDACTED]

[REDACTED] (Chan, Tr. 785, 787, *in camera*; CX 1095 at 6; CX 439 at 8). [REDACTED]

[REDACTED]

[REDACTED] (Chan, Tr. 786, 796 *in camera*).

Prior to the merger, Evanston also recognized that "the industry was moving" towards "per diem or even in some cases per case pricing." (Sirabian, Tr. 5725). Evanston "stayed within the standards that were being followed" in response to health plan pressure for fixed rates. (Sirabian, Tr. 5725. *See* Noether, Tr. 6090 ([REDACTED]), *in camera*).

[REDACTED]

(Chan, Tr. 796, *in camera*). [REDACTED]

[REDACTED] (*See, e.g.,* Holt-Darcy, Tr. 1521, 1526, *in camera*; Chan, Tr. 786, *in camera*; CX 5091 at 1, Neary, Tr. 775, *in camera*; CX 5059 at 17; CX 5065 at 17; Ballengee, Tr. 253-54, *in camera*; CX 5068 at 27, *in camera*; CX 5070 at 28. *See* CX 1099).

[REDACTED]

[REDACTED] (Holt-Darcy, Tr. 1526, *in camera*).

86. Since 2000, Chicago area hospitals have negotiated even more aggressively for the discount-off-charges on inpatient services. Even entire healthcare systems, such as Advocate, informed MCOs that it had made great efforts to move additional contracts to the discount-off-charges methodology. (RX 1266 at AE 15228).

**Response to Finding No. 86:**

Respondent's finding is not supported by the record and misleading to the extent that it attempts to generalize beyond the Advocate system. Respondent cites to only one document (RX 1266) regarding one Advocate negotiation with Aetna and uses that document to generalize for "Chicago area hospitals" and "healthcare systems" (plural).

Complaint Counsel disagree with the implication that there was a trend towards discount off charges contracts pre- or post-merger. As discussed above, in the years leading up to the merger, there was a movement by health plans towards fixed rate contracts. [REDACTED]

[REDACTED] (See CCRFF 85, *in camera*).

87. [REDACTED]  
[REDACTED]  
(Dorsey, Tr. 1485; Mendonsa, Tr. 558, 566-67, *in camera*; Holt-Darcy, Tr. 1600, *in camera*).

**Response to Finding No. 87:**

The witnesses cited by Respondent did not testify that asking for a protection does not mean that a health plan will get a protection. [REDACTED]

[REDACTED]

[REDACTED] (Mendonsa, Tr. 558, *in camera* (emphasis added)). [REDACTED]

[REDACTED]

[REDACTED] (Mendonsa, Tr.

566-67, *in camera*). [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Holt-Darcy, Tr. 1600 (emphasis added), *in camera*). Mr. Dorsey testified only that it was One Health's "philosophy" to negotiate for protections from chargemaster increases. He did not testify, however, that One Health (Great West) is successful today or would have been successful in 2000 in negotiating for such protections. One Health's "philosophy wasn't in place at the time of [the post-merger ENH] negotiations." (Dorsey, Tr. 1485-86).

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Holt-Darcy, Tr. 1524-25, *in camera*).

88. In particular, escalator clauses protect a MCO from a hospital's chargemaster increases. (Newton, Tr. 459). [REDACTED] } (Mendonsa, Tr. 566-67, 558, *in camera*). [REDACTED] } (Mendonsa, Tr. 567, *in camera*).

**Response to Finding No. 88:**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (See CCRFF 87, *in camera*).

89. [REDACTED] } (CX 5072 at 18-19, *in camera*; Ballengee, Tr. 260-61, *in camera*.) [REDACTED] } (Ballengee, Tr. 260-61, *in camera*).

**Response to Finding No. 89:**

{ [REDACTED] }  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] }

(Mendonsa, Tr. 567, *in camera*; Holt-Darcy, Tr. 1523, *in camera*).

{ [REDACTED] }  
[REDACTED]  
[REDACTED] } (Mendonsa, Tr. 567, *in camera*). { [REDACTED] }  
[REDACTED] } (Mendonsa, Tr. 567,  
*in camera*. See Holt-Darcy, Tr. 1523 ( { [REDACTED] }  
[REDACTED]  
[REDACTED] } ), *in camera*).

90. { [REDACTED] }  
[REDACTED]  
[REDACTED] } (Mendonsa, Tr. 567, *in camera*).

**Response to Finding No. 90**

The cited source does not say what Respondent's finding claims. { [REDACTED] }  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] } (Mendonsa, Tr. 567, *in camera*).

Respondent's finding also misstates the record. { [REDACTED] }  
[REDACTED]  
[REDACTED] }

(Holt-Darcy, Tr. 1523. *See, e.g.*, CX 44 at 1 (When ENH increased its chargemaster prices in April 2002, Mr. Hodges, ENH's executive vice-president for finance, wrote to ENH managers that "[f]or a number of reasons we want to be as quiet as possible and there are relatively few people who have seen the scope of the changes."); CX 54 at 1 (According to Mr. Hillebrand, "the only notification [of charge increases] we make is to Blue Cross . . . we should not notify anyone beyond those we have a contractual obligation to do so."). *See also* CX 59 at 1; Chan, Tr. 847-48 ({ [REDACTED] [REDACTED] [REDACTED] }), *in camera*).

91. To date, the primary payment methodology for outpatient services is the discount-off-charges method. (Sirabian, Tr. 5704).

**Response to Finding No. 91:**

Complaint Counsel do not disagree.

**b. Per Diem**

92. { [REDACTED] } (Mendonsa, Tr. 524-25, *in camera*). { [REDACTED] }  
{ [REDACTED] } (Ballengee, Tr. 228, *in camera*). { [REDACTED] }  
{ [REDACTED] } (Ballengee, Tr. 228, *in camera*).

**Response to Finding No. 92:**

Complaint Counsel do not disagree.

93. { [REDACTED] }  
{ [REDACTED] }  
{ [REDACTED] }  
{ [REDACTED] }  
{ [REDACTED] } (Chan, Tr. 785-86, *in camera*).

**Response to Finding No. 93:**

{ [REDACTED] }

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] } (Mendoza, Tr. 523-28, *in camera*; Ballengee, Tr. 234-35, 255, *in camera*; Neary, Tr. 609; Newton, Tr. 366; Holt-Darcy, Tr. 1522, *in camera*; Foucre, Tr. 889, *See* CCFF 790-803). { [REDACTED]

[REDACTED] } (Neary, Tr. 766, *in camera*). { [REDACTED]

[REDACTED]  
[REDACTED] }

{ [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED] } (Chan, Tr. 675-76).

94. { [REDACTED]  
[REDACTED] } (CX 5068 at 27, *in camera*; Chan, Tr. 785-786, *in camera*; RX 278 at ENH JL 5335, 5338).

**Response to Finding No. 94:**

{ [REDACTED]  
[REDACTED] } (CX 5068

at 27-28, *in camera*). { [REDACTED]

[REDACTED] } (CX 5068 at 27, *in camera*). Moreover, the cited source does not say what Respondent's finding claims. { [REDACTED]



[REDACTED]

[REDACTED] } (CX 5068 at 27, *in camera*). The discount discussed in RFF 829 was only applicable in situations where it would be more expensive for the health plan to pay the per diem rates. (CX 5070 at 28, 30). However, as Ms. Chan explained, per diem rates in general result in greater discounts “up to 50%” for services than do discount off charges arrangements. According to Ms. Chan, pre-merger, Evanston and Highland Park’s fixed rate contracts gave health plans “much higher” discounts than the contracts that were structured in a discount off charges arrangement. (Chan, Tr. 675-76).

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (See RFF 93, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (See CCRFF 93, *in camera*).

95. { [REDACTED]

[REDACTED] . (Chan, Tr. 786, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED] } (CX 1099 at 12, *in camera*). { [REDACTED]

[REDACTED] } (Chan, Tr. 818, *in camera*).

**Response to Finding No. 95:**

Respondent’s finding is incomplete because it fails to note that Cigna’s pre-merger contract with Highland Park was a *per diem contract* that had a stop-loss provision for scenarios in which charges exceeded \$2,300 per case.

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] } (See CCRFF 93, *in camera*).

[REDACTED]  
[REDACTED]  
[REDACTED] } (See CCRFF 590, *in camera*).

**c. Case Rates**

96. [REDACTED]  
(Ballengee, Tr. 229, *in camera*). [REDACTED]  
[REDACTED] } (Ballengee, Tr. 229, *in camera*).

**Response to Finding No. 96:**

[REDACTED]  
[REDACTED] } (Ballengee, Tr. 229, *in camera*). Respondent's finding is also incomplete.  
[REDACTED]  
[REDACTED] }  
(Sirabian, Tr. 5740).

**d. Capitation**

97. [REDACTED]  
[REDACTED] } (Mendonsa, Tr. 525, *in camera*; Holt-Darcy, Tr.  
1537-38, *in camera*). [REDACTED]  
[REDACTED] } (Mendonsa, Tr. 525, *in camera*; Holt-Darcy, Tr.  
1537-38, *in camera*).

**Response to Finding No. 97:**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

(Ballengee, Tr. 239, *in camera*; Ballengee, Tr. 196-97; Mendonsa, Tr. 483-84; Mendonsa, Tr. 549, *in camera*; Dorsey, Tr. 1450).

98. Despite the expectation that capitated contracts would become a prevalent payment mechanism in Chicago, this expectation never materialized. (RX 584 at ENH JH 2951).

**Response to Finding No. 98:**

Complaint Counsel have no specific response.

**E. Different Type of Hospitals (Academic And Community)**

99. [REDACTED] (Holt-Darcy, Tr. 1589, *in camera*).

**Response to Finding No. 99:**

This proposed finding is misleading, and the citation to this finding illustrates the misleading nature of the finding. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } There are many different ways to classify hospitals. Some of the classifications used by industry participants include community hospital, teaching hospital, tertiary hospital, academic teaching hospital, and academic hospital. (Ballengee, Tr. 158-59 (community, tertiary, advanced teaching); Neary, Tr. 622 (academic teaching hospital); Chan, Tr. 746 (Evanston Hospital

was a tertiary hospital)). There is no official designation as to which hospitals fall into which category.} (Noether, Tr. 6155). Different organizations have different criteria for including a hospital in one category as opposed to another category. For example, MedPac, the Medicare Payment Advisory Commission, an advisory body to Congress on Medicare reimbursement policy, defines a major teaching hospital as one that has at least 0.25 medical residents per bed. (Noether, Tr. 5995). Membership in the Council of Teaching Hospitals ("COTH") is another common measure of what a teaching hospital is. (Noether, Tr. 5995).

Dr. Noether used her own definitions of an academic hospital and a community hospital that are not consistent with the usage of those terms by those in the industry. For example, Dr. Noether required a hospital offering over 370 different DRGs to be classified as an academic hospital, (Noether, Tr. 5994), while neither MedPac nor COTH have any such requirement to be considered a teaching hospital or major teaching hospital. (Noether, Tr. 6155 (MedPac); Noether, Tr. 6165 (COTH)). Dr. Noether also had a bed size requirement in her definition of an academic hospital, requiring over 300 staffed beds. (Dr. Noether, Tr. 5995). MedPac has no bed requirement to be considered a major teaching hospital. (Dr. Noether, Tr. 6155).

These different definitions lead to such inconsistent results as Dr. Noether classifying as community hospitals that MedPac considered major teaching hospitals and that on average treated more complex cases than ENH while Dr. Noether treated ENH as an academic hospital.

One example is Louis A. Weiss Hospital, which had a teaching program with more than .25 residents per bed (Noether, Tr. 6170; RX 1912 at 60), meeting the MedPac criteria for a major teaching hospital. Louis A. Weiss also had a higher case mix index

than ENH for every year from 1997 through 2003, whether or not one included obstetrics cases (Noether, Tr. 6170; RX 1912 at 25 (same document as DX 7130) (including obstetrics cases); RX 1912 at 26 ({ [REDACTED] }), *in camera*), as well as a higher percentage of patients with a DRG weight greater than two than did ENH. (RX 1912 at 27). Yet Dr. Noether classified Louis A. Weiss as a community hospital. (Noether, Tr. 6170; RX 1912 at 60).

Another example is St. Francis Hospital, which also had a teaching program with more than .25 residents per bed (RX 1912 at 60), meeting the MedPAC criteria for a major teaching hospital. St. Francis also had a higher case mix index than ENH for every year from 1997 through 2003, whether or not one included obstetrics cases. (Noether, Tr. 6172; RX 1912 at 25 (the same document as DX 7130) (including obstetrics cases); RX 1912 at 26 ({ [REDACTED] }), *in camera*), and { [REDACTED] } [REDACTED] [REDACTED] } (RX 1912 at 27, *in camera*)). Yet Dr. Noether classified St. Francis as a community hospital. (Noether, Tr. 5999; RX 1912 at 60).

Moreover, the hospital categories may not be mutually exclusive, with some observers putting hospitals simultaneously into more than one category. For example, Jane Ballengee of PHCS classified hospitals into three categories, community hospitals, tertiary hospitals, and advanced teaching hospitals. (Ballengee, Tr. 158-59). Ms. Ballengee considered Evanston both a community and tertiary hospital, since it offered all of the services of a community hospital, the regular medical, surgery, child birth, and those types of things, but it also did have an additional, higher level of services. (Ballengee, Tr. 159). That there would be overlap in the perception of industry

participants is not surprising. All hospitals typically offer a core of basic services that are considered to be primary services. (Noether, Tr. 6159).

100. A community hospital offers services that are relatively simple, such as medical, surgical and maternity. (Ballengee, Tr. 158).

**Response to Finding No. 100:**

Respondent's finding is incomplete. Community hospitals can also offer more complex tertiary services and programs. For example, prior to the merger, Highland Park offered many leading edge and innovative clinical programs. (See, e.g., Newton, Tr. 291-92, 299, 339, 415; Dragon, Tr. 4403, 4399; CX 1863 at 10; CX 2415 at 2-4; CX 1052 at 4-5; CX 98 at 2; CX 413 at 7 (1999 Certificate of Need Application in which Evanston notes that "HPH has over the last several years brought leading edge and innovative clinical services to residents of Lake County."). See also CCF 2325-2352). This finding is also incomplete because, while community hospitals offer those relatively simple services, so do all hospitals. (Noether, Tr. 6159).

101. {

} (Neary, Tr. 622; Foucre, Tr. 935; Foucre, Tr. 1112, *in camera*; Mendonsa, Tr. 565, *in camera*).

**Response to Finding No. 101:**

See CCRFF 99 discussing the fact that there are many different ways to classify hospitals. This finding is inconsistent with the position Dr. Noether took in defining her academic control group. Dr. Noether required her academic control group to have provided a minimum of 370 different DRGs and have had a minimum of 300 staffed beds. (Noether, Tr. 5994-95). None of Respondent's citations in its finding have any requirement that there be a certain number of DRGs or staffed beds to be considered an academic hospital.

102. { [REDACTED] } (Ballengee, Tr. 158; Holt-Darcy, Tr. 1590, *in camera*).

**Response to Finding No. 102:**

Neither source cited by Respondent says what Respondent's finding claims. { [REDACTED]

[REDACTED]

{ [REDACTED] } (Ballengee, Tr. 158). { [REDACTED]

[REDACTED]

{ [REDACTED] } (Holt-Darcy, Tr. 1590-92 (emphasis added), *in camera*).

103. { [REDACTED] } (Mendonsa, Tr. 565, *in camera*). { [REDACTED]

[REDACTED]

{ [REDACTED] } (Mendonsa, Tr. 565, *in camera*; Ballengee, Tr. 158-59, 189; Holt-Darcy, Tr. 1590, 1592-93, *in camera*).

**Response to Finding No. 103:**

This finding is incomplete and misleading. { [REDACTED]

[REDACTED]

[REDACTED]

(See CCRFF 99; Mendonsa, Tr. 565 (academic teaching hospital); Ballengee, Tr. 158-159

(advanced teaching hospital); Holt Darcy, Tr. 1590 ({ [REDACTED]

}), *in camera*). { [REDACTED]

[REDACTED]

{ [REDACTED] } (See CCRFF 99).

{ [REDACTED]

[REDACTED]

{ [REDACTED] } For example, Ms. Ballengee agreed that "advanced teaching

hospitals” are significantly more expensive than community or tertiary hospitals, but included only Northwestern Memorial, Loyola University Medical Center, Rush-Presbyterian-St. Luke’s, University of Chicago, and University of Illinois as advanced teaching hospitals, while specifically excluding ENH from that category. (Ballengee, Tr. 188-89).

104. { [REDACTED] }  
{ [REDACTED] } (Holt-Darcy, Tr. 1590, *in camera*; Foucre, Tr. 1121-22, *in camera*).

**Response to Finding No. 104:**

This finding is misleading. { [REDACTED] }

{ [REDACTED] }

(Holt-Darcy, Tr. 1590, *in camera*). { [REDACTED] }

{ [REDACTED] } (Foucre, Tr. 1121-22, *in camera*). Because of the diverse way that industry

participants classify hospitals, it is impossible to draw conclusions from the finding’s

citations as to which hospitals are being compared to which hospitals. (See CCRFF 99).

**F. The Impact Of The Balanced Budget Act Of 1997 On Managed Care**

105. Congress passed the Balanced Budget Act of 1997 (“Balanced Budget Act”) as part of a larger deficit reduction package. Pub. L. 105-33, 1997 H.R. 2015. Overall, the Balanced Budget Act was intended to reduce the annual rate of Medicare spending growth. (Neaman, Tr. 1314). The Balanced Budget Act did, in fact, reduce expenditures in a number of areas, including: general hospital payments, teaching, research, home care and payments to physicians. (Neaman, Tr. 1314).

**Response to Finding No. 105:**

Respondent’s finding is incomplete because { [REDACTED] }

{ [REDACTED] }

{ [REDACTED] } (Haas-Wilson, Tr. 2483–85, 2495, 2542-

44, *in camera*). Prices at ENH rose relative to the prices at other hospitals. (CCFF 579).

{ [REDACTED] }



[REDACTED] } (Haas-Wilson, Tr. 2562-63, 2565, 2573-74, 2579, 2583, 2586, *in camera*).

The finding is also incomplete and misleading because, subsequent legislation restored, in part, reimbursement for various health care providers affected by Balanced Budget Act cuts. { [REDACTED]

[REDACTED] } (RX 1205 at FTC, RNSM0000345, *in camera*).

The finding also, by implication, ignores the financial status of Evanston and Highland Park. There has never been any question in this case as to the strong financial status of Evanston Hospital. In a November 1999, Evanston board meeting, Mr. Neaman highlighted that “[o]ver the past five years . . . [Evanston] experienced a 70% growth in operating revenue; total operating profits of \$121 million; total operating and investment returns of \$400 million and growth in our Second Century Fund from \$224 to \$613 million.” (CX 657 at 3). Evanston’s finance committee also noted that the audit report for the previous fiscal year showed “no material weakness.” (CX 874 at 3). Further, Mr. Neaman stated to employees that he expected “great results” in 1999 and that Evanston could expect a \$14 million return, which would be well ahead of neighboring hospitals. (CX 1566 at 3).

Highland Park’s president realized that the Balanced Budget Act simply meant that the hospital should continue “growing our business success as well as an enhanced control of our costs” (CX 99 at 1). Furthermore, he noted that even though there were payment reductions from Medicare, “the demand for service from patients and medical staff continues unabated.” (CX 97 at 1). HPH’s president pointed out that, “[i]n spite of the decline in operating margins, our historical cash flow has generated a strong balance

sheet including \$242 million of cash and investments through 6/30/98.” (CX 97 at 1).

He also emphasized that “our ability to absorb short-term declines in operating margins is a recognized asset that the Committee was willing to deploy.” (CX 97 at 1).

106. The reduction in general hospital payments placed significant strain on hospitals’ abilities to cover many of their high fixed (or shared) costs. (Noether, Tr. 5973). Additionally, these reductions limited hospitals’ abilities to care for their uninsured patients. According to federal regulations, hospitals must provide emergency care to all who require it, regardless of their ability to pay. 42 U.S.C. 1395dd; 42 C.F.R. § 489.24.

**Response to Finding No. 106:**

The finding is incomplete for the reasons stated in CCRFF 105. The finding is also misleading because subsequent legislation restored in part reimbursement for various health care providers affected by the Balanced Budget Act cuts. { [REDACTED]

[REDACTED] } RX 1205 at FTC RNSM0000345, *in camera*). The finding is also misleading because ENH’s payer mix includes only 3% Medicaid, indicating that ENH is not in an area where there would likely be many indigent, self-pay patients. (CX 84 at 8).

107. The reduction in Medicare payments for teaching and research also had an adverse impact on hospitals’ bottom lines. (RX 528 at ENH RS 005507). { [REDACTED]  
[REDACTED]  
[REDACTED] } (RX 1205 at FTC-RNSM 361, *in camera*). The overall impact was to reduce academic hospitals’ Medicare revenues. (Neaman, Tr. 962; Hillebrand, Tr. 1837).

**Response to Finding No. 107:**

{ [REDACTED]  
[REDACTED] }  
(CCRFF 105, *in camera*).

108. Finally, because hospitals provide both physician and home care services to their patients, the reduction in payments due to the Balanced Budget Act for these services further reduced hospital revenues. (Neaman, Tr. 1315)

**Response to Finding No. 108:**

The finding is incomplete for the reasons stated in CCRFF 105. The finding is also misleading because payments for physician and home care services are not part of the product market in this case. Dr. Haas-Wilson testified that the relevant product market is general acute care inpatient services (excluding quaternary services). (Haas-Wilson, Tr. 2663, 65-66). Furthermore, Mr. Neaman admitted that the cutbacks affected all hospitals. (Neaman, Tr. 1315).

109. Passage of the Balanced Budget Act coincided with a continuing decline in the growth of payments from MCOs. (RX 1346 at BCBSI-ENH 5540). { [REDACTED] } (RX 1393 at ENHL BW 3681, *in camera*). Meeting costs via cross-subsidization was standard practice among certain hospital administrators. (Haas-Wilson, Tr. 2684-85).

**Response to Finding No. 109:**

The finding is incomplete for the reasons stated in CCRFF 105. Respondent in its finding admits that payments from health plans were decreasing, not increasing, prior to the merger. To the extent that Respondent argues it should have been otherwise, Respondent claims that competition does not work.

Respondent also mischaracterizes the testimony of Dr. Haas-Wilson. She never testified that meeting costs via cross-subsidization was a standard practice. In fact, she testified that while some hospital administrators have taken that view, she has never said that. (Haas-Wilson, Tr. 2685).

110. Both ENH and HPH realized that the Balanced Budget Act would have a significant effect on their finances. (RX 491; RX 551 at ENH DR 3196). One HPH analysis projected that the hospital would lose over \$3 million in revenue in 1999. (RX 491). As an academic hospital, ENH was facing a larger effect, projecting a loss of \$80 million in revenue over 5 years, a prediction that came true. (RX 551 at ENH DR 3196; Hillebrand, Tr. 1844).

**Response to Finding No. 110:**

This finding is misleading as to the projected loss of \$80 million in revenue over

five years. As of April 14, 1999, Evanston projected a Balanced Budget Act impact of just \$47.9 million for Evanston and \$13.3 million for Highland Park between fiscal years 1999 and 2002. (CX 627 at 3). In its fiscal year 2000/2001 budget assumptions, ENH projected a Balanced Budget Act deduction from revenue of just \$2 million, while at the same time expecting at least \$13.5 million in favorable managed care payment increases. (CX 25 at 2)

The finding is also incomplete for the reasons stated in CCRFF 105. As to the finding's second assertion, the projection is based on 1997 and 1998 information. Yet in December 1998, Ronald Spaeth informed his board's chairman that "[i]n 1999, we will continue to generate positive cash flow." The finding is also incomplete and misleading because, subsequent legislation restored, in part, reimbursement for various health care providers affected by Balanced Budget Act cuts. [REDACTED]

[REDACTED] (RX 1205 at FTC RNSM0000345, *in camera*). Given the fact that all hospitals faced changes in regulation, and that Dr. Haas-Wilson's study controlled for changes in regulation (Haas-Wilson, Tr. 2483-85), the Medicare cutbacks have no relevance to the issues in this case.

**G. Hospitals Have Felt Substantial Pressure To Reduce Costs**

111. [REDACTED]  
[REDACTED]  
[REDACTED] (RX 1393 at ENHL BW 3681, *in camera*).

**Response to Finding No. 111:**

[REDACTED]  
[REDACTED]

[REDACTED] (CX 84 at 8). ENH had the second highest net income of the listed hospitals for the period 1996-1999 (first table following the Section XII title) and ranked highest among the listed hospitals in solvency ratio and investment income. (CX 2389).

In any event, Evanston enjoyed a very favorable financial position before the merger. In a November 1999, Evanston board meeting, Mr. Neaman highlighted that “[o]ver the past five years . . . [Evanston] experienced a 70% growth in operating revenue; total operating profits of \$121 million; total operating and investment returns of \$400 million and growth in our Second Century Fund from \$224 to \$613 million.” (CX 657 at 3). As to Evanston’s future expectations, Evanston’s December 7, 1999, Presentation to Standard and Poor’s, Strategic and Capital Structure Review, dated December 7, 1999, states as a goal “*maintain very strong capital structure* (over \$1 billion in cash and investments”). (RX 704 at ENHE JH 001616 (emphasis added)). In addition since the merger, the fund has reached nearly a billion dollars. (Hillebrand, Tr. 1843).

Before the merger, Evanston’s finance committee also noted that the audit report for the previous fiscal year showed “no material weakness.” (CX 874 at 3). Furthermore, Mr. Neaman stated to employees that he expected “great results” in 1999 and that Evanston could expect a \$14 million return, which would be well ahead of neighboring hospitals. (CX 1566 at 3). Similarly, Highland Park’s president pointed out that “[i]n spite of the decline in operating margins, our historical cash flow has generated a strong balance sheet including \$242 million of cash and investments through 6/30/98.” (CX 97 at 1). HPH also budgeted more than one million dollars a year in charitable gift income. (Spaeth, Tr. 2104).

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2483-85, 2495, 2542-44, *in camera*). Prices at ENH rose relative to the prices at other hospitals.

(CCFF 579). [REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2562-63, 2565, 2573-74, 2579, 2583, 2586, *in camera*).

112. In addition, costs have risen due to personnel shortages, Health Insurance Portability and Accountability Act of 1996 ("HIPAA") compliance, infrastructure changes in anticipation of Y-2K, increased consumer demand for new technologies, homeland security measures, malpractice costs and a rising number of uninsured Americans. (H. Jones, Tr. 4108; Hillebrand, Tr. 1779).

**Response to Finding No. 112:**

The finding is misleading and incomplete for the reasons stated in CCRFF 111.

The finding is also misleading because Mr. Hillebrand testified that many of the types of costs cited were non-recurring costs. (Hillebrand, Tr. 1779).

113. These cost constraints, combined with reduced payment rates, adversely impacted the operating margins of hospitals. (Spaeth, Tr. 2260, 2262-63; Neaman, Tr. 963, 1314-15; H. Jones, Tr. 4108).

**Response to Finding No. 113:**

The finding is misleading and incomplete for the reasons stated in CCRFF 111.

Complaint Counsel also point to the testimony of Mr. Neaman, regarding managed care contract discussions with Bain, cited in the finding. Mr. Neaman stated, "We had always had those discussions, that would include 1998 as well as other time [sic]." (Neaman, Tr. 963). There is no reason to believe that Evanston increased prices post-merger because it "learned about demand" or faced adverse economic conditions peculiar to ENH alone.

114. Personnel shortages have been among the cost drivers at hospitals in recent years. (H. Jones, Tr. 4108). Shortages among personnel affect not only the bottom line of hospitals, but also the quality of care they aim to provide. (RX 1109 at FTC-IFHA 598).

**Response to Finding No. 114:**

Respondent cites RX 1109, which is not in evidence. This is contrary to the Judge's April 6, 2005, Order on Post-Trial Briefs, stating that each proposed finding shall have a valid and correct cite to the record.

115. HIPAA also created standards for electronic health information transactions, such as claims, payment and coordination of benefits. (RX 1109 at FTC-IFHA 598). Such electronic exchanges were intended to protect the privacy of files that were individually identifiable and to set security provisions to maintain medical records privacy. (RX 1109 at FTC-IFHA 598). These requirements imposed additional costs on hospitals. (RX 1109 at FTC-IFHA 598; RX 1189 at ENHL JL 14125).

**Response to Finding No. 115:**

Respondent cites RX 1109, which is not in evidence. This is contrary to the Judge's April 6, 2005, Order on Post-Trial Briefs, stating that each proposed finding shall have a valid and correct cite to the record.

**H. Chicago Healthcare Market**

**a. Relevant Hospitals**

116. There are about 100 hospitals in the Chicago area market. (Noether, Tr. 5982). These hospitals are differentiated along a number of attributes, including geography and complexity of service offerings. (Noether, Tr. 5911).

**Response to Finding No. 116**

The finding is misleading because it assumes a "Chicago area market."

Respondent cites no support for this "market." Respondent refers here to a much broader product and geographic market than Evanston and Highland Park hospitals relied on at the time of the merger. The reports presented to and relied on by the boards of the two hospitals when they undertook the merger refer to a 20 zip code area termed the "Combined Core Service Area" ("CCSA"). (CX 84 at 21; CX 1876 at 18; CX 359 at 16; Hillebrand 1792-94; Spaeth 2158-61). In the CCSA, ENH (44%) and Highland Park (11%) together accounted for a 55% share in the CCSA of the two hospitals according to

reports produced for the Evanston and Highland Park boards in 1996 as part of the merger process. (CX 84 at 21; CX 1876 at 18; CX 359 at 16). In December 1999, Evanston presented this 55% share estimate to Standard and Poor's, in a Strategic and Capital Structure review, referring to its "negotiating strength as a combined system of 3 hospitals and 1,000 doctors." (RX 704 at ENH HJ 001631).

Respondent's reference to a Chicago "market" also ignores the Merger Guidelines analysis. (See Merger Guidelines, § 2.1). ( [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] } (Haas-Wilson, Tr. 2635-36, *in camera*; Baker, Tr. 4645, *in camera*). ENH did not see a decrease in the number of managed care admissions as a result of ENH's price increases in 2000. (Neaman, Tr. 1211-12). ENH management did not consider the risk of health plans switching to other hospitals. (Neaman, Tr. 1212; Hillebrand, Tr. 1764-65; Newton, Tr. 1757-58). Respondent presented no evidence of any demand side substitution that would make the price increase unprofitable as required by the Merger Guidelines. (Merger Guidelines, § 1.21).

The finding is also incomplete and misleading because it focuses on the institutional relationship between employees and hospitals, which is often referred to as "second-stage" competition in the economics literature. { [REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2463-65, *in camera*).

117. Before 2000, five health care systems in the Chicago area were responsible for over 43% of total inpatient admissions. (RX 531 at 13819). { [REDACTED]

[REDACTED] } (RX 1053 at



**Response to Finding No. 117:**

The finding is misleading for the reasons stated in CCRFF 116 because it assumes that the entire Chicago area is a “market.” Respondent cites no support for there being a Chicago “market” based on this patient flow data.

118. Local industry observers doubt that the healthcare market in the Chicago area will ever be reduced to a few large integrated delivery systems. (RX 1420 at CIG/ENH 1142).

**Response to Finding No. 118:**

The finding is misleading for the reasons stated in CCRFF 116 because it assumes a “healthcare” market and a “Chicago area” market. Respondent cites no support for either “market.” In any event, in the triangle area, the Evanston and HPH merger has reduced the number of players to one.

119. Certain hospitals that compete with ENH are discussed in more depth in Section VI.B. 2.

**Response to Finding No. 119:**

Respondent cites no support for any finding that “[c]ertain hospitals . . . compete with ENH.” This is contrary to the Judge's April 6, 2005, Order on Post Trial Briefs, stating that each proposed finding shall have a valid and correct cite to the record.

Furthermore, RFF 119 is not a finding of fact.

**b. Relevant MCOs**

120. A large number of MCOs operate in the Chicago area. The largest of these MCOs are discussed below.

**Response to Finding No. 120:**

Respondent cites no support for this finding. This is contrary to the Judge's April 6, 2005, Order on Post-Trial Briefs, stating that each proposed finding shall have a valid and correct cite to the record. Furthermore, the second sentence is not a finding of fact.

i. Aetna

121. Aetna Inc. ("Aetna") and its wholly owned subsidiaries constitute the nation's largest health benefits company based on membership as of December 31, 2000. (RX 1047 at 5). Aetna offers full-risk, where Aetna assumes the financial risk of health care costs, and employer-funded products, where employers assume the financial risk of health care costs. (RX 1650 at 6). Approximately 60% to two-thirds of Aetna's business in 2000 was self-insured. (Mendonsa, Tr. 480).

**Response to Finding No. 121:**

The size and relative wealth of a health plan paying the price increase in the first instance (ultimately the price paid by employer groups and employees) is irrelevant, because the law on anticompetitive price increases does not differentiate based on the wealth or poverty of the firm paying the price increase.

Complaint Counsel disagree with the implication that Aetna's size enabled it to fend off ENH's post-merger price increases. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] }

(Mendonsa, Tr. 540, *in camera*; Neaman, Tr. 960-1, 1269-71; Hillebrand, Tr. 1725-6).

{ [REDACTED]

[REDACTED] } (Mendonsa, Tr. 539-40, *in camera*;

Mendonsa, Tr. 478). { [REDACTED]

[REDACTED] } (CX

6279 at 18, *in camera*; Haas-Wilson, Tr. 2625, *in camera*. See CCFF 661-664, *in camera*).

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED] } (Ballengee, Tr. 239, *in camera*; Ballengee, Tr. 196-97; Mendonsa, Tr. 483-84; Mendonsa, Tr. 549, *in camera*; Dorsey, Tr. 1450).

122. Aetna's health care benefit products include HMO, POS, PPO, and indemnity plans. (RX 1650 at 6).

**Response to Finding No. 122:**

Complaint Counsel do not disagree.

123. Aetna reported net income of \$127.1 million in 2000. (RX 1047 at 35). By 2003, Aetna's net income increased seven-fold to \$933.8 million. (RX 1650 at 28). Aetna held \$13.776 billion in total assets in 2000. (RX 1047 at 36). Aetna held \$11.24 billion in total assets in 2003. (RX 1650 at 29).

**Response to Finding No. 123:**

The law on anticompetitive price increases does not differentiate based on the size, wealth, or poverty of the firm paying the price increase. (*See CCRFF 121*).

Complaint Counsel disagree with the implication that Aetna's size protected it from ENH's price increases post-merger. { [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED] } (*See CCRFF 121, in camera*).

124. Aetna is large and very successful nationally, but has been relatively unsuccessful in the Chicago area. (Hillebrand, Tr. 1895). For example, Aetna is the fourth or fifth largest insurer in the Chicago area behind Blue Cross and Blue Shield of Illinois ("Blue Cross"), United, Humana, Inc. ("Humana") and Unicare Life and Health Insurance Company ("Unicare"). (Mendonsa, Tr. 481).

**Response to Finding No. 124:**

The law on anticompetitive price increases does not differentiate based on the size, wealth or poverty of the firm paying the price increase. (See CCRFF 121). Further, Aetna's relative success in the Chicago area is irrelevant to the question of whether ENH's new-found market power after the merger enabled it to impose anticompetitive price increases on Aetna. { [REDACTED]

[REDACTED]

[REDACTED] } (See CCRFF 121, *in camera*). Moreover,

Respondent presents no documents or testimony to corroborate Mr. Hillebrand's self-serving claim that Aetna "has been relatively unsuccessful in the Chicago area." As of 2002, Aetna represented one of ENH's "top five hospital contracts." (CX 135 at 1-2).

125. During the late 1990s, Aetna's business was declining in the Chicago area market. (Hillebrand, Tr. 1725). In 2000, Aetna had approximately 500,000 covered lives in the Chicago area. (Mendonsa, Tr. 480). In 2000, Aetna had a network of 88 out of about 100 hospitals in the Chicago area. (Mendonsa, Tr. 484).

**Response to Finding No. 125:**

The law on anticompetitive price increases does not differentiate based on the size, wealth or poverty of the firm paying the price increase. (See CCRFF 121). Aetna's business in the Chicago area is irrelevant to the question of whether ENH's new-found market power after the merger enabled it to impose anticompetitive price increases on Aetna. { [REDACTED]

[REDACTED]

[REDACTED] } (See CCRFF 121, *in camera*).

Respondent presents no documents or testimony to corroborate Mr. Hillebrand's self-serving claim that Aetna's "business was declining in the Chicago area market"

during the late 1990s. Complaint Counsel further disagrees with this finding's implication that there is a "Chicago area market." The relevant geographic market in this case is a triangle formed by Evanston, Glenbrook, and Highland Park, including their campuses, the area in-between, and some additional area around them. This area is established through a range of evidence including post-merger pricing studies, testimony of payers and others, and documents of the parties. (Haas-Wilson, Tr. 2452, 2667; Newton, Tr. 351-52; Foucre, Tr. 901-903; Ballengee, Tr. 167-68; Holt-Darcy, Tr. 1425-1427).

**ii. Blue Cross**

126. Blue Cross is the largest insurer in Chicago. (Foucre, Tr. 939; Hillebrand, Tr. 1806). Blue Cross Blue Shield has a share of approximately 52-53%, and has about 2 million members in Illinois (Foucre, Tr. 949; Mendonsa, Tr. 481).

**Response to Finding No. 126:**

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2626, 2728, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2728, *in camera*; RX 1912 at 61-63, *in camera*; Noether, Tr. 6070-74, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2728, *in camera*; RX 1912 at 61-63, *in camera*; Noether, Tr. 6070-74, *in camera*).

ENH representatives, including Mr. Sirabian, Mr. Hillebrand, Mr. Neaman, and Mr. Livingston, admitted that it was Blue Cross's market power, not "learning about demand," that made it impossible to raise prices to Blue Cross post-merger. (*See, e.g.,* Sirabian, Tr. 5731-33 (Blue Cross presented a pricing and contract term proposal that "we either accepted or didn't."); Neaman, Tr. 1182-83 (ENH had less opportunity to negotiate successfully with Blue Cross/Blue Shield than with other health plans because of Blue Cross's size . . . There is little opportunity for ENH to improve its position in negotiations with Blue Cross/Blue Shield); Hillebrand, Tr. 1807 (Blue Cross/Blue Shield is the "dominant player" in Chicago); CX 6304 at 16 (Livingston, Dep.) (Blue Cross/Blue Shield is "such a big player, there is no way [ENH] can have any ability to negotiate with them significantly."); CX 1998 at 49 (According to Bain, the early 2000 negotiations with Blue Cross's HMO (HMO Illinois), would "be challenging given their strong strategic positions in [Illinois]."))).

127. Patients insured by Blue Cross represent approximately 20% of ENH's business. (Hillebrand, Tr. 1806).

**Response to Finding No. 127:**

[REDACTED]

[REDACTED]

[REDACTED]

(*See* CCRFF 126, *in camera*).

128. In 2000, Blue Cross contracted with hospitals for its HMO product, HMO Illinois; its PPO product, Blue Cross PPO; and its Blue Choice product. (RX 844 at ENH JL 2023).

**Response to Finding No. 128:**

Complaint Counsel do not disagree.

129. Health Care Service Corporation, the parent of Blue Cross Blue Shield of Illinois ("Blue Cross"), had total assets totaling about \$3.6 billion in 2001 and about \$3.3 billion in 2000. (RX 1198 at 4). Health Care Service Corporation's total assets equaled about \$4.2 billion in 2002, and grew to about \$5 billion in 2003. (RX 1587 at 5). Health Care Service Corporation posted net gains of over \$347 million in 2001 and \$173 million in 2000. (RX 1198 at 7). By 2003, Health Care Service Corporation posted net gains of over \$624 million. (RX 1587 at 7).

**Response to Finding No. 129:**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (See CCRFF 126, *in camera*). Moreover,

Respondent's finding is irrelevant because the law on anticompetitive price increases does not differentiate based on the size, wealth or poverty of the firm paying the price increase.

(See CCRFF 121).

130. Health Care Service Corporation is comprised of Blue Cross Blue Shield of Illinois, Blue Cross Blue Shield of Texas and Blue Cross Blue Shield of New Mexico. (RX 1198 at 8).

**Response to Finding No. 130:**

Complaint Counsel do not disagree.

**iii. CCN**

131. CCN was a provider of "network services," not a health insurer. (RX 832 at ENHL BW 12757). In 2000, CCN contracted with hospitals for its group health, automobile medical liability, and worker's compensation products. (RX 827 at ENH JL 12622).

**Response to Finding No. 131:**

Complaint Counsel do not disagree.

132. In 2000, the magazine *Business Insurance* ranked CCN as the largest PPO in the nation. (RX 832 at ENHL BW 12757). In 2000, CCN managed more than \$6 billion nationally in healthcare costs annually for over 9,500 employers, labor unions trust funds, national and self-insured employers and insurance carriers. (RX 801 at ENHL TC 2556). CCN had over 290,000 physicians and 2,700 hospitals in its networks. (RX 832 at ENHL BW 12757).

**Response to Finding No. 132:**

Respondent's finding is irrelevant. The law on anticompetitive price increases does not differentiate based on the size, wealth, or poverty of the firm paying the price increase. (See CCRFF 121). { [REDACTED]

[REDACTED] } (CX 121 at 1). In February 2000 CCN proposed new hospital rates that would "recogniz[e] ENH's market position." (CX 122 at 1 (emphasis added)). On February 29, 2000, Mr. Hillebrand sent Mr. Jans of CCN a letter including ENH's "best and final offer" on contract rates along with an "aggressive termination letter." (CX 120 at 1; CX 122 at 1). In a March 15, 2000 letter, CCN attempted to accept ENH's termination, but only one week later accepted ENH's "large increase." (CX 122 at 1; 121 at 1).

{ [REDACTED]

[REDACTED]

[REDACTED] } (CX 6279 at 4-5, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED] } (CX 24 at 2, 8, *in camera*).

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Ballengee, Tr. 239, *in camera*; Ballengee, Tr. 196-97; Mendonsa, Tr. 483-84; Mendonsa, Tr. 549, *in camera*; Dorsey, Tr. 1450).

133. First Health acquired CCN in August 2001 for approximately \$198 million. (RX



1661 at 58; RX 1469 at 8). First Health's net income was \$152,734,000 in 2003, up from \$132,938,000 in 2002, \$102,920,000 in 2001, and \$82,619,000 in 2000. (RX 1661 at 50; RX 1469 at 104).

**Response to Finding No. 133:**

Respondent's finding is irrelevant. The law on anticompetitive price increases does not differentiate based on the size, wealth, or poverty of the firm paying the price increase. (See CCRFF 121). { [REDACTED] } (See CCRFF 132, in camera).

**iv. Cigna**

134. Cigna is one of the largest investor-owned employee benefits organizations in the United States. (RX 1743 at 3). Cigna's subsidiaries are major providers of health care employee benefits through the workplace. (RX 1743 at 3).

**Response to Finding No. 134:**

Respondent's finding is irrelevant. The law on anticompetitive price increases does not differentiate based on the size, wealth, or poverty of the firm paying the price increase. (See CCRFF 121). { [REDACTED] } (CX 6279 at 5, in camera). { [REDACTED] } (CX 6279 at 20, in camera).

{ [REDACTED] }  
[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED] } (Ballengee, Tr. 239, *in camera*; Ballengee, Tr. 196-97; Mendonsa, Tr. 483-84; Mendonsa, Tr. 549, *in camera*; Dorsey, Tr. 1450).

135. Cigna, itself, is a holding company for several subsidiaries engaged in health care, group life, accident and disability insurance. (RX 1743 at 3).

**Response to Finding No. 135:**

The cited source does not say what Respondent claims. Respondent cites to a Humana document (an SEC form 10-K) that says nothing about Cigna.

136. Cigna offers HMO, POS, PPO and traditional indemnity medical insurance products. (RX 1742 at 6-7).

**Response to Finding No. 136:**

Complaint Counsel do not disagree

137. Cigna offers two varieties of HMO products. (RX 1742 at 7). In one type, the member selects a primary care physician who is responsible for primary care and preventive care and who must refer the member to a participating specialist for care. (RX 1742 at 7). Cigna's "open access" HMO removes the requirement of a referral from the member's primary care physician for specialist services. (RX 1742 at 7).

**Response to Finding No. 137:**

Complaint Counsel do not disagree, provided "who must refer the member to a participating specialist for care" means that, to obtain the care of a specialist requires a referral from the primary care physician (rather than meaning that the primary care physician is obliged to refer the member to a specialist even if the member does not need specialized care).

138. Cigna's POS product allows members to choose out-of-network providers for a higher cost in the form of a deductible or cost-sharing. (RX 1742 at 8).

**Response to Finding No. 138:**

Complaint Counsel do not disagree.

139. Under Cigna's PPO product, participants are free to use any health care provider.

(RX 1742 at 10).

**Response to Finding No. 139:**

Complaint Counsel do not disagree.

140. Cigna considered initiating a variable co-pay product that would differentiate hospitals by co-pay amounts based on the rate agreements negotiated. (RX 910).

**Response to Finding No. 140:**

The fact that Cigna may have “considered” initiating a variable co-pay product is irrelevant to the question of whether or not ENH used its market power to impose anticompetitive price increases on health plans post-merger. (See CCRFF 134).

141. Cigna posted net income of \$668 million in its 2003 financial statements. (RX 1742 at 54). Cigna reported net income of \$515 million for the second quarter of 2004. (RX 1715 at 1). Cigna holds over \$11.6 billion in assets. (RX 1742 at 55).

**Response to Finding No. 141:**

Respondent’s finding is irrelevant. The law on anticompetitive price increases does not differentiate based on the size, wealth, or poverty of the firm paying the price increase. (See CCRFF 121). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (See

CCRFF 134, *in camera*).

**v. Great West**

142. Great West Healthcare (“Great West”) was formerly known as One Health. (Neary, Tr. 581).

**Response to Finding No. 142**

The finding is incomplete. As late as 2001, Great West was still referred to as One Health. (See, e.g., CX 5067).

143. Great West is “the smallest payor at issue” in this case. (Neary, Tr. 614). During the 1997-2004 time period, Great West covered approximately 100,000 lives. (Neary, Tr. 585). Great West sells HMO, PPO, and POS insurance products. (Neary, Tr. 585; Dorsey, Tr. 1428).

**Response to Finding No. 143:**

The finding is inaccurate. Respondent completely misconstrues the record in its cite. Mr. Neary never testified that Great West/One Health is “the smallest payor at issue” in this case. Respondent cites to Mr. Martin’s discussion of statements made by counsel for ENH during the opening statements in this matter. (Martin, Tr. 614).

Respondent’s finding is also irrelevant because the law on anticompetitive price increases does not differentiate based on the size, wealth, or poverty of the firm paying the price increase. (See CCRFF 121). Respondent’s finding is also incorrect. There are various payers at issue in this case, such as Aetna, Beech Street, Blue Cross, Cigna, First Health/Affordable/CCN, Health Marketing, HFN, Humana, Ppo Next, Preferred Plan, PHCS, State of Illinois, United, and Wellpoint (Unicare). (CX 5910). A comparison of the pre- and post-merger contracts (identified in CX 5910 and in evidence) shows price increases and substantially discount off charges provisions following the merger. Nobody claimed that One Health/Great West was the smallest payer in this case. As far as ENH itself was concerned, One Health accounted for more business for ENH than some other health plans. (See CX 5905).

One Health’s size is irrelevant to the question of whether ENH used its new-found market power to impose price increases on health plans post-merger. {

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (CX 6282 at 6, *in camera*).

[REDACTED] } (CX 6279 at 20, in camera).

[REDACTED] } (Ballengee, Tr. 239, in camera; Ballengee, Tr. 196-97; Mendonsa, Tr. 483-84; Mendonsa, Tr. 549, in camera; Dorsey, Tr. 1450).

144. During the 1997-2004 time period, approximately 90% of Great West's business was self-insured. (Neary, Tr. 586). Rate increases on self-insured products are paid for by the client. (Neary, Tr. 586-87).

**Response to Finding No. 144:**

The cited source does not specify the 1997-2004 time period. (See Neary, Tr. 586-87).

[REDACTED] } (Ballengee, Tr. 239, in camera; Ballengee, Tr. 196-97; Mendonsa, Tr. 483-84; Mendonsa, Tr. 549, in camera; Dorsey, Tr. 1450). Price increases like those imposed by ENH post-merger can have a "direct impact" on the business's "bottom line." (Mendonsa, Tr. 483). For example, in response to ENH's rate increases to PHCS in 2000, PHCS's customers "had to raise their rates significantly in – the premiums to accommodate the increased rates at Evanston." (Ballengee, Tr. 196-97).

145. At the end of 1999, Great West had roughly 105 hospitals in its network in Illinois. (Dorsey, Tr. 1430).

**Response to Finding No. 145:**

Complaint Counsel agrees that Great West/One Health engaged in selective contracting in 1999. In fact, Mr. Neary testified that prior to the merger, One Health's network only contained "some subset" of the hospitals in the North Shore because "the premise behind a hospital discounting their prices or a physician discounting their prices is that they are going to get something in return, and that would be additional membership or patients going to their office or hospital." (Neary, Tr. 587-88).

**vi. HFN**

146. HFN, Inc. ("HFN") is a healthcare network that provides services through MCOs, physicians and hospitals. (RX 1710 at 1; Chan, Tr. 727). { [REDACTED] } (RX 1803, *in camera*). HFN is the largest such network in the six-county Chicago area, contracting with 103 hospitals and 31,405 physicians. (RX 1710 at 1).

**Response to Finding No. 146:**

Respondent cites RX 1710, which is not in evidence. The testimony cited by Respondent also does not say what Respondent claims. Ms. Chan did not testify that HFN is a healthcare network that provides services through MCOs, physicians and hospitals. (*See* Chan, Tr. 727). HFN develops networks that can be "rent[ed]" by employer groups or health plans. (Chan, Tr. 727).

{ [REDACTED] }

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (CX 5304 at 1; CX 6279 at 5, *in camera*). { [REDACTED] }

[REDACTED]

[REDACTED]  
[REDACTED] } (Ballengee, Tr. 239, *in camera*;  
Ballengee, Tr. 196-97; Mendonsa, Tr. 483-84; Mendonsa, Tr. 549, *in camera*; Dorsey,  
Tr. 1450).

147. { [REDACTED]  
[REDACTED] } (RX 1803, *in camera*).

**Response to Finding No. 147:**

Complaint Counsel have no specific response.

148. { [REDACTED]  
[REDACTED]  
[REDACTED] } (RX 1803, *in camera*).

**Response to Finding No. 148:**

*But see RFF 149-150, in camera.*

149. { [REDACTED] } (RX 1803, *in camera*; RX 1830 at HFN 516-18, *in camera*). { [REDACTED]  
[REDACTED]  
[REDACTED] } (RX 1803, *in camera*).

**Response to Finding No. 149:**

The finding is incomplete. { [REDACTED]  
[REDACTED]

[REDACTED] } (See CCRFF 145, 178, CCFF 192-254; RX 1803, *in camera*).

150. { [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] } (RX 1840 at HFN 72, *in camera*). { [REDACTED]  
[REDACTED] } (RX 1803, *in camera*).

**Response to Finding No. 150:**

{ [REDACTED]  
[REDACTED]

[REDACTED]

[REDACTED] (RX 1803, *in camera*). [REDACTED]

[REDACTED]

[REDACTED] (See CCFF 192-254; RX 1803, *in camera*).

**vii. Humana**

151. Humana is one of the nation's largest publicly traded health benefits companies, based on 2003 revenues of \$12.2 billion. (RX 1743 at 4, 27).

**Response to Finding No. 151:**

Respondent's finding is irrelevant. The law on anticompetitive price increases does not differentiate based on the size, wealth, or poverty of the firm paying the price increase. (See CCRFF 121). Complaint Counsel disagree with the implication that Humana's size enabled it to fend off ENH's post-merger price increases. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (Neaman,

Tr. 960-1, 1269-71; Hillebrand, Tr. 1725-6; CX 6279 at 19 (emphasis added)).

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (Ballengee, Tr. 239, *in camera*; Ballengee, Tr.

196-97; Mendonsa, Tr. 483-84; Mendonsa, Tr. 549, *in camera*; Dorsey, Tr. 1450).

152. Humana's net income was \$228.9 million in 2003 as compared to \$142.8 million



in 2002. (RX 1743 at 38). For the year ending December 31, 2003, commercial and individual PPO premium revenues at Humana totaled approximately \$3.4 billion, or 27.9% of Humana's total revenues and "administrative services only" ("ASO") fees, e.g., fees that a self-insured client would pay to an insurance company for processing claims. (RX 1743 at 6).

**Response to Finding No. 152:**

Respondent's finding is irrelevant. The law on anticompetitive price increases does not differentiate based on the size, wealth, or poverty of the firm paying the price increase. (See CCRFF 121). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (See

CCRFF 151, *in camera*).

153. Nationally and as of 2003, Humana had approximately 6.8 million members in its medical insurance programs, and 463,300 contracts with physicians, hospitals, and other providers of health care. (RX 1743 at 4). Humana had about 3,300 contracts with hospitals. (RX 1743 at 10). About 70% of Humana's premiums and administrative fees were from members located in Illinois, Florida, Texas, Kentucky and Ohio. (RX 1743 at 4).

**Response to Finding No. 153:**

Respondent's finding is irrelevant. The law on anticompetitive price increases does not differentiate based on the size, wealth, or poverty of the firm paying the price increase. (See CCRFF 121). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (See

CCRFF 151, *in camera*).

154. In Chicago, Humana is the third largest MCO in the market. (Foucre, Tr. 939-40). Humana has a share of about 10-11%. (Foucre, Tr. 949).

**Response to Finding No. 154:**

Respondent's finding is irrelevant. The law on anticompetitive price increases does not differentiate, based on the size, wealth, or poverty of the firm paying the price increase. (See CCRFF 121). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (See CCRFF 151, *in camera*).

155. Humana was unique in Chicago among MCOs in that it owned hospitals and physicians. (Hillebrand, Tr. 1863, 1867). Humana operated its hospitals, physicians and insurance products as a completely integrated provider during the 1980s. (Hillebrand, Tr. 1838). In fact, other insurers distinguished themselves from Humana with billboards on the Kennedy Expressway in Chicago that said: "We are your insurance company, not your doctor." (Hillebrand, Tr. 1867).

**Response to Finding No. 155:**

Whether Humana was in the 1980's an "integrated provider" or not is irrelevant to the question of whether, post-merger, ENH used its new-found market power to impose anticompetitive price increases on Humana and other health plans. (See CCRFF 151).

**viii. PHCS**

156. PHCS is not an insurance company. (Hillebrand, Tr. 1892; Ballengee, Tr. 204). PHCS is an organization that has come together to collectively negotiate prices with providers on behalf of independently owned businesses. (Hillebrand, Tr. 1892). PHCS is therefore different from Cigna, Aetna, United Healthcare and other MCOs that offer insurance. (Ballengee, Tr. 204).

**Response to Finding No. 156:**

Complaint Counsel do not disagree.

157. PHCS's customers are insurance companies. (Ballengee, Tr. 143). PHCS also has contracts for federal employee plans, Taft-Hartley union plans, and has some direct employers such as the Salvation Army. (Ballengee, Tr. 143).

**Response to Finding No. 157:**

Complaint Counsel do not disagree that PHCS's customers include insurance

companies, employers and others.

158. PHCS's customers pay PHCS for the use of the network on a per member basis. (Ballengee, Tr. 144). PHCS's customers make the payments to hospitals for hospital costs. (Ballengee, Tr. 144). PHCS takes a fee for what it provides to other smaller insurance companies that are part of its group. (Ballengee, Tr. 204). PHCS does not share the financial risk with its customers for healthcare costs. (Ballengee, Tr. 144).

**Response to Finding No. 158:**

The finding is incomplete. Because PHCS "does not share the financial risk with its customers for healthcare costs," when ENH imposed a 60% price increase on PHCS in 2000, PHCS's customers "had to raise their rates significantly in – the premiums to accommodate the increased rates at Evanston." (Ballengee, Tr. 179, 196-97).

159. PHCS also has third-party administrators ("TPAs") that handle administrative services for employers and other self-insured entities. (Ballengee, Tr. 143).

**Response to Finding No. 159:**

Complaint Counsel do not disagree.

160. In 2003, PHCS reported that its net revenue climbed to \$153 million, an increase of 6% over 2002. (RX 1615 at 3). PHCS's earnings exploded by "an astounding 50%" in 2003. (RX 1615 at 3).

**Response to Finding No. 160:**

Respondent's finding is irrelevant. The law on anticompetitive price increases does not differentiate based on the size, wealth, or poverty of the firm paying the price increase. (See CCRFF 121). Respondent's finding is also irrelevant to the question of whether ENH used its new-found market power to impose anticompetitive price increases post-merger, and misleading to the extent that it implies that PHCS's financial strength made it immune to ENH's post-merger price increases. [REDACTED]

[REDACTED] } (Ballengee, Tr. 196-97; CX 6279 at 4-5, *in camera*; Haas-Wilson, Tr. 2522, *in camera*). Because PHCS does not share the financial risk of healthcare costs with their customers, ENH's 60% price increase was passed down

directly to PHCS's customers, who subsequently "had to raise their rates significantly in – the premiums to accommodate the increased rates at Evanston." (Ballengee, Tr. 179, 196-97).

161. PHCS was ranked as the "Top National PPO in Chicago" by *Crain's Chicago Business* in 2003. (RX 1615 at 6). PHCS is also recognized in other regions as one of the largest networks in the nation. (RX 1615 at 6).

**Response to Finding No. 161:**

(See CCRFF 160 ({ [REDACTED] })), in camera)

**ix. Unicare**

162. Unicare is a product marketed by Wellpoint, Inc. ("Wellpoint"), a publicly traded company. (RX 1663 at 7, 11; Holt-Darcy, Tr. 1416). As of November 2004, Wellpoint, Inc., refers to the entity created by the merger of Wellpoint Health Networks and Anthem, Inc. (Holt-Darcy, Tr. 1416).

**Response to Finding No. 162:**

Complaint Counsel do not disagree.

163. Wellpoint, Unicare's parent company, is a huge and very successful national insurance company. (RX 1663). Unicare is a national brand operating from coast-to-coast. (Holt-Darcy, Tr. 1416).

**Response to Finding No. 163:**

The cited source (RX 1663) does not describe Wellpoint as "huge" and "very successful." That is Respondent's characterization of the financial numbers in that 2003 SEC filing (10-K) for Wellpoint.

Respondent's finding is irrelevant. The law on anticompetitive price increases does not differentiate based on the size, wealth, or poverty of the firm paying the price increase. (See CCRFF 121). Respondent's finding is misleading in its implication that the size of Wellpoint or Unicare protected Unicare from price increases from ENH post-merger. { [REDACTED] }

[REDACTED]  
[REDACTED] } (Holt-Darcy, Tr. 1536, 1539, 1563, *in camera*; CX 5075 at 17, *in camera*; CX 124 at 1, *in camera*). { [REDACTED]

[REDACTED]  
[REDACTED] } (Holt-Darcy, Tr. 1536, 1543, 1563, *in camera*). { [REDACTED]

[REDACTED] } (CX 6279 at 5, *in camera*).  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] }

(Ballengee, Tr. 239, *in camera*; Ballengee, Tr. 196-97; Mendonsa, Tr. 483-84; Mendonsa, Tr. 549, *in camera*; Dorsey, Tr. 1450).

164. Wellpoint's total assets in 2003 exceeded \$14.788 billion. (RX 1663 at 50). In 2003, Wellpoint's reported net income was \$935,229,000. (RX 1663 at 48). In 2000, by contrast, Wellpoint's reported net income was just \$342,287,000. (RX 1663 at 48).

**Response to Finding No. 164:**

Respondent's finding is irrelevant. The law on anticompetitive price increases does not differentiate based on the size, wealth, or poverty of the firm paying the price increase. (See CCRFF 121). Respondent's finding is misleading in its implication that the size of Wellpoint or Unicare protected Unicare from price increases from ENH post-merger. (See CCRFF 163). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (See CCRFF 163; *in camera*).

165. As of December 31, 2003, Wellpoint served approximately 15 million medical members nationwide. (RX 1663 at 6). Wellpoint's merger with Anthem added approximately 11.9 million medical members to its rolls. (RX 1663 at 7).

**Response to Finding No. 165:**

Respondent's finding is irrelevant. The law on anticompetitive price increases does not differentiate based on the size, wealth, or poverty of the firm paying the price increase. (See CCRFF 121). Respondent's finding is misleading in its implication that the size of Wellpoint or Unicare protected Unicare from price increases from ENH post-merger. (See CCRFF 163). [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (See CCRFF 163, *in camera*).

166. Wellpoint launched the Unicare brand and entered the Illinois marketplace in the late-1990's as a PPO. (Holt-Darcy, Tr. 1417). Unicare has been in the Chicago area since the early-1990's. (Holt-Darcy, Tr. 1417-18).

**Response to Finding No. 166:**

Complaint Counsel do not disagree assuming that Respondent means that Unicare has been in the Chicago area since the early 1990s but that the Unicare brand itself was not introduced until the late 1990s.

167. [REDACTED]  
(Holt-Darcy, Tr. 1535, *in camera*). [REDACTED]  
[REDACTED] } (Holt-Darcy, Tr. 1535, *in camera*).

**Response to Finding No. 167:**

Respondent's finding is irrelevant. The law on anticompetitive price increases

does not differentiate based on the size, wealth, or poverty of the firm paying the price increase. (See CCRFF 121). Respondent's finding is misleading in its implication that the size of Wellpoint or Unicare protected Unicare from price increases from ENH post-merger. (See CCRFF 163). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (See CCRFF 163, *in camera*).

168. { [REDACTED] }  
(Holt-Darcy, Tr. 1504-05, *in camera*; RX 1663 at 6). Unicare purchased the Rush Prudential health plan network business and converted it to Unicare. (Holt-Darcy, Tr. 1417).

**Response to Finding No. 168:**

Complaint Counsel do not disagree.

**x. United**

169. United is a subsidiary of United Healthcare, Incorporated ("United Healthcare"), which itself is a subsidiary of United Health Group. (Foucre, Tr. 877).

**Response to Finding No. 169:**

Complaint Counsel do not disagree.

170. By 2003, United Healthcare served approximately 8.3 million members in the country. (RX 1663 at 6). In Chicago, United is the second largest insurer as measured by membership. (Foucre, Tr. 939; Hillebrand, Tr. 1868). The current membership of United's network in Chicago is approximately 875,000. (Foucre, Tr. 880-81).

**Response to Finding No. 170:**

United's size is irrelevant. The law on anticompetitive price increases does not differentiate based on the size, wealth, or poverty of the firm paying the price increase. (See CCRFF 121). Complaint Counsel disagree with the implication that United's size or position in the market enabled it to fend off ENH's post-merger price increases. { [REDACTED]

[REDACTED]

[REDACTED] } (Neaman,  
Tr. 960-1, 1269-71; Hillebrand, Tr. 1725-6; CX 6279 at 19 (emphasis added), *in camera*).

[REDACTED] } (Ballengee, Tr. 239, *in camera*; Ballengee, Tr.  
196-97; Mendonsa, Tr. 483-84; Mendonsa, Tr. 549, *in camera*; Dorsey, Tr. 1450).

171. United Health Group is a multi-billion dollar insurance company. (Foucre, Tr. 939). As of February 2005, United Health Group was worth over \$30 billion. (Foucre, Tr. 939). United Health Group's most current 10-K filed with the Securities Exchange Commission reports that United Health Group received \$28.823 billion in revenues in 2003. (RX 1662).

**Response to Finding No. 171:**

The finding is irrelevant. (See CCRFF 170 discussing the fact that United's size and position in the market did not enable it to fend off ENH's post-merger price increases.).

172. United Healthcare's strongest financial year in its history occurred in 2000. (RX 1071 at 7). United Healthcare reported record revenues of \$21.1 billion, a 12% increase over 1999. (RX 1071 at 7). In 2000, United Healthcare's operating earnings increased by 27% over its 1999 operating earnings. (RX 1071 at 7). In 2000, United Healthcare posted net earnings of \$736 million. (RX 1071 at 7).

**Response to Finding No. 172:**

The finding is irrelevant. (See CCRFF 170 discussing the fact that United's size and position in the market did not enable it to fend off ENH's post-merger price increases.).



173. William W. McGuire, Chairman and Chief Executive Officer of United Health Group earned in excess of \$91,953,914 in 2003. (RX 1662 at 225, 227). Dr. McGuire's compensation included a \$5,550,000 bonus on top of his salary of \$1,996,154. (RX 1662 at 225). In 2003, Dr. McGuire also exercised stock options with a realized value of \$84,176,032. (RX 1662 at 227).

**Response to Finding No. 173:**

The issue of executive compensation or bonuses at United is irrelevant to the question of whether ENH exercised market power and imposed price increases on United and other health plans (and ultimately, health plan customers) post-merger. (See CCRFF 170).

174. Robert J. Sheehy, Chief Executive Officer of United Healthcare, was paid a salary of \$485,000 plus a bonus of \$500,000 in 2003. (RX 1662 at 225). In 2003, Mr. Sheehy exercised stock options with a realized value of \$9,283,536. (RX 1662 at 227).

**Response to Finding No. 174:**

The issue of executive compensation or bonuses at United is irrelevant to the question of whether ENH exercised market power and imposed price increases on United and other health plans (and ultimately, health plan customers) post-merger. (See CCRFF 170).

175. United has five primary health insurance products that it sells to employers. (Foucre, Tr. 881). Two products are sold on the HMO license and have no out-of-network benefits. (Foucre, Tr. 881). One of the products on United's HMO license requires a gatekeeper physician while the other product does not. (Foucre, Tr. 881).

**Response to Finding No. 175:**

Complaint Counsel do not disagree.

176. From 2001 through 2004, approximately 75% of United's business was self-insured. (Foucre, Tr. 881-82).

**Response to Finding No. 176:**

Complaint Counsel do not disagree.

177. In the late 1990s, United Healthcare acquired numerous other insurance companies, such as Share, Chicago HMO, MetLife, and Travelers, and quickly became one of the

larger players in Chicago. (Hillebrand, Tr. 1838-39). At present, United has a share in Chicago of approximately 15%. (Foucre, Tr. 949).

**Response to Finding No. 177:**

The finding is irrelevant. (See CCRFF 170 (discussing the fact that United's size and position in the market did not enable it to fend off ENH's post-merger price increases.)).

178. By the end of 2002, approximately 98 hospitals were in United's network in the Chicago area. (Foucre, Tr. 881). { [REDACTED] } (Foucre, Tr. 1122-23, *in camera*).

**Response to Finding No. 178:**

Respondent's finding is incomplete. The fact that United eliminated eight hospitals from its network between 2002 and the present is an example of selective contracting in the Chicago area. (Foucre, Tr. 934).

**I. MCO Negotiating Trends In The Chicago Area Market**

179. Relationships between hospitals and MCOs have long been strained. (Spaeth, Tr. 2298). As MCOs have become more aggressive with hospitals and physicians, hospitals and physicians have responded by becoming more aggressive with MCOs. (Neaman, Tr. 1347-48).

**Response to Finding No. 179:**

Respondent's sources for this finding are the self-serving testimony of Mr. Spaeth and Mr. Neaman. In any event, Respondent's finding is irrelevant. With regard to ENH itself, Mr. Hillebrand admitted that, with the exception of sending termination letters, ENH's negotiating stance in 2000 with health plans was no more aggressive than Evanston's stance in the late 1990s. (Hillebrand, Tr. 1733-34). With regard to termination letters, Mr. Sirabian testified that, prior to the merger, "with the major groups, the top seven to 10, we were always able to come to terms. With the smaller groups, if we couldn't come to terms quickly, we were able to – *we then just would terminate.*" (Sirabian, Tr. 5753-54 (emphasis added). See Hillebrand, Tr. 1734-35

(Evanston negotiators understood prior to the merger that they could send termination letters, with or without Bain's advice.)).

According to Mr. Hillebrand, very little changed in ENH's negotiation posture after the merger. Mr. Hillebrand, the man who oversaw managed care contracting at Evanston hospital during the 1990s and led the relationships with health plans, is still doing so today. (Hillebrand, Tr. 1727-8; Neaman, Tr. 1220-21). Similarly, Mr. Hillebrand supervised Mr. Sirabian in health plan negotiations during the 1990s, and continued to do so in 2000 and thereafter until shortly before Mr. Sirabian's retirement. (Hillebrand, Tr. 1700, 1729).

Significantly, Messrs. Hillebrand and Neaman believe that health plans' bargaining positions have increased since the merger. (Neaman, Tr. 960-1, 1269-71; Hillebrand, Tr. 1725-6). [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (CX 6279 at 20, *in camera*; Neaman, Tr. 960-61, 1269-71; Hillebrand, Tr. 1725-26, 1733-34).

Complaint Counsel further disagrees with this finding's implication that there is a "Chicago area market" (as the title of this section indicates). The relevant geographic market in this case is a triangle formed by Evanston, Glenbrook, and Highland Park, including their campuses, the area in-between, and some additional area around them. This area is established through a range of evidence including post-merger pricing

studies, testimony of payers and others, and documents of the parties. (Haas-Wilson, Tr. 2452, 2667; Newton, Tr. 351-52; Foucre, Tr. 901-903; Ballengee, Tr. 167-68; Holt-Darcy, Tr. 1425-1427).

180. During the late 1990's and early 2000s, there has been a trend of hospitals getting more aggressive in their negotiation tactics. (Dorsey, Tr. 1475). { [REDACTED] } (RX 1393 at ENHL BW 3682, *in camera*).

**Response to Finding No. 180:**

{ [REDACTED] }

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

{ [REDACTED] } (CX 6279 at 20, *in camera*; Neaman, Tr. 960-61, 1269-71; Hillebrand, Tr. 1725-26, 1733-34. *See* CCRFF 179).

181. { [REDACTED] } (RX 1393 at ENHL BW 3682, *in camera*).

**Response to Finding No. 181:**

{ [REDACTED] }

[REDACTED]

[REDACTED] } (*See* RX 1393 at ENHL BW 003682 ( { [REDACTED] } ), *in camera*). { [REDACTED] }

[REDACTED]

[REDACTED]

[REDACTED]

(CCRFF 189. See CCF 822-847).

182. To be sure, however, { [REDACTED] } (Mendonsa, Tr. 546, *in camera*). { [REDACTED] } (Mendonsa, Tr. 559, *in camera*; Holt-Darcy, Tr. 1588, *in camera*). { [REDACTED] } (Holt-Darcy, Tr. 1588, *in camera*). { [REDACTED] } (Holt-Darcy, Tr. 1586-87, *in camera*).

**Response to Finding No. 182:**

{ [REDACTED] }

[REDACTED]

{ [REDACTED] } The record shows that the difference at ENH between the pre- to post-merger period was ENH's market power. Mr. Hillebrand, the man who oversaw managed care contracting at Evanston hospital during the 1990s and led the relationships with health plans, is still doing so today. (Hillebrand, Tr. 1727-8; Neaman, Tr. 1220-21). Similarly, Mr. Hillebrand supervised Mr. Sirabian in health plan negotiations during the 1990s, and continued to do so in 2000 and thereafter until shortly before Mr. Sirabian's retirement. (Hillebrand, Tr. 1700, 1729). ENH senior management did not work to keep Mr. Gilbert and Ms. Chan – the Highland Park negotiators who had achieved purportedly "higher rates" than the Evanston negotiators prior to the merger – when they left ENH in 2000. (Hillebrand, Tr. 1730; Sirabian, Tr. 5756-57). The health plans that ENH negotiated with after the merger were the same that Evanston did business with before the merger. (Hillebrand, Tr. 1723)

{ [REDACTED] }

[REDACTED]

[REDACTED]

[REDACTED] } (Ballengee, Tr. 177, 194;

Holt-Darcy, Tr. 1529-30, 1544-45, *in camera*). The record shows that ENH exercised its market power, attained through the merger, to raise prices in at least five different ways, including: (1) moving health plans to one contract for all three ENH facilities, *i.e.*, the Evanston or Highland Park pre-merger contract, whichever had the higher rates; (2) adding a premium to the higher of the Evanston or Highland Park contract rates; (3) moving health plans from a fixed price contract to a discount off charges contract or to a contract that contained more discount off charges provisions than the pre-merger contract; (4) adopting in 2000 the higher of the Evanston or Highland Park chargemaster list prices for the particular product or service; and (5) repeatedly increasing ENH's chargemaster list prices in the years following the merger. (*See, e.g.*, Hillebrand, 1856, 1704-06; Newton, Tr. 364-65; Chan, Tr. 709-10. *See also* CCF 822-842, 848-880, 813-821, 881-903, 918-927, 942-958).

183. { [REDACTED] }  
{ [REDACTED] } (Holt-Darcy, Tr. 1587, *in camera*). { [REDACTED] }  
{ [REDACTED] } (Holt-Darcy, Tr. 1587-89, *in camera*).

**Response to Finding No. 183:**

{ [REDACTED] }  
[REDACTED]  
{ [REDACTED] } (*See* CCRFF 182).

**1. Hospitals Use Termination Letters To Open Negotiations With MCOs**

184. { [REDACTED] }  
{ [REDACTED] } (Dorsey, Tr. 1475, 1487; Ballengee, Tr. 198; Holt-Darcy, Tr. 1534-35, *in camera*; Chan, Tr. 734-35; Mendonsa, Tr. 559, *in camera*; RX 61; RX 172; RX 1372 at BCBSI-ENH 24630, *in camera*; RX 1075 at CIG/IL 200374, *in camera*). Actual terminations, however, are uncommon. (Dorsey, Tr. 1475).

**Response to Finding No. 184:**

{ [REDACTED] }

[REDACTED] (Dorsey, Tr. 1475, 1487;  
Ballengee, Tr. 198, Holt-Darcy, Tr. 1534-35, *in camera*; Chan, Tr. 734-35; Mendonsa, Tr.  
559, *in camera* (emphasis added)). [REDACTED]

[REDACTED]

(See, e.g., RX 61 (“since our good faith negotiations have not resulted in agreed upon,  
rates for 1994 . . .”); RX 172 (“after numerous unsuccessful attempts to contact you by  
phone”); RX 1075 at CIG/IL 200374, *in camera* ([REDACTED]  
[REDACTED]); RX 1372 at BCBSI-ENH 24630,  
*in camera* ([REDACTED]  
[REDACTED])).

Moreover, Respondent’s finding is irrelevant. Mr. Sirabian testified that, prior to  
the merger, “with the major groups, the top seven to 10, we were always able to come to  
terms. With the smaller groups, if we couldn’t come to terms quickly, we were able to –  
*we then just would terminate.*” (Sirabian, Tr. 5753-54 (emphasis added). See Hillebrand,  
Tr. 1734 (Evanston negotiators understood prior to the merger that they could send  
termination letters, with or without Bain’s advice.)). [REDACTED]

[REDACTED]

[REDACTED] (See, e.g., Holt-Darcy, Tr. 1527, *in camera* ([REDACTED]  
[REDACTED]  
[REDACTED])); Mendonsa, Tr. 531, *in camera* ((describing CX 123)

[REDACTED]

[REDACTED] ): See also Neaman, Tr. 1211-12; Hillebrand, Tr. 1764-65 (Messrs. Neaman and Hillebrand admitted that they did not believe that ENH's price demands had to change because of any risk that ENH would lose business to other hospitals or that other hospitals would change their prices in response to ENH's prices); Hillebrand, Tr. 1708 (ENH did not lose a single health plan customer after the price increases.)).

185. [REDACTED] (Neary, Tr. 630; Mendonsa, Tr. 559, *in camera*). For example, Lake Forest Hospital believed that "[m]ost contracts must be terminated to gain enough leverage to increase payment levels from insurance companies." (RX 987 at FTC-LFH 229).

**Response to Finding No. 185:**

[REDACTED]

[REDACTED] } Mr. Sirabian testified that, prior to the merger "with the major groups, the top seven to 10, [Evanston was] always able to come to terms. With the smaller groups, if we couldn't come to terms quickly, we were able to – *we then just would terminate.*" (Sirabian, Tr. 5753-54 (emphasis added). See Hillebrand, Tr. 1734 (Evanston negotiators understood prior to the merger that they could send termination letters, with or without Bain's advice.)). [REDACTED]

[REDACTED] } (See CCRFF 184, *in camera*).

186. [REDACTED]



[REDACTED]  
[REDACTED]  
(Ballengee, Tr. 198; Mendonsa, Tr. 560, *in camera*; RX 859; RX 906; RX 919; RX 927; RX 929; RX 950; RX 965; RX 983 at CIG/IL 141819; RX 995, *in camera*; RX 1070, *in camera*; RX 1075 at CIG/IL 200374, *in camera*; RX 1104; RX 1223, *in camera*; RX 1349; RX 1443; RX 1530).

**Response to Finding No. 186:**

[REDACTED]

[REDACTED]

[REDACTED] (See CCRFF 184, *in camera*). [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (See

CCRFF 184, *in camera*).

**2. System-Wide Contracts Are Gaining Popularity**

187. [REDACTED]  
[REDACTED] (RX 1223 at UHC 17769, *in camera*; RX 1982 at ALEX 2594-95).

[REDACTED]  
[REDACTED] (RX 1223 at UHC 17769, *in camera*).

**Response to Finding No. 187:**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (Compare RX 1223, *in camera* and RFF 189).

[REDACTED]

[REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]  
(See CCRFF 189, *in camera*).

188. Consultants have also advised hospital systems to negotiate as one system. (RX 1982 at ALEX 2594-95). For example, the Tintari Group prepared an assessment of all the active managed care contracts held by Alexian Brothers Health System and recommended that Alexian Brothers “negotiate in the market as one true system,” and “should aggressively negotiate[] using a discount-from-charges pricing methodology.” (RX 1982 at ALEX 2594-95).

**Response to Finding No. 188:**

[REDACTED]  
[REDACTED] } (See  
RFF 187, *in camera*). [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED] } As shown below,

Respondent overstates the case for system-wide contracts. (See CCRFF 189).

Moreover, it is irrelevant whether a consultant advised the Alexian Brothers to move towards discount off charges arrangements with health plans, particularly when Respondent cites nothing to show that the advice was followed. [REDACTED]

[REDACTED] } (See CCRFF 85,  
*in camera*).

189. But some 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. (Foucre, Tr. 890-91; Ballengee, Tr. 163-64).

**Response to Finding No. 189:**

The finding is incomplete. Complaint Counsel note the inherent contradiction in

Respondent down-playing these four hospitals systems as “some” healthcare networks when, in RFF 117, Respondent builds up these four systems (plus ENH) as the “five health care systems in Chicago” that are responsible for “over 43% of total inpatient admissions.” (RFF 117). { [REDACTED]

{ [REDACTED] } (Foucre, Tr. 890-92, 933, 935. See Foucre, Tr. 891-92 (Other than ENH, there are no other systems in United’s Chicago network that demand the same rate and contract for all the hospitals in the system.); Ballengee, Tr. 163-65; Dorsey, Tr. 1445-46; RX 1503, *in camera*; Holt-Darcy, Tr. 1528, *in camera*; RX 722, *in camera*).

**3. The Contract Negotiation “Pendulum” Is Swinging Back In Favor Of MCOs**

190. { [REDACTED] } (RX 1393 at ENHL BW 3683, *in camera*).

**Response to Finding No. 190:**

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Neaman, Tr. 960-1, 1269-71; Hillebrand, Tr. 1725-6). { [REDACTED]

[REDACTED] } (CX 6279 at 18-20, *in camera*).

{ [REDACTED]

[REDACTED] } First,

Respondent presents no pre- or post-merger documents to corroborate the idea that ENH

hospitals recognized or were following a "trend" in its post-merger price increase. {

[REDACTED]

[REDACTED]

[REDACTED]

(CX 3 at 2; CX 5 at 5; CX 6 at 7; CX 2070 at 3; CX 12 at 2; CX 13 at 1; CX 16 at 1; CX 17 at 2; CX 1879 at 3-4; CX 1 at 3; CX 2 at 7; CX 4 at 1-2, 9; CX 1566 at 9; CX 1519 at 1-2; CX 23 at 2; CX 24 at 2, *in camera*; CX 26 at 1; CX 25 at 9; CX 31 at 1; Neaman, Tr. 1138, *in camera*. See CCF 1346-1379).

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (CX 6279 at 20, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (CX 6279 at 18-19, *in*

*camera*; CX 6282 at 6, *in camera*).

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } Mr. Hillebrand admitted that none of the price

increases that ENH attained in 2000 were taken away subsequent to 2000, which means

that the merged entity is still reaping the benefits of the at least \$18 million in *annualized economic value* that it extracted from health plans in 2000. (CX 17 at 5-8; Hillebrand Tr. 1708-09. See CX 13 at 1 (In July 2000, Mr. Neaman reported an additional \$16 million/year in total managed care re-negotiation benefits to the board); CX 17 at 8 (September 2000 Humana contract re-negotiation resulted in \$2 million *annualized economic revenue*)). Health plans know that they continue to suffer the effects of ENH's price increases. { [REDACTED]

[REDACTED] } (Holt-Darcy, Tr. 1565, *in camera*). { [REDACTED]

[REDACTED] } (Foucre, Tr. 1103-04, *in camera*).

[REDACTED] } (Newton, Tr. 366; Hillebrand, Tr. 1855. See Hillebrand, Tr. 1705-06 (Mr. Hillebrand's "first negotiating step" with health plans in 2000 was to "move to discount off charges." ENH successfully moved a number of health plans to discount off charges arrangements after the merger.). See also Ballengee, Tr. 252, 255, *in camera*; Hillebrand, Tr. 1893; compare CX 116 at 2, *in camera*, CX 117 at 1, *in camera*, and CX 5072 at 23, *in camera*; Hillebrand, Tr. 1947, *in camera*; compare CX 5067 at 15, *in camera*, CX 5059 at 17, and CX 5065 at 17; Holt-Darcy, Tr. 1536, 1539, 1563, *in camera*; CX 5075 at 17, *in camera*). { [REDACTED]

[REDACTED] (RX 1687 at ENHL BW 027653, *in camera*).

191. [REDACTED]  
[REDACTED] (RX 1393 at ENHL BW 3683, *in camera*).

**Response to Finding No. 191:**

[REDACTED]  
[REDACTED]

[REDACTED] (See CCRFF 190). Respondent's finding is also incomplete because it leaves out the fact that there was no new entry despite ENH's price increases. (D. Jones, Tr. 1664).

192. [REDACTED]  
[REDACTED] (RX 1393 at ENHL BW 3683, *in camera*).

**Response to Finding No. 192:**

[REDACTED]  
[REDACTED]

[REDACTED] (See CCRFF 190). Most of ENH's contracts were renegotiated (with price increases) in 2000. (Hillebrand, Tr. 1707). Yet, as of 2005, ENH's price increases had not been constrained by entry. (CCFF 1729-1741). There is also no reason to think that the CON process will sunset since the law has been renewed in the past. (See CCFF 1740).

193. [REDACTED]  
[REDACTED] (RX 1393 at ENHL BW 3683, *in camera*).

**Response to Finding No. 193:**

[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED] } (See

CCRFF 190, *in camera*). [REDACTED]

[REDACTED]

[REDACTED] } (CX 6279 at 18-20, *in camera*; CX 6282 at 5, *in camera*).

194. [REDACTED]

[REDACTED] } (RX 1393 at ENHL BW 3683, *in camera*).

**Response to Finding No. 194:**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (CX 6279 at 18-20, *in camera*; CX 6282 at 5, *in camera*).

195. [REDACTED]

[REDACTED] } (RX 1393 at ENHL BW 3683, *in camera*).

**Response to Finding No. 195:**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (CX 6279 at 18-20, *in camera*; CX 6282 at 5, *in camera*). [REDACTED]

[REDACTED]

[REDACTED] } (See

CCRFF 190, *in camera*).

196. {

[REDACTED] (RX 1393 at  
ENHL BW 3683, *in camera*).

**Response to Finding No. 196:**

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (See CCRFF 190, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED] }



### III. PRE-MERGER BACKGROUND

197. The Merger should be viewed in a broader factual context. Evanston Hospital and HPH decided to merge only after: (1) the failure of a hospital network in which both parties participated, the Northwestern Healthcare Network (the “Network” or “NHN”); (2) a failed attempt by Evanston Hospital, HPH and another hospital to form a three-way hospital merger (“NH North”); and (3) the failures of several HPH joint ventures and merger negotiations with other hospitals. (Hillebrand, Tr. 1785-86, 1791-92; Neaman, Tr. 1035-36; Spaeth, Tr. 2266). This pre-Merger background – which confirms the pitfalls of loose corporate affiliations short of a full asset merger like the one at issue here as well as the hurdles to merger consummation – is described in more depth below.

#### **Response to Finding No. 197:**

Complaint Counsel agree that the Evanston-HPH merger “should be viewed in a broader factual context.” However, Respondent’s finding is incomplete. The previous merger and other partnership efforts were part of a systematic effort on the part of Evanston and HPH to increase their bargaining strength and market power vis-a-vis health care plans.

Through the formation of NHN, its members, including the founding members, Evanston and HPH, aimed to increase bargaining power versus healthcare plans by negotiating jointly and combining the bargaining strength of the individual members. (Neaman, Tr. 965 (unified contracting through NHN hopefully would result in better terms than individual negotiations)). This was a specific goal discussed by Mr. Neaman of ENH and Mr. Spaeth of HPH at NHN meetings and internally. (Spaeth, Tr. 2194; CX 1802 at 2 (HPH joined NHN for “leverage”); CX 1802 at 3 (ENH belief that reason for joining network was to get better pricing than negotiating alone); *see also* CCFF 1535-1552).

Likewise, Evanston, in its proposed NH-North merger with HPH and Northwest Community Hospital, had as one of the main purposes to negotiate collectively with

healthcare plans for the purpose of obtaining better rates. (Hillebrand, Tr. 1726 (NH-North's key goal to get better contracts by negotiating as one entity); *see also* CCF 1565-77).

Respondent cites no specific support for its broad statement of the "pitfalls of loose corporate affiliations." This is contrary to the Judge's April 6, 2005, Order on Post Trial Briefs stating that each proposed finding shall have a valid and correct cite to the record. Furthermore, this proposition is not a finding of fact.

**A. Northwestern Healthcare Network**

198. The Network was a system of hospitals formed in Chicago in the early 1990s. (CX 6306 at 2 (Mecklenburg, Dep.)). The Network was formed pursuant to an affiliation agreement dated October 23, 1989. (RX 22 at NHN 322).

**Response to Finding No. 198:**

Complaint Counsel have no specific response.

199. The earliest formal discussions concerning the formation of the Network were among a group of hospitals already related to one another through a common affiliation with Northwestern University Medical School. These hospitals included Evanston Hospital, the Rehabilitation Institute of Chicago and Children's Memorial Medical Center ("Children's Memorial"). (CX 6306 at 2 (Mecklenburg, Dep.)).

**Response to Finding No. 199:**

Complaint Counsel have no specific response.

200. Ultimately, the founding members of the Network were Children's Memorial, Evanston Hospital, Lakeland (HPH's parent) and Northwestern Memorial. (Neaman, Tr. 963; CX 1780 at 1).

**Response to Finding No. 200:**

Complaint Counsel have no specific response.

**1. Purpose Of The Network**

201. The goals and objectives of the Network included:

- (a) creating a vertically and horizontally integrated medical care delivery system for the Chicago metropolitan area;
- (b) developing fully integrated marketplace penetration strategies, including “the development of coordinated Phase I and Phase II systems and processes for managed care contracting”;
- (c) providing leadership in the development of systems for assuring high quality patient care;
- (d) enhancing the financial position of the member institutions through an expanded patient base, diversified health care programs and cost position improvements; and
- (e) strengthening the academic programs at the hospitals and Northwestern University. (CX 1780 at 5-6; CX 6306 at 2-4 (Mecklenburg, Dep.)).

**Response to Finding No. 201:**

Respondent’s finding is incomplete. A primary goal of the network was to grow enough for member hospitals to negotiate successfully as a group with health plans.

(Neaman, Tr. 963). Mr. Neaman testified that Network members understood that one of the problems they faced was that health plans had greater bargaining power than the hospitals. (Neaman, Tr. 964). Through the Network, members aimed to get better pricing and terms from health plans. (Neaman, Tr. 964). Mr. Hillebrand testified that Evanston had hoped to “level the playing field” by collectively negotiating with other Network members in the 1990s in order to obtain better rates from health plans.

(Hillebrand, Tr. 1726). For his part, Mr. Spaeth acknowledged discussing the idea of getting leverage over health plans as a by-product of the unity of the Network. (Spaeth, Tr. 2194. *See also* Spaeth, Tr. 2195-96).

Mr. Neaman’s and Mr. Spaeth’s comments at a 1994 meeting of the chief executives of NHN members, as set forth in meeting minutes, highlighted their goal of getting leverage over health plans. (CX 1802 at 1). Mr. Spaeth “remarked that HPH

joined NHN for leverage, and that if the member Institutions are not going to stand united, then he is not sure where the value is.” (CX 1802 at 2). Mr. Spaeth “hoped NHN would get to the point that when a situation presented itself, an Institution would be willing to ‘act in a manner that allows for best leverage.’” (CX 1802 at 2). At the same meeting, Mr. Neaman agreed with this sentiment. He “responded that Mr. Spaeth’s comments are the absolute heart of what NHN is about. He [Mr. Neaman] would expect NHN to get better pricing than the hospital, and that is the benefit of being in the network.” (CX 1802 at 3).

202. The Network hospitals came together to respond to anticipated marketplace behavior in terms of managed care contracting and in terms of exclusive contracting with certain MCOs. (RX 70 at NHN 873; CX 6306 at 4 (Mecklenburg, Dep.)).

**Response to Finding No. 202:**

Respondent’s finding is incomplete. They also came together to obtain better prices from MCOs through bargaining collectively. (See CCRFF 197, 201).

203. In particular, the Network was formed, in part, with an eye toward handling the anticipated trend towards capitated contracts, pursuant to which a MCO paid a group of providers a fixed amount of dollars per member per month, thus placing all financial risk on that group of providers. (Neaman, Tr. 1360).

**Response to Finding No. 203:**

Respondent’s finding is incomplete. A primary reason for the formation was to obtain better prices from MCOs through bargaining collectively. (See CCRFF 197, 201).

204. While capitated contracts did come to Chicago in the mid-1990s, they never became the major factor many had predicted. (Neaman, Tr. 1361). Thus, one of the driving forces behind the formation of the Network never materialized in the Chicago area marketplace. (RX 584 at ENH JH 2951).

**Response to Finding No. 204:**

Respondent’s finding is incomplete. A primary reason for the formation was to

obtain better prices from MCOs through bargaining collectively. (See CCRFF 197). A problem the Network experienced was that NHN "was not making collective decisions." (Newton, Tr. 310-11). In order for the Network to have gone forward rather than weakening and ultimately dissolving, it would have needed more central authority and less local authority. (CX 6306 at 18 (Mecklenburg, Dep.)). Mr. Neaman testified that the Network failed in getting better prices and terms from health plans because the hospital members would not act collectively in negotiations with health plans. (Neaman, Tr. 965-66).

205. Evanston Hospital joined the Network based on its belief that the then-existing Rush, Humana (at that point, Humana owned several hospitals in the Chicago area, including the former Michael Reese Hospital) and Evangelical (a precursor to the Advocate system) systems of ownership of several hospitals in the Chicago area would be the operating model for the future. There was some fear that Evanston Hospital might be left behind if it did not become an integral part of a hospital network. (RX 357 at ENH JH 10385).

**Response to Finding No. 205:**

Respondent's finding is incomplete. Evanston also had the goal to obtain better prices from MCOs through bargaining collectively. (See CCRFF 197, 201).

206. HPH joined the Network to enhance the hospital's quality of care as well as its perception in the marketplace. (Spaeth, Tr. 2194).

**Response to Finding No. 206:**

Respondent's finding is incomplete. HPH also had the goal to obtain better prices from MCOs through bargaining collectively. (See CCRFF 197, 201).

**2. Structure And Powers Of The Network**

207. Pursuant to the affiliation agreement, the Network became the "sole member" of the member hospitals, in accordance with the Illinois General Not For Profit Corporation Act of 1986, as amended. (RX 22 at NHN 339, 372). The affiliation agreement provided for the creation of a Council of Governors, appointed by the member hospitals, to serve as "Members" of the Network. These "Members" were granted rights under the affiliation agreement and under the Illinois General Not for Profit Corporation Act of 1986. (RX 22 at 340). In addition, the

Network had its own executive and its own board of directors. (CX 6306 at 5-6 (Mecklenburg, Dep.); Newton, Tr. 457; Neaman, Tr. 999). There "was a significant effort to integrate the local CEOs into the Network." (CX 6306 at 6 (Mecklenburg, Dep.)).

**Response to Finding No. 207:**

The finding is incomplete. Respondent neglects to mention the control the Council of Governors had over the Network. The Council of Governors consisted of seven representatives named by each of the member hospitals. (CX 1780 at 12). The affiliation agreement gave the Council of Governors control over the Network, including, *inter alia*, the authority to appoint and to remove members of the board of directors of the Network. (CX 1780 at 14). The Network adopted a policy in 1993 to state that the Network may not remove or replace the chief executive officer or board member of any individual member hospital except for limited, specifically defined reasons. (CX 1831 at 13).

208. The Network evolved in two phases, Phase I and Phase II. During both Phases I and II, however, the Network had the powers to: (1) approve the member institutions' respective strategic plans; (2) develop a "macro" strategic plan for the entire Network; and (3) approve the member institutions' respective operating and capital budgets. (Neaman, Tr. 967; CX 1780 at 16-17; Newton, Tr. 457-59; CX 6306 at 3 (Mecklenburg, Dep.)).

**Response to Finding No. 208:**

The finding is incomplete. Respondent neglects to mention that the authority of the Northwestern Healthcare Network was limited because under the affiliation agreement, as amended, a member institution could withdraw from the network if the network imposed financial responsibility on such member institution to pay off the debts of another member institution without the consent of the petitioning member. (CX 1831 at 9). Furthermore, under the Network Affiliation Agreement, the Network hospitals were autonomous in their financial operations, meaning each institution developed its

own budget. (CX 1777 at 50. See CX 6307 at 12-13 (Schelling, Dep.)).

Moreover, the financial integration of the member hospitals was limited. The Network did not have the authority to liquidate a member hospital or to require a member hospital to transfer its assets to the Network. Instead, even during Phase II, the affiliation agreement specifically limited the amount of capital a member hospital could be required to transfer to the Network, either in any year or in the first five years of Phase II. (CX 1780 at 48).

209. Phase I started when the Network was first approved around 1990. (Neaman, Tr. 967). During Phase I, the Network's governing board and the CEO of each of the member institutions continued to be nominated, elected and appointed in accordance with the procedures established by each institution. The Network had the reserved power and authority to approve the election and/or appointment of each institution's board members and CEOs. (CX 1780 at 15-16).

**Response to Finding No. 209:**

The finding is incomplete. Respondent neglects to mention that the individual members hospitals retained significant control over the Network. Under the affiliation agreement, the board of directors of Northwestern Healthcare Network was appointed by the Council of Governors, which was comprised of representatives of the member hospitals. (CX 1780 at 12). The Network's Council of Governors retained authority to remove any member of the Network's board of directors. (CX 1780 at 14). Furthermore, the Network did not have complete discretion to remove the directors or the chief executive officers of the individual member hospitals. (CX 1831 at 13).

210. Phase II started in 1993. (Neaman, Tr. 967). The Network received Hart-Scott-Rodino approval when it moved into this Phase. (Neaman, Tr. 1360).

**Response to Finding No. 210:**

The finding is irrelevant in that it relates only to purported actions of the Federal

Trade Commission under the Hart-Scott-Rodino Act, 15 U.S.C. § 18a, and actions taken by the Federal Trade Commission pursuant to 15 U.S.C. § 18a are irrelevant in evaluating any action by the Federal Trade Commission under Section 7 of the Clayton Act, 15 U.S.C. § 18. Furthermore, to the extent that Respondent refers to any action by the Federal Trade Commission as an “approval” of the transaction under the Hart-Scott-Rodino Act, 15 U.S.C. § 18a, Respondent’s statement is misleading in that the Act, which sets forth the obligations of private parties to notify the Federal Trade Commission and the Department of Justice of certain transactions, does not establish standards for either agency to approve (or disapprove) a transaction. Failure of an agency to challenge a transaction is not to be construed as the agency’s approval of that transaction.

211. During Phase II, the Network had the reserved power and authority to appoint institution directors and remove directors and the CEOs of the member institutions for cause. (CX 1780 at 15-16; Neaman, Tr. 974-77; CX 1831 at 13; Newton, Tr. 458). The Network also had the additional reserved power to direct asset transfers by the member institutions to the extent necessary to accomplish Network goals and objectives. (CX 1780 at 18).

**Response to Finding No. 211:**

The finding is incomplete. Respondent neglects to mention that the Northwestern Healthcare Network had very limited discretion to terminate the terms of directors and the employment of the chief executive officers of the individual member hospitals. (CX 1831 at 13). In particular, while the Network could terminate the terms of directors or the employment of chief executive officers, for gross misconduct and criminal activity, it could not terminate the terms of directors or the employment of chief executive officers at its discretion simply because it disagreed with the business decisions of the directors or chief executive officers. (CX 1831 at 13). As a result, the directors and chief executive officers of each member hospital retained significant discretion in their decision-making.



(CX 1831 at 13; CX 1780 at 6, 8, 10).

Furthermore, the Network Affiliation Agreement restricted the authority of the Network to transfer assets of any individual member hospital. (CX 1777 at 62). Under the Network Affiliation Agreement, a member hospital could withdraw from the Network if the Network attempted to impose certain obligations to transfer assets to another member of the Network. (CX 1831 at 9).

212. Once Phase II was initiated, there were a number of financial and operating mechanisms that needed the approval of the Network and the Network's Board. (Neaman, Tr. 969-70). For example, hospital budgets were modified as a result of discussions with the Network. (CX 6306 at 6-7 (Mecklenburg, Dep.)).

**Response to Finding No. 212:**

The finding is misleading and incomplete. Respondent implies that the Northwestern Healthcare Network had actual control over the individual member's financial operations. In reality, each institution developed its own budget and operated independently. (CX 6307 at 12 (Schelling, Dep.)). Under the Network Affiliation Agreement, the Network hospitals were autonomous in their financial operations. (CX 1777 at 50. See CX 6307 at 12-13 (Schelling, Dep.)). Furthermore, a member hospital could unilaterally withdraw from the Network for imposing certain financial obligations on the other member hospitals. (CX 1831 at 9-10).

In addition, the Network did not have the authority to liquidate a member hospital or to require a member hospital to transfer its assets to the Network. Instead, even during Phase II, the affiliation agreement specifically limited the amount of capital a member hospital could be required to transfer to the Network, either in any year or in the first five years of Phase II. (CX 1780 at 48).

213. The Network Board reviewed and commented on hospital expansion plans. (CX

6307 at 16-17 (Schelling, Dep.)).

**Response to Finding No. 213:**

The finding is incomplete. Respondent neglects to mention that each member hospital developed its own program expansion plans and remained autonomous. (CX 6307 at 12-13 (Schelling, Dep.)). Furthermore, a member hospital could unilaterally withdraw from the Network for imposing certain financial obligations on the other member hospitals. (CX 1831 at 9-10).

214. Evanston Hospital also submitted budget summaries to the Network. (RX 182 at ENHL HJ 3672-76).

**Response to Finding No. 214:**

The finding is incomplete. Respondent implies that the Northwestern Healthcare Network had actual control over the individual member's financial operations. Each institution, including Evanston, developed its own budget and operated independently. (CX 6307 at 12-13 (Schelling, Dep.)). Each individual hospital member of the Northwestern Healthcare Network agreed to exercise autonomy in its financial operations. (CX 1777 at 50). Furthermore, a member hospital could unilaterally withdraw from the Network for imposing certain financial obligations on the other member hospitals. (CX 1831 at 9-10).

215. The Network reviewed its member hospitals' "keys to success" for each hospital, new programs and Network initiatives. (RX 182 at ENHL HJ 3673).

**Response to Finding No. 215:**

The cited source does not say what Respondent's finding claims. The ENH Fiscal Budget Summary for 1997 simply states that ENH would undertake certain actions as "Keys to Success," and "New Programs/Activities." (RX 182 at ENHL HJ 3673).

However, the "Network Initiatives" were unrelated to ENH's own "Keys to Success" and "New Programs/Initiatives." (RX 182 at ENH HJ 3673).

216. The Network also pursued an employee benefits project that would cover the employee benefits for the member institutions and yield millions of dollars in savings. (RX 182 at ENHL HJ 3677-78).

**Response to Finding No. 216:**

The cited source does not say what Respondent's finding claims. The document cited by Respondent outlines a proposal, to establish a health plan for all employees of hospitals that were members of Northwestern Healthcare Network, that was merely at the "development" stage. (RX 182 at ENHL HJ 3679). That project was unsuccessful, however. Each member of the Northwestern Healthcare Network maintained its individual self-funded health insurance programs for its employees. (CX 6307 at 22 (Schelling, Dep.)).

217. Even when the Network did not directly exercise its powers, there was significant discussion about individual hospital actions and decisions at the Network level. (CX 6306 at 8 (Mecklenburg, Dep.)). Gary Mecklenburg, who served as the Network's President and CEO for approximately four years and was the CEO of Northwestern Memorial, did not recall any member that was "not committed to the exercise of the reserved powers." (CX 6306 at 15 (Mecklenburg, Dep.)).

**Response to Finding No. 217:**

The finding is misleading and incomplete. Respondent implies that the Network had central authority and that the members were committed to the exercise of that authority. The Northwestern Healthcare Network was not effective because the individual hospitals were unwilling to give up any of their autonomy. (CX 1777 at 49, 52; CX 6305 at 6 (Stearns, Dep.)). Under the Network Affiliation Agreement, the governing boards of each of the hospitals retained "local autonomy and control." (CX 1777 at 68). Furthermore, the member hospitals were not committed to the exercise of

the reserved powers inasmuch as the Council of Governors, comprised of representatives of the member hospitals, voted to dissolve the Network rather than permit the Network to exercise its reserved powers. (CX 2231 at 4).

218. Member hospitals invested a great deal of resources in developing the Network. (CX 6306 at 17 (Mecklenburg, Dep.)). In part, these resources were invested through member hospital contributions to the operating budget. (CX 6306 at 17 (Mecklenburg, Dep.)).

**Response to Finding No. 218:**

This finding is incomplete. Mr. Mecklenberg testified that he did not recall the sunk costs or any asset transfer to the Northwestern Healthcare Network. (CX 6306 at 17 (Mecklenberg, Dep.)).

**3. Managed Care Contracting By The Network**

219. The Network negotiated contracts for the provision of hospital services by its member hospitals with the International Brotherhood of Teamsters, Health Network, Great West and MultiPlan. (CX 6307 at 18 (Schelling, Dep.)).

**Response to Finding No. 219:**

The finding is incomplete. Mrs. Schelling further testified that the Network employed the "messenger model" in negotiating these contracts. (CX 6307 at 18 (Schelling, Dep.)). *See also* Statements of Antitrust Enforcement Policy in Health Care, Statement 9(c) (August, 1996)). Under the messenger model, the financial terms of the contract between the payer and the member hospital were negotiated separately by the payer and each individual hospital. Thus, the Network did not negotiate the pricing with the Teamsters or with each individual managed care organization. The Network did not have the authority to enter into a contract binding on the individual member hospitals, which retained the authority to enter into a contract or to refuse to enter into a contract with each individual managed care organization. (CX 6307 at 18, 20-21 (Schelling,

Dep.)).

220. The Network also negotiated and entered an agreement with North American Medical Management (“NAMM”), which “set out sort of a baseline of what the downstream documents would be with the local providers.” (CX 6307 at 6 (Schelling, Dep.)). Based on this agreement, each member institution had the option to enter into a direct contract with NAMM. (CX 6307 at 6 (Schelling, Dep.)).

**Response to Finding No. 220:**

The finding is incomplete. Respondent neglects to mention that the Network did not have the authority to contract with the North American Medical Management (“NAMM”) on behalf of its members. Instead, each individual member of the Network retained discretion in deciding whether to contract with NAMM to provide contract administration services, and not all members of the Network chose to enter into a contract with NAMM. (CX 6307 at 6-7 (Schelling, Dep.)). The members of the Network that did contract with NAMM did not jointly enter into contracts, but instead retained the discretion to contract or to refuse to contract with NAMM. (CX 6307 at 6-7 (Schelling, Dep.)).

221. The Network also previewed and pre-selected a credentialing firm for use by physicians affiliated with Network member institutions. (CX 6307 at 8 (Schelling, Dep.)).

**Response to Finding No. 221:**

The finding is incomplete. Respondent neglects to mention that the Northwestern Healthcare Network did not exercise the authority to contract with a credentialing firm on behalf of the member hospitals. Instead, the Network negotiated the contract, and each member hospital exercised discretion to decide whether to contract with the credentialing group or not to do so. (CX 6307 at 8-9 (Schelling, Dep.)).

222. The Network, however, had only relatively minor successes in negotiating with MCOs. (Neaman, Tr. 966). One of the agreements the Network was able to negotiate was a capitated Home Health services agreement with Humana. (CX 6307 at 5 (Schelling, Dep.)).

**Response to Finding No. 222:**

Respondent mischaracterizes the testimony of Mr. Neaman and Ms. Schelling. While Mr. Neaman testified that the Network had “relatively minor successes” in negotiating contracts with MCOs, Ms. Schelling testified that the Humana contract was the *only* contract negotiated by the Northwestern Healthcare Network that provided for a capitated rate and risk-sharing among the Network members. (Neaman, Tr. 966; CX 6307 at 5 (Schelling, Dep.)). Furthermore, this contract was for home health services and not acute care hospital services, and it is uncertain whether all members participated in this contract. (CX 6307 at 5 (Schelling, Dep.)).

223. The Network also engaged in extensive discussions with Chicago HMO to negotiate a capitated agreement. (CX 6307 at 5 (Schelling, Dep.)). Although the Network successfully negotiated a base contract, the agreement was never signed. (CX 6307 at 5 (Schelling, Dep.)).

**Response to Finding No. 223:**

Respondent mischaracterizes the facts relating to the negotiation of the contract with Chicago HMO. Because, as Respondent acknowledges, an agreement was never signed, it is inappropriate to characterize the Network’s negotiations as “successful.” (CX 6307 at 5 (Schelling, Dep.)).

**4. Failures And Limitations Of The Network**

224. By 1998, the Network had evolved into a “trade association.” (Neaman, Tr. 1008). As a “trade association,” the Network consisted of a general grouping of hospitals designed to support the general well-being of the association. (Neaman, Tr. 1008-09).

**Response to Finding No. 224:**

The finding is incomplete. In the remainder of the cited authority, Mr. Neaman agreed that the Network moved away from its initial attempt to become a strong, centrally managed and centrally run organization that would make decisions on behalf of all of its

members. (Neaman, Tr. 1009). Rather, as a trade association, it had much lower goals in terms of its authority and what it was trying to achieve. (Neaman, Tr. 1009).

225. The Network possessed the power to enforce the principle of unified action among its members, but the Network did not act in accordance with that principle. (Hillebrand, Tr. 1788-89). The Network looked better on paper than it did in real life. (Hillebrand, Tr. 1789).

**Response to Finding No. 225:**

The finding is misleading in that it implies that the Northwestern Healthcare Network had control over its members. The Network was not effective because the individual member hospitals were unwilling to give up any of their autonomy. (CX 1777 at 49, 52; CX 6305 at 6 (Stearns, Dep.)). Under the Network Affiliation Agreement of the Northwestern Healthcare Network, the governing boards of each of the hospitals retained "local autonomy and control." (CX 1777 at 50, 52, 68). The individual members of the Network retained the authority to refuse to be bound by contracts negotiated by the Network. (CX 6306 at 9-10 (Mecklenburg, Dep.); CX 1802 at 3). Furthermore, a member hospital could unilaterally withdraw from the Network for imposing certain financial obligations on the member hospital. (CX 1831 at 9-10).

226. The Network ultimately had limited success negotiating contracts with MCOs, in part, because it could not bring together the members for contract negotiations. (Neaman, Tr. 965-66). Some members were not convinced the Network could get better terms from MCOs and, instead, negotiated independently. (Neaman, Tr. 966). For example, Mecklenburg felt that managed care contracting decisions should be left to the individual member hospitals. (Neaman, Tr. 986). Mecklenburg recognized that there was no evidence in the Chicago area market that large networks would negotiate more favorable prices than smaller individual hospitals. (RX 177 at NHN 115).

**Response to Finding No. 226:**

Respondent mischaracterizes the statement by Mr. Mecklenburg in RX 177 at NHN 115. Mr. Mecklenburg made no reference to a "Chicago area market." The finding is also misleading because it assumes a "Chicago area market." Respondent cites

no support for this "market." Furthermore, the finding is incomplete. The Northwestern Healthcare Network lacked the authority to bring together the members for contract negotiations. The managed care organizations and each hospital retained complete discretion in negotiating the contracts, and the Network did not exercise contracting authority on behalf of its members. (CX 6307 at 21-22 (Schelling, Tr. Dep.)). The individual members of the Network retained the authority to refuse to be bound by contracts negotiated by the Network. (CX 6306 at 9-10 (Mecklenburg, Dep.); CX 1802 at 3). Moreover, a member hospital could unilaterally withdraw from the Network for imposing certain financial obligations on the other member hospitals. (CX 1831 at 9-10).

227. Similarly, the Network's inability to get its members to work in a unified fashion rendered it unable to achieve the hoped-for cost reductions. (CX 6306 at 4 (Mecklenburg, Dep.); RX 183 at NHN 81).

**Response to Finding No. 227:**

The finding is incomplete. The Northwestern Healthcare Network hoped to gain these cost reductions through increased bargaining power. Through formation of the Northwestern Healthcare Network, its members, including ENH and HPH, aimed to increase bargaining power versus health plans by negotiating jointly and combining the bargaining strength of the individual members to get a better price. (Neaman, Tr. 965 (unified contracting through NHN hopefully would result in better terms than individual negotiations)). This was a specific goal discussed by Mr. Neaman of ENH and Mr. Spaeth of HPH at Network meetings and internally. (Spaeth, Tr. 2194-96; CX 1802 at 2 (HPH joined NHN for "leverage"); CX 1802 at 3 (Mr. Neaman's belief that the reason for joining the Network was to get better pricing than negotiating alone)). Furthermore, a member hospital could unilaterally withdraw from the Network for imposing certain



financial obligations on the other member hospitals. (CX 1831 at 9-10).

228. The Network was formed for a specific purpose and in anticipation of a specific marketplace. But the marketplace did not form as anticipated, and so the Network was not delivering value the way that its members had anticipated that it would. (CX 6306 at 13 (Mecklenburg, Dep.)).

**Response to Finding No. 228:**

The finding is incomplete. Respondent neglects to mention the specific purpose for which the Network was formed. The specific purpose for which the Network was formed was to increase the bargaining power of the member hospitals to get better term such as pricing. (Neaman, Tr. 963-65; CX 1802 at 2-3. *See* CCRFF 227).

229. The cost of running the Network outweighed the value received from the Network. So the question arose as to whether the Network could generate enough value, whether it was managed care contracting or other activities. (CX 6306 at 12 (Mecklenburg, Dep.)).

**Response to Finding No. 229:**

Complaint Counsel have no specific response.

230. The Network dissolution agreement was dated December 20, 1999, but went into effect in January 2000. (Neaman, Tr. 1016). All members of the Network voted to dissolve the Network. (Neaman, Tr. 1017).

**Response to Finding No. 230:**

The finding is incomplete. Respondent neglects to mention all the dates relevant to the dissolution of the Northwestern Healthcare Network. In an August 3, 1999, board meeting, the ENH board of directors voted unanimously to authorize the termination of the Northwestern Healthcare Network effective October 31, 1999. (CX 872 at 7). The Lakeland Health Services board of directors voted on August 23, 1999, to approve the dissolution of the Northwestern Healthcare Network. (RX 592A at ENH RS 000880-81). The Northwestern Healthcare Network members authorized the dissolution of the Network on October 26, 1999. (CX 1833 at 2). The articles of dissolution were adopted

by the Northwestern Healthcare Network on December 22, 1999. (CX 1833 at 2).

**B. NH North**

231. HPH and Evanston Hospital discussed a further collaboration as far back as 1996. (CX 6305 at 7 (Stearns, Dep.); Neaman, Tr. 1017-18). These discussions between HPH and Evanston Hospital were conducted under the auspices of the Network and also involved Northwest Community Hospital. (CX 6305 at 7 (Stearns, Dep.); Neaman, Tr. 1017-18).

**Response to Finding No. 231:**

Complaint Counsel have no specific response.

232. The entity that would be created as the result of the proposed merger of HPH, Evanston Hospital and Northwest Community would have been called NH North. (Neaman, Tr. 1017-18).

**Response to Finding No. 232:**

Complaint Counsel have no specific response.

233. One "principle" of NH North was to be "an entity that differentiates its product, its brand and is indispensable to the marketplace." (CX 395 at 2). The idea behind this branding strategy was to use name-brand to differentiate NH North in such a way that it would make the NH North very distinctive and very desirable in the minds of customers. (Neaman, Tr. 1363-64).

**Response to Finding No. 233:**

Complaint Counsel have no specific response.

234. An August 1996 planning document for NH North prepared by Neaman and Hillebrand similarly explained that for NH North to achieve "market influence" and "indispensability," it had to achieve "differentiation" and "cost leadership." (CX 394 at 13; Neaman, Tr. 1018-19; Hillebrand, Tr. 1790). According to the planning document, "differentiation" was to be achieved through "superior outcomes," "brand equity" and "best physicians." (CX 394 at 13; Hillebrand, Tr. 2020). "Cost leadership" was to be achieved through reducing "cost per unit of care," "develop[ing] pathways" and "hospital & physicians common incentives." (CX 394 at 13; Hillebrand, Tr. 2020-21).

**Response to Finding No. 234:**

Respondent's finding is incomplete. Part of the "market influence" goal was for NH North to capture "30-40% of key health plans." (CX 394 at 13). A revenue-side goal for NH North was to "increase market leverage." (Cx 394 at 3; Hillebrand, Tr. 1790).

Increasing market leverage would provide the potential for ENH to obtain higher prices from health plans. (Hillebrand, Tr. 1790-91). Through the proposed NH North merger, ENH aimed “to increase market share and obtain premium sustainable pricing through managed care contracting.” (CX 395 at 1).

235. As used in the August 1996 NH North planning document, the word “indispensability” meant that the customer would view NH North as the system of choice for healthcare as a result of NH North having the best outcomes, the best service, the best physicians and the highest valued brand. (Hillebrand, Tr. 2021).

**Response to Finding No. 235:**

Respondent’s finding is misleading and incomplete. In the NH North planning document, “indispensability” was listed under “market influences” along with “30-40% of key health plans,” “sole contracting authority,” and “hospital-physician partnerships.” (CX 394 at 13). Factors such as “superior outcomes,” “brand equity,” and “best physicians” were listed under “differentiation” as part of the strategy of “winning as an integrated provider.” (CX 394 at 13).

236. Another goal of NH North was to make the NH North brand “stand for the right attributes in consumers’ minds.” (CX 393 at 14).

**Response to Finding No. 236:**

Complaint Counsel have no specific response.

237. Bain & Company (“Bain”), a consulting firm, was involved in strategizing for NH North. (Neaman, Tr. 1024). Bain listed two “key tactics” that should be used by NH North to “gain incremental market share.” (RX 477 at ENH JH 349). The two “key tactics” were: (1) “improved/coordinated physician recruitment and development”; and (2) “developing and leveraging brand name.” (RX 477 at ENH JH 349).

**Response to Finding No. 237:**

Respondent’s finding is incomplete. Bain also emphasized the “marketshare ‘clout’ (30-50%)” that the proposed merger would generate. (CX 393 at 1). Bain

recommended “unified contracting” among the three entities in order to “squeeze out independent hospitals” and “to obtain capitation/price premiums.” (CX 66 at 23).

Indeed, in the context of the NH North strategy, Bain counseled Evanston to “take share from independents (e.g., Condell)” and to be prepared “to act aggressively when opportunity presents itself to buy and close a weak competitor.” (CX 66 at 17).

238. NH North documents make it clear that it was not designed to succeed where the Network was failing. (RX 132 at ENH JH 274). A 1996 document stated: “must identify key linkages (and no duplication to NHN). Example, managed care contracting to be in conjunction with NHN. Everything else at local level.” (RX 132 at ENH JH 274).

**Response to Finding No. 238:**

Respondent’s finding is incomplete. As early as 1994, some members of the Northwestern Healthcare Network viewed the Network as a weak, non-cohesive organization (Neaman, Tr. 977-78), without a strong brand identity. (CX 6307 at 25 (Schelling, Dep.)). The NH North participants aimed to establish “unified contracting” among the three entities in order “to obtain capitation/price premiums.” (CX 66 at 23). By contrast, the Network was ineffective on the managed care contracting front. (Neaman, Tr. 966).

239. The three-way discussions between HPH, Evanston Hospital and Northwest Community with regard to the creation of NH North broke down in 1997 as the result of differences over the proposed merged entity’s organization (such as the composition of the board), personality conflicts and a lack of interest on the part of Northwest Community. (CX 6305 at 9 (Stearns, Dep.); Neaman, Tr. 1035; Hillebrand, Tr. 1791-92).

**Response to Finding No. 239:**

Complaint Counsel have no specific response.

**C. Other Failed Merger Negotiations And Failed Joint Ventures Involving HPH**

240. HPH started thinking about aligning with another hospital, through a joint venture or otherwise, as early as 1986. (Spaeth, Tr. 2264). During the mid-1980s, HPH discussed the possibility of merging with both Lake Forest Hospital and Condell and also discussed the

possibility of linking with the Mayo Clinic. (Spaeth, Tr. 2265). HPH's merger discussions in the 1980s eventually evolved into HPH joining the Network. (Spaeth, Tr. 2264-65).

**Response to Finding No. 240:**

Complaint Counsel have no specific response.

241. HPH first considered aligning with other hospitals through joint ventures in the late 1980s and early 1990s. (Spaeth, Tr. 2267). Overall, HPH sought to align with other hospitals because its Board and Spaeth knew that HPH would have a difficult time competing as a stand-alone institution. (Spaeth, Tr. 2266).

**Response to Finding No. 241:**

Respondent's finding that HPH's Board "knew that HPH would have a difficult time competing as a stand-alone institution" is contradicted by other record evidence. In the years before the merger, Highland Park's board and management consistently contemplated and made plans for a stand alone, "status quo" option in which Highland Park would not merge with another institution. (See, e.g., CX 1055 at 1 (Highland Park's strategic and financial plans "developed assuming no affiliation with another provider were to occur"); Spaeth, Tr. 2145-46 (plans set forth goals for "going forward without a merger"); CX 1869 at 5-6 (outlining benefits for stand-alone growth strategy)). In addition, Highland Park during the Evanston merger negotiations emphasized that it did not have a financial need to merge with Evanston. (CX 1923 at 2). In any event, HPH could have continued as a stand-alone competitor without the merger (CCFF 302-367), and was an attractive candidate for other mergers. (CCFF 368-372).

242. As the 1990s progressed, bringing capital to HPH became a major factor in seeking to align with another hospital. (Spaeth, Tr. 2266). Had HPH remained independent, it may have had enough capital to survive short-term, but it would have needed to link with another hospital if it ultimately were to thrive and benefit the Highland Park community. (Spaeth, Tr. 2272).

**Response to Finding No. 242:**

Respondent's finding is contradicted by other record evidence. Both the HPH board and management believed that Highland Park was financially strong in 1999 and for the foreseeable future. (CX 1055 at 3 (Highland Park "can remain financially strong over the foreseeable future.")). The management and board anticipated that Highland Park's income would grow (CX 1055 at 2 (projecting increased net revenues)), its debt would decline (CX 1903 at 1 (projecting reduction in long-term debt)), and its operating margin would increase from 1999 into the future (CX 1055 at 2 (setting forth higher operating margin forecasts)). They also believed that Highland Park would be able to make necessary capital investments, as well as create new strategic initiatives to further increase operating revenue. (CX 1903 at 1, 3 (outlining \$79 million in planned capital expenditures as well as \$28 million for strategic initiatives)). The 1999-2003 Highland Park financial plan emphasized that "[e]xisting cash and investments are available to fund strategic initiatives and generate new programs." (CX 545 at 3).

243. During this period, academic affiliation also was a factor in HPH's consideration of alignments with other hospitals because HPH wanted to give its community something beyond the quality of care provided by a community hospital. (Spaeth, Tr. 2267).

**Response to Finding No. 243:**

The finding is incomplete. Respondent neglects to mention that { [REDACTED]

[REDACTED]

[REDACTED] } (CCFF 2290-2293, *in camera*).

244. To this end, HPH had discussions with Northwestern Memorial concerning a potential merger, but the discussions did not progress beyond the initial stages. Northwestern Memorial was not responsive to HPH's inquiries. (Spaeth, Tr. 2270-71).

**Response to Finding No. 244:**

Complaint Counsel have no specific response.

245. Spaeth also spoke with Advocate senior executives about the possibility of linking. But, after initial discussions, HPH determined that Advocate was not the best fit because Advocate's religious affiliation might have affected patient care in the Highland Park community. (Spaeth, Tr. 2271-72).

**Response to Finding No. 245:**

Complaint Counsel have no specific response.

246. HPH also considered merging with a for-profit hospital, but HPH's board felt very strongly that HPH should remain a community hospital and not become a part of a for-profit corporation. (Spaeth, Tr. 2272).

**Response to Finding No. 246:**

Respondent's finding is irrelevant as to whether Highland Park's preferences regarding a merger with a for- or non-profit hospital.

247. As of May 1997, Spaeth and Neaman had talked about a variety of ways by which HPH and Evanston Hospital might "align," including through joint ventures for oncology and cardiac surgery. (Spaeth, Tr. 2202). Spaeth's general view, however, was that joint ventures suffered from a general lack of commitment. (Spaeth, Tr. 2269). According to Spaeth, "joint ventures' are confusing, lead to mistrust, and are full employment acts for accountants, lawyers, and consultants." (CX 1865 at 6; Spaeth, Tr. 2269).

**Response to Finding No. 247:**

Respondent's finding is incomplete. HPH continued to formulate plans with other institutions to create joint development projects and ventures, including with Evanston in cardiac surgery and oncology services. (See CCRFF 249). Indeed, HPH and Evanston actually signed an agreement to develop a joint cardiac surgery program at HPH in April 1999, prior to the agreement to merger. (See CCF 2357-60).

248. As further explained by HPH's former Vice President of Planning and Marketing, Mark Newton, joint ventures between medical institutions can be problematic because there may not be an alignment of business strategies or cultures. (Newton, Tr. 449). And joint ventures also can be difficult to operationalize. (Newton, Tr. 449).

**Response to Finding No. 248:**

Respondent's finding is incomplete. HPH continued to formulate plans with other

institutions to create joint development projects and ventures, including with Evanston in cardiac surgery and oncology services. (See CCRFF 249). HPH and Evanston moved forward with the cardiac surgery partnership and signed an agreement in April 1999, prior to the agreement to merger. (See CCF 2357-60).

249. During this same time frame, Mecklenburg likewise expressed his distrust of joint ventures, writing to Spaeth that joint ventures similar to a proposed HPH-Northwestern Memorial oncology program did not have a good history. (CX 1866 at 5; Spaeth, Tr. 2270).

**Response to Finding No. 249:**

Respondent's finding is incomplete. The cited exhibit (CX 1866) contains a September 1997 letter from Mark Neaman to Mr. Spaeth expressing enthusiasm for creating joint programs between Evanston and Highland Park in oncology and cardiac surgery. (CX 1866 at 2-4). Mr. Neaman wrote that Evanston "remain[s] enthusiastic about the opportunity of developing a [joint] cardiac surgery program." (CX 1866 at 2). Mr. Neaman also noted that Evanston's "interest and expertise in developing an oncology program with you, along the same lines as with cardiac surgery, is extremely high." (CX 1866 at 3). HPH and Evanston moved forward with the cardiac surgery partnership and signed an agreement in April 1999, prior to the agreement to merger. (See CCF 2357-2360).

250. See Section IX.B.4 for additional findings concerning HPH's failed joint ventures and merger negotiations.

**Response to Finding No. 250:**

Respondent cites no support for this finding. This is contrary to the judge's April 6, 2005, Order on Post Trial Briefs stating that each proposed finding shall have a valid and correct cite to the record. Furthermore, this is not a finding of fact. In any event, Complaint Counsel likewise have set forth reply findings addressing HPH's joint



ventures and merger negotiations in Section IX.B.4.

#### IV. THE MERGER

##### A. Merger Negotiations

##### 1. Initial Merger Discussions

251. After the NH North merger discussions broke down in 1997, some members of the Network Board suggested that Evanston Hospital's then-chairman of the Board, Jerry Pearlman, reinitiate discussions with HPH. (CX 6305 at 8 (Stearns, Dep.)). Pursuant to that suggestion, Pearlman contacted Stearns and explained that if HPH were interested and willing to resume linkage discussions, Evanston Hospital likewise would be interested. (CX 6305 at 8 (Stearns, Dep.)). After Pearlman contacted Stearns, Stearns informed the HPH Board, and the Board authorized HPH to enter into exploratory linkage discussions with Evanston Hospital. (CX 6305 at 8 (Stearns, Dep.)).

##### **Response to Finding 251:**

Complaint Counsel have no specific response.

252. Subsequently, Evanston Hospital and HPH started discussing a merger solely between the two hospitals. (Neaman, Tr. 1035; Spaeth, Tr. 2206).

##### **Response to Finding 252:**

Complaint Counsel note that the discussions for the Evanston-HPH merger began in earnest in late 1998. (See CX 1879 (HPH's November 1998 response to Evanston's merger proposal)).

253. Evanston Hospital and HPH were required under the Network Affiliation Agreement to seek approval from the Network Board of Directors for the proposed merger since both hospitals were members of the Network. (RX 562). Pre-Merger planning documents show that the proposed merger between Evanston Hospital and HPH was not designed to replace the Network. (RX 288 at ENH RS 1031-32; RX 518 at ENH GW 2063; RX 558 at ENH RS 7725). To the contrary, in April 1999, the Evanston Hospital executive committee was informed that one "strategic rationale" for the Merger with HPH was to "strengthen network presence." (RX 518 at ENH GW 2063).

##### **Response to Finding 253:**

In part given the limited role played by the Network in the mid to late 1990s, Respondent's finding is incomplete and misleading. As early as 1994, some saw NHN as a weak, non-cohesive organization, (Neaman, Tr. 977-78), without a strong brand

identity. (CX 6307 at 25 (Schelling Dep.)). Mr. Neaman testified that by 1998, NHN had evolved into more of a general grouping of hospitals, becoming like a trade association, rather than a centralized organization. (Neaman, Tr. 1008). The members decided to terminate NHN in the late 1990s. In the absence of full integration, the Network members decided NHN's future was not necessary. (CX 6306 at 7 (Mecklenburg Dep.)). In June 1999, the NHN board voted to dissolve the Network and implemented plans to "close down" the Network by October 31, 1999. (CX 2231 at 4).

254. On June 29, 1999, HPH sought permission to move forward with the Merger. (RX 562). HPH explained to the Network that the two hospitals were "very excited about the opportunities the merger presents to enhance and expand services for [Evanston Hospital and Highland Park's] respective patient communities." (RX 562).

**Response to Finding 254:**

Respondent's finding is incomplete, misleading and irrelevant. There is no requirement of proving an anticompetitive intent in a merger case. Furthermore, Respondent's finding regarding the parties' purportedly philanthropic or innocent intentions is misleading in implying that the merging parties' motive in merging was philanthropic or innocent. Even if, *arguendo*, the merging parties had one or more philanthropic or innocent motives, they were by no means the only motives. HPH aimed to eliminate competition between it and Evanston and increase the combined entity's bargaining leverage against health plans. (See CCRFF 2306).

255. Pearlman, Homer Livingston (Chairman of the ENH Board from 2000 through 2004), Lester Knight III, Mikesell Thomas, William White and Dan Toll represented the Evanston Hospital Board during Merger negotiations. (RX 636 at ENH GW 5701; Styer, Tr. 4965; see (CX 6305 at 8 (Stearns, Dep. ))).

**Response to Finding 255:**

Complaint Counsel have no specific response.

256. Neele Stearns, Harvey Medvin, Stan Golder and James Styer represented the HPH board during Merger negotiations. (Styer, Tr. 4964; (CX 6305 at 8 (Stearns, Dep.)).

**Response to Finding 256:**

Complaint Counsel have no specific response.

257. Neaman led the Merger discussions from Evanston Hospital's side, while Spaeth led HPH's efforts. (Neaman, Tr. 1320; Spaeth, Tr. 2283).

**Response to Finding 257:**

Complaint Counsel have no specific response.

258. Neaman had overall responsibility for the Merger and the subsequent Merger integration. (Neaman, Tr. 955).

**Response to Finding 258:**

Complaint Counsel have no specific response.

**2. Letter Of Intent**

259. The Merger discussions resulted in a Letter of Intent, which became effective July 1, 1999. (RX 567; Neaman, Tr. 1328; Spaeth, Tr. 2273-74). The purpose of the Letter of Intent was to identify a series of service enhancements HPH desired for its community – such as a multidisciplinary and comprehensive oncology program, a cardiac surgery program, an academic linkage, and the creation of a community trust, among many others. (Spaeth, Tr. 2274; Styer, Tr. 4968; RX 518 at ENH GW 2084). This Letter of Intent thus emphasized specific commitments by Evanston Hospital to improve the quality of care at HPH for the benefit of the Highland Park community. (Spaeth, Tr. 2274; CX 6305 at 9-10 (Stearns, Dep.)).

**Response to Finding 259:**

Respondent's finding is misleading and incomplete. The Letter of Intent outlined several principles for the merger, including economic ones. For example, the parties recognized that "changing market dynamics, enhanced competition, reductions in reimbursement and other factors require a more locally integrated approach to achieve identified patient care and economic successes in the markets served by ENH and HPH." (RX 567 at ENH MN 1365). In addition, HPH pre-merger already had a pre-existing

oncology program and was looking to expand their services through partnerships that did not involve a merger. (See CCF 2374-2380). Pre-merger, Highland Park also had a foundation serving the HP community. (Newton, Tr. 283).

In any event, Respondent's finding generally is incomplete, misleading and irrelevant. There is no requirement of proving an anticompetitive intent in a merger case. Furthermore, Respondent's finding regarding the parties' purportedly philanthropic or innocent intentions is misleading in implying that the merging parties' motive in merging was philanthropic or innocent. Even if, *arguendo*, the merging parties had one or more philanthropic or innocent motives, they were by no means the only motives. HPH aimed to eliminate competition between it and Evanston and increase the combined entity's bargaining leverage against health plans. (See CCRFF 2306).

For its part, Evanston's pre-merger strategic documents and testimony from ENH senior managers show that Evanston's goals through the merger were the same:

- "[T]o join forces and grow together rather than compete with each other" (CX 2 at 7);
- To "not 'compete with self'" (CX 1 at 3);
- To "strengthen negotiation capability with managed care companies through merged entities" (CX 1 at 3);
- { [REDACTED] } (CX 1566 at 9; Neaman, Tr. 1138, *in camera*; RX 2015 at ENHL MO 003485);
- { [REDACTED] } (CX 1566 at 9; Neaman, Tr. 1138, *in camera*; RX 2015 at ENHL MO 003485);

- To make the merged entity “indispensable to marketplace” (CX 19 at 1);
- To get better prices and better terms on contracts with health plans (Neaman, Tr. 1036).
- To achieve “negotiating strength as a combined system of 3 hospitals.” (RX 704 at ENH HJ 001645).

260. Specifically, as a condition of HPH agreeing to the Merger, the Letter of Intent required Evanston Hospital to “build a new multi-disciplinary Cancer Center at the HPH campus modeled after the Kellogg Cancer Care Centers at Evanston and Glenbrook.” (RX 567 at ENH MN 1374).

**Response to Finding 260:**

As set forth in CCRFF 259, Respondent’s finding is misleading, incomplete and irrelevant. (See CCRFF 259). In addition, HPH was actively pursuing a joint cancer program with other hospitals, including Evanston, before the merger. (See CCFF 2374-2380).

261. The Letter of Intent also required Evanston Hospital to “establish a cardiac surgery program at HPH by extending the cardiovascular surgery program at ENH.” (RX 567 at ENH MN 1376).

**Response to Finding 261:**

As set forth in CCRFF 259, Respondent’s finding is misleading, incomplete and irrelevant. (See CCRFF 259). In addition, HPH and ENH actually signed an agreement to develop a joint cardiac surgery program at HPH in April 1999, before they agreed to merger. (Rosengart, Tr. 4527-30, 4557; CX 2094. See Also CCFF 2357-2373 (HPH had decided to develop a cardiac surgery program before the merger)).

262. The Letter of Intent further required Evanston Hospital to commit to create what ultimately became the Healthcare Foundation of Highland Park (“Healthcare Foundation”). (RX 567 at ENH MN 1384-85). Such a separate and independent, community-based foundation would support health and social-related activities in the Highland Park area. (RX 385 at FTC-KHA 2284). HPH and Evanston Hospital agreed to establish the Healthcare Foundation

using \$60 million from the old HPH Foundation and another \$40 million from Evanston Hospital. (Styer, Tr. 4969-70). The \$100 million Healthcare Foundation corpus was to be used to support HPH and enhance healthcare in other areas of the community. (Styer, Tr. 4969-70). The creation of the Healthcare Foundation was a critical part of the Merger discussions because HPH wanted to show the Highland Park community that the money the community used to build and fund HPH would remain within the community after the Merger. (Styer, Tr. 4968-69; Kaufman, Tr. 5832-33).

**Response to Finding 262:**

As set forth in CCRFF 259, Respondent's finding is misleading, incomplete and irrelevant. (See CCRFF 259). The finding is also inaccurate. Respondent's finding that Evanston contributed \$40 million to the post-merger Highland Park foundation is contradicted by Mr. Neaman's testimony. Mr. Neaman testified that Evanston and Highland Park discussed several different funding alternatives but that eventually, the foundation was funded entirely by \$100 million of cash and assets previously controlled by Lakeland Health Services (HPH's parent). (Neaman, Tr. 1260-61; CX 84 at 49 (\$100 million principal balance – all from HPH funds)).

More fundamentally, without the merger, the pre-merger foundation's assets would have remained in the corporate structure of Highland Park and been used to the benefit of the Highland Park community. (Kaufman, Tr. 5856). The establishment of a separate post-merger foundation was designed to compensate the Highland Park community for the loss of control following the merger. (Kaufman, Tr. 5855-56). If there were no merger, there would be no loss of control and hence no need to compensate the community. (Kaufman, Tr. 5856).

263. The Letter of Intent detailed a series of "key principles and goals established by the Parties as reasons to support and guide the merger." (RX 567 at ENH MN 1365).

**Response to Finding 263:**

Respondent's finding is misleading, incomplete and irrelevant to the extent that it

implies that the Letter of Intent set forth purely philanthropic and innocent motivations for the merger. As discussed in CCRFF 259, the Letter of Intent outlined several principles for the merger, including economic ones. (See CCRFF 259). In addition, there is no requirement of proving an anticompetitive intent in a merger case, and in any event, both HPH and Evanston had more than philanthropic and innocent motivations for the merger. (See CCRFF 259).

264. These "key principles" included: (1) Approach the merger as partners with a common vision; (2) Pursue a merger between ENH and LHS for the purpose of best serving the healthcare interests and needs of their respective and combined patient communities; (3) Combine the skills and talent of the Parties' respective organizations so as to enhance the ability to mutually achieve the stated patient care and key goals; (4) Develop a coordinated plan between the Parties to achieve growth for the resulting system; (5) Improve the existing clinical services at HPH and develop new specialty services to be rendered on the HPH campus in order to enhance and expand community health, outreach and patient access; (6) Support a plurality of physician practice styles, including the independent practice of medicine as well as the group faculty practice plan, with all current and future physicians being entitled to the same privileges at each site. It is further recognized that physicians, in general, practice primarily at one hospital site, and, hence, a fair and appropriate mechanism will be established on how representation on Committees (including Medical Staff Executive Committee) from physicians practicing primarily at Evanston, Glenbrook, Highland Park Hospitals will occur; (7) Strive to provide quality, cost efficient healthcare services in a manner which promotes and allows local access to the facilities of the Parties and respects a patient's choice of physicians; (8) Use reasonable efforts to see that all employees of the merged entity receive a fair and equitable salary and benefit package; (9) With the exception of Highland Park Hospital Foundation and Highland Park Health Care, Inc., functionally, merge all aspects of the two organizations as much as possible on "day one." Areas not merged "day one" must come together as soon as possible but no later than three years following closing. (RX 567 at ENH MN 1366).

**Response to Finding 264:**

Respondent's finding is misleading, incomplete and irrelevant to the extent that it implies that the Letter of Intent set forth purely philanthropic and innocent motivations for the merger. As discussed in CCRFF 259, the Letter of Intent outlined several principles for the merger, including economic ones. (See CCRFF 259). In addition, there is no requirement of proving an anticompetitive intent in a merger case, and in any event,



both HPH and Evanston had more than philanthropic and innocent motivations for the merger. (See CCRFF 259).

265. The Letter of Intent further detailed the “key goals” of the merger as follows: (1) Grow patient volumes through a collective, coordinated effort, particularly in Lake and northern Cook Counties; (2) Increase the quality and value of clinical services to the respective communities by achieving a greater critical mass of patient volume; (3) Implement the “Evanston Northwestern Healthcare” name brand throughout the merged entity in order to enhance the Parties’ and the merged entity’s reputations and make the resulting healthcare system the provider of choice in the combined healthcare markets. Enhancement of the individual hospital names – “Highland Park Hospital,” “Evanston Hospital,” and “Glenbrook Hospital” – will also be undertaken; (4) Develop new medical office and ambulatory care sites in locations within the combined service area that have relatively low market share and that bring additional strategic value to the system; (5) Enhance the future viability of the HPH campus by strengthening existing programs and developing new clinical services; (6) Maintain each of HPH, Evanston Hospital and Glenbrook Hospital as a separately licensed, fully accredited hospital with the goal of obtaining one Medicare provider number for all; (7) Assure an effective and coordinated merger of the Medical Staffs so as to maintain the highest level of continuity of patient care services while enhancing patient volumes, quality and reputation for all physicians; (8) Strive to achieve cost benefits and economies of scale on a system-wide basis; (9) Establish a fully accredited residency training program with ENH and the Northwestern University Medical School at HPH in Family Medicine and/or other disciplines; (10) Allow HPH patients to access specific ENH specialists and services; (11) Ensure that both HPH and ENH will continue to make a significant organizational commitment to enhancing healthcare services in their respective communities. (RX 567 at ENH MN 1367-68).

**Response to Finding 265:**

Respondent’s finding is misleading, incomplete and irrelevant to the extent that it implies that the Letter of Intent set forth purely philanthropic and innocent motivations for the merger. As discussed in CCRFF 259, the Letter of Intent outlined several principles for the merger, including economic ones. (See CCRFF 259). In addition, there is no requirement of proving an anticompetitive intent in a merger case, and in any event, both HPH and Evanston had more than philanthropic and innocent motivations for the merger. (See CCRFF 259).

266. Evanston Hospital took its commitments in the Letter of Intent seriously. On June 25, 1999, Neaman informed the Evanston Hospital Board of the “requirements” of the Merger. (RX 557 at ENH GW 4252). Neaman explained to the Board that these “requirements” included

an "immediate merger of hospital-based physician groups into ENH Medical Group, expansion of Kellogg Cancer Care Center, additional on-site ambulatory care, cardiac surgery and related programs." (RX 557 at ENH GW 4252-53). Neaman further informed the Evanston Hospital Board on June 25, 1999, that "[a]n investment in marketing support of the ENH name in Lake County and cost improvements in purchasing, systems, 'overhead,' and related cost effective measures will be made." (RX 557 at ENH GW 4253).

**Response to Finding 266:**

Respondent's finding is misleading, incomplete and irrelevant to the extent that it implies that the Letter of Intent set forth purely philanthropic and innocent motivations for the merger. As discussed in CCRFF 259, the Letter of Intent outlined several principles for the merger, including economic ones. (See CCRFF 259). In addition, there is no requirement of proving an anticompetitive intent in a merger case, and in any event, both HPH and Evanston had more than philanthropic and innocent motivations for the merger. (See CCRFF 259). HPH also was actively pursuing and developing cancer and cardiac surgery programs. (See CCRFF 260-261).

Finally, Respondent has not shown that the cost improvements cited in the finding are "merger-specific efficiencies" that could only be achieved by the merger between Evanston and HPH. (Merger Guidelines § 4). If either Evanston or HPH merged with another entity, they may have been able to realize the savings (such as from consolidating administrative operations) without the anticompetitive effect. Respondent has not alleged a cost savings efficiencies defense, and has not shown any savings were actually passed on to consumers. In any event, even assuming, *arguendo*, that certain efficiencies were achieved and passed on, the anticompetitive impacts of the merger substantially outweighed any purported benefits. For example, just from the year 2000 health plan contract re-negotiations alone, ENH increased its net revenues by a minimum of \$18 million annually. (See CCRFF 1329-1337).

267. The provisions of the Letter of Intent discussed above helped put to rest HPH's fears that Evanston Hospital would merely hang its shingle on HPH's door, move HPH's patients to Evanston Hospital and not follow through on the promises to expand services at HPH. (Neaman, Tr. 1329-30; Styer, Tr. 4966-67).

**Response to Finding 267:**

Respondent's finding is misleading, incomplete and irrelevant to the extent that it implies that the Letter of Intent set forth purely philanthropic and innocent motivations for the merger. As discussed in CCRFF 259, the Letter of Intent outlined several principles for the merger, including economic ones. (See CCRFF 259). In addition, there is no requirement of proving an anticompetitive intent in a merger case, and in any event, both HPH and Evanston had more than philanthropic and innocent motivations for the merger. (See CCRFF 259).

268. Simultaneous with the execution of the Letter of Intent, Evanston Hospital and HPH sent a press release to area employers, elected officials, managed care companies and the press describing the goals of the Merger – specifically, the service enhancements Evanston Hospital planned to make at HPH. (RX 563 at ENH TH 1568-76; Hillebrand, Tr. 1857-58). For example, RX 564 is the copy of the press release sent to Blue Cross Blue Shield. (RX 564).

**Response to Finding 268:**

Respondent's finding is misleading, incomplete and irrelevant to the extent that it implies that the Letter of Intent set forth purely philanthropic and innocent motivations for the merger. As discussed in CCRFF 259, the Letter of Intent outlined several principles for the merger, including economic ones. (See CCRFF 259). In addition, there is no requirement of proving an anticompetitive intent in a merger case, and in any event, both HPH and Evanston had more than philanthropic and innocent motivations for the merger. (See CCRFF 259).

269. Evanston Hospital did not know how MCOs would react to the Merger. (RX 609 at EY 172). In its merger due diligence, Evanston Hospital wrote: "Until actual negotiations begin, one can only speculate payor reaction to the combined organization." (RX 609 at EY

172). Evanston Hospital thought that “[a] few payors are likely to take this opportunity to increase downward pressure on rates.” (RX 609 at EY 172).

**Response to Finding 269:**

Respondent’s finding is misleading and incomplete. Evanston also believed that the merged entity could “strengthen negotiating positions with managed care through merged entities and one voice.” (CX 19 at 1; Neaman, Tr. 1039; RX 74 at ENH HJ 001645 (Evanston told Standard and Poor’s that an advantage of the merger would be “negotiating strength as a combined system of 3 hospitals” with managed care.)). One of the goals of the merger with Highland Park was to get better prices and terms from health plans for the post-merger ENH. (Neaman, Tr. 1036). In addition, the merger was seen as an opportunity for the hospitals to “join forces and grow together rather than compete with each other.” (CX 2 at 7). As it turned out, ENH was able to raise prices above-market by utilizing its new found market power. (See CCF 392-393, 739-740).

**B. Reasons For The Merger**

270. The overriding reason for the Merger, from both parties’ perspectives, was to improve healthcare for the communities surrounding the hospitals by upgrading the HPH facility, enhancing HPH’s quality of care, supporting the respective physician practices and extending academic teaching to HPH. (Spaeth, Tr. 2274, 2297; Neaman, Tr. 1322, 1327; Styer, Tr. 4966; RX 288 at ENH RS 1031; RX 385 at FTC-KHA 2281).

**Response to Finding 270:**

Respondent’s finding is incomplete, misleading and irrelevant. There is no requirement of proving an anticompetitive intent in a merger case. Furthermore, Respondent’s finding regarding the parties’ purportedly philanthropic or innocent intentions is misleading in implying that the merging parties’ motive in merging was philanthropic or innocent. Even if, *arguendo*, the merging parties had one or more philanthropic or innocent motives, they were by no means the only motives. HPH and

Evanston both aimed to eliminate competition between themselves and increase their bargaining leverage against health plans. (See CCRFF 259, 2306).

271. Both parties intended for the Merger to expand the breadth and depth of HPH's clinical services by adding services such as cardiac surgery and oncology, as well as by implementing common pathways, protocols and strong physician leadership at all three hospitals. (Styer, Tr. 5027; Neaman, Tr. 1322-23). As discussed below, each party also had its own, additional reasons to merge.

**Response to Finding 271:**

Respondent's finding is incomplete, misleading and irrelevant. There is no requirement of proving an anticompetitive intent in a merger case. Furthermore, Respondent's finding regarding the parties' purportedly philanthropic or innocent intentions is misleading in implying that the merging parties' motive in merging was philanthropic or innocent. Even if, *arguendo*, the merging parties had one or more philanthropic or innocent motives, they were by no means the only motives. Respondent is correct: each did have its own, additional reasons to merge. HPH and Evanston both aimed to eliminate competition between themselves and increase their bargaining leverage against health plans. (See CCRFF 259, 2306). Finally, HPH also was actively pursuing and developing cancer and cardiac surgery programs. (See CCRFF 260-261).

**1. HPH's Reasons For The Merger**

272. In the late 1990s, the HPH Board concluded that it needed to find a merger partner that would: (1) enhance the hospital's ability to serve the community by bringing new programs to HPH that it could not justify creating as an independent institution; and (2) infuse much-needed capital into the hospital. (CX 6305 at 7, 9-10, 15 (Stearns, Dep.)); RX 288 at ENH RS 1031; RX 384 at ENH RS 7196; RX 385 at FTC-KHA 2282; Spaeth, Tr. 2273; RX 683 at ENH RS 7694). The HPH Board was concerned about what would be necessary to sustain the hospital in the future. (CX 6305 at 4 (Stearns, Dep.)).

**Response to Finding 272:**

Respondent's finding is incomplete, misleading and irrelevant. There is no

requirement of proving an anticompetitive intent in a merger case. Furthermore, Respondent's finding regarding the parties' purportedly philanthropic or innocent intentions is misleading in implying that the merging parties' motive in merging was philanthropic or innocent. Even if, *arguendo*, the merging parties had one or more philanthropic or innocent motives, they were by no means the only motives. HPH and Evanston both aimed to eliminate competition between themselves and increase their bargaining leverage against health plans. (See CCRFF 259, 2306).

In addition, HPH did not require Evanston's financial assistance to develop new programs and sustain itself for the future. (See CCRFF 2298-2318). HPH also was an attractive candidate for other mergers. (See CCF 368-372).

273. For the reasons discussed in more depth below, the HPH Board did not believe that the hospital could continue to serve its community in the long run absent a partnership with another institution. (CX 6305 at 11-12 (Stearns, Dep.)).

**Response to Finding 273:**

Respondent's finding is incomplete and misleading. First, Mr. Stearns testified that "had the merger [with Evanston] not gone through, financially, Highland Park would have been able to maintain itself sufficiently to not be under pressure to have to merge with anybody." (CX 6305 at 11 (Stearns Dep.)). Second, Mr. Stearns believed that, at the time of the merger negotiations, Highland Park's continued existence was not in question for at least ten years. (CX 6305 at 5 (Stearns Dep.)). See CX 1065 at 3). HPH did not require Evanston's financial assistance to develop new programs and sustain itself for the future. (See CCRFF 2298-2318). HPH also was an attractive candidate for other mergers. (See CCF 368-372).

- a. **The Merger Would Improve Quality Of Care At HPH And In The Community In General**

274. Before the Merger, HPH's continued viability as a critical care facility was in jeopardy. (Styer, Tr. 4965).

**Response to Finding No. 274:**

HPH was already a good hospital before the merger, it was also continually improving its services and adding new clinical services before the merger. (Newton, Tr. 292, 293, 376, 377, 388; CX 2415 at 2-9; CX 1052 at 4-5; CX 98 at 2; CX 96 at 1; Spaeth, Tr. 2102-05, 2110-11, 2113-17, 2120-22; Ballengee, Tr. 160, 185; CX 6321 at 61. *See also* CCF 2295-2352).

HPH was well-respected in the community and considered by many to be one of the "finest community hospitals in the country." (Newton, Tr. 301. *See also* Spaeth, Tr. 2095-97). As a matter of fact, JCAHO gave HPH an exceptional preliminary score of 95 on its accreditation report. (Neaman, Tr. 1198; Newton, Tr. 388; CX 96 at 1). { [REDACTED] } (RX 412 at ENHL PK 017794, *in camera*). ENH clinical administrators testified that HPH was a good hospital before the merger. (Dragon, Tr. 4402-03; Ankin, Tr. 5087-88).

HPH offered leading edge and innovative clinical programs before the merger. (Newton, Tr. 291-92, 339, 415; Dragon, Tr. 4402, 4399; CX 1863 at 10; CX 413 at 3 ("HPH . . . brought leading edge and innovative clinical services to residents of Lake County.")). HPH created "Centers of Excellence" before the merger; it would focus on certain clinical functions for which HPH would be particularly distinguished. (Newton, Tr. 291-92; CX 6321 at 61 ("During the last several years the hospital has significantly expanded the clinical services provided to the communities it serves"))).

Before the merger, HPH had already planned to add many new clinical services, such as cardiac surgery and comprehensive oncology programs, regardless of whether it

merged with another hospital. (CX 92 at 3, 12; CX 545 at 3; CX 1868 at 17; CX 1908 at 12, 19). In fact, before merger discussions with ENH even began, as early as December 1997, HPH pursued a joint oncology program with Northwestern Memorial Hospital and a joint cardiac surgery program with Evanston Hospital, neither involving a merger. (CX 541 at 1). { [REDACTED]

[REDACTED] }  
(Romano, Tr. 3107-08, *in camera*). In the field of heart surgery, HPH and ENH actually signed an agreement, which was not connected with the merger, to develop a joint cardiac surgery program at HPH before they agreed to merge. (Rosengart, Tr. 4527-30, 4557; CX 2094).

Before the merger, HPH had the financial wherewithal to improve the quality of services on its own. It certainly had the wherewithal to maintain its viability as a critical care facility. (Newton, Tr. 383-84, 430-32; Spaeth, Tr. 2137-38, 2147; CX 97 at 1; CX 545 at 3; CX 627 at 6; CX 1055 at 3; CX 1065 at 2-3; CX 1877 at 1. *See also* CCFF 302-372, 2440-2443).

HPH had a strong balance sheet pre-merger. Through its parent, Lakeland Health Services, HPH was financially backed up by the assets of the Highland Park Foundation. (Kaufman, Tr. 5843, 5846, 5860; Styer, Tr. 4954; CX 1912 at 2; CX 413 at 120). Even without the merger, the assets of the Highland Park Foundation would have continued to be available. (Kaufman, Tr. 5856). In 1999, before the merger, HPH's board and management believed it was financially strong and would remain so for the foreseeable future. (CX 1055 at 3; Newton, Tr. 432-34; Spaeth, Tr. 2147). Highland Park did not have a financial need to merge with ENH. (CX 1923 at 2 (Highland Park does not



“require a financial reason” for the merger); Kaufman, Tr. 5840).

275. HPH was not up to Evanston Hospital’s quality standards and, therefore, HPH asked for Evanston Hospital’s assistance in improving quality of care. (CX 6304 at 4, 8 (Livingston, Dep.)). HPH hoped to improve its quality of care to a level on par with that provided by the Evanston and Glenbrook Hospitals, thus benefiting the community as a whole. (CX 6304 at 8 (Livingston, Dep.)); RX 683 at ENH RS 7694; CX 6305 at 9, 13 (Stearns, Dep.)).

**Response to Finding No. 275:**

The citations do not support the statement that HPH thought that its quality of services were not on par with Evanston and Glenbrook Hospitals. (See CX 6304 at 4, 8 (Livingston, Dep.). See also CCRFF 274 (discussing the fact that HPH was already a good hospital before the merger and was continually improving its services and adding new clinical services before the merger)).

276. One of the written principles of the negotiations regarding the Merger was that “[t]he purpose of the affiliation [with Evanston Hospital was] to assure the availability of the widest range of quality medical services to the North Shore marketplace.” (RX 385 at FTC-KHA 2281). “The Highland Park community clearly expect[ed] that one outcome of the affiliation [with Evanston Hospital would be] that local access to medical services would be increased, not diminished.” (RX 385 at FTC-KHA 2281).

**Response to Finding No. 276:**

These quotations are misleading in that they ignore that HPH was perfectly capable of maintaining its high quality of care without the merger. In fact, HPH had specific plans to continue to improve its quality of care, including by implementing some of the same services now claimed as a benefit of the merger. (See, e.g., CCRFF 274).

There is no requirement of proving an anticompetitive intent in a merger case. Furthermore, Respondent’s finding implies that the merging parties’ motive with regard to the merger was to increase “local access to medical services.” Even if, *arguendo*, the merging parties had one or more motives related to the quality of services provided by HPH, they were by no means the only motives. Pre-merger documents of HPH show the

motivation of Highland Park senior management and board members with regard to the merger:

- To reap “the economic benefit” of “not do[ing] battle” with Evanston (CX 4 at 1)
- To “stop competing with each other” (CX 1879 at 3-4)
- To “push back on the managed care phenomenon” (CX 4 at 2)
- To be “a big enough concerted enough entity” (CX 4 at 2)
- To “get geographic leverage” (CX 4 at 9)
- To achieve “critical mass” in the North Shore (CX 4 at 9)
- To “exploit an area of the market in a meaningful way” (CX 3 at 1-2)
- To build “power to deal with managed care” (CX 3 at 2).

In short, Highland Park knew that *“it would be real tough for any of the Fortune 40 companies in this area whose CEOs use either this place or that place to walk from Evanston, Highland Park, Glenbrook, and 1700 of their doctors.”* (CX 4 at 1-2; Spaeth, Tr. 2210-11 (emphasis added)).

Pre-merger strategic documents and testimony from ENH senior managers show that Evanston’s goals through the merger were the same:

- “[T]o join forces and grow together rather than compete with each other” (CX 2 at 7)
- To “not compete with self” (CX 1 at 3)
- To “strengthen negotiation capability with managed care companies through merged entities” (CX 1 at 3)
- { [REDACTED] } (CX 1566 at 9;

Neaman, Tr. 1138, *in camera*; RX 2015 at ENHL MO 003485)

- { [REDACTED] } (CX 1566 at 9; Neaman, Tr. 1138, *in camera*; RX, 2015 at ENHL MO 003485)
- To make the merged entity “indispensable to marketplace” (CX 19 at 1)
- To get better prices and better terms on contracts with health plans (Neaman, Tr. 1036).
- To achieve “negotiating strength as a combined system of 3 hospitals.” (RX 704 at ENH HJ 001645).

277. HPH sought a “meaningful relationship” with Evanston Hospital to enhance the quality of care and access for the Northern Cook and Lake County communities. (RX 389 at FTC-KHA 2226). The expectation of the Merger was that it would “lead to a relationship which [would] provide the highest quality comprehensive services to the citizens of northern Cook and Lake Counties.” (RX 385 at FTC-KHA 2281).

**Response to Finding No. 277:**

A merger with Evanston Hospital was not necessary to have a mutually beneficial relationship. (See CCRFF 274; CCF 2353-2439). For example, even before the merger Evanston sent perinatal specialists to offer services at HPH. (Krasner, Tr. 3750). Before the merger, HPH was able to refer high-risk obstetrics cases to Evanston Hospital, as it still does after the merger. (Silver, Tr. 3829). Also before the merger, HPH and ENH contracted to begin a cardiac surgery program at HPH. (Rosengart, Tr. 4527-29, 4531; CX 2094. See CCRFF 276 above for a discussion on the intent or motives of the merging parties).

278. As early as November 1998, HPH had a “high commitment to doing what is right for the community” with respect to whether to combine with Evanston Hospital. (RX 389 at FTC-KHA 2226). In November 1998, HPH emphasized its goal to “grow clinical services including oncology, heart, orthopedics, [obstetrics] and other medical and surgical specialties” as a result of combining with Evanston Hospital. (RX 389 at FTC-KHA 2226). One of the key goals from the beginning of Merger negotiations was to achieve growth in oncology, cardiology and other services at HPH. (RX 385 at FTC-KHA 2282).

**Response to Finding No. 278:**

This finding is misleading in that it suggests that the merger was necessary in order for HPH to “grow” the referenced services. As explained above, HPH planned to add or expand many service offerings, including heart surgery and oncology, regardless of a merger. (See, e.g., CCRFF 274. See CCRFF 276 above for a discussion on the intent or motives of the merging parties).

279. At the inception of the Merger negotiations, HPH asked how the Kellogg Cancer Care Center might be developed and implemented at HPH. (RX 389 at FTC-KHA 2227). HPH also highlighted the possibility that both HPH and Evanston Hospital would identify and agree on a level of quality to be met by all providers after the Merger. (RX 389 at FTC-KHA 2227).

**Response to Finding No. 279:**

For a discussion on some additions and improvements to clinical services HPH made before the merger and some additions and improvements HPH planned to make regardless of a merger, see CCRFF 274. { [REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr. 3907, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

(Romano, Tr. 3097-98, *in camera*). { [REDACTED]

[REDACTED]

(Romano, Tr. 3097, *in camera*. See CCRFF 276 (discussing the intent or motives of the merging parties)).

280. Other issues pertaining to quality of care at pre-Merger HPH are discussed in more depth in Section VIII.

**Response to Finding No. 280:**

Respondent cites no support for this finding. This is contrary to the judge's April 6, 2005, Order on Post Trial Briefs stating that each proposed finding shall have a valid and correct cite to the record. In any event, Complaint Counsel's position on these issues is likewise discussed in Section VIII.

**b. The Merger Would Address HPH's Deteriorating Financial Condition**

281. HPH also sought to merge with Evanston Hospital because HPH's long-term survival, specifically over the next five to ten years, was in doubt from a financial perspective. (Styer, Tr. 4965; CX 6305 at 2 (Stearns, Dep.); Kaufman, Tr. 5830-31).

**Response to Finding 281:**

Respondent's finding is contradicted by HPH's internal documents at the time. For example, in a March 23, 1999, joint meeting of the finance and planning committees of Lakeland Health Services and HPH, the attendees (including the chairman of the board, Neele Stearns) discussed the "long term financial viability of the organization" should the merger not occur. The attendees "concluded that the organization can remain financially strong over the foreseeable future." (CX 1055 at 3). Mr. Stearns also testified that, at the time of the merger negotiations, Highland Park's continued existence was not in question for at least ten years. (CX 6305 at 5 (Stearns Dep.)).

HPH did not require Evanston's financial assistance to develop new programs and sustain itself for the future. (See CCRFF 2298-2318). HPH also was an attractive candidate for other mergers. (See CCF 368-372).

282. Financial issues at pre-Merger HPH are discussed in more depth in Section IX.B.

**Response to Finding 282:**

Respondent cites no specific support for its finding. This is contrary to the court's April 6, 2005, Order on Post Trial Briefs stating that each proposed finding shall have a

valid and correct cite to the record. Furthermore, this proposition is not a finding of fact.

In any event, Complaint Counsel's reply findings also provide more discussion in Section

IX.B.

**c. The Merger Would Provide A Good "Fit"**

283. HPH also decided to merge with Evanston Hospital because there seemed to be a good "fit" between the hospitals. Both were part of the North Shore culture, and many of the hospitals' physicians knew each other and trained with each other in the same medical schools. (Spaeth, Tr. 2273; RX 288 at ENH RS 1031).

**Response to Finding 283:**

Respondent's finding implies that Evanston and HPH were similar in important respects and thus a "good fit." Indeed, pre-merger Evanston and Highland Park were direct competitors before the merger, with overlapping service offerings and service areas. (See CCFF 284-301).

284. Just before the Merger, HPH communicated to its community the types of services the Merger would bring to the hospital. (Spaeth, Tr. 2304). The Highland Park community and area business were thrilled about the proposed merger with Evanston Hospital. (Spaeth, Tr. 2304).

**Response to Finding 284:**

Respondent's finding is irrelevant to the merger analysis. In addition, both HPH and Evanston had more than philanthropic and innocent motivations for the merger. (See CCRFF 259).

285. Other neighboring hospitals did not provide viable merger opportunities for HPH. HPH approached Lake Forest Hospital from time to time about partnering. But Lake Forest Hospital was not interested, in part, because of its affiliation with Rush Presbyterian. (CX 6305 at 12 (Stearns, Dep.)).

**Response to Finding 285:**

Respondent's finding is misleading to the extent that it implies that HPH believed it had no other options besides Evanston as a merger partner or that its merger

opportunities were limited to “neighboring hospitals.” If the Evanston merger had not closed, Highland Park was prepared to “continu[e] to explore other options, “ meaning “other partnership options.” (CX 6305 at 11 (Stearns Dep.)). According to Mr. Stearns, Highland Park “had at least some contact with other institutions and . . . would have pursued those more aggressively had this – the merger with Evanston not gone through.” (CX 6305 at 11-12 (Stearns Dep.)).

286. In the late 1990s, Condell did not have the financial and clinical wherewithal to be an attractive merger partner to HPH. (CX 6305 at 12 (Stearns, Dep.)).

**Response to Finding 286:**

Respondent’s finding is misleading to the extent that it implies that HPH believed it had no other options besides Evanston as a merger partner. (See CCRFF 285).

Moreover, the testimony does not support the cite. Mr. Stearns did not testify about the “financial and clinical wherewithal” of Condell. (CX 6305 at 12 (Stearns, Dep.)).

287. HPH was skeptical that the downtown Chicago hospitals, such as Northwestern Memorial, would commit to delivering the type of quality improvements HPH thought the Highland Park community needed. (Spaeth, Tr. 2270-71).

**Response to Finding 287:**

Respondent’s finding is misleading to the extent that it implies that HPH believed it had no other options besides Evanston as a merger partner. (See CCRFF 285). HPH believed it would not gain as much leverage if it merged with Northwestern Memorial. (CX 4 at 9; Spaeth, Tr. 2212).

**2. Evanston Hospital’s Reasons For The Merger**

**a. The Merger Would Allow Evanston Hospital To Improve Quality Of Care By Expanding The Volume Of Its Services**

288. Evanston Hospital viewed HPH’s geography as an attractive opportunity to expand its volume of services because HPH is located in fast-growing Lake County. (Neaman,

Tr. 1325).

**Response to Finding No. 288:**

Evanston and Highland Park sought market power through the merger. (See CCF 1346-1400). Geography came into play as a merger opportunity, according to an HPH representative, in terms of giving the combined entity “geographic leverage” with health plans. (CX 4 at 9; Spaeth, Tr. 2211-12. See also CX 2 at 7; Spaeth, Tr. 2213-14).

289. Expanding the volume of services is critically important to support subspecialty practices of medicine because a hospital needs to have enough patient volume to help physicians maintain excellent and up-to-date quality of care. (Neaman, Tr. 1324-25). The ENH 1996-2000 Strategic Plan confirmed this, identifying ways of achieving growth and becoming the “best integrated healthcare delivery system,” such as by significantly broadening the portfolio of services through acquisition of, or affiliation with, additional hospitals. (CX 2037 at 9; Neaman, Tr. 1153-54).

**Response to Finding No. 289:**

This finding is irrelevant because there is no requirement of proving an anticompetitive intent in a merger case. Furthermore, this finding is misleading in implying that the merging parties’ motive with regard to the merger was to expand the volume of services offered by the Evanston. Even if, *arguendo*, this was truly a motive, it was not the only motive. Evanston’s pre-merger strategic documents and testimony from ENH senior managers show that Evanston’s goals through the merger were to increase and use its market power. (See CCF 276). Also, Respondent failed to show why Evanston could only grow by acquiring HPH, and why it could not have merged with other hospitals in the Chicago area and elsewhere simply to have grown its services.

290. A hospital also needs to have enough volume of services so that the cost per case, cost per admission and the cost per procedure are all competitive with what the hospital gets paid. (Neaman, Tr. 1325).

**Response to Finding No. 290:**



This finding is irrelevant since, based on this finding, the calculation is done separately for each hospital, it is irrelevant to a merger between hospitals.

**b. The Merger Would Allow Evanston Hospital To Improve Quality Of Care By Rationalizing Its Services**

291. Evanston Hospital was a space-constrained facility, with only 14 acres of available land. (Neaman, Tr. 1324). Attempts to expand the Evanston Hospital campus failed because of strong protests from the surrounding residential areas. (Neaman, Tr. 1324).

**Response to Finding No. 291:**

This finding is irrelevant and incomplete. It is irrelevant to the clinical rationalization aspect of the quality of care question. Respondent's quality expert never discussed how hospital size relates to quality of care. Furthermore, Respondent's expert did not study the effect of the merger on the quality of care at Evanston Hospital. (Chassin, Tr. 5446-47). This finding also does not explain why Evanston couldn't have expanded by acquiring another hospital.

292. Because certain services at Evanston Hospital had reached the limit of that campus' capacity, Evanston Hospital viewed the Merger as an opportunity to allow it to rationalize resources and free-up capacity by moving various services from Evanston Hospital to HPH, thus improving the quality of care at both campuses. (Neaman, Tr. 1323; Hillebrand, Tr. 1798).

**Response to Finding No. 292:**

This finding is irrelevant since there is no requirement of proving an anticompetitive intent in a merger case. This finding is misleading in implying that the merging parties' motive with regard to the merger was to allow Evanston to rationalize its resources. Even if, *arguendo*, this was truly a motive, it was not the only motive. Evanston's pre-merger strategic documents and testimony from ENH senior managers show that Evanston's goals through the merger were to increase and use its market power. (See CCRFF 1, 276).

[REDACTED]  
[REDACTED] (Romano, Tr. 3174-76, *in camera*). [REDACTED]

[REDACTED] (Romano, Tr. 3174-75, *in camera*).

[REDACTED] (Romano, Tr. 3176, *in camera*). Furthermore, the citation given to Mr. Hillebrand's testimony does not support the finding.

293. For example, if patients needed to be relocated because of operating room overcrowding, the Merger would create clinical efficiencies because the merged entity would not have to spend capital to build more operating room capacity. (Newton, Tr. 451).

**Response to Finding No. 293:**

This finding is speculative. It ignores the fact that there is no evidence that patients needed to be relocated from Evanston to HPH or back because of operating room overcrowding.

294. Other clinical services also stood to benefit from centralizing the resources of the multiple hospitals after the Merger. For example, reproductive endocrinology services are better served by the efficiency of a single, rather than multiple, labs. (Newton, Tr. 451-52). Moreover, the Merger was anticipated to create potential synergies in clinical areas such as behavioral health, home health, skilled nursing and pediatrics. (RX 518 at ENH GW 2066).

**Response to Finding No. 294**

See CCRFF 292 above discussing the uncertainty as to whether the alleged clinical rationalization of some clinical services after the merger improved the quality of care. This finding is misleading because the cite to Mr. Newton's testimony implies that reproductive endocrinology services have been rationalized at ENH for a fact, when in

reality Mr. Newton was responding to a hypothetical question. (Newton, Tr. 451-52). {

[REDACTED]

[REDACTED]

(Romano, Tr. 3176, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3115-16, *in camera*. See also CCFF 2283-2289.)

**c. The Merger Would Result In Corporate Efficiencies**

295. The Merger presented Evanston Hospital with an opportunity to improve the combined operating margin through: (1) overhead cost reduction, through the consolidation of core central functions like accounting, finance, billing and human resources; (2) the application of benchmarks to those functions to achieve both scale benefit and process redesign; (3) the use of best practices to improve service and cost reduce the on-site functions like care provision, labs, food and environment; and (4) the identification of outsourcing opportunities for cost reduction or service improvement. (RX 477 at ENH JH 326; Hillebrand, Tr. 1798).

**Response to Finding 295:**

Respondent has not shown that the cost improvements cited in the finding are “merger-specific efficiencies” that could only be achieved by the merger between Evanston and HPH. (Merger Guidelines § 4). If either Evanston or HPH merged with another entity, they may have been able to realize the savings (such as from consolidating administrative operations) without the anticompetitive effect. Respondent has not alleged a cost savings efficiencies defense, and has not shown any savings were actually passed on to consumers. In any event, even assuming, *arguendo*, that certain efficiencies were achieved and passed on, the anticompetitive impacts of the merger substantially outweighed any purported benefits. For example, just from the year 2000 health plan contract re-negotiations alone, ENH increased its net revenues by a minimum of \$18

million annually. (See CCFF 1329-1337).

296. The Merger was to be a total integration from the outset. The hospitals recognized that cost savings could be realized by improving and merging the core central functions such as accounting, finance, billing, purchasing, information systems, human resources and strategy. (RX 385 at FTC-KHA 2284; RX 518 at ENH GW 2066). Part of Evanston Hospital's strategic rationale for the Merger was to become a low-cost provider by achieving \$2-4 million in estimated cost reduction. (RX 518 at ENH GW 2063, 2066).

**Response to Finding 296:**

Respondent has not shown that the cost improvements cited in the finding are "merger-specific efficiencies" that could only be achieved by the merger between Evanston and HPH and were passed on from ENH to its customers. (Merger Guidelines § 4). In any event, even assuming, *arguendo*, that certain efficiencies were achieved and passed on, the anticompetitive impacts of the merger substantially outweighed any purported benefits. (See CCRFF 295).

**d. The Merger Would Provide Evanston Hospital With An Additional Teaching Site**

297. Part of Evanston Hospital's strategic rationale for the merger was to provide an additional teaching site for ENH and the Northwestern University Medical School. (RX 518 at ENH GW 2063; RX 704 at ENH HJ 1625).

**Response to Finding 297:**

Respondent's finding is incomplete, misleading and irrelevant. There is no requirement of proving an anticompetitive intent in a merger case. Furthermore, Respondent's finding regarding the parties' purportedly philanthropic or innocent intentions is misleading in implying that the merging parties' motive in merging was philanthropic or innocent. Even if, *arguendo*, the merging parties had one or more philanthropic or innocent motives, they were by no means the only motives. HPH and Evanston both aimed to eliminate competition between themselves and increase their

bargaining leverage against health plans. (See CCRFF 259, 2306).

In any event, providing an additional teaching facility at HPH could have been accomplished through something less than a merger. Northwestern University Medical School was affiliated with Evanston but was not merged with Evanston. (O'Brien, Tr. 3540; Harris, Tr. 4251).

### **C. Merger Consummation**

298. In August 1999, before the Merger, the FTC Pre-Merger Notification Office notified the Network, Evanston Hospital and Lakeland, the parent company of HPH, that it viewed the Network as already holding the assets of both Evanston Hospital and Lakeland Health Services. (RX 586 at 2).

#### **Response to Finding No. 298:**

Respondent cites RX 586 for its truth. RX 586 at 2 concerns the letter to the FTC claiming to set forth the FTC's opinion. This is contrary to paragraph 5 of the Joint Stipulation Regarding Admissibility of Trial Exhibits dated February 10, 2005, which provides that "'Hearsay within hearsay' (see Fed. R. Evid. 805) in documents admitted into evidence shall not be admitted for the truth of the matter asserted therein unless the parties shall have separately satisfied the evidentiary requirements for the admission of hearsay within hearsay." (JX 1 at 2) Furthermore, RX 586 does not say what Respondent's finding claims, inasmuch as RX 586 refers to a hypothetical transaction (involving Hospital Network A, Hospital B, etc.) and does not reference the Northwestern Healthcare Network, Evanston Northwestern Healthcare Corporation, Lakeland Health Services, Inc. or the relationship among those three entities. Moreover, RX 586 is irrelevant in that it relates only to the filing requirements under the Hart-Scott-Rodino Act, 15 U.S.C. § 18a, and actions taken by the Federal Trade Commission pursuant to 15 U.S.C. § 18a, are irrelevant in evaluating any action by the Federal Trade Commission

under Section 7 of the Clayton Act, 15 U.S.C. § 18.

299. As such, the FTC Pre-Merger Notification Office did not view the Merger between Evanston Hospital and HPH as an acquisition of assets under the HSR Act. (RX 586 at 2). “This conclusion is not altered by the fact that [the Network] will be dissolved and removed as a member of [ENH] following the effective date of the merger. . . . [A]s long as [the Network] exists and holds the reserved power over appointments to the boards of [Evanston Hospital] and [Lakeland] at the time of the merger, the merger will not be reportable.” (RX 586 at 2).

**Response to Finding No. 299:**

Respondent cites RX 586 for its truth. The quotation and other part cited come from the letter to the FTC claiming to set forth the FTC’s opinion. This is contrary to paragraph 5 of the Joint Stipulation Regarding Admissibility of Trial Exhibits dated February 10, 2005, which provides that “‘Hearsay within hearsay’ (see Fed. R. Evid. 805) in documents admitted into evidence shall not be admitted for the truth of the matter asserted therein unless the parties shall have separately satisfied the evidentiary requirements for the admission of hearsay within hearsay.” (JX 1 at 2). Furthermore, RX 586 does not say what Respondent’s finding claims, inasmuch as RX 586 refers to a hypothetical transaction (involving Hospital Network A, Hospital B, etc.) and does not reference the Northwestern Healthcare Network, Evanston Northwestern Healthcare Corporation, Lakeland Health Services, Inc. or the relationship among those three entities. Further, RX 586 is irrelevant in that it relates only to the filing requirements under the Hart-Scott-Rodino Act, 15 U.S.C. § 18a, and actions taken by the Federal Trade Commission pursuant to 15 U.S.C. § 18a, are irrelevant in evaluating any action by the Federal Trade Commission under Section 7 of the Clayton Act, 15 U.S.C. § 18.

300. On or about August 7, 1999, Evanston Hospital received notice from the FTC that Evanston Hospital and HPH did not have to seek Hart-Scott-Rodino approval to proceed with the Merger. (RX 589; RX 586; Neaman, Tr. 1330).

**Response to Finding No. 300:**

Respondent cites RX 586 and RX 589 for their truth. This is contrary to paragraph 5 of the Joint Stipulation Regarding Admissibility of Trial Exhibits dated February 10, 2005, which provides that “‘Hearsay within hearsay’ (*see* Fed. R. Evid. 805) in documents admitted into evidence shall not be admitted for the truth of the matter asserted therein unless the parties shall have separately satisfied the evidentiary requirements for the admission of hearsay within hearsay.” (JX 1 at 2). Furthermore, RX 586 and RX 589 do not say what Respondent’s finding claims, inasmuch as RX 586 refers to a hypothetical transaction (involving Hospital Network A, Hospital B, etc.) and does not reference the Northwestern Healthcare Network, Evanston Northwestern Healthcare Corporation, Lakeland Health Services, Inc. or the relationship among those three entities. Further, the cited testimony (Neaman, Tr. 1330) relates only to the witness’s understanding of the purported action of the Federal Trade Commission and, therefore, does not say what Respondent asserts with respect to any action of the Federal Trade Commission. Moreover, the cited authority is irrelevant in that it relates only to purported actions of the Federal Trade Commission under the Hart-Scott-Rodino Act, 15 U.S.C. § 18a, and actions taken by the Federal Trade Commission pursuant to 15 U.S.C. § 18a, are irrelevant in evaluating any action by the Federal Trade Commission under Section 7 of the Clayton Act, 15 U.S.C. § 18.

Furthermore, to the extent that Respondent refers to any action by the Federal Trade Commission as an “approval” of the transaction under the Hart-Scott-Rodino Act, 15 U.S.C. § 18a, Respondent’s statement is misleading in that the Act, which sets forth the obligations of private parties to notify the Federal Trade Commission and the Department of Justice of certain transactions, does not establish standards for either

agency to approve (or disapprove) a transaction. Failure of an agency to challenge a transaction is not to be construed as the agency's approval of that transaction.

301. On October 29, 1999, the parties entered into the Agreement and Plan of Merger. (RX 651). This Merger agreement enumerated the same key principles and goals as found in the Letter of Intent. (RX 651 at ENH MN 1557-58). The effective date of the Merger was January 1, 2000. (RX 651 at ENH MN 1517).

**Response to Finding No. 301:**

The cited source does not support this finding inasmuch as Respondent does not cite the Letter of Intent to which the Agreement and Plan of Merger (RX 651) purportedly relate. However, Complaint Counsel do not disagree that the effective date of the merger was January 1, 2000.

302. After the Merger, ENH published newsletters informing the community of the achievements of the Merger. (RX 864 at ENH HJ 1781). In the newsletter, ENH advised the community that HPH had undergone a "major turnaround" from the operating losses it had before the Merger. (RX 864 at ENH HJ 1781).

**Response to Finding No. 302:**

To the extent that Respondent cites RX 864 for the purpose of proving that "HPH had undergone a 'major turnaround' from the operating losses it had before the Merger," it is citing RX 864 for its truth. The newsletter purports to say what people said at employee meetings. This is contrary to paragraph 5 of the Joint Stipulation Regarding Admissibility of Trial Exhibits dated February 10, 2005, which provides that "'Hearsay within hearsay' (see Fed. R. Evid. 805) in documents admitted into evidence shall not be admitted for the truth of the matter asserted therein unless the parties shall have separately satisfied the evidentiary requirements for the admission of hearsay within hearsay." (JX 1 at 2).

The finding is also misleading and incomplete in implying that Highland Park was



in serious financial difficulty before the merger and needed a “major turnaround.”

Highland Park could have continued as a stand-alone competitor without the merger (*See* CCF 302-367) and was an attractive candidate for other mergers (*See* CCF 368-372).

**D. Effect Of The Merger On ENH's Operations**

303. To realize the full benefit of the Merger, ENH consolidated all corporate activities at the Evanston Hospital campus and eliminated all corporate functions at HPH – including human resources, purchasing, payor contracting, the business office and information systems. (Hillebrand, Tr. 1839-40; Neaman, Tr. 1345-46).

**Response to Finding 303:**

Respondent has not shown that the cost improvements cited in the finding are “merger-specific efficiencies” that could only be achieved by the merger between Evanston and HPH and were passed on from ENH to its customers. (Merger Guidelines § 4). In any event, even assuming, *arguendo*, that certain efficiencies were achieved and passed on, the anticompetitive impacts of the merger substantially outweighed any purported benefits. (*See* CCRFF 295).

304. To achieve maximum cost efficiency from the Merger, ENH determined to institute one billing system and one business office. (Hillebrand, Tr. 1839-40).

**Response to Finding 304:**

Respondent has not shown that the cost improvements cited in the finding are “merger-specific efficiencies” that could only be achieved by the merger between Evanston and HPH and were passed on from ENH to its customers. (Merger Guidelines § 4). In any event, even assuming, *arguendo*, that certain efficiencies were achieved and passed on, the anticompetitive impacts of the merger substantially outweighed any purported benefits. (*See* CCRFF 295).

305. In particular, ENH implemented a coordinated registration, scheduling and charging system throughout its three hospitals. (Hillebrand, Tr. 1840). This system allows any

ENH patient to receive the same care at any ENH site and pay the same price for that care at any ENH site. (Hillebrand, Tr. 1840; Chan, Tr. 714).

**Response to Finding 305:**

To the extent that Respondent is implying that paying the “same price” at any ENH facility was unambiguously a positive development for patients, the finding is misleading and incomplete. Prices for ENH’s services rose due to this harmonization. ENH management planned to “use the better of the two [hospital] contracts” for health plans post-merger. (Hillebrand, Tr. 1856, 1705; Neaman, Tr. 1031, 1346-47). After the merger closing, ENH did convert the health plan contracts to whatever pre-merger rate was more favorable. (CX 2386 at 2).

In fact, using the more favorable of the two pre-merger hospital contracts was only ENH’s “starting point” in health plan renegotiations after the merger. (Hillebrand, Tr. 1856, 1705). In the 2000 renegotiations, ENH demanded the higher of the two contract rates plus a premium. (See CCFF 848-880). In addition, ENH adopted the higher of the Evanston or Highland Park pre-merger chargemaster rates in the post-merger period. (See CCFF 884-895).

306. Consequently, after the Merger, HPH physicians became part of the unitary medical staff of Evanston and Glenbrook Hospitals. If a physician had clinical privileges with ENH after the Merger, the clinical privileges were good at any of the three hospital sites. (RX 518 at ENH GW 2082; Hillebrand, Tr. 1840-41).

**Response to Finding 306:**

Respondent’s finding is irrelevant. No merger was required to allow HPH physicians to have clinical privileges at the Evanston facilities. (See, e.g., Ankin, Tr. 5034-35 (a physician may have privileges at a variety of hospitals)).

307. Allowing all ENH physicians to have privileges at all three ENH campuses is a very unique quality measure because ENH’s twelve full-time clinical department chairmen are

responsible for quality of care regardless of where it is rendered in the ENH system. (Hillebrand, Tr. 1841-42). No other hospital system in Chicago, besides ENH, allows its physicians to automatically have privileges at all campuses in those systems. (Hillebrand, Tr. 1841-42).

**Response to Finding 307:**

Respondent's finding is irrelevant. No merger was required to allow HPH physicians to have clinical privileges at the Evanston facilities. (See CCRFF 306).

308. ENH's system of allowing all physicians to have privileges at all three ENH campuses is very difficult to achieve because it requires having hundreds, if not thousands, of physicians successfully working together. (Hillebrand, Tr. 1842). ENH's decision to coordinate its registration, scheduling and charging systems throughout the three ENH hospitals resulted in the three hospitals having a single chargemaster and a single Medicare ID number. (Hillebrand, Tr. 1840; Neaman, Tr. 1346). This practice was consistent with Evanston Hospital's prior practice in that Evanston and Glenbrook Hospitals had used the same Medicare ID since Glenbrook opened on April 3, 1977. (Neaman, Tr. 1346; Hillebrand, Tr. 1842). From April 1977, through at least February 2005, no MCO complained about ENH using a single Medicare ID for all campuses in the ENH system. (Hillebrand, Tr. 1843).

**Response to Finding 308:**

It was possible for health plans to pay different rates at different facilities even under a single tax I.D. number. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (CX 5902 at 1, 3, *in camera*).

With regard to the fourth sentence, Respondent confuses Medicare I.D. and tax

I.D. (TIN) numbers. While health plans can not complain about ENH using a single Medicare ID number, because the government pays for Medicare, United and One Health testified that ENH's insistence on one tax I.D. number and identical rates for all three facilities was "challenging" (Foucre, Tr. 890-92) because, under ENH's proposed billing system, health plans "can't distinguish between services at the three hospitals" to determine which services were rendered at a particular hospital in the system and because Evanston Hospital, Glenbrook Hospital, and Highland Park hospital do not merit equal reimbursement rates. (Foucre, Tr. 890-92; Dorsey, Tr. 1446-47).

309. These post-Merger corporate changes required ENH to renegotiate its MCO contracts. (Hillebrand, Tr. 1839; Neaman, Tr. 1345-46). Merger planning documents explained that the merged entity "[m]ust have same managed care contracts, pricing, technical/professional fees, etc. so patients/physicians can go to any site." (RX 402 at ENH MN 2049).

**Response to Finding 309:**

Respondent's finding is inaccurate and incomplete. The finding notes "changes" that "required" ENH to renegotiate contracts. In fact, the contract renegotiations were not requirements at all. ENH could have maintained separate contracts or consolidated both contracts under a consent to assignment. (See CCRFF 862). As shown in CCRFF 308, health plans can pay different rates at different facilities even under a single tax I.D. number. (See CCRFF 308). Furthermore, other hospital systems have different rates for different hospitals. (See CCFF 909-917). Respondent's finding is misleading in its implication that ENH stopped at simply renegotiating contracts to meet a "requirement," because post-merger ENH moved health plans to discount off charges contracts, added a premium to the higher of the Evanston or Highland Park contracts, and increased its chargemaster. (CCFF 817-821, 848-859, 884-895, 918-927). An ENH representative admitted that the merged entity was successful in 2000 in negotiating prices above the

pre-merger rates of either Evanston or Highland Park for numerous payors. (Hillebrand, Tr. 1705).

The question of whether to increase prices using any of the mechanisms listed above arose as a result of the merger. (See CX 17 at 2 (“None of this could have been achieved by either Evanston or Highland Park alone”); CX 13 at 1 (“Neither Evanston nor Highland Park alone could achieve these results.”); Hillebrand, Tr. 1703-05; CX 30 at 3; Neaman, Tr. 1031 (The shift of all three hospitals to one of the two pre-merger contracts for each health plan and the price increases resulting from the shift to the more favorable contract were both due to the merger.); (Hillebrand, Tr. 1704 (The shift of all three hospitals to one of the two chargemasters for that product or service and the price increases resulting from the shift to the higher of the two chargemaster rates were both due to the merger.)).

310. Moreover, ENH immediately shut down most of the pre-Merger joint ventures operated by Lakeland Health Ventures under the supervision of Mark Newton, former Vice President of Planning and Marketing at HPH. (Newton, Tr. 449). Newton – who left HPH soon after the Merger to work for a competitor hospital, Swedish Covenant Hospital – did not oversee the quality of clinical services at HPH. (Spaeth, Tr. 2282-83; Newton, Tr. 279). Moreover, Newton had no responsibility for clinical quality at HPH, he was not responsible for information technology at HPH, nor was he tasked with overseeing the credentialing or disciplining of physicians. (Spaeth, Tr. 2283, 2285). The joint ventures Newton operated under Lakeland Health Ventures were losing money when the Merger was consummated. (Newton, Tr. 449).

**Response to Finding 310:**

Respondent’s finding is inaccurate. Throughout his 12-year tenure as a member of the senior management team at Highland Park, Mr. Newton was routinely “involved in . . . the issues of quality.” (Newton, Tr. 282-84, 289-90). As a member of the senior management team, Mr. Newton was involved in many issues, ranging from the “functional operations of the hospital,” the “pricing, quality, clinical service, [and]

medical staff relationships” at Highland Park; the hospital’s finances, and contract negotiations with health plans throughout his tenure. (Newton, Tr. 285-89).

**E. Post-Merger Healthcare Foundation Of Highland Park**

311. As a result of the Merger, Evanston Hospital and HPH also created the Healthcare Foundation of Highland Park on January 1, 2000. (Styer, Tr. 4951, 4971; Belsky, Tr. 4894; Spaeth, Tr. 2281). Evanston Hospital and the HPH Foundation signed the agreement creating the Healthcare Foundation of Highland Park in December 1999. (RX 2037; Styer, Tr. 4977-78).

**Response to Finding 311:**

Respondent’s finding is incomplete and misleading to the extent that it implies the Foundation was a new, merger-related benefit to the Highland Park community. Pre-merger, HPH had an affiliated foundation “responsible for fund raising for and on behalf of Lakeland Health Services, Inc. (“Lakeland”), the Hospital [HPH] and their affiliates” that benefited the community and the hospital. (CX 6321 at 61).

The establishment of a separate, post-merger foundation to serve Highland Park was designed to compensate the Highland Park community for the loss of control when HPH merged with Evanston. (Kaufman, Tr. 5855-56). Without the merger, there would be no loss of control and hence no need to compensate the community. (Kaufman, Tr. 5856).

Respondent’s reference to the creation of the foundation is especially ironic given that, during the merger negotiations, Evanston attempted to minimize the amount of funds that Highland Park would contribute to the post-merger foundation. (Kaufman, Tr. 5863).

Respondent’s finding is also irrelevant. There is no requirement of proving an anticompetitive intent in a merger case. Furthermore, Respondent’s finding regarding the parties’ purportedly philanthropic or innocent intentions is misleading in implying that

the merging parties' motive in merging was philanthropic or innocent. Even if, *arguendo*, the merging parties had one or more philanthropic or innocent motives, they were by no means the only motives. HPH and Evanston both aimed to eliminate competition between themselves and increase their bargaining leverage against health plans. (See CCRFF 259, 2306).

312. The Foundation Agreement establishing the Healthcare Foundation of Highland Park describes the Foundation's mission to support HPH and healthcare in the general Highland Park community. (RX 2037 at HFHP 1356; Styer, Tr. 4951, 4979; Neaman, Tr. 1373). The creation of the Healthcare Foundation of Highland Park was another means of fulfilling HPH's primary merger goal of benefiting the Highland Park community. (CX 6305 at 16 (Stearns, Dep.); Neaman, Tr. 1373).

**Response to Finding 312:**

Respondent's finding is incomplete, misleading and irrelevant. Philanthropic motivations are irrelevant. (See CCRFF 259, 2306; CCFF 1346-1362, 1486-1496). In addition, a pre-merger foundation for the benefit of the Highland Park community already existed. (See CCRFF 311).

313. The Highland Park Healthcare Foundation provides grants to HPH and other healthcare organizations in the community. (Styer, Tr. 4980-81, 4987-88; RX 2037 at HFHP 1362). The Foundation Agreement also gives the Highland Park Healthcare Foundation the power to notify the Illinois Attorney General of "a material breach by ENH of any of its obligations under the Merger Agreement which substantially undermines or adversely affects the Highland Park community" if ENH and the Healthcare Foundation cannot themselves resolve ENH's alleged breaches within 90 days. (RX 2037 at HFHP 1364; Styer, Tr. 4971, 4985).

**Response to Finding 313:**

Respondent's finding is incomplete, misleading and irrelevant. Philanthropic motivations are irrelevant. (See CCRFF 259, 2306). In addition, a pre-merger foundation for the benefit of the Highland Park community already existed. (See CCRFF 311).

314. See Section IX.C.4 for additional findings on the Highland Park Healthcare Foundation.

**Response to Finding 314:**

Respondent cites no specific support for its finding. This is contrary to the Judge's April 6, 2005, Order on Post Trial Briefs stating that each proposed finding shall have a valid and correct cite to the record. Furthermore, this proposition is not a finding of fact. In any event, Complaint Counsel's reply findings also provide more discussion in Section IX.C.4.



## V. ANALYTIC FRAMEWORK

### A. The Court Should Analyze The Price Increases In The Context Of The Relevant Market

#### 1. All Experts Agree That Price Increases Alone Are Not Anticompetitive

315. { [REDACTED] } (Baker, Tr. 4702, *in camera*; Noether, Tr. 5989; Noether, Tr. 6108, 6114, *in camera*). Even Dr. Haas-Wilson, Complaint Counsel's primary economic expert, admitted that price changes, alone, do not demonstrate the existence of market power. (Haas-Wilson, Tr. 2482).

#### Response to Finding No. 315:

Complaint Counsel have no specific response.

#### 2. All Experts Agree That One Must Rule Out Viable Alternative Explanations Before Concluding That A Price Increase Is The Result Of Anticompetitive Market Power

316. Before concluding that post-Merger price increases were caused by the gain and exercise of market power, viable alternatives for the price increases must be evaluated and eliminated. (Haas-Wilson, Tr. 2677-78; Noether, Tr. 5903-04). { [REDACTED] } (Baker, Tr. 4649-50, *in camera*; Elzinga, Tr. 2404).

#### Response to Finding No. 316:

With respect to the second sentence, the first cited source, Baker Tr. 4649-50, *in camera*, does not say what Respondent's proposed finding says. In any event, Dr. Baker lacked credibility. (See CCF 1742-1762).

The finding is incomplete and misleading. In order for alternative explanations to eliminate the finding of market power, the alternative explanations must *fully* explain the price increase. It is possible for there to be more than one explanation for a price increase. (See Noether Tr. 6142 (It is possible that a hospital could merge and both learn about its demand and also obtain market power.)). It is for this reason that Dr. Haas-

Wilson ran a multiple regression model. { [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED] } (Haas-Wilson, Tr. 2615, *in camera*).

317. { [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] } (Haas-Wilson, Tr. 2481-88; Baker, Tr. 4650-53, *in camera*; Elzinga, Tr. 2403-04).

**Response to Finding No. 317:**

The proposed finding is incomplete and misleading. While there can be many possible explanations for a price increase, any explanation for the large post-merger price increase at ENH must be grounded in economic theory. (Haas-Wilson, Tr. 2481). In order for an alternative explanation to eliminate a finding of market power, it must fully explain the price increase. (*See CCRFF 316*).

**3. Market Definition Provides The Necessary Framework In Which To Evaluate These Alternative Explanations**

318. { [REDACTED]  
[REDACTED] } (Baker, Tr. 4702, *in camera*). Market definition is necessary to rule out possible alternative explanations to market power, and when there are alternative explanations – either pre- or post- merger – market definition is necessary in the analysis. (Noether, Tr. 5904).

**Response to Finding No. 318:**

The finding is incorrect. When there is persuasive evidence on the consequences of a merger, it is not necessary to define product or geographic markets. (Elzinga, Tr. 2355; Haas-Wilson, Tr. 2658-59). In this case, Dr. Haas-Wilson was able to reach a

conclusion about the consequences of the merger without first having to address the issue of the relevant markets. (Haas-Wilson, Tr. 2658). { [REDACTED]

[REDACTED] }  
(Haas-Wilson, Tr, 2732-33).

{ [REDACTED] } (Haas-Wilson, Tr. 2534, *in camera*), and then, based on economic theory and healthcare research, compiling a list of the factors that could have caused such a price increase. (Haas-Wilson, Tr. 2480-81). [REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2733, *in camera*). { [REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2734, *in camera*). { [REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2733-34, *in camera*).

319. { [REDACTED]

**Response to Finding No. 319:**

The finding is misleading. { [REDACTED]

[REDACTED] } (See CCRFF 318; Haas-Wilson, Tr. 2733-34, *in camera*).

It is also misleading because in this case, if a market structure analysis is applied, it leads to the same conclusion that the merger increased concentration to highly concentrated, presumptively anticompetitive levels. In RFF 509, Dr. Noether estimated ENH's post-merger market share at 30%. Complaint counsel note that even using Respondent's internal market analysis, Evanston (44%) and Highland Park (11%) had a combined 55% share of their combined service area. (CX 84 at 21; CX 1876 at 18; CX 359 at 16). Moreover, Dr. Baker, the only source cited for this finding, lacks credibility. (CCFF 1742-1762).

**B. The Court Should Evaluate The Competitive Effects Of The Merger**

**1. The Court Should Evaluate Price Effects Of The Merger**

320. The goal of economic analysis of a merger is to "assess or infer whether combining these two firms will raise market prices *and* reduce industry output." (Elzinga, Tr. 2360, emphasis added). A merger only harms consumers when both prices go up and output goes down. (Elzinga, Tr. 2403).

**Response to Finding No. 320:**

The cited source does not say what Respondent's proposed finding claims. Dr. Elzinga did not say a merger *only* harms consumers when both prices go up and output goes down. (Elzinga, Tr. 2403-04 (emphasis added)).

The particular nature of this industry disguises the quantity effect. Because of what Dr. Elzinga called the "payer problem," individual patients who choose the hospital at which to seek services do not bear the costs of those hospital services. (CCFF 1669). Instead, it is the managed care plan that pays for the hospital services. Thus, the person who chooses the hospital at which to obtain hospital services is not the same person who pays for those services. (CCFF 1670).

In this case, when ENH raised its prices, only one managed care plan, One

Health/Great West, tried to drop the hospitals (reduce quantity). It was not successful, so it entered into a contract with ENH. (See CCFF 1133-1162). As such, ENH did not see a direct decline in the number of patients treated. This is because individual patients did not directly pay the price increases that ENH charged the managed care plan. (See CCFF 1669-1673). When managed care plans pass on the increased cost to employers in terms of higher prices, the quantity effect would be seen at the employer/employee level where employers raised the employee's costs or dropped health insurance altogether. (See CCFF 145-151; CCFF 1338-1343; Mendonsa, Tr. 483-84; Dorsey, Tr. 1450).

321. {

} (Noether, Tr. 5987-88; Baker, Tr. 4620-21, *in camera*).

**Response to Finding No. 321:**

The cited sources do not say what Respondent's proposed finding claims. Neither source mentions many various alternative explanations and neither mentions quality improvements. Neither source says that one must consider price increases and price levels to rule out all possible explanations for the price increase.

Relative price changes, not relative prices, is the appropriate methodology to test for market power. Using the price changes approach, one can conclude there is a change in market power if there is a price increase after having ruled out the other possible explanations for greater price increases at one hospital versus another. (CCFF 503-504).

322. For example, ENH's price increases can be explained by the fact that it learned more about MCOs' demand for its services. Just before the Merger, Evanston Hospital learned about HPH's surprisingly more favorable contract rates with a number of MCOs. (Hillebrand, Tr. 1871; Neaman, Tr. 1344-45; RX 2047 at 10-11 (Ogden, Dep.)). At or about this same time, ENH retained Bain, a consulting firm, to learn more effective negotiation strategies and to help ENH obtain a one-time corrective adjustment in its own negotiated prices. (RX 2047 at 10-11

(Ogden, Dep.) { [REDACTED]  
[REDACTED]  
[REDACTED] } (Noether, Tr. 6060, *in camera*; RX 1912 at 73, *in camera*; Baker, Tr. 4669-71, *in camera* (explaining DX 8046)).

**Response to Finding No. 322:**

One of the cited sources, in particular RX 2047 at 10-11, does not say what Respondent's proposed finding claims.

The proposed finding is incorrect. ENH's price increases cannot be explained by Respondent's learning about demand excuse. ENH could not learn about its demand from seeing HPH's contract rates. First, learning about contract rates does not necessarily tell one which hospital has the higher prices. { [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED] } (Haas-Wilson, Tr. 2645-48, *in camera*; CCF 696-702, *in camera*).

Second, hospital services are an example of a differentiated product, and Evanston and Highland Park were different in a number of dimensions. Since Evanston and Highland Park had some different characteristics, they were in somewhat different bargaining positions relative to MCOs pre-merger. The bargaining position of the hospital and the health plan will greatly affect the outcome of the bargaining over the price that a hospital charges an MCO. Therefore, learning how another hospital made out in its bargaining with an MCO will not necessarily inform a hospital how it will make out. (Haas-Wilson, Tr. 2469-70; Noether, Tr. 5910, 6131; CCF 1797-1809. *See also* CCF 1763-2031 discussing the fact that the learning about demand excuse is without merit).

This proposed finding is also incorrect because ENH's true competitors are not

academic hospitals. { [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] } (Haas-Wilson, Tr. 2699-2700, 2702, 2708-09, 2711-13, *in camera*; RX 1912 at 25; CCFF 703-727). Health plans also did not view ENH as an academic hospital. (CCFF 722-727).

323. Moreover, quality improvements need to be considered in evaluating competitive effects because, if quality improves, the buyer gets more for its money. (Baker, Tr. 4604-06). The quality-adjusted price is a way of accounting for the value of quality improvements. (Baker, Tr. 4604-06). If quality improves, the observed or nominal price could rise, but the quality-adjusted price could stay the same or decline. (Baker, Tr. 4604-08). If the quality-adjusted prices stayed the same or declined, consumers would be better off with the Merger – or at least not worse off – than they would have been had the Merger not occurred. (Baker, Tr. 4606).

**Response to Finding No. 323:**

This finding is incorrect. { [REDACTED]

[REDACTED] } (Baker, Tr. 4799-80, *in camera*). In this case, the only comparison of the relative quality changes at ENH compared to a control group was done by Dr. Romano. (CCFF 2045). [REDACTED]  
[REDACTED]  
[REDACTED] } (Romano, Tr. 3004-05, 3008, *in camera*. See also CCFF 597-599 and CCFF 2032-2293 discussing that Respondent failed to prove that quality improved at ENH after the merger.)

Moreover, Dr. Baker, the only source cited for Respondent's finding, lacked credibility. (See CCFF 1742-1762).

**2. The Court Should Evaluate Quality Effects Of The Merger As A Pro-Competitive Effect**

324. Quality has both clinical and non-clinical aspects. (Noether, Tr. 6016). Clinical quality in healthcare is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with the state of current professional knowledge. (Chassin, Tr. 5141). The non-clinical aspects of quality include: service, amenities and patient convenience. (Noether, Tr. 6016). These non-clinical aspects are economically significant because patients value them. (Noether, Tr. 6018).

**Response to Finding No. 324:**

This finding is misleading. To the extent that this section of Respondent's proposed findings are making a legal argument that this court must evaluate the quality effects of this merger, it is inappropriate to make such arguments in proposed findings of fact, and moreover, the findings misstate the appropriate standards. To the extent that this section of proposed findings are making an economic argument that this court should weigh quality improvements against the anticompetitive price increases, the findings misstate the appropriate economic principals.

The standards for considering quality improvements or other efficiencies in a merger case are set forth in the Merger Guidelines. Complaint Counsel treat the issue of quality improvements in our post-trial brief, as is appropriate, and merely note here that under Section 4 on Efficiencies, of the Merger Guidelines, "[t]he [FTC] will consider only those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects. These are termed *merger-specific efficiencies*." (Merger Guidelines, Section 4). Nowhere in Respondent's findings does Respondent address the requirement that the efficiencies, in this case the alleged quality improvements, must be merger-specific.



[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2545, *in camera*) . Experts in the field of healthcare quality rely principally on outcome and process measures, (Romano, Tr. 2988-89; CCF 2122-2132). In looking at quality, outcomes are “what we all care about”. (Chassin, Tr. 5153, 5461). ENH itself focused on outcomes when evaluating its quality of care. (O’Brien, Tr. 3555-56). Non-clinical aspects of care, such as amenities, are unlikely to actually affect health outcomes. (Romano, Tr. 2987-88).

325. Quality is important in the analysis of competitive effects because it is one of the dimensions in which hospitals compete. (Noether, Tr. 6011). Patients are made better off when quality is improved, and they certainly use quality to the extent that they can evaluate it as one of the dimensions by which they choose hospitals. (Noether, Tr. 6011). Quality “certainly affects the competitive strength of the institution as well as the benefits to the consumers.” (Noether, Tr. 6039).

**Response to Finding No. 325:**

This finding is misleading. [REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2545, *in camera*). [REDACTED]

[REDACTED] } (Baker, Tr. 4799-800, *in camera*).

The only comparison of quality at ENH relative to other hospitals was done by Dr. Romano, and he found that quality did not improve at ENH relative to other hospitals. (Romano, Tr. 3004-5; Chassin, Tr. 5448-49; Noether, Tr. 6181-83). Respondent has not shown how any changes to HPH’s quality of services outweighed the anticompetitive effects of the merger. (CCFF 2038-2045). It should also be noted that alleged quality improvements did not factor into ENH’s negotiation of managed care contract price

increases with health plans. (CCFF 2470-2496). Moreover, virtually all of the alleged quality improvements occurred after the price increases were negotiated. (CCFF 2444-2469).

326. Quality improvements should be considered in the analysis of competitive effects regardless of whether outpatient services are included in the relevant product market. (Baker, Tr. 4602, 4608). In this case, improvements in both inpatient and outpatient services should be examined in the analysis of the competitive effects of the Merger. (Baker, Tr. 4608-09).

**Response to Finding No. 326:**

This finding is incomplete and misleading. Like any efficiency, an increase in the quality of outpatient services would have to be merger specific and would have to be shown to be greater than the quality increase at other hospitals in order to affect the competitive analysis of this merger. (See CCRFF 324-325). Respondent has shown neither requirement here. Outpatient services are irrelevant to an analysis of the anti-competitive effects of the merger. Outpatient services are not substitutable with inpatient services. (See CCFF 1625-1628, 1635-1644). { [REDACTED]

[REDACTED]

[REDACTED]

(Haas-Wilson, Tr. 2614-15, *in camera*. See also CCREF 325). Furthermore, Respondent has not offered any evidence why any alleged improvements in outpatient services at HPH necessitated a merger with ENH. Moreover, Dr. Baker, the only source cited for this finding, lacks credibility. (CCFF 1742-1762).

327. All improvements in the quality of *inpatient* services should be counted because they are improvements that are within the product markets of both Drs. Noether and Haas-Wilson. (Baker, Tr. 4608-09). Similarly, improvements in the quality of *outpatient* services also should be counted in the analysis of the competitive effects of the Merger because they are part of the proper relevant market of all acute care hospital-based services, as defined by Dr. Noether. (Baker, Tr. 4609).

**Response to Finding No. 327:**

The finding is irrelevant, and the reasons for its irrelevance are explained in greater detail at CCRFF 324-326. Moreover, Dr. Baker, the only source cited for this finding, lacks credibility. (CCFF 1742-1762).

328. Improvements in the quality of outpatient services are relevant even under Dr. Haas-Wilson's more limited relevant product market, which excludes outpatient services. Outpatient quality improvements should be counted in that circumstance because the benefits of those services accrue to the MCOs, which purchase inpatient and outpatient services in the same contract. Moreover, outpatient services are inextricably linked to quality improvements in inpatient services. (Baker, Tr. 4609).

**Response to Finding No. 328:**

The finding is irrelevant, and the reasons for its irrelevance are explained in greater detail at CCRFF 324-326. Moreover, Dr. Baker, the only source cited for this finding lacks credibility. (CCFF 1742-1762).

329. Although Dr. Noether relied on Dr. Chassin for an evaluation of clinical quality, she independently analyzed non-clinical quality. (Noether, Tr. 6016). Dr. Noether concluded, "based on the evidence in the record, that quality [including clinical and non-clinical quality] improved substantially at Highland Park Hospital post-merger." (Noether, Tr. 5901-02). By contrast, Dr. Haas-Wilson did not do an independent empirical analysis of post-Merger quality changes and, instead, relied on the analysis of Dr. Romano alone to conclude that clinical quality did not improve after the Merger. (Haas-Wilson, Tr. 2446-47, 2586; Noether, Tr. 6018-19). Dr. Haas-Wilson did not evaluate the non-clinical aspects of quality. (Noether, Tr. 6019).

**Response to Finding No. 329:**

The finding is misleading. Dr. Noether has never previously given opinions about whether quality at a particular hospital has improved over time. (Noether, Tr. 6183). In fact, Dr. Noether does not have the skills, training and ability to do her own evaluation of the expert report of Complaint Counsel's quality expert, Dr. Romano. (Noether, Tr. 6182).

This finding is also irrelevant and the reasons for its irrelevance are given at

**3. The Court Should Take Into Account Other Competitive Effects Considerations**

**a. The Court Should Evaluate Issues Pertaining To Market Entry And Repositioning**

330. Repositioning or entry is “the enhancement of competition either through brand new entry – in a hospital case, it would be a new hospital being constructed and opened – or more modestly, repositioning can imply an existing hospital upgrading its capacity, expanding its capacity, adding new services, updating its physical plant, doing things that essentially make it a more attractive facility to managed care organizations and their enrollees and thereby making it more competitive in the marketplace.” (Noether, Tr. 6023).

**Response to Finding No. 330:**

The finding is irrelevant. Respondent’s proposed finding of fact is irrelevant because there was no meaningful repositioning or entry and no meaningful demand or supply side substitution following a large sustained price increase by ENH. ENH’s price increases were not constrained by entry, nor was ENH forced to roll back prices increases because of repositioning or entry. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2635-36, *in camera*. See

*also* CCFF 643-692). Following the price increases ENH did not see a decrease in the number of managed care admissions. (Neaman, Tr. 1211-12). ENH management did not believe that other hospitals would act as a pricing constraint by changing their prices as a result of ENH’s 2000 price increases (Neaman, Tr. 1212; Hillebrand, Tr. 1764-65; Newton, Tr. 367. See also CCFF 952-954).

331. In evaluating the competitive effects of the Merger, the proper economic analysis

compares the actual situation post-Merger to the situation that would have existed during the post-Merger time period if the Merger had not occurred. (Noether, Tr. 6024). Consequently, if hospitals that compete with ENH have become more competitive through repositioning, then it is likely that competition would have increased in this way even absent the Merger. (Noether, Tr. 6024).

**Response to Finding No. 331:**

The finding is irrelevant. ENH's price increases have not been constrained by repositioning or entry, nor was ENH forced to roll back price increases because of repositioning or entry. (See CCFF 952-954). If hospitals became more competitive through repositioning, the premise of the finding of fact, and these hospitals were not able to constrain or force the rollback of the price increases at ENH, it is irrelevant whether or not such repositioning would have occurred absent the merger.

332. Repositioning is significant because, in this case, there is substantial evidence that a number of hospitals in the Chicago area – and, most particularly, hospitals around Highland Park – have spent, and are spending, substantial resources to upgrade their facilities and to make themselves competitive in the market place. (Noether, Tr. 6023).

**Response to Finding No. 332:**

The finding is irrelevant. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (See CCFF 1982-2015, *in camera*; Noether,

Tr. 6201 (no health plans switched business away from ENH following the merger)). If hospitals were not able to constrain or force the roll back of the price increases at ENH, it is irrelevant whether these hospitals upgraded their facilities to make themselves more competitive. No hospitals moved their facilities to the area within the triangle formed by Evanston, Glenbrook and Highland Park

**b. The Court Should Evaluate The Financial Condition Of HPH Before The Merger**

333. The financial condition of HPH before the Merger is important to take into account in evaluating competitive effects because if HPH were in a weakened financial condition before the Merger, this would have limited HPH's ability to have any competitive significance going forward had it remained independent. (Noether, Tr. 6026).

**Response to Finding No. 333:**

Respondent's finding is irrelevant. Respondent's finding is only relevant if HPH were in a seriously weakened financial condition before the merger and if HPH were not an attractive candidate for other mergers. Both scenarios are contrary to the facts. As HPH management noted in 1999, Highland Park "can remain financially strong over the foreseeable future." (CX 1055 at 3). As discussed in greater detail in the reply findings to Section IX.B, Highland Park had a strong balance sheet, good operational results, and a strong strategic plan for the future. (See CCRFF 2319-2404). Highland Park was also an attractive candidate for other mergers (See CCF 368-372), meaning it might have increased its competitive significance through another merger had it not been acquired by Evanston.

334. To understand HPH's pre-Merger financial condition, one must weigh HPH's future cash needs against its sources of cash. (Noether, Tr. 6028).

**Response to Finding No. 334:**

Respondent's finding is irrelevant. Respondent's finding is only relevant if weighing HPH's future cash needs and sources of cash would lead to some conclusion that HPH's financial condition was somehow seriously poor. This is contrary to the facts as explained in the reply findings to Section IX.B. (See CCRFF 2319-2404).

**c. The Court Should Evaluate ENH's Not-For-Profit Status**

335. Not-for-profit hospitals, like ENH, reinvest their revenue into the hospitals. (CX

6304 at 11-12 (Livingston, Dep.)). Revenue earned by a not-for-profit hospital, like ENH, does not leak out of the hospital system in any way at all. (CX 6304 at 11-12 (Livingston, Dep.)).

**Response to Finding No. 335:**

The finding is misleading, because it implies, incorrectly, that the excess revenue gained through the market power resulting from the merger went for medical purposes. Surplus resulting from supra-competitive prices can be used to benefit hospital executives rather than consumers. (Simpson, Tr. 1649). Following the Evanston and Highland Park merger, ENH's compensation contracts did not align management's interests with consumers on the issue of price. (Simpson, Tr. 1629).

In fact, ENH management had a plan for using some of the money derived from raising hospital prices post-merger. The president of ENH proposed adding an additional \$3 million into the 2000 bonus pool attributable to the merger integration activities. (Neaman, Tr. 1263-64; CX 31 at 1). Furthermore, ENH's managers were given bonuses for meeting revenue targets from operations. (Simpson, Tr. 1629-30). Additionally, shortly before the Letter of Intent to Merge was signed, Highland Park senior executives entered into enhanced compensation agreements that "offered additional retention bonuses as well as enhanced severance agreements" at a cost of \$8 million. (CX 534 at 3). Several of ENH's senior executives received merit increases in their salaries in the range of 5-6% in 1998 to 1999 and another salary increase of 10% from the fall of 2000 to the fall of 2001. (Neaman, Tr. 1265-67; CX 2099 at 2-3). A similar trend is apparent with annual incentive compensation awards. Various ENH executives received substantially higher awards at the end of 2000, compared to the awards in 1998 and 1999. (Neaman, Tr. 1267-69; CX 2099 at 8-9).

336. Economic theory does not necessarily predict that a not-for-profit hospital would

try to maximize profits. (Simpson, Tr. 1646). In fact there is expert theory by Drs. William Lynk and Lynette Neumann that “found that non-profit hospitals tended not to exploit market power.” (Simpson, Tr. 1626).

**Response to Finding No. 336:**

The finding is incomplete. The theory by Drs. Lynk and Neumann requires that the board set up a mechanism to ensure that the not-for-profit hospital basically sets the competitive price, which was not the case here. (Simpson, Tr. 1622, 1629 (The ENH board did not actively monitor the pricing decisions of hospital management and “did not try to ensure that price was set at basically the competitive level.”)).

Furthermore, Respondent neglects to mention that Dr. Simpson also testified that economic studies do support the view that not-for-profit hospitals exercise market power. (Simpson, Tr. 1621). Four peer-reviewed studies performed by four different sets of researchers and using four different research methods found that hospitals tend to exploit market power and that not-for-profit hospitals in concentrated markets set higher prices than in less concentrated markets. (Simpson, Tr. 1624-25). An additional case study, involving a merger of not-for-profit hospitals, that was done by a different set of researchers, using a different methodology, also found that non-profit hospitals exercised market power. (Simpson, Tr. 1627-28). The two studies finding that non-profit hospitals tend not to exploit market power were both performed by Dr. Lynk and used different data sets and a different analysis structure from the four studies finding that hospitals do tend to exploit market power. (Simpson, Tr. 1625-27).

337. The decision to open a new service not in the hospital where it would be most profitable, but in the hospital that would best benefit the community, is evidence that the hospital system is not acting like a profit-maximizing firm. (Simpson, Tr. 1633). The provision of more charity care that would benefit the community is another example of how a not-for-profit hospital provides benefits to the community that a for-profit hospital might not. (Simpson, Tr. 1633-34).



**Response to Finding No. 337:**

The finding is incomplete, and Respondent has not provided any evidence demonstrating that this finding is relevant. Respondent neglects to mention that Dr. Simpson also said that a not-for-profit hospital could both exploit market power and do some good things for a community. (Simpson, Tr. 1648-49). For example, a not-for-profit hospital might set prices above a competitive level, and that would generate a surplus, which could be used in part for charity care, and in part for things that people might view as wasteful. (Simpson, Tr. 1648-49).

338. Complaint Counsel's expert on not-for-profit issues did not testify that ENH used surplus funds in a wasteful manner, or tried to build a prestigious facility that the community would not otherwise need. (Simpson, Tr. 1635, 1648, 1650).

**Response to Finding No. 338:**

The finding is misleading. While Dr. Simpson never claimed that ENH built unnecessary facilities, this was merely an illustrative example. Dr. Simpson did testify that the surplus resulting from supra-competitive prices can be used for higher executive salaries. In other words, it can be used to benefit the hospital executives rather than consumers. (Simpson, Tr. 1649). This is precisely what happened following the Highland Park and Evanston merger. (*See, e.g.*, CCRFF 335). Dr. Simpson also testified that ENH's compensation contracts did not align management's interests with consumers on the issue of price. (Simpson, Tr. 1629).

**C. ENH's Economist Experts Analyzed The Facts Of The Case In The Context Of This Analytic Framework**

**1. Dr. Monica Noether**

339. Dr. Monica Noether is an economist who specializes in the economics of industrial organization. She has focused on healthcare markets for the past eighteen years. (Noether, Tr. 5889).

**Response to Finding No. 339:**

Complaint Counsel have no specific response.

340. Dr. Noether received her Bachelor's degree from Wesleyan University in 1974. She received her Masters of Business Administration degree with a specialization in finance from the University of Chicago in 1980. And she received her Ph.D. in Economics from the University of Chicago in 1983. (Noether, Tr. 5890). Dr. Noether lived in Chicago during the time she studied for her MBA and Ph.D. (Noether, Tr. 5890).

**Response to Finding No. 340:**

Complaint Counsel have no specific response.

341. After receiving her graduate degrees, Dr. Noether worked for the FTC from 1983-1987 as a staff economist, a part-time adviser to one of the Commissioners and, eventually, as the Deputy Assistant Director of the Bureau of Economics. (Noether, Tr. 5892).

**Response to Finding No. 341:**

Complaint Counsel have no specific response.

342. From 1987-1996, Dr. Noether worked at a policy research and consulting firm called ABT Associates, where she eventually served as managing vice president. (Noether, Tr. 5892).

**Response to Finding No. 342:**

Complaint Counsel have no specific response.

343. In 1996, Dr. Noether joined Charles River Associates. (Noether, Tr. 5892). Dr. Noether is currently a Vice President at Charles River Associates and, since 2001, she has served as the head of Charles River's Competition Practice. (Noether, Tr. 5889, 5892-93).

**Response to Finding No. 343:**

The finding is incomplete. Dr. Noether is paid both a salary and bonus by Charles River Associates. Her bonus is based on the overall profitability of Charles River. In this case, she had thirty employees of Charles River assisting her. Charles River makes a profit on the time billed by the people who assisted Dr. Noether in this matter. Dr. Noether could not say how much Charles River billed for its work in this matter.

(Noether, Tr. 6134)

344. Dr. Noether has published various papers in peer-reviewed journals. (Noether, Tr. 5891).

**Response to Finding No. 344:**

The finding is incomplete. The articles that Dr. Noether wrote do not address the key issues in this litigation. Dr. Noether knows of no articles in any refereed journal that even consider the question of whether a hospital's prices increased because of learning about demand as opposed to increasing because of a hospital's obtaining market power through a merger. (Noether, Tr. 6144). Not knowing of any such articles, none of the articles she had published could have addressed that issue. Dr. Noether did not base her selection of hospitals for her control group on any articles in economic literature.

(Noether, Tr. 6150). Having no articles to base her selection of a control group on none of the articles that she published could have addressed that issue.

345. Dr. Noether has worked on a variety of different hospital mergers, both for the merging parties as well as for the Government, as well as a number of health plan merger cases on behalf of the merging parties generally. (Noether, Tr. 5893).

**Response to Finding No. 345:**

The finding is incomplete. Dr. Noether never previously gave opinions about key issues in this litigation. Dr. Noether has never previously testified in a merger case where the merger was already consummated. (Noether, Tr. 6134). Dr. Noether has never previously given opinions about whether quality at a particular hospital has improved over time. (Noether, Tr. 6183). In fact, Dr. Noether does not have the skills, training and ability to do her own evaluation of the expert report of Complaint Counsel's quality expert, Dr. Romano. (Noether, Tr. 6182).

346. Dr. Noether has testified as an expert in three hospital merger cases on behalf of

the Federal Government, including: *FTC v. University Health*, *FTC v. Columbia Hospital Corp.*, *U.S. v. Mercy Health and Finley Health Services*. (Noether, Tr. 5893-94).

**Response to Finding No. 346:**

The finding is incomplete. The positions that Dr. Noether took when she was testifying as an expert retained by the government are inconsistent with the positions she is taking in the ENH case. In her previous litigation, Dr. Noether testified that the relevant product market in which to evaluate a merger of acute care hospitals was limited to inpatient care, but in this case she testified that the relevant market in which to evaluate a merger of acute care hospitals includes both inpatient and outpatient care. (Noether, Tr. 5924-25).

347. Dr. Noether was invited to testify twice in the recent FTC/DOJ joint hearings on healthcare competition and policy. (Noether, Tr. 5894, 6194-95).

**Response to Finding No. 347:**

Complaint Counsel have no specific response.

348. Dr. Noether is the vice-chair of the Antitrust Practice Group of the American Health Lawyers Association, she is a member of the American Bar Association where she participates on the Antitrust Committee and the Health Law Committee, and she is a member of the Association for Health Services Research. (Noether, Tr. 5894).

**Response to Finding No. 348:**

Complaint Counsel have no specific response.

349. Dr. Noether was retained by ENH to conduct an economic analysis of competitive effects, and to review the work of Complaint Counsel's experts retained in this case. (Noether, Tr. 5895).

**Response to Finding No. 349:**

The finding is incomplete. Dr. Noether is paid both a salary and bonus by Charles River Associates. Her bonus is based on the overall profitability of Charles River. In this case, she had thirty employees of Charles River assisting her. Charles River bills out its

employees' time at rates such that Charles River makes a profit on their time. Dr. Noether could not say how much Charles River billed for its work in this matter. Dr. Noether's time was billed out at \$520 per hour, and she had put in approximately 850 hours prior to her testimony. (Noether, Tr. 5898-99, 6134).

350. Dr. Noether performed a comprehensive analysis using the economic principles underlying the Merger Guidelines. (Noether, Tr. 5895). In assessing competitive effects, Dr. Noether considered both price and quality. (Noether, Tr. 5895).

**Response to Finding No. 350:**

The finding is incorrect. Dr. Noether performed a less than comprehensive analysis and did not appropriately apply the economic principles underlying the Merger Guidelines. Although she claims to have applied the Merger Guidelines principles in her analysis, she never performed the test in the Merger Guidelines for arriving at definitions of relevant markets, *i.e.* she never assumed a small but significant and non-transitory price increase and examined what would have happened in her proposed market. (Noether, Tr. 6198-99).

In addition, while Dr. Noether claims to have considered quality, Dr. Noether does not have the skills, training and ability to do her own evaluation of the expert report of Complaint Counsel's quality expert, Dr. Romano. Dr. Noether does not have a medical degree, and she never performed an examination of the relative changes in quality at Highland Park compared to control group hospitals. (Noether, Tr. 6181-83).

Finally, while Dr. Noether purports to have performed a comprehensive analysis, her arbitrary and biased control groups used in her price level analysis preclude her conclusions from being given any weight. (*See* CCFF 1814-1951).

351. Dr. Noether used testimony, documents and data analysis as the basis for her conclusions about the competitive effects of the Merger. (Noether, Tr. 5895-96). Dr. Noether

reviewed Investigational Hearing transcripts, deposition transcripts and trial testimony. (Noether, Tr. 5897). The documents that Dr. Noether considered included, among other things: strategic plans, documents prepared by consultants, financial statements of HPH and managed care contracts. (Noether, Tr. 5896).

**Response to Finding No. 351:**

The finding is incomplete. While Dr. Noether may have reviewed documents and testimony in this case, a critical part of Dr. Noether's analysis is based on her control groups, which she selected herself. Her selection of these control groups was arbitrary, and her comparisons of ENH's prices to these control groups are biased and inappropriate. (See CCF 1814-1951).

352. The data used in Dr. Noether's analysis included: (1) claims data provided by some of the relevant MCOs; (2) hospital discharge data provided by the Illinois Hospital Association; and (3) data contained in the Medicare Cost Reports. (Noether, Tr. 5896-97).

**Response to Finding No. 352:**

The finding is incomplete. While Dr. Noether analyzed this data, she relied on control groups, which she selected herself. Her selection of these control groups was arbitrary, and her comparisons of ENH's prices to these control groups are biased and inappropriate. (See CCF 1814-1951).

**2. Professor Jonathan Baker**

353. Professor Jonathan Baker is an economist specializing in applied industrial organization. He is employed as a Professor of Law at the Washington College of Law at American University, and is also a Senior Consultant at Charles River Associates, an economics consulting firm. (Baker, Tr. 4588; RX 2036 at 1).

**Response to Finding No. 353:**

Complaint Counsel have no specific response.

354. Professor Baker worked at the Antitrust Division of the United States Department of Justice from 1990 through 1993, in the Economic Analysis Group, as the Director of Litigation Studies and Special Assistant to the Deputy Assistant Attorney General for Economics, the chief economist at the Antitrust Division. (Baker, Tr. 4592; RX 2036 at 1).

**Response to Finding No. 354:**

Complaint Counsel have no specific response.

355. While working at the Antitrust Division of the Justice Department, Professor Baker advised the Deputy Assistant Attorney General for Economics on all major merger and non-merger cases that the Antitrust Division was investigating. (Baker, Tr. 4593-94). Professor Baker also helped write the first draft of the 1992 Merger Guidelines. (Baker, Tr. 4593).

**Response to Finding No. 355:**

Complaint Counsel have no specific response.

356. After leaving the Antitrust Division, Professor Baker was the senior economist for regulation, industrial organization and law at the Council of Economic Advisors in the Executive Office of the President, an organization within the White House that provides dispassionate academic economic advice to the President. He served in that position from June 1993 through April 1995. (Baker, Tr. 4593; RX 2036 at 1).

**Response to Finding No. 356:**

Complaint Counsel have no specific response.

357. Professor Baker then worked for the FTC, where he was the Director of the Bureau of Economics from April 1995 through December 1998. (Baker, Tr. 4594; RX 2036 at 1).

**Response to Finding No. 357:**

Complaint Counsel have no specific response.

358. While Bureau Director, Professor Baker advised the Commission on every antitrust and consumer protection matter that the Commission considered, supervised a staff of around 60 Ph.D. economists, and was a member of the task force of senior FTC and Justice Department officials who drafted the revisions to the efficiency section of the Merger Guidelines. (Baker, Tr. 4594-95). Professor Baker received an award for distinguished service from the FTC in October 1998. (Baker, Tr. 4595; RX 2036 at 1).

**Response to Finding No. 358:**

Complaint Counsel have no specific response.

359. In 2002, Professor Baker was invited by former FTC Chairman Timothy Muris to be an unpaid consultant to the FTC on merger policy. (Baker, Tr. 4595).

**Response to Finding No. 359:**

Complaint Counsel have no specific response.

360. Professor Baker worked on hospital merger cases while at the Justice Department and the FTC, has participated in an FTC/DOJ workshop on merger policy and testified in FTC/DOJ hearings on healthcare policy. (Baker, Tr. 4595-96).

**Response to Finding No. 360:**

Complaint Counsel have no specific response.

361. Professor Baker was the chair of the Antitrust and Economic Regulation Section of the Association of American Law Schools, an organization of law professors. (Baker, Tr. 4596; RX 2036 at 1). Professor Baker currently is a member of the Council of the Section of Antitrust Law of the American Bar Association, and was the editorial chair of Antitrust Law Journal, which is the publication of the American Bar Association's Section of Antitrust Law that publishes legal and economic articles regarding antitrust issues. (Baker, Tr. 4596-97; RX 2036 at 9).

**Response to Finding No. 361:**

Complaint Counsel have no specific response.

362. Professor Baker has authored several articles involving the application of econometric methods to the measurement of market power, including: "Empirical Methods in Antitrust Litigation: Review and Critique," "Contemporary Empirical Merger Analysis," "Econometric Analysis in FTC Versus Staples," and "Empirical Methods of Identifying and Measuring Market Power." (Baker, Tr. 4597-98; RX 2036 at 2-9).

**Response to Finding No. 362:**

The finding is incomplete. {

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Baker, Tr. 4771, *in camera*).

Professor Baker also wrote an article titled "Unilateral Competitive Effects

Theories in Merger Analysis." {

[REDACTED]

[REDACTED]

[REDACTED]



[REDACTED]  
[REDACTED]  
[REDACTED]  
(Baker, Tr. 4787-88, *in camera*).

363. Professor Baker provided trial and deposition testimony on behalf of the merging firms in the case of *FTC v. H.J. Heinz & Co.*, and gave deposition testimony on behalf of the Government in the case of *United States v. Northwest Airlines, Inc.* (Baker, Tr. 4598; RX 2036 at 10).

**Response to Finding No. 363:**

The finding is incomplete. Neither of these cases involved hospital mergers. (See *FTC v. H.J. Heinz & Co.* and *United States v. Northwest Airlines, Inc.*) [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED] (Baker, Tr. 4751, *in camera*).

In the *Heinz* case, the only prior case in which Professor Baker gave trial testimony, Professor Baker testified to a defense theory about competitive harm that was refuted by the record evidence. *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 724 (D.C. Cir. 2001).

364. Professor Baker worked on more limited aspects of this case than Dr. Noether. (Baker, Tr. 4600-01). He was retained by ENH to conduct an analysis of the magnitude of the price changes that followed the Merger. In particular, he was asked to determine whether there was a benign explanation for the price change – *i.e.*, whether learning about demand could explain the price change. (Baker, Tr. 4601). Professor Baker also examined the role of quality improvements in the analysis of competitive effects. (Baker, Tr. 4601). Finally, Professor Baker was asked to review the methodology used by Complaint Counsel's experts retained in this case. (Baker, Tr. 4601).

**Response to Finding No. 364:**

The finding is incomplete. [REDACTED]

[REDACTED] (Baker, Tr. 4708, *in camera*).

[REDACTED]

[REDACTED]

[REDACTED] (Baker, Tr. 4706, *in camera*; Baker, Tr. 4598-99). [REDACTED]

[REDACTED]

[REDACTED] (Baker, Tr. 4708, *in camera*).

Moreover, the work done by Professor Baker in this case is not credible. (See CCFF 1742-1762).

365. Professor Baker analyzed claims data provided by four MCOs; reviewed trial, deposition and investigational transcripts; toured the three ENH hospitals; and interviewed some of ENH's executives. (Baker, Tr. 4601). He also examined all of the expert reports provided by both ENH and Complaint Counsel. (Baker, Tr. 4601). Finally, Professor Baker relied on work performed by Dr. Noether. (Baker, Tr. 4600-01).

**Response to Finding No. 365:**

The finding is incomplete. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

(Baker, Tr. 4752-54, *in camera*). Moreover, the work done by Professor Baker in this case is not credible. (See CCFF 1742-1762).

## VI. RELEVANT MARKET

### A. The Relevant Product Market Consists Of All Acute Care Hospital-Based Services

366. To identify the relevant product market, “the [M]erger [G]uidelines instruct that one should look at the product actually being sold to relevant customers.” (Noether, Tr. 5905).

#### Response to Finding No. 366:

The finding is incomplete and misleading. The Merger Guidelines instruct that “[a] market is defined as a product or group of products and a geographic area in which it is produced or sold such that a hypothetical profit-maximizing firm, . . . that was the only present and future producer or seller of those products in that area likely would impose at least a ‘small but significant and nontransitory’ increase in price [“SSNIP”], assuming the terms of sale of all other products are held constant.” (Merger Guidelines, § 1.0). Using this approach, Dr. Haas-Wilson testified that the relevant product market is general acute care inpatient services (excluding quaternary services) sold to managed care plans. (Haas-Wilson, Tr. 2659, 2663, 2665-66). “A relevant market is a group of products . . . that is no bigger than necessary to satisfy this test.” (Merger Guidelines, § 1.0). More specifically, with reference to product market definition, one must look at “each product (narrowly defined) produced or sold by each merging firm and ask what would happen if a hypothetical monopolist of that product imposed at least a ‘small but significant and nontransitory’ increase in price, but the terms of sale of all other products remained constant.” (Merger Guidelines, § 1.11).

Thus, one does not simply “look at the product” being sold as Dr. Noether testified. (Among other reasons, a firm may sell relevant customers various different products that do not fall in the same product market.) Rather, one applies a rigorous

analytical framework that attempts to answer the question of what would happen as a hypothetical monopolist imposes a SSNIP for a narrowly defined product.

**1. The Product At Issue Being Sold Includes All Acute Care Hospital-Based Services**

367. The product at issue is acute care hospital-based services. The term “acute care services” refers to services of a “relatively short-term nature” provided “to patients with an acute need” and is “distinguished from more long-term services, such as rehab or sometimes psychiatric care that are applied to more chronically ill patients.” (Noether, Tr. 5905).

**Response to Finding No. 367:**

The finding is incorrect, incomplete, and misleading. Respondent’s assertion is incorrect because the Merger Guidelines require that one begin the analysis with “each product (narrowly defined).” (Merger Guidelines, Section 1.11). Using this approach, Dr. Haas-Wilson testified that the relevant product market is general acute care inpatient services (excluding quaternary services). (Haas-Wilson, Tr. 2659, 2663, 2665-66). By comparison, Dr. Noether began with the set of “all acute care hospital-based services,” including both inpatient and outpatient services. Dr. Noether skipped a step required by the Merger Guidelines, which is to look at “each product” “narrowly defined” and then to apply the hypothetical monopolist test to that product. Under the Merger Guidelines it is inappropriate to start the analysis by grouping all services that are provided at an acute care hospital facility. Respondent also ignored the evidence that, when faced with a price increase for inpatient services, health plans could not substitute inpatient for outpatient services. (CCFF 1635). Moreover, Respondent ignored testimony from Mr. Neaman and Mr. Hillebrand that changes in inpatient pricing have no impact on whether patients switch from inpatient services to outpatient services. (Neaman Tr. 1210; Hillebrand, Tr. 1755-56).

368. Hospital services are a differentiated product. (Noether, Tr. 5910; Haas-Wilson, Tr. 2492). Hospital services are differentiated on both product and geographic dimensions. (Noether, Tr. 5911).

**Response to Finding No. 368:**

Complaint Counsel have no specific response.

**2. The Relevant Customers, i.e., MCOs, Purchase All Acute Care Hospital-Based Services Together**

**a. MCOs Purchase Inpatient And Outpatient Services Together**

369. { [REDACTED] }  
(Spaeth, Tr. 2299-2300; Ballengee, Tr. 144-45, 200; Mendonsa, Tr. 556, *in camera*; Hillebrand, Tr. 1862; Foucre, Tr. 1122-23, *in camera*; Holt-Darcy, Tr. 1585, *in camera*).

**Response to Finding No. 369:**

The finding is irrelevant. The fact that a buyer contracts for the purchase of different services under the same contract is not a basis for concluding that the different products are in the same product market. The Merger Guidelines make clear that the definition of the relevant product market is determined by looking at the likely reaction of buyers to a price increase, including (among other things): (1) "evidence that buyers have shifted or have considered shifting purchases between products in response to relative changes in price or other competitive variables," and (2) "evidence that sellers base business decisions on the prospect of buyer substitution between products in response to relative changes in price or other competitive variables." (Merger Guidelines, § 1.11). The record evidence is that changes in inpatient pricing have no impact on patients switching from inpatient to outpatient services. (Neaman Tr. 1210; Hillebrand, Tr. 1755-56). To the extent that the buyer's perspective is taken into account in defining a product market, it is also inappropriate to include both inpatient and outpatient services in the same market. ENH did not base its business decisions on the prospect that patients would

switch from inpatient services to outpatient services as a result of the inpatient price changes. (Neaman, Tr. 1210-11). Moreover, when ENH developed its plan to negotiate higher prices, ENH did not prepare or ask for any documents analyzing whether more patients would switch from inpatient to outpatient services as a result of changes in inpatient prices. (Hillebrand, Tr. 1756).

370. { [REDACTED] } (Foucre, Tr. 1122, *in camera*). In addition, Ballengee testified that when entering into a contract with a hospital, she contracts “for the entire set of services at a hospital.” (Ballengee, Tr. 200).

**Response to Finding No. 370:**

The finding is misleading and incomplete. Ms. Ballengee testified that she distinguishes inpatient acute care hospital services and outpatient hospital services, and that PHCS contracts for them separately. (Ballengee, Tr. 144-45). Moreover, Dr. Haas-Wilson testified that “many sellers offer multiple products,” and the mere packaging of the products together “would not be any basis” for concluding that the two products are in the same product market. (Haas-Wilson, Tr. 2664-65). Thus, Dr. Haas-Wilson concluded that the relevant product market is general acute care inpatient services (excluding quaternary services). (Haas-Wilson, Tr. 2665-66).

371. { [REDACTED] } (Neary, Tr. 590-91; Holt-Darcy, Tr. 1587, *in camera*; Mendonsa, Tr. 557, *in camera*). { [REDACTED] } (Neary, Tr. 590-91; Holt-Darcy, Tr. 1586, *in camera*)

**Response to Finding No. 371:**

The finding is irrelevant. The fact that services are purchased together does not have any significance under the Merger Guidelines in terms of defining a product market.

(Merger Guidelines, § 1.11). Furthermore, Dr. Haas-Wilson testified that the testimony concerning health plans accepting higher prices for inpatient services in return for lower prices for outpatient services is consistent with the fact that many sellers offer multiple products and may trade off an increase in price for one product. That does not mean here that the two products are in the same product market. (Haas-Wilson, Tr. 2663-65).

372. Moreover, inpatient and outpatient services are intertwined. (Neaman, Tr. 1295). Depending on the patient, some procedures may be done on either an inpatient or an outpatient basis, one example being a laparoscopy. (Neary, Tr. 592-93).

**Response to Finding No. 372:**

The finding is incorrect, incomplete and misleading. Mr. Neaman never used the word “intertwined.” Instead, he stated that “medicine,” in general, cannot be performed on just an inpatient or outpatient basis. (Neaman, Tr. 1295). When Mr. Neary was asked what percentage of services that are done on an inpatient basis can also be done on an outpatient basis, he replied “None.” (Neary, Tr. 592) Also, Mr. Neary testified that none of the services that are done on an inpatient basis can be done on an outpatient basis, because, “[I]f the service is an inpatient service, then it should be done inpatient not vice versa,” and “If it’s inpatient, it should be done inpatient. If it’s outpatient, it should be done outpatient.” (Neary Tr. 592). Even if there was a possibility of having a surgery done on an outpatient basis, “it would depend on factors, . . . , the general health of the – of the patient and what the physician wanted.” (Neary, Tr. 593). Mr. Neary also explained that, even in instances where there could be overlap (e.g., MRI services or outpatient surgery services), “you could not substitute that in totality for a hospital.” (Neary, Tr. 594).

ENH officials did not contradict Mr. Neary’s testimony. Mr. Spaeth, former

president of Highland Park, and Mr. Newton both testified that the physician determines whether a patient should be admitted to the hospital. (Spaeth, Tr. 2076; Newton, Tr. 302). Indeed, Mr. Hillebrand testified that any shift toward outpatient services from inpatient services is a factor of a change in medicine and other factors rather than pricing. (Hillebrand, Tr. 1756).

373. Dr. Noether found that in this case, Evanston Hospital and HPH both provided a range of acute care services (inpatient and outpatient services) that they sold as a package to MCOs. (Noether, Tr. 5906).

**Response to Finding No. 373:**

The finding is irrelevant. The fact that services are purchased together does not have any significance under the Merger Guidelines in terms of defining a product market. The Merger Guidelines make clear that the definition of the relevant product market is determined by looking at the likely reaction of buyers to a price increase. (Merger Guidelines, § 1.11).

Dr. Noether's analysis is unfounded in economic theory and unfounded in the Merger Guidelines, because she merely points to testimony that inpatient and outpatient services are contracted for in the same contract. Dr. Haas-Wilson testified that "many sellers offer multiple products," and the mere packaging of the products together "would not be any basis" for concluding that the two products are in the same product market. (Haas-Wilson, Tr. 2664-65). Even Respondent's executives recognized that changes in inpatient pricing have no impact on patients switching from inpatient to outpatient services. (Neaman Tr. 1210; Hillebrand, Tr. 1755-56).

Executives of ENH confirmed that buyers do not consider inpatient acute care hospital services and outpatient services to be interchangeable. ENH does not base its



business decisions on the prospect that patients would switch from inpatient services to outpatient services as a result of the inpatient price changes. (Neaman, Tr. 1210-11).

Moreover, when ENH developed its plan to negotiate higher prices, ENH did not prepare or ask for any documents analyzing whether more patients would switch from inpatient to outpatient services as a result of changes in inpatient prices. (Hillebrand, Tr. 1756).

374. { [REDACTED] } (Haas-Wilson, Tr. 2891, *in camera*).

**Response to Finding No. 374:**

The finding is irrelevant, incomplete and misleading. Dr. Haas-Wilson testified that “many sellers offer multiple products,” and the mere packaging of the products together “would not be any basis” for concluding that the two products are in the same product market. (Haas-Wilson, Tr. 2664-65). Furthermore, Dr. Haas-Wilson testified that the testimony concerning health plans accepting higher prices for inpatient services in return for lower prices for outpatient services is consistent with the fact that many sellers offer multiple products and may trade one product off on price for the other. That does not mean here that the two products are in the same product market. (Haas-Wilson, Tr. 2664-65).

375. { [REDACTED] } (Neaman, Tr. 1295-96; *see also* Foucre, Tr. 1123, *in camera*).

**Response to Finding No. 375:**

The finding is irrelevant. Respondent has failed to demonstrate that outpatient services should be included in the same market as inpatient services using a Merger Guidelines’ analysis. The Merger Guidelines make no reference to the percentage of various goods or services sold by a seller that should be considered in determining

whether those goods and services are in the same product market. Instead, the Merger Guidelines make clear that the definition of the relevant product market is determined by looking at the likely reaction of buyers to a price increase. (Merger Guidelines, § 1.11). Further Respondent's witnesses acknowledged that changes in inpatient pricing have no impact on patients electing to purchase outpatient services. (Neaman Tr. 1210; Hillebrand, Tr. 1755-56).

**b. MCOs Purchase Primary, Secondary And Tertiary Services Together**

376. { [REDACTED] } (Ballengee, Tr. 200; Mendonsa, Tr. 557, *in camera*; Holt-Darcy, Tr. 1585, *in camera*). MCOs thus essentially purchase all of the services of a particular hospital in one contract when they negotiate prices with that hospital. (Noether, Tr. 5906-08, 5927).

**Response to Finding No. 376:**

The finding is misleading and irrelevant. Managed care organizations do not always purchase all of the services of a particular hospital in one contract when they negotiate with that hospital. { [REDACTED] } (Mendonsa, Tr. 556-57, *in camera*).

**3. Dr. Noether Has Correctly Defined The Relevant Product Market**

377. The relevant product market, as defined by Dr. Noether, appropriately includes all acute care hospital-based services sold to MCOs. (Noether, Tr. 5901, 5904). Dr. Noether's product market is consistent with the Complaint, which identified the relevant customer in this case as the MCOs. (Compl. ¶ 16; Noether, Tr. 5906). Moreover, Dr. Noether followed the economic principles underlying the Merger Guidelines in defining her relevant product market. (Noether, Tr. 5905).

**Response to Finding No. 377:**

The first sentence of the finding is misleading. It suggests that the relevant

product market includes all acute care hospital-based services sold to managed care plans rather than the general acute care “inpatient” services sold to managed care plans. (Haas-Wilson, Tr. 2659, 2663, 2665-66). ENH successfully over the long term raised the prices of inpatient services. Applying the principles of the hypothetical monopolist test found in the Merger Guidelines, Dr. Haas-Wilson concluded that inpatient services, excluding quaternary services, were a product market. (Haas-Wilson, Tr. 2665-67). [REDACTED]

[REDACTED] (Haas-Wilson, Tr. 2615, *in camera*). By comparison, Dr. Noether drew her erroneous conclusion from the mere fact that inpatient services and outpatient services often are purchased and sold pursuant to the same contract between the managed care organization and the acute care hospital.

The second sentence of the finding is incorrect and misleading. The Complaint alleges in Paragraph 16 that the “relevant product market is general acute care hospital *inpatient* services sold to private payers, including commercial payors, managed care plans, and self-insurance plans (collectively ‘private payers’). (Complaint, ¶ 16 (emphasis added)).

The third sentence of the finding is incorrect and misleading. Dr. Noether did not follow the Merger Guidelines in determining the relevant product market. Rather than relying on the Merger Guidelines to find an “economically meaningful market, *i.e.* markets that could be subject to the exercise of market power” (*see* Merger Guidelines, § 1.0), Dr. Noether attempted to find a basis to include both inpatient and outpatient

services in the same product market based on the fact that both services are purchased and sold pursuant to the same contract between managed care organizations and hospitals.

This approach is not consistent with the Merger Guidelines because: (1) it does not focus on demand substitution factors, (2) the purported market is bigger than necessary to satisfy the hypothetical monopolist test, and (3) the approach ignores record evidence that buyers did not shift their purchases in response to relative changes in price and that the seller – ENH – did not base its business decision on the prospect that buyers would substitute between products in response to changes in price or other competitive variables. (Merger Guidelines, §§ 1.0-1.1).

378. This relevant product market includes both inpatient and outpatient services. (Noether, Tr. 5904). This market definition, however, does not assume that inpatient and outpatient services are substitutes for each other, just that they are bought together by MCOs. (Noether, Tr. 5908). Individual services, for example, would not be substitutes for each other either. Even Dr. Haas-Wilson lumps all the individual inpatient services together in her market. (Noether, Tr. 5909).

**Response to Finding No. 378:**

The first sentence of the finding is misleading. As discussed in CCRFF 377, Dr. Noether did not employ the Merger Guidelines approach, but rather based her conclusion on the fact that inpatient services and outpatient services are sold pursuant to the same contract between the managed care organization and the hospital as a principal basis for concluding that inpatient and outpatient services are in the same product market. The Merger Guidelines, however, make clear that the definition of the relevant product market begins with the likely reaction of buyers to a small but significant and non-transitory price increase by a hypothetical monopolist and that the “Agency will begin with each product (narrowly defined).” (Merger Guidelines, § 1.11).

The second sentence of the finding is incomplete. Under the Merger Guidelines,

the basis for defining a product market is demand substitution and consumer responses to price increases. (Merger Guidelines, § 1.0). Furthermore, although an individual patient may not be able to substitute specific individual hospital services for others, this market is defined in the context of the purchase of acute care inpatient hospital services purchased by managed care organizations. (See CCF 192-254).

The third sentence of the finding is incorrect and misleading. Health plans can substitute and regularly substitute one hospital's inpatient services for another's by not contracting with hospitals whose prices are excessive and employing selective contracting to keep prices competitive. (See CCF 192-254). The sentence also ignores evidence that, before the merger, health plans had the alternative of excluding Evanston or Highland Park. (See CCF 255-283). By comparison, health plans cannot substitute outpatient for inpatient services. (See Ballengee, Tr. 144; Neary Tr. 590; Hillebrand, Tr. 1756. See generally Spaeth, Tr. 2076, 79; Newton, Tr. 302),

The fourth sentence of the finding is misleading. Respondent mischaracterizes Dr. Haas-Wilson's testimony as it ignores the context in which she views inpatient hospital services. (CCF 192-210). Dr. Haas-Wilson used the Merger Guidelines approach to distinguish situations where product substitution was possible from those where it was not. Using the Merger Guidelines approach, she found that outpatient services were not substitutes for inpatient services from the perspective of the purchaser or, for that matter, from the perspective of the seller. (Haas-Wilson, Tr. 2663). She determined that the relevant product market is the market for "general acute care inpatient services" (Haas-Wilson, Tr. 2451-52), that primary, secondary and tertiary services are included in the relevant product market (Haas-Wilson, Tr. 2661), but that quaternary

services are not in the relevant product market. (Haas-Wilson, Tr. 2665-66). Moreover, health plans testified that ENH did not offer quaternary services that are offered by noted academic teaching hospitals in Chicago. (Ballengee, Tr. 188-89; Dorsey, Tr. 1443-44; Foucre, Tr. 935-36).

379. Some services in Dr. Noether's product market are provided by providers that are not hospitals. (Noether, Tr. 5923). By defining the product market to include only hospital-based services, Dr. Noether thus does not include as market participants providers that perform some of these services outside the hospital setting (such as outpatient surgery centers). (Noether, Tr. 5923).

**Response to Finding No. 379:**

The finding is incomplete. While Dr. Noether testified that general acute care hospitals contract with managed care organizations for both inpatient and outpatient services, often in the same contract, she did not provide any basis for concluding that the outpatient services that are furnished by outpatient surgery centers are, from the perspective of the buyer, interchangeable with the outpatient services sold by an acute care hospital.

380. Dr. Noether also excludes from her product market specialty hospitals that do not provide the full range of services, such as Children's Memorial Hospital. (Noether, Tr. 5924)

**Response to Finding No. 380:**

The finding is incomplete. Although Dr. Noether testified that she did not include in her product market the services of specialty hospitals like Children's Memorial Hospital, she did not provide any basis for concluding that such services are, from the perspective of the buyer, interchangeable with the services sold by a general acute care hospital.

**4. Dr. Haas-Wilson Has Not Correctly Defined The Relevant Product Market**

381. Dr. Haas-Wilson defined the relevant product market as “general acute care *inpatient* hospital services.” (Haas-Wilson, Tr. 2489) (emphasis added). Unlike Dr. Noether, Dr. Haas-Wilson did not follow the Merger Guidelines methodology in defining this relevant product market. (Noether, Tr. 6216).

**Response to Finding No. 381:**

Complaint Counsel have no specific response to the first sentence.

The finding in the second sentence is misleading. Using the Merger Guidelines methodology, Dr. Haas-Wilson found that, from the perspective of the buyer, outpatient services were not substitutes for inpatient services. (Haas-Wilson, Tr. 2660, 2663). Dr. Haas-Wilson’s conclusion was supported both by testimony from representatives of health plans (Holt-Darcy, Tr. 1422-1423; Ballengee, Tr. 144; Neary, Tr. 590) and testimony from present and former executives of ENH. (Newton Tr. 302; Neaman Tr. 1210-11; Hillebrand Tr. 755-56; Spaeth Tr. 2076-77). Applying economic analysis, Dr. Haas-Wilson testified that “many sellers offer multiple products,” and the mere packaging of the products together “would not be any basis” for concluding that the two products are in the same product market. (Haas-Wilson, Tr. 2663-65).

382. Although Dr. Haas-Wilson includes tertiary services in her relevant product market, she excludes outpatient services. (Haas-Wilson, Tr. 2489-90, 2660). Dr. Haas-Wilson’s decision to exclude outpatient services from the relevant product market makes no economic sense given that the customers at issue are the MCOs, which, as discussed above, purchase both inpatient and outpatient services in the same contract. (Noether, Tr. 5909-10).

**Response to Finding No. 382:**

Complaint Counsel have no specific response to the finding’s first sentence.

The finding’s second sentence is irrelevant and misleading. Respondent relies on the fact that some of the managed care organizations purchased inpatient services and outpatient services under the same contract as the basis for the conclusion that the two services are included in the same product market. Under the Merger Guidelines,

however, the relevant inquiry is, “if ENH were to raise its prices for inpatient services, would the relevant customers be able to substitute other services” in place of those inpatient services. (Haas-Wilson, Tr. 2659-60). The view of the buyer in the market is confirmed by the views of ENH management, which did not believe that patients would switch from inpatient services to outpatient services as a result of inpatient price changes. (Neaman, Tr. 1210-11). Thus, ENH never analyzed the interchangeability of inpatient and outpatient services when it set its prices for inpatient services. (Hillebrand, Tr. 1756).

**B. The Relevant Geographic Market Consists Of Multiple Competitor Hospitals In The Chicago Area**

**1. The Court Should Consider Patient Preferences And Physician Admitting Patterns When Evaluating The Relevant Geographic Market**

383. An appropriate starting point in analyzing the relevant geographic market is to identify the closest competitors of Evanston Hospital and HPH, respectively, from a geographic perspective. (Noether, Tr. 5928). Dr. Noether applied the methodology underlying the Merger Guidelines in defining her minimum geographic market by taking each of the merging hospitals and identifying its closest competitors to build up the markets, an iterative kind of approach. (Noether, Tr. 595)

**Response to Finding No. 383:**

The finding is misleading and irrelevant. Respondent’s first assertion is inconsistent with the Merger Guidelines. The Merger Guidelines state that “the Agency will begin *with the location of each merging firm (or each plant of a multiplant firm)* and ask *what would happen if a hypothetical monopolist of the relevant product at that point imposed at least a ‘small but significant and nontransitory’ increase in price,*” and, “[i]f in response to the price increase, the reduction in sales of the product at that location would be large enough that a hypothetical monopolist producing or selling the relevant product at the merging firm’s location *would not find it profitable to impose such an*



*increase in price, then the Agency will add the location from which production is the next-best substitute for production at the merging firm's location.”* (Merger Guidelines, § 1.21 (emphasis added)).

Respondent's second assertion also is inconsistent with the Merger Guidelines because the Guidelines call for analyzing “evidence that buyers have shifted or have considered shifting purchases between different geographic locations in response to relative changes in price” or “evidence that sellers base business decisions on the prospect of buyer substitution between geographic locations in response to relative changes in price or other competitive variables.” (Merger Guidelines, § 1.21).

Again, Respondent and its economic expert Dr. Noether offer an approach that is not consistent with the substance or the intent of the Merger Guidelines or with good economic analysis. Dr. Haas-Wilson, by contrast, employed the principles of the Merger Guidelines, in particular the hypothetical monopolist test, to demonstrate that ENH raised its prices in a significant way over the long term and that customers did not turn to alternative sellers located outside of the geographic area. (Haas-Wilson, Tr. 2667-68). Moreover, ENH management did not believe that other hospitals would change their prices as a result of ENH's price setting, nor did management consider the risk of health plans switching to other hospitals. (Neaman, Tr. 1212; Hillebrand, Tr. 1764-65; Newton, Tr. 367). Furthermore, ENH did not see a decrease in the number of managed care admissions as a result of ENH's price increases in 2000 (Neaman, Tr. 1211-12; Haas-Wilson, Tr. 2667) and, with the exception of a partial decrease at Humana, did not have to roll back its price increases (Hillebrand, Tr. 1709-10).

████████████████████ } (Haas-Wilson, Tr. 2902, *in camera*). In fact, it would have been impossible for Dr. Haas-Wilson to define the geographic market as containing only the merged hospitals if she had employed the iterative approach of identifying closest competitors because all of the evidence discussed in the following subsections suggest that Evanston Hospital and HPH were not closest competitors in geographic space. (Noether, Tr. 5959).

**Response to Finding No. 384:**

The finding is misleading as to Dr. Haas-Wilson's application of the Merger Guidelines and its characterization of what the Merger Guidelines require. Dr. Haas-Wilson did define the relevant geographic market as including only the three ENH hospitals, "beginning with the location of each merging firm (or each plant of a multiplant firm)." (See Merger Guidelines, § 1.21 (emphasis added)). Because ENH was able to impose a price increase in excess of the SSNIP standard, there was no need to undertake further iterations of the hypothetical monopolist test. The Merger Guidelines state, "This process will continue *until a group of locations is identified such that a hypothetical monopolist over that group of locations would profitably impose at least a 'small but significant and nontransitory' increase, including the price charged at a location of one of the merging firms.* (Merger Guidelines, § 1.21 (emphasis added)). Having satisfied that test with just the three ENH hospitals, there was no reason to go further in a mechanical way ignoring the substantial price increase. At the same time, Dr. Noether ignored testimony from Dr. Elzinga that under the Merger Guidelines test, if a hypothetical monopolist could profitably impose a SSNIP, then a geographic area is considered a geographic market for the product in question. (Elzinga, Tr. 2377-78).

a.           **Patient Preferences Are Relevant To The Geographic Market Analysis**

385.   ████████████████████ }  
(Haas-Wilson, Tr. 2803, *in camera*). This view is supported by the testimony of Foucre (United),

Mendonsa (Aetna) and Holt-Darcy (Unicare), all of whom testified that MCOs consider patient preferences. (Noether, Tr. 5937; Foucre, Tr. 885; Mendonsa, Tr. 485; Holt-Darcy, Tr. 1420). Similarly, Ballengee (PHCS) testified that geography and price play roles in what patients demand from their health care network; in general, patients want to know that they are receiving cost-effective healthcare as well as access to quality health care. (Ballengee, Tr. 152-53).

**Response to Finding No. 385:**

The first sentence is misleading. Dr. Haas-Wilson testified that { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2803-05, *in camera*).

The second sentence is misleading. Representatives of the managed care organizations similarly testified that they took into account various factors when building a network, one of which was patient preferences. (*E.g.*, Fourcre, Tr. 885 (in addition to patient preferences, managed care organization takes into account residence of the individuals who negotiate contracts with managed care plans); Mendonsa, Tr. 485 (patient preferences are but one factor that is taken into account in building a network); Holt-Darcy, Tr. 1420-21 (managed care plan assesses geographic needs, marketing needs, access, credentialing criteria).

The third sentence is misleading, in that it suggests that Ms. Ballengee testified that price and geography are the only two factors managed care plans take into account in negotiating contracts with hospitals. Ms. Ballengee testified that managed care organizations take a variety of factors into account, including the quality of the hospital, the quality of services, the breadth of services, and ease of accessibility. (Ballengee, Tr. 151-53).

386. Even though insurance companies may be the purchasers in the first instance of hospital services, they construct hospital networks to create plans that are attractive to their customers, the employers. (Elzinga, Tr. 2407). The employers, in turn, are driven to provide a plan that is attractive to their employees, subject to the constraints of cost, because employees may consider health care benefits in deciding where to accept employment. (Elzinga, Tr. 2407). Therefore, MCOs must take patient preferences into consideration in constructing their hospital networks. (Elzinga, Tr. 2407-08).

**Response to Finding No. 386:**

The statement is misleading. Dr. Elzinga testified that managed care plans construct their networks to be attractive to employers, who are the customer of the managed care plans; and that, in turn, the employer, in choosing a plan, considers the costs of the plan, its employees' convenience, and other factors in choosing the health plans to make available to its employees. (Elzinga, Tr. 2407). As a result, Dr. Elzinga agreed that managed care plans "would attempt" to take patient preferences into account as one element of their choice of plans. (Elzinga, Tr. 2407-08). Furthermore, Dr. Elzinga testified that, notwithstanding the managed care plans' consideration of patient preferences in choosing the hospitals with which they contract, the use of patient flow analysis for the purposes of defining geographic markets has inherent flaws, which would lead to the definition of a geographic market that is much larger than it actually is. (Elzinga, Tr. 2417-18).

**i. Geographic Proximity Is Relevant To Patient Preferences**

387. Travel distances for employees is a critical component for employers that are evaluating health care benefit plans. (Foucre, Tr. 885). Patients generally want access to a hospital within 30 miles of where they live or work. (Holt-Darcy, Tr. 1420). { [REDACTED] } (RX 1912 at 20, *in camera*).

**Response to Finding No. 387:**

The finding in the first sentence is irrelevant, misleading and incomplete. Ms.

Foucre testified that there were a variety of different factors that managed care organizations took into account in selecting hospitals, one of which was the employers' consideration of their employees' preference. (Foucre, Tr. 884-85). In turn, the employees' concerns are a critical component for the employer, but only to the extent it relates to employees' preferences. (Foucre, Tr. 885).

The finding in the second sentence is misleading. Ms. Holt-Darcy testified that a managed care plan wanted "to make sure that members have access to the hospital within 30 miles of where they live or work" in order "to meet the standards that the plans put together." (Holt-Darcy, Tr. 1420). Ms. Holt-Darcy did not purport to speak about this in the context of what "patients generally want," or what a managed care plan perceived as necessary to make a health care plan marketable, as suggested by Respondent. (Holt-Darcy, Tr. 1420). Ms. Holt-Darcy testified that "You look at geographic need, you look at marketing needs, you look at access," and that "You want to see what population that you have or potentially have, what marketing thinks that they need in a particular service area." (Holt-Darcy, Tr. 1420) Thus, having access to a hospital within 30 miles of where enrollees live or work is merely one aspect of an overall process of marketing a network. (Holt-Darcy, Tr. 1420).

#### No Price-Constraining Substitute

The third sentence of the finding claims that there are at least 47 hospitals within thirty miles of an ENH hospital. Even if, *arguendo*, there are 47-plus hospitals within thirty miles of ENH, they are not price-constraining substitutes for ENH because they did not prevent or put an end to ENH's post-merger price increases, which have remained in effect. Indeed, if *any* hospital or group of hospitals had been a competitive substitute for

ENH, health plans could have declined to pay ENH's post-merger prices and dropped ENH from their networks (which health plans could not do), while substituting the other hospital or group of hospitals. In contrast, pre-merger, Evanston and its "main competitor" HPH were price-constraining substitutes for each other in the eyes of their customers, the health plans. (See, e.g., Neary, Tr. 600-601; CCFF 295-299, 999-1001, 1083-84, 1152, 1204-1210, 1281-1288, 1729).

388. [REDACTED] (RX 1912 at 20, *in camera*). The travel time between the two locations is approximately 25 to 30 minutes. (Spaeth, Tr. 2157). [REDACTED] (RX 1912 at 21, *in camera*).

**Response to Finding No. 388:**

Complaint Counsel have no specific response to the finding's first sentence.

The findings in the second and third sentences are misleading. The driving time between the two hospitals is as little as 15 to 25 minutes. (Rosengart, Tr. 4445-46; Spaeth, Tr. 2157)

389. [REDACTED]:

(a) [REDACTED] (Neaman, Tr. 1303; Ballengee, Tr. 212; Ballengee, Tr. 263, *in camera*; RX 1912 at 20-21, *in camera*).

**Response to Finding No. 389 (a):**

The finding is also misleading. Prices charged to health plans are determined at the "first-stage" of competition, in which hospitals compete for contracts with managed care organizations. (Haas-Wilson, Tr. 2456). This finding, however, is the basis for examining competition for patients and physicians, when they choose a hospital at which to seek services for that patient. This constitutes the "second-stage" of competition

among hospitals for patients (and their physicians) based on non-price variables, such as geographic distances between hospitals. (Haas-Wilson, Tr. 2463-65; CCFF 192-194).

The finding is also misleading to the extent that it purports to form a basis for defining the geographic market based on patient flow analysis. As Dr. Elzinga testified, basing geographic market definition on patient migration and patient flow analysis inherently will overstate the size of the geographic market for general inpatient acute care hospital services. First, as Dr. Elzinga testified, it is incorrect to base geographic market definitions for acute care hospital services on static analysis of current patient flow, inasmuch as the existing willingness of certain residents of an area to migrate to more distant hospitals is not probative of the willingness of other residents of that area, known as the "silent majority," to travel longer distances for hospital services. (Elzinga, Tr. 2385-94. See CCFF 1674-1679). Furthermore, as Dr. Elzinga testified, it is incorrect to base geographic market definitions for acute care hospital services on current patient flow, due to the payer problem, inasmuch as individuals will not respond to the price changes for the services because insurance companies, rather than the patient, will pay for the price increases. (Elzinga, Tr. 2395-99. See CCFF 1680-1684).

(b) { [REDACTED] }  
(Neaman, Tr. 1302-03; RX 1912 at 20-21, *in camera*; Mendonsa, Tr. 562, *in camera*).

**Response to Finding No. 389 (b):**

This finding is misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(a)).

(c) { [REDACTED] } (Neaman, Tr. 1297; RX 1912 at 20-21, *in camera*; see also

Mendonsa, Tr. 556, *in camera*). { [REDACTED] } (Neaman, Tr. 1301; RX 1912 at 21, *in camera*).

**Response to Finding No. 389 (c):**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (*See* CCRFF 389(a)).

(d) { [REDACTED] } (Neaman, Tr. 1303-04; Ballengee, Tr. 263, *in camera*; RX 1912 at 20-21, *in camera*).

**Response to Finding No. 389 (d):**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (*See* CCRFF 389(a)).

(e) { [REDACTED] } (Neaman, Tr. 1298; RX 1912 at 20-21, *in camera*).

**Response to Finding No. 389 (e):**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (*See* CCRFF 389(a)).

(f) { [REDACTED] } (Neaman, Tr. 1305; RX 1912 at 20-21, *in camera*).

**Response to Finding No. 389 (f):**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (*See* CCRFF 389(a)).



(g) { [REDACTED] } (RX 1912 at 20-21, *in camera*).

**Response to Finding No. 389 (g):**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(a)).

(h) { [REDACTED] } (RX 1912 at 20-21, *in camera*).

**Response to Finding No. 389 (h)**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(a)).

(i) { [REDACTED] } (RX 1912 at 20-21, *in camera*).

**Response to Finding No. 389 (i):**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(a)).

390. { [REDACTED] }:

(a) Lake Forest Hospital is about six miles from HPH.} (Neaman, Tr. 1304; Spaeth, Tr. 2240; Mendonsa, Tr. 555, *in camera*). { [REDACTED] } (RX 1310 at FTC-LFH 669; RX 1912 at 20-21, *in camera*).

**Response to Finding No. 390 (a):**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is

appropriate in this case. (See CCRFF 389(a)).

(b) { [REDACTED] } (Neaman, Tr. 1304-05; Hillebrand, Tr. 2006; Spaeth, Tr. 2240; Mendonsa, Tr. 555, *in camera*; RX 1912 at 20-21, *in camera*). { [REDACTED] } (RX 1912 at 20-21, *in camera*; Hillebrand, Tr. 2006).

**Response to Finding No. 390 (b):**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(a)).

(c) { [REDACTED] } (RX 1912 at 20-21, *in camera*).

**Response to Finding No. 390 (c):**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(a)).

**ii. Travel Patterns Are Relevant To Patient Preferences**

391. MCOs also consider patient travel patterns because they recognize that they need to put together provider networks that are going to be attractive to employers. And employers, in turn, are concerned about where their employees want to seek hospital care. (Noether, Tr. 5936-37, 5948). Consequently, to the extent that patients value convenience, there is a derived demand by the MCOs for hospitals that are convenient to their enrollees. (Noether, Tr. 5937).

**Response to Finding No. 391:**

The finding is incomplete and misleading because the relationship between a managed care plan’s choice of hospitals and a patient’s choice of managed care plans is attenuated. The choice of hospitals by a managed care organization may rest on both the perceptions of the employer of its employees’ preferences as well as the individual preferences of the employers’ personnel officers in selecting managed care plans located

in the areas in which they live. (Foucre, Tr. 885). Ms. Holt-Darcy emphasized, in the context of how a hospital comes to be in Unicare's network, that "you want to see what population that you have" and "what marketing thinks they need in a particular service area." (Holt-Darcy, Tr. 1420). Also, Mr. Mendonsa emphasized, in the context of developing a hospital network, "[a]ccess is . . . making sure that employees can get to the facilities *that we believe and have determined are the facilities they want to go to.*"

(Mendonsa, Tr. 485 (emphasis added)). { [REDACTED]

[REDACTED] }"

(Mendonsa, Tr. 517, *in camera*).

392. To identify the closest geographic competitors, Dr. Noether started with the location of each merging hospital, and looked to see which hospitals were geographically closest to each of the merging hospitals. (Noether, Tr. 5931). To identify "geographically close" hospitals Dr. Noether looked at the driving times between hospitals, discussed above. (Noether, Tr. 5933). Driving times are a better measure of geographic proximity than driving distances because distances do not account for variations in road and/or traffic patterns that can affect patient preferences. (Noether, Tr. 5933).

**Response to Finding No. 392:**

Complaint Counsel have no specific response to the finding, insofar as it is limited to a description of the methodologies employed by Dr. Noether.

393. { [REDACTED]

[REDACTED] } (Noether, Tr. 5934-35; RX 1912 at 21, *in camera*). Even Northwestern Memorial (26 minutes), located in downtown Chicago, is about the same distance from Evanston Hospital as HPH. (Noether, Tr. 5935).

**Response to Finding No. 393:**

The finding is misleading because, even if some hospitals are close to particular ENH hospitals, there are a significant number of residents of the area between the three ENH hospitals and for whom the closest hospital is a hospital owned by ENH. A person

traveling up the North Shore from Chicago “would stop at Evanston” first, and then “Highland Park would be the next hospital.” (Holt-Darcy, Tr. 1426. *See* Ballengee, Tr. 167-68 (“Highland Park sits to the north of these communities, Evanston on the south. There’s [*sic*] no hospitals in between, and it tends to be a north-south migration of the populace.”)). Evanston and Highland Park Hospitals compete for patients from people living in between those two communities. (Neary, Tr. 600-01; CX 1 at 3-5; CX 2 at 7).

This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (*See* CCRFF 389(a)).

The finding is also irrelevant because the application of the Merger Guidelines hypothetical monopolist test is the proper method for delineation of the geographic market. (Merger Guidelines, § 1.2). Dr. Haas-Wilson’s empirical study determined that the hypothetical monopolist test supports the conclusion that ENH successfully raised its prices without managed care organizations terminating their contracts with ENH hospitals in favor of other hospitals located outside the triangle formed by ENH facilities. (Haas-Wilson, Tr. 2667). In any event, even if some hospitals are closer to Evanston than HPH, those hospitals are not price-constraining substitutes for ENH. (*See* CCRFF 387).

394. { [REDACTED] } (Noether, Tr. 5935, RX 1912 at 21, *in camera*).

**Response to Finding No. 394:**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (*See* CCRFF 389(a)). The finding is also irrelevant because the

application of the Merger Guidelines hypothetical monopolist test is the proper method for delineation of the geographic market. (See CCRFF 393). In any event, even if Lake Forest, Rush North Shore, Holy Family, and Condell are close to ENH, those hospitals are not price-constraining substitutes for ENH. (See CCRFF 387).

395. To evaluate patient travel patterns, Dr. Noether considered, for all of the merging hospitals and other relevant hospitals, where they drew 80% of their patients. (Noether, Tr. 5938). This analysis showed that Evanston Hospital was drawing 80% of its patients from a reasonably broad area that extended north, included a variety of hospitals, and covered thirty-two zip codes. (Noether, Tr. 5939). Pre-Merger HPH was drawing 80% of its patients from a somewhat smaller area than Evanston Hospital, pulling more from the north than from the south and only covering twenty zip codes. (Noether, Tr. 5941-42). Evanston and Glenbrook Hospitals did not fall within HPH's pre-Merger 80% service area. (Noether, Tr. 5942).

**Response to Finding No. 395:**

This finding is misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(a)). The finding is also irrelevant because the application of the Merger Guidelines hypothetical monopolist test is the proper method for delineation of the geographic market. (See CCRFF 393).

396. Dr. Noether also considered the overlap of zip codes between Evanston Hospital and HPH's pre-Merger 80% service areas with the 80% service areas of other hospitals. (Noether, Tr. 5943).

**Response to Finding No. 396:**

The finding is irrelevant because the application of the Merger Guidelines hypothetical monopolist test is the proper method for delineation of the geographic market. (See CCRFF 393). This finding is also misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

397. { [REDACTED]

[REDACTED] } (Noether, Tr. 5943-44; RX 1912 at 54, *in camera*). To the extent patient travel patterns are indicative of patient preferences, this suggests that are several hospitals that are closer substitutes to Evanston Hospital than HPH. (Noether, 5944-45 (*explaining DX 8120*)).

**Response to Finding No. 397:**

The finding is irrelevant because the application of the Merger Guidelines hypothetical monopolist test is the proper method for delineation of the geographic market. (*See CCRFF 393*). This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (*See CCRFF 389(c)*).

To the extent that the patient flow analysis was considered by managed care organizations, Dr. Noether’s theoretical analysis is inconsistent with the actual business practices of managed care plans. Managed care plans considered Evanston Hospital and Highland Park Hospital as competitors, because a person traveling up the North Shore from Chicago “would stop at Evanston” first, and then “Highland Park would be the next hospital.” (*Holt-Darcy, Tr. 1426*). There are no other hospitals located between Highland Park and Evanston. (*Ballengee, Tr. 168*). People “could go either way [to Highland Park or Evanston] and receive the same services at the same level.” (*Ballengee, Tr. 166*). Thus, Evanston Hospital and Highland Park Hospital competed for business with the managed care plans (covering patients living between those two communities), even if the patient flow analysis of Respondent yields a different conclusion. (*Neary, Tr. 600-01; CX 1 at 3-5; CX 2 at 7*). { [REDACTED]

[REDACTED] } (*Ballengee, Tr. 166; Neary Tr. 600-01; Mendonsa, Tr. 569, in*

camera). PHCS relied on Evanston and Highland Park as the “primary” alternatives to each other. (Ballengee, Tr. 166-68). [REDACTED]

[REDACTED] (Mendonsa, Tr. 530, 569, *in camera*). One Health viewed Evanston and Highland Park as “main” competitors because their services were “comparable,” and the two hospitals drew patients from the same general population.

(Neary, Tr. 600-02). [REDACTED]

[REDACTED] (Holt-Darcy, Tr. 1517-19, *in camera*).

398. [REDACTED]

(Noether, Tr. 5945; RX 1912 at 54, *in camera*). Advocate Lutheran General had the most overlap with HPH’s 80% service area with thirteen out of nineteen zip codes. (Noether, Tr. 5945). Lake Forest Hospital had overlaps in ten out of nineteen zip codes. (Noether, Tr. 5945 (*explaining* DX 8119)).

**Response to Finding No. 398:**

The finding is irrelevant because the application of the Merger Guidelines hypothetical monopolist test is the proper method for delineation of the geographic market. (*See* CCRFF 393). This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (*See* CCRFF 389(c)). To the extent that the patient flow analysis was considered by managed care organizations, Dr. Noether’s theoretical analysis is inconsistent with the actual business practices of

managed care plans. (See CCRFF 397).

399. Dr. Noether further looked at the 80% service area for Northwestern Memorial's obstetric services. (Noether, Tr. 5947 (*describing* DX 8121)). "This examination revealed that Northwestern Memorial is drawing from a very large geographic area for its obstetrical services. (Noether, Tr. 5947).

**Response to Finding No. 399:**

This finding is irrelevant and misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)). To the extent that the patient flow analysis was considered by managed care organizations, Dr. Noether's theoretical analysis is inconsistent with the actual business practices of managed care plans. (See CCRFF 397).

400. Hospitals frequently consider patient travel patterns in evaluating competition. (RX 518 at ENH GW 2055-57, 2059; RX 2021 at 3; RX 135 at 4; RX 1361 at 1; RX 1564. According to a Lake Forest Hospital customer survey report, dated November 8, 2001, 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. (RX 1179 at LFH 845). { [REDACTED] } (RX 1912 at 21, in camera.)

**Response to Finding No. 400:**

This finding is irrelevant and misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

401. One quarter of consumers in Lake County have left the county for medical services, and 28% of Lake County consumers travel to Chicago. (RX 1179 at LFH 895). Lake Forest Hospital used this information to "provide[] some parameters for determining the potential geographic draw of [Lake Forest] and its medical staff, and for identifying the optimal distance for placing services in outlying areas." (RX 1179 at LFH 845). Lake Forest Hospital recognizes that Northwestern Memorial is one of its competitors because "[p]art of the community goes downtown every day so it is natural for them to use Northwestern." (RX 306 at FTC-LFH 68).



**Response to Finding No. 401:**

This finding is irrelevant and misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)). To the extent that the patient flow analysis was considered by managed care organizations, Dr. Noether’s theoretical analysis is inconsistent with the actual business practices of managed care plans. (See CCRFF 397). In any event, even if, *arguendo*, there are more than fifteen hospitals located within 35 minutes of ENH, those hospitals are not price-constraining substitutes for ENH. (See CCRFF 387).

402. Similarly, Condell found that around 31% of Lake County residents left Lake County for hospital services in 2001. (RX 1352 at CMC 20371). Condell runs ads in ENH’s area emphasizing Condell’s marketing strategy of encouraging patients to use that hospital instead of the downtown hospitals. (Hillebrand, Tr. 2004).

**Response to Finding No. 402:**

This finding is irrelevant and misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)). To the extent that the patient flow analysis was considered by managed care organizations, Dr. Noether’s theoretical analysis is inconsistent with the actual business practices of managed care plans. (See CCRFF 397).

403. ENH, Rush North Shore and Advocate Lutheran General have similar marketing material aimed at patients who use, or are inclined to use, the downtown hospitals by emphasizing that patients can receive quality healthcare in their suburban neighborhoods. (Hillebrand, Tr. 2004).

**Response to Finding No. 403:**

This finding is irrelevant and misleading because it addresses “second-stage”

competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)). To the extent that the patient flow analysis was considered by managed care organizations, Dr. Noether's theoretical analysis is inconsistent with the actual business practices of managed care plans. (See CCRFF 397).

404. Rush Presbyterian, the University of Chicago, Loyola and the University of Illinois at Chicago – all downtown Chicago hospitals – are within driving range of patients who live in ENH's general service area in northern Illinois. (Neaman, Tr. 1301). This is especially true given that wealthier, more affluent patients (such as those who live in the Chicago North Shore) generally are more willing to travel to receive health care treatment because, among other reasons, they may have the income to supplement what might not be paid for under their health insurance program. (Elzinga, Tr. 2408).

**Response to Finding No. 404:**

This finding is irrelevant and misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)). To the extent that the patient flow analysis was considered by managed care organizations, Dr. Noether's theoretical analysis is inconsistent with the actual business practices of managed care plans. (See CCRFF 397).

Mr. Hillebrand did not see any analysis or ever hear anyone at ENH warn against the increases on the grounds that the price increase would lead to ENH losing health plans to other hospitals. (Hillebrand, Tr. 1757-58). On the other hand, Mr. Hillebrand testified that employers would have balked at the idea of a health plan telling the employer's enrollees that they have to go to another hospital system instead of ENH. (Hillebrand, Tr. 1764). Moreover, Mr. Hillebrand testified that Evanston and Highland Park could not have achieved the increased revenues from the post-merger health plan negotiations if

they had been independent hospitals (Hillebrand, Tr. 1816-17), thus indicating that Evanston and HPH were pre-merger price constraints on each other.

405. An evaluation of patient travel patterns in this context is not an Elzinga-Hogarty analysis "in disguise." (Noether, Tr. 5947-48). Instead, Dr. Noether was simply using patient travel patterns as one piece of evidence, among other pieces, in considering the likely dimensions of geographic competition. (Noether, Tr. 5948).

**Response to Finding No. 405:**

This finding is misleading. Dr. Noether, contrary to the testimony of Dr. Elzinga, relied on patient flow analysis in an effort to define geographic markets for acute care inpatient hospital services, and her analysis suffers the defects that Dr. Elzinga identified in the use of patient flow analysis for the purposes of defining geographic markets for acute care hospital services. (Elzinga, Tr. 2393; Noether, Tr. 5948).

As Dr. Elzinga testified, basing geographic market definition on patient migration and patient flow analysis inherently will overstate the size of the geographic market for general inpatient acute care hospital services. (Elzinga, Tr. 2393). First, as Dr. Elzinga testified, it is incorrect to base geographic market definitions for acute care hospital services on static analysis of current patient flow, inasmuch as the existing willingness of certain residents of an area to migrate to more distant hospitals is not probative of the willingness of other residents of that area, known as the "silent majority," to travel longer distances for hospital services. (Elzinga, Tr. 2385-94). Furthermore, as Dr. Elzinga testified, it is incorrect to base geographic market definitions for acute care hospital services on current patient flow, due to the payer problem, inasmuch as individuals will not respond to the price changes for the services because insurance companies, rather than the patient will pay for the price increases. (Elzinga, Tr. 2395-99).

Significantly, Dr. Elzinga expressly stated that the problems with using patient

flow analysis in geographic market definitions – the silent majority fallacy and the payer problem – were inherent in any use of patient flow in defining the geographic markets for acute care hospital services. (Elzinga, Tr. 2417-18). While Dr. Noether did not use the traditional Elzinga-Hogarty test for the purposes of defining the geographic markets, she did use patient flow analysis for the purposes of defining the geographic markets of Evanston Hospital and Highland Park Hospital. (See, e.g., Noether, Tr. 5947-48). Nevertheless, Dr. Noether failed to explain how her use of patient flow analysis to define the geographic markets of ENH did not suffer the defects in the use of patient flow analysis identified by Dr. Elzinga. (See CCF 1669-1673).

**b. Physician Admitting Patterns Are Relevant To The Geographic Market Analysis**

406. Dr. Noether also considered physician admitting patterns in evaluating geographic competition. (Noether, Tr. 5949). Physician admitting practices are significant “because the physician is the one who is often the most responsible for choosing where a particular patient is going to be admitted to a hospital.” (Noether, Tr. 5949).

**Response to Finding No. 406:**

The finding is irrelevant and misleading. Prices charged to health plans are determined at the “first stage” of competition, in which hospitals compete for contracts with managed care organizations. (Haas-Wilson, Tr. 2456). As stated in this finding, Dr. Noether is examining the hospital’s competition for physicians, when the latter choose to admit a patient to a hospital. This constitutes the “second-stage” of competition among hospitals for patients (and their physicians) based on non-price variables. (Haas-Wilson, Tr. 2463-65; CCF 192-194).

In any event, the application of the Merger Guidelines hypothetical monopolist test is the proper method for delineation of the geographic market. (Merger Guidelines, §

1.2). Dr. Haas-Wilson's empirical study determined that the hypothetical monopolist test supports the conclusion that ENH successfully raised its prices without customers turning to other hospitals outside of the North Shore triangle of ENH facilities. (Haas-Wilson, Tr. 2667).

407. Lake Forest Hospital conducted a survey of customers in Lake Forest Hospital's service area in 2001, and found that the customers' primary care physicians ("PCP") admitted patients to such hospitals as Lake Forest Hospital, Condell, HPH, Evanston Hospital, Northwest Community and Advocate Lutheran General. (RX 1179 at LFH 857). The survey also found that the most utilized hospitals were Lake Forest Hospital, Condell, HPH, Victory Memorial, Provena St. Therese, Evanston Hospital, Advocate Lutheran General, Good Shepherd, Northwestern Memorial, Glenbrook Hospital and Rush Presbyterian. (RX 1179 at LFH 891).

**Response to Finding No. 407:**

Complaint Counsel objects to the use of RX 1179, to the extent that it is being used to prove the truth of the matter asserted therein, as constituting hearsay, as defined by Rule 801(a), F.R.E. Furthermore, the results of the surveys set forth in RX 1179 constitute double hearsay, and are inadmissible for the purpose of proving the truth of the matter asserted therein pursuant to Rule 805, F.R.E., and JX 1 ¶ 5 (February 10, 2005).

Subject to this objection, this finding is irrelevant and misleading as it relates merely to the "second-stage" of competition among acute care hospitals for patients (and their physicians) based on non-price competition. (Haas-Wilson, Tr. 2463-65).

**2. The Court Should Consider The Fact That There Are Multiple Hospitals In The Chicago Area When Evaluating The Relevant Geographic Market**

409. A number of hospitals compete for patients within ENH's core service area. (RX 518 at ENH GW 2057).

**Response to Finding No. 409:**

This finding is misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is

appropriate in this case. (See CCRFF 389(c)). In any event, even if, *arguendo*, there are more than fifteen hospitals located within 35 minutes of ENH, those hospitals are not price-constraining substitutes for ENH. (See CCRFF 387).

410. By way of example, in 1998, over 15,000 patients were admitted to hospitals other than Evanston Hospital or HPH from the combined core service areas. (RX 518 at ENH GW 2059). Rush North Shore attracted 30% of the outmigration from ENH's core service area. (RX 518 at 18). Advocate Lutheran General represented 16% of the outmigration. (RX 518 at ENH GW 2059). 16% of the outmigration went to the downtown academic hospitals, a trend of increasing "leakage" to the downtown academic hospitals from ENH's core service area. (RX 518 at ENH GW 2058-59). 15% of the outmigration chose St. Francis Hospital of Evanston. (RX 518 at ENH GW 2059). 6% of the outmigration was to Lake Forest Hospital. (RX 518 at ENH GW 2059). 17% percent of the outmigration selected other hospitals. (RX 518 at ENH GW 2059).

**Response to Finding No. 410:**

This finding is misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

In any event, the finding and the related findings (RFF 411-454) below are irrelevant because the application of the Merger Guidelines hypothetical monopolist test is the proper method for delineation of the geographic market. (Merger Guidelines, § 1.2). Dr. Haas-Wilson's empirical study determined that the hypothetical monopolist test supports the conclusion that ENH successfully raised its prices without customers turning to other hospitals outside of the North Shore triangle of ENH facilities. (Haas-Wilson, Tr. 2452, 2667). ENH did not see a decrease in the number of managed care admissions as a result of ENH's price increases in 2000 (Neaman, Tr. 1211-12; Haas-Wilson, Tr. 2667), and, with the exception of a partial decrease at Humana, did not have to roll back its price increases (Hillebrand, Tr. 1709-10). ENH management did not consider the risk of health plans switching to other hospitals. (Neaman, Tr. 1212; Hillebrand, Tr. 1764-65;

Newton, Tr. 1757-58): Finally, even if there is some outmigration of patients from the Evanston and HPH service area to other hospitals, these hospitals are not a price-constraining substitute for ENH. (See CCRFF 387).

**a. Advocate Lutheran General**

411. { [REDACTED]  
[REDACTED]  
[REDACTED] } (Neaman, Tr. 1296-97; see also Ballengee, Tr. 225, *in camera*; RX 1503 at PHCS 3667, *in camera*; RX 1912 at 60; Mendonsa, Tr. 558, *in camera*). { [REDACTED]  
[REDACTED] } (RX 1053 at AHHC 363, *in camera*; RX 1095 at AHHC 374, *in camera*; RX 1141 at AHHC 385, *in camera*; Mendonsa, Tr. 558, *in camera*).

**Response to Finding No. 411:**

The finding is misleading, irrelevant and incomplete. Respondent presents this information without providing any proof that the Chicago area is the relevant geographic market or that Advocate Lutheran General is properly considered a competitor in the market. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2635-36, *in camera*; Baker, Tr. 4645, *in camera*).

Based on her empirical study, and applying the Merger Guidelines hypothetical monopolist test, Dr. Haas-Wilson determined that the relevant geographic market is not larger than a triangle adjacent or contiguous to the three hospital campuses that make up ENH: Evanston Hospital, Highland Park Hospital and Glenbrook Hospital. Dr. Haas-Wilson's definition of the relevant geographic market is consistent with the testimony of





monopolist test; Dr. Haas-Wilson determined that the relevant geographic market is not larger than a triangle adjacent or contiguous to the three hospital campuses that make up ENH: Evanston Hospital, Highland Park Hospital and Glenbrook Hospital. Dr. Haas-Wilson's definition of the relevant geographic market is consistent with the testimony of health plans that ENH had power over price in network contracting due to its strong presence in the North Shore triangle area. (Newton, Tr. 351-52; Foucre, Tr. 901-903; Ballengee, Tr. 167-68; Holt-Darcy, Tr. 1425-27; Mendonsa, Tr. 543-44 ({}  
{}), *in camera*, and 568 ({}  
{}))  
(emphasis added), *in camera*).

413. Advocate Lutheran General provided 379 diagnosis-related groups ("DRGs") in 1999. (RX 1912 at 60). DRGs are a system that can be used to categorize inpatients into what are thought to be relatively homogenous groups based on the resources that are used to treat patients on average. (Noether, Tr. 5912).

**Response to Finding No. 413:**

The finding is incomplete. This calculation was performed by Respondent's expert, Dr. Noether, who made several specific adjustments to the calculation. For example, Dr. Noether did not designate a hospital as providing care for patients in a particular diagnosis-related group ("DRG") unless the hospital provided care to four or more patients in that DRG. (RX 1912 at 60; Noether, Tr. 5914-15). Therefore, this methodology does not necessarily accurately reflect the capacity of the hospital to provide services to a patient within a particular DRG but rather reflects the hospital's provision of care to four or more patients in that DRG in 1999. (See Noether, Tr. 5914-15).  
Furthermore, because this methodology does not reflect the actual number of patients in

each DRG, it does not accurately reflect the number of patients treated at one hospital in a DRG that was regularly treated at another hospital. (*See* Noether, Tr. 6172). Dr. Noether did not calculate the relative number of patients at one hospital who were in DRGs that also are treated at a second hospital. (Noether, Tr. 6172). Thus, for example, in 1999 Alexian Brothers treated patients in 334 DRGs, while ENH treated patients in 384 DRGs. (RX 1912 at 60). However, 97.2 percent of the ENH patients were in DRGs for which Alexian Brothers had provided care in that year. (Noether, Tr. 6169).

The finding's second sentence is incomplete. Complaint Counsel refers the Court to the definition of "Diagnosis Related Group," as set forth in the parties' joint Amended Glossary of Terms dated April 22, 2005.

414. { [REDACTED] } (Haas-Wilson, Tr. 2706, *in camera*).

**Response to Finding No. 414:**

The finding is misleading. In her evaluation of other hospitals, Dr. Haas-Wilson { [REDACTED] } (Haas-Wilson, Tr. 2706, *in camera*). { [REDACTED] }

The finding is also misleading because prices charged to health plans are determined at the "first stage" of competition, in which hospitals compete for contracts with managed care organizations. (Haas-Wilson, Tr. 2456). This finding, however, considers competition for patients and physicians, when they choose a hospital at which to seek services for that patient. This constitutes the "second stage" of competition

among hospitals for patients (and their physicians) based on non-price variables, such as geographic distances between hospitals. (Haas-Wilson, Tr. 2463-65; CCRFF 192-194).

415. In 1999, Advocate Lutheran General had .36 residents per bed. (RX 1912 at 60).

**Response to Finding No. 415:**

Complaint Counsel have no specific response but have the general response discussed in CCRFF 410.

416. Before the Merger, patients who went to HPH's or Lake Forest Hospital's emergency room with a heart attack were referred to Advocate Lutheran General for more advanced care. (Spaeth, Tr. 2241-42)

**Response to Finding No. 416:**

Complaint Counsel have no specific response but have the general response discussed in CCRFF 410.

**b. Condell**

417. { [REDACTED] } (Neaman, Tr. 1326; Hillebrand, Tr. 2006; Mendonsa, Tr. 562, *in camera*; RX 1912 at 60). { [REDACTED] } (RX 1220 at CIG/IL 120108, *in camera*).

**Response to Finding No. 417:**

Complaint Counsel have no specific response to the finding's first sentence.

The finding's second sentence is incomplete insofar as it does not specify the methodology that was used to calculate "market share." To the extent it is based on patient flow, this finding is misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (*See* CCRFF 389(c)).

418. As of February 2005, Condell provided a full array of services, including everything from general obstetrics to cardiac surgery. (Neaman, Tr. 1305). Condell is not,

however, an academic hospital as in 1999 it had no residents per bed. (RX 1912 at 60).

**Response to Finding No. 418:**

Complaint Counsel have no specific response.

419. In 1999, Condell provided 292 DRGs. (RX 1912 at 60).

**Response to Finding No. 419:**

The finding is incomplete. This calculation was performed by Respondent's expert, Dr. Noether, who made several specific adjustments to the calculation. For example, Dr. Noether did not designate a hospital as providing care for patients in a particular diagnosis-related group ("DRG") unless the hospital provided care to four or more patients in that DRG. (RX 1912 at 60; Noether, Tr. 5914-15). Therefore, this methodology does not necessarily accurately reflect the capacity of the hospital to provide services to a patient within a particular DRG but rather reflects the hospital's provision of care to four or more patients in that DRG in 1999. (See Noether, Tr. 5914-15).

Furthermore, because this methodology does not reflect the actual number of patients in each DRG, it does not accurately reflect the number of patients treated at one hospital in a DRG that was regularly treated at another hospital. (See Noether, Tr. 6172). Dr. Noether did not calculate the relative number of patients at one hospital who were in DRGs that also are treated at a second hospital. (Noether, Tr. 6172). Thus, for example, in 1999 Alexian Brothers treated patients in 334 DRGs, while ENH treated patients in 384 DRGs. However, 97.2 percent of the ENH patients were in DRGs for which Alexian Brothers had provided care in that year. (Noether, Tr. 6169).

420. { [REDACTED] } (RX 1521 at CMC 19875, *in camera*).

**Response to Finding No. 420:**

Complaint Counsel have no specific response.

421. Condell has a cardiac surgery program that does more open heart procedures per year than HPH. (Hillebrand, Tr. 2005).

**Response to Finding No. 421:**

Complaint Counsel have no specific response.

422. Condell did a market share study of Lake County residents in 2002 and found that “Evanston & Highland Park show[ed] a drop [in market share] from 14.4% to 13% over the 6 quarters reviewed. In absolute terms, their discharges fell by 249 cases.” (RX 1352 at CMC 20374).

**Response to Finding No. 422:**

The finding is irrelevant and misleading because Lake County is a political division and not an economic “market,” and quarterly data can reflect seasonal changes.

This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

**c. Lake Forest Hospital**

423. { [REDACTED]  
[REDACTED]  
[REDACTED] } (Hillebrand, Tr. 2005; Holt-Darcy, Tr. 1595, *in camera*; RX 1912 at 60).

**Response to Finding No. 423:**

The finding is misleading, to the extent that Mr. Hillebrand merely spoke of services relating to the active obstetrics program at Lake Forest Hospital but concluded, on the basis of this testimony, that Lake Forest is a “significant competitor” of Highland Park. (Hillebrand, Tr. 2005). Furthermore, this finding mischaracterizes Ms. Holt

Darcy's testimony. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Holt-Darcy, Tr. 1595,

*in camera*). In any event, Respondent's expert excluded specialty hospitals (which include children's hospitals and women's hospitals) from the product market. (See RFF 380).

424. Lake Forest Hospital is a "very good general hospital" and "nice facility" with a particular strength in obstetrics. (Neaman, Tr. 1304). Lake Forest Hospital does not provide any tertiary care. (Neaman, Tr. 1304).

**Response to Finding No. 424:**

Complaint Counsel has no specific response.

425. In 1999, Lake Forest Hospital provided 213 DRGs. (RX 1912 at 60).

**Response to Finding No. 425:**

The finding is incomplete. This calculation was performed by Respondent's expert, Dr. Noether, who made several specific adjustments to the calculation. For example, Dr. Noether did not designate a hospital as providing care for patients in a particular diagnosis-related group ("DRG") unless the hospital provided care to four or more patients in that DRG. (RX 1912 at 60; Noether, Tr. 5914-15). Therefore, this methodology does not necessarily accurately reflect the capacity of the hospital to provide services to a patient within a particular DRG but rather reflects the hospital's provision of care to four or more patients in that DRG in 1999. (See Noether, Tr. 5914-15).

Furthermore, because this methodology does not reflect the actual number of patients in each DRG, it does not necessarily reflect the extent to which the services actually

furnished by the two hospitals in 1999 overlap. Dr. Noether did not calculate the relative number of patients at one hospital who were in DRGs that also are treated at a second hospital. (Noether, Tr. 6172). Thus, for example, in 1999 Alexian Brothers treated patients in 334 DRGs, while ENH treated patients in 384 DRGs. However, 97.2 percent of the ENH patients were in DRGs for which Alexian Brothers had provided care in that year. (Noether, Tr. 6169).

426. Lake Forest Hospital is not an academic hospital, as in 1999 it had no residents per bed. (RX 1912 at 60).

**Response to Finding No. 426:**

The finding is misleading, to the extent Respondent relies on 1999 data regarding the number of residents per bed, but asserts that Lake Forest Hospital “is” not now an academic hospital. The evidence presented by Respondent is limited to a conclusion that, in 1999, Lake Forest Hospital was not an academic hospital.

427. In 2003, Lake Forest Hospital found that there was “an increasingly competitive landscape as Condell Medical Center complete[d] their \$100 million facility replacement, Evanston Northwestern Healthcare invest[ed] \$70 million in the Highland Park facility and Vista Healthcare plan[ed] to close St. Therese and build a new hospital in Lindenhurst.” (RX 1206 at FTC-LFH 217.)

**Response to Finding No. 427:**

The finding is incomplete and misleading. Lake Forest’s Hospital Foundation Strategic Plan Implementation as of November 2000 concluded that the acquisition of Highland Park Hospital by Evanston was designed to enhance “price negotiating leverage with managed care plans.” (RX 987 at FTC-LFH 0000227). Also, the September 2001 Lake Forest Strategic Planning Competitive Analysis of Lake County found that the ENH strategy is to “dominate the North Shore” market to obtain more favorable pricing from insurance companies. (RX 1144 at FTC-LFH 0001953). Furthermore, Lake Forest noted

that ENH had been “successful with their pricing approach and have secured higher prices as a result of their market position.” (RX 1144 at FTC-LFH 0001953-54). Lake Forest concluded that “the stated strategy of ENH is to “continue the dominance” of the North Shore. (RX 1144 at FTC-LFH 0001954).

This finding also is irrelevant to an analysis of the relevant market because there is no proof that managed care organizations turned to the named third-party hospitals in response to an ENH price increase. When setting its prices in 2000, ENH was not concerned with and did not factor in whether those hospitals raised or lowered their prices in response. (Hillebrand, Tr. 1753-55).

**d. Loyola**

428. Loyola is a 474-bed tertiary care and academic hospital. (Neaman, Tr. 1300; RX 1912 at 60). Like ENH, Loyola has a faculty practice group. (Neaman, Tr. 1288).

**Response to Finding No. 428:**

Complaint Counsel have no specific response.

429. Loyola had 405 DRGs in 1999. (RX 1912 at 60).

**Response to Finding No. 429:**

The finding is incomplete. This calculation was performed by Respondent’s expert, Dr. Noether, who made several specific adjustments to the calculation. For example, Dr. Noether did not designate a hospital as providing care for patients in a particular diagnosis-related group (“DRG”) unless the hospital provided care to four or more patients in that DRG. (RX 1912 at 60; Noether, Tr. 5914-15). Therefore, this methodology does not necessarily accurately reflect the capacity of the hospital to provide services to a patient within a particular DRG but rather reflects the hospital’s provision of care to four or more patients in that DRG in 1999. (Noether, Tr. 5914-15). Furthermore,



because this methodology does not reflect the actual number of patients in each DRG, it does not necessarily reflect the extent to which the services actually furnished by the two hospitals in 1999 overlap. Dr. Noether did not calculate the relative number of patients at one hospital who were in DRGs that also are treated at a second hospital. (Noether, Tr. 6169). { [REDACTED]

(Noether, Tr. 6169; RX 1912 at 44, *in camera*).

430. In 1999, Loyola had .60 residents per bed. (RX 1912 at 60).

**Response to Finding No. 430:**

Complaint Counsel has no specific response to this finding.

**e. Northwestern Memorial**

431. Northwestern Memorial is a tertiary and academic hospital that has more than 700 beds. It provides a full range of inpatient and outpatient services, from general obstetrics to cardiac surgery. (Neaman, Tr. 1298). Northwestern Memorial is affiliated with the Northwestern Medical School and, in 1999, had .56 residents per bed. (Neaman, Tr. 1299; RX 1912 at 60).

**Response to Finding No. 431:**

Complaint Counsel have no specific response.

432. In 1999, Northwestern Memorial provided 381 DRGs. (RX 1912 at 60).

**Response to Finding No. 432:**

The finding is incomplete. This calculation was performed by Respondent's expert, Dr. Noether, who made several specific adjustments to the calculation. For example, Dr. Noether did not designate a hospital as providing care for patients in a particular diagnosis-related group ("DRG") unless the hospital provided care to four or

more patients in that DRG. (RX 1912 at 60; Noether, Tr. 5914-15). Therefore, this methodology does not necessarily accurately reflect the capacity of the hospital to provide services to a patient within a particular DRG but rather reflects the hospital's provision of care to four or more patients in that DRG in 1999. (Noether, Tr. 5914-15). Furthermore, because this methodology does not reflect the actual number of patients in each DRG, it does not necessarily reflect the extent to which the services actually furnished by the two hospitals in 1999 overlap. Dr. Noether did not calculate the relative number of patients at one hospital who were in DRGs that also are treated at a second hospital. (Noether, Tr. 6169). { [REDACTED]

(Noether, Tr. 6169; RX 1912 at 44, *in camera*).

433. Northwestern Memorial recognized that, in the Chicago market, there is a "demand for more capacity." (RX 1296 at NMH 2507). In response to this demand, Northwestern Memorial has invested in growth strategies, including investing in the recruitment of primary care physicians, new technology and equipment, facilities expansion, land holdings and community outreach programs. (RX 1296 at NMH 2508).

**Response to Finding No. 433:**

This finding is misleading because it suggests that the exhibit's use of the term "market" is synonymous with the concepts of product and geographic markets, as those terms are used under section 7 of the Clayton Act. The assertion in the first sentence of the finding is contradicted by the record; there is not a demand for more capacity. In fact, "[d]espite the closure of 16 Chicago hospitals since 1987 . . . there remains an oversupply of beds and hospitals in metropolitan Chicago and Lake County." (RX 987 at FTC-LFH 0000227).

434. Northwestern Memorial is the number one provider of obstetrical services in Illinois. (Neaman, Tr. 1298). It has the premier obstetrics brand in Chicago because of its Prentice Women's Hospital and possesses the largest volume of delivering mothers in the Chicago area, including a large volume of those mothers from ENH's area. (Hillebrand, Tr. 2003-04). Northwestern Memorial is increasing its obstetrics capabilities, having received approval from the Illinois Health Facilities Planning Board to construct a \$350 million women's hospital. (Hillebrand, Tr. 2004; D. Jones, Tr. 1681).

**Response to Finding No. 434:**

Respondent's expert excluded specialty hospitals (which include children's hospitals and women's hospitals) from the product market. (See RFF 380). In any event, Respondent's finding is irrelevant to an analysis of the relevant market because there is no proof that consumers turned to Northwestern Memorial in response to an ENH price increase. When setting its prices in 2000, ENH was not concerned with and did not consider whether any hospital raised or lowered its prices in response. (Hillebrand, Tr. 1753-55).

**f. Rush North Shore And Rush Presbyterian**

435. Rush North Shore has 150-200 beds and as of February 2005 it was affiliated with Rush Presbyterian, a major tertiary and academic hospital. The Rush Presbyterian affiliation clearly improved the breadth, quality and the perception of services offered at Rush North Shore. (Neaman, Tr. 1302).

**Response to Finding No. 435:**

Complaint Counsel have no specific response.

436. In 1999, Rush North Shore provided 245 DRGs. (RX 1912 at 60).

**Response to Finding No. 436:**

The finding is incomplete. This calculation was performed by Respondent's expert, Dr. Noether, who made several specific adjustments to the calculation. For example, Dr. Noether did not designate a hospital as providing care for patients in a particular diagnosis-related group ("DRG") unless the hospital provided care to four or

more patients in that DRG. (RX 1912 at 60; Noether, Tr. 5914-15). Therefore, this methodology does not necessarily accurately reflect the capacity of the hospital to provide services to a patient within a particular DRG but rather reflects the hospital's provision of care to four or more patients in that DRG in 1999. (Noether, Tr. 5914-15). Furthermore, because this methodology does not reflect the actual number of patients in each DRG, it does not necessarily reflect the extent to which the services actually furnished by the two hospitals in 1999 overlap. Dr. Noether did not calculate the relative number of patients at one hospital who were in DRGs that also are treated at a second hospital. (Noether, Tr. 6169). { [REDACTED]

(Noether, Tr. 6169; RX 1912 at 44, *in camera*).

437. In 1999, Rush North Shore had .12 residents per bed. (RX 1912 at 60).

**Response to Finding No. 437:**

Complaint Counsel have no specific response.

438. Rush Presbyterian has 500-600 beds. (RX 1912 at 60). Like other major academic hospitals, Rush Presbyterian offers everything from general obstetrics through cardiac surgery and performs some transplants as well. (Neaman, Tr. 1299).

**Response to Finding No. 438:**

The finding is irrelevant to an analysis of the relevant market because there is no proof that consumers turned to Rush Presbyterian in response to an ENH price increase.

When setting its prices in 2000, ENH was not concerned with and did not factor in whether Rush Presbyterian raised or lowered its prices in response. (Hillebrand, Tr.

1753-55). { [REDACTED]

[REDACTED]  
[REDACTED] } (Mendonsa, Tr. 568,  
*in camera*).

439. In 1999, Rush Presbyterian provided 370 DRGs. (RX 1912 at 60).

**Response to Finding No. 439:**

The finding is incomplete. This calculation was performed by Respondent's expert, Dr. Noether, who made several specific adjustments to the calculation. For example, Dr. Noether did not designate a hospital as providing care for patients in a particular diagnosis-related group ("DRG") unless the hospital provided care to four or more patients in that DRG. (RX 1912 at 60; Noether, Tr. 5914-15). Therefore, this methodology does not necessarily accurately reflect the capacity of the hospital to provide services to a patient within a particular DRG but rather reflects the hospital's provision of care to four or more patients in that DRG in 1999. (Noether, Tr. 5914-15). Furthermore, because this methodology does not reflect the actual number of patients in each DRG, it does not necessarily reflect the extent to which the services actually furnished by the two hospitals in 1999 overlap. Dr. Noether did not calculate the relative number of patients at one hospital who were in DRGs that also are treated at a second hospital. (Noether, Tr. 6169). [REDACTED]

[REDACTED]  
[REDACTED] }  
(Noether, Tr. 6169; RX 1912 at 44, *in camera*).

440. In 1999, Rush Presbyterian had .76 residents per bed. (RX 1912 at 60).

**Response to Finding No. 440:**

Complaint Counsel have no specific response.

441. Before the Merger, Rush North Shore demonstrated consistent growth in the combined core service areas of HPH and Evanston Hospital. (RX 518 at ENH GW 2058). From 1995 through 1998, Rush North Shore gained 6% market share. (RX 518 at ENH GW 2058).

**Response to Finding No. 441:**

The finding is incomplete because the exhibit states that the market was “relatively constant.” (RX 518 at ENH GW 2058). Furthermore, the finding is misleading, inasmuch as the exhibit uses the term “market” to describe the “Combined Core Service Area” that is discussed in the exhibit. Furthermore, the exhibit specifically states that, “[t]ogether, ENH and Highland Park comprise 55 % of the market in the Combined Core Service Area.” (RX 518 at ENH GW 2057).

**g. St. Francis**

442. St. Francis is a “very good hospital,” with 300-400 beds. As of February 2005, St. Francis was part of the Resurrection System. (Neaman, Tr. 1303). St. Francis’ services range from cardiology and obstetrics all the way to general surgery. (RX 1854 at ENHE F16 426).

**Response to Finding No. 442:**

Complaint Counsel have no specific response.

443. In 1999, St. Francis provided 312 DRGs. (RX 1912 at 60).

**Response to Finding No. 443:**

The finding is incomplete. This calculation was performed by Respondent’s expert, Dr. Noether, who made several specific adjustments to the calculation. For example, Dr. Noether did not designate a hospital as providing care for patients in a particular diagnosis-related group (“DRG”) unless the hospital provided care to four or more patients in that DRG. (RX 1912 at 60; Noether, Tr. 5914-15). Therefore, this methodology does not necessarily accurately reflect the capacity of the hospital to provide

services to a patient within a particular DRG but rather reflects the hospital's provision of care to four or more patients in that DRG in 1999. (Noether, Tr. 5914-15). Furthermore, because this methodology does not reflect the actual number of patients in each DRG, it does not necessarily reflect the extent to which the services actually furnished by the two hospitals in 1999 overlap. Dr. Noether did not calculate the relative number of patients at one hospital who were in DRGs that also are treated at a second hospital. (Noether, Tr. 6169). [REDACTED]

(Noether, Tr. 6169; RX 1912 at 44, *in camera*).

444. St. Francis had .36 residents per bed in 1999. (RX 1912 at 60).

**Response to Finding No. 444:**

This finding is incomplete. The Medicare Payment Advisory Commission ("MedPAC"), an advisory body to Congress on Medicare reimbursement criteria, defines a "major teaching hospital" as a hospital with at least .25 residents per bed. (Noether, Tr. 5921-22). St. Francis had .36 residents per bed and, thus, meets MedPAC's standards as a "major teaching hospital." (RX 1912 at 60). Nevertheless, while Dr. Noether intended to compare ENH's prices to the prices charged by a control group consisting of "major teaching hospitals," which she referred to as "academic hospitals," she did not include St. Francis in the control group. (Noether, Tr. 5993, 6000; RX 1912 at 60).

Also, Louis Weiss Hospital has .35 residents per bed and, thus, meets MedPAC's standard for a "major teaching hospital." (RX 1912 at 60). Nevertheless, Dr. Noether did not include Louis Weiss Hospital in the group of academic hospitals for the purposes of

evaluating the post-merger prices of Respondent. (Noether, Tr. 6000, RX 1912 at 60)

445. The Resurrection system, which owns St. Francis, considers several of Evanston Hospital's zip codes as a part of St. Francis' service area. (RX 135 at 12976). As of 1995, Resurrection considered Evanston Hospital the "market leader" in St. Francis' service area, with an 11.6% share. (RX 135 at 12930).

**Response to Finding No. 445:**

The cited source does not say what Respondent's finding claims, because the source does not refer to any zip codes as Evanston Hospital's, nor does it have a page 12930.

**h. Swedish Covenant**

446. As of February 2005, Swedish Covenant had 324 beds. (Newton, Tr. 472). Also as of February 2005, Swedish Covenant had approximately 18 family medicine physicians, 6 critical care physicians, 8 transitional students and a series of other residents. (Newton, Tr. 472).

**Response to Finding No. 446:**

Complaint Counsel have no specific response.

447. In 1999, Swedish Covenant provided 274 DRGs, (RX 1912 at 60).

**Response to Finding No. 447:**

The finding is incomplete. This calculation was performed by Respondent's expert, Dr. Noether, who made several specific adjustments to the calculation. For example, Dr. Noether did not designate a hospital as providing care for patients in a particular diagnosis-related group ("DRG") unless the hospital provided care to four or more patients in that DRG. (RX 1912 at 60; Noether, Tr. 5914-15). Therefore, this methodology does not necessarily accurately reflect the capacity of the hospital to provide services to a patient within a particular DRG but rather reflects the hospital's provision of care to four or more patients in that DRG in 1999. (Noether, Tr. 5914-15). Furthermore,



because this methodology does not reflect the actual number of patients in each DRG, it does not necessarily reflect the extent to which the services actually furnished by the two hospitals in 1999 overlap. Dr. Noether did not calculate the relative number of patients at one hospital who were in DRGs that also are treated at a second hospital. (Noether, Tr. 6169). { [REDACTED]

[REDACTED]

[REDACTED]

(Noether, Tr. 6169; RX 1912 at 44, *in camera*).

448. In 1999, Swedish Covenant had .13 residents per bed. (RX 1912 at 60).

**Response to Finding No. 448:**

Complaint Counsel have no specific response.

**i. University Of Chicago**

449. The University of Chicago hospital, a major tertiary and academic hospital, has about 400 beds. (Neaman, Tr. 1299).

**Response to Finding No. 449:**

Complaint Counsel have no specific response.

450. The University of Chicago provides everything from basic obstetrics to major surgical procedures. The University of Chicago hospital is affiliated with the medical school at the University of Chicago. (Neaman, Tr. 1299-1300).

**Response to Finding No. 450:**

The finding is irrelevant to an analysis of the relevant market because there is no proof that consumers turned to the University of Chicago in response to an ENH price increase. When setting its prices in 2000, ENH was not concerned with and did not factor in whether any hospital raised or lowered its prices in response. (Hillebrand, Tr. 1753-55).

451. In 1999, the University of Chicago had .79 residents per bed. (RX 1912 at 60).

**Response to Finding No. 451:**

Complaint Counsel have no specific response to this finding.

452. In 1999, the University of Chicago provided 394 DRGs. (RX 1912 at 60)

**Response to Finding No. 452:**

The finding is incomplete. This calculation was performed by Respondent's expert, Dr. Noether, who made several specific adjustments to the calculation. For example, Dr. Noether did not designate a hospital as providing care for patients in a particular diagnosis-related group ("DRG") unless the hospital provided care to four or more patients in that DRG. (RX 1912 at 60; Noether, Tr. 5914-15). Therefore, this methodology does not necessarily accurately reflect the capacity of the hospital to provide services to a patient within a particular DRG but rather reflects the hospital's provision of care to four or more patients in that DRG in 1999. (Noether, Tr. 5914-15). Furthermore, because this methodology does not reflect the actual number of patients in each DRG, it does not necessarily reflect the extent to which the services actually furnished by the two hospitals in 1999 overlap. Dr. Noether did not calculate the relative number of patients at one hospital who were in DRGs that also are treated at a second hospital. (Noether, Tr. 6169). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

(Noether, Tr. 6169; RX 1912 at 44, *in camera*).

**j. University Of Illinois At Chicago**

453. The University of Illinois at Chicago is a tertiary care and academic hospital located in downtown Chicago. (Neaman, Tr. 1300).

**Response to Finding No. 453:**

Complaint Counsel have no specific response.

3. **The Relevant Geographic Market Broadly Encompasses A Large Number Of Competitor Hospitals In The Chicago Area**
  - a. **MCO Testimony And Documents Confirm A Broad Geographic Market**

454. The Court heard testimony from five MCOs: United, PHCS, Aetna, Unicare and Great West. All of the private MCO representatives agreed that ENH competes with a broad number of hospitals, including, among others, the hospitals discussed above.

**Response to Finding No. 454:**

The finding fails to comply with the requirements of Rule 46(a) of the Commission's Rules and the Court's Order on Post Trial Briefs, dated April 6, 2005, in that it does not contain a reference to the record to support the finding. In any event, even if there is, *arguendo*, a broad number of hospitals competing, those hospitals are not price-constraining substitutes for ENH. (*See CCRFF 387*).

455. The Aetna representative agreed that there are a large number of competing hospitals in the North Shore region of Chicago, including, among others: Rush North Shore, Advocate Lutheran General, St. Francis, Evanston Hospital, Glenbrook Hospital, HPH, Lake Forest Hospital, and Condell. (Mendonsa, Tr. 484). { [REDACTED]

[REDACTED] } (Mendonsa, Tr. 561-62, *in camera*).

**Response to Finding No. 455:**

Respondent mischaracterizes the testimony cited to support the finding's first sentence. The Aetna representative testified that there were a large number of hospitals in the North Shore area of Chicago, but he did not characterize those hospitals as "competing." (Mendonsa, Tr. 484.)

Respondent also mischaracterizes the testimony cited to support the finding's second sentence. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (Mendonsa, Tr. 561, *in camera*). Furthermore, the finding is incomplete, in that the questions eliciting the testimony cited by Respondent were limited to [REDACTED] [REDACTED]. (Mendonsa, Tr. 560-61, *in camera*).

456. According to the United representative, { [REDACTED] [REDACTED] } (Foucre, Tr. 1114-15, *in camera*; RX 1208 at UHCENH 3380, *in camera*). { [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] } (Foucre, Tr. 1115 *in camera*; RX 1208 at UHCENH 3380, *in camera*). { [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] } (RX 1208 at UHCENH 3380, *in camera*).

**Response to Finding No. 456:**

Respondent mischaracterizes the testimony cited to support the finding. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Foucre, Tr. 1114-15, *in camera*; RX 1208 at UHCENH 3380, *in camera*). { [REDACTED] [REDACTED] [REDACTED] } (Foucre, Tr. 1114-15, *in camera*; RX 1208 at UHCENH 3380, *in camera*).

This finding is also misleading because it addresses “second-stage” competition

and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

457. When PHCS notified its customers about the Merger, PHCS specifically recognized alternatives to ENH in the "same geographical area," including: "St. Francis Hospital (Evanston, IL), Lake Forest Hospital (Lake Forest, IL), Advocate Lutheran General Hospital (Park Ridge, IL), Rush North Shore Medical Center (Skokie, IL), and Holy Family Medical Center (Des Plaines, IL)." (RX 712 at PHCS 891; Ballengee, Tr. 213-14). [REDACTED] [REDACTED] (RX 773 at ENH JL 12534, *in camera*).

**Response to Finding No. 457:**

The finding is incomplete and misleading and mischaracterizes the testimony in the record. Before the merger, PHCS "could choose between the two [hospitals – Evanston and HPH] and work them against each other" because they were "competitors." (Ballengee, Tr. 166-67). As a result of pre-merger negotiations, PHCS obtained lower prices than Evanston was demanding because PHCS "had a competitive environment between the two hospitals" and could trade one off for the other." (Ballengee, Tr. 170).

Although the PHCS document cited lists the hospitals mentioned, the notification merely identified for the benefit of its customers the providers in the same area as ENH with which PHCS had contracts. PHCS did not represent that any of these hospitals constituted alternatives to or competitors of Evanston or Highland Park, nor did Ms. Ballengee so testify. Rather, Ms. Ballengee was merely asked to read the document into the trial record without ever being asked anything about her views or the views of PHCS. (Ballengee, Tr. 214).

The second sentence of the finding is misleading and incomplete. [REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (RX 773 at ENH JL 012534, *in camera*). However, this does not constitute a reference to all hospitals within a North Shore area as constituting competitors, or the “North Shore” area as constituting a geographic market.

458. Great West also provided its subscribers with a list of hospitals in its network that were alternatives for the ENH hospitals. (Dorsey, Tr. 1478-79). This list included Lake Forest Hospital, St. Therese and Victory Memorial as alternatives for HPH, and St. Francis and Advocate Lutheran General as alternatives for Evanston Hospital. (Dorsey, Tr. 1479-80). Great West also considered Northwestern Memorial and Condell as alternatives to the ENH hospitals. (Neary, Tr. 631).

**Response to Finding No. 458:**

The finding is incomplete and mischaracterizes the testimony of Great West’s employee. Mr. Neary testified that after receiving ENH’s May 2000 price increase demands, One Health terminated ENH because One Health believed the increases to be “excessive” but was forced to return to the negotiating table – in a weakened negotiating position – because it could not market its network without the ENH hospitals. (Neary, Tr. 609-11; 615-16; 618-19).

Furthermore, Mr. Dorsey was asked whether Great West provided subscribers with some information about “alternative hospitals” in the context of whether subscribers in the most general sense “could utilize” them, in that those hospitals were available in the network. Mr. Dorsey was not asked whether these hospitals are accessible or convenient substitutes for ENH in any economically meaningful way. (Dorsey, Tr. 1478-79). Mr. Dorsey also testified that, while Advocate Lutheran General was in the network,

he did not know whether Great West considered it an alternative. (Dorsey, Tr. 1478-79).

The second sentence of the finding is misleading. This testimony did not constitute a representation that these hospitals were viewed as competitors of Highland Park Hospital or Evanston. Instead, Mr. Dorsey merely meant that these hospitals were available through the network. (Dorsey, Tr. 1479).

459. According to the Unicare representative, { [REDACTED] } (Holt-Darcy, Tr. 1596-97, *in camera*). { [REDACTED] } (Holt-Darcy, Tr. 1596, *in camera*). { [REDACTED] } (Holt-Darcy, Tr. 1596-98, *in camera*).

**Response to Finding No. 459:**

The finding is incomplete. { [REDACTED] }

{ [REDACTED] } (Holt-Darcy, Tr. 1595, *in camera*). This institutional relationship between the employed population and hospitals is often referred to as “second-stage” competition in the economics literature. Second-stage competition is the competition among hospitals for patients based on non-price variables. (Haas-Wilson, Tr. 2463-65). This testimony did not address whether these hospitals competed for contracts with managed care plans, which is the market at issue in this case. (*See CCRFF 387*).

Furthermore, during its negotiations with ENH, Unicare was not able to use the potential option of contracting with these other hospitals to discipline ENH’s demands for price increases. { [REDACTED] }

██████████} (Holt-Darcy, Tr. 1550-51, *in camera*).

460. The Unicare representative testified that Unicare ensures that its “members have access to the hospital within 30 miles of where they live or where they work so that [its plans] have sufficient access.” (Holt-Darcy, Tr. 1420.)

**Response to Finding No. 460:**

The finding is incomplete and mischaracterizes the testimony of Unicare’s representative. Ms. Holt-Darcy testified that a managed care plan wanted “to make sure that members have access to the hospital within 30 miles of where they live or work” in order “to meet the standards that the plans put together.” (Holt-Darcy, Tr. 1420). Ms. Holt-Darcy did not purport to speak about this in the context of what patients generally want, or what a managed care plan perceived as necessary to make a health care plan marketable, as suggested by Respondent. (Holt-Darcy, Tr. 1420). Thus, Ms. Holt-Darcy testified that “[y]ou look at geographic need, you look at marketing needs, you look at access” and that “[y]ou want to see what population you have or potentially have, what marketing thinks that they need in a particular service area.” (Holt-Darcy, Tr. 1420) Thus, having access to a hospital within 30 miles of where all enrollees live or work was merely one aspect of an overall process of the contracting decisions of a managed care plan. (Holt-Darcy, Tr. 1420).

461. In defining the geographic market, Dr. Noether considered this MCO testimony identifying competitors of both HPH and Evanston Hospital. (Noether, Tr. 5951, 6049, *in camera*).

**Response to Finding No. 461**

Complaint Counsel have no specific response to this finding.

**b. Third Party Hospital Documents Confirm A Broad Geographic Market**

462. Documents produced from certain of the hospitals discussed above confirm that



these hospitals competed with, and were alternative hospitals to, the ENH hospitals.

**Response to Finding No. 462:**

This finding fails to comply with the requirements of Rule 46(a) of the Commission's rules and paragraph 9 of the Court's Order on Post Trial Briefs, dated April 6, 2005, in that the finding does not contain a reference to the record to support the finding.

463. St. Francis viewed Evanston Hospital as its strongest competitor to the north. (RX 531 at 13818).

**Response to Finding No. 463:**

The finding is misleading. Although St. Francis viewed Evanston Hospital as a competitor "to the north," it is irrelevant and misleading for the reasons stated in CCRFF 411 above. In any event, St. Francis is not a price-constraining substitute for ENH. (See CCRFF 387).

This finding is also misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

464. { [REDACTED]  
[REDACTED]  
[REDACTED] } (RX 1205 at FTC-RNSMC 387, *in camera*). { [REDACTED]  
[REDACTED]  
[REDACTED] } (RX 1564 at ENH-RNSMC 1200, 1207, *in camera*). { [REDACTED]  
[REDACTED]  
[REDACTED] } (RX 1564 at ENH-RNSMC 1208, *in camera*).

**Response to Finding No. 464:**

This finding is misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is

appropriate in this case. (See CCRFF 389(c)). In any event, Rush North Shore is not a price-constraining substitute for ENH. (See CCRFF 387).

465. In 2002, Rush North Shore viewed its competitors as Advocate Lutheran General, Evanston Hospital, St. Francis and Swedish Covenant. (Noether, Tr. 5955-56; RX 1314 at A 5896)

**Response to Finding No. 465:**

The finding is misleading and incomplete for the reasons stated in CCRFF 411 above. The finding is misleading because the document was not prepared by Rush North Shore, but rather by Cap Gemini consultants. As such, it reflects the work of a third party, and not necessarily the views of Rush North Shore. Dr. Noether speculated that the document "suggests" these are competitors Rush is focusing on because the hospitals were "listed" in the document. (Noether, Tr. 5955-56; RX 1314 at A 5896).

This finding is also misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

466. Condell viewed hospitals such as Evanston Hospital, HPH, Lake Forest Hospital and Advocate Lutheran General as competitors in its primary service area. (RX 997 at CMC 132; RX 1338 at CMC 20375).

**Response to Finding No. 466:**

The finding is misleading and incomplete for the reasons stated in CCRFF 411 above. This finding is also misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

467. Indeed, Condell's market share has grown significantly over the last two decades. For example, from 1985 to 2002, Condell's market share in Lake County more than doubled from 13.3% to 28.2%. (RX 1329 at CMC 19866; RX 1398 at CMC 19869; RX 1764 at CMC 19920). During the same period, HPH's Lake County market share actually dropped from 16.5%

to 11.8%. (RX 1329 at CMC 19866; RX 1398 at CMC 19869). By late 2002, Condell had become the cardiac surgery leader in Lake County, capturing a 36% share of the Lake County market. (RX 1398 at CMC 19868).

**Response to Finding No. 467:**

The finding is misleading and incomplete for the reasons stated in CCRFF 411 above. The finding is also misleading because Lake County is a political division and not an economic “market.” { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (RX 703 at FTC-LFH

0000305, *in camera*). { [REDACTED]

[REDACTED] (RX 997 at CMC 000131, *in camera*), but not in HPH’s primary service area.

Even if, *arguendo*, HPH lost some share in Condell’s territory, the loss was not sufficient to cause ENH to roll back its price increases (*i.e.*, this was not price-constraining competition). With the exception of a partial price decrease at Humana, ENH did not have to roll back its price increases. (Hillebrand, Tr. 1709-10).

This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (*See* CCRFF 389(c)).

468. Provena Saint Therese Medical Center viewed its major competitors as Condell, Lake Forest Hospital, Victory Memorial Hospital, and HPH. (RX 397 at VIS 71865-66; Noether, Tr. 5956-57).

**Response to Finding No. 468:**

The finding is misleading and incomplete for the reasons stated in CCRFF 411

above. This finding is also misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

469. Lake Forest Hospital recognized HPH, Condell, St. Therese, and Victory as other acute care hospitals that operate in its service area. (RX 1310 at FTC-LFH 669). Internal Lake Forest Hospital documents further show that, in the 1990s, HPH was one of Lake Forest Hospital's major competitors for inpatient admissions in Lake County. (RX 394 at FTC-LFH 374-75). Indeed, by late 1997, Lake Forest Hospital had identified HPH as its "number two key competitor." (RX 306 at FTC-LFH 67-68).

**Response to Finding No. 469:**

The finding is misleading and incomplete for the reasons stated in CCRFF 411 above. This finding is also misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

470. By late 1997, Lake Forest Hospital also recognized that it competed with Evanston Hospital. (RX 306 at FTC-LFH 67). A market survey that Lake Forest Hospital conducted in late 1997 showed that Evanston Hospital was perceived to be one of Lake Forest Hospital's secondary competitors along with Northwestern Memorial, Victory Memorial and St. Therese hospitals. (RX 306 at FTC-LFH 68). Lake Forest Hospital's 1997 market survey further revealed that Evanston Hospital was "taking some of the outflow from [Lake Forest's] traditional market." (RX 306 at FTC-LFH 68)

**Response to Finding No. 470:**

The finding is based on a survey of six focus groups of 54 Lake Forest employees and, as double hearsay, cannot be introduced for the purpose of proving the truth of the matter asserted therein. (JX 1, ¶ 5; RX 306 at FTC-LFH 67).

This finding is also misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

The finding is also incomplete and misleading because Lake Forest analyzed the

market as becoming more concentrated, with hospitals merging to enhance negotiating leverage with health plans, and with the HPH and Evanston merger being one in which a market dominant firm was created. For example, in its 2001 budget for its strategic plan implementation, Lake Forest characterized the Chicago area as “evolving from loose (affiliation) to tight (merger) hospital combinations” that were intended to “enhance price negotiating leverage with managed care plans,” citing Evanston’s merger with Highland Park and the merger of Victory Memorial and St. Therese Medical Center in Lake County. The document notes that, “[a]lthough several of the larger networks have dissolved, the consensus is there will be fewer independent hospitals in the future.” (RX 987 at FTC-LFH 0000227). Also, a September 2001, Lake Forest Strategic Planning Competitive Analysis of Lake County, found that the ENH strategy is to “dominate the North Shore” market to obtain more favorable pricing from insurance companies. Furthermore, Lake Forest noted that ENH had been “successful with the [ENH] pricing approach and have secured higher prices as a result of their market position.” Lake Forest concluded that “the stated strategy of ENH is to “continue the dominance” of the North Shore. (RX 1144 at FTC-LFH 0001953-54).

471. In 1998, Lake Forest Hospital identified its “key competitors” as Condell and HPH. (Noether, Tr. 5954; RX 306 at FTC-LFH 68).

**Response to Finding No. 471:**

The finding is unreliable hearsay based on a survey of six focus groups of 54 Lake Forest employees and, as double hearsay, cannot be introduced for the purpose of proving the truth of the matter asserted therein. ( JX 1, ¶ 5; RX 306 at FTC-LFH 67).

This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which

is appropriate in this case. (See CCRFF 389(c)). In any event, Lake Forest is not a price-constraining substitute for ENH. (See CCRFF 387).

472. In 1999, Lake Forest Hospital identified its strong competitors as Evanston Hospital, Condell, Victory, the Rush System for Health, the Northwestern Healthcare Network, which it acknowledged was dissolving, the Advocate System and several hospitals in Wisconsin. (Noether, Tr. 5953; RX 703 at FTC-LFH 306-07). In the same document, Lake Forest Hospital acknowledged the impending merger of HPH and Evanston Hospital and expressed the view that the Merger could make HPH a more formidable competitor “depending on how Evanston chooses to manage Highland Park.” (Noether, Tr. 5953; RX 703 at FTC-LFH 306).

**Response to Finding No. 472:**

The finding is misleading and incomplete for the reasons stated in CCRFF 411 above. RX 703 does not refer to “strong competitors” but generally “stronger competition.” (Noether, Tr. 5953; RX 703 at FTC-LFH 306-07). Other Lake Forest planning documents after the merger suggest that there is less, not more, competition. For example, in its 2001 budget for its strategic plan implementation, Lake Forest characterized the Chicago area as “evolving from loose (affiliation) to tight (merger) hospital combinations” that were intended to “enhance price negotiating leverage with managed care plans,” citing Evanston’s merger with Highland Park and the merger of Victory Memorial and St. Therese Medical Center in Lake County. The document notes that, “although several of the larger networks have dissolved, the consensus is there will be fewer independent hospitals in the future.” (RX 987 at FTC-LFH 0000227). Also, the September 2001 Lake Forest Strategic Planning Competitive Analysis of Lake County found that the ENH strategy is to “dominate the North Shore” market to obtain more favorable pricing from insurance companies. Furthermore, Lake Forest noted that ENH had been “successful with their pricing approach and have secured higher prices as a result of their market position.” Lake Forest concluded that “the stated strategy of ENH

is to “continue the dominance” of the North Shore. (RX 1144 at FTC-LFH 0001953-54).

This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

473. [REDACTED]

[REDACTED] (RX 1292 at SCH 4592, *in camera*; RX 1354 at SCH 4663, 4713, 4721, *in camera*; Newton, Tr. 434).

**Response to Finding No. 473:**

The finding is misleading and incomplete for the reasons stated in CCRFF 411 above. This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

Also, [REDACTED] (RX 306 at FTC-LFH 68, *in camera*), [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (RX 1292 at SCH 4608, *in camera*; RX 1354 at SCH 4713, 4721.

See CCRFF 387). The finding is also irrelevant, in that it refers to second-stage competition among the hospitals for the provision of care to individual patients, rather than first stage competition in the market among acute care hospitals for the purchase and sale of services to managed care organizations. (See Elzinga, Tr. 2399-2400; Haas-Wilson, Tr. 2459-64).

474. Dr. Noether also considered these hospital documents in defining the geographic

market. (Noether, Tr. 5948-49).

**Response to Finding No. 474:**

Complaint Counsel have no specific response.

**c. ENH Testimony And Documents Confirm A Broad Geographic Market**

475. ENH and HPH representatives and documents confirm the relevant competitive landscape.

**Response to Finding No. 475:**

The finding fails to comply with the requirements of Rule 3.46(a) of the Commission's Rules of Practice and the Court's Order on Post Trial Briefs, dated April 6, 2005, in that it does not contain a reference to the record to support the finding.

476. According to current and former HPH representatives, pre-Merger, Condell, Rush North Shore, Advocate Lutheran General and Evanston Hospital all competed with HPH because of their "reasonably close" geography and because they all offered comparable or more sophisticated services than HPH. (Spaeth, Tr. 2157, 2239-40). Pre-Merger HPH's primary competitors were Lake Forest Hospital and Condell. (CX 6305 at 5 (Stearns, Dep.); RX 148 at ENHL TC 7927; Chan, Tr. 730; Krasner, Tr. 3699-3700). MCOs, however, also were able to use Rush North Shore, Evanston Hospital, St. Francis, Advocate Lutheran General and the downtown Chicago hospitals as substitutes for HPH in their networks. (Spaeth, Tr. 2299; Chan, Tr. 730).

**Response to Finding No. 476:**

The finding is misleading and incomplete. When setting its prices in 2000, ENH was not concerned with and did not factor in whether any hospital raised or lowered its prices in response. (Hillebrand, Tr. 1753-55). In addition, documents presented to the board of directors at the time of the merger showed that ENH was the most significant competitor, in terms of market share, in Highland Park's core service area. (Spaeth, Tr. 2161; CX 1876 at 16). In any event, the third-party hospitals referred to in Respondent's finding are not price-constraining substitutes for ENH. (See CCRFF 387).



This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

477. According to ENH representatives, ENH’s “major competitors” include Advocate Lutheran General, Rush North Shore, St. Francis, Condell, Lake Forest Hospital, Northwestern Memorial, Rush Presbyterian and University of Chicago because all of these hospitals offer a comparable breadth and type of services. (Hillebrand, Tr. 1748-51; Neaman, Tr. 1301). These hospitals target ENH’s service area with advertisements. (Hillebrand, Tr. 2001).

**Response to Finding No. 477:**

The finding is misleading. After the merger, ENH’s “Market Dashboard” and other business documents have typically listed only Lutheran, Northwest Community, Condell, St. Francis and Swedish Covenant as “top competitors” in its 50 zip code service area, and do not mention Northwestern Memorial, Rush and University of Chicago. (RX 1430 at ENH F16 6171 (2003 FY); RX 1300 at ENH MN 003108-09 (FY 02); CX 350 at 2 (2002)).

The finding is also misleading because health plans do not consider ENH to be comparable to Northwestern Memorial Hospital, Rush-Presbyterian or the University of Chicago. (CCFF 1927-1940). ENH’s patient mix also differed from the patient mix of those hospitals. (CCFF 705-709). [REDACTED]

[REDACTED] (Ballengee, Tr. 178-88; Dorsey, Tr. 1443-44, Foucre, Tr. 935-36.) In any event, the third-party hospitals listed in Respondent’s finding are not price-constraining substitutes for ENH (See CCRFF 387).

This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

478. ENH documents show that, in 2002, it faces strong competition in its own service area. For example, while ENH had a 16.4% share of its service area, Advocate had a 14.4% share and Resurrection had an even larger share at 17.7%. (RX 1361 at ENHE DL 6610).

**Response to Finding No. 478:**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

479. Other ENH documents confirm that its service area is “defined as 51 zip codes representing the communities where approximately 85% of [ENH’s] patients reside. Fifteen hospitals are located in this 51 zip code service area and provide services to this population.” (RX 1429 at ENHE F16 4561).

**Response to Finding No. 479:**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

480. Evanston Hospital’s and HPH’s respective service areas thus overlapped “a little bit” in the northern tier of Evanston Hospital’s service market. (Neaman, Tr. 1306). HPH competed with Evanston Hospital where the two overlapped to HPH’s south. (Spaeth, Tr. 2088; CX 6305 at 5 (Stearns, Dep.); Newton Tr., 328).

**Response to Finding No. 480:**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

To the extent patient flow analysis is relevant, the finding is misleading and incomplete. There are a large number of people situated between the three ENH facilities – for whom either Highland Park or Evanston would have been the first choice. A person traveling up the North Shore from Chicago “would stop at Evanston” first, and then

“Highland Park would be the next hospital.” (Holt-Darcy, Tr. 1426). There are no other hospitals located between Highland Park and Evanston. (Ballengee, Tr. 168). People “could go either way [to Highland Park or Evanston] and receive the same services at the same level.” (Ballengee, Tr. 166). Thus, Evanston and Highland Park Hospital competed for patients from people living in between those two communities. (Neary, Tr. 600-01; CX 1 at 3-5; CX 2 at 7). The driving time between the two hospitals ranges from 15 to 30 minutes. (Rosengart, Tr. 4445-46; Spaeth, Tr. 2157; Noether Tr. 5934. See CCFF 286).

{ [REDACTED] }

(Ballengee, Tr. 166; Neary Tr. 600-01; Mendonsa, Tr. 569, *in camera*). PHCS relied on Evanston and Highland Park as the “primary”, alternatives to each other. (Ballengee, Tr. 166-68). { [REDACTED]

[REDACTED]

[REDACTED]

{ [REDACTED] } (Mendonsa, Tr. 530, 569, *in camera*). One Health viewed Evanston and Highland Park as “main competitors” because their services were “comparable,” and the two hospitals drew patients from the same general population. (Neary, Tr. 600-02).

{ [REDACTED]

[REDACTED]

[REDACTED]

{ [REDACTED] } (Holt-Darcy, Tr. 1517-19, *in camera*).

481. Nevertheless, it is important to recognize that, before the Merger, HPH and Evanston Hospital offered very different levels of service. (CX 6305 at 19 (Stearns, Dep.)). For example, pre-Merger HPH did not offer cardiac surgery while Evanston Hospital did. Pre-merger HPH did not have a fully developed oncology program like Evanston’s Kellogg

Cancer Care Center. (CX 6305 at 19 (Stearns, Dep.)). Because HPH did not offer cardiac surgery or advanced oncological care, Evanston Hospital did not compete with HPH for these services. (CX 6305 at 19 (Stearns, Dep.); Neaman, Tr. 1306; Spaeth, Tr. 2244). Indeed, HPH's 1997 bond filings do not include Evanston Hospital as a competitor in its core market. (CX 6321 at 73).

**Response to Finding No. 481:**

The finding is misleading and incomplete. It is misleading with respect to oncology and the opportunity to offer cardiac services. In April 1999, Evanston and Highland Park signed an agreement to develop a cardiac surgery program at Highland Park Hospital. (Rosengart, Tr. 4527-30; CX 2094). In November 1999, the state approved a certificate of need for an open heart surgery program at Evanston and Highland Park. (Newton, Tr. 423). { [REDACTED] } (Dragon, Tr. 4390-91; Spaeth, Tr. 2084-86; Romano, Tr. 3097, *in camera*), { [REDACTED] } (CX 348 at 8; CX 360 at 15 (for oncology services, ENH estimated it had a 35% share, and with the addition of Highland Park (10%), the combined entity would have a 45% share.)).

The finding is also misleading with respect to the breadth of service offering of Highland Park Hospital. Before the merger, both Highland Park Hospital and Evanston had, among other things, operating rooms, pediatric services, obstetrical services, radiation therapy, cancer services, and psychiatric services. (Spaeth, Tr. 2083-2088). Highland Park's Annual Report to the community gives a rather comprehensive listing of the scope of the hospital's services and the most visible service improvements just before the merger. (CX 699 at 5-8; 24-26). Evanston also had all of the services that one would expect within a community hospital, as well as some tertiary services. (Ballengee, Tr. 159). The only difference was that Evanston provided tertiary services before the merger

while Highland Park generally did not. (Haas-Wilson, Tr. 2491). Indeed, Evanston compared itself to Highland Park before the merger along a number of service lines including oncology, orthopedics, obstetrics, general surgery, and neurosurgery. (CX 360 at 15).

**d. Other Third Party Testimony And Documents Confirm A Broad Geographic Market**

482. The 10 peer group hospitals used by Deloitte Consulting ("Deloitte") in 2002 to benchmark ENH's chargemaster in the marketplace were Loyola, Advocate Lutheran General, Illinois Masonic Medical Center, Resurrection Medical Center, Northwest Community, Northwestern Memorial, University of Chicago, Alexian Brothers, Condell, and Rush Presbyterian. (CX 1846 at 3). See Section VI.B.2. They were chosen by Deloitte because they were deemed to be ENH's chief competitors. (Hillebrand, Tr. 1993).

**Response to Finding No. 482:**

The finding is misleading and incomplete because it assumes that the term "benchmark" hospitals is synonymous with "competitors," but there is no basis for that assumption. It is apparent that some of these hospitals were chosen as benchmarks because of the similarity of the mix of hospital services and not because they are market competitors. For instance, key Evanston documents, which were presented to the board at the time of the merger, do not specifically list the share of Loyola, Illinois Masonic Medical Center, Resurrection Medical Center, Northwestern Memorial, University of Chicago, Alexian Brothers or Rush Presbyterian. (CX 84 at 21, 25; RX 704 at ENH HJ 001631, 32). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (RX 1331 at ENHE

DL 011882-84, *in camera*).

[REDACTED]

[REDACTED]

[REDACTED] (RX 1912 at 57, *in camera*). In any event, none of the listed third-party hospitals are price-constraining substitutes for ENH. (*See* CCRFF 387).

483. Kaufman Hall & Associates examined the competitive landscape that HPH was facing in the Chicago marketplace as part of its strategic work for the hospital. (Kaufman, Tr. 5836). HPH's primary competitors were Lake Forest Hospital and Condell. (Kaufman, Tr. 5836). HPH was also feeling competitive pressure from Northwest Community, Advocate Lutheran General, and Northwestern Memorial. (Kaufman, Tr. 5836-37). Northwestern Memorial was constructing a new women's hospital in downtown Chicago, a construction product that was changing the competitive landscape in a significant way. (Kaufman, Tr. 5837).

**Response to Finding No. 483:**

This finding is misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (*See* CCRFF 389(c)).

484. Moreover, the Illinois Health Facilities Planning Board uses "planning areas" to determine the need for services and beds. Condell and Lake Forest Hospital are in HPH's planning area. (D. Jones, Tr. 1685). Significantly, Evanston and HPH are in different planning areas. (D. Jones, Tr. 1670).

**Response to Finding No. 484:**

The finding is irrelevant and incomplete. The Illinois Health Facilities Planning Board's planning areas are regulatory demarcations used for the purpose of regulating hospital expansion ("to determine the need for services or beds"), and there is no evidence that they were developed using any form of economic analysis, let alone to define a relevant geographic market. (D. Jones, Tr. 1670).

**e. Dr. Noether Defined A Reasonable Relevant Geographic Market Based On The Evidence Discussed Above**

485. Considering all the evidence, including the documents and testimony of market participants discussed above, Dr. Noether concluded that Evanston Hospital and HPH were not

each other's closest geographic substitutes, "rather, each one of them had several other hospitals that were closer competitors." (Noether, Tr. 5957, 5951-56). As a consequence, it is analytically impossible for Evanston Hospital and HPH to be the only hospitals in the geographic market. (Noether, Tr. 5956).

**Response to Finding No. 485:**

The finding is misleading and incorrect. Dr. Noether's analysis did not satisfy the requirements of the Merger Guidelines (Merger Guidelines, § 1.21), but rather reached an arbitrary conclusion regarding which hospitals were the closest competitors of each other, while at the same time never applying the hypothetical monopolist test. The Merger Guidelines state that the Agency will begin with the location of each merging firm (or each plant of a multiplant firm) and ask what would happen if a hypothetical monopolist of the relevant product at that point imposed at least a "small but significant and nontransitory" increase in price, but the terms of sale at all other locations remained constant. (Merger Guidelines, § 1.21).

In defining a geographic market, there is no requirement that the analysis start with the two "closest competitors." Moreover, rather than using arbitrary criteria to make such a determination, the Merger Guidelines call for the Agency to look at: (1) evidence of whether buyers have shifted or have considered shifting purchases between different geographic locations in response to relative changes in price or other competitive variables; and (2) evidence that sellers base business decisions on the prospect of buyer substitution between geographic locations in response to relative changes in price or other competitive variables. (Merger Guidelines, § 1.21). Here ENH did not see a decrease in the number of managed care admissions as a result of ENH's price increases in 2000 (Neaman, Tr. 1211-12; Haas-Wilson, Tr. 2667; Hillebrand, Tr. 1764-65) and, with the exception of a partial decrease at Humana, did not have to roll back its price increases

(Hillebrand, Tr. 1709-10). At the same time, ENH management did not believe that other hospitals would act as a pricing constraint by changing their prices as a result of ENH's 2000 price increases. (Neaman, Tr. 1212; Hillebrand, Tr. 1764-65; Newton, Tr. 367).

This finding is also misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

**486. Dr. Noether concluded that Evanston Hospital's closest geographic competitors were Rush North Shore, St. Francis and Advocate Lutheran General. (Noether, Tr. 5958).**

**Response to Finding No. 486:**

The finding is misleading and incomplete. Dr. Noether did not comply with the requirements of the Merger Guidelines (*see* Merger Guidelines § 1.21), but rather reached an arbitrary conclusion regarding which hospitals were the closest geographic competitors of Evanston. The arbitrary selection of three hospitals as Evanston's closest competitors is at heart a descriptive approach that lacks the analytical method and economics associated with the Merger Guidelines hypothetical monopolist test. (*See* Merger Guidelines, § 1.21). The Merger Guidelines state that the Agency will begin with the location of each merging firm (or each plant of a multiplant firm) and ask what would happen if a hypothetical monopolist of the relevant product at that point imposed at least a "small but significant and nontransitory" increase in price, but the terms of sale at all other locations remained constant. (Merger Guidelines, § 1.21). In any event, the third-party hospitals listed are not price-constraining substitutes for ENH. (*See* CCRFF 387).

This finding is also misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which



is appropriate in this case. (See CCRFF 389(c)).

487. Dr. Noether concluded that HPH's closest geographic competitors were Lake Forest Hospital and Condell. (Noether, Tr. 5959).

**Response to Finding No. 487:**

The finding is incomplete. Dr. Noether did not comply with the requirements of the Merger Guidelines (see Merger Guidelines, § 1.21), but rather reached an arbitrary conclusion regarding which hospitals were the closest geographic competitors of Highland Park. The arbitrary selection of two hospitals as HPH's closest geographic competitors is at heart a descriptive approach that lacks the analytical method and economics associated with the Merger Guidelines' hypothetical monopolist test. In any event, the third-party hospitals listed in Respondent's finding are not price-constraining substitutes for ENH. (See CCRFF 387).

This finding is also misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

488. At a minimum, therefore, Dr. Noether's geographic market includes, in addition to the merging hospitals, Rush North Shore, St. Francis, Advocate Lutheran General, Resurrection, Lake Forest Hospital and Condell. (Noether, Tr. 5928, 5960).

**Response to Finding No. 488:**

The finding is misleading in that it includes Resurrection Hospital in the geographic market, which was not included in RFF 485-487, above. The finding is also incomplete because Dr. Noether did not comply with the Merger Guidelines and did not apply the hypothetical monopolist test. The Merger Guidelines' hypothetical monopolist test provides an analytical framework for reaching a conclusion about the relevant geographic market that has a nexus to economic analysis rather than unscientific

guesswork. (See Merger Guidelines, §§ 1.0 to 1.21).

This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)). In any event, the listed third-party hospitals are not price-constraining substitutes for ENH. (See CCRFF 387).

489. There are some hospitals outside of this minimum market that provide at least some competitive constraint on the hospitals inside the minimum area. (Noether, Tr. 5929). In particular, from a geographic perspective, some of the hospitals that are “quite near” the minimum geographic area provide competitive constraint on the hospitals in the minimum area, and may even be in the relevant geographic market. (Noether, Tr. 5930). These hospitals include, for example: Holy Family, Swedish Covenant, and Vista. (Noether, Tr. 5930-31).

**Response to Finding No. 489:**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)). In any event, the listed third-party hospitals are not price-constraining substitutes for ENH. (See CCRFF 387).

490. In addition, Northwestern Memorial places “substantial competitive constraint” on ENH and the other hospitals in the minimum geographic market even though it is located in downtown Chicago. (Noether, Tr. 5931).

**Response to Finding No. 490:**

This finding is misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

Furthermore, ENH management did not believe that other hospitals would act as a pricing constraint by changing their prices as a result of ENH’s 2000 price increases.

(Neaman, Tr. 1212; Hillebrand, Tr. 1764-65; Newton, Tr. 367). In any event,

Northwestern Memorial is not a price-constraining substitute for ENH. (See CCRFF

387).

**f. Dr. Haas-Wilson Did Not Define A Reasonable Geographic Market Based On The Evidence Discussed Above**

491. Dr. Haas-Wilson defined the relevant geographic market as “the area contiguous to the three hospitals of ENH. So, that would be the campuses of HPH, Evanston Hospital and Glenbrook Hospital.” (Haas-Wilson, Tr. 2667).

**Response to Finding No. 491:**

The finding is incomplete and misleading. Dr. Haas-Wilson included in her geographic market “the area that lies inside the -- I guess it's a triangle, three points, of the hospitals, and possibly some of the area around those hospitals.” (Haas-Wilson, Tr. 2667).

492. {

} (Baker, Tr. 4703, *in camera*)

**Response to Finding No. 492**

The finding is incorrect. In defining the relevant geographic market, Dr. Haas-Wilson “relied on the principles laid out in the Horizontal Merger Guidelines; in particular, the principle of the hypothetical monopoly test.” (Haas-Wilson, Tr. 2667). “ENH successfully raised the prices of its services, and they did so over the long term, and it was a not insignificant price increase over the long term, and the relevant customer did not turn to alternative sellers located outside of that geographic area.” (Dr. Haas-Wilson, Tr. 2667).

Dr. Baker, the sole source Respondent cites for this finding, lacks credibility.

(CCFF 1742-62).

493. Dr. Noether found additional support for her conclusion that Dr. Haas-Wilson did

not follow the Merger Guidelines in her geographic market analysis in the deposition testimony under oath by another expert retained by Complaint Counsel in this litigation, Dr. Gregory Werden. [Footnote reference omitted] Complaint Counsel ultimately decided not to call Dr. Werden to testify at trial. (Noether, Tr. 5959-60)

**Response to Finding No. 493:**

The finding is irrelevant. How someone who never testified might or might not view Dr. Haas-Wilson's use of the principles of the Merger Guidelines is irrelevant.

494. Dr. Haas-Wilson's geographic market only makes sense, under the Merger Guidelines, if Evanston Hospital and HPH were closest competitors in geographic terms. (Noether, Tr. 5932). As discussed above, however, Evanston Hospital and HPH were not each other's closest geographic competitors. (Noether, Tr. 5932).

**Response to Finding No. 494:**

The finding is incorrect. In defining a geographic market, there is no requirement that the analysis start with the two "closest competitors" geographically. (See Merger Guidelines, § 1.21). Moreover, rather than using arbitrary criteria to make such a determination, the Merger Guidelines call for the Agency "to begin with the location of each merging firm (or each plant of a multiplant firm)." The Agency is supposed to look at: (1) evidence of whether buyers have shifted or have considered shifting purchases between different geographic locations in response to relative changes in price or other competitive variables; and (2) evidence that sellers base business decisions on the prospect of buyer substitution between geographic locations in response to relative changes in price or other competitive variables. (Merger Guidelines, § 1.21) Here, ENH did not see a decrease in the number of managed care admissions as a result of ENH's price increases in 2000 (Neaman, Tr. 1211-12; Haas-Wilson, Tr. 2667) and, with the exception of a partial decrease at Humana, did not have to roll back its price increases. (Hillebrand, Tr. 1709-10). At the same time, ENH management did not believe that other

hospitals would act as a pricing constraint by changing their prices as a result of ENH's 2000 price increases (Neaman, Tr. 1212; Hillebrand, Tr. 1764-65; Newton, Tr. 367).

495. [REDACTED]  
[REDACTED]  
[REDACTED] } (Baker, Tr. 4704, *in camera*).

**Response to Finding No. 495:**

The finding is incorrect. [REDACTED]

[REDACTED]  
[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2480-81). [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED] (Haas-Wilson, Tr. 2733, *in camera*). [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2734, *in camera*). Dr. Haas Wilson reached her conclusions about market power without having defined the relevant markets. (Haas-Wilson, Tr. 2658-59).

Having determined that the merger enhanced the market power of ENH and that ENH exercised that market power (Haas-Wilson, Tr. 2657-58), without relying on the definition of the market, Dr. Haas-Wilson then followed the principles of the Merger

Guidelines, beginning with the merging hospitals, and considering what would happen if a hypothetical monopolist raised its prices. (Haas-Wilson, Tr. 2667) { [REDACTED]

[REDACTED]

[REDACTED] (Haas-Wilson, Tr. 2734, *in camera*), { [REDACTED]

[REDACTED]

[REDACTED]

Dr. Baker, the sole source Respondent cite for this finding, lacks credibility.

(CCFF 1742-62).

496. { [REDACTED]

[REDACTED]  
[REDACTED] (Baker, Tr. 4704-05, *in camera*).

**Response to Finding No. 496:**

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (Haas-Wilson, Tr. 2733, *in camera*). [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (Haas-Wilson,

Tr. 2734, *in camera*). { [REDACTED]

[REDACTED]

Dr. Baker, the sole source Respondent cites for this finding, lacks credibility.

(CCFF 1742-1762).

497. As proof that Dr. Haas-Wilson's proposed relevant geographic market was gerrymandered, she was unwilling and unable to draw a line around her geographic market, or to identify the maximum and minimum bounds of her geographic market. (Haas-Wilson, Tr. 2920-21).

**Response to Finding No. 497:**

The finding is misleading and incomplete. The Merger Guidelines do not require as part of the hypothetical monopolist test that the Agency draw formal lines "around" a geographic market, nor do they require that the "maximum and minimum" bounds of the market be defined. (See Merger Guidelines, § 1.21). The Merger Guidelines attempt to illuminate the effects of a merger through economic analysis, and there is no requirement to provide a precise metes and bounds description of the market. Dr. Haas-Wilson concluded it was not necessary to draw a line specifically delineating the boundaries of the geographic market. (Haas-Wilson, Tr. 2920-21).

498. Indeed, it is possible that Dr. Haas-Wilson's geographic market goes up to the area outside the campus of the next closest hospitals, but not onto or beyond the campuses of those hospitals. (Haas-Wilson, Tr. 2922-23).

**Response to Finding No. 498:**

The finding is misleading and incomplete because the Merger Guidelines do not require as part of the hypothetical monopolist test that the Agency draw formal lines "around" a geographic market, nor do they require that the "maximum and minimum" bounds of the market be defined. (See Merger Guidelines, § 1.21). The Merger Guidelines attempt to illuminate the effects of a merger through economic analysis, and there is no requirement to provide a precise metes and bounds description of the market. By contiguous, Dr. Haas-Wilson meant the area that lies inside the three points of the

hospitals, and possibly some of the area around those hospitals. (Haas-Wilson, Tr. 2667).

Dr. Haas-Wilson concluded it was not necessary to draw a line specifically delineating the boundaries of the geographic market. (Haas-Wilson, Tr. 2920-21).

**C. ENH's Market Share Is Less Than That In Other Hospital Merger Cases**

**1. ENH's Core Market Consists Of About 20 Zip Code**

499. "Core market" is a term of art that ENH uses to describe a subsection of its total market.

**Response to Finding No. 499:**

This finding fails to comply with the requirements of Rule 3.46(a) of the Commission's Rules of Practice and the Court's Order on Post Trial Briefs, dated April 6, 2005, in that this finding does not contain a reference to the record to support the finding.

Also, the finding is irrelevant. "[A] market definition 'which ignores the buyers and focuses on what the sellers do, or theoretically can do, is not meaningful.'" *Sargent-Welch Scientific Co. v. Ventron Corp.*, 567 F.2d 701, 710 (7<sup>th</sup> Cir. 1977), *citing, inter alia, Cass Student Advertising, Inc. v. National Educational Advertising Service, Inc.*, 516 F.2d 1092, 1095 (7<sup>th</sup> Cir.), *cert. denied*, 423 U.S. 986 (1975). *See* Horizontal Merger Guidelines, § 1.21.

500. ENH's "core" market represents about 20 zip codes. (Neaman, Tr. 1055).

**Response to Finding No. 500:**

The finding is irrelevant. "[A] market definition 'which ignores the buyers and focuses on what the sellers do, or theoretically can do, is not meaningful.'" *Sargent-Welch Scientific Co. v. Ventron Corp.*, 567 F.2d 701, 710 (7<sup>th</sup> Cir. 1977), *citing, inter alia, Cass Student Advertising, Inc. v. National Educational Advertising Service*, 516 F.2d 1092, 1095 (7<sup>th</sup> Cir.), *cert. denied*, 423 U.S. 986 (1975). *See* Horizontal Merger Guidelines,



§ 1.21.

This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

Dr. Haas-Wilson concluded that the relevant geographic market in this case includes the area contiguous to the three hospitals of ENH, which includes the campuses of Highland Park, Evanston and Glenbrook Hospitals. (Haas-Wilson, Tr. 2667). By contiguous, Dr. Haas-Wilson meant the area that lies inside the three points of the hospitals, and possibly some of the area around those hospitals (Haas-Wilson, Tr. 2667). Dr. Haas-Wilson employed the principles of the Merger Guidelines, in particular the hypothetical monopolist test, to find that ENH successfully raised its prices in a significant way over the long term and that customers did not turn to alternative sellers located outside of the geographic area. (Haas-Wilson, Tr. 2667).

501. ENH usually has a 50% market share of the “core” zip codes. (Neaman, Tr. 1056). The 20 zip codes of the “core” are the closest zip codes to ENH in terms of proximity. (Neaman, Tr. 1057).

**Response to Finding No. 501:**

The finding is irrelevant. “[A] market definition ‘which ignores the buyers and focuses on what the sellers do, or theoretically can do, is not meaningful.’” *Sargent-Welch Scientific Co. v. Ventron Corp.*, 567 F.2d 701, 710 (7<sup>th</sup> Cir. 1977), citing, *inter alia*, *Cass Student Advertising, Inc. v. National Educational Advertising Service*, 516 F.2d 1092, 1095 (7<sup>th</sup> Cir.), cert. denied, 423 U.S. 986 (1975). See Horizontal Merger Guidelines, § 1.21.

The finding is also misleading and incomplete. When setting its prices in 2000,

ENH was not concerned with and did not factor in whether any hospital raised or lowered its prices in response. (Hillebrand, Tr. 1753-55). In addition, documents presented to the board of directors at the time of the merger showed that Evanston was the most significant competitor, in terms of market share, in Highland Park's core service area. (Spaeth, Tr. 2161; CX 1876 at 16). In any event, the third-party hospitals in ENH's 20 zip code area are not price-constraining substitutes for ENH. (See CCRFF 387).

This finding is also misleading because it addresses "" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

## **2. ENH's Service Area Consists Of About 51 Zip Codes**

502. At ENH, the term "service area" refers to the 51 zip code area from which 80-85% of ENH's patient come. (RX 1429 at ENHE F16 4561; Hillebrand, Tr. 1996; Spaeth, Tr. 2156; Neaman, Tr. 1055, 1307).

### **Response to Finding No. 502**

The finding is irrelevant. "[A] market definition 'which ignores the buyers and focuses on what the sellers do, or theoretically can do, is not meaningful.'" *Sargent-Welch Scientific Co. v. Ventron Corp.*, 567 F.2d 701, 710 (7<sup>th</sup> Cir. 1977), citing, *inter alia*, *Cass Student Advertising, Inc. v. National Educational Advertising Service*, 516 F.2d 1092, 1095 (7<sup>th</sup> Cir.), cert. denied, 423 U.S. 986 (1975). See Horizontal Merger Guidelines, § 1.21.

The finding is also misleading and incomplete. When setting its prices in 2000, ENH was not concerned with and did not factor in whether any hospital raised or lowered its prices in response. (Hillebrand, Tr. 1753-55). In addition, documents presented to the board of directors at the time of the merger showed that Evanston was the most

significant competitor, in terms of market share, in Highland Park's core service area. (Spaeth, Tr. 2161; CX 1876 at 16). In any event, the third-party hospitals referred to in Evanston's 51 zip code area are not price-constraining substitutes for ENH. (See CCRFF 387).

This finding is also misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

503. ENH's service area has stayed fairly constant at 50-52 zip codes for as long as Hillebrand could recall and extends from the northern tier of the City of Chicago up north to the Wisconsin line, from the lake on the east and out west to various communities such as Arlington Heights, Vernon Hills and Mundelein. (Hillebrand, Tr. 1996; Neaman Tr. 1307). ENH also uses the term "secondary market" to describe the 50-52 zip code market. (Neaman, Tr. 1056-57).

**Response to Finding No. 503:**

The finding is irrelevant. "[A] market definition 'which ignores the buyers and focuses on what the sellers do, or theoretically can do, is not meaningful.'" *Sargent-Welch Scientific Co. v. Ventron Corp.*, 567 F.2d 701, 710 (7<sup>th</sup> Cir. 1977), citing, *inter alia*, *Cass Student Advertising, Inc. v. National Educational Advertising Service*, 516 F.2d 1092, 1095 (7<sup>th</sup> Cir.), cert. denied, 423 U.S. 986 (1975). See Horizontal Merger Guidelines, § 1.21.

The finding is misleading and incomplete. When setting its prices in 2000, ENH was not concerned with and did not factor in whether any hospital raised or lowered its prices in response. (Hillebrand, Tr. 1753-55). In addition, documents presented to the board of directors at the time of the merger showed that Evanston was the most significant competitor, in terms of market share, in Highland Park's core service area. (Spaeth, Tr. 2161; CX 1876 at 16). In any event, the third-party hospitals in ENH's 50-52

zip code area are not price-constraining substitutes for ENH. (See CCRFF 387).

This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

504. Hospital administrators will typically look to their “service area” to determine their respective hospitals’ market shares. (Spaeth, Tr. 2156).

**Response to Finding No. 504:**

The finding is irrelevant. “[A] market definition ‘which ignores the buyers and focuses on what the sellers do, or theoretically can do, is not meaningful.’” *Sargent-Welch Scientific Co. v. Ventron Corp.*, 567 F.2d 701, 710 (7<sup>th</sup> Cir. 1977), citing, *inter alia*, *Cass Student Advertising, Inc. v. National Educational Advertising Service*, 516 F.2d 1092, 1095 (7<sup>th</sup> Cir.), cert. denied, 423 U.S. 986 (1975). See Horizontal Merger Guidelines, § 1.21).

The finding is also misleading and incomplete. When setting its prices in 2000, ENH was not concerned with and did not factor in whether any hospital raised or lowered its prices in response. (Hillebrand, Tr. 1753-55). In addition, documents presented to the board of directors at the time of the merger showed that Evanston was the most significant competitor, in terms of market share, in Highland Park’s core service area. (Spaeth, Tr. 2161; CX 1876 at 16). In any event, the third-party hospitals in ENH’s service area are not price-constraining substitutes for ENH. (See CCRFF 387).

This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

505. 20% of ENH’s patients come from outside ENH’s service area, including such

places as the city of Chicago and from around the world. (Hillebrand, Tr. 1998). Patients come from around to world to see ENH's Neurology Department Chairman, who is a widely recognized brain tumor specialist and a professor at Northwestern University Medical School. (Hillebrand, Tr. 1998).

**Response to Finding No. 505:**

This finding is misleading because it addresses "second-stage" competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

506. { [REDACTED]  
[REDACTED]  
[REDACTED] } (RX 2021 at ENH DL 3443, *in camera*; Neaman, Tr. 1311; Hillebrand, Tr. 1996-98).

**Response to Finding No. 506:**

The finding is irrelevant. "[A] market definition 'which ignores the buyers and focuses on what the sellers do, or theoretically can do, is not meaningful.'" *Sargent-Welch Scientific Co. v. Ventron Corp.*, 567 F.2d 701, 710 (7<sup>th</sup> Cir. 1977), *citing, inter alia, Cass Student Advertising, Inc. v. National Educational Advertising Service*, 516 F.2d 1092, 1095 (7<sup>th</sup> Cir.), *cert. denied*, 423 U.S. 986 (1975). See Horizontal Merger Guidelines, § 1.21.

The finding is also misleading and incomplete. When setting its prices in 2000, ENH was not concerned with and did not factor in whether any hospital raised or lowered its prices in response. (Hillebrand, Tr. 1753-55). In addition, documents presented to the board of directors at the time of the merger showed that Evanston was the most significant competitor, in terms of market share, in Highland Park's core service area. (Spaeth, Tr. 2161; CX 1876 at 16). In any event, the third-party hospitals referred to in Respondent's finding are not price-constraining substitutes for ENH. (See CCRFF 387).

This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which is appropriate in this case. (See CCRFF 389(c)).

507. { [REDACTED] } (RX 2021 at ENH DL 3443, *in camera*; Neaman, Tr. 1311).

**Response to Finding No. 507:**

The finding is irrelevant. “[A] market definition ‘which ignores the buyers and focuses on what the sellers do, or theoretically can do, is not meaningful.’” *Sargent-Welch Scientific Co. v. Ventron Corp.*, 567 F.2d 701, 710 (7<sup>th</sup> Cir. 1977), *citing, inter alia*, *Cass Student Advertising, Inc. v. National Educational Advertising Service*, 516 F.2d 1092, 1095 (7<sup>th</sup> Cir.), *cert. denied*, 423 U.S. 986 (1975). See Horizontal Merger Guidelines, § 1.21).

Furthermore, this is a consummated merger, and there is direct evidence of price effects from the merger. Therefore, there is no need to infer from service area data a share for ENH. (Haas-Wilson, Tr. 2468, Elzinga, Tr. 2355, 2362-63).

The finding is also misleading and incomplete. When setting its prices in 2000, ENH was not concerned with and did not factor in whether any hospital raised or lowered its prices in response. (Hillebrand, Tr. 1753-55). In addition, documents presented to the board of directors at the time of the merger showed that Evanston was the most significant competitor, in terms of market share, in Highland Park’s core service area. (Spaeth, Tr. 2161; CX 1876 at 16). In any event, the third-party hospitals in ENH’s service area are not price-constraining substitutes for ENH. (See CCRFF 387).

This finding is also misleading because it addresses “second-stage” competition and patient flow analysis as a basis for defining the geographic market, neither of which

is appropriate in this case. (See CCRFF 389(c)).

### 3. The Concentration Resulting From The Merger Is Acceptable

508. Given the available data, Dr. Noether was not able to calculate exact market shares. (Noether, Tr. 5961). Dr. Noether did, however, calculate proxy shares using the best available information, contained in the Medicare Cost Reports. (Noether, Tr. 5961). The Medicare Cost reports provide information on total net revenues, both inpatient and outpatient, across all MCOs for each hospital. (Noether, Tr. 5961).

#### **Response to Finding No. 508:**

The finding is irrelevant, because it is based on Respondent's perception of the market. "[A] market definition 'which ignores the buyers and focuses on what the sellers do, or theoretically can do, is not meaningful.'" *Sargent-Welch Scientific Co. v. Ventron Corp.*, 567 F.2d 701, 710 (7<sup>th</sup> Cir. 1977), citing, *inter alia*, *Cass Student Advertising, Inc. v. National Educational Advertising Service*, 516 F.2d 1092, 1095 (7<sup>th</sup> Cir.), cert. denied, 423 U.S. 986 (1975). See Horizontal Merger Guidelines, § 1.21.

In any event, this is a consummated merger, and there is direct evidence of price effects from the merger. Therefore, there is no need to infer from service area data a share for ENH. (Haas-Wilson, Tr. 2468, Elzinga Tr. 2355, 2362-63).

509. Dr. Noether calculated, based on her product market definition and using her minimum geographic market – comprised of Rush North Shore, St. Francis, Advocate Lutheran General, Resurrection, Lake Forest Hospital and Condell – that Evanston Hospital had a pre-Merger share of about 23%. (Noether, Tr. 5962 (*describing* DX 8115)). Dr. Noether calculated that HPH had a pre-Merger share of about 7%. (Noether, Tr. 5962). Consequently, the combined, post-Merger market share was about 30%. (Noether, Tr. 5962).

#### **Response to Finding No. 509:**

The finding is irrelevant. "[A] market definition 'which ignores the buyers and focuses on what the sellers do, or theoretically can do, is not meaningful.'" *Sargent-Welch Scientific Co. v. Ventron Corp.*, 567 F.2d 701, 710 (7<sup>th</sup> Cir. 1977), citing, *inter alia*, *Cass Student Advertising, Inc. v. National Educational Advertising Service*, 516 F.2d 1092,

1095 (7<sup>th</sup> Cir.), *cert. denied*, 423 U.S. 986 (1975). See Horizontal Merger Guidelines, § 1.21).

The finding is also irrelevant because this is a consummated merger, and there is direct evidence of the anticompetitive effects from the merger. As such, there is no need to infer from service area data and concentration a share for ENH. (Haas-Wilson, Tr. 2468, Elzinga Tr. 2355, 2362-63).

510. Dr. Noether also calculated Herfindahl-Hirschman Index (“HHI”) statistics based on her product market and using her minimum geographic market. (Noether, Tr. 5962). HHI is a measure suggested by the Merger Guidelines as a way of capturing market concentration to that take into account of all of the players in the market, as opposed to something like a four firm concentration issue, which would only look at the top four, and it takes essentially the shares of each of those firms, squares them and then sums the squared shares. So, HHI is a statistic that can range from zero, in the case of a infinite number of very small players, up to 10,000, which is 100 squared, if there were a single monopolist in the market. (Noether, Tr. 5962-63).

**Response to Finding No. 510:**

Complaint Counsel have no specific response.

511. The post-Merger HHI for Dr. Noether’s minimum geographic market, treating St. Francis and Resurrection Medical Center as separate hospitals, was slightly greater than 1900, and the change in HHI between pre- and post-Merger was about 300. (Noether, Tr. 5963).

**Response to Finding No. 511:**

The finding is incomplete. { [REDACTED]

[REDACTED] } (RX 1912 at 57, *in camera*). Even using Dr. Noether’s HHI calculation, the post-merger HHIs are above the threshold level that the Merger Guidelines signify as a “highly concentrated market” (Noether, Tr. 5963), and the increase in the HHI is in excess of 100, which creates a presumption that the merger is “likely to create or enhance market power.” (Merger Guidelines, § 1.51 (c)). Moreover, Dr. Noether overlooked in her calculation the fact that



St. Francis and Resurrection Medical Center should not be treated as separate hospitals.

(See RFF 511-512).

512. St. Francis and Resurrection Medical Center merged in the late 1990's. (RX 531 at 13916). { [REDACTED] }  
{ [REDACTED] }  
(Noether, Tr. 6248, *in camera*). { [REDACTED] }  
(Noether, Tr. 6248, *in camera*). { [REDACTED] }  
{ [REDACTED] }  
{ [REDACTED] } (Noether, Tr. 6248-49, *in camera*).

**Response to Finding No. 512:**

The finding is incomplete. { [REDACTED] }  
{ [REDACTED] } (RX 1912 at 57, *in camera*). Even using Dr. Noether's HHI calculation, the post-merger HHIs are above the threshold level that the Merger Guidelines signify as a "highly concentrated market" (Noether, Tr. 5963), and the increase in the HHI is in excess of 100, which creates a presumption that the merger is "likely to create or enhance market power." (Merger Guidelines, § 1.51 (c)).

513. This market is not concentrated relative to the types of transactions that are "typically challenged as likely to cause anti-competitive effects. (Noether, Tr. 5963). Also these shares are conservative because they are calculated only based on hospitals located in Dr. Noether's minimum geographic market and do not reflect the competitive constraint hospitals outside Dr. Noether's minimum market may place on those inside the market. (Noether, Tr. 5964).

**Response to Finding No. 513:**

The finding is incomplete. { [REDACTED] }  
{ [REDACTED] } (RX 1912 at 57, *in camera*). Even using Dr. Noether's HHI calculation, the post-merger HHIs are above the threshold level that the Merger Guidelines signify as a "highly concentrated market"

(Noether, Tr. 5963), and the increase in the HHI is in excess of 100, which creates a presumption that the merger is “likely to create or enhance market power.” (Merger Guidelines, § 1.51 (c)). Moreover, Dr. Noether left out of her calculation the fact that St. Francis and Resurrection Medical Center should not be treated as separate hospitals. (See RFF 511-512). In any event, the third-party hospitals inside and outside of Dr. Noether geographic market are not price-constraining substitutes for ENH. (See CCRFF 387).

514. [REDACTED]

[REDACTED] (Noether, Tr. 5964). [REDACTED]

[REDACTED] (Noether, Tr. 5965). [REDACTED]

[REDACTED] (Noether, Tr. 5965; RX 1912 at 58, *in camera*). [REDACTED]

[REDACTED] (Noether, Tr. 5965-66).

**Response to Finding No. 514:**

The finding is incomplete. { [REDACTED]

[REDACTED] } (RX 1912 at 57, *in camera*). Even using Dr. Noether’s HHI calculation, the post-merger HHIs are above 1800, which the Merger Guidelines signify as a “highly concentrated market” (Noether, Tr. 5963), and the increase in the HHI is in excess of 100, which creates a presumption that the merger is “likely to create or enhance market power.” (Merger Guidelines, § 1.51 (c)). Moreover, Dr. Noether left out of her calculation the fact that St. Francis and Resurrection Medical Center should not be treated as separate hospitals. (See RFF 511-512).