United States of America

FEDERAL TRADE COMMISSION

Docket No. 9315

IN THE MATTER OF
EVANSTON NORTHWESTERN
HEALTHCARE CORPORATION

RESPONDENT'S CORRECTED APPEAL BRIEF

PUBLIC VERSION

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TABLE OF ABBREVIATIONS

The following abbreviations and citation forms are used:

CCFF	Complaint Counsel's Proposed Finding of Fact
CCPTB	Complaint Counsel's Post Trial Brief
CCRB	Complaint Counsel's Reply Brief
CX	Complaint Counsel's Exhibit
DX	Demonstrative Exhibit
ID	Initial Decision
IDF	Initial Decision Finding of Fact
RB	Respondent's Post Trial Brief
RFF	Respondent's Proposed Finding of Fact
RFF-Reply	Respondent's Proposed Reply Finding of Fact
RRB	Respondent's Reply Brief
RX	Respondent's Exhibit
{Text in bold and brackets}	*In Camera* Protected Information*

*In accordance with 16 CFR 3.45(e), any references to information that has been granted in camera protection in this case have been identified with brackets and bold typeface. Attached to this brief are copies of the ALJ's in camera orders (Attachment A), pages from the brief containing in camera references (Attachment B), and a list of parties who should be notified in the event the Commission intends to disclose any in camera information in its final decision (Attachment C).

SUMMARY OF THE ARGUMENT

The merger combining Evanston Northwestern Healthcare Corporation ("ENH"), a major academic hospital system, and Highland Park Hospital ("HPH"), a community hospital, resulted in extraordinary quality improvements for patients, without harm to competition. Three findings by the Administrative Law Judge ("ALJ") are dispositive:

- ENH's investment of more than $120 million in HPH after the January 1, 2000 merger resulted in "significant" and "verified" quality improvements at HPH. ID177-78.

- It is "highly probable" that other hospitals in the relevant market—Lake Forest, Lutheran General, St. Francis and Rush North Shore—"would have the ability to constrain prices at ENH, either now or in the future, and could be utilized by managed care organizations to create alternate hospital networks." ID144; *accord* ID147,149.

- Complaint Counsel failed to prove that ENH's post-merger prices exceeded competitive levels. ID155.

Under these findings, the merger neither produced anticompetitive effects nor is likely to do so. To the contrary, it has produced and will continue to produce substantial benefits—many of them of life and death importance—to thousands of consumers.

The ALJ nevertheless found a presumption of likely anticompetitive effects based, apparently, on a combination of concentration and post-merger pricing information, and that ENH did not "rebut" this presumption. But those conclusions were based on a market definition that is far too narrow in light of the undisputed facts that these hospitals are located in two different counties nearly 14 miles apart, and that 18 other hospitals are closer to one of the merging parties than they are to each other. Further, even in the ALJ's artificial market, the market shares are lower than those

identified in the complaint, lower than those routinely required to support liability in cases based on a theory of "unilateral" effects, and lower than those alleged in past hospital merger challenges. These facts all confirm that the price changes that concerned the ALJ were the result of something other than market power.

Respondent, moreover, did rebut any presumption of anticompetitive effects and demonstrated that the merger never has nor is likely to substantially lessen competition. As the *Merger Guidelines* ("*Guidelines*") and case law explain, a merger in a differentiated product market may create unilateral market power only where (a) a significant share of sales in the market are to consumers who regard the products of the merging firms as their first and second choices and (b) it is unlikely that the remaining firms would "reposition" their services in response to supra-competitive prices by the merged firm. Here the evidence (unlike the allegations in the complaint) demonstrated that Evanston Hospital ("Evanston") and HPH were highly differentiated from each other and that each had closer competitors in both "product" and "geographic" space. Eighteen hospitals were geographically closer to Evanston and HPH than they were to each other. Further, area hospitals can and have repositioned their product offerings. The ALJ's correct conclusion that nearby hospitals severely constrain post-merger ENH's ability to impose anticompetitive price increases—a conclusion also supported by the size and sophistication of ENH's managed care organization ("MCO") customers—is further evidence that the post-merger prices resulted from something other than market power and, indeed, required dismissal of the case. ID144,147,149.

Complaint Counsel, moreover, not only failed to prove price increases at anything near the levels alleged in the complaint, but also offered no evidence that prices rose above *competitive levels* or that output declined. And the ALJ ignored contemporaneous documents and uncontested testimony establishing that the real reason Evanston increased its prices after the merger was that it learned, contemporaneously with the merger, that its rates were below-market and its negotiation tactics outdated. Accordingly, Complaint Counsel's pricing evidence neither bolsters any presumption nor constitutes direct evidence of anticompetitive effects.

By contrast, the undisputed evidence showed that the merger *strengthened* competition in the market (properly defined) in two important ways. First, the merger provided HPH with the financial strength to make it a more potent competitor. HPH's financial health was steadily declining in the years before the merger, and it could not fully service its debt and operate at a loss while making upgrades necessary to remain competitive in the face of repositioning by competitors. This fact further establishes that the merger could not have posed a serious threat to competition, and that it cannot explain the post-merger price increases. The ALJ erroneously disregarded this evidence by confusing it with the failing firm defense, which Respondent did not advance. The ALJ also erred in relying instead upon rosy HPH projections designed to impress a merger partner—in the face of contemporaneous financial statements and due diligence reports by independent auditors and consultants that proved those projections wrong.

Second, unrebutted evidence showed that the merger further strengthened HPH's competitive position by enhancing its quality and expanding its range of services. Before

the merger, HPH had serious and systemic quality of care problems and lacked the institutional resources and leadership to address them. For example, one HPH physician routinely performed **REDACTED** RFF1317,1452; Silver, Tr. 3898, *in camera*. Other HPH physicians improperly performed abortions in emergency room ("ER") facilities that provided limited privacy. HPH lacked in-house evening obstetrics coverage, and had problems getting physicians to respond to emergency calls. The nursing staff lacked "critical thinking" skills, which—combined with poor physician/nurse teamwork—put patients at risk. RFF1360-84. And HPH needed more than $14 million to repair "critical" physical plant deficiencies that threatened patient safety and Medicare certification. RFF1536-48.

After the merger, ENH swiftly corrected these and other quality problems at HPH by transforming governance, exporting ENH's collaborative culture, and infusing HPH with the benefits of a major teaching hospital. At a cost of more than $120 million, ENH paid for major renovations, new equipment, and improved staffing in most of HPH's clinical departments, including radiology, oncology, intensive care, cardiac surgery, interventional cardiology, laboratory services, nursing, pharmacy, and psychiatry. As a result of all these changes, in just a few short years, HPH has been transformed from a weak, regional competitor into a top-flight hospital recently recognized as one of the 50 best in the entire nation.

While acknowledging some quality improvements, the ALJ erroneously discounted HPH's pre-merger problems and ignored numerous merger-specific quality improvements in other areas. And he ignored overwhelming evidence that these quality

improvements would not have occurred *as fast or as well*—if at all—without the merger. Those benefits are of incalculable importance to the thousands of patients who use these hospital facilities every year for acute inpatient care, and greatly outweigh the speculative competitive risks identified by the ALJ.

Finally, even if a violation could be found on this meager record, divestiture is not an appropriate remedy. Divestiture would deprive HPH of access to ENH's medical staff, supervisory skill, academic activities, research partnerships, multidisciplinary care conferences, and case consultations, all of which benefit HPH patients. Divestiture would deprive HPH of the financial strength and capital it obtained from the merger, including $45 million in additional improvements (beyond the $120 million described above) that ENH has committed to make in the near term. And divestiture would result in the loss of HPH's cardiac surgery program, the closing of its interventional cardiology program, and a severely reduced ability to provide life-saving treatments to heart attack patients, many of whom would again be subjected to the severe risks inherent in transfer to other hospitals. In these and other ways, divestiture would cause extraordinary injury to the public interest and thoroughly subvert the consumer welfare objectives of the Clayton Act.

STATEMENT OF FACTS

The ALJ's errors become apparent when one considers: (1) the competitive relationship between ENH and HPH pre- and post-merger; (2) the reasons for the merger; (3) the substantial quality improvements the merger produced; (4) the circumstances surrounding pricing negotiations with MCOs and how Evanston developed and carried out its strategy for raising its below-market prices to market levels; and (5) the many critical differences between the facts alleged in the complaint and the evidence presented at trial.

1. ENH and HPH Were Not Close Competitors Pre-Merger.

ENH is a not-for-profit, integrated health care delivery system affiliated with Northwestern University's Feinberg School of Medicine. Post-merger, ENH runs three hospitals—Evanston, Glenbrook Hospital (built by Evanston in 1977) and HPH—which provide a broad array of primary, secondary and tertiary acute care inpatient and outpatient services. IDF87; RFF7,17. The three hospitals, which share one Federal Medicare identification number, are fully integrated and operate as a single entity. IDF88; RFF7,11. The Medicare Payment Advisory Commission ("MedPAC"), a federal agency, deems the ENH hospitals to be academic or "teaching" hospitals, and the MCOs agree. IDF809,828; RFF8-9. The ENH system also includes a system wide, 480-physician multispecialty faculty group practice; a federally funded $100 million research enterprise affiliated with Northwestern University; and a charitable foundation. IDF87; RFF1.

Since the Merger, ENH has received national recognition for its quality of care in numerous areas. In 2004, ENH received the KLAS and Davies Awards for its top-ranked medical information system. RFF3. In 2005, ENH received the Leapfrog Award as the top hospital system in Illinois. RFF3. ENH recently received the National Quality Award based on its outstanding program to improve the quality of healthcare delivery in the community. RFF3. And *Consumers Digest* has named all three ENH hospitals as three of the 50 exceptional hospitals in the United States. RFF3.

Before the merger, Evanston—one of approximately 100 hospitals in the Chicago metropolitan area—was consistently recognized nationally as a top academic hospital that performed complicated tertiary services as well as primary and secondary services. Since the mid-1990s, Evanston/ENH has been named ten times by Solucient as both a Top 15 Teaching Hospital and a Top 100 Hospital nationally. RFF3,30-33,2189-93. Only one other hospital in the United States achieved this success. O'Brien, Tr. 3546.

HPH, the sole hospital subsidiary of Lakeland Health Services, was a very different institution before the merger. Located in Highland Park (Lake County), Illinois, it did not provide tertiary services, but only primary and secondary services. IDF18,24,202; RFF20,35,41-42. Unlike Evanston, HPH was a community-based hospital that principally served local residents. RFF41. According to HPH's former CEO, pre-merger HPH was a "good community hospital, but if you were really sick, you went somewhere else." IDF784; RFF43. Members of the Highland Park community tended to go to Evanston, Northwestern Memorial Hospital, the University of Chicago, Loyola University Medical Center, or Rush University Medical Center, rather than HPH,

because HPH could not satisfy their needs. RFF43. HPH physicians tended to refer patients away from HPH for many services. IDF277; RFF43.

Part of the reason patients traveled elsewhere for care was that HPH lacked the financial resources to compete directly with Evanston and other academic hospitals. HPH's records and financial consultants revealed that HPH faced serious financial problems before the merger. RFF2298-2413. HPH's operating income steadily declined during the 1990s, and from 1996-1999 HPH had losses from operations. RFF45. Indeed, in 1999, HPH had operating losses of over $3 million, and its audited financials reported an $11 million loss. RFF45. HPH, moreover, had resorted to the risky practice of offsetting these operational losses with investment income. RFF2347-53. As a result, HPH had $120 million in debt and required millions in "critical" facility improvements because of years of insufficient capital investments. IDF1045; RFF46,2376-77.

HPH's weak financial position exacerbated the hospital's quality problems and thereby endangered patients' lives. RFF1414-17. For example, a lack of managerial oversight too often resulted in **REDACTED**, medically unsound inductions of labor, and inappropriate terminations of late-stage pregnancies. RFF1269-75,1446-57. Moreover, failing pregnancies were often ended in the ER without adequate pain relief or maternal support services, and with the patients separated from other ER patients by only a thin curtain. RFF1271-72. These and other systemic deficiencies were catalogued in a 1998 on-site review by the American College of Obstetrics and Gynecology. RFF1239,1252-55,1258,1265,1309.

Deficiencies in HPH's physical plant posed a further danger to patients' safety. In 1999, architects commissioned by ENH to review HPH's facilities as part of its pre-merger due diligence determined that HPH had "high risk" problems with ventilation, electrical systems, pressure in isolation rooms, emergency power, and even exposed asbestos—all direct threats to patient safety. RFF1537-48. Concurrently, the Department of Health and Human Services sent a letter to HPH threatening to revoke its Medicare accreditation and stating "the deficiencies are significant and limit [HPH's] capacity to render adequate care and ensure the health and safety of [its] patents." RFF49,1531-32; *see also* RFF1227,1233-1563. It was not until after the merger that

REDACTED . RFF1534.

HPH also lacked the organizational strength to solve its many problems. RFF1424. HPH lacked effective procedures to discipline problem doctors, and it tended to address quality issues only when confronted with adverse media coverage.[1] The hospital also suffered from poor quality assurance processes (RFF1435-40), weak quality improvement programs, and a dysfunctional nursing culture. RFF48.

Beyond these stark differences in quality, Evanston and HPH were not close substitutes in product space before the merger. Evanston had far more beds, treated more diagnostic related groups ("DRGs") and had more medical residents. Unlike HPH,

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[1] Before the merger, HPH had a particular problem with physician non-responsiveness.

REDACTED

REDACTED Harris, Tr. 4420; RFF1425-28.

REDACTED RFF1438.

RFF1427,1438. **REDACTED**

Evanston was an academic teaching hospital—not a community hospital. Evanston's closest substitutes from a product perspective were Advocate Lutheran General and Northwestern Memorial. IDF234-42,276; RFF563-69. HPH's closest substitutes from a product perspective were Lake Forest Hospital and Condell. IDF234-242,244; RFF577-87.

Nor were Evanston and HPH close substitutes from a geographic perspective. RFF560. HPH is located 13.7 miles, a 25- to 30-minute drive, from Evanston. IDF21; RFF388. Eighteen hospitals are closer to Evanston or HPH than they are to each other, and at least 35 hospitals are within a 20-mile radius of any ENH hospital. RFF389-90; RX1912 at 20. Evanston's closest substitutes from a geographic perspective were St. Francis and Rush North Shore. IDF281,287; RFF570-76. HPH's closest substitutes from a geographic perspective were Lake Forest, Rush North Shore and Condell. IDF266,293; RFF577-87.

2. The Merger Was Driven By Legitimate Patient-Care And Business Considerations.

Because HPH's financial health and continued viability as a critical care facility were in jeopardy, its board concluded that a merger partner was necessary. RFF274,281. The board wanted a merger that would bring new programs, services and capital to HPH. RFF272. The board believed the hospital could not continue to serve its community in the long run absent a partnership with another institution that could satisfy these conditions. RFF273.

After searching for a suitable partner, HPH determined that a merger with Evanston would provide these much-needed improvements. RFF275. Contemporaneous documents show that HPH wanted the merger to raise its breadth and quality of care to a level commensurate with ENH. RFF275. The anticipated quality improvements were consistent with HPH's desire to become "indispensable" to the community. RFF1001. A key goal from the beginning of merger negotiations was to improve HPH's obstetrics services and to expand its oncology, cardiology and other services. RFF278-79.

Other hospitals did not offer viable merger opportunities for HPH. Lake Forest was not interested in merging because of its affiliation with Rush Presbyterian. RFF285. Condell did not have the required financial and clinical resources. RFF286. And HPH believed downtown Chicago hospitals, such as Northwestern Memorial, would not commit to the desired quality improvements. RFF287.

For its part, Evanston was willing to merge with HPH because: (1) HPH's location in fast-growing Lake County provided an opportunity to expand volume (RFF288-89); (2) the space-constrained Evanston campus could rationalize resources and move services to HPH, thus improving the quality of care at both campuses (RFF291-94); (3) corporate efficiencies would result from integration (IDF89-90,464; RFF295-96); and (4) the merger would provide an additional teaching site for ENH and the Northwestern University Medical School. RFF297.

3. The Merger Produced Substantial Quality Improvements, Especially At HPH.

As anticipated, the merger substantially benefited patients and the community by improving quality at both HPH and ENH. Post-merger, ENH invested more than $120 million in HPH, resulting in "significant" and "verified" improvements to HPH's quality of care. The ALJ conclusively found improvements in obstetrics, quality assurance, nursing, physical plant, oncology, radiology, radiation medicine, emergency care, laboratory, pharmacy services, cardiac surgery, psychiatry, intensive care, electronic medical records, academic affiliation, and clinical integration. ID183-91; IDF876-90,903,909-18,921-23,929-33,935-36,942-43,947-49,952-53,961-62,965-68,970-72,976-93. Complaint Counsel's quality expert also found that care improved in nearly every service line examined. RFF1231; RFF-Reply2037,2058. And ENH's quality expert and 13 fact witnesses proved dramatic advancements in 16 fields of healthcare—improvements that touched virtually every patient. RFF1228-31,1250,2217-19.

ENH made significant improvements at HPH almost immediately after the 2000 merger. IDF888; RFF1389,1442,1565. For example, ENH overhauled the system of physician governance by integrating the medical staffs and replacing part-time, private-practice physicians with full-time clinical chairmen. IDF888; RFF1389,1442. ENH terminated inappropriate practices and procedures in the ER, added a preoperative gynecologic surgical review program, and improved physician/nurse teamwork. IDF877-80; RFF1269-75,1293-97,1304-20,1333. ENH changed Ob/Gyn protocols to ensure that

mothers experiencing failed pregnancies were treated in outpatient operating rooms and that psychologists and social workers were present to help care for them. RFF1301-03.

ENH also remedied the lack of physician coverage. RFF1254,1287. As a result, HPH became the first hospital in Lake County with full-time in-house obstetrical coverage. RFF1283. The extended coverage meant that in 2004, more than 200 women were provided emergency care by an in-house ENH obstetrician. Without that coverage, those mothers likely would not have had an attending physician at the birth of their children. RFF1285.

Increased staffing corrected other gaps in patient care. RFF1256,1276-92,1677-90. ENH increased coverage in the ER and the pharmacy and added specialized physicians to cover HPH's Intensive Care Unit around the clock. IDF877-80,970; RFF1276-77,1672-75,1691-1703,1708-10,1911-19,1955-63; *see also* RFF1687-88.

ENH also improved psychiatric services by creating a specialized, adolescent center at HPH and locating adult psychiatric patients at Evanston Hospital. RFF2172. Prior to the merger, adolescents were commingled with adult psychiatric inpatients at HPH, which offered only limited treatment options for these very different groups of patients. RFF2175. ENH's rationalization of psychiatric service resolved the obvious problem of a single psychiatric unit in which adolescents, many quite vulnerable, were mixed in with adults exhibiting significant disturbances. RFF2172, 2178-79.

In addition, ENH resolved HPH's critical physical plant deficiencies, including the problems enumerated in an expansive architectural assessment it had previously

undertaken. RFF1530-41,1543-57. ENH spent almost $15 million responding to physical plant deficiencies that did or could threaten patient safety. RFF1534,1540-41.

ENH quickly made other structural improvements to HPH. It built a cardiac catheterization lab (completed March 2002) to support a new interventional cardiology program; renovated and expanded the ER, psychiatry, and radiology departments; and added $2 million in sophisticated operating room equipment. IDF912; RFF1516,1562, 1653. In June 2000, ENH took over HPH's lab operations, converted the immediate response lab to a full-service lab, and installed over $1 million in equipment to replace faulty and ill-maintained instrumentation. IDF943; RFF1796,1827. In mid-2000, ENH opened the Kellogg Cancer Care Center at HPH, which provides cancer care far exceeding the norm for community hospitals. IDF921; RFF1755. Within a year of the merger, ENH installed 20 high-tech automated drug distribution machines (Pyxis) throughout HPH. IDF947; RFF1974. ENH improved the quality of HPH's radiology department by extending PACS, its filmless radiology imaging system, to HPH. IDF929-933; RFF2136. And in 2003, ENH introduced at all of its sites and faculty practice outpatient offices a state-of-the-art, fully-integrated, electronic medical records system called Epic. IDF976-82; RFF2002-04.

In March 2000, to enhance HPH's quality improvement program, ENH implemented multi-disciplinary clinical pathways—data-driven treatment plans aimed at improving patient care. By August 2002, ENH introduced 33 new critical pathways to HPH, including a heart attack critical pathway (introduced immediately after the merger in 2000), which improved performance on life-saving measures for heart attack patients

by requiring aspirin and beta blockers. IDF896; IDF896; RFF1476,1478,1482-1483,1487,1490. Immediately,

REDACTED RFF1490,1492,1494-1504,1509-11.

In February 2005, ENH completed a 67,000-square-foot Ambulatory Care Center ("ACC") at HPH. IDF911; RFF1516,1559-61. The ACC houses a new linear accelerator to furnish state-of-the-art radiation treatment and a CT/PET scanner, a state-of-the-art diagnostic device for cancer patients. IDF929; RFF1786-87.

ENH also opened a new cardiac surgery program at HPH, which required substantial changes, including hiring a new cardiac surgeon, constructing a state-of-the-art operating room, procuring complex equipment, and hiring and training key ancillary staff. IDF952; RFF1558,1579,1586,1709. As a result, HPH performed the first open heart surgery in Lake County in June 2000—only six months after the merger. RFF1565.

As a direct result of HPH's new capacity to perform open heart surgery it obtained authorization to begin an interventional cardiology program. RFF1667-71. Pre-merger, HPH performed only *diagnostic* catheterizations, which merely determine the degree of blockage in a heart vessel. Now, HPH can treat those life-threatening blockages, a capability rarely found in community hospitals. RFF1576,1650-52.

The impact of these new services at HPH has been dramatic. Pre-merger, half of all patients initially admitted to HPH with a heart attack were transferred to another hospital—a process that put their lives at risk. RFF1568,1658-59,1706. For example, before the merger, HPH would have had to transfer a patient who presented with a torn

aorta or heart attack to another hospital, where the patient would have to be re-evaluated and then sent to the transferee hospital's operating room for surgery. RFF1568. Such transfers, aside from being inconvenient to both patient and family, created life-threatening dangers. RFF1658-59. Accordingly,

REDACTED RFF1656-58.

REDACTED (RFF 1657), an undisputed, life-saving benefit to the community.

4. ENH Was Forced To Focus On Negotiations With MCOs.

By 2000, ENH itself faced significant financial pressure because of the Balanced Budget Act of 1997 ("the Act"), which ultimately reduced payments to hospitals and physicians by $225 billion. IDF183; RFF625,627. The Act disproportionately affected hospitals, like Evanston, with many clinical service lines, employed physicians, home care programs, teaching programs and research institutes. RFF629. In particular, from 1998-2003, the Act reduced Evanston's operating revenue by $16 million per year and caused its operating income to decline severely. RFF630,633.

These pressures provoked Evanston to reevaluate its MCO contracting strategy. In the early 1990s, Evanston had focused on building relationships with insurers, not increasing revenue. ID172; RFF595. The goal was to be included in all the MCO networks. ID172; RFF605. Evanston, however, "underestimated how [it] was positioned in the marketplace to begin with." RFF609. It focused only on relationships with its

largest customers, Blue Cross Blue Shield ("Blue Cross") and Humana. RFF604. In light of the Act, a change in strategy was sorely needed.

Accordingly, Evanston hired Bain & Co. ("Bain") in the fall of 1999, in part to advise on MCO contract negotiations. IDF356; RFF670. After examining Evanston's and HPH's MCO contracts as part of the merger due diligence process (IDF356; RFF672), Bain advised that, in eight out of the 13 reviewed contracts, HPH had more favorable contract terms than Evanston. RFF679. For example, Bain's analysis—confirmed by contemporaneous documents—revealed that HPH's United Healthcare ("United") contract rates were roughly double Evanston's United contract rates. IDF395; RFF680. Bain documents further showed that the rates paid to HPH by another MCO, Private Health Care Systems ("PHCS"), were 30-35% higher than Evanston's rates. IDF411; RFF685-87. Bain provided similar information about Aetna, Cigna and other MCOs. IDF422,436; RFF689-91. HPH documents confirmed that "applying ENH's hospital contract rates to [HPH] would reduce [HPH's] annual net revenue from managed care payors by approximately $8,000,000." RFF665.

Bain also advised Evanston that it was charging below-market rates compared to its peer academic hospitals. According to Bain, Evanston had failed to take advantage of its favorable pre-merger market position to negotiate MCO contract rates. As a result, it was "very far behind in the marketplace, and that seemed to be supported by the reactions of payors." RFF701. Accordingly, Bain advised ENH that it "should recognize its position" in the market based on its under-market contract rates (sometimes referred to imprecisely by Bain as "leverage") "and not be afraid to ask to be paid fair market value"

for its services. IDF764; RFF996. ENH understood from Bain's advice that, if it was being paid less than HPH, a community hospital, it was no doubt far below its peer academic medical centers, which generally receive higher reimbursement rates. RFF103,703.

Bain thus advised ENH to seek a one-time corrective adjustment to many of its current contract rates and seek higher rates regardless of whether the merger was consummated. RFF697,705. ENH accepted Bain's recommendations. RFF723-24.

Moreover, Bain advised Evanston on how to become more effective in MCO negotiations, including, but not limited to: (1) seeking a change from the per diem method to the discount-off-charges method; (2) requesting a rate higher than may ultimately be acceptable; (3) setting minimum contract rate targets; and (4) adopting a more confrontational negotiating style. RFF713,715-18. The result was higher rates in many of ENH's 2000 contract renegotiations and, with one brief exception, no loss of contracts with MCOs. RFF726. ENH did not, however, receive higher rates for Blue Cross, whose PPO rates were already higher for Evanston than for HPH. RFF693.

The addition of HPH to the ENH system did not create market power, and therefore was not the reason for higher rates. The Bain vice president responsible for overseeing Bain's merger-related work testified that HPH was a "tiny hospital" and that the merger did not change ENH's "position in the marketplace at all." RFF731. Instead, HPH had previously obtained higher rates than Evanston because it had a better contracting process and more effective contract negotiators. RFF731. The rates that ENH received after the merger "were not significantly higher . . . than rates that already

existed in the market for a lot of other hospitals." RFF732. Instead, ENH "just played catch up." RFF732. In short, ENH was able to obtain more favorable rates after the merger simply because "Evanston was just so far behind" the market *before* the merger. RFF733. One of ENH's MCO customers, United, conceded as much during post-merger negotiations. RFF684.

To be sure, ENH benefited "from understanding Highland Park's contracts and the process they had gone through in negotiating their contracts." RFF733. But, as the Bain vice president testified, "armed with that knowledge, . . . Evanston could have absolutely got the same contracting rates" without the merger. RFF733.

Not surprisingly, ENH's internal documents reflect that ENH officials were proud of their success in negotiations. IDF457-65. But those documents are consistent with the fact that Evanston's prior contract rates were not only below those charged by HPH, but also well below those charged by peer academic hospitals. ENH needed to "catch up" to market rates, which it did with information and negotiation strategies learned from Bain, not because of merger-related market power. *See, e.g.*, RFF-Reply1365. Moreover, as demonstrated below, ENH's post-merger MCO rates did not exceed the rate levels of its peer academic hospitals, refuting the ALJ's finding of anticompetitive effects.

Indeed, neither ENH's patients nor the employers who ultimately fund the services that ENH provides have complained about ENH's prices. The only complaints about those prices have come from a few (but by no means all) of ENH's MCO customers, who may be more motivated by a desire to increase their profits than by any desire to provide

lower prices—or high-quality service—to area residents and the businesses who employ them.

5. Complaint Counsel's Theories And The Evidence Presented At Trial Differed Significantly From The Allegations In The Complaint.

This case on appeal is very different from the case the Commission authorized in February 2004. The Commission issued a complaint with three counts. Two counts challenged the hospital merger directly under Section 7 of the Clayton Act, while the third challenged certain negotiating practices relating to both physician and hospital services under Section 5 of the FTC Act. After the ALJ denied Complaint Counsel's motion for summary judgment on the physician claim, Complaint Counsel and Respondent agreed to a cease and desist order with no admission of liability to resolve that claim. The Commission then removed Count III from the adjudication which thereafter focused on the other counts directly challenging the hospital merger. Decision and Order, May 17, 2005 (available at http://www.ftc.gov/os/adjpro/d9315/ index.htm).

Besides this change, the case tried below differed from the case authorized by the Commission in several important respects. First, the complaint specifically alleged that the relevant product market—"general acute care inpatient hospital services sold to private payers" that "include an overnight stay"—excluded "tertiary services." Compl. ¶16. Excluded tertiary services were defined as "sophisticated services" that include "services such as open heart surgery and transplants." Compl. ¶16. But by the time of trial, Complaint Counsel shifted its theory and maintained that the product market

necessarily *included* tertiary services. RFF382; Haas-Wilson, Tr. 2490.[2] Thus, the product market alleged by Complaint Counsel at trial was significantly broader than the product market alleged in the complaint, and therefore necessarily included a significantly larger group of hospitals.

Second, the complaint alleged that the relevant geographic market was an area "directly proximate to the three ENH hospitals and contiguous areas." Compl. ¶17. Complaint Counsel and its expert thus gerrymandered the alleged geographic market to include only the three ENH hospitals and an area that could go up to, but would never include, the next closest hospital in any direction. RFF497-98.

The unrebutted evidence at trial, however—including contemporaneous evidence from other market participants—demonstrated that many hospitals competed with Evanston and HPH before the merger and continue to do so today. Even the ALJ rejected Complaint Counsel's effort to portray this as a merger to monopoly, and concluded instead that ENH faces substantial competitive constraints from other hospitals in the Chicago area. ID144,147,149. Thus, the evidence at trial unambiguously showed that the geographic market is significantly broader than that alleged in the complaint.

Third, these changes in market definition inevitably mean—and the testimony and contemporaneous documents of market participants confirmed—that concentration in this

[2] At trial, Complaint Counsel and its economic expert tried to distinguish ENH from certain other hospitals on the ground that they offer certain "quaternary" services—which Complaint Counsel defined as solid organ transplants and burn treatments—not available at ENH. RFF1087. But the complaint itself referred to sophisticated services, including transplants, as "tertiary" services, and Dr. Haas-Wilson conceded that her own book defines tertiary services to include solid organ transplants. RFF1087.

market is well below the levels alleged in the complaint. Although the complaint never specified which hospitals were included in the relevant market, it alleged that the post-merger HHI exceeded 3000 and had increased more than 500 points as a result of the merger. Compl. ¶18. Yet even the ALJ's artificial market definition resulted in a post-merger HHI hundreds of points shy of these figures. IDF318-19.

Finally, Count II of the complaint alleged that the merger resulted in enormous absolute (as opposed to relative) price increases for selected health plans or MCOs. Yet at trial, all the experts agreed that absolute price increases have no legal or economic significance by themselves. RFF315,519-20. Although the experts disagreed on data sets and methodologies, none of them disputed that many of ENH's contracts were old and had not been renegotiated for years. Further, the evidence from both sides showed that the overall price increases were far more modest than those suggested by the allegations in the complaint. For example, ENH's expert, Prof. Jonathan Baker, estimated ENH's relative price increases measured over a period of several years from before to after the merger, were at only 9-10%, based on Complaint Counsel's alleged product market and using the most reliable data set, while even Complaint Counsel's expert estimated relatively modest overall increases of 11%-18%. ID2; IDF688; RFF1004. Moreover, ENH showed that the ultimate prices did not exceed *competitive levels*, and Complaint Counsel failed to offer any alternative analysis on that point.

In short, Complaint Counsel's theory in bringing the case changed at trial because the facts did not support its claims. As a result, it is now left with a theory that has neither factual nor legal support.

QUESTIONS PRESENTED

1. Whether, in a unilateral effects case, a presumption or finding of anticompetitive effects can be established when the market share of the merged firm is far below a monopoly level?

2. Whether Complaint Counsel adduced evidence sufficient to create a presumption of anticompetitive effects in a well-defined relevant product and geographic market as required under Section 7?

3. Whether, if such a presumption exists, the evidence presented by Respondent rebutted it and, based on the totality of the circumstances, Complaint Counsel carried its burden of persuasion that the merger is likely to substantially lessen competition in well-defined relevant product and geographic markets?

4. Whether divestiture is the appropriate remedy for a consummated merger where the alleged anticompetitive effects occurred at the time of the merger more than four years before the filing of the complaint, significant consumer welfare-enhancing integration between the merged firms has occurred, divestiture would result in loss of substantial benefits, and less draconian remedies are available?

ARGUMENT

In determining whether a merger will "substantially lessen competition" in a relevant market in violation of Section 7, "the economic concept of competition, rather than any desire to preserve rivals as such, is the lodestar" that controls the analysis. *Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1386 (7th Cir. 1986)(hereinafter "*HCA*"). As then-Judge Thomas explained, in an opinion joined by then-Judge Ginsburg, the analysis begins by determining whether the government (here Complaint Counsel) has "establishe[d] a presumption that the transaction will substantially lessen competition" by showing that it "will lead to undue concentration" in a well-defined market. *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 982 (D.C. Cir. 1990); *accord United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1283-1284 (7th Cir. 1990)(hereinafter "*Rockford*"). If such a presumption is established, the defendant then has an opportunity to rebut it—and thereby establish that the merger is *not* likely to reduce competition—through evidence on a "variety of factors" consistent with the Supreme Court's "totality-of-the-circumstances" approach. *Baker Hughes*, 908 F.2d at 984 (citing *United States v. Gen. Dynamics Corp.*, 415 U.S. 486 (1974)). For example, a defendant can show that the raw concentration or market share numbers are "misleading"; that factors such as product differentiation or seller heterogeneity reduce the risk of anticompetitive behavior; that customers are sufficiently sophisticated to make any exercise of market power unlikely; that the merger will strengthen the competitive position of either firm; or that the merger will likely produce efficiencies or other benefits to consumers. *Baker Hughes,* 908 F.2d at 984-85; *Rockford,* 898 F.2d at 1284; *HCA,* 807 F.2d at 1390. Once such a showing has

been made, the government—which bears the burden of persuasion at all times—must establish some other basis for concluding that the merger is likely to be anticompetitive, or the complaint must be dismissed. *Baker Hughes,* 908 F.2d at 983; *accord FTC v. H.J. Heinz Co.,* 246 F.3d 708, 715 (D.C. Cir. 2001).

Even assuming a presumption of illegality has been established, a merger's legality ultimately depends upon a weighing of risks and benefits—specifically, any risks the merger may pose to competition versus the merger's pro-competitive benefits. *Baker Hughes,* 908 F.2d at 984; *see also Chicago Bridge & Iron*, Dkt. 9300 at 7, n.35 (Op. of FTC Comm'n)(Jan. 6, 2005)(hereinafter "*CB&I*"). Respondent vigorously denies that Complaint Counsel presented any evidence of competitive risks sufficient to establish a presumption that the merger would substantially lessen competition. Nevertheless, the following analysis proceeds to an examination, in Section I, of both sides' evidence on competitive risks, and demonstrates that Complaint Counsel failed to carry its ultimate burden of demonstrating a significant risk to competition. Section II, moreover, demonstrates that any such risk is more than outweighed by the merger's substantial benefits, not only to patients in the relevant communities, but to competition among Chicago-area hospitals. Finally, Section III shows that divestiture is an inappropriate remedy because, among other things, it would destroy the quality enhancements and other pro-competitive effects that the merger produced without reducing prices. In this case, then, a divestiture remedy would be a heavy blow to consumer welfare.

I. COMPLAINT COUNSEL FAILED TO CARRY ITS BURDEN OF ESTABLISHING ANY SUBSTANTIAL RISK TO COMPETITION.

Throughout these proceedings, Complaint Counsel attempted to establish that the merger poses a risk to competition—not from coordinated effects, but solely from unilateral effects. As shown below, even if this were a traditional coordinated effects case, the market structure evidence would not warrant a presumption of illegality, much less a finding of anticompetitive effects. *See HCA,* 807 F.2d at 1389-90; *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251 (N.D. Ill. 1989) *aff'd on other grounds* 898 F.2d 1278 (7th Cir. 1990). Moreover, Complaint Counsel's concession that the potential competitive effects here are unilateral rather than coordinated makes any such presumption wholly inappropriate. That is especially true in light of the acknowledged sophistication and size of the hospitals' principal customers—large managed care organizations. And Complaint Counsel's pricing evidence utterly fails to compensate for the structural evidence, which demonstrates that ENH's post-merger price increases were not and could not have been the result of merger-related market power.

A. The Market Analysis By Complaint Counsel And The ALJ Was Fundamentally Flawed.

Any presumption of likely competitive harm based on market concentration must begin with a well-defined market, a necessary predicate for finding a Section 7 violation. *United States v. E.I. DuPont De Nemours & Co.*, 353 U.S. 586, 593 (1957); ID131. Here, the relevant product market must be defined as a cluster of hospital-based services, while an appropriately-defined geographic market includes "not only where consumers have gone in the past for hospital services, but what 'practical alternatives' they would

have in the future." ID131-32,136. The ALJ erred, however, both by failing to include hospital-based outpatient services in the product market,[3] and more importantly, by failing to include several additional hospitals in the geographic market. The ALJ's entire market structure analysis is flawed and cannot create any presumption of illegality even under a traditional coordinated-effects analysis.

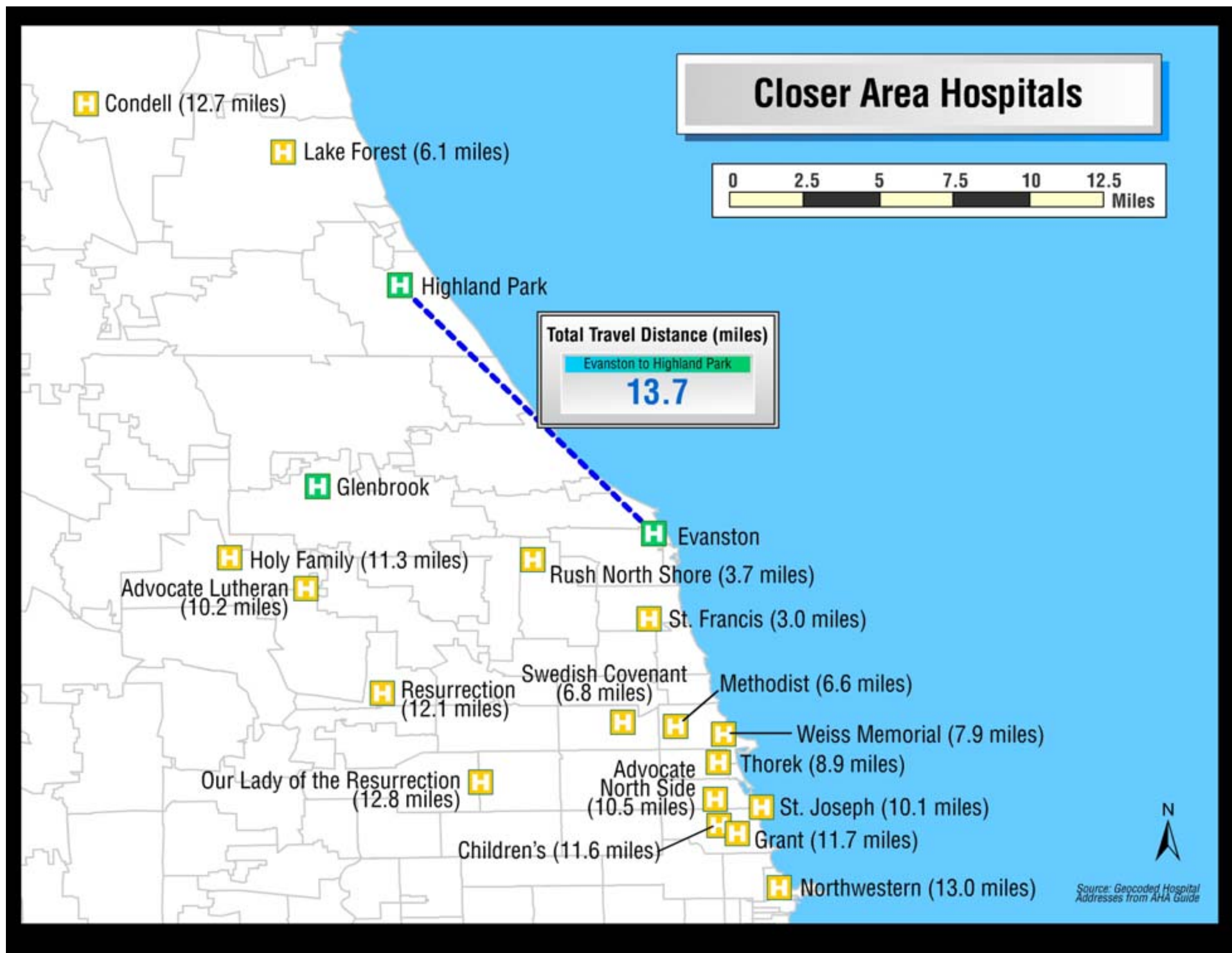
1. **The ALJ Erred In Excluding From The Relevant Geographic Market Numerous Hospitals That Compete With ENH.**

Even assuming the product market is properly limited to "general acute care inpatient services," the geographic market must still "both 'correspond to the commercial realities' of the industry and be economically signifficant." *Brown Shoe Co. v. United States*, 370 U.S. 294, 336-37 (1962). The commercial reality is that MCOs market their health care plans to employers, for whom travel times are a critical factor in evaluating such plans. RFF387. Accordingly, the ALJ correctly found that geographic proximity, travel times, physician admitting patterns, and market participants' views are all germane to a determination of the relevant geographic market. ID138; RB21-25. Yet the ALJ defined the relevant market very narrowly and in stark contrast to virtually all of the decided hospital merger cases, in which the geographic market has typically

[3] Although correctly recognizing that a "cluster of services" defines the product market, the ALJ erroneously excluded hospital-based outpatient services because they cannot substitute for inpatient services. ID133. Given Complaint Counsel's focus on MCOs as the consumers, the critical issue is how MCOs purchase hospital services. RB16-18. The evidence established that MCOs contract with hospitals for the entire bundle of inpatient and outpatient services that hospitals provide, which the MCOs then combine and market as part of a network or plan. RB17; RRB50-51; RFF77,366-376; RFF-Reply1625-1628. Such a product market was adopted by the ALJ in *In re Hosp. Corp. of Am.*, 1985 FTC LEXIS 15, at *210-11 (Oct. 25, 1985). Although the Commission expressed reservations about this market because, at that time (unlike at ENH today), hospitals provided far more inpatient than outpatient care, the Commission accepted the market definition for the purpose of that proceeding. *Id.* at *210-12.

encompassed entire counties, or multiple counties, even in urban and suburban areas. *See, e.g.*, *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 141-42 (E.D.N.Y. 1997) (Queens and Nassau Counties); *Rockford*, 898 F.2d at 1284-85 (Winnebago County and pieces of other counties); *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1123 (N.D. Cal. 2001) (Inner East Bay and parts of Contra Costa County); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1293 (W.D. Mich. 1996), *aff'd per curiam without published opinion*, 121 F.3d 708 (6th Cir. 1997) ("greater Kent County area"); *see also FTC v. Tenet Health Corp.* 186 F.3d 1045, 1053 (8th Cir. 1999) (hospitals located in multiple counties and up to sixty miles away from the merging parties, were practical alternatives).

Here too, additional hospitals located near the ENH hospitals must be included in the geographic market. RFF116. As indicated in the following diagram, Evanston and HPH are 13.7 miles, and 27 minutes, from each other. RFF388.



Moreover, eighteen hospitals are closer to Evanston or HPH than those two are to each other. RX1912 at 20,21. Yet, the ALJ's defined market excluded such easily accessible hospitals as Advocate Illinois Masonic and Advocate Ravenswood (North Side), Children's Memorial, Swedish Covenant, Holy Family, Northwestern Memorial, Condell, Grant, Louis A. Weiss Memorial, Methodist Hospital of Chicago, Our Lady of the Resurrection, Resurrection, and Saint Joseph. RX1912 at 20,21; RFF389-390; *see* ID, Attachment1, DX8173. Additionally, six other hospitals are within 27 minutes driving time of the Glenbrook campus. RX1912 at 021.

Documentary evidence from area hospitals confirms that ENH faces competition from such hospitals as Condell (RFF466), Northwestern Memorial (RFF1074), Provena Saint Therese (RFF468), and **REDACTED** (RFF473). *See generally* RFF454-481. Indeed, Condell recognized that HPH was among its top competitors. RX1329 at CMC19866; RX1338 at CMC20375 (in Condell's service area, HPH and Evanston drew the third and fifth most patients, respectively, from its key zip codes); RX1275 at CMC2577; RX997 at CMC132-134. Similarly, internal Northwestern Memorial documents confirm that ENH was viewed as a primary competitor. RX1316 at NMH9392,9394,9397; RX1316 at NMH9420,9425 (Northwestern Memorial's study of "Key Competitors" includes ENH).[4]

MCO testimony and documents further establish that the geographic market should include Condell, Northwestern Memorial, Rush-Presbyterian, University of Chicago, Holy Family, Lake Forest, Advocate Lutheran General, Northwest Community, Resurrection, Swedish Covenant, Victory Memorial, St. Therese, Christ, Loyola University, Michael Reese, Weiss and University of Illinois. RFF454-60.

REDACTED

RFF456.

REDACTED

[4] *See also* RX306 at FTC-LFH66 (residents in Lake Forest service area tended to receive services at Chicago hospitals such as Northwestern Memorial and Children's Memorial); RX1205 at FTC-RNSMC425; RX1311 at ENH-RNSMC1064 (

REDACTED).

RFF456. One MCO wanted only to ensure 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*." RFF460(emphasis added). By that standard, at least 47 hospitals within 30 miles of at least one of the ENH hospitals must be included in the relevant market.RFF387-90.[5]

In determining the geographic market, the ALJ also relied on a 2001 Lake Forest Hospital customer survey reporting that consumers are willing to travel, on average, 35 minutes for an overnight hospital stay. RFF400; ID142; IDF257. Because the ALJ defined the market as general acute care inpatient services "furnished to a patient who, to obtain the services, must stay overnight at the hospital," a geographic market of 35 minutes from either Evanston or HPH would necessarily include all 18 additional hospitals referenced above. ID135; IDF195; RFF389,393-94. Yet the ALJ inexplicably used the study to *limit* the geographic market based on patients' willingness to travel only 16 minutes for *emergency care*. ID142,144-46,149.

That was a fundamental error. The geographic boundaries of the market cannot plausibly be based on consumers' willingness to travel for emergency care, especially because such care is predominantly provided on an outpatient basis—and is therefore outside the ALJ's own product market. Indeed, if 16 minutes defines the parameters of the geographic market, Evanston and HPH are not within the same geographic market, making their merger incapable of violating Section 7 and thus requiring dismissal of the

[5] Third-party documents, testimony, and physicians' patient admissions confirm that additional hospitals belong in the geographic market, including, among others, Condell, Northwest Community, the Vista hospitals and the downtown Chicago hospitals. RFF406-408,475-484, 953; Kaufman, Tr. 5836-37; RX477 at ENHJH323; Belsky, Tr. 4889.

complaint. Moreover, the ALJ acknowledged that patients are willing to travel farther for tertiary services (ID135,149), which are in the product market. Thus, downtown teaching hospitals must be included in the geographic market, even if the MCOs are the relevant customers. *See Long Island Jewish Med. Ctr.*, 983 F. Supp. at 141.

The geographic market is therefore far broader than the artificially narrow market drawn by the ALJ. Indeed, the evidence that consumers are willing to travel 35 minutes or more for an overnight hospital stay comports with both common sense and the fact that the ENH hospitals are located in suburban communities populated by residents well accustomed to traveling such distances both for work and to service their daily needs. RFF387,400-401,404.

The ALJ also erred in ignoring patient flow data, which represent patients' current preferences. Using an "80% service area," which hospitals typically consider in evaluating the geographic scope of competition (RFF502-04), Evanston had

REDACTED RFF397. Similarly, there was at least as great an overlap before the merger between HPH and Advocate Lutheran General or Lake Forest as between Evanston and HPH. RFF398; *see also* RFF401.

The ALJ refused to consider such evidence because, in his view, it reflects patient, not MCO, preferences. That is incorrect. An MCO's demand for hospital services is a "derived demand" based on the patients/employees' desire for convenience (IDF253), and the two "stages" of competition identified by the ALJ—competition for inclusion in MCO networks and competition for patients—are inextricably intertwined because the

MCOs must take into account current patients' geographic preferences when building their networks. ID142; RFF,385-387,391. *See Long Island Jewish Med. Ctr.*, 983 F. Supp. at 134, 141-42 (identifying MCOs as hospital customers and noting that patient preferences are important in the formation of hospital networks, relying on patient origins and travel pattern data). Thus, patient flow data are highly relevant and confirm in this case that the many additional hospitals noted above participate in the relevant market.[6]

2. Complaint Counsel Failed To Demonstrate Sufficient Concentration In A Properly Defined Market.

If the geographic market were properly defined, the resulting concentration statistics foreclose, rather than support, a presumption of anticompetitive effects. By following the analytical approach of the *Guidelines*, Respondent's expert, Dr. Monica Noether, conservatively identified a minimum geographic market that included: Lake Forest, Advocate Lutheran General, Rush North Shore, St. Francis, Condell, Resurrection and the ENH system. Dr. Noether's analysis showed that a market defined with just six hospitals located near the merging entities produced a modest post-merger HHI of 1919 with a delta of 222. ID151.

[6] The ALJ also erred in discounting patient preferences based on the misperception that patients do not care about hospital pricing. The evidence clearly established that employers and MCOs use various mechanisms to share the cost of hospital services with patients, such as co-pays and tiered networks, both of which align the patients' interests with the MCO's interest. RFF61-62; RFF-Reply139. Hospitals also compete for patients and physicians on the basis of quality, and such nonprice competition influences demand for hospitals in managed care networks. *See In re Hosp. Corp. of Am.*, 1985 FTC LEXIS 15, at *239-40, 249-50.

The ALJ further erred in rejecting patient flow data on the ground that it reflects only the preferences of patients who are willing to travel and not of the majority of the patient population who may not be willing to travel in response to a price increase. ID139. Complaint Counsel presented no evidence that such a "silent majority" exists here. And, as explained in the text, the evidence directly refutes that suggestion.

Although slightly above the challenge threshold levels in the *Guidelines*, such concentration levels are well within accepted bounds by today's economic and case law standards, especially given Complaint Counsel's theory of the case. *See infra* Section I.B.; *Baker Hughes*, 908 F.2d at 983, n.3 (merger not enjoined although it "increased the HHI ... from 2878 to 4303."); *Butterworth*, 946 F. Supp. at 1294 (no Section 7 violation notwithstanding market shares of 47-65% and post-merger HHI figures ranging from 2767 to 4521, with a delta of 1064 and 1889); *see also* John Miles, *Health Care and Antitrust Law* §12:14 (2005) (listing alleged concentration figures and post-merger market shares in hospital merger challenges). As a former Health Care Assistant Director at the FTC observed, "[t]he Merger Guidelines set market concentration thresholds at which concern about potential anticompetitive effects may arise that clearly are below the level at which we normally bring an enforcement action in hospital merger cases." Robert F. Leibenluft, *Antitrust Enforcement and Hospital Mergers: A Closer Look*, Speech by FTC Health Care Assistant Director before the Alliance for Health, Grand Rapids Michigan (June 5, 1998).

Moreover, the empirical evidence discussed above demonstrates that well over a dozen additional hospitals belong in the geographic market. This is also consistent with Dr. Noether's testimony that before the merger several additional hospitals, including Northwestern Memorial, Holy Family, Swedish Covenant and others, acted as significant competitive constraints on ENH, and therefore should be included in the relevant

market.[7] RFF489-90. Although the record lacks data to compute reliable HHI levels (because Complaint Counsel offered <u>no</u> evidence from which such figures could be computed), including even one or two of these hospitals would drive the HHI well below the levels for highly concentrated markets under the *Guidelines*. In any event, Complaint Counsel has failed to prove the relevant geographic market alleged in its complaint and the complaint should be dismissed for that reason alone. *In re Adventist Health Sys. /West*, 117 F.T.C. 224, 285, 289 (1994).

B. The Market Shares Found By The ALJ Are Inadequate To Support A Presumption Of Illegality Under A Unilateral Effects Theory.

Even if the ALJ's market definition were accepted, the resulting market shares could not give rise to any presumption of likely anticompetitive effects given Complaint Counsel's theory of the case. The *Guidelines* provide that a merger may cause two types of anticompetitive effects: (a) facilitation of collusion among the remaining competitors ("coordinated effects"), and/or (b) exercise of market power by a single firm ("unilateral effects"). *Guidelines* §§2.1, 2.2.

The predictive value of an increase in market concentration is most probative in coordinated effects cases. *See H.J. Heinz,* 246 F.3d at 715 ("Merger law rests upon the theory that, where rivals are few, firms will be able to coordinate their behavior, either by

[7] Dr. Noether did not include these other hospitals in her "minimum" geographic market solely for a technical reason: she could not conclude that certain other hospitals located *closer* to ENH constrain ENH's pricing, and therefore, under the *Guidelines'* technical approach, the more distant hospitals could not be included in the relevant geographic market. *Guidelines* §1.21. She made clear, however, that these hospitals have a substantial restraining effect on prices. RFF 488-90.

overt collusion or implicit understanding, in order to restrict output and achieve profits above competitive levels.")(citations and quotations omitted); *CB&I,* Dkt. No. 9300 at 5; *HCA,* 807 F.2d at 1387. Yet Complaint Counsel never alleged the merger would facilitate collusion, and there is neither evidence nor findings to support such a theory. Moreover, none of the industry characteristics that may give rise to coordinated effects—product or firm homogeneity, standardized pricing or product variables, availability of competitive information to rival firms—is present here. *Guidelines* §2.11. It is undisputed that the hospital services at issue are differentiated on both product and geographic lines. RFF368; Baker, Tr. 4763, *in camera*. Moreover, rates negotiated with MCOs are kept confidential and are thus impossible to monitor. RFF79. And hospital rates and contract reimbursement methodologies are complex, so much so that a typical hospital chargemaster has 15,000-20,000 line items. RFF78-98,648,924-26. These factors impede hospitals' ability to act collusively, and the merger therefore cannot violate Section 7 based on a coordinated effects theory.

Instead, this case was brought and litigated as a unilateral effects case in a differentiated products market. Pak, Tr. 6537; RFF517. In such unilateral effects cases, whether the transaction will likely cause competitive harm "depends on the 'closeness of the products at the merging firms' and the 'ability of rival sellers to replace lost competition.'" *In re R.R. Donnelley & Sons Co.*, 120 F.T.C. 36, 195 (1995)(quoting *Guidelines* §2.21); *accord United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1117-18 (N.D. Cal. 2004); *New York v. Kraft Gen. Foods, Inc.,* 926 F. Supp. 321, 356 (S.D.N.Y. 1995). As the Commission has stated, closeness of the firms' products "is the primary

factor determining the market power that will be created by a merger in a differentiated product setting, and ... market concentration plays a lesser role." *R.R. Donnelley,* 120 F.T.C. at 196, 140 (citing Robert D. Willig, *Merger Analysis, Industrial Organization Theory, and Merger Guidelines,* BROOKINGS PAPERS ON ECONOMIC ACTIVITY 281, 300-01)(1991)). As the *Guidelines* explain, "market shares alone may overstate the competitive effects of concern when, for example, the relevant products are less similar in their attributes to one another than to other products in the relevant market." *Guidelines* § 2.211(emphasis added).

The market shares cited in the Initial Decision, while artificially high because of faulty market definition, are still well below the level at which any presumption of illegality can arise based on unilateral effects. Indeed, Judge Posner has questioned whether a firm with less than a *monopoly* market share could unilaterally sustain prices above the competitive level. Richard A. Posner, *Antitrust Law* 124 (2d Ed. 2001). And in *R.R. Donnelley*, the Commission found that a structural presumption of anticompetitive effects was "very weak" in a case involving both coordinated and unilateral effects, despite evidence that the firm's post-merger market share (43.5%) and increase in concentration level (852) far exceeded those found here. 120 F.T.C. at 182, 197. Similarly, federal courts have been willing to block mergers based on a unilateral effects theory *only* when the merger would have created a truly dominant firm. *See, e.g., FTC v. Swedish Match*, 131 F. Supp. 2d 151, 166 (D.D.C. 2000)(60% share, nearly double the closest competitor); *FTC v. Staples*, 970 F. Supp. 1066, 1081 (D.D.C. 1997)(100% market share in 15 markets); *accord Oracle*, 331 F. Supp. 2d at 1123 ("To prevail on a

differentiated products unilateral effects claim, a plaintiff must prove a relevant market in which the merging parties would have essentially a monopoly or dominant position."). Any presumption of illegality in a unilateral effects case therefore requires a substantially higher measure of concentration than was proven in this case.

Under the ALJ's flawed market definition, ENH's post-merger market share is only **REDACTED**, and it is only **REDACTED** using the "minimum" geographic market that Respondent's expert defined. IDF322; RX1912-058. Moreover, **REDACTED**— a hospital included in the ALJ's geographic market and acknowledged to be Evanston's closest competitor—has a **REDACTED** in the ALJ's market and **REDACTED** in the minimum market, thereby undermining any argument that ENH is a dominant or "leading" firm. IDF322; RX1912-058. The fact that **REDACTED** has a market share **REDACTED** to ENH's three-hospital integrated system further refutes any claim of ENH's dominance. As there is no evidence that ENH has a dominant post-merger share in this differentiated product market, the ALJ's presumption of anticompetitive effects was unwarranted.

Having failed to establish a presumption of illegality, Complaint Counsel must affirmatively prove that the merger is likely to produce anticompetitive effects that outweigh procompetitive benefits. *See supra* at 24-25. As noted above, a growing body of legal authority indicates that anticompetitive *unilateral* effects are likely only if the merged firm achieves a dominant or near-monopoly position in a well-defined relevant market. That is because a firm lacking a monopoly market share generally cannot unilaterally maintain prices substantially above the competitive level. *See* Posner,

Antitrust Law at 124. Thus, Complaint Counsel's failure to demonstrate that ENH acquired a monopoly or dominant share of a well-defined market refutes its theory of competitive harm and requires dismissal of the complaint.

C. Limited Substitutability Between ENH And HPH, And The Ability Of Competitors To "Reposition" Their Services, Further Rebut Any Presumption Of Anticompetitive Effect.

Even if Complaint Counsel had established a sufficiently high market share in a relevant market, the complaint still must be dismissed under the more wide-ranging totality-of-the-circumstances inquiry required by the courts. As noted earlier, even when a presumption of illegality has been established, a defendant may rebut it through "evidence on a variety of factors" bearing on the likelihood of anticompetitive effect. *Baker Hughes*, 908 F.2d at 984-85; *Gen. Dynamics*, 415 U.S. at 497-98; *see supra* at 24-25.

In this case, because the essence of a unilateral effects claim is the ability to raise prices above *competitive levels*, the critical issue is whether sales lost by one of the merging parties due to price increases will be captured by its merging partner, making such supra-competitive prices profitable. *R.R. Donnelley,* 120 F.T.C. at 195; *Guidelines* §2.21. Thus, a unilateral effects claim requires proof not only that the merged entity acquired a sufficient share of a well-defined market, but also of two additional facts: (a) pre-merger Evanston and HPH were regarded as "first" and "second" choice hospitals by a significant share of consumers; *and* (b) "repositioning" of service offerings by other hospitals in response to an anticompetitive price increase is unlikely. *R.R. Donnelley,* 120 F.T.C. at 195-96; *Oracle*, 331 F. Supp. 2d at 1117-18; *CB&I,* Dkt. No. 9300 at 6

n.34; *Kraft*, 926 F. Supp. at 365-66; *Guidelines* §§ 2.2, 2.211-2. Complaint Counsel failed to make either showing.

Throughout this case, Complaint Counsel maintained that ENH was able to increase prices unilaterally above competitive levels because MCOs could not effectively market a provider network without at least one of the ENH hospitals. Pak, Tr. 18,6382-88; CCB at 4-5,34-44; CCRB30-33. But no Chicago-area employers testified on this point, and Complaint Counsel offered only hearsay and lay opinion from interested MCO witnesses, whose testimony was inherently unreliable and not supported by quantitative data or expert testimony. *Oracle,* 331 F. Supp. 2d at 1131; RRB39-40. The evidence actually demonstrated, and the ALJ correctly found, that non-ENH hospitals "would have the ability to constrain prices at ENH, either now or in the future, and could be utilized by managed care organizations to create hospital networks." ID144 (emphasis added); *accord* ID149. This holding should have been dispositive in Respondent's favor. The fact that MCOs can build alternative networks without ENH is buttressed by overwhelming evidence that Evanston and HPH were not close substitutes before the merger. All of this evidence confirms the ALJ's finding that MCOs do not need these three hospitals—out of approximately 100 in the Chicago area—to develop alternative networks.

1. The evidence demonstrates that HPH and Evanston were not close product substitutes prior to the merger.

MCO witness testimony and contemporaneous documents confirm the ability of MCOs to build a network without Evanston or HPH, and demonstrate that these two

hospitals were not close substitutes. For example, a PHCS memo noted that, in the event of a termination with ENH, "there are other contracted providers within the geographical area as that of Highland Park Hospital and Evanston Northwestern Healthcare." IDF238; RFF457. The MCO witnesses acknowledged that

REDACTED than Evanston. IDF235-36,240,242; RFF577-78. Similarly, the MCOs testified that Evanston's most significant competitors were Advocate Lutheran General, Rush North Shore, and St. Francis. IDF235-40,242,278-280. The MCOs unanimously agreed that "Lutheran General [was] the most comparable facility from type of services, quality of services, [and] size of facility" to Evanston. IDF276; RFF564-69. In short, MCO documents and testimony demonstrate that Rush North Shore, St. Francis, Advocate Lutheran General, Lake Forest, Condell and Northwestern Memorial were all suitable alternatives to the ENH hospitals. IDF234-242; CCFF1298; CCPTB at 4; RFF455-59,568.

That the parties were not each other's closest substitutes is further confirmed by pre-merger contract negotiations. PHCS admitted at trial that it never played HPH against Evanston, or vice versa, in negotiations. RFF975. Nor did other MCOs, including Great West, REDACTED Unicare, REDACTED

RFF977-81. The fact that the MCOs did not play Evanston and HPH off each other, and the ALJ's finding that MCOs have available alternatives (ID144), conclusively refutes any claim that MCOs could not create a network without both hospitals.

Why were Evanston and HPH *not* viewed as close substitutes? The evidence demonstrated that, geography aside, Evanston and HPH were objectively "different in a number of dimensions" before the merger. IDF784-85; CCFF1798-1799; RFF538-59. First, Evanston's breadth of service was far greater than HPH's, with HPH providing only about half the number of DRGs that Evanston did. RFF544-49. HPH's breadth of service, with 212 DRGs in 1999, was similar to that of other community hospitals such as Lake Forest (213 DRGs) and Vista (221-231 DRGs). RFF547; RX1912 at 60. By contrast, Evanston's breadth of service, with 384 DRGs in 1999, was similar to that of other teaching hospitals such as Advocate Lutheran General (379 DRGs), University of Chicago (394 DRGs), Advocate Northside (388 DRGs), Northwestern Memorial (381 DRGs), and Loyola (405 DRGs). RFF545-546; RX1912 at 60.

Second, Evanston was much larger. Its 411 staffed beds in 1999 demonstrates its similarity to academic hospitals such as Advocate Northside, Rush Presbyterian, Northwestern Memorial, Advocate Lutheran General, University of Chicago and Loyola in terms of number of beds. IDF273,276; RFF555-556. In contrast, HPH, with 157 beds in 1999, was similar to community hospitals such as Condell and Lake Forest. IDF22,267,294; RFF557.

Third, Evanston had far greater teaching intensity. In that dimension, HPH resembled Lake Forest and Condell, neither of which had any residents. IDF22,268,296. By contrast, Evanston, with .34 residents per bed in 1999, resembled several other Chicago-area teaching hospitals whose residents per bed exceeded the .25 threshold used

by MedPac, the advisory board to Congress on hospital reimbursement issues. IDF6,275; RFF415,559; RX1912 at 60.

2. Evanston and HPH also were not close geographic substitutes.

In addition, the two hospitals were not close geographic substitutes. As noted earlier, Evanston and HPH are 13.7 miles (27 minutes) from each other. RFF388. And, as demonstrated by the map above (*supra* at 29), a number of hospitals—including St. Francis, Rush North Shore, Advocate Lutheran General, Resurrection, Northwestern Memorial, Swedish Covenant, Louis A. Weiss, Advocate Northside and Holy Family—are located closer to Evanston in both distance and driving time than is HPH. IDF21,272,281,287,298,305,308; RFF389. Also, three hospitals—Lake Forest, Rush North Shore, and Condell—are closer to HPH in both distance and driving time than is Evanston. IDF21,266,293; RFF390.

The many similarities in both services and geography demonstrate without doubt that hospitals such as Rush North Shore, St. Francis, Advocate Lutheran General, and Northwestern Memorial are closer substitutes for Evanston than HPH, and that Lake Forest and Condell are much closer substitutes for HPH than Evanston. ID7,36-38.

3. Complaint Counsel failed to demonstrate that "repositioning" is unlikely if ENH were to raise prices above competitive levels.

As noted, to prove anticompetitive harm under a unilateral effects theory, Complaint Counsel must also demonstrate that "repositioning"—i.e., supply by other firms of "products sufficiently similar to the products controlled by the merging firms"—

is unlikely. *Oracle*, 331 F. Supp. 2d at 1118; *Guidelines* § 2.212; *see also Rebel Oil Co. v. Atlantic Richfield Co.,* 51 F.3d 1421, 1441 (9th Cir. 1995); Philip E. Areeda & Herbert Hovenkamp, ANTITRUST LAW ¶ 501 at 90 (2d ed. 2002). Here, there is no evidence that rival hospitals would not reposition themselves to compete with ENH if ENH raised prices to supra-competitive levels.

To the contrary, not only are competitor hospitals able to expand their capacity and service offerings, but they have already done so aggressively. For example, Northwestern Memorial, an obstetrics giant, recently received approval to construct a new women's hospital on the north side of Chicago. RFF434,2290-2291. In addition, Condell, located just 12.7 miles from HPH, received permits to expand its medical/surgical department by 20 beds (10 in 2002 and another 10 in 2004), its ICU department by 8 beds (33%), and its obstetrics department by 10 beds (40%). RFF390(b),2293-2296. During the same period, Lake Forest Hospital, located just 6.1 miles from HPH, added 10 medical/surgical beds and upgraded its obstetrics unit. RFF390(a),423,2297.

As demonstrated above, the Illinois Certificate of Need law has not stood in the way of competitors repositioning. Moreover, the regulatory environment for entry and expansion will ease significantly with the repeal of the law, scheduled for July 1, 2006. RFF2280-82. Once that statute expires, all regulatory barriers to entry and expansion will be removed. RFF2282. In the face of the aggressive repositioning/expansion of hospitals in the Chicago area and the impending repeal of certification laws, Complaint

Counsel failed to demonstrate the "unlikely repositioning" element of a unilateral effects claim.

D. The Sophistication Of MCO Customers And The Existence Of Ample Fringe Sellers Make Anticompetitive Effects Even More Unlikely.

That the merger did not give ENH unilateral market power is strongly supported by evidence that the key buyers of hospital services—large MCOs—are highly sophisticated, multi-billion-dollar businesses that could easily facilitate "repositioning" by ENH's many competitors. As now-Justices Thomas and Ginsburg recognized in *Baker Hughes*, even in concentrated markets, sophisticated buyers can usually be counted on to promote competition, especially where, as the ALJ correctly found, they have alternatives. 908 F.2d at 986. Moreover, as two Commissioners explained in *Adventist Health Sys./West*, "[a]s large and sophisticated purchasers of acute care inpatient hospital services, third-party payors would likely be able to constrain anticompetitive behavior by exerting countervailing power..." 117 F.T.C. at 312 (concurring opinion of Commissioners Owen & Yao). And, as the full Commission explained there, one way an MCO would do this is to "offer incentives to persuade patients to shift to lower cost, but more distant, providers." *Id.* at 291; *accord United States v. Syufy Enters.,* 903 F.2d 659, 663 (9th Cir. 1990); *United States v. Mercy Health Servs.,* 902 F. Supp. 968, 984-85 (N.D. Iowa 1995), *vacating as moot*, 107 F.3d 632 (8th Cir. 1997).

The evidence in this case strongly indicates that MCOs would have such an impact here. MCOs such as Blue Cross, United, Humana, Aetna, and PHCS are billion-dollar firms with the knowledge, ability and experience to structure their networks to defeat any

potential anticompetitive price increase. IDF187. Moreover, those MCOs enjoyed double- or even triple-digit percentage revenue increases during the post-merger period through 2003. IDF187; RFF123(Aetna), RFF129(Blue Cross), RFF152(Humana), RFF160(PHCS), RFF172(United). The ALJ recognized the size and sophistication of the MCOs (IDF187) as well the substantial number of other hospitals they could use, but failed to account for their competitive significance.

The evidence further shows that these MCOs could minimize the risk of rate increases by structuring their networks to decrease reliance upon ENH, or as the ALJ found, excluding ENH altogether and creating a network using other hospitals. *See* ID144,149; *see also Oracle*, 331 F. Supp. at 1131. MCOs also have the ability to protect themselves contractually by using mechanisms such as "chargemaster" protections—i.e., negotiated limits on future price increases. RFF87-89; RFF-Reply809,897.

The MCOs' sophistication also gives them the ability to create new plans that blunt any perceived anti-competitive price increases. RFF58-62; RFF-Reply139. MCOs can create alternative plans that provide higher volume to providers in exchange for lower prices. RFF61. MCOs can use co-payment structures that give members an incentive to visit preferred providers while avoiding higher-cost providers. RFF61-62; *see* RX1346 at BCBSI-ENH 5536 (identifying emerging trend of insurers "launching nested and tiered network models"); RX1189 at ENHLJL 14132-14135 (designing plan to "align out-of-pocket differentials with hospital costs"). Such well-known options are well within the ability of sophisticated MCOs and could be implemented in the face of anti-competitive price increases.

Finally, MCOs have the ability to constrain hospital prices to competitive levels even though they are indirect purchasers of services chosen in the first instance by patients who subscribe to employer-sponsored health plans. MCOs and employers have ample means to control total insurance costs, such as co-pays and cafeteria plans. RFF61-62; RFF-Reply139.

For all these reasons, the size and sophistication of ENH's customers strengthen their ability to use alternative hospitals in fashioning networks and to take other protective measures, and thus deprive ENH of any ability to charge supra-competitive prices.

E. Complaint Counsel Utterly Failed To Establish That Post-Merger Price Changes Were Either Excessive Or Due To Enhanced Market Power.

Despite evidence of the merger's pro-competitive effects, the ALJ based his finding of liability on a study purporting to show that ENH's post-merger prices increased more than those of other hospitals. As discussed above, any suggestion that price increases were the result of market power is refuted by evidence that the merged firm has only a modest share of a properly defined market; that Evanston and HPH were not viewed as close substitutes; that other hospitals could easily "reposition" themselves in response to an exercise of market power by a rival; that ENH's customers are sophisticated and experienced in negotiations; and that HPH was at best a weak competitor prior to the merger. As we now show, even without these structural protections, the price increases on which the ALJ relied cannot be attributed to market power gained as a result of the merger.

1. **Evanston's pre-merger prices were below-market and increased to competitive levels because of new information.**

The fundamental flaw in the ALJ's approach is a failure to recognize that post-merger price increases, even increases relative to other firms, do not necessarily demonstrate market power. As the *Guidelines* state, and as Complaint Counsel acknowledged, "[m]arket power to a seller is the ability profitably to maintain prices *above competitive levels* for a significant period of time." *Guidelines* §§ 0.1,2.2(emphasis added); CCB1,8,22; *Forsyth v. Humana, Inc.,* 114 F.3d 1467, 1476 (9th Cir. 1997); *Levine v. Cent. Fla. Med. Affiliates*, 72 F.3d 1538, 1552 (11th Cir. 1996). It follows that, if post-merger increases do not lead to supra-competitive prices, those increases necessarily result from something other than market power.

Nor can this problem be overcome simply by assuming that pre-merger prices were at competitive levels. Because firms often find it unprofitable (or unnecessary) to become perfectly informed, most markets reflect a distribution of prices, with some firms pricing *below* the theoretical fully-informed competitive level.[8] Moreover, if a firm's prices were below-market before a merger, a post-merger price increase may not result from or reflect market power but instead some other factor—such as new information about market prices. Here, Complaint Counsel's own expert admitted both that price changes resulting from additional market information is plausible as a matter of economic

[8] *See, e.g.,* George Stigler, *The Economics of Information*, JOURNAL OF POLITICAL ECONOMY, Vol. LXIX, No. 3, 213-25 (June 1961); Michael Rothschild, *Models of Market Organization with Imperfect Information: A Survey*, JOURNAL OF POLITICAL ECONOMY, Vol. 81, 1283-1308 (Nov. 1973).

theory, and that relative price increases resulting from it are not anticompetitive. RFF523(k),1063. The evidence shows that this is precisely what happened.

a. **ENH's explanation for the post-merger price increases is supported by the documentary evidence.**

First, substantial evidence showed that ENH learned, coincident with the merger, that it had been short-changing itself for years in its negotiations with MCOs. RFF734; *see also* RFF656-709; RFF-Reply755,758. For ten years prior to the merger, Evanston's goal was to participate in every MCO network, and it therefore allowed contracts to lapse and reimbursement rates to linger for years without re-evaluation. ID172; RFF600,605-607,613-23. Many MCO representatives testified that they expected ENH to request higher rates on this basis alone. RFF684(United), RFF754(REDACTED) RFF796(Great West), RFF864(REDACTED). In fact, Evanston made significant improvements to its academic qualifications during the 1990s, but never attempted to negotiate rates that reflected these improvements. RFF3(a),8,24,34; Neaman, Tr. 1287-88; H. Jones, Tr. 4138.

In the late 1990s, however, hospitals began to face new and increasing financial pressures. IDF184,186; RFF106,110,624,630-33,637. As a result, Evanston critically reviewed and revised its MCO contracting strategy. That process began in late 1999, when Evanston hired Bain to advise it regarding MCO contracting as well as merger due diligence. IDF356; RFF670. Bain's analysis revealed that many of Evanston's contracts contained unfavorable terms, including contract rates far lower than HPH's. RFF679-91. For example, one Bain document indicated that "United reimbursed Evanston 45 to 50%

less than it paid Highland Park" which cost Evanston "$30 million over the preceding five years." IDF395; ID160; RFF681,884. The same was true for most of the major MCOs, including PHCS (IDF411,ID161; RFF685-87), Great West (IDF422; ID161), and Aetna (IDF436; ID162; RFF689).

ENH executives were "horrified," "shocked" and "embarrassed" by Bain's findings. RFF669,683,695,703. Accordingly, ENH engaged Bain to help ENH negotiate MCO contracts more effectively. Following Bain's advice, and coincident with the merger, ENH took a tougher stance in MCO negotiations by, for example, making an opening request at the higher of the two hospitals' rates plus a 10% premium. RFF710-25; RFF-Reply834,1387,1777.

The ALJ dismissed this evidence on three grounds, none of which holds water. First, the ALJ erred in concluding that Evanston's pre-merger prices were actually higher than HPH's. In fact, the referenced "prices" were based on *econometric* analyses of imperfect data, conducted by economists five years after the fact, that attempt to control for a variety of factors. Those were not the actual "prices" examined by the MCOs and the hospitals in their negotiations. RB42-44; RFF-Reply696-700; ID173; IDF794-797. To the contrary, the evidence clearly shows that HPH generally had higher contract rates than Evanston, and it was these rates that market participants analyzed when negotiating MCO contracts. RFF656-703; *see also* IDF395,411,436.

Second, the ALJ erred in speculating that ENH could not have learned anything useful about market prices from HPH's rates because ENH believed Evanston was more comparable to "academic hospitals" than to community hospitals like HPH. ID171.

Whether or not knowledge of HPH's pricing would give ENH *sufficient* information to determine market prices for Evanston's services, the fact that HPH was charging *more* for most services than Evanston—a far more comprehensive and advanced institution than HPH (RFF538-559; *see also* IDF784-86)—certainly showed Evanston that it was undermarket.[9]

Third, the ALJ's assertion that newly acquired information cannot explain the price increases at HPH is similarly unfounded. ID171-72. Price increases at HPH do not negate the fact that Evanston realized, coincident with the merger, that its own prices were below-market. Moreover, the evidence showed that HPH's prices increased for several benign reasons. First, after the merger, HPH was no longer a small community hospital; it improved quality through its adoption of practices typical of academic hospitals and its integration with ENH. Second, given the benefits of integration and consistency, ENH reasonably decided after the merger to charge the same prices at all of its hospitals, as it had done before the merger. Third, the quality improvements were concentrated at HPH, thus justifying higher rates. Finally, ENH listened to Bain and asked for a 10% premium as a negotiating strategy and, through the idiosyncrasies of bargaining, it sometimes received its asking price. None of these factors indicate that ENH gained market power as a result of the merger.

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[9] The fact that post-merger ENH "retained" Evanston's long-time contract negotiator, Jack Sirabian, and that HPH's negotiator, Terry Chan, chose to resign is irrelevant to that conclusion. ID172. ENH's retention of Bain to assist with MCO contracting gave ENH a new, stronger negotiating partner with a wealth of prior experience. RFF322,710-723. Moreover, Sirabian retired from ENH in 2003 after 35 years of service. Sirabian, Tr. 5691. He testified that his negotiating responsibilities were sharply curtailed after the merger, when Jeff Hillebrand assumed responsibility for face-to-face MCO negotiations. Sirabian, Tr. 5757-59; RFF600,676.

b. **The pattern of post-merger price increases is consistent with bringing ENH's prices to competitive levels.**

The pattern of post-merger prices is entirely consistent with ENH's obtaining new information about market prices, and inconsistent with any exercise of market power obtained from the merger. United is a good example. Coincident with the merger, Evanston learned that its pre-merger rates with United were nearly 50% less than HPH's pre-merger rates, but that its pre-merger rates with Aetna were only somewhat lower than HPH's. RB51-52; IDF395,RFF680,745. Therefore,

REDACTED RFF1136. In fact, United was "embarrassed" during post-merger negotiations with ENH when confronted with the fact that HPH's rates were "so much higher than Evanston's" and United offered to begin negotiations with the better of the two contracts. RFF684,888. This experience was repeated with virtually all the MCOs. *See* RB44; RFF754,851,864,883-84.

ENH's experience with Blue Cross further confirms that ENH's price increases resulted from additional information about market prices. Blue Cross did not incur a relative post-merger price increase because Blue Cross was one of the few MCOs with which Evanston had *higher* pre-merger rates than did HPH. IDF571-72; RB52; RRB68. ENH therefore obtained no information by which it could negotiate higher rates with Blue Cross. RFF760,769-70,1120-1124; RFF-Reply729,731-32,1942,1967. With other MCOs, however, Evanston's pre-merger contract rates were, in varying degrees, lower

than HPH's. ENH was able to present these data to the payors to support higher rates. *See, e.g.,* RFF747(REDACTED) RFF779-80(Cigna), RFF785-87(CCN), RFF794-96(Great West), RFF809-12(HFN), RFF831-37(PHCS), RFF849-51(Preferred Plan), RFF883-84,888(United).

The pattern of Respondent's price increases, moreover, is flatly *inconsistent* with Complaint Counsel's hypothesis, that a larger MCO would have a better bargaining position, and would therefore see smaller price increases. RFF1050-52. In other words, according to this theory, if ENH were exercising market power, ENH's larger MCO customers should have experienced lower post-merger price changes than smaller MCOs. RFF1049-52. The undisputed evidence, however, established that there was no correlation between MCO size and ENH's post-merger pricing. RFF1049-52. For example, even though United was a significantly larger customer than Aetna (RFF125,1051), its post-merger price increase exceeded that of Aetna. IDF655,673; RFF1052.

c. Post-merger prices did not exceed competitive levels.

Respondent also produced compelling evidence that ENH's prices did *not* exceed competitive levels and thus could not be the product of market power. Using sound statistical principles, Dr. Noether constructed both an "academic" and "community" hospital control group to determine whether ENH's post-merger prices were above

competitive levels. RFF559, 1065-72.[10]

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RFF1111.

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RFF1110-14.

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[11] IDF262,276,280,322; ID145-46. This is significant because the ALJ, MCOs, and Dr. Haas-Wilson all agreed that, in "terms of range of services, Advocate Lutheran General is the most similar to Evanston Hospital." IDF276,280; ID145-46; RFF414; Foucre, Tr. 944.

The ALJ was wrong to criticize these comparisons on the ground that, in his view, ENH is not comparable to members of the academic control group. ID173-75. First, as

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[10] The academic control group consisted of Northwestern Memorial, Rush-Presbyterian, Advocate Lutheran General, Advocate Northside, University of Chicago and Loyola University. RFF1071.

[11]

IDF831,833; ID155. **REDACTED**

REDACTED RFF1145,1150.

REDACTED IDF833; RX1912 at 147, *in camera*.

noted earlier, ENH's breadth of services is comparable to, and in some instances broader than, members of the academic control group. RFF541-46,548; RX1912 at 44, *in camera*. Second, the MCOs correctly identified ENH as an advanced teaching hospital. RFF30-31. Indeed, ENH is affiliated with a leading medical school, Northwestern University. Third, contrary to the ALJ, the provision of "quaternary" services does not distinguish ENH from the academic control group. ID171. There is no standard definition of quaternary services. Although Dr. Haas-Wilson testified at trial that solid organ transplants were considered quaternary services, both her own book on the managed care industry and the Complaint in this case classify these same services as tertiary. RFF1087. Moreover, ENH does provide "quaternary" services (IDF8; RFF16; Neaman, Tr. 1377), which in all events, account for only a minute percentage of a hospital's services. RFF1088; *see also* RRB50,n.51.

2. Complaint Counsel's pricing analysis did not satisfy its burden of establishing that ENH exercised market power.

In the face of Respondent's overwhelming evidence that its post-merger prices were competitively benign, Complaint Counsel propounded the speculative theory that ENH acquired and exercised market power as a result of the merger because ENH's prices rose at a faster rate than the prices of other area hospitals within a short, artificially defined time period. This "differences-of-differences" theory, and the evidence presented to support it, is fatally flawed for at least three fundamental reasons.

First, Complaint Counsel's whole analysis is circular because it *assumes* that pre-merger prices are at competitive levels and not, as the evidence showed, below the

market. As explained earlier (*see* supra Section I.E.1.), if the baseline price is below competitive levels, then subsequent price changes cannot demonstrate market power. Moreover, it is entirely lawful—and competitively benign—for a company that has learned its prices are below-market to raise them to competitive levels. And a company that does that will generally see its prices increase, both absolutely *and* by comparison to other companies in the same industry.

Neither Complaint Counsel, its principal expert on this issue (Dr. Haas-Wilson), nor the ALJ ever came to grips with this fundamental defect. To the contrary, Dr. Haas-Wilson admitted that ENH's efforts to ascertain and charge true market prices was a plausible explanation for the relative price changes, and that she could not rule it out as the correct explanation.

Second, Complaint Counsel's attempt to wring an inference of market power out of its comparative price analysis is independently foreclosed by Complaint Counsel's admission that ENH's output was not reduced after the merger. CCFF1653("ENH did not see a decrease in the number of managed care admissions as a result of ENH's price increases in 2000."). As the Commission recognized in *CB&I*, a theory of competitive harm must show an "exercise of market power [which] results in *lower output* and higher prices and a corresponding transfer of wealth from buyers to sellers . . ." *CB&I*, Dkt. No. 9300 at 6-7(emphasis added). Thus, as a matter of law, evidence of price increases is not even probative of market power unless accompanied by evidence of a systematic reduction in output. *Forsyth,* 114 F.3d at 1476 (proof of higher prices and profits, without a corresponding decrease in output, is insufficient direct evidence of market

power); *see also* Frank H. Easterbrook, *Limits of Antitrust Law*, 63 Tex. L. Rev. 1, 31-33 (1984); RB35-38; RRB41-43. There is no credible evidence of output reduction here.[12]

Third, Complaint Counsel and its expert failed to accomplish what even they acknowledged was necessary for their theory to have any relevance, namely, eliminating all the other plausible reasons for the price increases. In that regard, Dr. Haas-Wilson admitted that she did not analyze several competitively neutral factors that could have caused the post-merger price increases at ENH, including: success of advertising and marketing programs; addition of nicer amenities; idiosyncratic cost changes; idiosyncratic demand changes; and payor-specific factors such as recent payor mergers or the sale of staff model practices to hospitals. RFF523(d),523(e),523(l),523(n),523(p), 1023. In addition, Dr. Haas-Wilson admitted that she failed to control for a number of other factors that influence the negotiation of hospital rates, but which would not reflect market power, including: the other hospitals included in the MCO's provider network; the negotiators' personalities; the size of the MCO; patient loyalty to the MCO; and the amount of information available to a hospital or MCO about market conditions. RFF526,1021-22. Complaint Counsel's failure to eliminate these plausible, alternative explanations for the post-merger price increases makes its "differences of differences" analysis irrelevant to the issue of market power, and highlights the clear error in the ALJ's reliance on that analysis.

[12] Despite Complaint Counsel's admission, the ALJ erroneously found that the termination of one small MCO, Great West, represented a decline in output. ID154-55. Termination of a single payor is not equivalent to a reduction of output because there is no evidence that ENH provided service to fewer *patients* as a result of the termination. Neary, Tr. 635-36; Dorsey, Tr. 1481. In fact, the evidence established that output at ENH *increased* after the merger. RB37-38.

That failure was particularly pronounced with regard to the increased quality that the merger produced. Dr. Haas-Wilson admitted that her analysis failed to take into account the fact that ENH's quality improved proportionately faster than other hospitals in critical areas. RFF329,2205-16. And she admitted that ENH's quality enhancements should have been excluded as a potential explanation for the post-merger price increases before inferring that the merger enhanced ENH's market power. IDF714-16,839. Such relative quality improvements must be considered in any evaluation of price increases or price levels because, as quality improves, customers benefit, and nominal price increases may no longer reflect true price increases. RFF1157-59; RB47; RRB70-71. In other words, even though nominal prices may be increasing, quality-adjusted prices may be constant or even declining. This is true, regardless of whether the customers—such as the MCOs here—are actually aware of the benefits. As Prof. Baker explained, "if the sticker price on the Hershey Bar stays at $1 but the bar gets bigger, the buyer of that Hershey Bar...is better off even if the buyer hasn't noticed that the bar is bigger." RFF1160; Baker, Tr. 4607.[13]

[13] Dr. Haas-Wilson's analysis also suffers from serious, but more technical, inaccuracies. For example, her calculation of ENH's relative price changes, upon which the ALJ relied, was marred by substantial errors, including her reliance on erroneous data. *See, e.g.,* IDF574,580,614,641; RFF-Reply392-396; CCFF375; *see also* RFF-Reply402-03; RFF1028-30. Indeed, two of Dr. Haas-Wilson's four datasets included information about ENH alone, and three of her datasets could not isolate prices charged to MCO customers, as opposed to other types of consumers. Even where Dr. Haas-Wilson analyzed a potentially reliable dataset—the MCO data provided by United, Aetna, Humana, and Blue Cross—her methods created biased results. RFF1008,1024-30.

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In short, Complaint Counsel's theory of relative price increases falls of its own weight. It offers no plausible means to distinguish between entirely lawful and procompetitive price increases and price increases that result from increased market power. And any conclusion that ENH exercised market power here is further undermined by the fact that the only people complaining about ENH's prices were a select few MCOs seeking to improve their own bottom lines.

F. ENH's Documents And Contemporaneous Statements Do Not Support A Conclusion That It Obtained Or Exercised Market Power.

The ALJ's finding that ENH's contemporaneous business records support a finding of market power likewise reflects a misunderstanding of the law and the facts. Intent is not an element of a Section 7 violation nor can it establish such a violation. *DuPont*, 353 U.S. at 589; *see also A.A. Poultry Farms v. Rose Acre Farms, Inc.*, 881 F.2d 1396, 1402 (7th Cir. 1989); *Ball Mem'l Hosp. v. Mutual Hosp.*, 784 F.2d 1325, 1338-39 (7th Cir. 1986). Thus, it does not matter whether the parties sought to use the merger to improve prices charged to MCOs. Nor does it matter whether ENH executives later tied the merger to price increases. All that matters is whether the evidence demonstrates that the merger produced or is likely to produce net anticompetitive results. *Ball Mem'l,* 784 F.2d at 1339 ("[t]he focus must [still] be on the objective basis, not the mental state" of

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IDF688-90; RFF1003-04,1010,1013-15,1103.

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IDF470; RFF1012-14,1156; Noether, Tr. 6051, *in camera*.

the accused party). None of the documents relied on by the ALJ demonstrates that the merger produced or is likely to produce anticompetitive effects.

The documents, moreover, do not even show anticompetitive intent. They show instead that the merger's principal purposes were to improve the quality of care for the Evanston and Highland Park communities, to bolster the financial health of HPH, and to generate cost savings for both hospitals. RFF259-297. Indeed, many of the pre-merger planning documents on which the ALJ relied are identically titled "Improving Healthcare in Our North Shore Communities: Vision for a Combined Healthcare Provider System." IDF331-32; ID156 (*citing* CX1,CX19,CX442). In each instance, the first and second means of improving healthcare described in these documents are to implement comprehensive oncology and cardiac programs throughout the merged system. CX1 at 3; CX19 at 1; CX442 at 5. It is the enhanced quality produced by the merger that would make the merged hospitals "important enough to the employers in the community" because "[s]omething has to be distinctly different to assure yourself the volumes for your doctors and volumes that doctors can go get themselves..." Spaeth, Tr. 2303; CX4 at 2. The ALJ selectively quoted portions of these documents, ignoring their context and the meaning provided by the remainder.[14]

The Initial Decision also misinterpreted certain terms such as "indispensability" and "leverage." ID156,164-65. Being "indispensable" was simply a function of

[14] For example, references to the "geographic advantages" of the merger were directed not toward MCO negotiations, but toward quality improvements, which require the merged hospitals to be within a short distance of each other to achieve many of the most significant quality improvements. IDF250,331; RFF2470-2471; RFF-Reply1359.

quality, brand, and cost efficiency. CX394 at 13; RX367 at ENHDR4205; RFF1001; Hillebrand, Tr. 2021. Similarly, as used by the parties and their consultants, "leverage" was shorthand for the advice given to ENH that it "should recognize its position and not be afraid to ask to be paid fair market value" rather than continue under MCO contracts that were under-market and out-of-date. IDF395; ID158; RX2047 at 39-40 (Ogden, Dep.); RFF996-99; RFF-Reply1361,1450,1460,1524. In fact, the ALJ, in his own findings and opinion, connected "leverage" to ENH's brand, patient access, cost management and quality—none of which is associated with anticompetitive prices. IDF367-68; ID158.

The ALJ also confused references to reducing *physician* competition for patients with ending competition *between HPH and Evanston* for inclusion in MCO networks. IDF332,333,341,345; IDF156-57. In fact, all references to reducing competition as a goal of the merger concerned physicians and medical offices, not hospitals and MCO networks. CX1 at 3; CX2 at 7; Spaeth, Tr. 2209,2213-2214,2302-03; RFF-Reply47,57,1351,1355,1357,1588. Thus, the documents on which the ALJ relied do not support his conclusion that the merger is likely to produce anticompetitive effects. [15]

Finally, the ALJ erred in dismissing as unreliable post-acquisition documents and evidence supporting Respondent's positions because, in his view, they were susceptible

[15] If the internal documents relied upon by the ALJ suggest anything, it is that any market power ENH gained was from having the hospital and physicians negotiate together. Indeed, the Complaint alleges that "ENH required private payers to accept its terms for both hospital and physician services or face termination of both hospital and physician contracts." Compl. ¶¶3,34. Because there is now a consent order prohibiting negotiations for non-employed physicians, ENH cannot use them to garner greater bargaining strength in the future.

to manipulation. ID153. Here, unlike *HCA*, the merger was not reportable under the Hart-Scott-Rodino Act ("HSR"), the investigation was not commenced until several years after the merger, and there is no reason to believe that ENH representatives altered their conduct or statements in anticipation of post-consummation investigations. 807 F.2d at 1384. As a result, the post-acquisition evidence ignored by the ALJ is entitled to its full weight. *See, e.g.,* RFF658-66,679,694 (documents demonstrating pre-merger HPH had better MCO rates than pre-merger Evanston); RFF2320-22,2329-30,2334-35,2341-42 (documents discussing declining HPH revenues and false future projections); RFF478-79 (documents regarding area competitors); RFF259-67 (documents regarding pro-competitive reasons for the merger). As we now show, that evidence and other undisputed facts of record clearly establish that the merger benefited competition rather than harming it.

II. THE MERGER PRODUCED SIGNIFICANT COMPETITIVE BENEFITS WHICH FAR OUTWEIGH THE SPECULATIVE ALLEGED COMPETITIVE RISKS.

In contrast to Complaint Counsel's weak evidence of risks to competition, Respondent presented overwhelming evidence that the merger created two significant benefits to competition—evidence that further rebuts the notion that ENH's post-merger price increases were due to increased market power. First, the merger increased HPH's financial strength, thereby transforming it from a weak to a formidable competitor. Second, the merger produced significant quality improvements at both institutions—but especially at HPH—and thereby enhanced both hospitals' ability to compete with other hospitals in the Chicago area. Indeed, as noted earlier, ENH completely transformed

HPH from an inefficient and sub-standard regional institution to a powerful competitor recently recognized by *Consumers Digest* as one of the 50 best hospitals in the nation. RFF2197-99.

A. The Merger Increased The Financial Strength Of A Weak Firm And Made It A More Effective Competitor.

One of the ALJ's most serious errors was his failure to give adequate consideration to HPH's financial weakness prior to the merger—which prevented HPH from competing effectively with ENH or any other institution—and the significant improvement the merger produced.

1. The ALJ erred by applying the "Failing Firm" test.

First, the ALJ applied the wrong legal standard to the overwhelming evidence that HPH was on a financial "downward spiral." RB61-65; RFF2298-2413; ID195-97. Because Respondent never claimed that HPH was a "failing firm," the ALJ should not have considered this evidence under "failing firm" criteria. Respondent relied instead on the principle in *General Dynamics* and its progeny that an acquired firm with "severely limited" future resources has far less competitive significance than its market share or present market status might otherwise indicate. *See* 415 U.S. at 503-04; *Baker Hughes,* 908 F.2d at 984-86; *Ball Mem'l Hosp.*, 784 F.2d at 1336; *Kaiser Aluminum & Chem. Corp. v. FTC,* 652 F.2d 1324,1341 (7th Cir. 1981); *United States v. Int'l Harvester Co.*, 564 F.2d 769, 773-74 (7th Cir. 1977). Under these decisions, even if one of the parties is not "failing," its "competitive status remains relevant to an examination of whether substantial anticompetitive effects are likely from the transactions." *FTC v. Arch Coal,*

329 F. Supp. 2d 109, 157 (D.D.C. 2004). As explained below, the evidence of HPH's weakened financial condition prior to the merger confirms that the merger is not likely to cause competitive harm.

2. The ALJ gave short shrift to overwhelming evidence that HPH was financially weak.

The ALJ also erred in finding that HPH had "sufficient cash and assets to cover debts . . ., continue operations, expand services, and invest in new facilities and equipment." ID196. The ALJ ignored evidence proving HPH's declining financial condition from six witnesses, including HPH's independent financial consultant, a certified public accountant, HPH's former President, both ENH's and HPH's former Board Chairmen, and an unrebutted expert witness. That evidence established four important facts that refute the ALJ's finding.

First, HPH's operations were losing money and were on a financial "downward spiral." H. Jones, Tr. 4157; RFF2319-2353. HPH's financial statements proved that it was showing positive operational income only because the hospital was heavily subsidizing its operations with investment income. RFF2347-53. When HPH's investment subsidy was removed, the hospital showed a "significant operating loss." Kaufman, Tr. 5811; RFF2347-53. The audited financials showed an operating loss in excess of $1 million in 1997, a $7 million loss in 1998, and an $11 million loss in 1999. RX408 at ENHLTH1509; CX1732 at 4; RFF2320,2351. The merger due diligence projected that HPH needed $45 million merely to cover operating losses through 2002. RX609 at EY000038.

In response to these significant losses, HPH was forced to adopt stringent cost containment programs. Spaeth, Tr. 2263,2305; RFF2333. These included cutting vital patient services such as nursing and radiology, which inevitably reduced quality of care. RFF1233-1511,2333.

Second, HPH had long-term debt totaling $120 million, which required significant cash reserves and was considered a "big problem." Kaufman, Tr. 5816; RFF2354-2364. HPH borrowed heavily, issuing $61.7 million in bonds in 1991, $30 million in 1992, and an additional $40 million in 1997. RFF2358-64. Because of mounting debt, HPH had to obtain bond insurance to guarantee the 1992 and 1997 issuances because its credit was insufficient to secure the bonds. RFF2358. Thus, HPH was "significantly over leveraged" and kept its credit afloat only by maintaining large cash balances required by its bondholders. Kaufman, Tr. 5802,5806; Spaeth, Tr. 2261; RFF2359,2367. At the time of the merger, HPH was no longer able to borrow additional funds. RFF2354-56.

Accordingly, HPH's financial advisors recommended that it <u>not</u> spend its cash and investment income on improving services because (1) such expenditures would jeopardize the hospital's bonds and (2) the hospital then "would have nothing at all, because they had no [revenue from] operations." Kaufman, Tr. 5809; RFF2354-70. Thus, the cash on HPH's balance sheet was the only thing keeping the hospital afloat. Kaufman, Tr. 5809; RFF2368.

Third, HPH needed substantial facility upgrades. As noted, its physical plant was so deficient that the Department of Health and Human Services threatened to terminate the hospital's Medicare certification in June 1999. RX545 at ENHJH11578; RFF1530-

35,2376-82. The regulators determined that "the deficiencies are significant and limit [HPH's] capacity to render adequate care and ensure the health and safety of [its] patients." RX545 at ENHJH11578. The pre-merger due diligence thus allocated $14-19 million to immediate safety and code compliance improvements that were required merely to qualify for Medicare certification. RX635 at ENHJH4002; RFF1512-18.

Fourth, the evidence showed that HPH's financial weakness severely limited its ability to make capital improvements and reposition itself to compete with other area hospitals. The ALJ ignored the substantial need for capital improvements and assumed that HPH would have made them on its own. However, HPH did not have the financial resources to make those improvements. And the "planned" capital investment cited by the ALJ totaled only $65 million for physical improvements and $43 million for "strategic initiatives" (a total of $108 million), far short of the $120 million actually invested by ENH since the merger. IDF1030; ID196; RFF1515-18.[16] Moreover, HPH's "planned" investment was insufficient in light of the millions required merely to qualify for Medicare certification and the hundreds of millions being spent by area competitors such as Lake Forest, Condell and Northwestern Memorial that were rapidly expanding emergency rooms, intensive care units, and building new hospitals. RFF434,2290-97,2376-86.

[16] The ALJ inconsistently presents what HPH actually "planned" to do. The ALJ's findings of fact assume either $43 million in "strategic initiatives" and $65 million in "hospital construction" (total of $108 million), or $79 million for "routine capital" investment and $28 million for "initiatives." (total of $107 million). *See* IDF1030,1037. However, the ALJ's legal analysis presumes $79 million in "capital expenditures" and $24 million in "strategic initiatives" (total of $103 million). ID196. For purposes of this discussion and analysis, we use the $108 million assumption relied on by the ALJ.

In sum, simple subtraction—based on HPH's financial condition just before the merger—refutes the ALJ's contention that HPH could satisfy its financial needs and continue to operate as a competitive hospital. *See* ID196; RFF2308-2413; CX 545 at 3; RX609 at EY000038.

Available cash and investments		=	$235 million
2000-02 projected operating loss		-	$45 million
long term debt		-	$120 million
"planned" investment		-	$108 million
Remaining cash and investments	(negative)	-	$38 million

Thus, in light of the $45 million in operating losses projected through 2002 and the $14-19 million in immediate safety and code improvements that were required, if HPH had attempted to make only the minimal investments that all agreed needed to be made (and far less than the $120 million actually spent by ENH to upgrade HPH), it would not have had sufficient resources to cover its operating losses. It would have deteriorated even more quickly than it had before the merger. Only a merger with ENH could rescue it from that fate.

3. The ALJ improperly relied on speculative assumptions.

Disregarding all of this evidence, the ALJ erred by relying on optimistic pre-merger projections which were later proven false—HPH lost $11 million in 1999 alone. RFF2319-35; RFF2393-2404. The ALJ also erred by relying on financial forecasts predicting large gains on investments between 1999-2003, the very period when the 2000 stock market crash produced a staggering decline in portfolio values. ID196; H. Jones, Tr. 4107-08. The ALJ simply ignored the fact that, in 1999, before the merger, over $94 million of HPH's $136 million total investment assets were in mutual funds and common

stock. RX 724 at ENHRS 2748. If HPH had not merged, nearly 70 percent of its investment portfolio would have been hurt by the stock market crash. The ALJ also failed to recognize that investment gains would not be realized if HPH spent all its funds on capital improvements, debt coverage, and operations (all of which the ALJ assumed would happen), because there would then have been no money left to invest.

Finally, the ALJ speculatively predicted what "would have" happened had HPH not merged, while prohibiting Respondents from introducing evidence on that very issue. *See* H. Jones, Tr. 4135,4137-38 (sustaining Complaint Counsel's objections to questions regarding what "would have happened" to HPH's financial situation had it remained independent); Neaman, Tr. 1375(sustaining Complaint Counsel's objections to questions asking what "would" happen in the event of divestiture); Victor, Tr. 3637-38(same); Harris, Tr. 4263(same). In fact, HPH's contemporaneous and fact-based 1999 financial assessments showed that, absent the merger, HPH would not have had the resources to compete effectively, much less make needed improvements in quality.

In short, the ALJ's conclusion that HPH's "pre-merger financial condition was essentially sound" is flatly contrary to the evidence. ID196.

B. The Merger Produced Significant, Verified Quality Improvements

Besides providing financial strength to HPH, the merger also strengthened that hospital's competitive position through what the ALJ found to be "significant" and "verified" quality improvements in 16 clinical areas at HPH—enhanced by some $120 million in new investments by ENH. ID177-78.

For example, ENH rectified many pre-merger problems that had threatened patient safety across many service lines, including nursing, obstetrics, labor and delivery, heart care, physician discipline (quality assurance) and the core facilities of the hospital itself. RFF1233-1563. Many of those pre-merger problems had created highly publicized adverse events in which **REDACTED** and, in some instances, RFF1420-28,1539.

Additionally, ENH brought new services rarely found in community hospitals and some never performed before in Lake County, such as interventional cardiology, cardiac surgery, highly-specialized multidisciplinary cancer care, advanced electronic medical records, and coverage by specialized physicians called intensivists. RFF1564-2188. Thus, in numerous ways, a patient at HPH today receives superior care and is less likely to face the unnecessary risks that were endemic at HPH before the merger. RFF1269-75,1442-57,1539. Moreover, ENH's clinical improvements fit squarely within the Institute of Medicine's ("IOM") definition of clinical "quality" improvements because they "increase the likelihood of desired health outcomes" for individuals and populations and are "consistent with the state of current professional knowledge." Chassin, Tr. 5141; RFF324,1165-70.[17]

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[17] ENH's quality improvement evidence was directed at three widely-recognized measures of quality: structural improvements (e.g., facilities and staffing), processes of care (e.g., prescribing medication), and outcomes (e.g., mortality). RFF1171-74. This analysis was consistent with the approach used by major third-party organizations and state governing bodies in the field. RFF1196,1211,1226.

Against Respondent's compelling evidence of quality improvements, Complaint Counsel relied upon two types of evidence that the ALJ correctly rejected as unreliable (ID180-81): (1) patient satisfaction studies and (2) an analysis of outcomes using inferior "administrative data" (rather

Such quality improvements are highly relevant to the analysis of the merger's effects on competition. Hospitals unquestionably compete on the basis of quality, and quality improvements unquestionably benefit both patients and MCOs and affect how MCOs build their networks. RFF325. Moreover, such non-price competition impacts a hospital's ability to attract physicians (who admit patients), and who in turn are attracted by up-to-date equipment, a qualified nursing staff, and convenient office space—all improvements that ENH made to HPH. *In re Hosp. Corp. of Am.*, 1985 FTC LEXIS 15, *239-40 (Oct. 25, 1985). Thus, there was no disagreement here that "quality improvements should be taken into account in evaluating whether the merger, on balance, had a positive or negative impact on competition." ID176; RFF323,325,329,523(g). Indeed, considering merger-related quality improvements as part of a merger's ultimate effect on competition is consistent with both case law and current enforcement policy. *See, e.g., Tenet Health Care Corp.,* 186 F.3d at 1054-55.[18] As former Chairman Muris observed, "because quality is so important in health care, we should err on the side of conduct that promises to improve patient care" in weighing the competitive implications of health-care mergers. Timothy J. Muris, Chairman, Fed. Trade Comm'n, *Everything Old is New Again: Health Care and Competition in the 21st Century*, Nov. 7, 2002 at 18

than clinical data) generated in the course of hospital administrative processes (e.g., primarily billing). RFF2245-46; RFF-Reply2059,2222,2053).

[18] *See also United States v. Brown Univ.*, 5 F.3d 658, 674-75 (3d Cir. 1993); *United States v. Idaho First Nat'l Bank*, No. 1699, 1970 WL 511, at *11 (D. Idaho Apr. 22, 1970). Even if quality improvements were not deemed efficiencies, they should be treated as competitive effects in an "integrated" analysis. Deborah Platt Majoras, Chairman, Fed. Trade Comm'n, ABA Antitrust Section Fall Forum, Nov. 18, 2004 at 6; *see also* RRB72.

(available at www.ftc.gov/speeches/muris/murishealthcarespeech0211.pdf); *see also* RB68; RRB72.

Rather than give full effect to Respondent's evidence on this important issue, the ALJ committed four fundamental errors that led him to understate the significance of the quality improvements produced by the merger. First, as shown below, he refused to consider those improvements because Respondent supposedly failed to prove that HPH's quality improved faster than at other hospitals. ID179-81. Second, he dismissed the quality improvements on the ground that they purportedly did not produce an "overall" improvement in quality at HPH or throughout the system. Third, he imposed heightened merger-specificity requirements on Respondent and speculated that the quality improvements could have been achieved without the merger. Finally, he mistakenly discounted Respondent's quality improvements on the ground that, in his view, they were not sufficient to "justify" the post-merger price increases. ID179. The ALJ's approach is manifestly inconsistent with *Baker Hughes* because it effectively shifted to Respondent the burden of persuasion on this important aspect of the competitive effects analysis. 908 F.2d at 983.

1. The ALJ erred in failing to consider verified quality improvements because Respondent purportedly did not establish that HPH improved faster than other hospitals.

Contrary to the ALJ's conclusion, it is not Respondent's burden to prove that quality improved faster at ENH or HPH than at other hospitals. ID179. While a comparison of post-merger quality changes may be relevant for determining post-merger "quality-adjusted" prices and price changes (addressed in the next section), there is no

authority for dismissing evidence of actual quality improvements as procompetitive effects of a merger based on improvements at other hospitals. The only relevant question is whether, absent the merger, the improvements at HPH and ENH would likely have occurred *as fast, as well, or at all.* Complaint Counsel utterly failed to make such a showing.

Beyond this, the evidence showed that, as a result of the merger, HPH's quality actually improved faster than at its peer community hospitals in a number of areas. RFF-Reply2033-34; RFF1483-1504,1622. That was established, first by quantifiable clinical data. RFF-Reply 2033-35, 2087-97, 2212-13; RFF1331,1490-1504, 1609-1616, 1620, 1644, 2191, 2205-16; RX1400, RX1411, RX1571, RX1985, RX2032 at 5-7, RX2043, DX8079, CX1947. For example, those data showed

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RFF1482-1504. Those data also showed that HPH's performance with respect to major surgical complications for cardiac surgery, a new service ENH added after the merger, exceeded national benchmarks and was comparable to the best surgical centers in the country. RFF1609-11,1614-16;1622-23. Further, ENH brought HPH the capability to perform life-saving elective percutaneous coronary interventions ("PCI") for heart attack patients in the community. RFF1659-60,1664.

ENH also demonstrated relative quality improvements by identifying clinical programs and technology it added to HPH that are rarely, if ever, found at community hospitals. These include new programs and technology used in areas such as oncology, electronic medical records, obstetrics, and nursing. For example, ENH is the only

hospital system in the Chicago area that installed Epic or a comparable advanced electronic medical records system across inpatient and ambulatory care areas. Such systems continue to be rare in community hospitals across the country. RFF2105-2109,2118-2120,2211,2473-75. While the ALJ found that Respondent improved quality at ENH by installing the Epic system, he underestimated the impact that Epic has on the safety and care provided to patients at all three hospitals. ID190-91. Both quality of care experts in the case testified that ENH's roll-out of Epic was a major improvement in quality. RFF2004. In fact, Complaint Counsel's own expert advocated the use of Epic at his home hospital because it would result in improved quality for patients. RFF2005. Finally, the IOM, Leap Frog Group, and the federal government have all endorsed electronic medical records systems such as Epic as an unquestioned improvement in care with enormous potential to improve the safety, quality and efficiency of health care in the United States. RFF1999-2005,2011-17.[19]

The ALJ also ignored evidence that the merger enabled ENH to create an intensivist program at HPH and that such programs remain rare in any hospital in Illinois, let alone a local community hospital. RFF1721,2480-81.

The ALJ further disregarded the fact that ENH brought to HPH advanced cardiac surgery techniques, including vein harvesting and bloodless open heart surgery, that are offered by few hospitals in the country. RFF1640. ENH also brought new stenting

[19] The ALJ also minimized the impact of Epic at HPH by holding that HPH's previous records system, Meditech, was "excellent." ID190-91. To the contrary, the evidence established that HPH's previous system was out of date, incomplete, and far behind what ENH provided the community hospital as a direct result of the merger. RFF2121-27.

technology for heart surgery at HPH—far more advanced than other cardiac surgery programs at larger hospitals in Chicago. RFF1642.

Moreover, the ALJ overlooked evidence that HPH's oncology program was enhanced far beyond improvements at peer community hospitals. Indeed, the American College of Surgeons changed its designation of HPH's oncology program from a community program to an academic hospital cancer center, and the National Cancer Institute designated HPH as one of only 50 programs nationally with a Community Clinical Oncology Program. RFF1726,1781-84. As a Highland Park oncologist testified, before the merger, HPH had antiquated diagnostic and therapeutic equipment that was inferior to equipment at typical community hospitals in Chicago. RFF1744. But after the merger, ENH opened the Kellogg Cancer Center at HPH, which in turn acquired state-of-the art equipment and began using highly sub-specialized physicians and multi-disciplinary care conferences unlike any peer community hospital in Chicago. RFF1759,1762,1771,1778,1782,1788,2476-79.

All of this evidence demonstrates that quality improved faster at HPH than at other comparable hospitals, even though Respondent was not required to make such a showing.

2. The ALJ erred in requiring Respondent to demonstrate that "overall" quality improved at HPH and ENH, and in relying on JCAHO scores.

The ALJ also erred by discounting Respondent's quality-improvement evidence on the ground that the improvements purportedly did not reflect improvements in "overall" hospital quality. ID179-81. As a matter of common sense, a quality improvement in one area can enhance a hospital's competitiveness—and patient

service—even if that improvement is not matched by similar improvements in every other area.

But even if proof of "overall" quality improvement were required in competitive effects analysis, which it is not, the evidence shows that HPH and ENH did achieve overall quality improvements. ENH improved care at all three ENH hospitals through the "rationalization" of clinical services, i.e., enhancing quality and cost efficiency by determining at what location in a hospital system particular clinical services can best be rendered. RFF2174. For example, after the merger, ENH made HPH the focus of plastic surgery and Glenbrook Hospital a Center for Excellence for orthopedics (joint and knee replacement surgery) and neurology. Hillebrand, Tr. 1987; Neaman Tr. 1358. Operating room strains at Evanston were eased through the merger as volume was shared with HPH. Neaman, Tr. 1357-58. ENH also extended training for HPH nurses for specialized areas of care. RFF1400-04. ENH improved the clinical lab system by moving all lab work from HPH to Evanston and developing a large laboratory facility that produced breakthroughs in molecular diagnostics and molecular biology. Neaman, Tr. 1358. ENH also enhanced the laboratory computer system at all three campuses. RFF1850-51.

Epic is another example of improved care across all three hospitals because its enhancement of patient safety and outcomes is proportional to the number of patients, care sites, and care providers captured in the system. RFF2523-25. By bringing HPH physicians and patients into the Epic system, the merger thus enhanced Epic's value to the entire ENH community and raised the quality of care throughout the system. RFF2525.

The ALJ also mistakenly relied on the JCAHO accreditation score as a "measure of overall quality," contrary to the evidence that this score established only a *minimum level* needed to maintain HPH's eligibility for Medicare reimbursement. ID181; RRB92n.31; RFF-Reply2128,2301. There is no evidence that JCAHO scores measure overall hospital quality or that differences in such scores may be used to measure changes in hospital quality.[20]

3. The ALJ erred by imposing heightened merger-specificity requirements and dismissing key evidence on that issue.

The ALJ's ultimate determination to discount the quality improvements in analyzing the competitive effects of the merger was based on his erroneous conclusion that most of the improvements were not merger specific. ID179-180. But the ALJ inappropriately imposed heightened merger-specificity requirements on Respondent's evidence on that issue. In most merger cases, the merging parties seek to demonstrate that a merger will lead to as yet unrealized efficiencies. *Heinz*, 246 F.3d at 720. Even then, the Merger Guidelines provide that only "alternatives that are practical in a business situation faced by the merging firms" will be considered. *Guidelines* §4.

But unlike in the typical pre-consummation case, the quality improvements that have occurred since this merger have all been "verified" and are "significant." ID177. Because they occurred in the wake of the merger, and at ENH's expense, the natural inference is that they resulted from the merger. If merger specificity is relevant at all in

[20] Shortly after HPH obtained a pre-merger final score of 96, the IDPH found physical plant violations that threatened HPH's eligibility for Medicare reimbursement. RB85; RFF1530-35,2446-52; RFF-Reply2319.

this context, Complaint Counsel should have been required to rebut that inference by proving that the improvements would have occurred as fast and as well absent the merger. By requiring ENH to provide additional evidence that quality enhancements directly resulted from the merger, the ALJ erroneously shifted the burden of persuasion to ENH, in violation of *Baker Hughes*. 908 F.2d at 983.

But even if Respondent bore the burden of persuasion, it satisfied it. Thirteen fact witnesses, including seven physicians, a pharmacist, a nurse leader, and four hospital administrators, testified based on personal knowledge that healthcare quality at HPH improved *as a direct result of actions that ENH took following the merger. See* RFF(Attach. B)(Respondent's Witness List). Five of these witnesses worked at HPH prior to the merger and were intimately familiar with its quality both before and after the merger. Five more conducted in-depth assessments shortly after the merger, including investigations into the state of quality just prior to January 2000.

The unrebutted evidence also showed that, beyond the financial difficulties which limited HPH's ability to invest in quality improvements, HPH faced significant structural and organizational barriers to the quality changes made possible by the merger. RFF2453-54. Money alone was insufficient to transform HPH from a private practice model with critical deficiencies in physician staffing, physician/nurse relationships, and nurse "critical thinking" skills into the superior institution it became. RFF1338-40,1878-82,1911-19. Clinical integration and a more collaborative culture were necessary to achieve these improvements. RFF2455.

ENH accomplished these improvements in three ways: (1) by integrating the two hospitals' clinical and administrative management systems, which required merging all of the clinical departments, service departments and management structures; (2) by immediately exporting Evanston's collaborative and multidisciplinary culture to HPH; and (3) by expanding clinical services, upgrading equipment, and reconditioning the physical plant. RFF272-84,1226-28,2453-54.

The first two changes were necessary to bring about the complete transformation of leadership that was required to achieve improvements in quality assurance. RFF2455. Pre-merger, there was no effective physician discipline because HPH's physician leaders were unable to address physician behavior. RFF2455. But the integration of the clinical departments at Evanston and HPH gave full-time Evanston clinical chairs the ability to implement quality assurance systems already in place at Evanston. RFF2455.

Moreover, HPH has been able to recruit and retain more qualified physicians and nurses as a result of the merger. ID191; RFF1350-59,1389-96,1586,1772-78,2166-71. These are important quality improvements in their own right. *See Adventist Health Sys./West*, 117 F.T.C. at 314 (concurring opinion of Commissioners Owen and Yao).

The relatively close geographic proximity of Evanston to HPH also enabled physicians and other specialists to rotate between the two campuses—particularly in the pathology, radiology, emergency and cardiac surgery departments. RFF2471. The uncontested evidence shows that if the cardiac surgery program at HPH had been launched through an affiliation or joint venture, the program would not have achieved

such quality enhancements, based on ENH's experience with affiliated programs at Weiss and Swedish Covenant. RFF2460-63.[21]

The evidence also demonstrated significant merger-related improvements to HPH's Ob/Gyn services. Although HPH had already identified and begun correcting certain pre-merger problems in that area (ID184; IDF886-87), it did not address problems of inadequate obstetrician coverage,

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All of these improvements occurred only *after* the merger with ENH. There was no evidence that, pre-merger, HPH had the capacity to implement the quality changes that occurred post-merger, or that it could have accomplished similar improvements through a joint venture. RFF2446-49.[22]

Accordingly, the ALJ was simply speculating when he remarked that the improvements at HPH would have happened anyway as part of a "nationwide trend of

[21] Contrary to the ALJ's finding (ID189), the evidence showed that HPH could not establish an interventional cardiology program before the merger because it did not have a cardiac surgery program on-site to respond immediately to emergencies arising during an interventional procedure. RFF1671. Without cardiac surgery, HPH—which performs only 50 or 60 emergent PCI cases annually—does not have a high enough volume to support a stand-alone emergent PCI program. RFF1670.

[22] Complaint Counsel's only witness on quality of care issues, Mark Newton, had no foundation for assertions about HPH's pre-merger quality and its quality improvement plans. Newton is a former HPH business executive who is not a physician and had no clinical responsibilities for any of the clinical areas in which improvements were made at HPH. RFF-Reply2161. His testimony (IDF850,907,926) is entitled to no weight, particularly given the contrast with the testimony from Respondent's physician witnesses who had direct clinical responsibility for their respective areas at HPH.

improved quality." ID180,182-83. As shown above, before the merger HPH simply did not have the financial strength to participate in this supposed "nationwide trend."[23]

Beyond this, the undisputed evidence showed that HPH's improvements in existing services and its rapid development of new clinical services far *exceeded* what would be expected of similarly-situated community hospitals during the same period. RFF1759,1762,1773,2119-20,2215. These improvements included, for example, (1) a

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(RFF1314); (2)

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(RFF1482-1504); (3) Epic, one of the most advanced electronic medical records systems (ID190-91); (4)

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(RFF1576); and (5)

REDACTED (RFF1724,1750,1984,2096, 2160,2217,2477).

[23] The ALJ's finding of a nationwide trend of improved quality was based on testimony of Dr. Romano which, in turn, was predicated on a single study of quality focusing on Medicare patients, concluded in 2001, that was not admitted into evidence. IDF859; RFF-Reply2388. The ALJ improperly overruled Respondent's objection to this testimony, which was based on the fact that neither of Dr. Romano's expert reports mentioned this purported trend. Romano, Tr. 2997; *see also Lamarca v. United States*, 31 F. Supp. 2d 110, 122-23 (E.D.N.Y. 1999) (striking expert testimony on this ground). The ALJ's ruling was inconsistent with his pre-trial order confirming that Dr. Romano's reports did not cover "nationwide initiatives to improve hospital quality of care"; that topic was addressed in the report of another expert who never testified at trial. Order at 5 (Jan. 13, 2005). Moreover, Dr. Romano did not offer any opinion during his deposition about this purported "nationwide trend." Romano Dep. 234-36. Finally, the referenced "study" by Dr. Jencks is not in evidence and, therefore, cannot be afforded any weight.

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RFF1490; RFF-Reply2227.

Nor is there credible evidence that any other community hospital in HPH's peer group improved as much or opened as many new clinical services as HPH did after the merger. RFF-Reply2388. And there was no evidence of the impact of the purported "nationwide trend" on any other Illinois hospital, nor how any such trend affected clinical areas at peer group hospitals.[24]

In short, the ALJ's "nationwide trend" discussion is nothing but vague and inadmissible conjecture. It cannot rebut the substantial evidence that HPH's quality improvements were due to the merger.

[24] Further, Dr. Romano misstated the conclusions of the Jencks study. He mistakenly implied that the Illinois improvement reported in the study was commensurate with the national trend of 12% improvement (IDF859; Romano, Tr. 3001) when, in fact, the Jencks study shows Illinois in the lowest quartile for average performance as well as relative improvement, with a range of between 5.6 and 9.8%. *See* Timothy Cuerson, Edwin Huff & Stephen Jencks, *Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001*, 289 J. AM. MED. ASS'N. 305, 310 (2002); IDF859. The Jencks study fails to account for the rapid development of HPH's new, high-quality services and numerous improvements resulting from the merger that dwarf the anemic level of improvement shown by peer hospitals in Illinois through 2001.

4. The ALJ erred in rejecting Respondent's evidence of quality improvements because in his view they did not justify the post-merger price increases.

Finally, the ALJ erred in rejecting Respondent's quality-improvement evidence on the ground that it did not justify the post-merger price increases. ID178-79. That is a red herring. ENH has never claimed that its post-merger price increases are "justified" by its post-merger quality improvements. Instead, ENH's post-merger quality improvements are procompetitive effects that must be weighed against the merger's likely anticompetitive effects, and are not a "post-hoc attempt to justify" its post-merger price increases.[25] ID179. Whether ENH attempted to "justify" its price increases with quality improvements in MCO negotiations is thus irrelevant, and unrebutted expert testimony confirmed this point. RFF1160. Indeed, the quality improvements are procompetitive effects whenever they occur—whether or not the MCOs were told about them in advance[26]—and the ALJ erred by dismissing them merely because some improvements occurred after the contracts were negotiated.

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[25] Although there is no dollar value attached to such procompetitive benefits, courts routinely balance interests that are not quantified or quantifiable. *See, e.g., Katz v. Georgetown Univ.*, 246 F.3d 685, 687 (D.C. Cir. 2001) (balancing public interest concerns in the context of a preliminary injunction); *Brown Univ.*, 5 F.3d at 674-75, 678 (considering enhanced quality of education and promoting of socio-economic diversity); *Banks v. NCAA*, 746 F. Supp. 850, 861-62 (N.D. Ind. 1990) (preserving integrity and quality of amateur sports considered a procompetitive benefit) (discussing similar cases). Here, the Commission must weigh the interests of consumers in higher quality and life-saving healthcare against entirely speculative claims of supracompetitive pricing.

[26] As a matter of law, companies do not have a duty to disclose in advance information such as innovations or improvements. *See Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 281 (2d Cir. 1979) (finding that a firm may "keep its innovations secret from its rivals as long as it wishes, forcing them to catch up on the strength of their own efforts after the new product is introduced.").

Similarly, it is irrelevant whether the quality improvements were focused solely at HPH. *See* ID180. As long as there was no merger related decline in quality elsewhere—and there is no evidence of such a decline here—the quality improvements discussed above clearly produced a net increase in consumer welfare.[27]

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In sum, the ALJ erred in finding, under a "totality of the circumstances" analysis, that the substantial procompetitive benefits of the merger were outweighed by Complaint Counsel's speculative evidence of anticompetitive effect. The ALJ's finding of competitive harm was based on a presumption improperly derived from market concentration and an inaccurate and ambiguous pricing study. ID200. Moreover, the fact that Evanston and HPH did not achieve a monopoly-level market share and were not close substitutes, combined with the ability of competing hospitals to "reposition" their

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[27] The ALJ also erred in dismissing ENH's not-for-profit status as a relevant piece of the "totality of the circumstances" inquiry. ID192-94. Not-for-profit status is a relevant consideration in evaluating the alleged competitive effect of any merger like that at issue here. *See Long Island Jewish Med. Cntr.*, 983 F. Supp. at 146; *Butterworth*, 946 F. Supp. at 1296-97. Here, the evidence showed that, unlike a for-profit entity, ENH reinvests all of its profits into the hospital for the benefit of patients. RFF335-38,2414-45. As recognized by several cases, ENH's not-for-profit status, its mission and community commitment, as well as its close ties to the community, all significantly reduce any likelihood of competitive harm. RB65-67. Indeed, ENH expanded certain services at HPH even though it would have been more profitable to expand them at Evanston. RFF2418. Complaint Counsel's own expert confirmed that such behavior is inconsistent with how a profit maximizing firm would be expected to behave. RFF2417.

Furthermore, not-for-profit hospitals such as ENH provide more charity care than for-profit hospitals. RFF337,2420,2440. The Healthcare Foundation of Highland Park, which was created and funded as part of the merger, provides significant charity care and services to the community, including awarding grants to charitable organizations and establishing a clinic for underserved populations in Lake County. RFF2443-44. In the event of a divestiture, the Foundation may be forced to dissolve because ENH would be entitled to recover the funds it devoted to creating the Foundation.

services and the sophistication of the MCO customers, makes it even less likely that the price increases in the study resulted from market power. By contrast, the ALJ correctly found "verified" improvements in the quality of care. ID178,190. In short, the weak plight of HPH before the merger, and the substantial, verified quality improvements that the merger created—resulting in HPH's being recognized as one of the 50 best hospitals in the entire nation—stand in stark contrast to the ambiguous and conjectural evidence that Complaint Counsel offered on the issue of price. Thus, even assuming some risk to competition, the necessary weighing of competitive effects requires a finding that, *on balance*, the merger is likely to promote competition rather than lessen it.

III. DIVESTITURE WOULD HARM CONSUMERS WITHOUT CURING THE MERGER'S ALLEGED ANTI-COMPETITIVE EFFECTS.

Even if a finding of liability were warranted, divestiture would not be the appropriate remedy. Prior Commission opinions reject the notion that "divestiture is an automatic sanction, mechanically invoked in merger cases." *In re Retail Credit Co.*, No 8920, 1978 FTC LEXIS 246 at *258-59 (July 7, 1978). Instead, the Commission has stressed that "due regard should be given to the preservation of substantial efficiencies or important benefits to the consumer in the choice of an appropriate remedy." *Id.* at 259. Thus, the Commission has even refused to require for-profit businesses to "unscramble the assets," where "greater efficiency" would result from less drastic relief. *Id.* at 338-340. In fashioning remedies, it is the "public interest" that must be "paramount." *In re Ekco Products*, No. 8122, 1964 FTC LEXIS 115, at *127 (June 30, 1964). The Supreme Court has likewise ruled that divestiture may not be ordered when contrary to principles

of equity or inconsistent with the public interest, especially where, as here, there is evidence that "divestiture would not benefit competition." *Gen. Dynamics*, 415 U.S. at 511; *see Timken Roller Bearing Co. v. United States*, 341 U.S. 593, 601, 602-05 (1951) (Reed, J., concurring)(divestiture is "not to be used indiscriminately" where "less harsh" methods are available).

The cases also make clear that "divestiture is an extremely harsh remedy," *Reynolds Metals Co. v. FTC*, 309 F.2d 223, 231 (D.C. Cir. 1962) (Burger, J.), which "cannot be had on assumptions." *United States v. Crowell, Collier, & Macmillan, Inc.*, 361 F. Supp. 983, 991 (S.D.N.Y. 1973). That admonition has particular force in a case such as this one, involving, as we have shown, at most a weak inference of anticompetitive effects; verified and substantial procompetitive benefits in the form of enhanced health care; large acknowledged investments in the acquired hospital; a four-year delay by Complaint Counsel in bringing suit; and a threatened waste of charitable funds to "unscramble" closely integrated hospital facilities. Indeed, divestiture would have the most injurious consequences for the continued <u>viability</u> of HPH, not to mention its status as one of the 50 best hospitals in the country. *See Fishman v. Estate of Wirtz*, 807 F.2d 520, 562 (7th Cir. 1986)(holding divestiture was properly denied given harm to defendant and affected "third parties").

Further, the equities of this case weigh heavily against divestiture. As noted by the ALJ, Evanston and HPH had been part of the Northwestern Healthcare Network ("the

Network") since 1990. ID197; *see* RFF208-12,298-301.[28] The Network received HSR clearance in 1993. RFF210. When a full asset merger was contemplated by Evanston and HPH in 1999, the parties confirmed with the FTC Pre-Merger Notification Office that they did not need to seek additional clearance under HSR because the assets of both hospitals were already deemed to be under common control, and the parties consummated the merger on January 1, 2000. RFF298-99; RFF300-01,2536-37. Over four years after the merger Complaint Counsel filed a complaint seeking divestiture. Forcing divestiture upon two hospitals that have acted in accord with all premerger requirements over the past 15 years and made substantial investments producing significant, verified pro-competitive effects is contrary to settled equitable principles.

In the face of this authority and history, and the manifest risks to HPH, its patients, and health care competition in the Chicago area, the ALJ decided that divestiture was appropriate based in part on the fact that divestiture of integrated assets has previously been ordered in cases such as *CB&I*, Dkt. 9300 (Jan. 6, 2005) and *In re Olin Corp.*, 113 F.T.C. 400 (1990). ID206. The ALJ's conclusion was wrong for two fundamental reasons.

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[28] This fact highlights the error in the ALJ's conclusion that the merger was even covered by §7 of the Clayton Act, which applies only when one legal person acquires the stock or assets of "*another person.*" 15 U.S.C. §18(a). Prior to the merger the membership interests of Evanston and HPH were held by the same parent network. Yet *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984), precludes treating corporate entities with a common parent as distinct legal persons. Further, *Copperweld* clearly applies to network affiliations of nonprofit entities. *Jack Russell Terrier Network of Northern California v. American Kennel Club, Inc.*, 407 F.3d 1027, 1034-35 (9th Cir. 2005); *see also Chicago Prof'l Sports Ltd. P'ship v. NBA*, 95 F.3d 593, 598-99 (7th Cir. 1996).

A. Divestiture At This Point Would Harm Patients And Their Communities And Would Provide No Countervailing Benefits.

First, especially in light of the time that has passed since the merger, divestiture would harm patients and their communities. In the cases cited by the ALJ, the entities merged only months before the Commission brought a complaint. *CB&I*, Dkt. 9300 at 1; *Olin*, 113 F.T.C. at 413, 431. Here, by contrast, where the complaint was brought years after ENH merged and made large improvements to the merged entity, divestiture would be "extreme" and inappropriate in light of "years of extension and development of the new company's business." *United States v. U.S. Steel Corp.*, 251 U.S. 417, 452-453 (1920); *United States v. U.S. Shoe Mach. Co. of N.J.,* 247 U.S. 32, 45-46 (1918).

Indeed, the FTC has no experience in divesting a fully-integrated hospital system and staff. This case is entirely different from *Hosp. Corp. of America,* 1985 FTC LEXIS 15, at *320-21, where there was no integration of hospital services at divestiture. Here, as the ALJ found, "ENH has, in fact, invested $120 million into Highland Park and has made many improvements to Highland Park that can be verified." ID178. Evanston also has committed to invest an additional $45 million in the future. RFF1518. The initial massive infusion enabled HPH to make a variety of improvements in the level of care its patients receive. Although the ALJ acknowledged that "the improvements made by Highland Park, without a merger, may have differed from the improvements actually made by ENH" (ID183), this is a remarkable understatement considering the host of real-world benefits that the ALJ found actually flowed from the new capital and organizational resources provided by ENH. *See supra* Section II.

By contrast, a divested HPH would lose access to the capital that brought about these improvements, returning it to its pre-acquisition plight as a declining provider. Even the ALJ conceded that, without Evanston, HPH would lose benefits from the merger including electronic patient medical records, academic affiliation, clinical integration, and cardiac surgery. ID205. But even this concession understates the magnitude of the injury. Many of the most important improvements in patient care resulting from the merger, including improved physician and nursing skills, improved clinical protocols, interventional cardiology, and computerized record keeping, would be eroded or eliminated upon divestiture of HPH. RFF1232,2483-2532; RFF-Reply2567,2570,2576. Divestiture would also sever the integration of medical staffs, thereby depriving HPH of the intensity and scope of academic activities, research partnerships, multidisciplinary care conferences, and case consultations from which its patients now benefit. RFF2514-2518; RFF-Reply2578-2579. The integrated relationship between Evanston and HPH is essential to maintaining these improvements, and their loss would be felt throughout the North Shore community. RFF2484.

For example, significant financial and technological barriers would prevent HPH from maintaining Epic, ENH's cutting-edge electronic record system, upon divestiture. RFF2527-29. The loss of Epic would harm HPH patients who today are direct beneficiaries of this powerful and life-saving technology. RFF2118-20,2523-30. The ALJ acknowledged, in part, that the benefits of Epic would be lost upon divestiture, but he failed to give sufficient weight to the loss of this benefit at HPH. ID191-92.

Complaint Counsel, on the other hand, has offered only guesses and speculation to suggest that HPH would maintain the quality improvements brought to it by the merger if divestiture were ordered. RFF1203,1209; RFF-Reply2041. But guesswork is not enough to support divestiture when there is actual evidence showing that divestiture would destroy the quality improvements that the merger created, thereby harming patients. RFF2483-2532. Accordingly, once the ALJ found (correctly) that there were "significant improvements at Highland Park" resulting from Evanston's commitment of "the substantial time and resources" required "to fund and make such improvements a reality," (ID191-92(emphasis added)), the ALJ should not have speculated that those benefits would have materialized without these same resources or that they would remain available in the future with no visible means of support.

Even under the ALJ's narrow interpretation of merger-specific benefits, the public interest would suffer from a forced divestiture. Complaint Counsel failed to show that another acquiring institution would make these necessary improvements; nor has Complaint Counsel explained how HPH could maintain its newly-achieved healthcare improvements without a continued infusion of funding, academic expertise, and quality supervision from the larger ENH organization. As informed observers have noted, "[w]here two companies have combined their business operations... a post-close order of divestiture may be difficult, costly, punitive to the business involved in the merger, and, overall, detrimental to customers." Scott Sher, *Closed But Not Forgotten: Government Review of Consummated Mergers Under Section 7 of the Clayton Act*, 45 Santa Clara L. Rev. 41, 81-82 (2004); *see also*, Posner, *Antitrust Law* at 268 ("[s]tructural remedies such

as divestiture are, as we know, slow, costly, frequently ineffectual, and sometimes anticompetitive").

Perhaps most tellingly, Complaint Counsel failed to provide any evidence that divestiture would lead to lower prices by either Evanston or HPH. As shown earlier, the price increases on which Complaint Counsel relies, which almost all occurred at Evanston, were the result of ENH's discovery that its pre-merger prices were significantly below prices at comparable Chicago-area hospitals. *See supra* Section I.E. Complaint Counsel presented no evidence that those prices would be reduced if divestiture were ordered, that MCOs would reduce rates or profit margins to benefit consumers, or even that divestiture would forestall price increases in the future. Having become a more sophisticated, price-conscious provider, there is no reason to believe that ENH would revert to its prior, below-market pricing practices. It would be ludicrous as a matter of policy—and contrary to settled legal principles—to order a remedy that has not been shown capable of curing the principal harm allegedly flowing from the combination. *See United States v. Microsoft Corp.*, 253 F.3d 34, 80 (D.C. Cir. 2001)(en banc)(holding "[d]ivestiture is a remedy that is imposed only with great caution, in part because its long-term efficacy is rarely certain"); *In re Nat'l Tea Co.*, No.7453, 1966 FTC LEXIS 41, at *89 (Mar. 4, 1966)("[W]e think it appropriate, in the circumstances of this case, to give those natural forces of competition a chance to correct the imbalances in those markets before turning to the more stringent remedy of divestiture").

B. The ALJ Failed To Consider The Public Interest When Rejecting Alternative Remedies.

The ALJ also failed to consider properly whether remedies other than divestiture would, on balance, satisfy the goals of Section 7. Rather, he found that "Respondent has failed to meet its burden by identifying any hardship which would entitle it to an exception to the divestiture rule." ID203. But there is no "rule" requiring divestiture. Case law instead requires a balancing of risks and benefits and a disciplined effort to avoid injury to the public interest. *Microsoft Corp.*, 253 F.3d at 80 (stating "wisdom counsels against adopting radical structural relief" such as divestiture). Courts also require careful consideration of "the appropriate remedy for the redress of antitrust violations where something short of divestiture will effectively redress the violation." *United States v. Int'l Tel. & Tel. Corp.*, 349 F. Supp. 22, 31 (D. Conn. 1972). Thus, the proper question is not whether ENH demonstrated it would suffer hardship, but whether the adverse effects of divestiture on the public interest weigh in favor of an alternative, less draconian remedy. And here, the harm suffered by the community must be measured not just in dollars, but in lives saved or lost due to the financial, technological, academic, and organizational resources that ENH has made available to HPH. There is no doubt that the public would suffer from divestiture.

At least two alternative remedies would preserve the benefits of the merger while providing structural protections against competitive risks. First, the Commission could require ENH to negotiate and maintain separate MCO contracts on behalf of Evanston and HPH. This would allow MCOs to contract with one hospital and not the other if they

so choose. While the ALJ declined to employ such a remedy, he did not analyze whether it would invigorate bargaining and price competition for the benefit of large and sophisticated MCOs. In fact, a number of Chicago-area medical providers use this kind of separate negotiation with MCOs to produce diverse contractual terms for their commonly owned hospitals. IDF 366. And, as explained above (*see* supra Section I.D.), the MCOs' sophistication can be expected to provide a substantial check on any attempt by the hospitals to exercise market power.

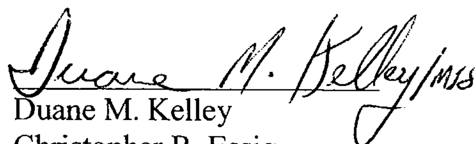
Second, to the extent that the Commission is concerned about a trend toward concentration, it could require ENH to give prior notification of any acquisition or joint venture in the future, and could enjoin any combination deemed anticompetitive. RB124-25.

By relying on remedies other than divesture, the Commission can ensure that the public interest is adequately served, even if it concludes (as it should not) that the merger violated the Clayton Act. Alternative remedies make good sense in a case involving a market populated by sophisticated MCOs that can avail themselves of separate negotiation opportunities. Divestiture, by contrast, would strip away the significant health-care benefits now enjoyed by the community—including the enormous benefit to Highland Park residents of having a top-50 hospital in their own neighborhood—without any countervailing benefits such as price reductions. Antitrust law should not pit itself against consumers' well-being in this short-sighted fashion.

CONCLUSION

For all these reasons, the Complaint should be dismissed.

Respectfully submitted,



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UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION

COMMISSIONERS: Deborah Platt Major as, Chairman
Pamela Jones Harbour
Jon Leibowitz
William E. Kovacic
J. Thomas Rosch

In the Matter of EVANSTON NORTHWESTERN HEALTHCARE CORPORATION a corporation	)	Docket No. 9315 Public Version

PROPOSED ORDER

Upon consideration of Respondent's Appeal Brief, and any opposition thereto, it is hereby ORDERED that the complaint against Respondent is dismissed with prejudice.

Date: ___________

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The Commission

CHI:1644280.1

CERTIFICATE OF SERVICE

I hereby certify that on January 12, 2006, copies of **Respondent's Corrected Appeal Brief (Public Version)** were served (unless otherwise indicated) by messenger on:

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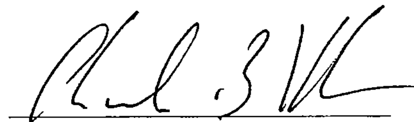

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