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**UNITED STATES OF AMERICA  
FEDERAL TRADE COMMISSION**

**In the Matter of**

***EVANSTON NORTHWESTERN HEALTHCARE CORP.***

**Docket No. 9315**

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**COMPLAINT COUNSEL'S POST-TRIAL REPLY BRIEF**

**(Public Version)**

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Federal Trade Commission  
601 New Jersey Avenue, N.W.  
Washington, DC 20580

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## *INTRODUCTION*

It is undisputed that ENH's post-merger price increases exceeded, by significant percentages, the price increases of other hospitals during the same time period.<sup>1</sup> The record plainly shows that ENH's unprecedented price increases contrast sharply with the lower prices of hospitals located outside the ENH geographic triangle that offer comparable services but not at the same North Shore locations as ENH. We know the price increases were profitable because ENH did not lose a single health plan as a customer. Health plans also did not substitute ENH in their networks with the lower-priced hospitals located outside the ENH geographic triangle.

ENH defends its post-merger price increases as merely reaching what its experts deem a "competitive" level, a benchmark set by arbitrarily picking { [REDACTED] }  
[REDACTED] } To the extent there was anticompetitive harm from the merger, Respondent lauds its quality of care changes at Highland Park as a benefit that, in ENH's calculus, outweighs the harm the merger inflicted on customers of both Highland Park and Evanston.<sup>2</sup>

In essence, ENH assures the Court that there is no antitrust problem here. Indeed, Respondent would have the Court conclude that its customers should praise this merger for increasing quality without raising prices above competitive levels. But the Court heard directly from these very customers, health plan witnesses who described this post-merger marketplace and explained how the merger substantially lessened competition in that market. The health plan

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<sup>1</sup> Throughout this reply brief, we refer to "Respondent" and "ENH" as the post-merger entity Evanston Northwestern Healthcare Corp., which consists of the Evanston, Glenbrook and Highland Park hospitals. Except where noted, we refer to "Evanston" as the pre-merger Evanston and Glenbrook hospitals, and to "Highland Park" as the pre-merger Highland Park Hospital, which was then owned by Lakeland Health Services, Inc. Particularly in the Quality of Care defense and Remedy portions of this brief, we will refer to "Highland Park" interchangeably as the pre-merger entity as well as the post-merger hospital.

<sup>2</sup> Respondent's Post-Trial Brief ("RPTB") at 1-2.

witnesses uniformly attested to the competitive harm they incurred as a result of the merger. They rejected the notion that they paid ENH more because it was the “competitive” price, and saw no evidence that their customers benefitted by way of a better hospital at Highland Park. In contrast, Respondent did not call any health plan witnesses, choosing instead to rely on its paid experts and employees or those affiliated with it to make self-serving statements in defense of the merger. Since the objective here is to assess whether the “effect” of the merger is substantially to lessen competition, Complaint Counsel submits that the answer comes from those harmed by the merger rather than those enriched by it.

According to ENH, coincident with the merger it learned that Evanston had been underpricing itself before the merger, and thus having learned about demand for its services, raised prices after the merger to the “competitive” level. The record in this case shows that this argument is contradicted by marketplace realities. Health plans are rational and knowledgeable profit-maximizing firms. If Evanston had been underpricing itself pre-merger, health plans would have seized the bargain pre-merger by abandoning nearby higher-priced hospitals and asking Evanston to take on more volume. But this did not happen.

Alternatively, while ENH claims its post-merger price increases put it in line with the prices of the comparison group created by its expert, the evidence shows that numerous teaching and non-teaching hospitals outside the ENH geographic triangle routinely handle the same types of cases as ENH but at substantially lower prices than ENH. As profit-maximizing firms, health plans should be seizing the bargain by abandoning ENH for the lower-priced hospitals, if this alternative network would be viable with customers. But this did not happen either.

What did happen, as the record shows, is that ENH’s post-merger prices rose because the merger removed each of the merging firms as a constraint on the other’s prices. In this regard,



ENH asks the Court to turn a blind eye to its contemporaneous business documents and the testimony of former employees. While ENH speaks to the Court of a benign desire to price at the “competitive” level of its so-called peers, its former employee Mark Newton testified to ENH’s decision to extract a “premium” price for its newly acquired “negotiating power and leverage.” (Newton, Tr. 364-5). Similarly, ENH’s consultant Bain urged ENH not to settle just for a competitive price, but rather to obtain “premium pricing (i.e., *above* the competitive average).” (CX 67 at 49 (emphasis added)). Although ENH also tries to evoke goodwill images of saving Highland Park from ruin – an image not shared by health plans, who viewed Highland Park as a “very good” hospital before the merger – ENH’s business records reflect a strategy to achieve market power. Words like “leverage,” “make indispensable to marketplace,” and “strengthen negotiating positions” permeate senior management documents before and after the merger.

Confronted by the stark record facts that post-merger prices rose because the merger substantially lessened competition, ENH then shifts gears and argues ENH’s customers should be pleased to pay anticompetitive prices so ENH can offer higher quality services, even if those ostensible improvements in quality are ones that the customers were never informed about, and even if ENH cannot verify and cannot quantify the improvements. Taken to its logical conclusion, ENH’s argument effectively would allow all anticompetitive mergers to proceed, so long as the merging party can identify some quality improvement that will take place after the merger, no matter how uncertain or insubstantial. Clearly that cannot be, and is not, the law. Of course, improvements in product quality are good for consumers. But this is not to say that any time some product improvement accompanies a merger that all antitrust inquiry ends. To the contrary, as the *Merger Guidelines* make clear, any claim of improved quality, like any other efficiency, must be *merger-specific* (i.e., Highland Park on its own or with others could not have

achieved the same benefits); it must be *verified*, so that it is not merely vague or speculative, but subject to reasonable efforts at quantification; and it must be sufficient to reverse the merger's potential to harm consumers in the relevant market. U.S. Dep't of Justice and Fed. Trade Comm'n, 1992 Horizontal Merger Guidelines § 4 (Rev. 1997) ("*Merger Guidelines*"); *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 720-2 (D.C. Cir. 2001). ENH failed to make any of these showings.<sup>3</sup>

In yet another line of defense, ENH insists upon the need to define relevant product and geographic markets and then defines them broadly, thereby implying that health plans can restrain ENH's prices by switching to outpatient services or to hospitals located outside its geographic triangle. ENH's argument again fails to stand up to the facts. Health plans testified that they cannot substitute outpatient services for inpatient services, and that an alternative network configuration that excluded ENH but included other hospitals was not practicable. Other industry participants, including ENH's executives, agreed with the health plans.

Respondent lastly argues that a divestiture order is neither required by law nor prudent. But the law is unequivocal that divestiture is *the* appropriate remedy to an unlawful merger. As with its doomsday description of Highland Park before the merger, ENH exaggerates the state of affairs at Highland Park today and after a divestiture. An independent Highland Park will have every incentive and capacity, just as it did before the merger, to compete against Evanston and other hospitals for health plan business by offering cost-effective, high quality hospital care.

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<sup>3</sup> Respondent claims that its "strong quality evidence is Complaint Counsel's worst nightmare." (RPTB at 2). To the contrary, Complaint Counsel sleeps well knowing that ENH failed to present (1) verifiable evidence of quality improvements, (2) an empirical study comparing quality at Highland Park to other hospitals, or (3) a measurable way to quantify and value the quality changes.

## ***ARGUMENT***

### **I.**

#### **ENH MUST PROVE ITS “QUALITY OF CARE” DEFENSE**

ENH’s analysis of the proof burdens in a Section 7 case glosses over its own burden to prove its “improved quality of care defense.” (RPTB at 13-14).<sup>4</sup> Rule 3.43(a) of the FTC’s Rules of Practice explicitly puts the burden on ENH: the “proponent of any factual proposition shall be required to sustain the burden of proof with respect thereto.” 16 C.F.R. § 3.43.

Complaint Counsel has demonstrated that this merger created a “highly concentrated” market in which a merger is “presumed” likely to “create or enhance market power.” *Merger Guidelines* § 1.51; Complaint Counsel’s Post-Trial Brief (“CCPTB”) at 55-56. As a result, it is ENH’s burden to prove “extraordinary” benefits from the merger. *H.J. Heinz*, 246 F.3d at 720; *FTC v. University Health, Inc.*, 938 F.2d 1206, 1223 (11th Cir. 1991); *FTC v. Staples, Inc.*, 970 F.Supp. 1066, 1089 (D.D.C. 1997).<sup>5</sup>

More specifically, ENH must clear three hurdles. *First*, the “improved quality of care” claims must be verified and quantified so that the Court can assess the “likelihood and magnitude” of the claim. *Merger Guidelines* § 4. “Vague,” “speculative” and unverifiable claims should not be considered. *Merger Guidelines* § 4. A “rigorous analysis” is required in order to ensure that the claims “represent more than mere speculation and promises.” *H.J. Heinz*,

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<sup>4</sup> Elsewhere, ENH incorrectly asserts that it is Complaint Counsel’s burden to show that the anticompetitive effects outweigh the alleged quality improvements. (*E.g.*, RPTB at 2, 4, 35, 68). For the same reasons discussed below, ENH misstates the law.

<sup>5</sup> Separate from the “quality of care defense,” ENH incorrectly claims that as a general matter Complaint Counsel’s “burden is even higher” in a consummated merger. (RPTB at 13 n.4). There is no difference: using market structure analysis and without the need to prove actual anticompetitive effects, a consummated merger can violate Section 7 in the same way as a prospective merger. *Chicago Bridge & Iron Co.*, Docket No. 9300 at 90 (January 6, 2005).

246 F.3d at 721; *FTC v. Swedish Match*, 131 F.Supp.2d 151, 171-2 (D.D.C. 2000) (rejecting efficiencies claims that were “at best speculative”); *Staples*, 970 F.Supp. at 1089 (rejecting efficiencies claims that were not verifiable, credible or reliable). The harm from this merger has been verified and quantified, down to the percentage. Any quality of care claims must be similarly precise to be relevant.

*Second*, the pro-competitive benefits of the “improved quality of care” claims must outweigh the anticompetitive harm. *Merger Guidelines* § 4. When the anticompetitive effects are “particularly large,” “extraordinarily great” benefits are necessary. *Merger Guidelines* § 4. “Efficiencies almost never justify a merger to monopoly or near-monopoly.” *H.J. Heinz*, 246 F.3d at 720 (quoting *Merger Guidelines* § 4).

*Third*, the benefits must be “merger-specific,” *i.e.*, benefits that cannot be achieved by the acquired entity alone or with others because, “if they can, the merger’s asserted benefits can be achieved without the concomitant loss of a competitor.” *H.J. Heinz*, 246 F.3d at 721-2; *Staples*, 970 F.Supp. at 1090. “In light of the anti-competitive concerns that mergers raise, efficiencies, no matter how great, should not be considered if they could also be accomplished without a merger.” *FTC v. Cardinal Health, Inc.*, 12 F.Supp.2d 34, 62 (D.D.C. 1998).<sup>6</sup>

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<sup>6</sup> Because the Court’s Order instructs Complaint Counsel to reply to arguments in the sequence in which they are presented by ENH, we address the merits of ENH’s “improved quality of care” defense later in this reply brief.

## II.

### **ALTHOUGH ELABORATE MARKET ANALYSIS IS NOT REQUIRED, COMPLAINT COUNSEL PROVED THE RELEVANT MARKETS**

#### **A. Complaint Counsel Proved a Relevant Product Market**

Complaint Counsel proved that the relevant product market for analyzing this merger is general acute-care inpatient hospital services sold to health plans, which includes primary, secondary and tertiary inpatient services, but excludes quaternary and outpatient services. (CCPTB at 52-53). ENH argues that the product market should be expanded to include outpatient services because the relevant customers here – health plans – purchase a “bundle” of services that includes both inpatient and outpatient services. (RPTB at 16-17).

Product market definition focuses on demand substitution, *i.e.*, whether consumers regard products as substitutes and whether a hypothetical monopolist of one of the products could profitably impose a small but significant nontransitory increase in price (“SSNIP”) (5% in the *Merger Guidelines*). *H.J. Heinz*, 246 F.3d at 718; *Swedish Match*, 131 F.Supp.2d at 158-160; *Merger Guidelines* § 1.11. Courts reviewing hospital mergers consistently adopt a product market limited to inpatient services. *University Health*, 938 F.2d at 1210-11; *U.S. v. Rockford Memorial Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990). The reason is very simple:

If you need a kidney transplant . . . you will go (or be taken) to an acute-care hospital for inpatient treatment. . . . If you need your hip replaced, you can’t decide to have chemotherapy instead because it’s available on an outpatient basis at a lower price. . . . Hospitals can and do distinguish between the patient who wants a coronary bypass and the patient who wants a wart removed from his foot; these services are not in the same product market merely because they have a common provider.

*Rockford Memorial*, 898 F.2d at 1284.

The inpatient market in the North Shore is no different. There is an inherent inability to

substitute outpatient services for inpatient services. If a physician decides that a patient requires inpatient care, health plans and hospitals do not switch the patient to outpatient care. (Newton, Tr. 302; Spaeth, Tr. 2076; Holt-Darcy, Tr. 1422-3). ENH's expert concedes that inpatient and outpatient services are not functionally interchangeable. (Noether, Tr. 6194).<sup>7</sup>

Prices for inpatient services are not restrained by outpatient prices. ENH and Highland Park set inpatient rates independent of their outpatient rates and without concern that patients would switch to outpatient services. (Neaman, Tr. 1210-12; Newton, Tr. 330-1; CX 1868 at 11). Health plans cannot substitute outpatient services for inpatient services if prices for the latter increase significantly. (Neary, Tr. 591; Holt-Darcy, Tr. 1422-3).<sup>8</sup>

That health plans purchase inpatient and outpatient services together and some firms occasionally "trade-off" inpatient and outpatient rates tell us nothing about the relevant product market. (RPTB at 17). A dealer who sells a car at a higher price but offers more generous financing terms does not make the car and the financing one product market. (Haas-Wilson, Tr. 2664-5). Such behavior must be taken into account in computing the price of the car, but it does not prove that consumers can trade off between transportation and borrowing, any more than they can use outpatient care for a kidney transplant.

**B. Complaint Counsel Proved a Relevant Geographic Market**

A relevant geographic market is the "area of effective competition." *U.S. v. Philadelphia Nat'l Bank*, 374 U.S. 321, 359 (1963). The geographic market must "correspond to the

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<sup>7</sup> Dr. Noether's (ENH's expert) current view for a broader market is inconsistent with her view in a prior hospital merger case that the appropriate market is limited to inpatient services. (Noether, Tr. 6194-5; *U.S. v. Mercy Health Services*, 902 F.Supp. 968, 976 (N.D. Iowa 1995)).

<sup>8</sup> It is irrelevant that volume for outpatient services has increased. (RPTB at 17). Shifts toward outpatient services are the result of innovations in medicine and other factors independent of any impact from inpatient prices. (Hillebrand, Tr. 1755-6).

commercial realities' of the industry and be economically significant." *Brown Shoe Co. v. U.S.*, 370 U.S. 294, 336-7 (1962) (citations omitted). The key is to identify the area in which price competition is threatened and those firms, if any, that constrain the merged entity's prices. *Cardinal Health*, 12 F.Supp.2d at 49-50; see also *Hospital Corp. of America v. FTC*, 807 F.2d 1381, 1388 (7th Cir. 1986) (hospitals excluded from geographic market because doctor will not send patient to another hospital "for reasons of price"); *Merger Guidelines* § 1.21; Noether, Tr. 6196. The geographic market need not be identified with "scientific precision" nor "by metes and bounds." *Cardinal Health*, 12 F.Supp.2d at 49.<sup>9</sup>

Complaint Counsel has proved that the relevant geographic market is the geographic triangle formed by the three ENH hospitals.<sup>10</sup> (CCPTB at 53-55). ENH claims a broader market that includes numerous hospitals in close proximity to ENH and who "place a significant competitive constraint on ENH," such as Rush North Shore, St. Francis, Lutheran General, Resurrection, Lake Forest and Condell. (RPTB at 20-23).<sup>11</sup> [REDACTED]

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<sup>9</sup> The *Merger Guidelines* start with the locations of the merging firms and ask whether a hypothetical monopolist of the relevant product could profitably impose a SSNIP (e.g., 5%). *Merger Guidelines* § 1.21. If the SSNIP would be profitable because customers would not substitute from the hypothetical monopolist to other firms in nearby locations, the locations of the merging firms are a proper geographic market. *Merger Guidelines* § 1.21.

<sup>10</sup> ENH criticizes Complaint Counsel's expert's geographic market definition (Dr. Haas-Wilson), but her opinion that hospitals outside the ENH geographic triangle are not viable substitutes for health plan networks and do not constrain ENH's prices is consistent with and fully supported by the evidence, including ENH's admissions. (RPTB at 27-30; CCRFF 387).

<sup>11</sup> ENH relies on Dr. Noether's opinion that the geographic market should be expanded because hospitals outside the ENH geographic triangle "place a significant competitive constraint on ENH." (RPTB at 23-28). However, Dr. Noether conceded that she did not employ a *Merger Guidelines* SSNIP test, and that after the merger, health plans did not switch their purchases away from ENH and use other hospitals instead in their networks. (Noether, Tr. 6199-6201).





ENH's prices by substituting for ENH with other hospitals and still maintain a viable network. As demonstrated by the facts, hospitals outside the ENH geographic triangle do not constrain ENH and are properly excluded from the geographic market.

Prior to the merger, health plans viewed Evanston and Highland Park as substitutes and price constraints for purposes of building viable hospital networks in the area.<sup>13</sup> Health plans described the hospitals as each other's "main" competitors or "primary" alternative, thereby permitting health plans to "trade off one for the other" or "work them against each other" in contract negotiations. (Neary, Tr. 600-2; Ballengee, Tr. 166-70). { [REDACTED]

[REDACTED] } (Mendonsa, Tr. 520, 530, *in camera*). { [REDACTED]

[REDACTED] } (Holt-Darcy, Tr. 1517-9, *in camera*). PHCS knew that if rate negotiations were not "going well" at Evanston or Highland Park, PHCS could turn to the other as the alternative and use this fact to work the negotiations favorably its way. (Ballengee, Tr. 166-7).

After the merger, health plans found that the hospitals outside the ENH geographic triangle – the hospitals proposed by ENH for inclusion in its geographic market – were not viable substitutes and not price constraints to the merged entity, regardless of their lower cost, physical proximity to ENH or travel time. (RPTB at 20-22). { [REDACTED]

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<sup>13</sup> ENH falsely accuses Complaint Counsel of being "inconsistent" in its reliance on the views of health plans for purposes of geographic market analysis but not for product market analysis. (RPTB at 30). In both instances, Complaint Counsel focuses on health plans as the purchasers and payers of hospital services and examines the practical realities they face in defining the product and geographic markets, including consideration of how health plans take into account the needs of their customers (employers and their employees).

[REDACTED]

[REDACTED]

[REDACTED] } (RX 1912 at 147-9). The fact that customers did not switch to lower-cost hospitals shows that hospitals outside the ENH geographic market are not price constraints and should be excluded from the relevant antitrust market. *Staples*, 970 F.Supp. at 1078, 1080.

An important reason for this is that, for geographic market definition in hospitals (as in retailing generally), it matters where the patients are in relation to the hospital. Hospital A may be closer to Hospital B than is Hospital C, but for the patients between Hospitals B and C, Hospital A may not be a good substitute.

United concluded that without ENH in its network (but with Lake Forest, Rush North Shore, St. Francis and other hospitals in its network), United “could not have a viable network that would support our sales and growth objectives.” (Foucre, Tr. 901-2, 925-6, 931-4). [REDACTED]

[REDACTED]

[REDACTED] } (Foucre, Tr. 901-2; CX 21 at 5, *in camera*). [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (CX 6277 at 3, *in camera*; Foucre, Tr. 901).

PHCS’s experience with the local marketplace is the same as United’s. [REDACTED]

[REDACTED]

[REDACTED] } (Ballengee, Tr. 244-9, *in camera*; CX 46 at 1, *in camera*). PHCS customers made it “very clear” that a network without ENH was not “marketable.” (Ballengee, Tr. 179-80). PHCS suggested to customers that they could utilize Rush North Shore, Lutheran General and Lake Forest as alternatives to ENH

but learned that the area within the ENH geographic triangle “would not be served” by these other hospitals because people “do not like to drive by a local hospital and have to go to another hospital.” (Ballengee, Tr. 183-4).

In 2000, PHCS offered to exclude St. Francis, Rush North Shore, Condell and Lutheran General from its network – four of the six hospitals in Respondent’s proposed geographic market – in return for a discount, but ENH refused, except to offer a nominal discount for the exclusion of Lutheran General. (Ballengee, Tr. 181-2; Hillebrand, Tr. 1746-7). This actual negotiation clearly shows that ENH is neither constrained by hospitals outside the ENH geographic triangle nor concerned that PHCS will substitute ENH with these other hospitals in its network.

In 2000, One Health actually excluded ENH from its network after the merger but lost customers even though its alternative network contained Lake Forest, Lutheran General, Rush North Shore and St. Francis, among others. (Neary, Tr. 611, 617; Dorsey, Tr. 1451-2, 1459, 1488). Unable to substitute for ENH with other hospitals, One Health returned to ENH several months later. (Neary, Tr. 618-9; Dorsey, Tr. 1439-42).

[REDACTED]

[REDACTED]

[REDACTED] } (Mendonsa, Tr. 518, 520, 530, 541, *in camera*).

Contrary to its assertions in this litigation, ENH knew as a matter of business reality that hospitals located outside its geographic triangle would not provide “effective competition” for health plans. Messrs. Neaman and Hillebrand (ENH’s CEO and COO, respectively) set ENH’s prices to health plans after the merger without any concern that other hospitals would constrain ENH’s prices or that ENH would lose business to hospitals outside its geographic triangle. (Neaman, Tr. 1211-12; Hillebrand, Tr. 1751-5, 1757-8, 1764-5). By its senior executives’ own

admissions then, ENH's prices are not "affected" by other hospitals and, therefore, hospitals outside the ENH geographic triangle are properly excluded from the geographic market. *Staples*, 970 F.Supp. at 1077 (product market excluded non-office superstores because pricing evidence showed office superstore prices are not "affected" by non-office superstores).

Mr. Spaeth (Highland Park's President) believed that the merged entity could profitably raise prices because it would be "real tough" for any health plan and employer "whose CEOs either use this place or that place to walk from [ENH] and 1700 of their doctors." (CX 4 at 2). Mr. Spaeth's emphasis on the affluent population within the ENH geographic triangle underscores the economic literature's observation that such consumers are less willing to travel because they "impute a higher value to their time and consequently travel becomes more costly to them in the opportunity cost sense . . . affluent people have to stay close to home . . . so they can move on earning their – the high income that makes them affluent." (Elzinga, Tr. 2408).

Mr. Newton (formerly a senior executive at Highland Park and ENH) saw that the merged entity would have greater price "leverage" because of the "geographical placement" of the three ENH facilities. (Newton, Tr. 360-1). Within the ENH geographic triangle live many executives who "make decisions about health benefits for their employers, employees," and have "immense influence and power with the health plans." (Newton, Tr. 360-1). It did not matter that hospitals like Lake Forest, Lutheran General and others were nearby. (Newton, Tr. 360-1). ENH knew it could command a "premium" price without concern that health plans would walk away because health plans "really needed" ENH in their networks. (Newton, Tr. 364, 367).

ENH argues that since health plans must take into account patient travel preferences the proximity of other hospitals necessitates their inclusion in the geographic market. (RPTB at 22-25). But rather than expand the geographic market, Bain, ENH's consultant for the post-merger

contract negotiations, advised that patient travel preferences and ENH's unique geographic position would actually narrow the geographic market and give ENH pricing leverage with health plans. "Patient access – with the Highland Park merger, ENH offers the largest regional network for more convenient access." (CX 75 at 37). ENH, "with the Highland Park merger," commanded a "55% market share," meaning that health plans had many customers who already used one of the three ENH facilities, and likely would be unwilling to switch to physicians and hospitals outside the ENH geographic triangle. (RX 679 at ENHL RG 004136). This fact gave ENH "significant leverage" to obtain higher prices and improved terms, such as with PHCS, who had a "strong North Shore presence and need [ENH] in their network." (CX 1998 at 44).

ENH's reliance on patient travel patterns is a thinly-veiled run-around "patient flow" data to define geographic markets. As explained by Dr. Elzinga, patient-flow data and the Elzinga-Hogarty Test are inapplicable to geographic market definition in hospital mergers. (Elzinga, Tr. 2368-9; *see also* Complaint Counsel's Proposed Findings of Fact ("CCFF") 1661-1684). One problem with patient flow analysis is that it incorrectly assumes that if some patients are willing to travel to distant hospitals, then others will too in response to a change in hospital prices, thereby incorrectly suggesting a broader geographic market. (Elzinga, Tr. 2385-90). But the truth is that a "silent majority" of people will not travel in response to a change in hospital prices, and those people can be subject to an anticompetitive price increase. (*Id.*)<sup>14</sup>

ENH suggests that prior hospital merger challenges are controlling here on the issue of geographic markets. (RPTB at 30-31). As discussed in our opening brief, the hospital merger

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<sup>14</sup> The other problem with use of patient flow data and the Elzinga-Hogarty Test is the "payor problem," which recognizes that in the hospital industry health plans pay for hospital services but their enrollees are the ones who use the services. (Elzinga, Tr. 2395). Because patients do not set the price of hospital services, their willingness to travel tells us nothing about their sensitivity to price changes by the merging hospitals. (*Id.* at 2395-7).

challenges of recent vintage are not instructive here because they were decided in the context of prospective mergers, without the benefit of the direct evidence of actual anticompetitive effects available here. These cases also relied on patient-flow data and the Elzinga-Hogarty Test, which both parties agree should have no application to hospital mergers. (CCPTB at 56-59).

A close reading of the prior hospital merger decisions reveals an important theme directly applicable here. At issue in these cases was a predictive judgment about what would happen if the merged entity raised prices – could health plans practicably defeat the price increase by eliminating the merged entity from the network and switching to a lower-cost alternative network configuration. In *Tenet*, the court doubted that health plans, which are “for-profit entities,” would “unhesitatingly accept a price increase rather than steer their subscribers to hospitals [outside the geographic market].” *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999) (health plans’ “economic interests” would be to resist price increase). *See also State of California v. Sutter Health System*, 130 F.Supp.2d 1109, 1132 (N.D. Cal. 2001) (managed care organizations likely to “steer” members away from merged entity’s price increases to other hospitals); *U.S. v. Long Island Jewish Medical Center*, 983 F.Supp. 121, 144 (E.D.N.Y. 1997) (health plans testified that if confronted with 20% price increase by merged entity, they would “drop” the hospital from their networks, as they had done in comparable situations).

Compare how health plans were predicted to behave in these prior cases with their actual conduct in this case. When ENH raised prices after the merger, health plans, consistent with their “economic interests” (as well as those of their cost-minded employer customers), tried to avoid the price increases via alternative network configurations excluding ENH but including lower-priced hospitals located outside the ENH geographic triangle. The fact that health plans failed in the substitution and price increase avoidance exercise is powerful evidence not only that

the prior hospital merger cases are distinguishable, but also that an antitrust market limited to the ENH geographic triangle conforms with the economic and business realities.

**C. Section 7 Does Not Require an Elaborate Market Analysis**

Respondent again argues that Count II of the Complaint should be dismissed because it does not explicitly allege a “product market” and a “geographic market.” (RPTB at 31). As discussed in Complaint Counsel’s opening post-trial brief, because there is direct evidence of actual anticompetitive effects, the antitrust laws do not require an elaborate market analysis. (CCPTB 49-51).<sup>15</sup> Complaint Counsel satisfied Section 7 with overwhelming evidence that the “effect” of this merger has been substantially to lessen competition in a “line of commerce” – the sale of acute-care inpatient hospital services to health plans – in a “section of the country” – the geographic triangle formed by the three ENH facilities. In any event, Complaint Counsel has already proved the relevant markets.<sup>16</sup>

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<sup>15</sup> ENH’s expert, Dr. Baker, agrees. He wrote that the tort law concept of “res ipsa loquitur” should apply to antitrust analysis: “When a piano crashes to the sidewalk, tort law does not ask whether someone is negligent; it goes right to the question of who is negligent. Similarly, if the likely harm to competition from a merger can be demonstrated directly, there exists a market where harm will occur, but there is little need to specify the market’s precise boundaries.” J. Baker, “Contemporary Empirical Merger Analysis,” 5 *Geo. Mason L. Rev.* 347, 351 (1997).

<sup>16</sup> The cases cited by ENH are distinguishable because all involved challenges to prospective mergers in which direct evidence of anticompetitive effects was unavailable, thereby mandating reliance on market structure analysis as an indirect proxy. (RPTB at 32-33). The only consummated mergers cited by ENH are *U.S. v. E.I. duPont de Nemours*, 353 U.S. 586 (1957) and *Chicago Bridge & Iron*. (RPTB at 32 and 33 n.17). In *E.I. duPont* the Government did not present evidence of actual anticompetitive effects, thereby requiring the Supreme Court to draw inferences from the market structure. 353 U.S. at 605. In *Chicago Bridge & Iron*, the Commission conducted a market structure analysis and decided that proof of actual anticompetitive effects was unnecessary, thereby foregoing discussion of the appropriate line of analysis when such evidence exists. *Chicago Bridge & Iron*, Docket No. 9300 at 90.

### III.

#### **COMPLAINT COUNSEL PROVED THAT THE MERGER CAUSED COMPETITIVE HARM**

Relying on the theories of its experts (Drs. Noether and Baker) while ignoring the facts of this case, ENH contends that Complaint Counsel failed to prove that the merger caused anticompetitive harm. (RPTB at 34). Complaint Counsel's economic expert, Dr. Haas-Wilson, demonstrated that ENH's relative post-merger price increases exceeded the price increases of other hospitals by a wide margin, even after accounting for competitively neutral factors, and that market power from the merger provided the only economically sound and factually well-founded explanation for the pricing disparity. (CCPTB at 44-49).<sup>17</sup> ENH hopes to explain away the prices with the "learning about demand" story, but doing so requires a strained interpretation of facts and manipulation of data. Even then Drs. Baker's and Noether's results are self-defeating and also suggest behavior by health plans inconsistent with rational economic behavior.

As the record shows, real-world competitive dynamics clear away any doubts about ENH's market power. The health plan witnesses uniformly testified to ENH's market power and the competitive harm caused by the merger. (CCPTB at 34-43). None attributed the higher prices to their acknowledgment that ENH had "learned about demand," or that ENH provided a better quality product. Moreover, the health plan witnesses did not testify about what *might* happen, but rather about what actually transpired in the marketplace after the merger. Given their

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<sup>17</sup> It is an exaggeration to say that Complaint Counsel "based its proof of competitive harm on evidence that ENH raised prices after the Merger." (RPTB at 36). ENH's post-merger price increases was just the starting point of Complaint Counsel's analysis; Complaint Counsel then went on to compare ENH's price increases against other hospitals; found ENH's relative price increases to be staggeringly larger; applied well-established scientific and economic methodology to conclude that non-anticompetitive causes did not explain the price disparity; learned that health plans and ENH itself believed that the merger caused the relative higher prices; and based on the totality of all this evidence, concluded that the merger was anticompetitive.



economic incentives to avoid price increases, if practicable, and their knowledge about the location, quality of care and prices of the hospitals with which they do business, the health plans provide compelling proof that the merger singularly caused anticompetitive effects.

Also probative are the admissions of ENH employees and consultants, in testimony, documents, or sometimes both. On multiple occasions, Evanston's and Highland Park's lead contract negotiators, senior executives and consultants admitted that the "addition of Highland Park" gave the merged entity "leverage" and "negotiating strength" to "push back" against health plans and obtain "premium pricing (i.e., above the competitive average)," none of which could have been achieved by "either Evanston or Highland Park alone." (CCPTB at 28-33, 43-44). ENH conveyed the same message to the public financial community on the eve of the merger: "Negotiating strength as a combined system of 3 hospitals and 1,000 doctors." (RX.704 at ENH HJ 001645). ENH cannot rewrite its own history.

**A. Complaint Counsel Demonstrated a Decrease in Output**

Respondent incorrectly asserts that Complaint Counsel failed to show a "decrease in output of hospital services." (RPTB at 37). It is difficult to know what to make of ENH's apparent assertion that Complaint Counsel must prove not only that relative prices went up, but also that output declined. We do not presume that purchasers wish to buy more if only prices will increase. The "consequence of a price going up will be a reduction in the quantity demanded, follows from what we in economics call the law of demand." (Elzinga, Tr. 2403).

Nevertheless, Complaint Counsel has shown decreases in output caused by ENH's higher prices. ENH's price increases in 2000 caused One Health to end its contract with ENH, thereby temporarily depriving One Health customers of access to ENH and causing other customers to leave One Health. (Neary, Tr. 610-11, 617; Dorsey, Tr. 1451-2, 1488). The evidence also

showed that ENH's price increases caused health plans to raise their premiums to customers, which in turn caused employers to raise the cost of health benefits coverage for employees, or in some cases, terminated health benefits coverage entirely. (Ballengee, Tr. 172, 196-7; Mendonsa, Tr. 483-4; Dorsey, Tr. 1450; Elzinga, Tr. 2405-6). Many individuals could no longer afford to go to the ENH facilities, thereby causing a decrease in output of hospital services.

**B. Market Power Is the Only Plausible, Economically Sound and Factually Well-Founded Explanation for ENH's Post-Merger Relative Price Increases**

There was nothing "fallacious" about Dr. Haas-Wilson's analysis nor her conclusions. (RPTB at 39). As fully explained in our post-trial brief, the pricing analysis showed large price increases at ENH after the merger, and those price increases were significantly larger than the price increases of other hospitals during the same time period. (CCPTB at 44-47). But observing the higher relative price increases was only the "first-step" in Dr. Haas-Wilson's empirical analysis. (Haas-Wilson, Tr. 2489). Dr. Haas-Wilson next analyzed ten potential explanations that could account for the price increases, including two advanced by ENH. Dr. Haas-Wilson did not include every conceivable reason for the price increase; only those that had a sound basis in economic theory and the specific facts of this case. (*Id.* at 2481-2).<sup>18</sup> After a rigorous scientific analysis of the data, including multiple regression analyses to account for unique circumstances at ENH, Dr. Haas-Wilson concluded that the only economic explanation for the price increases was that the merger gave ENH market power. (*Id.* at 2451). Her conclusion was corroborated by evidence from health plans and ENH employees and documents attributing the price increases to ENH's enhanced market power from the merger.

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<sup>18</sup> Respondent criticizes Dr. Haas-Wilson for failing to consider other potential explanations. (RPTB at 39-40). But these factors are just details that were already captured in the explanations that Dr. Haas-Wilson examined or were not well-supported by economic theory as a plausible explanation for the price increases. (Haas-Wilson, Tr. 2681-3, 2941-2).

**C. The “Learning about Demand” Defense Is Flawed**

Respondent attributes ENH’s higher post-merger price increases to learning, coincident with the merger, that in contract negotiations with health plans before the merger it had been “short-changing itself for years.” (RPTB at 40). ENH, through its experts (Drs. Baker and Noether), asserts that as a result of “learning about the demand for its services,” ENH was able to negotiate price increases that brought its prices “in-line with those charged by other comparison hospitals.” (RPTB at 40).<sup>19</sup> The record in this case disproves both assertions.

1. *ENH Did Not “Learn about Demand” through the Merger*

The factual predicate for the “learning about demand” defense – that Evanston had been unknowingly underpricing itself before the merger – is incorrect. Evanston did not, as a consequence of the merger, learn new facts about the demand for its services. Rather, the merger changed the *conditions* affecting the demand for Evanston’s services, removing Highland Park as a price constraint. That is what enabled Evanston to increase its prices.

First, { [REDACTED] }  
[REDACTED]  
[REDACTED] } (Haas-  
Wilson, Tr. 2645-7, *in camera*; Baker, Tr. 4745-7, *in camera*).<sup>20</sup>

<sup>19</sup> Respondent falsely writes that Dr. Haas-Wilson “admitted that ‘learning about demand’ is both a plausible economic theory and relative price increases resulting from it are not anti-competitive.” (RPTB at 41). Dr. Haas-Wilson explained that “there is no good way” to measure the amount of information hospitals possess about demand for their services, and explicitly rejected “learning about demand” as an explanation for ENH’s price increases. (Haas-Wilson, Tr. 2643-4). { [REDACTED] } (Haas-Wilson, Tr. 2732-3, *in camera*).

<sup>20</sup> { [REDACTED] }  
[REDACTED]

(continued...)

*Second*, if Evanston's pre-merger prices were "far below the marketplace" (RPTB at 44), health plans, being rational and knowledgeable profit-maximizing firms, would have dropped higher-priced hospitals near Evanston, such as the hospitals in Respondent's proposed geographic market, in order to take advantage of the purported bargain prices at Evanston. (Noether, Tr. 6138-42). This never occurred. (Sirabian, Tr. 5755-6).

*Third*, competition among hospitals for placement in provider networks explains Evanston's pre-merger contracts, not some lack of knowledge, inattention or negotiating style that ENH today blames. (RPTB at 41-45). ENH attributes some of the blame for its supposedly below-market prices to Mr. Sirabian, one of Evanston's contract negotiators throughout the 1990s, but Mr. Hillebrand admitted that ENH's negotiating stance was equally aggressive before and after the merger. (RPTB at 41; Hillebrand, Tr. 1731, 1733).<sup>21</sup> Moreover, Mr. Sirabian can hardly be faulted for the competitive dynamics sweeping the marketplace. Employers competed to control their costs, including the cost of health care benefits, while simultaneously competing to hire and retain workers; health plans competed to provide cost-effective health care coverage and convenient access to provider networks; and hospitals, eager for the patient volume health plans provided, competed for placement in networks by providing high quality care at low prices. (Sirabian, Tr. 5743-5; CCPTB at 21-33 (competitive dynamics of selective contracting and

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<sup>20</sup> (...continued)

[REDACTED] (Haas-Wilson, Tr. 2647, *in camera*).

<sup>21</sup> ENH gives insufficient credit to Mr. Sirabian. Evanston's contracts with health plans (there were about 35-40 contracts) usually had "12-month cycles" and as each matured throughout the year, Mr. Sirabian dealt with each. (Sirabian, Tr. 5700-1). Mr. Sirabian always tried to get the highest price for Evanston. (*Id.* at 5734). Sometimes he was successful, other times less so. (*Id.* at 5734, 5744-5). Generally, Mr. Sirabian was a tough negotiator and held firm against unreasonable prices, requiring health plans to appeal to Mr. Hillebrand. (*Id.* at 5739). Evanston gave positive performance reviews to Mr. Sirabian. (*Id.* at 5728-9).

impact on ENH).<sup>22</sup> Evanston, not just Mr. Sirabian, succumbed to the forces of competition.

Throughout the 1990s, Evanston understood that competition among hospitals for network placement was a huge impediment to its desire to raise prices. Ultimately, Evanston identified a merger with Highland Park as the most expeditious way to overcome that impediment. (CX 19 at 1; CX 442 at 4; CCPTB at 28-33, 43-44). Throughout this time, Evanston received advice from Bain about how to improve its contracting with health plans. (CX 393 at 1 (1996); CX 2037 at 1-3 (1998)). In 1996, Evanston shared with Bain its vision to increase its “market share” through “acquisition” of “additional hospitals.” (CX 2037 at 1, 9). In early 1998, Evanston sought feedback from Bain about the “pricing pressures” caused by the “significant reductions in reimbursement” by health plans. (CX 2037 at 1-3).<sup>23</sup>

As the merger with Highland Park neared fruition, Evanston brought in Bain to help with health plan strategies. Despite all the emphasis Respondent places on Bain’s analysis of Evanston’s negotiating style (RPTB at 42-45), in fact Bain zeroed in on how *the merger with Highland Park* would change Evanston’s pre-merger contracts. Bain saw that the “addition of Highland Park” would “substantially improve ENH’s leverage” and help obtain “premium pricing (i.e., above the competitive average).” (CX 74 at 3, 15, 19, 22; CX 67 at 49). And while it talked about the details of how to achieve higher prices, Bain stuck to the fundamental points to make with health plans: “Marketplace Position – with the Highland Park merger, ENH now

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<sup>22</sup> There was no lack of effort by Mr. Sirabian to get better deals. Throughout the mid to late 1990s, Mr. Sirabian frequently reminded health plans that they had not increased Evanston’s rates for years, told health plans that they were below what other health plans were paying Evanston and tried to get them to renegotiate, but competition prevented Evanston from getting more. (Sirabian, Tr. 5711-6).

<sup>23</sup> Thus, while ENH attempts to pinpoint the evolution of “learning about demand” to the time of the merger with Highland Park, Evanston’s and Bain’s recognition of the underlying competitive dynamics trace back to the entire 1990s. (RPTB at 42).

commands a 55% market share.” (RX 679 at ENHL RG 004136).

Respondent implies that health plans recognized that Evanston’s pre-merger prices were “far below the marketplace” so, consistent with “learning about demand,” they were not surprised that ENH would seek price increases after the merger. (RPTB at 44). However, the price increases ENH demanded after the merger far exceeded the health plans’ expectations. (CCRFF 616 – 622). For example, { [REDACTED]

[REDACTED]

[REDACTED] } (Mendonsa, Tr. 533-4, *in camera*).

[REDACTED]

[REDACTED]

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

2. “Learning about Demand” Does Not Explain ENH’s Price Increases

The only pricing analysis that reflects price increases across all health plans was done by Complaint Counsel’s expert, Dr. Haas-Wilson.<sup>24</sup> { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr.

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<sup>24</sup> Respondent states that the “aggregate relative price increase across all payors is the appropriate way to look at the relative measure of price increases.” (RPTB at 46-47) (emphasis supplied). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (RPTB at 47; Baker, Tr. 4621, 4660-1, 4739-40, *in camera*; Haas-Wilson, Tr. 2625-6, *in camera*; CX 6279 at 18-19, *in camera*; CX 6282 at 6, *in camera*). { [REDACTED]

[REDACTED]

2500, 2580, 2633-5, *in camera*; CX 6279 at 20, *in camera*). { [REDACTED]

[REDACTED] } (RPTB at 46).

ENH asserts that Dr. Baker's { [REDACTED] } is "conservative" because it is not adjusted to account for quality improvements and the observed prices "overstate the true quality-adjusted prices for its services." (RPTB at 47). { [REDACTED]

[REDACTED] } (Baker, Tr. 4799, *in camera*). The only analysis comparing ENH's quality of care to other hospitals was conducted by Complaint Counsel's quality expert, Dr. Romano, who concluded that there was no evidence of quality improvement at ENH relative to other hospitals. (CCPTB at 67-74). { [REDACTED]

[REDACTED] } (Baker, Tr. 4799, *in camera*).

Since there is no dispute here that ENH implemented higher relative price increases after the merger, ENH attempts to provide a competitively neutral explanation. { [REDACTED]

[REDACTED]

[REDACTED] } (RPTB at 48).<sup>25</sup> { [REDACTED]

[REDACTED]

[REDACTED] } (RPTB at 48-49). As

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<sup>25</sup> Although ENH characterizes the "learning about demand" as a "sea change" to a decade-long contracting strategy, its corporate documents are remarkably silent on the event. (Hillebrand, Tr. 2050). There are no contemporaneous documents from ENH – e-mails, memos or meeting minutes – that reflect a decision by ENH to raise prices because it should no longer price itself as a "community" hospital but more like "comparable" hospitals. (Neaman, Tr. 1384-9; Hillebrand, Tr. 2050-3).

discussed below, the record in this case shows that the methodology and the results of ENH's experts are flawed and contradict the "learning about demand" defense.<sup>26</sup>

a. Dr. Noether's Flawed Control Group

Critical to the "learning about demand" explanation, and one reason it fails, is the flawed control group created by ENH's expert, Dr. Noether (and her 30-person team). In order to escape the conclusion that the merger enhanced ENH's market power, ENH tries to show that its post-merger prices "rose to, but remained below" a "competitive" level, which in turn requires establishing a "competitive" level against which to compare ENH's prices. Dr. Noether began by selecting 18 hospitals in the Chicago area and then dividing them into two control groups, what she calls the "community" hospital group and the "academic" hospital group. Dr. Noether decided that ENH should be compared to the "academic" group, which she defines as

{ [REDACTED]  
[REDACTED] } (RPTB at 49).<sup>27</sup>

First, the rules Dr. Noether used to differentiate the hospitals into two distinct groups, "community" hospitals and "academic" hospitals, are a creation of Dr. Noether, unsupported by

<sup>26</sup>

[REDACTED]  
[REDACTED] } (RPTB at 48). { [REDACTED]  
[REDACTED] } (CX 6277 at 3 { [REDACTED]  
[REDACTED] }, *in camera*). { [REDACTED]  
[REDACTED] } (CX 6277 at 3, *in camera*; Foucre, Tr. 899-902).

<sup>27</sup> In another example of the contradictions in ENH's litigation positions, except for { [REDACTED] }, none of these hospitals are in Dr. Noether's proposed geographic market of ENH's purported competitors. (RPTB at 23, 49).



any published standards;<sup>28</sup> and { [REDACTED]

[REDACTED]

[REDACTED] } (Noether, Tr. 6154-5; Haas-Wilson, Tr. 2550-1, *in camera*). The concept of an “academic” hospital is also unsupported. The Medicare Payment Advisory Commission, an advisory body to Congress, only recognizes a distinct group of hospitals called “major teaching hospitals” but Dr. Noether’s definition of an “academic” hospital does not follow MedPAC. (CCFF 1836; Noether, Tr. 6155).

*Second*, Dr. Noether’s “academic” control group is arbitrary. Dr. Noether never even considered, in her original 18 hospitals, two Chicago area hospitals that meet her own criteria of an “academic” hospital (Christ Hospital and the University of Illinois). (CCFF 1846-1853). These two facilities never even reached her list to be divided into her “academic” and “community” group. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (CCFF 1854-1906).

Importantly, { [REDACTED]

[REDACTED]

[REDACTED] } (CCFF 1854-1906; RX

1912 at 148-9, 151-2, *in camera*).<sup>29</sup>

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<sup>28</sup> PHCS, for example, recognizes three broad groups – “community,” “tertiary” and “advanced teaching.” (Ballengee, Tr. 158-9).

<sup>29</sup> Also excluded from Dr. Noether’s “community” group of hospitals, from which she selected the six hospitals for her “academic” group, are numerous hospitals mentioned in ENH documents. Included in her “academic” group are hospitals never mentioned in ENH documents. (continued...)

Third, { [REDACTED]

[REDACTED]

[REDACTED] } (CCFF 1912-1925).

{ [REDACTED]

[REDACTED]

[REDACTED] } (RX 1912 at 147, 150, *in camera*).

*Fourth*, health plans, who must evaluate which hospitals merit which prices, do not consider ENH to be of the same stature as the six hospitals selected by Dr. Noether. (Ballengee, Tr. 188-9; Neary, Tr. 621; Dorsey, Tr. 1443-5; Foucre, Tr. 935-6). { [REDACTED]

[REDACTED]

[REDACTED] }

(Haas-Wilson, Tr. 2728, *in camera*).<sup>30</sup>

b. "Learning about Demand" Does Not Explain ENH's Higher Prices

{ [REDACTED]

[REDACTED]

[REDACTED] } (RPTB at 48,

<sup>29</sup> (...continued)  
(CCFF 1822-1833).

<sup>30</sup> { [REDACTED] } (RPTB at 52). It is entirely consistent with Complaint Counsel's "bargaining theory" for ENH to be able to exercise market power with some health plans but not others. { [REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2638-42, *in camera*; Neaman, Tr. 1181-3). As Bain recognized, ENH's bargaining position with each health plan was different, and in the case of Blue Cross, ENH's "leverage" was "less than with most payors." (CX 67 at 36).

50, 53-54).<sup>31</sup> { [REDACTED]

[REDACTED]

[REDACTED] (Baker, Tr. 4710-2, 4717-8, 4734-6, 4741, *in camera*; RX 2038 at 4, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED] (Baker, Tr. 4739, *in camera*; Haas-Wilson, Tr. 2728-9, 2731-2, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED] (Baker, Tr. 4732, *in camera*; RX 2038 at 5, *in camera*).

Because this is exactly what happened according to ENH's expert's own analysis, the Court should { [REDACTED] } on the "learning about demand" explanation.

Dr. Noether's results also cast doubt on the learning about demand explanation. (RPTB at 50-51). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (RX 1912 at 147, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (RX 1912 at 20, 25, 147-9, *in camera*; Noether, Tr. 6000).

{ [REDACTED] } (CX 6277 at 3, *in camera*).

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<sup>31</sup> { [REDACTED]

[REDACTED]

[REDACTED] (RPTB at 50, 53).

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } The fact that health plans do not follow the alternative network course suggests that something more than ENH “learning about demand” and raising prices to “competitive” levels is happening here. Health plans are paying ENH above the “competitive” levels – that is, ENH is exercising market power.<sup>32</sup>

**D. ENH Successfully Increased Prices Because the Merger Increased Its Bargaining Position Vis-a-Vis Health Plans**

The evidence clearly demonstrates that the merger altered the competitive dynamics by changing the bargaining positions of ENH and health plans, thereby enhancing ENH’s market power. The testimony and documents all prove that ENH gained increased “leverage” and negotiating strength through the merger. These facts reveal one example of a simple and well-established form of competitive harm. Yet ENH misconstrues Complaint Counsel’s explanation of these data and seeks to escape liability with straw man arguments. (RPTB at 54-60).

ENH claims that Complaint Counsel must establish that Evanston and Highland Park were “close substitutes” before the merger, without defining what it means to be “close” substitutes. (RPTB 54-58). Through “selective contracting,” health plans can exclude a hospital

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[REDACTED] } (RPTB at 51-52). This fact is meaningless because each health plan’s contract with ENH started at a different price point. Moreover, ENH forgets that, as Bain once advised it, each negotiation is different because the relative bargaining position of each health plan and ENH’s “leverage” varies from health plan to health plan. (CX 67 at 36; CX 1998 at 42, 44, 46 (comparing ENH’s leverage with PHCS, Humana and Blue Cross). As a result, the fact that ENH obtained larger price increases with [REDACTED] than with smaller health plans says nothing about bargaining theory or “learning about demand.”

from its network and substitute from it to another hospital, thereby creating a powerful competitive tool with which to constrain hospital prices. (Haas-Wilson, Tr. 2470; Noether, Tr. 6189). Clearly, before the merger, Evanston and Highland Park were viable substitutes for each other in hospital networks. Health plans viewed Evanston and Highland Park as competitors for placement in their networks, and the ability to choose one or the other as an alternative to each other constrained both hospital's prices. (E.g., Ballengee, Tr. 166-7; CCPTB 24-26). Highland Park and Evanston acknowledged that competition against each other had reduced their negotiating strength with health plans. (E.g., CX 1868 at 3; CX 2 at 7; Newton, Tr. 324-6). ENH's expert, Dr. Noether, conceded the existence of pre-merger competition between Evanston and Highland Park – competition eliminated by the merger. (Noether, Tr. 6133-4).<sup>33</sup>

It was equally well-understood by health plans and ENH that the merger would change the competitive dynamics by eliminating the ability of health plans to substitute Evanston and Highland Park, thereby giving ENH greater “leverage” and negotiating strength. In their business documents and testimony, ENH and Bain emphasized the merged entity's larger market share, greater geographic scope and the consequent inability of health plans to exclude it from their networks, all of which would translate into higher prices. (CCPTB at 29-33, 43-44). As explained by Mr. Newton, ENH concluded that it was entitled to higher prices that included a “premium” because the “geographical placement” of the three hospitals in a “very concentrated community that's extremely affluent has immense influence and power with the health plans” – health plans “really needed” ENH in their networks. (Newton, Tr. 361, 364, 367).

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<sup>33</sup> This evidence renders meaningless and irrelevant Respondent's reliance on the service and size differences between Evanston and Highland Park. (RPTB at 56-58). Moreover, the fact that health plans did not have to explicitly threaten either Highland Park or Evanston only tells us that all the participants to the negotiations understood their respective bargaining positions and did not have to shout it to each other. (Ballengee, Tr. 171).

The health plan witnesses testified to the same facts. With the merger, health plans could no longer choose between networks including either Evanston or Highland Park but excluding the other. The next best alternative network, excluding ENH and relying on lower-cost hospitals with services comparable to ENH but outside the ENH geographic triangle, was not viable with customers. (CCPTB 34-43). { [REDACTED]

[REDACTED] } (Ballengee, Tr. 176-7, 194; Holt-Darcy, Tr. 1559-60, *in camera*; CX 129 at 1, *in camera*).

Contrary to Respondent's claim that health plans "rarely engage in selective contracting," (RPTB at 60), the evidence demonstrates that health plans will not hesitate to exert their ability to terminate contracts and exclude hospitals from their networks if viable substitutes exist.

(Ballengee, Tr. 155, 189-90 (PHCS excludes Ingalls Memorial Hospital and University of Chicago from network); Ballengee, Tr. 181-2 (PHCS offers to exclude Lutheran General, St. Francis, Rush North Shore and Condell from network in exchange for lower prices from ENH); Mendonsa, Tr. 543-4, 568-9, *in camera* { [REDACTED]

[REDACTED] }). One Health actually did terminate its contract when ENH demanded huge prices increases after the merger, only to lose customers and learn that an alternative network configuration without ENH was not viable. (CCFF 1101-1177).

The fact that these profit-maximizing firms (and their employer customers) acquiesced to ENH's higher prices rather than switching to lower-cost network configurations is a powerful testament to the enhanced bargaining position of ENH through the merger. It is proof of market

power and the validity of Complaint Counsel's bargaining theory of harm.<sup>34</sup>

Dr. Haas-Wilson studied the evidence and found it consistent with her bargaining theory, a theory well-founded in the economic literature and the hospital merger field. (Haas-Wilson, Tr. 2468-79). As explained by Dr. Haas-Wilson, Evanston and Highland Park did not have to be each other's "closest competitors" prior to the merger. They only needed to be competitors in some meaningful way. (Haas-Wilson, Tr. 2476). Mergers between firms that are competitors, but not necessarily the "closest" competitors, can be anticompetitive. *Swedish Match*, 131 F.Supp.2d at 168-70 (merger of largest and third-largest suppliers of chewing tobacco raised unilateral effects concern even though second-largest firm also competed in the market).<sup>35</sup>

**E. Absent the Merger, Highland Park Would Remain a Vibrant Competitor**

Relying on some ill-defined "flailing" firm defense, Respondent contends that the anticompetitive consequences of the merger are not as significant as they appear because Highland Park's purportedly "deteriorating financial condition would have significantly reduced

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<sup>34</sup> ENH claims that other hospitals are "repositioning" themselves and that there are no barriers to expansion by such hospitals. (RPTB at 58-59). The fact that other hospitals are engaging in business activities is meaningless. The critical question is whether the activities of hospitals outside the ENH geographic triangle, either labeled as "expansion" or "entry," are sufficient to constrain ENH's prices. *Chicago Bridge & Iron*, Docket No. 9300 at 31-31. The evidence clearly shows that hospitals outside the ENH geographic triangle do not constrain ENH's prices. Messrs. Neaman and Hillebrand admitted this, and health plans have not been able to constrain ENH by switching to lower-cost alternative network configurations that exclude ENH from their networks. (CCPTB at 34-44).

<sup>35</sup> ENH misplaces reliance on *Long Island Jewish Med. Ctr.* (RPTB at 60). The district court did not reject the bargaining theory as a matter of law; it denied preliminary injunction because of geographic market issues and the testimony of health plans that they could defeat an anticompetitive price increase by switching enrollees to alternative hospitals. *Long Island Jewish Med. Ctr.*, 983 F.Supp. at 144. The facts of this case demonstrate that the bargaining positions of health plans dramatically decreased as a result of the merger and that the plans could not defeat the price increases at ENH by switching to lower-cost alternative hospitals located outside the ENH geographic triangle. (CCPTB at 34-43).

its competitive significance.” (RPTB at 61). But there is no legal or factual basis to permit such rank speculation to save this anticompetitive merger.<sup>36</sup>

The *Merger Guidelines* recognize only one set of facts in which the financial condition of the acquired entity is relevant to the merger analysis – if the firm is “failing.” *Merger Guidelines* § 5.1.<sup>37</sup> Respondent concedes that it cannot satisfy a “failing” firm defense since, among other things, there is no evidence that Highland Park was on the verge of bankruptcy or that it had made unsuccessful good-faith efforts to elicit alternative offers of acquisition. (CCFF 302).

Respondent relies on a “failing” firm defense that its own cited cases describe as “probably the weakest ground of all for justifying a merger” and “certainly cannot be the primary justification” for permitting one. *Kaiser Aluminum & Chemical Corp. v. FTC*, 652 F.2d 1324, 1339, 1341 (7th Cir. 1981); *see also FTC v. University Health, Inc.*, 938 F.2d 1206, 1221 (11th Cir. 1991) (weakened firm defense will be credited “only in rare cases, when the defendant makes a substantial showing that the acquired firm’s weakness, which cannot be resolved by any competitive means, would cause that firm’s market share to reduce to a level that would

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<sup>36</sup> The speculative nature of ENH’s argument can be seen by its focus on Highland Park’s \$3 million loss in 1999 to paint negative predictions about Highland Park’s future. (RPTB at 62). Much of the loss was attributable to “one-time” costs related to the merger. The exclusion of those merger-related items would have resulted in an operating *surplus* of \$1 million. (CCFF 352-355). More importantly, the loss was viewed as so meaningless to the hospital’s overall health that it did nothing to stop Highland Park from approving plans to invest over \$100 million through 2003 to increase the hospital’s ability to compete more effectively and vigorously against other hospitals, including Evanston. (CCPTB 26-28, 81-83).

<sup>37</sup> A merger is not likely to enhance market power if: “(1) the allegedly failing firm would be unable to meet its financial obligations in the near future; (2) it would not be able to reorganize successfully under Chapter 11 of the Bankruptcy Act; (3) it has made unsuccessful good-faith efforts to elicit reasonable alternative offers of acquisition of the assets of the failing firm that would both keep its tangible and intangible assets in the relevant market and pose a less severe danger to competition than does the proposed merger; and (4) absent the acquisition, the assets of the failing firm would exit the relevant market.” *Merger Guidelines* § 5.1.



undermine the government's prima facie case"); 4 Areeda, et al., Antitrust Law ¶ 963(a)(3), at 13 (financial difficulties "are relevant only where they indicate that market shares would decline in the future and by enough to bring the merger below the threshold of presumptive illegality").

Contrary to ENH's dire characterizations (RPTB at 62-65), Highland Park's pre-merger financial condition was sound. It had more than sufficient cash and assets to cover debts (\$240 million in cash and assets v. \$120 million in long-term debt), continue operations, expand services and invest in new facilities and equipment. (CCFF 303-367). In the business judgment of its executives and Board, Highland Park had a "strong balance sheet," could remain "financially strong over the foreseeable future," and could compete effectively as a stand-alone entity for years to come. (CCPTB at 81-82). Mr. Newton added that Highland Park had a wealthy base of community support that consistently provided the hospital with the financial wherewithal to continue and expand operations. (Newton, Tr. 320-1).<sup>38</sup>

But even assuming for the sake of argument that Highland Park's financial health was questionable, the relevant question of law is whether Highland Park could have pursued an arrangement – a sale, merger or alliance – with another entity that would have resolved the financial issues without the attendant antitrust problems of this merger. *University Health*, 938

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<sup>38</sup> Although it explicitly conceded that there were no issues as to bias by Mr. Newton (Newton, Tr. 434), ENH now suggests that Mr. Newton cannot be relied upon. (RPTB at 63-64, 106-7). Mr. Newton, for 10 years, was one of four senior executives of the "executive council" that oversaw the management of Highland Park, including its negotiations with health plans, finances, quality of care, long-term strategy and daily operations. (Newton, Tr. 283-5, 289). ENH asks the Court to rely instead on Kenneth Kaufman, a financial consultant, and others. (RPTB at 63-64). However, Mr. Kaufman had previously advised Highland Park's Board that it did not have a "financial reason" to proceed with the merger, and that it had "exceptional liquidity." (Kaufman, Tr. 5840; CX 1912 at 2). Complaint Counsel submits that on witness credibility, the testimony of Highland Park's Chairman of the Board, Mr. Stearns, who was charged with overseeing its then and future financial health, trumps ENH's witnesses: "We had the financial wherewithal to sustain ourselves. There was no urgency to have an alternative [to the Evanston merger] immediately available." (CX 6305 at 4-5, 11 (Stearns, Dep.)).

F.2d at 1221; *Merger Guidelines* § 5:1. This option was clearly viable, as explained by Mr. Stearns, Highland Park's Board Chairman: Highland Park was an "attractive" candidate and without Evanston, it would have continued to explore other options. (CX 6305 at 11-12 (Stearns, Dep.); CCFF 368-372).

**F. ENH's Non-Profit Status Did Not Stop It from Exercising Market Power**

Despite undisputed evidence that it raised prices more than other hospitals after the merger, Respondent claims that its non-profit status will protect the public from anticompetitive harm. (RPTB at 65-67). This defense also does not save the merger.<sup>39</sup>

*First*, ENH waived this non-profit status defense by failing to assert it as an affirmative defense in its Second Amended Answer. Moreover, neither ENH's experts nor its fact witnesses testified that ENH's non-profit status prevented it from exercising market power after the merger and, therefore, the Court need not accord the argument any weight.

*Second*, economic studies have found that non-profit hospitals exercise market power and that the non-profit status is economically irrelevant. (CCFF 2524-2534). Consistent with the economic studies, Complaint Counsel's expert, Dr. Simpson, concluded that ENH's non-profit status did not prevent ENH from exercising market power and that ENH's management structure, just like for-profit entities, created incentives for ENH to raise prices, including awarding significant bonuses and salary increases for achieving revenue and income growth. (CCFF 2497-2523).

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<sup>39</sup> Respondent cites several trial court decisions that took into consideration the hospitals' non-profit status in the merger analysis. (RPTB at 65-66). However, Respondent fails to cite higher court decisions explicitly rejecting the notion that a hospital's non-profit status renders a merger not anticompetitive. *University Health*, 938 F.2d at 1224 ("the Supreme Court has rejected the notion that nonprofit corporations act under such a different set of incentives than for-profit corporations"); *U.S. v. Rockford Memorial Corp.*, 898 F.2d 1278, 1285 (7th Cir. 1990).

*Third*, Mr. Neaman admitted that it was “nonsensical” to link ENH’s pricing decisions to its non-profit status because “[t]here is no relationship of one to the other.” (Neaman, Tr. 1032-3). Throughout its post-merger price increase decisions, ENH never considered taking smaller price increases in order to minimize its profits. (CCFF 2500-2503). The entirety of the merger-related evidence, including ENH’s contemporaneous documents, testimony and the post-merger pricing data, shows that ENH exercised market power and that its non-profit status was utterly irrelevant. Having ignored its non-profit status in raising prices to health plans and their local customers (employers and employees) since 2000, there is no basis for the Court to embrace ENH’s promise today that its non-profit status, its “deep commitment to the community,” its “mission” or its “close ties to the community” will reduce the potential for competitive harm in the future. (RPTB at 66-67).

#### IV.

### **ENH'S "IMPROVED QUALITY OF CARE" DEFENSE DOES NOT SAVE THIS ANTICOMPETITIVE MERGER**

In assessing the "quality of care" defense, it is important to remember the legal context in which it arises. The fact of ENH's significantly higher relative price increases stands undisputed. Those price increases do not have to be adjusted to account for quality changes because there is no evidence that quality improved relative to other hospitals. As a result, ENH does not and cannot claim that the quality changes actually account for or justify the price increases.<sup>40</sup>

ENH raises the "improved quality of care" issue then not to argue that there were no anticompetitive effects, but rather to claim that the quality improvements "outweigh" the anticompetitive effects. (RPTB at 67). To prevail on this defense, ENH must show that the claimed efficiencies were of such character and magnitude that the merger is not likely to be anticompetitive in any relevant market. In other words, the efficiencies must be likely to reverse the merger's potential to harm consumers in the relevant market. *Merger Guidelines* § 4; *H.J. Heinz*, 246 F.3d at 720-2; CCPTB 11-18.

In making such a showing, ENH must prove, *inter alia*, that quality of care improved more than it did at other comparable hospitals during the same period; that the purported quality improvements were of such magnitude that the benefits to consumers outweighed any consumer harm; and that the improvements were "merger-specific," *i.e.*, that Highland Park could have

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<sup>40</sup> Both sides of the negotiations (Mr. Hillebrand for ENH and the various health plan witnesses) agreed that the purported quality changes at Highland Park were never the topic of discussion during the negotiations and that the price increases were not linked to the quality changes. (CCPTB at 76-77). That link is absent both because ENH failed to convince (or even assert to) health plans that quality, in fact, improved, and because the price increases started in 2000 but the asserted quality improvements occurred as late as 2005. (*E.g.*, Ballengee, Tr. 187-8; Foucre, Tr. 926-7; CCF 2444-2469).

achieved the improvements only through this anticompetitive merger. ENH fell far short of the “extraordinary” showing, *Heinz*, 246 F.3d at 720-21, that it would have had to make in view of the demonstrated anticompetitive effects in this case.

**A. ENH Has Not Proved that Quality of Care In Fact Improved**

Respondent first must demonstrate that there actually were significant, measurable improvements in the quality of care rendered at Highland Park. *Merger Guidelines* § 4 (the “merging firms must substantiate efficiency claims so that the Agency can verify by reasonable means the likelihood and magnitude of each asserted efficiency”); *H.J. Heinz*, 246 F.3d at 720-22 (benefits must be “quantified” and “extraordinary”). ENH must show that the improvements actually benefitted competition and consumers. *H.J. Heinz*, 246 F.3d at 720.

Complaint Counsel’s quality expert, Dr. Romano, conducted the only comprehensive and quantified analysis that measured and compared patient outcomes and patient satisfaction at ENH to other hospitals. His study showed that, by these measures, there was no evidence that ENH’s quality improved relative to other hospitals. (CCPTB at 66-75). In contrast, ENH makes the attenuated argument that it improved the structure and the process of delivering care at Highland Park, without providing any means to verify and quantify these changes, and that overall quality of care therefore must have improved. (RPTB at 67, 72-75). Even though its quality expert, Dr. Chassin, and everyone else agrees that patient outcomes are “what we all care about” (Chassin, Tr. 5153; CCRFF 2122-2132), ENH relies on qualitative assessments about such amorphous, non-verifiable, non-quantifiable intangibles as Highland Park’s medical “leadership,” “teamwork” and “culture.” (RPTB at 76, 84).<sup>41</sup>

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<sup>41</sup> ENH’s misguided criticisms of Dr. Romano’s methodology and dubious applause of Dr. Chassin’s techniques (RPTB at 99-104) are addressed at CCRFF 1196-1211, 2217-2277.

In some instances, ENH readily acknowledges that it cannot provide real, measurable evidence that quality of care improved. (*E.g.*, Wagner, Tr. 4065 (no studies on how its electronic medical record system has affected patient outcomes)). In other instances, ENH relies on anecdotal testimony regarding one or two cases that Highland Park now would handle differently than it did in the past. (*See, e.g.*, Harris, Tr. 4237). In still other instances, ENH turns to conclusory testimony that, due to the changes in the delivery of care, Highland Park might render unmeasured cost savings or better care in the future. (*See, e.g.*, Dragon, Tr. 4390; Wagner, Tr. 3988). However, ENH never quantified these benefits and, therefore, these theoretical improvements are too speculative. *See H.J. Heinz*, 246 F.3d at 721.

In the absence of any verifiable and quantified proof that consumers benefitted, ENH asks the Court to infer that there must have been some real improvements because ENH spent large sums of money to change the structure and process for the delivery of care at Highland Park. (RPTB at 86). However, Respondent's burden of proof cannot be met through an unquantified leap of faith. Changes in the structure or process for the delivery of care can be implemented for reasons divorced from the interest of consumers. In a non-profit firm like ENH, management "may want the prestige that comes from operating a hospital that is very large and very sophisticated. If you have a non-profit hospital with market power, they may get that non-profit hospital to set high prices so they can build up a surplus that would be used to fund a hospital that is larger and more sophisticated than the community needs." (Simpson, Tr. at 1623).

Moreover, there is no evidence that consumers received better outcomes or more satisfaction at ENH relative to other hospitals after the merger. For example, ENH spent \$1 million to finance a coronary artery bypass graft surgery program at Highland Park (RPTB at 93), but the benefit to consumers is questionable because the number of patients Highland Park

treated was too small to ensure optimal outcomes to its cardiac patients. (Romano, Tr. at 3022-23).<sup>42</sup> Similarly, ENH spent money to expand the Kellogg Cancer Center at Highland Park.

(RPTB at 86-88). However, { [REDACTED] }  
{ [REDACTED] } (Romano, Tr. 3097-8, *in camera*).<sup>43</sup>

**B. ENH Has Not Proved that Quality Improvements Outweigh the Harm**

ENH also failed to offer evidence demonstrating that the purported increase in quality of care at Highland Park yielded benefits to consumers that outweigh the harmful effects of the merger to consumers. In fact, on its face, ENH's argument can be rejected out of hand. ENH merely argues that it improved quality exclusively at Highland Park, but it never explains how this justifies the price increases at Evanston as well. (CCPTB at 77). As a result, there is no explanation for why health plan enrollees who use Evanston but not Highland Park should have to pay more today than before the merger when there is no claim that quality improved at Evanston, and in some important clinical areas { [REDACTED] } Evanston's quality got *worse*. (Romano, Tr. 3007).

It is insufficient for ENH simply to prove that, after the merger, it furnished a better service. Complaint Counsel documented and quantified the precise anticompetitive effects of this merger. That loss cannot be measured in any meaningful way against the unspecified, non-quantified, speculative "quality improvements" that ENH describes in general terms. As

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<sup>42</sup> And as ENH put more of its resources into this cardiac facility at Highland Park, { [REDACTED] } actually got worse at Evanston, as measured by both outcomes and processes, which correlation "increases our confidence in the truth of those findings because of the linkage between process and outcome measures." (Romano, Tr. 3007).

<sup>43</sup> That third-party organizations have credited ENH with furnishing good care does not demonstrate that quality improved at ENH in the absolute or relative to other hospitals. (RPTB at 104-106).

confirmed in each of the decisions on which it relies (RPTB at 69-71), ENH must do more than assert changes were made. It must demonstrate that the benefits of the merger outweigh the merger's anticompetitive effects.

In *U.S. v. Idaho First National Bank*, 315 F. Supp. 261 (D. Idaho 1970), for example, the court concluded that it was insufficient for the defendant to prove that the merged bank would be "a better bank with better services." *Id.* Instead, the merger was acceptable because "the better banks with better services" would "increase competition in services now provided by all banks in the community." *Id.*<sup>44</sup> Similarly, in *U.S. v. Baker Hughes, Inc.*, 908 F.2d 981 (D.C. Cir. 1990), the court reasoned that the "totality of the circumstances" must be examined to determine "the effects of particular transactions *on competition.*" *Id.* at 984 (emphasis added).<sup>45</sup>

This analysis was further endorsed in the more recent decision in *H.J. Heinz*, in which the court did not attempt to assign an intrinsic value to the product innovation, but instead examined "whether the merger is required to enable Heinz to innovate, *and thus to improve its competitive position . . . .*" 246 F.3d at 722 (emphasis added).

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<sup>44</sup> An antitrust defendant cannot argue that "competition itself is unreasonable or leads to socially undesirable results," because even in the purchase and sale of health care services, "there is no reason to believe that informed consumers will make unwise tradeoffs between quality and price." *Polygram Holdings, Inc.*, Docket No. 9298 at 31 and n.40 (FTC Decision, July 24, 2003) (citing *FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 463-4 (1986)).

<sup>45</sup> In *NCAA v. Board of Regents*, 468 U.S. 85 (1984), the NCAA's meritorious goals were not an abstract justification for the anticompetitive conduct; instead, the Court endorsed the challenged restrictions because the NCAA's conduct designed to achieve those meritorious goals had pro-competitive effects that outweighed the anticompetitive concerns. *Id.* at 114-15. In *Banks v. NCAA*, 746 F.Supp. 850 (N.D. Ind. 1990), the court endorsed the challenged NCAA's bylaws not because of their innate "wisdom" or "soundness," but because the bylaws had a pro-competitive impact that was greater than the potential anticompetitive effects. *Id.* at 862. And, in *U.S. v. Brown University*, 5 F.3d 658 (3d Cir. 1993), the court reversed the district court's decision because it had failed to assess whether the defendants' challenged conduct "merely regulate[d] competition in order to enhance it . . . ." *Id.* at 677.



Examining the impact on consumers, ENH has not demonstrated that the merger actually had a positive net impact or provided this Court with the means to make such a calculation. The health plan witnesses testified that the price increases they incurred as a result of the merger, price increases that exceeded the price increases of other hospitals, likely reduced consumers' access to healthcare. (CCPTB at 77-78). As illustrated by Aetna, smaller employers "are very susceptible to these cost increases. . . . if we needed to pass on a larger increase [in premiums] because of [increases in prices for hospital services], the big impact would be small insureds dropping coverage altogether and people not having insurance." (Mendonsa, Tr. at 483-4).

**C. ENH Cannot Prove that the Quality Improvements Are Merger Specific**

ENH must show that the purported improvements in quality of care were "merger-specific," *i.e.*, that the claimed improvements could have been achieved only through the merger. This element of the defense "is often a speculative proposition," presenting "'truly formidable' proof problems" for the merger defendant. *H.J. Heinz*, 246 F.3d at 721-722 (*quoting* 4A Areeda, *Antitrust Law* ¶ 975(g)). Unless the merged party can prove that the pro-competitive advantages are merger-specific, "the merger's asserted benefits [could] be achieved without the concomitant loss of a competitor." *Id.* at 722, *citing* 4A Areeda, ¶ 973.

Here, ENH has offered only a transparently false assumption that coincidence proves causation. ENH would have this Court conclude that because changes to Highland Park's operations occurred after the merger, those changes obviously were due to the merger. The record demonstrates, though, that Highland Park was a vibrant competitor before the merger; that it already had undertaken many of the innovations for which ENH claims credit today; that there was a national trend to improve quality of care starting around the time of the merger; and that Highland Park could have implemented the changes to its operations without this anticompetitive

merger, either alone, in partnership with another hospital or a merger with another hospital. (CCPTB at 79-83). Respondent's silence on this issue is deafening. ENH cannot show that improvement could occur only with this merger. Yet this is precisely what ENH must prove.

1. *Obstetrics and Gynecological Services*

ENHL insists that Highland Park had "major quality deficiencies," including "inadequate coverage" and "inappropriate practice patterns," in its delivery of obstetrics and gynecological services. (RPTB at 75-77). According to ENHL, these problems were "identified" in 1998 but corrections were not instituted until ENHL intervened after the merger. (RPTB at 75-76). Actually, Highland Park, at its own initiative, had invited the American College of Obstetrics and Gynecology ("ACOG") in early 1998 to conduct an on-site review of the hospital. Contrary to ENH's suggestion, Highland Park had undertaken comprehensive efforts to address every issue that ACOG had identified. (Newton, Tr. 391-93). In fact, { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr. 3155-56, *in camera*; CX 6265, *in camera*).

2. *Quality Assurance and Quality Improvement Programs*

Contrary to ENH's claims (RPTB at 77-82), Highland Park had aggressive quality assurance and quality improvement programs in place before the merger. Like ENH, Highland Park implemented and constantly improved its quality programs, to keep its operations current with cutting-edge changes throughout the country. (Newton, Tr. 331-2). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (O'Brien, Tr. 3526; Romano, Tr. 3168, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Silver, Tr. 3839; Romano, Tr. 3170-1, *in camera*). Finally, Highland Park regularly initiated disciplinary actions against its physicians, including the suspension, reduction, or removal of staff privileges. (Newton, Tr. 382-3).

### 3. *Nursing Staff*

ENH claims that Highland Park suffered pre-merger staffing problems that ENH addressed after the merger. (RPTB at 83-84).<sup>46</sup> However, prior to the merger, Highland Park had “a high quality nursing staff.” (Newton, Tr. 383). [REDACTED]

[REDACTED] } (CX 1908 at 23, *in camera*; CX 6264 at 1; Newton, Tr. 410-11).

### 4. *Physical Plant*

ENH asserts that it “poured millions of dollars” into renovations of Highland Park’s facilities. (RPTB at 85-86). ENH did not prove that these expenditures were merger-specific because right before the merger, Highland Park had budgeted approximately \$108 million in capital expenditures through 2003, \$65 million in the hospital’s baseline budget, together with another \$43 million in supplemental expenditures. (CX 545 at 3).

### 5. *Oncology Services*

ENH claims for itself the benefits of improvements in the delivery of oncology services at Highland Park through the expansion of the Kellogg Cancer Center. (RPTB at 86-88). Any claims regarding the advantages of these capital expenditures are highly speculative, inasmuch as

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<sup>46</sup> Contrary to ENH’s negative suggestion, Highland Park, like every hospital at the time, faced an industry-wide nursing shortage and lacked “available candidates” in a “volatile” labor market. (CX 6264 at 1).

the renovated care center was completed only in March of this year. (Dragon, Tr. 4390).

Before the merger, Highland Park already had undertaken numerous initiatives in this area and had a variety of options other than the merger to achieve these same ends. In the 1990s, Highland Park had created Centers of Excellence for oncology and breast cancer that it was continually improving until the time of the merger. (Newton, Tr. 291-2, 419-20). These Centers of Excellence already had access to the necessary technology, physicians, and research protocols in place to develop a comprehensive oncology program, and it merely needed to develop the community perception to provide these services. (Newton, Tr. 291-2, 419-20). To this end, Highland Park could have expanded its oncology services and research activities through an affiliation agreement with hospitals other than ENH and, in fact, it was exploring these options before the merger, including the possibility of a joint venture with ENH or another hospital for oncology services. (Newton, Tr. 340-2, 417-20; Neaman, Tr. 1243; Hillebrand, Tr. 2044).

#### 6. *Radiology Services*

ENH claims that the changes in the radiology services at HPH have improved, including the commitment of \$6.4 million to new equipment. (RPTB at 88-89). ENH fails to mention that Highland Park had a pre-merger budget of \$9.5 million to that same end. (CX 545 at 20).

#### 7. *Emergency Care*

ENH claims that it has significantly improved the emergency care rendered at Highland Park. (RPTB at 89-90). Prior to the merger, the Emergency Department at Highland Park was “very good,” and was “on par, if not better” than Highland Park’s peers. (Newton, Tr. 394-5). Throughout the 1990s, Highland Park had continually made improvements to its emergency care: it had implemented a fast-track program to improve turnaround times; it had added physician assistants to the emergency room; it had streamlined the radiology process; and it had reduced the

time that it take for a patient to receive an EKG. (Harris, Tr. 4266-70). Further, Highland Park planned to “expand the Emergency Department from a facilities standpoint.” (Newton, Tr. 394).

In fact, { [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] }

(Romano, Tr. 3111-2, *in camera*; Harris, Tr. 4204-07).

#### 8. *Laboratory Services*

ENH asserts that it made significant changes in the lab services that were furnished at Highland Park. (RPTB at 90-91). Prior to the merger, Highland Park’s joint venture for laboratory services with Lake Forest “operated actually exceptionally well,” providing Highland Park with “greater specialty in terms of some pathologists on staff.” (Newton, Tr. 395-6). The joint venture also increased the quality of the services because it afforded Highland Park’s lab “greater volume,” “access to greater human pathology,” and the “opportunity to provide a greater benchmark in terms of [the lab’s] performance.” (Newton, Tr. 396-7). { [REDACTED]  
[REDACTED] }

(Romano, Tr. 3178, *in camera*). { [REDACTED]  
[REDACTED]  
[REDACTED] } (Romano, Tr. 3179, *in camera*).

#### 9. *Pharmacy Services*

ENH highlights changes to pharmacy services at Highland Park, including the installation of Pyxis, an automated drug distribution system. (RPTB at 91-92). But the changes are no different than those implemented by Highland Park before the merger. Highland Park’s strategy

was to repeatedly implement "the latest technology to support patient care across the continuum." (CX 1868 at 12). ENH takes credit for its system when it was not until the late 1990s that there was a "trend" in which pharmaceuticals and medications were decentralized to be located on the unit itself. (Newton, Tr. 397-8). Indeed, the Pyxis system did not become available to hospitals until the late 1990s. (*Id.* at 398). Pyxis costs only about \$20,000 per machine, and { [REDACTED] } (Newton, Tr. 399; Romano, Tr. 3180, *in camera*).

#### 10. *Cardiac Surgery and Interventional Cardiology*

ENH touts the benefits of introducing cardiac surgery and interventional cardiology programs at Highland Park. (RPTB at 94-96). But there is nothing new here. ENH today runs successful joint cardiac surgery programs with Swedish Covenant and Weiss Hospital. Before the merger, Highland Park already had plans to open a cardiac surgery program with Evanston or another hospital. (Newton, Tr. 335-8; CX 1868 at 13). Highland Park and Evanston executed a contract for a joint cardiac surgery program before the merger. (Newton 335-6; CX 2094). If there had been no merger with Evanston, Highland Park was ready to pursue a joint program with Northwestern Memorial or Lutheran General. (Newton, Tr. 338).

The same is true with the interventional cardiology program. Highland Park's medical staff included physicians with the expertise to perform interventional cardiac procedures. (Newton, Tr. 466). Highland Park planned to expand the diagnostic capabilities of its existing cardiac catheterization lab and to provide emergent angioplasty in conjunction with the planned cardiac surgery program or even "without open heart on-site." (Newton, Tr. 337, 416-7).

ENH notably now excludes from its list of "improvements" heart attack care. { [REDACTED] }

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } Romano, Tr. 3212-3, *in camera*).

11. *Intensivist Program*

ENH also claims credit for the intensivist program at Highland Park. (RPTB at 96-97).

[REDACTED]

[REDACTED] } (Romano, Tr. 3113-14, *in camera*; Ankin, Tr. 5078). { [REDACTED]

[REDACTED]

[REDACTED] } (Ankin, Tr. 5104-5, *in camera*).

12. *Electronic Medical Records System*

ENH contends that it improved quality by installing "EPIC," an electronic medical records system. (RPTB at 97-99). There are a number of electronic medical records systems other than EPIC, including Meditech and McKesson. (Wagner, Tr. 4067-9). Individual hospitals have purchased EPIC as well as these competing systems. (Wagner, Tr. 4067-9).

{ [REDACTED]

[REDACTED]

[REDACTED] } (Wagner, Tr. 4069-70; Neaman, Tr. 1251; Romano, Tr. 3161-2, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3160, 3165-6, *in camera*). { [REDACTED]

[REDACTED]

(Newton, Tr. 333-34; Romano, Tr. 3165, *in camera*).

To the extent that quality of care today at Highland Park is better than 1999, the critical

question is whether this merger was necessary to attain the improvements. The answer is no. Indeed, ENH tacitly concedes this point. There is, then, quite simply *no basis* upon which the Court could conclude that this merger produced verifiable, quantifiable improvements in the quality of care that outweigh the substantial, quantified and verified harms to competition that this merger caused.

## V.

### **THIS MERGER IS LIKELY TO LESSEN COMPETITION IN THE FUTURE**

ENH misstates Complaint Counsel's case as limited to the "past" and on "past, one-time price increases" that occurred in 2000 but will not produce anticompetitive effects in the future. (RPTB at 107-108). ENH is simply incorrect. Complaint Counsel demonstrated that, beginning in 2000 and continuing thereafter, ENH repeatedly exercised its market power and increased prices to health plans, *inter alia*, by insisting that all three hospitals be paid under the more favorable pre-merger contract of either Evanston or Highland Park and then adding a "premium" on top of that; by converting contracts to discount off charges arrangements that permit ENH unilaterally to raise prices; and by continuously (sometimes twice a year) subjecting discount off charges contracts to higher prices by increasing chagemaster list prices. The contracts entered into between ENH and the health plans in 2000 remain in effect today, except that the prices have increased more with time. (CCPTB at 33-34). As a result, the anticompetitive effects of these events are in effect today and will continue until a divestiture of Highland Park is ordered.

Moreover, Complaint Counsel, through traditional market structure analysis, demonstrated that this merger has substantially lessened competition and, given the structure of the market, is likely to continue to do so in the future because the merger created a "highly concentrated" market in which it is "presumed" that the merger will illegally enhance market



power. *Merger Guidelines* § 1.51. (CCPTB 55-56).

To this day, health plans testified that they must pay ENH's higher prices because alternative network configurations that exclude ENH and rely on lower-cost hospitals located outside the ENH geographic market are not viable for local customers. (*E.g.*, Foucre, Tr. 901-2, 925-6, 931-4). One only need look at United's example to understand the continuing market power that ENH has. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (Foucre, Tr. 888, 892-3, 897, 906-9, 1085, 1091, 1093,

1096, 1103-4, *in camera*). This evidence is highly probative that the merger will continue to have future anticompetitive effects: "past performances imply an ability to continue to dominate with at least equal vigor." *U.S. v. General Dynamics Corp.*, 415 U.S. 486, 501 (1974).

ENH also mistakenly reasons that the Clayton Act, by prohibiting acquisitions that are anticompetitive "in their incipiency," applies only to transactions that demonstrably will have anticompetitive effects "in the future." (RPTB at 107-8). As the legislative history makes clear, however, the "incipiency" standard bans mergers that might even possibly be anticompetitive, rather than only those mergers with actual future anticompetitive effects. Thus, as stated in the Senate Report accompanying the 1950 amendments to the Clayton Act: "The intent here, as in other parts of the Clayton Act, is to cope with monopolistic tendencies in their incipiency and well before they have attained such effects as would justify a Sherman Act proceeding." S. Rep. 1775, 81st Cong., 2d Sess. 4-5 (June 2, 1950). And, according to the corresponding House Report, the incipiency standard makes it "unnecessary for the Government . . . to show that, as a

result of the merger, [the merged firm] had already obtained such a degree of control that it possessed the power to destroy or exclude competitors or to fix prices.” H.R. Rep. No. 1191, 81st Cong., 1st Sess. 8 (Aug. 4, 1949).

Thus, the incipency standard does not constitute a limited prohibition of only those mergers that will have demonstrable anticompetitive effects in the future. As the Supreme Court concluded in a case cited by ENH, a violation of Section 7 depends on whether a “substantial lessening of competition *occurred or was threatened* by the acquisition.” *General Dynamics*, 415 U.S. at 498 (emphasis added).<sup>47</sup>

## VI.

### THE “COPPERWELD” DEFENSE FAILS TO SAVE THIS MERGER

ENH renews its stale assertion that because of the Northwestern Healthcare Network (the “NH Network”), Evanston and Highland Park were already “one person” at the time of their merger and, therefore, not subject to Section 7 of the Clayton Act. (RPTB at 110-113). ENH’s argument draws from the holding in *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984), that a parent corporation and its subsidiary were a single entity that could not engage in an intra-company conspiracy in violation of Section 1 of the Sherman Act. (RPTB at 112).

Even if Evanston and Highland Park merged through the formation of the NH Network, their merger is subject to Section 7 review. Courts routinely entertain merger challenges that are filed a significant time after the merger occurred. *E.g., General Dynamics*, 415 U.S. 486

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<sup>47</sup> ENH is trying to hide behind its pricing policies since 2002, after the FTC opened its investigation. (CX 20 at 1). However, ENH cannot “stave off” enforcement actions “merely by refraining from aggressive or anticompetitive behavior when such a suit was threatened or pending.” *General Dynamics*, 415 U.S. at 504-05; *see Hospital Corp. of America*, 807 F.2d at 1384. This case offers textbook support for this principle: after the FTC initiated the investigation, ENH offered United a more favorable contract at the same time it asked United to voice its support for the merger to the FTC. (CX 6284 at 1-2; Foucre, Tr. 921-5, 927).

(complaint filed 8 years after merger); *E.I. duPont*, 353 U.S. at 597 (complaint filed 30 years after merger). Section 7 permits a merger challenge at “any time the acquisition threatens to ripen into a prohibited effect.” *E.I. duPont*, 353 U.S. at 597. Indeed, *Copperweld* recognized that, notwithstanding the holding regarding intra-company conspiracies, “A corporation’s initial acquisition of control will always be subject to scrutiny under . . . § 7 of the Clayton Act.” *Copperweld*, 467 U.S. at 777. Thus, Evanston’s merger with Highland Park is subject to Section 7 regardless whether it took place through the NH Network’s formation or in 2000.

That the parties may not have been required to file a Report and Notification Form pursuant to the Hart-Scott-Rodino Act does not change this conclusion. (RPTB at 111-112).<sup>48</sup> The Clayton Act makes clear that the administration of the HSR Act has no bearing on an FTC action brought under Section 7: “Any action taken by the [FTC] . . . or any failure . . . to take any action under [the HSR Act] shall not bar any proceeding or any action with respect to such acquisition at any time under any other section of this Act.” 15 U.S.C. § 18a(i).

Factually, Evanston and Highland Park do not qualify for the *Copperweld* defense. Each hospital, before the merger in 2000, remained a “separate economic actor[] pursuing separate economic interests,” and their merger “suddenly brought together economic power that was previously pursuing divergent goals.” *Copperweld*, 467 U.S. at 769. The NH Network’s organizational documents protected each member hospital’s independence, the autonomy of its

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<sup>48</sup> ENH fails to present any evidence to support its naked assertion that the Evanston-Highland Park merger was not subject to the HSR Act filing requirements. The exhibit on which it relies merely sets forth a hypothetical transaction among Hospital Network A, Hospital B and Hospital Holding Company C. (RX 586 at 1-2). The exhibit is double hearsay, and not admissible for the purpose of proving the facts asserted therein, *see* F.R.E. 801(c), such as its description of the business relationship that actually existed among the NH Network and the individual member hospitals. *See* JX 1 ¶ 5. Further, the exhibit merely sets forth the author’s expectations regarding the future conduct of the NH Network and its members, and it certainly cannot be used as evidence that the events set forth in the exhibit actually took place.

medical staff, and the autonomy of its management and financial operations, and each hospital explicitly preserved rights to withdraw from the Network and discretion to hire and fire the hospital's executives. (CX 1831 at 9, 10, 13; CX 1777 at 49-50, 72, 77).

Exercising this autonomy, the NH Network's members, including Highland Park and Evanston, kept "slicing each other up in the market" and "undercutting each other" to attract business from health plans. (CX 1768 at 3). Unlike a true subsidiary, each NH Network hospital routinely repudiated the nominal "parent" company and "operated as [an] independent" entity. (CX 6305 at 6 (Stearns, Dep.); Newton, Tr. 307); see *Copperweld*, 467 U.S. at 771.

The mechanics of this merger and the dissolution of the NH Network further confirm that Evanston and Highland Park were not a single entity controlled by the NH Network. Tellingly, the NH Network did not direct the hospitals to merge; instead, Evanston and Highland Park independently agreed to merge and gratuitously notified the NH Network of their plans. (CX 2186 at 2). Likewise, the NH Network members confirmed their independence – and repudiated *Copperweld* – when in 1999 the member hospitals voted to dissolve the NH Network rather than submit themselves to the "full control" of the NH Network. (CX 2231 at 4; CX 872 at 7; CX 1833 at 2; Neaman, Tr. 1016-17; RX 592A at ENH RS 000880; CX 6306 at 2 (Mecklenburg, Dep.); CX 6305 at 6-7 (Stearns Dep.)); see *Copperweld*, 467 U.S. at 771-72.

## VII.

### **DIVESTITURE OF HIGHLAND PARK IS REQUIRED AND APPROPRIATE**

ENH presents a multi-faceted attack on the FTC's proposed remedy to avoid having to divest Highland Park. (RPTB at 113-126). Missing from ENH's discussion of why divestiture would purportedly harm the public interest and why a lesser remedy would suffice is the very reason the Clayton Act (and courts applying it) favors divestiture: divestiture is the only remedy that will restore competition. As separate entities before the merger, Highland Park and Evanston competed for placement in the provider networks assembled by health plans and sold to local employers. (CCPTB at 21-26). That competition benefitted consumers by requiring Evanston and Highland Park to lower prices, operate more efficiently and provide better quality of care. Highland Park, as an independent hospital, was ready, willing and able to continue the competition (CCPTB at 26-28), and it is the restoration of this competitive dynamic that Complaint Counsel seeks in its proposed divestiture order.

#### **A. Divestiture Is the Appropriate Remedy**

Once liability has been decided, Section 11(b) of the Clayton Act contemplates that the Commission "shall" order a divestiture. 15 U.S.C. § 21(b). Much of the case law has "echoed this sentiment and found divestiture the most appropriate means for restoring competition lost as a consequence of a merger or acquisition." *Chicago Bridge & Iron*, Docket No. 9300 at 93.

ENH seeks an exception to the rule on a claim of "hardship." (RPTB at 114 (*citing United States v. Int'l Tel. & Tel. Corp.*, 349 F. Supp. 22, 31 (D. Conn. 1972))). But ENH does not identify the hardship in this case that would entitle it to an exception to the rule of divestiture. Moreover, in order to invoke a "hardship" claim, there must first be a remedy short of divestiture that would actually and effectively redress the violation – which ENH has failed to identify. "If

the Court concludes that other measures will not be effective to redress a violation, and that complete divestiture is a necessary element of effective relief, the Government cannot be denied the latter remedy because economic hardship, however severe, may result.” *E.I. du Pont*, 366 U.S. at 327. There is no remedy other than divestiture that would as effectively restore the competition lost through the merger, and ENH’s hardship claim is therefore irrelevant.

**B. ENH Has the Burden to Prove that Divestiture Should Not Be Ordered**

Contrary to ENH’s assertion (RPTB at 114-115), it is ENH who bears the burden of proving that a remedy short of divestiture is appropriate: the “burden rests with respondent to demonstrate that a remedy other than full divestiture would adequately redress any violation which is found.” *Fruehauf Corp.*, 90 F.T.C. 891, 892 (1977) (emphasis added). ENH must come forth with “clear and convincing” evidence that something short of divestiture is more appropriate. *Diamond Alkali Co.*, 72 F.T.C. 700, 742 (1967). ENH has failed to come forward with any legitimate proof that a non-divestiture remedy would be equally effective as divestiture, and the record shows that such evidence simply does not exist.<sup>49</sup>

**C. ENH Failed to Prove that Divestiture Is Not the Appropriate Remedy**

ENH offers a host of reasons as to why divestiture would not be in the public interest, all of which amount to nothing more than unfounded speculation. (RPTB at 116-123).

1. *Divestiture Will Benefit Consumers*

ENH contends that divestiture will harm the community by eliminating or threatening a number of quality of care improvements at Highland Park. (RPTB at 116-20). Contrary to ENH’s contentions, divestiture of Highland Park will benefit consumers, not harm them.

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<sup>49</sup> ENH misplaces reliance on *U.S. v. Crowell, Collier & MacMillan, Inc.*, 361 F. Supp. 983, 991 (S.D.N.Y. 1973) because that case addressed only the issue of liability and had nothing to do with remedy.

Evaluation of a merger remedy begins with the basic premise that the merger violated Section 7, which is to say that anticompetitive harm has occurred (or is likely to occur) and that the Court has already found that quality improvements (1) did not occur or were not significant, (2) did not outweigh the anticompetitive harm created by the merger, and (3) that Highland Park, on its own or with another person, would have achieved substantially the same quality improvements. Thus, it logically follows that even if a divestiture were to erode *all* of the alleged quality improvements at Highland Park, divestiture could not, on balance, harm consumers because the divestiture would also be expected to eliminate the anticompetitive harm that *exceeded* the quality benefits.<sup>50</sup>

2. *Divestiture Will Not Erode Quality of Care at Highland Park*

Contrary to ENH's hyperbole (RPTB at 116-120), quality of care at Highland Park will not diminish as a result of the divestiture. ENH provides no valid reason to believe that an acquirer of Highland Park (1) would not continue cardiac surgery at Highland Park, (2) would not pursue its own EPIC license after divestiture, or (3) that the management of Highland Park would deteriorate after divestiture.<sup>51</sup>

Well before they agreed to merge, Highland Park and Evanston, in April of 1999, signed an agreement to develop a joint cardiac surgery program at Highland Park. (Rosengart, Tr. 4527-30, 4557-8; CX 2094). This agreement is an asset that the acquirer will have the right to enforce and keep in place at Highland Park after the divestiture.<sup>52</sup> { [REDACTED]

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<sup>50</sup> There is no evidence that the true costs of a divestiture (aside from the liability considerations) would off-set this expected net gain to consumers.

<sup>51</sup> Divestiture would not have a significant impact in other areas where ENH alleges post-merger quality improvements at Highland Park. (See CCFF 2567-2580).

<sup>52</sup> Pursuant to CCPO ¶ II.A,C,E, ENH would be obligated to divest these rights to an

(continued...)

[REDACTED] } (Romano, Tr. 3060, *in camera*).

[REDACTED] } (Romano, Tr. 3193, *in camera*).<sup>53</sup>

ENH currently operates a joint cardiac surgery program with Swedish Covenant and Weiss Memorial, each pursuant to an affiliation agreement. (See CCFF 2363-2372). Mr. Newton, who today runs Swedish Covenant, testified that the arrangement is “exceeding its quality parameters,” and ENH is comfortable with the results from the Weiss Memorial program to continue participation in it. (Newton, Tr. 424; Rosengart, Tr. 4502-4).

It is also likely that an acquirer of Highland Park would retain the EPIC computer system now used by ENH in all of its hospitals.<sup>54</sup> Complaint Counsel’s Proposed Order requires ENH to provide transitional services to the acquirer for 12 months, including services to allow the acquirer to obtain and implement its own computer system, and requires ENH to grant a non-exclusive license to the acquirer to give it access to EPIC until the acquirer can obtain its own license (if it so chooses). (CCPO ¶ II.G. and ¶ II.D.).<sup>55</sup>

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<sup>52</sup> (...continued)

acquirer who could then continue to practice cardiac surgery pursuant to that affiliation agreement. It is likely that an acquirer would elect to simply continue providing cardiac surgery as it is done today. Because cardiac surgery is likely to be retained, any other alleged benefits flowing from its existence, such as interventional cardiology, heart attack care, intensive care, and nursing would also be retained by the post-divestiture Highland Park.

<sup>53</sup> If Highland Park is divested, the new operating room suite, the equipment used in cardiac surgery, and the clinical protocols all would remain in place at Highland Park. (Rosengart, Tr. 4558-60; Complaint Counsel’s Proposed Order (“CCPO”) ¶¶ I.O., II.A.).

<sup>54</sup> [REDACTED] } (Romano, Tr. 3197, *in camera*).

<sup>55</sup> ENH provides no evidence to show what the EPIC license itself costs (that is, the license  
(continued...))



ENH's rhetoric aside, there is no reason to credit the new Highland Park with inferior management that will permit quality of care to slide.<sup>56</sup> Before the merger, Highland Park had appropriate committee structures in place to look at quality issues, peer review issues, and risk management activities, and took disciplinary actions when necessary and sought outside advice when appropriate. (CCFF 2210-26). { [REDACTED]

[REDACTED]

[REDACTED] } (See, e.g., Silver, Tr. 3848-50, 3864; Romano, Tr. 3196-97, *in camera*). To assure continuity of management at Highland Park, Complaint Counsel's Proposed Order requires ENH to cooperate, and not interfere, with an acquirer to hire key personnel from among ENH's ranks. (CCPO ¶ II.H).

Nor would a divestiture necessarily cut off Highland Park's academic related contacts with ENH. ENH cites no reason why doctors would lose their incentive to continue their professional development at Northwestern Memorial or other hospitals. To the extent that there would be information sharing concerns that would make interaction less beneficial, and those concerns could not be resolved contractually, it is doubtful that any lost integration would be particularly detrimental. An important underlying fact is that { [REDACTED]

[REDACTED]

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<sup>55</sup> (...continued)  
only, not counting other installation and training costs). Thus, ENH cannot argue that it would be too expensive for an acquirer to obtain its own license. (RPTB at 119-120).

<sup>56</sup> The new management at Highland Park may even outperform ENH's current management. { [REDACTED]  
[REDACTED]  
[REDACTED] }  
(See CCFF 1439, *in camera*; 2205, *in camera*, 2230-31; Silver, Tr. 3931-32, *in camera*).

[REDACTED] } (Romano, Tr. 3118, 3123-5, 3218-22, *in camera*).<sup>57</sup>

3. *Divestiture Can Be Expected to Restore Competition*

ENH further speculates that divestiture will not significantly increase competition because, among other things, ENH will not “forget” what it has learned about demand for its services among health plans. (RPTB at 121-123). ENH again confounds liability with remedy. In finding a Section 7 violation, the Court will have found that the merger enhanced ENH’s market power and the cause of ENH’s significantly higher relative price increases was market power rather than “learning about demand.” If “learning about demand” did not explain the price increases in the first place when considering liability, it cannot explain the continuation of those price increases for remedy purposes.<sup>58</sup>

The health plan witnesses testified that having Highland Park as an independent entity gave them a valuable alternative with which to restrain Evanston’s prices. (CCPTB at 21-28). Evanston may not be able to forget what it has learned, but the restoration of the competitive dynamics that existed before the merger would likely prevent Evanston from predicated anticompetitive pricing on that knowledge. Health plans will tell Evanston that it is not entitled to the prices of major teaching hospitals (CCPTB at 62), and if Evanston persists, health plans will then be able to turn to the new Highland Park and other hospitals offering services

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<sup>57</sup> ENH claims that the loss of access to clinical protocols would deprive Highland Park of access to subspecialists with knowledge of clinical advancements. (RPTB at 117). It is unlikely that divestiture would effect the use and development of such protocols. { [REDACTED]

[REDACTED] } (Romano, Tr. 3170-71, *in camera*).

<sup>58</sup> ENH also argues that divestiture would not restore competition because before the merger Evanston and Highland Park were not “close” competitors. (RPTB at 120-121). Again, this contention only denies liability and is therefore irrelevant to remedy, and is factually incorrect.

comparable to Evanston.

ENH adds that it would be unfair for the Court to order divestiture given that the Complaint was filed more than four years after the merger and that ENH improved quality at Highland Park. (RPTB at 122). ENH cites no case law to support this position and is again simply arguing the liability issue. As discussed earlier, there is no time-limit on the FTC's ability to commence an antitrust challenge to a merger or order a divestiture if the merger is illegal. *Chicago Bridge & Iron*, Docket No. 9300.

ENH also seeks to shift the burden of showing that divestiture is appropriate onto Complaint Counsel by claiming that Highland Park cannot survive on its own or find buyers. (RPTB at 122-123). Not only is the burden on ENH, but the evidence contradicts ENH's assertions. Prior to the merger, Highland Park was in fact financially sound. (CCFF 302-367). Moreover, Neele Stearns, Highland Park's Chairman of the Board prior to the merger, testified that Highland Park was an attractive candidate for other mergers. (CCFF 368-372). Evanston wanted to merge with Highland Park in part because it was afraid someone else would acquire it. (CCPTB at 31). ENH offers no evidence proving that anything has changed.

**D. ENH's Proposed Alternative Remedies Are Inadequate**

ENH offers two alternative remedies that it claims are more appropriate than divestiture. Neither option, however, would effectively remedy a Section 7 violation. Relief in an antitrust case must be effective to redress the violations and to restore competition. *Ford Motor Co. v. U.S.*, 405 U.S. 562, 573 (1972); *E.I. du Pont*, 366 U.S. at 326. The Commission itself has reiterated that the purpose of relief in Section 7 cases is to "undo the probable anticompetitive effects of the unlawful merger, to restore competition to the state in which it existed at the time of the merger, or to the state in which it would be existing at the time relief is ordered." *Retail*

*Credit Co.*, 92 F.T.C. 1, 161(1978); *see also Olin Corporation*, 113 F.T.C. 400, 619 (1990); *Ekco Products Co.*, 65 F.T.C. 1163, 1216-7 (1964). It is against this standard, then, that ENH's proposed alternative remedies must be measured.

ENH first suggests that a "prior notice" order would be appropriate in this case (Respondent's Proposed Order A). Such an order would obligate ENH to notify the Commission before acquiring any other hospitals in the relevant geographic market. (RPTB at 124-25). ENH does not explain how giving notice to the FTC for future acquisitions solves the problem of the anticompetitive effects of this merger.

ENH's rationale for the prior notice remedy is that any Section 7 violation occurred immediately after the merger and was subsequently cured by quality improvements made by ENH after the merger. (RPTB at 124). This rationale, however, again confuses liability with remedy. Section 7 liability means that the anticompetitive effects of the merger outweighed any pro-competitive benefits. Among other things, this means that the Court found that quality improvements either did not occur or were not significant enough to avoid Section 7 liability. Because the alleged quality improvements would have been considered in determining liability in the first place, it is not possible that quality improvements could "cure" a Section 7 violation. ENH is simply denying liability when, for the sake of argument on remedy, liability must be presumed. ENH's "prior notice" proposal therefore not only fails to achieve the purpose of a merger remedy, but *it does not even address* that purpose.

ENH alternatively suggests that an appropriate order would be one that requires Evanston and Highland Park to negotiate and maintain separate contracts with health plans. (RPTB at 125-126). It is inconceivable that negotiation of separate hospital contracts without divestiture would restore competition to its pre-merger state or to the state in which it would be existing at the time

relief is ordered. This proposal does nothing more than divide managed care contracting responsibilities among employees of the same firm.

ENH asserts that there are hospital systems in the Chicago area with multiple hospitals and separate contracts for each hospital, but it is sheer speculation to conclude that requiring the same of Evanston and Highland Park will restore competition. Nothing here demonstrates that separate contracting practices will actually transform a non-competitive market into a competitive one. Separate contracting could just as well be viewed as a consequence of competition, rather than as a means of restoring it.<sup>59</sup>

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<sup>59</sup> Any attempt to create two independent decision-making competitors out of ENH without divestiture would require implementation of a complex injunctive remedy. As the Supreme Court noted in *E.I. du Pont*, the “public interest should not . . . be required to depend upon the often cumbersome and time-consuming injunctive remedy.” *E.I. du Pont*, 366 U.S. at 333-34.

## **CONCLUSION**

Respondent has presented a series of false and misleading statements of law and facts that it hopes will distort the Court's understanding of the true effects of this merger. But facts are stubborn and legal rules are strict. The record in this case plainly and unmistakably documents a series of anticompetitive price increases imposed by ENH on health plans and their customers as a result of this merger. Confronted with those stark record facts, ENH asserts that these anticompetitive effects were "outweighed" by increases in "quality of care" at Highland Park (but not Evanston). These assertions, however, are insufficient as a matter of law to justify the merger because Respondent has failed to come forth with credible proof that this merger was the only way to make quality changes at Highland Park, that the changes truly improved quality of care for consumers and that the benefits of the changes truly outweigh the harm. For these reasons, Complaint Counsel respectfully submits that the only way to undo the harm and restore competition is to order ENH to divest Highland Park.

Respectfully submitted,

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July 1, 2005

**CERTIFICATE OF SERVICE.**

I hereby certify that on July 1, 2005, I caused the attached "Complaint Counsel's Post-Trial Reply Brief" to be served upon the persons identified below and in the manner indicated:

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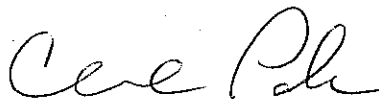
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