
**UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION**

In the Matter of

EVANSTON NORTHWESTERN HEALTHCARE CORP.

Docket No. 9315

**ANSWERING AND CROSS-APPEAL BRIEF OF
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The following abbreviations and citation are used:

F	–	Administrative Law Judge’s Findings of Fact
ID	–	Administrative Law Judge’s Initial Decision
ALJ	–	Administrative Law Judge
CX	–	Complaint Counsel Exhibit
RX	–	Respondents’ Exhibits
JX	–	Joint Exhibit
Tr.	–	Transcript of Testimony before the Administrative Law Judge
Dep.	–	Transcript of Deposition
CCB	–	Complaint Counsel’s Post Hearing Brief
CCRB	–	Complaint Counsel’s Post Hearing Reply Brief
CCFF	–	Complaint Counsel’s Proposed Findings of Fact
CCRFF	–	Complaint Counsel’s Response to Respondents’ Proposed Findings of Fact
RB	–	Respondents’ Post Hearing Brief
RRB	–	Respondents’ Post Hearing Reply Brief
RAB	–	Respondents’ Appeal Brief
RFF	–	Respondents’ Proposed Findings of Fact
RRFF	–	Respondents’ Response to Complaint Counsel’s Proposed Findings of Fact

**Text appearing in bold font and bracketed {} contains *in camera* protected information.

I. Introduction

Complaint Counsel challenges the 2000 merger between Evanston Hospital and Highland Park Hospital, which Chief ALJ McGuire found violated Section 7 of the Clayton Act and ordered divestiture of Highland Park.¹ There is no dispute concerning what happened following the merger. ENH raised the prices it charged managed care organizations (“MCOs”), and the economic experts for both Complaint Counsel and Respondents agreed that those prices increased by more than the price increases of the other groups of hospitals in the Chicago area studied by either sides’ experts. F 474, 688-90; ID at 168. Respondents’ economic expert calculated that inpatient prices increased at ENH by 9 to 10 percentage points more than at other Chicago area hospitals, and Complaint Counsel’s economic expert calculated an increase of 11 to 18 percentage points more than at other Chicago area hospitals.² ID at 2.

The dispute in this case is not whether, after the merger, ENH raised its prices, but what caused those price increases. Complaint Counsel contends, looking at the totality of the

¹ “Evanston” or “Evanston Hospital” refers to the premerger Evanston Northwestern Healthcare entity which includes the Evanston facility and the Glenbrook facility. F 1-13. “Highland Park” refers to the pre- and post-merger Highland Park Hospital facility as well as its parent, Lakeland Health Services. F 18-25. “ENH” refers to the post-merger system encompassing all three hospital facilities.

² Thus, if prices at Chicago hospitals on average increased by 20% in the period examined by Dr. Baker, Respondents’ expert, the prices at ENH increased by between 20+9% and 20+10%, *i.e.* 29 to 30%. This estimate is based on only four MCOs and is biased. ID at 168. Dr. Haas-Wilson, Complaint Counsel’s expert, used the Universal Dataset from the Illinois Department of Public Health which included all MCOs, and estimated, using multiple regression, that, after controlling for other things that affected hospital pricing, the price increase at ENH was [REDACTED] CCF 643-51. Compare either Respondents’ expert’s estimates or Dr. Haas-Wilson’s estimates to the five percent price increase typically used in the *Merger Guidelines* to test whether a product and a geographic market constitutes a relevant market in which a hypothetical profit-maximizing monopolist would profitably impose a price increase.

evidence, that the merged firm's post-merger prices increased because, as a consequence of the merger, ENH obtained and exercised market power. CCB at 47-49. Complaint Counsel, through its expert, Dr. Deborah Haas-Wilson, a Professor at Smith College, sets forth an economic model, based on bargaining theory, that explained why this merger could give ENH market power. Haas-Wilson Tr. 2468-74. Complaint Counsel also introduced Respondents' contemporaneous business documents and testimony from ENH's customers (*i.e.*, MCOs) of their actual experiences in negotiating with ENH and reacting to the price increases. *See infra* pp 22 to 31. Finally, Dr. Haas-Wilson explained why she concluded that the price increases at ENH were a result of market power attained through the merger with Highland Park. F 697-755; CCFF 741-45, *in camera*. The economic model, the business documents, the MCOs' testimony, and the analyses of pricing data all pointed consistently to the same conclusion: post-merger market power caused those price increases.

Respondents put forth two alternative explanations for the price increases, a "knowledge increase" at ENH, which Respondents have styled "learning about demand," and a quality of service increase at Highland Park. RAB 48-53, 68-84. After the merger, ENH increased the prices at both Highland Park and Evanston Hospital. F 473-74, 688-90; ID at 160-69. By the very terms of Respondents' alternative explanations, however, each explanation potentially applied to only one of the two hospitals. Evanston allegedly "learned about demand" because it learned how successful Highland Park had been in contracting premerger. ID at 170-71. Because Highland Park already knew how "successful" Highland Park had been, "learning about

demand” could, if proved, justify or explain increased prices only at Evanston Hospital.³ Any proven quality increase at Highland Park could explain increased prices only at Highland Park, not Evanston Hospital. ID at 171-72. While Complaint Counsel believes that the evidence is inconsistent with both proffered explanations for the price increase, if the Commission finds that either justification is not supported by the facts, it must conclude that the price increase at one of the two hospitals was the result of the exercise of market power obtained through the merger.

Moreover, Respondents’ explanations are after-the-fact rationalizations, unconfirmed by any contemporaneous business documents or the experiences of ENH’s customers. They are also unsupported by the data.

In the “learning about demand” explanation of the price increase, Respondents put forth an explanation that is anchored to an unsupported proposition. The unsupported proposition is that ENH was comparable to the most expensive teaching hospitals in the Chicago area, and that so long as its prices were below the prices at those hospitals, ENH was not exercising market power. RAB at 53-55, *in camera*. This proposition is wrong because the appropriate way to test for an increase in market power from a merger is to test relative price changes after the merger, not to look at the relative absolute price levels at a particular time. F 476-77; Haas-Wilson, Tr. 2492-93, 95. Second, the proposition is inconsistent with the evidence because ENH was not comparable to the major teaching hospitals used by the Respondents’ experts as a comparison

³ It is interesting to juxtapose Respondents’ claim that by looking at Highland Park, Evanston Hospital could learn how to negotiate successfully, with Respondents’ claim that Highland Park was a poorly run, “flailing” firm. *See* RAB at 63-65.

group.⁴ F 801-30; ID at 173-74; CCF 1927-32 (PHCS), 1933-38 (One Health), 1939-40 (United). Finally, if one accepts the Respondents' proposition as correct, ENH increased prices to some MCOs beyond what the expensive teaching institutions were charging, refuting the claim that ENH had no market power.⁵

To prove the quality increase at Highland Park, Respondents presented only anecdotal evidence. RAB at 68-81. Complaint Counsel's expert, Dr. Patrick Romano, used the most modern and scientific statistical techniques to analyze the quality of patient care at ENH following the merger and found virtually no increases in quality relative to other hospitals. Respondents offer no quantitative analysis of the change in quality to rebut Dr. Romano and no metric for comparing the alleged quality changes to the post-merger price increases to determine whether consumers were better or worse off after the merger. CCB at 66-68. However, unless the quality of care increased at Highland Park more than at other hospitals, the real quality-adjusted price at ENH increased relative to other hospitals, and consumers therefore obtained no benefit from ENH's higher prices, while suffering a plain reduction in consumer welfare. Unless

⁴ There are other reasons not to credit "learning about demand." See Section IV. A. *infra*.

⁵ This fact led to one of the Respondents' experts, Dr. Jonathan Baker, to submit a second expert report stating new opinions. In his original report, Dr. Baker incorrectly calculated the price comparison between ENH and the comparison group of hospitals and concluded that the post-merger ENH prices to MCOs were below the prices charged by hospitals in his comparison group. Dr. Baker concluded that ENH's prices were therefore consistent with "learning about demand." Complaint Counsel's rebuttal expert Dr. Orley Ashenfelter, found Dr. Baker's error, after which, Dr. Baker corrected his calculations. In his second report, Dr. Baker admitted that for ██████████ MCOs, ENH's ██████████ the prices charged by hospitals in his control group. Dr. Baker then concluded that it no longer mattered if some of ENH's ██████████ his control group hospital prices. In his opinion, ENH's prices were still consistent with "learning about demand." For a fuller description of Dr. Baker's multiple expert reports See CCF 1742-62, *in camera*.

Respondents can show that the value of a quality increase at Highland Park fully reversed the consumer injury from higher prices, the post-merger price increase reduced consumer welfare, and the merger should be condemned under Section 7.

Finally, in their brief to this Commission, Respondents strive to make this a case about market definition and market share calculation, and rely on cases that examine prospective mergers or mergers that are challenged before there is evidence of actual competitive effects. This case is not an instance where one must define markets and calculate market shares in order to predict whether the merger is likely to have an adverse impact on consumers. In this case, Complaint Counsel accepted the burden of proving actual competitive effects from the merger, rather than simply predicting what would happen in the future. Complaint Counsel documented what actually happened to show that there were actual, quantified anticompetitive effects from the merger. ID at 166-69. Thus, market definition that follows the formal model set forth in the *Merger Guidelines* for predicting competitive effects of prospective mergers is not needed in this case.

II. Statement of Facts

A. The Merger and Its Aftermath

In January 2000, Evanston Hospital (which already owned Glenbrook Hospital), merged with Highland Park to form a three-hospital system in the North Shore region of the Chicago area, which includes the communities along Lake Michigan north of Chicago. F 1-28, 78-86. The locations of the three ENH hospitals form a geographic triangle that contains no other hospitals. F 93, 339; CCF 54, 55. The North Shore region is heavily populated by some of the

most affluent communities in the Chicago region as well as the senior executives and decision-makers of the major MCO customers. F 227; CCF 50, *in camera*. Before the merger, Evanston and Highland Park both served patients living in the North Shore region between the two hospitals. CCF 47, 1102; Neary, Tr. 601-02.

With the merger, ENH demanded and obtained large price increases from its MCO customers. Beginning in late 1999, right before the merger closed, and continuing into 2000, ENH required MCOs to renegotiate their contracts and pay higher prices. *See, e.g.*, F 410 (PHCS), 421 (One Health); CCF 756 (United). The price increases were large in absolute terms and significantly larger than the contemporaneous price increases of other hospitals in the Chicago area. F 583, 610; CCF 392-579, *in camera*. In addition to increasing prices, ENH changed the basis of its pricing to many MCOs, converting numerous contracts from fixed rate contracts to discount-off-charges arrangements. F 373. With discount-off-charges arrangements, the price an MCO pays increases as the hospital unilaterally increases its own list prices. F 375. Because the MCO has no control over the hospital's setting of list prices, this allowed ENH to increase prices further in subsequent years. F 385-91.

B. Background of Industry

For most insured individuals who are not covered by government health insurance programs, healthcare costs are covered by managed care plans operated by MCOs and obtained through employers. Under managed care plans, members are given financial incentives to use hospitals (and other healthcare providers) that are in the managed care plan's "network."⁶ The

⁶ Depending upon the rules of their plan, members get reduced or no insurance coverage if they use a provider not in the network. CCF 214; Haas-Wilson, Tr. 2461-62.

network includes the hospitals and other healthcare providers who contract with the MCO to provide medical services to the MCO's members at agreed upon prices. F 106-10.

MCOs "selectively contract," that is contract with only a subset of the hospitals in a geographic area. F 158, 160, 163. Selective contracting introduces price competition into markets for hospital services. F 158-62. The MCO is the customer of the hospital, selecting the hospitals to be included in the network and negotiating prices with the hospitals.⁷ F 107; Haas-Wilson, Tr. 2456-57. Employers who offer health insurance and the members of the health plans are customers of the MCOs. F 111-12, 119-20.

Hospitals and MCOs negotiate the prices the hospitals charge the MCOs. F 107; Haas-Wilson, Tr. 2456-58. The relative negotiating or bargaining strength of the parties depends on how important it is to each party to reach an agreement with the other. CCFF 199. The more important it is for either side to obtain the contract, the weaker that party's bargaining strength. F 161; CCFF 201-202, 207-208; Haas-Wilson, Tr. 2470-72.

In negotiations with hospitals, MCOs have two, often conflicting goals: achieving low prices and achieving broad network coverage. F 117; CCFF 211-213; Haas-Wilson, Tr. 2461-62. The employers who arrange for health insurance and the employees who use it want low prices, but they also want broad network coverage. CCFF 219-44. By restricting the number of

⁷ Managed care plans differ from indemnity insurance plans, the predominant form of insurance into the 1980's. F 153. Indemnity insurance plans reimbursed members for whatever services the members received, from whichever doctor or healthcare facility the members went to, paying a usual and customary price. F 155; Haas-Wilson, Tr. 2465-66. Managed care plans try to manage the cost of healthcare by, among other tools, selecting the medical care providers that their members use and contracting with those providers for predetermined discount prices. F 158-62; Haas-Wilson, Tr. 2457-60. Under indemnity insurance the customer of the hospital is the patient. Haas-Wilson, Tr. 2466.

providers in its network (or credibly threatening to do so), an MCO may be able to get lower prices, but at the cost of a narrower network. Haas-Wilson, Tr. 2461-62. Selecting the right combination of hospitals to achieve an attractive combination of low cost and broad coverage is the business of the MCOs. CCB at 21-24. As a One Health representative explained, the “only way” that One Health can “stay in business” is to provide “the right number of hospitals, the right level of care, [and] the right number of physicians” to its members. Dorsey, Tr. 1451; CCFF 236.

C. Attempts by Evanston and Highland Park to Consolidate Bargaining Power before the Merger

Over the years, Evanston and Highland Park repeatedly attempted to thwart MCOs’ ability to bargain for lower prices. ID at 156-58. In 1989, Evanston and Highland Park, along with seven other Chicago hospitals, formed the Northwestern Healthcare Network (“NHN”). F 35. The members of NHN attempted to increase their bargaining power versus healthcare plans by negotiating jointly and combining the bargaining strength of the individual members to extract higher prices. CCFF 1536. “Better pricing” for hospitals was the explicit goal. ID at 156; CX 1802 at 2-3. The members, however, would not give up individual autonomy in contracting, and voted to dissolve the network in 1999. F 75-76; CCFF 1536, 1564.

Next, in 1996, Evanston, Highland Park and Northwest Community Hospital explored the possibility of creating a sub-regional merger, Northwestern Healthcare-North (“NH-North”). CCFF 1565-66. Among the goals for NH-North was to “increase market leverage” and get better contracts through negotiating as one entity. CX 394 at 3; CCFF 1568-71. Ultimately, the discussions never resulted in a completed merger. CCFF 1578.

D. Evanston and Highland Park Merger

Finally, Evanston and Highland Park entered into bilateral merger discussions in late 1998. CCFF 1579. Although more telling proof that the merger conferred market power on ENH lies in its post-merger pricing, the contemporaneous evidence from the merger discussions reveals Respondents' own assessment of the competitive effects of the merger. ID at 156-58. At a January 4, 1999, meeting between Evanston and Highland Park leaders, the merger was identified as an opportunity to "strengthen negotiation capability with [MCOs] through merged entities." CX 1 at 3; F 332. Later, it was described by an Evanston representative as "an opportunity to join forces and grow together rather than compete with each other." CX 2 at 7; F 333; *see also* CX 1879 at 3-4 ("Stop competing with each other"); CX 4 at 1.

Highland Park management saw that a merger with Evanston would build "negotiating strength with payers." CX 1869 at 7; F 340. Mr. Spaeth, then Highland Park's CEO, reported that "[t]here are ways to at least I think to push back on the managed care phenomenon and get the rates back where they ought to be if you are a big enough concerted enough entity which is important enough to the employers in this community." CX 4 at 2; F 343. Mr. Spaeth continued, "I think it would be real tough for any of the Fortune 40 companies in this area whose CEOs either use this place or that place to walk from Evanston, Highland Park, Glenbrook, and 1700 of their doctors." CX 4 at 2; F 343.

In August 1999, Evanston retained Bain & Co. ("Bain") to advise on contracting strategy with MCOs in light of the pending Highland Park merger.⁸ CCFF 1515. Bain advised Evanston

⁸ Bain had previously worked for Evanston on the NHN and NH-North projects. F 33; CCFF 1548-51, 1572-77.

that the “merger provides the opportunity to . . . negotiate contracts with payors from a stronger position.” CX 2072 at 1; CX 74 at 15, 19, 22; CCFF 1516-30. For example, for the PHCS negotiations in early 2000, Bain concluded that with “over 30%” of PHCS’ North Shore admissions going to the three ENH hospitals, ENH could negotiate better terms because “ENH has significant leverage in negotiations with PHCS as they have strong North Shore presence and need [ENH] in their network.” CX 1998 at 44; CX 67 at 39; CCFF 1527-28.

E. Post-Merger Negotiations

Immediately after closing the deal, ENH raised prices to MCOs, successfully negotiating prices above the premerger prices of either hospital for numerous MCOs. ID at 160-64. The demands for increased prices were unprecedented. CCFF 1006 (United), *in camera*; CCFF 1093 (PHCS); CCFF 1119 (One Health), *in camera*; CCFF1215 (Aetna), *in camera*; CCFF 1257 (Unicare), *in camera*. The MCOs acquiesced to the demands because they had no viable alternatives. F 392-456. One MCO, One Health, attempted to drop ENH from its network in July, 2000, because of the high prices demanded by ENH. CCFF 1121, 1141, 1144. However, One Health’s customers immediately began to complain about the loss of ENH, and One Health began losing customers. F 427-28. Six months later, One Health returned to the negotiating table and acceded to ENH’s price increase demands. F 430-31, 432-33, *in camera*. Its bid to create a network without the ENH facilities failed.

The price increases were implemented in a series of steps in 2000. ID at 158-60. First, ENH required each MCO to pay for all services at ENH hospitals under the terms of whichever

hospital, Evanston or Highland Park, had higher prices in its premerger contract.⁹ F 358-59, 364, 367. Second, ENH demanded that the contracts themselves be renegotiated at higher prices, a process described as taking “the better of the Highland Park or Evanston [contract rate] and then add[ing] a premium to that.” Newton, Tr. 364; F 367. ENH successfully negotiated prices above the premerger rates of either system for numerous MCOs. F 369. Third, ENH converted numerous contracts from fixed rates (per diem or per case) to discount-off-charges arrangements. F 373. A discount-off-charge arrangement is one in which the price paid by the MCO is a percentage of the list price for the service as reflected in the hospital’s list of prices, referred to as a “chargemaster.” MCOs generally disfavor discount-off-charges arrangements because the hospital retains unilateral pricing power to raise the “charges,” the prices in its chargemaster, increasing the prices the MCO must pay. CCF 798-803, *in camera*, 804-05; F 374.¹⁰ Except for losing One Health for a short period of time, ENH lost no MCO customers over the course of the 2000 negotiations. F 372.

Having converted numerous contracts to more favorable (for ENH) discount-off-charges arrangements, ENH later instituted substantial increases in its chargemaster. In April 2002, ENH

⁹ This was unusual in the Chicago market, where other hospital organizations set different prices for different hospitals, and MCOs objected to the change. F 360, 365-66.

¹⁰ At least some other MCOs were unable to negotiate ceilings on such unilateral price increases by ENH. F 375. For at least one MCO, the protection from price increases they were able to negotiate turned out to be illusory. United negotiated the right to terminate its contract with ENH if the subsequent ENH price increases went above 6% or, [REDACTED]. However, although the subsequent price increases gave United the right to terminate, United still believed it had to have ENH in its network, so United did not feel it could terminate the contract and had to pay the increases. Foucre, Tr. 900-02; CX 5174 at 7, *in camera*; CX 21 at 5, *in camera*.

increased its chargemaster, increasing its gross charges by [REDACTED] annually, yielding [REDACTED] additional net revenue annually. F 385, *in camera*. ENH raised its chargemaster prices again in October, 2002, June, 2003, and October, 2003. F 388-90.

ENH closely tracked the revenue impacts of the MCO renegotiations after the merger. In internal statements, ENH management repeatedly touted the price increases as merger accomplishments. ID at 164-66. Some examples include:

“The major economic accomplishments in June [2000] were the successful re-negotiation of two of our HMO agreements . . . , that will collectively produce some \$6 million of additional revenues on an annualized basis. This brings the total managed care re-negotiation benefits to some \$16 million/year to the Institution.” CX 13 at 1; F 461.

“[O]ur success in the merger integration effort is not a product of our “independence,” but of our “interdependence.” Neither Evanston nor Highland Park alone could achieve these results.” CX 13 at 1; F 462.

“The larger market share created by adding Highland Park Hospital has translated to better managed care contracts.” CX 16 at 1; F 463.

F. The Issue of Quality Was Not Part of the Renegotiation of the Managed Care Organization Contracts

The arguments advanced at trial for ENH make it important to note what was *not* included in the contract renegotiations between ENH and the MCOs. ENH did not claim to MCOs that its post-merger price increases were based on improvements made at Highland Park. F 842, 844-47; CCFF 2470-96. Mr. Hillebrand, then ENH’s chief contract negotiator, admitted that he did not tell MCOs that the higher prices demanded by ENH were justified by quality improvements.¹¹ F 842; CCFF 2489. Managed care representatives also testified that during

¹¹ In addition, ENH’s Chief Executive Officer, Mr. Neaman, admitted that he never saw any documents correlating the higher prices negotiated with MCOs in 2000 with the quality changes at Highland Park. F 843; CCFF 2486.

contract negotiations, the topic of quality improvements never came up. F 844-47. Even after implementing the changes at Highland Park, ENH neither advertised the changes to MCOs or otherwise informed its customers of the changes. F 842-47.

Virtually all the changes made by ENH at Highland Park occurred well after ENH had renegotiated its MCO contracts at significantly higher rates. Many of the price increases were instituted in early 2000, long before many of the improvements occurred. ID at 179. For example, ENH began remodeling all of its patient units in December 2003. The process of remodeling patient rooms is continuing and scheduled at least through 2006. F 916. ENH did not implement the EPIC computer system at Highland Park until December 2003. Highland Park's new Ambulatory Center did not open until 2005. F 911. Certainly few quality improvements had occurred as quickly as the imposition of higher prices which began at most six days after the merger was consummated. F 457.

III. Argument

Section 7 of the Clayton Act prohibits mergers whose effect “may be substantially to lessen competition, or to tend to create a monopoly.” 15 U.S.C. § 18 (2005). Putting the “lessen competition” into context, “[t]he unifying theme of the [*Merger Guidelines*] is that mergers should not be permitted to create or enhance market power or to facilitate its exercise.” *Merger Guidelines* § 0.1; *see also FTC v. H.J. Heinz Co.*, 246 F.3d 708, 713 (D.C. Cir. 2001) (“Merger enforcement, like other areas of antitrust, is directed at market power.”). “Market power to a seller is the ability profitably to maintain prices above competitive levels for a significant period of time.” *Merger Guidelines* § 0.1.

The merger between Evanston and Highland Park created market power and ENH exercised that market power through anticompetitive price increases. ID at 155; CCB at 47-49. Prior to the merger, competition in the marketplace constrained Evanston's and Highland Park's prices. ID at 156-58; CCB 22-28. The totality of the evidence – including contemporaneous business documents, testimony of industry participants, and econometric analyses of prices – confirms that the merger fundamentally altered the competitive dynamics by eliminating Highland Park as an independent competitor and changed the relative bargaining positions of ENH and its MCO customers. ID at 155, 169; CCB at 47-49. Given the unique geographic locations of Evanston and Highland Park, their merger substantially lessened competition – *i.e.* conferred market power on the merged entity. ID at 1-2.

This case differs from other hospital merger cases. ID at 1. Previous antitrust challenges to hospital mergers were litigated before the merger took place or before any actual and measurable anticompetitive effects occurred. ID at 137-38. As a result, the government and the courts were forced to predict whether the mergers were likely to have an adverse impact on competition.

This merger took place in 2000. Here, Complaint Counsel has shown that there was an actual, substantial reduction in competition following the merger. Thus, the approach used to predict the likely future competitive effects in earlier hospital merger cases has little precedential value for this case.¹²

¹² The one area where the earlier cases have value as precedent is the definition of the relevant product market. Earlier cases defined the relevant product market as general acute care hospital services, recognizing a cluster market that includes all acute care hospital services that require an overnight stay, with the exception of some high-end services that the hospitals in question do not provide. *FTC v. University Health, Inc.*, 938 F.2d 1206, 1210-11 (11th Cir.

Issues important to those earlier cases are not important to this case. For example, whether a not-for-profit hospital would, after the merger, exercise market power to the detriment of consumers was an issue in some earlier cases. *See, e.g., FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1296-97 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997); *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1222-23 (W.D. Mo. 1995), *aff'd*, 69 F.3d 260 (8th Cir. 1995); *U.S. v. Carilion Health Sys.*, 707 F. Supp. 840, 849 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042 (4th Cir. 1989) (per curiam). Because Complaint Counsel showed that ENH actually exercised market power, its non-profit status is not relevant.¹³ ID at 192-94.

Likewise, some earlier prospective hospital merger cases turned on failures of proof regarding the geographic market. Specifically, some courts accepted arguments that, in response to future anticompetitive price increases by the merged hospitals, a sufficient number of patients would switch to more distant hospitals so that the price increase would not be profitable. *California v. Sutter Health Sys.*, 130 F. Supp.2d 1109, 1124, 1132 (N.D. Cal. 2001). Because the evidence demonstrates that ENH was able to raise prices profitably for an extended period of time, and (with one temporary exception) its managed care customers did not drop the ENH system in response to the significant post-merger price increase, disagreements about the precise metes and bounds of the geographic market do not undermine a finding that the merger violates

1991); *U.S. v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990); *Hosp. Corp. of America v. FTC*, 807 F.2d 1381, 1388 (7th Cir. 1986).

¹³ Nonetheless, Complaint Counsel put on an expert witness who explained that economic research has shown that non-profit hospitals will exercise market power. CCF 2497-34.

Section 7.¹⁴

A. The Basis for and Nature of the Competitive Harm Caused by the Merger

Through the merger, ENH acquired unilateral market power which it then used to raise prices. ENH did not need the cooperation or coordination of other competitors to exercise this market power. A combination of the institutional environment in which hospitals competed and the unique geographic location of the three ENH hospitals led to this result.

1. The Institutional Environment in Which ENH Competed

This case centers on the competition of hospitals to sell inpatient hospital services to MCOs for use by the members of those MCOs' managed care plans. ID at 135-36; CCB at 21-24. The underlying concern is the effect of the merger on the prices of hospital services for those plan members.¹⁵

¹⁴ The earlier hospital cases relied heavily on patient flow data and the Elzinga-Hogarty test to determine the extent of the geographic market. Respondents, as well as the American Hospital Association ("AHA") in its amicus brief, argue that the ALJ improperly disregarded patient-flow data in his geographic market analysis. *See* RAB at 32-33; Am. Hosp. Ass'n, Amicus Brief at 6-9, Dec. 16, 2005. Complaint Counsel called Dr. Elzinga, one of the authors of the Elzinga-Hogarty test, to testify that patient flow in general and the Elzinga-Hogarty test in particular are not useful in defining the contours of the geographic markets in hospital mergers. CCF 1661-84. *See also* CCB at 57-59. The ALJ agreed with Dr. Elzinga and described the Elzinga-Hogarty test and patient-flow data as "inapplicable" to hospital mergers analysis. F 216.

¹⁵ There is no difference analytically between health plans where the employer buys insurance to cover the risks of employees needing healthcare and plans where the employer hires a managed care company to run the plan, *e.g.*, choosing a network of healthcare providers, contracting with those providers, handling claims, etc., but the employer retains the risk of the actual amount of healthcare costs incurred by employees. Plans where the employer retains the risk are sometimes referred to as administrative services only ("ASO") contracts. Complaint Counsel treats all managed care plans the same whether the plan includes insurance or is ASO and refers to companies offering traditional insurance and/or ASO contracts as MCOs.

a. Contracting Between Hospitals and Managed Care Organizations

Selective contracting, the ability of the MCO to exclude a hospital from its network, is a “powerful” competition tool. F 161. Selective contracting need not severely restrict the number of providers in an area in the MCO’s network.¹⁶ When a hospital makes unacceptable price demands, MCOs in Chicago will exclude it from their networks to help control their costs, if viable substitutes exist. F 164-65; CCF 258, 263-67 (PHCS excludes hospitals from network); CCF 272, *in camera* ([REDACTED]); Foucre, Tr. 931 (United excludes Advocate Lutheran General from network). Evanston and Highland Park understood the threat of exclusion and competed to lower prices and improve hospital services in order to remain in networks. CCF 245-54.

b. Insulation of Patients from Hospital Prices

The prevalent use of health insurance to pay hospital costs has consequences for economic behavior of hospitals and patients. The use of insurance and the structure of modern managed care plans has partially divorced the decision of which hospital to use from the prices charged by the hospital. CCF 1670; CCB at 57-59. The decision of which hospital within an MCO’s network to use is made by the patient (generally with the assistance of the patient’s doctor). CCF 1669-73. So long as the hospitals under consideration are all in the network of the patient’s insurance coverage, the patient is insensitive to differences in hospital prices in

¹⁶ For example, Dr. Haas-Wilson identified MCOs with as few as 70 hospitals and as many as 93 hospitals in their networks in the Chicago area. F 163; Haas-Wilson, Tr. 2458-60.

making his choice.¹⁷ This separation of the decision-maker on hospital choice from the costs of the hospital stay is sometimes referred to as the “payer problem.” CCFF 1669.

As a consequence of the payer problem, once a hospital is in an MCO’s network, the price that the hospital charges will not directly affect the number of patients it gets from that MCO’s plans. CCFF 1673. Patients do not know the relative prices of hospitals when deciding which hospital to use, so the relative prices do not directly affect that patient choice. CCFF 1670-73. Even if the patients knew the hospitals’ prices, patients generally will not care about the price differences because little, if any, of the price difference is paid by the patient. Thus, if a hospital can charge a higher price and still get included in an MCO’s plans, it will increase its profits.

A hospital’s incentive to increase prices is stronger because the financial impact of higher prices is spread by the MCO across a larger region than the local community served by the hospital. F 188. Consequently, when higher hospital prices lead to higher insurance prices and some individuals lose insurance coverage, any effect on the hospital that increased prices is attenuated. First, in a large urban area such as Chicago, any single hospital accounts for only a fraction of the hospital stays of any MCO. F 163-66. Thus, any percentage increase in prices at any one hospital will increase the MCO’s overall costs and the MCO’s prices charged per individual member by a much smaller percentage. When increases in healthcare insurance prices

¹⁷ The MCOs’ witnesses testified that they could not predict what the cost of a hospital stay was going to be under a discount-off-charges contract. ID at 159; CCFF 790, *in camera*, 799, *in camera*. If MCOs, relatively sophisticated in hospital pricing, cannot predict what a hospital stay is going to cost, how could an individual patient, who does not even have access to the terms of the contract between his insurance provider and the hospitals in the network?

lead to the loss of insurance customers, the effect on the number of patients who use the hospital that increased prices is further attenuated. Any loss of insured patients will be spread over all the hospitals in Chicago that the members of the managed care plan use, meaning that the hospital that raised prices will suffer only a small percentage of the total lost patients. Thus, as long a hospital can stay in an MCO's networks, the hospital has a strong incentive to charge higher prices.¹⁸

2. Bargaining Theory

Bilateral negotiations between each hospital and each MCO determine the prices the hospital will charge the MCO. Haas-Wilson, Tr. 2470. As explained by Dr. Haas-Wilson, bargaining theory – the branch of economic theory that seeks to explain the nature and outcomes of negotiations – is used by economists to study hospital competition for MCO customers. Haas-Wilson, Tr. 2469-70. Many recent peer-reviewed articles published in some of the best economics journals have analyzed hospital competition using bargaining theory. Haas-Wilson, Tr. 2473.

One important insight from bargaining theory is that when two parties negotiate, the outcome of the negotiation is determined in large part by the alternatives each party faces if the negotiation fails to produce an agreement.¹⁹ Haas-Wilson, Tr. 2470-71. If the value and

¹⁸ Respondents claim that Complaint Counsel can show market power only by showing higher prices and a loss of customers. RAB at 3, 56. As is explained here, in this industry, so long as ENH is able to retain its contracts with MCOs, which it was able to do, one would expect that even after exercising market power ENH would lose few, if any patients. Any “lost” patients may be lost to hospitals, other than ENH, that are in the MCOs’ networks.

¹⁹ An example of bilateral negotiations from another market is employment negotiations. If a potential employee has many job offers, she will be able to negotiate a relatively large salary from any of the potential employers. Likewise, if there are many similarly

marketability of an MCO's network would be greatly diminished by not including a particular hospital, that hospital will be able to negotiate a higher price with the MCO. Haas-Wilson, Tr. 2470, 2475. Likewise, if a hospital's profits would be greatly reduced without access to a certain MCO's patients, that MCO would be able to negotiate a lower price from the hospital, all else equal. Haas-Wilson, Tr. 2471.

A merger of competing hospitals, like that between Evanston and Highland Park, can eliminate alternatives available to MCOs and lead to a price increase. CCF 255-60; Haas-Wilson, Tr. 2472. An MCO needs a network of hospitals for its members to use when they need hospital care. To the MCO, the relevant alternative to contracting with any given hospital is the network that the MCO can form without that hospital. CCB at 22; Haas-Wilson, Tr. 2472, 2475. If the merger eliminates the opportunity to contract with a second hospital that the MCO needed in its best alternative network, then the merger makes that best alternative network unavailable. The MCO must then rely on a less desirable alternative if it cannot reach a contract agreement with the given hospital. Forcing the MCO to rely on a less desirable alternative weakens the MCO's bargaining position, leading the MCO to pay more to keep the given hospital in its network. Haas-Wilson, Tr. 2472-73.

The location of the ENH hospitals caused the merger to give ENH market power. ID at 164 (merger gave ENH "geographic exclusivity"). The three hospitals form a geographic triangle. No other hospital is within that triangle. CCF 6, 55, 1001, 1646, 1701, 1707; Foucre, Tr. 902.

qualified candidates for a position, an employer will be able to hire one by offering a relatively low salary. Haas-Wilson, Tr. 2471-72.

The MCO's customers demand that an MCO provide its members with access to local hospitals.²⁰ In the neighborhoods between Highland Park and Evanston, those two hospitals were the first and second choices of the MCOs to provide that access.²¹ F 254, *See e.g.* Ballengee Tr. 166-167 (“could have one or the other hospital in the network “). When Evanston and Highland Park merged, the MCOs lost the option of forming an alternative network that excluded one of the two hospitals while using the other to provide hospital services to residents in the North Shore area. Given the importance of this alternative network option to the MCOs, their bargaining positions were adversely affected by the merger, and, not surprisingly, prices increased.²²

²⁰ Ballengee, Tr. 184 (“People do not like to drive by a local hospital and have to go to another hospital”); Mendonsa, Tr. 485, 568, *in camera*; CCFF 230, *in camera* ([REDACTED]); Holt-Darcy, Tr. 1420 (Unicare verifies that providers are conveniently located near members’ places of residence or employment); Foucre, Tr. 884-885 (consumer’s “primary-decision making factor in selecting a hospital is very often the location of the hospital and the distance they have to travel to seek services”).

²¹ Complaint Counsel does not claim that Evanston and Highland Park were the first and second choice of hospital for all individuals who lived in the North Shore or even all the people who lived in the triangle formed by the three hospitals. Complaint Counsel claims that, when the MCOs were evaluating alternative networks and choosing the hospitals they wanted to use to provide hospital services in that area, Evanston and Highland Park were the first and second choice of hospitals to include in their network to appeal to the residents of that area.

²² Respondents’ contention that bargaining theory implies that the price increases will be inversely correlated to an MCOs size, *see* RAB at 53-54, mischaracterizes the theory articulated by Dr. Haas-Wilson. Dr. Haas-Wilson testified that the outcome of bargaining is determined by the alternatives available to each party if no deal can be reached. In the case of an MCO, the alternative to reaching agreement with ENH is using the network that can be formed without ENH. Haas-Wilson, Tr. 2470-71. Nowhere does Dr. Haas-Wilson say that the available alternatives depend on the size of the MCO. Bain understood this when it gave advise to ENH on bargaining with the MCOs. In advising ENH how to bargain with PHCS, Bain told ENH that “it had “significant leverage in negotiations with PHCS as they [PHCS] have strong North Shore presence and need [ENH] in their network.” CX 1998 at 44; CCFF 1527. An MCO with less

B. The Totality of the Evidence Proves That ENH Achieved Market Power Through the Merger with Highland Park

The foregoing explains how the merger generated market power. But Complaint Counsel did not claim that this evidence shows that market power was probable. Rather, Complaint Counsel proved actual market power directly.

Complaint Counsel relied upon three principle types of evidence to prove that the price increases were the result of the acquisition of market power: contemporaneous business records of the Respondents; testimony of the hospitals' customers, the MCOs that did business in Chicago; and the nature of the price increases themselves. ID at 152-60. Although the evidence is presented serially below, it should be considered as an integrated whole.

1. The Contemporaneous Business Records of Evanston and Highland Park Demonstrate That the Parties Intended to and Did Obtain Market Power

For nearly a decade before the merger and thereafter, senior executives at Evanston and Highland Park, and their respective Boards and business consultants, discussed the competitive dynamics between hospitals and MCOs, and developed three different consolidation strategies to increase the bargaining power of the hospitals relative to the MCOs so that the hospitals would obtain higher prices.²³ Interspersed among the corporate documents are terms like “pricing

“North Shore presence” and less “need” for ENH, and would be in a stronger bargaining position to resist ENH’s demands, without regard to its size.

²³ Documents and testimony in the record make clear that the desire to increase bargaining strength in negotiations with MCOs was the principal factor motivating this merger. Complaint Counsel is aware that an increase in bargaining power through a merger is not necessarily synonymous with an increase in market power. In this instance, however, the increase in bargaining strength is what produced the anticompetitive effects that make this merger unlawful. Specifically, the increase in bargaining strength in this case came about because the merger eliminated a hospital competitor from the bargaining table in the relevant

pressure” (that hospitals faced from MCOs) and references to the need to become “indispensable” and to build “leverage” and “negotiating strength” against MCOs in order to secure “premium” prices. CCFF 1363-79, 1579-608. After the merger, ENH’s documents lauded its new-found market power and higher prices.²⁴

a. First Unsuccessful Consolidation Attempt: NHN

Founded in 1989, NHN, including founding members Evanston and Highland Park, sought to utilize its combined strength to exert “leverage” against MCOs in order to obtain “better pricing” than any individual member could on its own. CX 1802 at 2-3; CCFF 1546-47. In 1996, NHN hired Bain to help guide strategy. Bain observed that one MCO believed that it had greater “bargaining power” in Chicago than other cities because hospitals elsewhere “stick together” more. CX 1860 at 54; CCFF 1549. NHN ultimately fell apart because it did not have the authority to make collective business decisions for its members. F 48-77; CCFF 1536, 1564.

b. Second Unsuccessful Consolidation Attempt: NH-North

In 1996, frustrated with NHN’s inability to secure “better pricing,” Evanston (advised by Bain), Highland Park, and Northwestern Community Hospital began to negotiate a merger into a regional system, NH-North. The hospitals sought “market influence,” and to achieve a level of “indispensability” so that they could obtain “premium sustainable pricing” from MCOs. CX 393

market for selling hospital services to MCOs, thereby giving ENH the means to raise prices. CCB at 30-33.

²⁴ Intent is not an element of a violation of Section 7 of the Clayton Act. In this case, evidence of Respondents’ intent is useful in distinguishing between two competing explanations of why ENH was able to raise price post-merger: the explanation that it obtained market power and the alternative explanation that it simply learned about demand and charged prices that it could have charged premerger.

at 1, 14; CX 394 at 2, 3, 13; CX 395 at 1, 2; CCFF 1569, 1571, 1576. Regardless of the phrase, the guiding principle remained “no competition” among the hospitals. CX 66 at 17; CX 393 at 2; CCFF 1573. The hospitals never consummated the NH-North transaction. CCFF 1578.

c. Successful Consolidation: Evanston-Highland Park

In the late 1990s, Evanston and Highland Park pursued their own bilateral merger discussions. CCFF 69-79. The leadership of both hospitals recognized the “[p]ricing pressures” they faced from MCOs and agreed that the merger would solve their problems by “[s]trengthen[ing] negotiating positions with managed care.” CX 19 at 1; CX 1869 at 7; CCFF 1585, 1593; *see also* CX 442 at 4-5. The merger would allow the two hospitals to “[s]top competing with each other.” CX 1879 at 4; CX 2 at 7. With the merger, the hospitals could “push back on the managed care phenomenon and get the rates back where they ought to be . . .” CX 4 at 2; CCFF 1605. Highland Park predicted that “it would be real tough for any of the Fortune 40 companies in this area whose CEOs either use this place [Highland Park] or that place [Evanston and Glenbrook] to walk from Evanston, Highland Park, Glenbrook and 1700 of their doctors.” CX 4 at 2; CCFF 1605.²⁵

Bain again advised Evanston and pushed the same strategy. CX 66 at 6; CCFF 1577. Bain agreed that the merger provided the opportunity to “negotiate contracts with payors from a stronger position.” CX 2072 at 1; CCFF 1516. The merger would “substantially improve ENH’s leverage” with MCOs. CX 74 at 15, 22; CCFF 1518, 1519. Bain counseled Evanston to use its

²⁵ Evanston’s management recommended the merger to its Board because it would give the combined hospital a large share in its core service area (nearly four times larger than the next hospital), and because there was a risk that if Evanston did not merge, some other hospital system might acquire Highland Park, thereby creating an even stronger competitor. CX 84 at 21, 58; Hillebrand, Tr. 1795-97; CCFF 1589.

“significant leverage” to “justify premium pricing (*i.e.*, above the competitive average).” CX 75 at 16; CCFF 1525.²⁶

In the eyes of ENH’s management, the link between the merger and ENH’s market power was unmistakable. CX 5 at 5; CX 16 at 1; CX 68 at 11, 13; CX 2070 at 3. The millions of dollars in higher revenues from renegotiations with MCOs were substantial. CX 17 at 5-8; CCFF 1398. ENH’s management bluntly concluded that the higher prices and revenues could not have been achieved by “either Evanston or Highland Park alone.” CX 17 at 2.

2. The Testimony from MCO Representatives

Consistent with the corporate documents, MCO representatives testified at trial that the merger gave ENH market power. F 392-456. The witnesses explained how Evanston and Highland Park were their best choices to provide hospital services to customers residing within the North Shore neighborhoods served by the two hospitals. After the merger, ENH gave MCOs an “all-or-nothing” option for the hospital system, and MCOs had no option but to take “all,” which came with substantial price increases and more onerous contract terms.²⁷

²⁶ It was obvious to the former Highland Park contract negotiators who joined ENH that the new entity possessed more “leverage” and “power” with MCOs than either Evanston or Highland Park alone, and that the new entity would secure “premium” prices as a result of its “geographical placement” and “immense influence and power” with the MCOs. CCFF 1486-96; Newton, Tr. 361, 364-65, 367; Chan, Tr. 709-10.

²⁷ The inclusion of both Evanston and Highland Park hospitals in MCOs networks before the merger does not mean that the hospitals did not compete or that they were not alternatives to one another in forming networks. In a competitive environment, so long as both hospitals were offering competitive prices, it is not remarkable that networks would contract with both hospitals. An example of an MCO that did contract only with one of the hospitals was Unicare, which did not contract with Highland Park prior to 2000, when Unicare acquired an MCO that had Highland Park in its network. F 447. This demonstrates that premerger one could create a viable network with only one of the two hospitals in the network, as compared to the post-merger situation when MCOs found that they could not create a viable, competitive network

Tellingly, these sophisticated MCOs, representing the interests of employers throughout the Chicago area, succumbed to ENH's unprecedented price increases – higher than other hospitals – even though less expensive but equally good (if not better) hospitals were already in their networks. As profit-maximizing firms, these MCOs would have dropped ENH from their plan networks if good substitutes had existed. The fact that these firms did not go elsewhere but instead acquiesced to ENH's persistent and significant price increases proves that the merger gave ENH market power.²⁸

a. United Healthcare

In late 1999, before the merger was even consummated, ENH exerted its new “leverage” in renegotiations with United, the second-largest commercial insurer in Chicago. CCFF 959, 961-63, *in camera*. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] CX 21 at 5, *in camera*; CCFF 967, 969, 971, *in camera*.

Prices continued to escalate dramatically in subsequent years as ENH raised its chargemaster list prices. CCFF 980-90, *in camera*, 1004-08, *in camera*. In August 2002, alarmed that ENH had become an “outlier” hospital with out-of-line prices, United requested that its contract revert back to fixed rates and that United be given an overall reduction in prices.

without ENH. F 398, 408, 427, 445-46, *in camera*, 456.

²⁸ ENH's CEO and COO admitted that their post-merger pricing decisions were not constrained by how other hospitals would react nor by fear that ENH would lose managed care business to other hospitals. Hillebrand, Tr. 1751-55, 1757-58, 1764-65; Neaman, Tr. 1211-12.

Foucre, Tr. 888; CCF 979. ENH refused to consider United's requests. Foucre, Tr. 893; CCF 985. In October 2002, United tried again, this time presenting data showing that [REDACTED]

[REDACTED] CX 2381 at 4, *in camera*; CCF 988-90, *in camera*. [REDACTED]

[REDACTED] CX 2381 at 4, *in camera*; CCF 991, *in camera*. Nonetheless, United was told that there would not be [REDACTED] in reimbursement rates. Foucre, Tr. 897; CCF 997, *in camera*.

Terminating and excluding ENH from United's network was not a realistic option. Foucre, Tr. 901; CCF 999. A network without the ENH hospitals would not provide adequate service to the "very heavily populated" area between the three hospitals because "there are no other facilities" within the geographic triangle formed by the ENH system. Foucre, Tr. 902, 933; CCF 1001. Employer group customers resisted a network without ENH even though [REDACTED] [REDACTED] Foucre, Tr. 903-05; CX 6277 at 3, *in camera*; CCF 1004, *in camera*, 1009.

In 2003, United and its largest employer groups met with ENH to request at least more fixed rates and less discount-off-charges arrangements. Foucre, Tr. 906-09; CCF 1013. ENH asked United to send a letter to the FTC in which United would state that the merger "has not had any adverse impact on competition." Foucre, Tr. 922-23; CX 6284 at 1; CCF 1019-20. United disagreed with the substance of the letter and refused to send it. Foucre, Tr. 927; CCF 1021.

[REDACTED]
[REDACTED] CX 426 at 1, *in camera*; CCFF 1025, *in camera*. Despite this change, [REDACTED]

[REDACTED] Foucre, Tr. 1103-04, *in camera*; CCFF 1028, *in camera*.

b. PHCS

Prior to the merger, PHCS obtained competitive pricing from Evanston and Highland Park because PHCS “could choose between the two and work them against each other.” Ballengee, Tr. 167; CCFF 1033. That choice was eliminated by the merger. ENH raised prices to PHCS by 60% in 2000 across all three hospitals (in contrast to the 4-8% average rate increases prior to the merger). Ballengee, Tr. 179, 196; CCFF 1093.

When previously faced with unreasonable price increases, PHCS constructed networks with alternative hospitals. In the late 1990s, PHCS terminated the University of Chicago when it demanded higher rates, and utilized other hospitals with comparable services and locations. Ballengee, Tr. 155, 189-90; CCFF 258. However, PHCS was unable to follow a similar strategy with ENH’s price hikes. Customers “made it very clear” that they did not want to “buy the network if they did not have [ENH in] it.” Ballengee, Tr. 180-81, 183-84; CCFF 1080. Other hospitals in PHCS’s network, such as the Rush North Shore, Lake Forest, or Lutheran General hospitals, were not “viable alternatives” to ENH because “there would be a large area that would not be served by the community hospitals.” Ballengee, Tr. 181, 183-84; CCFF 1082.²⁹

²⁹ ENH capitalized on the absence of viable alternatives by refusing to lower its price increase demands despite PHCS’ offer to exclude St. Francis, Rush North Shore, Condell and Lutheran General from its network of hospital providers. Ballengee, Tr. 181-82; Hillebrand,

c. One Health

Prior to the merger, One Health considered Highland Park to be Evanston's "main competitor" because of their locations near each other and their offering of "comparable" services. Neary, Tr. 601-02; CCFF 1101-03. After the merger, One Health knew that it "was not in a strong negotiating position" because "Evanston had purchased [Evanston's] main competitor," Highland Park. Neary, Tr. 600-01; CCFF 1107. ENH demanded "excessive" price increases. Neary, Tr. 609; CCFF 1121. [REDACTED]

[REDACTED]

[REDACTED] CX 2085 at 1, *in camera*; Neary, Tr. 762, *in camera*; CCFF 1122, *in camera*.

In July 2000, One Health dropped ENH from its network. CCFF 1136-44. One Health quickly realized its error when customers complained about not having access to ENH. Neary, Tr. 617; CCFF 1153. One Health tried to market its network to employer groups, but the other North Shore hospitals in its network did not provide adequate access to One Health's customers in the North Shore. CCFF 1154. As a result, One Health began losing members. Neary, Tr. 617; Dorsey, Tr. 1452; CCFF 1155-56. Having failed to exclude the ENH system from its network, One Health returned to ENH and [REDACTED] Neary, Tr. 617-19, 763-64, *in camera*; Dorsey, Tr. 1447, *in camera*; CCFF 1159, 1161, 1164.

d. Aetna

Before the merger, [REDACTED]

[REDACTED] Mendonsa, Tr. 530, *in camera*; CCFF 1183, *in camera*. [REDACTED]

Tr. 1746-47.

[REDACTED]

[REDACTED] Mendonsa, Tr. 544, 568-69, *in camera*; F 444.

With the merger, Aetna became [REDACTED]

[REDACTED]

[REDACTED] Mendonsa, Tr. 530, *in camera*. Aetna “frankly . . . couldn’t walk away” from post-merger ENH because it would have “devastated us,” “killed our marketing,” and “shut down” Aetna’s marketing to local employers. Mendonsa, Tr. 518, 520, 530, *in camera*; F 446.

[REDACTED]

[REDACTED] Mendonsa, Tr. 541-42, *in camera*.

Aetna conceded to ENH’s price increase demands. [REDACTED]

[REDACTED]

[REDACTED] Mendonsa, Tr. 540, *in camera*. [REDACTED]

[REDACTED] Mendonsa, Tr. 478, 539-40, *in camera*.

e. Unicare

Before the merger, Unicare had the viable option of configuring a network consisting either of Evanston or Highland Park, together with other North Shore hospitals. Holt-Darcy, Tr. 1518-19, *in camera*. The merger eliminated this option. Holt-Darcy, Tr. 1552-54, *in camera*; CCFF 1281-88. [REDACTED]

[REDACTED]

[REDACTED] Holt-Darcy, Tr. 1503, 1539, 1563, *in camera*; CCFF 1249, 1253, 1255.

[REDACTED]

[REDACTED]

[REDACTED] Holt-Darcy, Tr. 1545, *in camera*; CCFF 1265-66. [REDACTED]

[REDACTED] Holt-Darcy, Tr. 1559, *in camera*; CX 129 at 1, *in camera*; CCFF 1275, *in camera*. [REDACTED]

[REDACTED]

[REDACTED] Holt-Darcy, Tr. 1551-53, *in camera*; CCFF 1276, 1282, 1289-92, *in camera*.

3. The Post-Merger Price Increases

It is undisputed that ENH increased its prices after the merger with Highland Park. ID at 168. The price increases to individual managed care plans ranged as high as [REDACTED]

[REDACTED]

[REDACTED] Haas-Wilson, Tr. 2516-17, *in camera*; CX 06279-003, *in camera*.³⁰

Additionally, as noted above, it is uncontroverted that following the merger ENH raised its prices to MCOs by more than other hospitals in the Chicago area. ID at 168. On average, Dr. Haas-Wilson calculated that the prices at ENH [REDACTED] than

³⁰ Dr. Haas-Wilson used four data sources in her work, payment data from the MCOs, the Universal Dataset from the Illinois Department of Public Health, data from NERA (a consulting firm working for ENH), and data from ENH in response to a CID issued by the Commission. The four data sources covered somewhat different time periods and had somewhat different data. Haas-Wilson, Tr. 2495-2500. Dr. Haas-Wilson used all four data sources to see if there was a post-merger price increase at ENH. Haas-Wilson, Tr. 2500- 2501. Dr. Haas-Wilson's results are shown on CX 6279-003 (MCO data), *in camera*; CX 6279-004 (NERA data), *in camera*; CX 6279-005 (ENH CID data), *in camera*; and CX 6279-007 (Universal Dataset), *in camera*. Dr. Haas-Wilson found overall that there was a price increase at ENH after the merger and that it was large for some MCOs. Haas-Wilson, Tr. 2501, *in camera*.

the prices at other Chicago hospitals over the same period.³¹ However, price increases, standing alone, do not prove that ENH was exercising market power. Haas-Wilson, Tr. 2492-95. In order to determine whether the price increases were caused by market power created by the merger, or by some other cause, Dr. Haas-Wilson did an exhaustive analysis of the price increases in the context of the Chicago area and the nature of healthcare institutions. Haas-Wilson, Tr. 2480-89.

Dr. Haas-Wilson used price changes rather than price levels in her analysis.³² Hospital services are differentiated along a number of dimensions that are important to customers and that

³¹ These results do not control for the other factors in Dr. Haas-Wilson's multiple regression analysis, the results of which are reported in footnote 2 and explained later in this section. Only the data from the MCOs and the Universal Dataset had prices data at hospitals other than ENH, so Dr. Haas-Wilson could use only those two sources of data to test whether prices at ENH increased by more than at other hospitals. Haas-Wilson, Tr. 2552, *in camera*. Using three different control groups (Haas-Wilson, Tr. 2548-2549, *in camera*), Dr. Haas-Wilson compared the price increases at ENH with the price increases at control group hospitals using difference in differences methodology. Haas-Wilson, Tr. 2546-2548, *in camera*. Dr. Haas-Wilson's results are shown on CX 6279-008 (MCO data payment per day), *in camera*; CX 6279-009 (MCO data payment per case), *in camera*; CX 6279-010 (Universal Dataset price per day), *in camera*; and CX 6279-011 (Universal Dataset price per case), *in camera*. Dr. Haas-Wilson concluded that from the Universal Dataset numbers, which include all MCOs doing business at Evanston, that prices [REDACTED] in her control groups. The difference was statistically significant at the highest level of significance. Haas-Wilson, Tr. 2581-2583, *in camera*.

³² Respondents assert that "Complaint Counsel failed to prove that ENH's post-merger prices exceeded competitive levels" and claim this as one of three "findings" that Respondents proclaim are "dispositive" in this case. RAB at 1, *citing* ID at 155. This is not, however, what the ALJ said. The ALJ first noted that "Complaint Counsel did not attempt to compare ENH's prices to a competitive level . . ." This is true and the reasoning behind that decision is stated here in the text. Then the ALJ found that the evidence "strongly suggests that prices did rise to a supra competitive level . . . although the evidence on that issue is not conclusive." ID at 155. Finally, putting all the evidence together the ALJ finds that "[t]he evidence therefore demonstrates that the relative price increases were the result of ENH's enhanced market power, achieved through elimination of a competitor as a consequence of the merger." ID at 155. The evidence "clearly establishes the probable anticompetitive effects of the merger necessary to find a violation of Section 7 of the Clayton Act." ID at 155.

influence the prices of those services. F 476; Haas-Wilson, Tr. 2492. Some of these dimensions are not readily measurable, at least with available data, and some may not even be known to the researcher. F 476-77; Haas-Wilson, Tr. 2492-95. When one cannot take into account all the factors that are likely to cause differences in price levels, one cannot reach reliable conclusions regarding market power based on comparisons of price levels. F 694; CCF 582; Haas-Wilson, Tr. 2492.

However, many of the factors influencing prices that vary significantly across hospitals at a point in time do not change over a short period of time for individual hospitals. As a result, after finding that ENH's prices increased more following the merger than did prices at comparison hospitals in the Chicago area, and after ruling out other possible explanations, Dr. Haas-Wilson was able to conclude reliably that the greater price increases at ENH were the result of market power acquired as a result of the merger. ID at 155; F 697; Haas-Wilson, Tr. 2657-58.

After first cataloging the extent of the price increases at ENH, Dr. Haas-Wilson developed a list of potential explanations for the price increases other than market power acquired as a result of the merger. These pricing data cannot be used to test directly for market power, so Dr. Haas-Wilson had to proceed by eliminating other potential causes of the price increase. F 693, 695.

Using both published economic research and her knowledge of healthcare and hospital markets,³³ Dr. Haas-Wilson developed a list of potential explanations that had support in the literature and that could explain a price increase of the magnitude that was observed at ENH. Dr. Haas-Wilson stated that it was impossible to eliminate all possible causes of the price increase,

³³ For Dr. Haas-Wilson's qualifications *see* Haas-Wilson Tr. 2434-38.

no matter how implausible, so she focused on those that she had a basis to believe could reasonably explain such a price increase. F 694; Haas-Wilson, Tr. 2481.

Dr. Haas-Wilson developed a list of eight possible explanations other than market power. These eight are: (1) overall cost increases; (2) regulatory changes; (3) changes in consumer demand; (4) increases in quality; (5) a trade-off for lower outpatient prices; (6) a change in teaching intensity; (7) a change in the mix of customers; and (8) a change in the mix of patients. F 696; CCF 582-85. In addition, in light of the Respondents' argument, Dr. Haas-Wilson examined whether the ENH price increases could be explained by "learning about demand."

Dr. Haas-Wilson was able to directly rule out five of the potential explanations of the price increase. Because prices rose more at ENH than at the control groups of hospitals, Dr. Haas-Wilson directly ruled out the first three possible explanations. F 707, 711, 713. These potential causes of a price increase would have affected all the hospitals in Chicago to the same degree and therefore these explanations do not justify the disproportionately larger price increases at ENH.³⁴

For the next potential explanation of the price increase, an increase in quality at ENH, Dr. Haas-Wilson first relied on Dr. Patrick Romano, Complaint Counsel's expert on quality, who found that there was no increase in quality at ENH relative to other hospitals in Chicago. Haas-Wilson, Tr. 2586-88, *in camera*. Given the larger price increases at ENH than at other hospitals with no increase in quality relative to other hospitals, she ruled out quality as a potential

³⁴ These are cost increases, changes in regulations, and changes in consumer demand. Since these factors would affect all hospitals in Chicago, they could not explain prices at ENH rising more than prices at other hospitals. CCF 586-608, *in camera*.

explanation.³⁵ F 714-16.

The fifth possible explanation, a decline in outpatient prices, might occur if the higher prices for inpatient hospital care were merely a trade-off for lower outpatient prices. Dr. Haas-Wilson ruled this out based on an analysis that showed that outpatient prices, in comparison to other hospitals, did not fall following the merger. CCF 600-608, *in camera*.

The last three potential causes of the price increase – changes in the mix of patients, changes in the mix of customers, and changes in teaching intensity – could not be ruled out, as these three variables did change differently at ENH than at other hospitals in Chicago. CCF 609-30, *in camera*. Dr. Haas-Wilson could not rule out that these had some impact on the prices at ENH. To isolate the effect of each of these final three factors, Dr. Haas-Wilson used multiple regression analysis, which allows the researcher to measure simultaneously the impact of each of these factors (the independent variables) on the price changes at ENH (the dependent variables.) F 727-34; CCF 633, *in camera*.

Using multiple regression, Dr. Haas-Wilson tested to determine if the price increases at ENH were larger than at other hospitals after accounting for the changes in the mix of patients, changes in the mix of customers, and changes in teaching intensity. F 727-34; CCF 634-39, *in camera*. Using two different data sets, and a variety of control groups, Dr. Haas-Wilson tested whether the three remaining potential explanations other than market power or learning about

³⁵ Even if there were quality improvements, it is clear that they did not cause or explain the price increases. F 838-52. Both MCOs and ENH 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. F 844-47; CCF 2470-96. That link is absent both because ENH failed to convince (or even assert to) MCOs that quality in fact improved, and because the price increases started in 2000 but the asserted quality improvements occurred as late as 2005. F 457, 911, 916, 981; CCF 2444-69.

demand could explain the price increases at ENH. F 734; Haas-Wilson, Tr. 2619-37, *in camera*. Her conclusion was that they could not. F 755; Haas-Wilson, Tr. 2637, *in camera*. Even accounting for changes in the mix of patients, mix of customers and teaching intensity, prices at ENH rose significantly more than prices at other hospitals. F 755; CCFF 640-93, *in camera*.

[REDACTED]

[REDACTED]

[REDACTED] CCFF 643-51, *in camera*.

Having completed her analysis, Dr. Haas-Wilson then examined whether “learning about demand” could explain the change in prices at ENH and concluded that it could not.³⁶ Dr. Haas-Wilson’s conclusion, to which her scientific analysis of the data inevitably leads, is that through the merger, ENH obtained market power and it exercised that market power.

C. The Evidence Demonstrates a Violation of the Clayton Act under Count I of the Complaint

Count I of the Complaint pled a Section 7 violation following conventional *Merger Guidelines* methodology, alleging relevant product and geographic markets and levels of concentration that have been sufficient in past cases to establish a *prima facie* case that the merger would lessen competition. ID at 2-3. The evidence supports geographic and product markets that are consistent with a violation of Section 7.

³⁶ Dr. Haas-Wilson’s reasons for rejecting “learning about demand” are presented at Haas-Wilson, Tr. 2642-733, *in camera*, and summarized at CCFF 694-738, *in camera*. For ease of presentation, and mindful of the word limitation on this brief, Complaint Counsel present the evidence against learning about demand in Section IV.A. below, including the evidence that Dr. Haas-Wilson relied upon.

1. Product Market

The relevant product market established by the evidence is general acute care hospital services, including primary, secondary, and tertiary services, sold to MCOs.³⁷ Although there is no bright line separating tertiary from primary and secondary services, Evanston clearly provided tertiary services prior to the merger with Highland Park. F 202. The hospitals' contracts for inpatient care included all types of services. *See, e.g.,* Ballengee, Tr. 200; Mendonsa, Tr. 557, *in camera*. The contracts, pre- and post-merger, generally did not divide services along "primary," "secondary," or "tertiary" lines. *See, e.g.,* Holt-Darcy, Tr. 1584-85, *in camera*. Instead, the hospitals charged rates for broad categories of services without regard to whether all the individual services performed in a particular case would be classified as primary, secondary, or tertiary. *See, e.g.,* CX 5174 at 11-12, *in camera*; CX 5007 at 4, 7. When ENH raised prices post-merger, the prices were increased for all categories, meaning that prices effectively increased for all the services utilized in that category, including primary, secondary, and tertiary services. *Compare, e.g.,* CX 5074 at 14 *with* CX 5075 at 17.

The relevant product market excludes outpatient services, which are provided not only by hospitals, but also by physician offices and outpatient clinics. Outpatient services are not a substitute for inpatient services. An MCO would not turn to outpatient services to replace

³⁷ Tertiary services were excluded from the relevant product market alleged in the Complaint. Nonetheless, after reviewing all the evidence, Dr. Haas-Wilson determined that the relevant market included all three types of services (although it excluded other, even more sophisticated services which were denoted as quaternary services.) Haas-Wilson, Tr. 2489-91, 2665-66, 2701-03, *in camera*, 2876-88, *in camera*.

inpatient services in the face of an increase in the price of inpatient services.³⁸ ID at 135; Haas-Wilson, Tr. 2659-2660.

2. Geographic Market

The relevant geographic market established by the evidence was the geographic triangle formed by the three ENH hospitals. CCF 1645-46. This geographic market is established by the ability of ENH to raise prices to MCOs after the merger, an ability that was not present before the merger.

The ALJ recognized that the market was local, but included four hospitals besides the three ENH hospitals in the relevant geographic market. ID at 143-46. His basis for including these other hospitals was that he concluded that “[i]t is highly probable that the four non-ENH hospitals in the geographic market would have the ability to constrain prices at ENH, either now or in the future, and could be utilized by [MCOs] to create alternat[ive] hospital networks.” ID at 144.

However, as the record shows, this finding is incorrect. As explained above, when faced with an increase in prices at ENH relative to those at other hospitals, the MCOs were unable to craft a viable alternative network without the ENH hospitals, even though they contracted with the other hospitals in the “market” defined by the ALJ. CCF 261-83, *in camera*. In fact,

³⁸ There was testimony at trial that sometimes MCOs would accept higher inpatient prices in return for lower outpatient prices. As Dr. Haas-Wilson explained, that does not put the two products in the same market any more than new cars and loans should be in the same market because some customers will accept a higher price on a car in return for a lower cost of financing. Haas-Wilson, Tr. 2664-2665. Dr. Haas-Wilson also tested to see if the higher prices she found were the result of a trade-off by MCOs to get lower outpatient prices. She found no evidence of that. CCF 601-08, *in camera*. [REDACTED]

[REDACTED] Baker, Tr. 4795-97, *in camera*.

according to Respondents' own expert's analysis, these other hospitals offered even more complex, or at least comparable, services to ENH and at [REDACTED]. ID at 155, *in camera*; F 825, 831-37, *in camera*; CCFF 1892-95, *in camera*; CCFF 1900-04, *in camera*; RX 1912 at 25-26, *in camera*. The only conclusion one can draw is that MCOs could not craft a viable alternative network with the ENH hospitals, otherwise the MCOs would have crafted such a network.³⁹ Thus, the factual predicate for including the other four hospitals in the geographic market is simply incorrect.⁴⁰

The ALJ recognized that the other hospitals could not constrain ENH's pricing a few pages later in his opinion where he wrote, "The evidence therefore demonstrates that the relative price increases were the result of ENH's enhanced market power, achieved through [the] elimination of a competitor as a consequence of the merger." ID at 155.

³⁹ For the same reason it is inappropriate to include the additional hospitals Dr. Noether identified as in her market. Several of the additional hospitals included in Dr. Noether's geographic market have a higher case mix index and [REDACTED], as measured by Dr. Noether, than ENH. These hospitals included Louis A. Weiss Hospital, CCFF 1873-79, *in camera*; Northwest Community Hospital, CCFF 1880-85, *in camera*; and Resurrection Medical Center, CCFF 1886-91, *in camera*. If they were truly in the same geographic market as ENH, when ENH raised prices, the MCOs would have used them to replace ENH.

⁴⁰ For the same reasons, Respondents' contention that even more hospitals belong in the relevant geographic market is incorrect. *See* RAB at 27-33. The key focus in this case is the competition between hospitals for placement in MCO networks, not competition between hospitals to attract patients once the hospitals are in a network. Healthcare plans could not substitute for ENH hospitals located outside the ENH geographic triangle. This is demonstrated by the testimony of the MCOs. *See* III.B.2. Furthermore, the court's product market discussion in *Staples* distills what is important for both product and geographic market definition. *FTC v. Staples, Inc.*, 970 F.Supp. 1066 (D.D.C. 1997). The *Staples* decision instructs that the "mere fact that a firm may be termed a competitor in the overall marketplace does not necessarily require that it be included in the relevant product market for antitrust purposes." *Id.* at 1075. More critical to the analysis is whether the merged entity's prices are "affected" by the so-called competitors. *Id.* at 1077. As demonstrated by the overwhelming actual effects evidence, hospitals outside the geographic triangle did not constrain ENH's large price increases.

Nonetheless, any error in demarcating the exact contours of the geographic market is harmless in this case. This case was not an instance where Complaint Counsel articulated a coordinated interaction theory of anticompetitive harm under which the number of firms that must agree on a coordinated price increase is important to the case and directly dependent on the precise geographic market. In this case, Complaint Counsel articulated a specific theory of unilateral market power that ENH achieved through the merger, based on bargaining theory and the reality of the negotiation process between hospitals and MCOs.

As explained earlier, when firms such as hospitals and MCOs bargain over prices, the outcome of the bargaining depends upon the next best alternative available to each party to the negotiation. *See* Section III.A.2. Before the merger, the next best alternative to a network that contained Evanston would have contained Highland Park, and the next best alternative to a network that contained Highland Park would have contained Evanston. After the merger, if an MCO could not reach agreement with Evanston, the option of putting together a network including Highland Park as an alternative to provide hospital services to customers in the North Shore area served by Evanston and Highland Park was no longer available. After the merger, the MCOs that contracted with Evanston were in worse bargaining positions and less able to resist ENH's demands for higher prices than before the merger.

This unilateral effects analysis, which is consistent with the contemporaneous business documents of ENH as well as the testimony of the MCOs, does not depend upon the exact boundaries of the relevant market or the exact number of hospitals within the geographic market. It depends on the commercial realities that the MCOs were deprived of their second best alternative to having a network with Evanston in it, and their second best alternative to having a

network with Highland Park in it. Thus, although Complaint Counsel still contends that the record shows that the appropriate geographic market is the triangle formed by the three ENH hospitals, if the Commission finds that the market is as large as that postulated by the Respondents' expert, or the middle ground found by the ALJ, the merger nonetheless violated Section 7 because it gave ENH the market power to extract higher prices from the MCO customers.⁴¹

3. Concentration

The level of concentration in the market depends on the contours of the geographic market and which hospitals are included therein. As with the exact contours of the geographic market, the precise level of concentration is not necessary to the finding of liability in this case. Ranging from the broadest market definition – that proffered by Respondents' expert, with a post-merger HHI of 1919 and an increase due to the merger of 222 points⁴² – to the narrowest

⁴¹ The AHA contends that the ALJ's rejection of the three-hospital geographic market precludes a viable unilateral effects theory. AHA Brief at 15-19. As explained in the discussion above, unilateral effects are possible in this case even without a post-merger monopoly. Even Dr. Baker, one of Respondents' experts, agreed that for some theories of unilateral effects [REDACTED] Baker, Tr. 4787, *in camera*. Moreover, the AHA, like Respondents, place undue emphasis on structural presumptions when this case is about actual anticompetitive effects flowing from ENH's increased market power.

⁴² Dr. Noether's proposed market included two hospitals, St. Francis and Resurrection, that had merged in the late 1990's. Dr. Noether treated them as independent firms when she calculated the HHI, squaring the market share of each, rather than adding the shares and squaring the sum. The ALJ erred in concluding that such treatment was correct. The ALJ is correct that, if only one hospital that is part of a multi-hospital system is located in a geographic market, the share of that entity in that market should be based solely on the revenue of the hospital located in the market. ID at 151. However, when two hospitals are under common ownership and both are in the market, the revenues should be combined before being squared to calculate the HHI, just as the revenues from ENH's three hospitals are combined, and just as the sales of multiple plants under common ownership in the same market are combined to calculate

market definition – Dr. Haas-Wilson’s definition of the area contiguous to the three ENH hospitals, with the post-merger HHI of 10,000 – any of the markets will support a finding of liability. The basis of competitive harm, as articulated by Dr. Haas-Wilson and as verified by the facts, does not depend on a particular level of concentration as measured by the HHI; rather, it depends on the merger taking away the second best alternative network for MCOs to use if they could not reach agreement with Evanston Hospital or with Highland Park.

4. Conclusion

Having demonstrated that ENH obtained and exercised market power through its merger with Highland Park and that the merger took place in a “line of commerce” in a “section of the country” that allowed ENH to obtain and exercise market power, Complaint Counsel has met its burden of proving a violation of Section 7 of the Clayton Act under Count 1 of the Complaint.

D. The Evidence Demonstrates a Violation of the Clayton Act under Count II of the Complaint

In Count II of the Complaint, Complaint Counsel does not plead specific relevant product or geographic markets or a level of concentration. Instead, Complaint Counsel pleads that the competitive effects of the merger were sufficient to demonstrate a violation of Section 7. Count II relies on the same evidence of anticompetitive effect that was used to show the anticompetitive effect for Count I.

Under Count II, Complaint Counsel does not deny that there are relevant product and geographic markets in which ENH’s merger could be evaluated. The fact that there are anticompetitive effects consistent with the theory of competitive harm espoused by Complaint

market shares.

Counsel demonstrates that there are relevant markets in which this merger substantially lessened competition. The ALJ correctly found as much when he delineated the relevant markets for Count I of the Complaint. ID at 131-49.

The only issue with respect to Count II is whether the Complaint must specifically plead the existence of relevant markets or whether proof of the actual competitive effects is sufficient to prove that there exist relevant markets and no specific pleading is required. Because the ALJ ruled against Complaint Counsel on Count II, this issue is discussed below in Section VI. in which Complaint Counsel lays out the cross-appeal.

E. Having Demonstrated a Violation of Section 7, Divestiture of Highland Park is the Appropriate Remedy

Section 11(b) of the Clayton Act contemplates that the Commission “shall” order divestiture upon finding a Section 7 violation. 15 U.S.C. § 21(b). Substantial precedent 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*, Dkt. No. 9300, Opinion of the Commission at 93 (Dec. 21, 2004); *U.S. v E.I. du Pont*, 366 U.S. 316, 326-27 (1961); *Ford Motor Co. v. U.S.*, 405 U.S. 562, 573 (1972). The ALJ properly ordered ENH to divest itself of Highland Park. Respondents challenge the relief, and Complaint Counsel cross-appeals on specific provisions of the Order, all of which are addressed in Section VI.

IV. Respondents Failed to Rebut Complaint Counsel’s Affirmative Case

Respondents offered two explanations of the price increases at ENH following the merger, “learning about demand” for Evanston and an increase in quality at Highland Park. ID at 170; RAB at 49-52, 58. Neither explanation is consistent with the facts at trial, and therefore

they cannot explain the price increases.

A. “Learning About Demand”⁴³

Respondents’ self-styled “learning about demand” explanation for the price increases is based on the premise that Evanston could have raised its prices to the post-merger level, even without the merger with Highland Park, had it just known what MCOs were willing to pay for its services. ID at 170-71; RAB at 49-52. The claim is that, before the merger, Evanston was pricing as a “community” hospital, even though it was an “academic hospital” and should have been pricing at the level of other “academic hospitals.”⁴⁴ According to “learning about demand,” Evanston learned its pricing error when it acquired Highland Park and examined Highland Park’s pricing. ID at 170-71; RAB at 49-50. After that, the explanation goes, ENH simply priced appropriately to the level of service that it offered. There are many reasons to reject

⁴³ Complaint Counsel’s findings of fact relating to learning about demand are found at CCFF 694-738, *in camera*; and CCFF 1763-2031, *in camera*.

⁴⁴ In part, this is a semantic game by Respondents. Respondents and their experts take words that are in common usage in the healthcare industry, attribute to those words precise meanings that are not supported by the record, and then attempt to draw conclusions based on those artificially precise meanings. Respondents repeatedly employ the terms “community hospital” and “academic hospital.” Participants in the industry use “community hospital” to categorize smaller hospitals that tend to offer less complex services, and “academic hospital” to categorize hospitals attached to medical schools. However, there is no fixed definition of “community” and “academic” hospitals, and there is no “official” designation of “community” and “academic” hospitals in the industry. ID at 174; CCFF 1834. Hospitals can and do offer a varied mix of services. Hospitals can and do offer a varied mix of involvement in teaching.

However, some hospitals that Respondents classify as “community” treat cases more complex than those treated at some hospitals that Respondents classify as “academic.” CCFF 1854-911, *in camera*. Some hospitals that Respondents classify as “community” meet industry criteria for major teaching hospitals. CCFF 1907-11, *in camera*. Respondents’ classification, although not based on any industry norms, arbitrarily designates low-priced hospitals as “community” and high-priced hospitals as “academic.” ID at 170-72; RAB at 53-55; CCFF 1814-20, *in camera*.

Respondents' "learning about demand" theory.

1. The Underlying Factual Premises of "Learning about Demand" Are Inconsistent With the Record

There are no contemporaneous business records reflecting or substantiating any desire or determination by Evanston or ENH to price like an "academic" hospital. CCFF 1777-1785. Moreover, it is unlikely that examining Highland Park's contracting practices would have taught Evanston or ENH how to price like a higher priced "academic" hospital. Evanston and Highland Park had different characteristics.⁴⁵ Both hospitals were geographically situated to provide hospital services to residents of the North Shore communities, and they both offered the same core of basic services, general medical and surgical care, maternity, etc., that allowed MCOs to rely on either hospital to serve their members in the North Shore area. However, they differed in that Highland Park, when compared to Evanston, offered a more narrow range of services, had fewer beds, and was not involved in teaching.⁴⁶

As will be discussed below, Evanston was not similar to the "academic" hospitals to which Respondents' experts compared it because Evanston was smaller, did not offer the same level of sophisticated services, and was involved in fewer teaching activities than the academic hospitals. It is simply not logical that learning about the pricing at Highland Park, which was smaller, offered fewer sophisticated services and had fewer teaching activities than Evanston, would "teach" ENH how to price like other hospitals that were themselves larger, offered more

⁴⁵ Respondents point out the differences between Evanston and Highland Park when arguing that they were not each other's closest competitor, but ignore those differences when arguing learning about demand. *Compare* RAB at 42 *with* RAB at 52-55.

⁴⁶ All these differences are recognized by Respondents when Respondents argue that Evanston and Highland Park were not each others closest competitor. RAB 42.

sophisticated services and had more teaching activities than either Highland Park or Evanston.

Moreover, despite Respondents' claims to the contrary, the data show that for many, if not most MCOs, Highland Park's premerger prices were lower than the premerger prices at Evanston for like cases.⁴⁷ Mr. Sirabian (formerly responsible for contracting at Evanston) testified that only a third of Highland Park's contracts had higher prices than Evanston's contracts. Sirabian, Tr. 5717. Of the four MCOs whose data were analyzed by Dr. Baker and Dr. Noether, the prices at Highland Park were lower for all four.⁴⁸

2. Respondents' Experts' "Tests" on "Learning about Demand" Are Flawed

Respondents' experts constructed "tests" to show that the pricing at ENH was consistent

⁴⁷ The Respondents' claim appears to rest upon another semantic game. Respondents and their experts assert that premerger Highland Park's "rates" were higher than Evanston's "rates." Literally that may be true, at least for some MCOs, but "rates" tell only part of the story. If hospitals are charging on the basis of discount off charges, as was Highland Park premerger, the "rates," *i.e.* the discount, alone is not the price paid by MCOs. One must also know the prices in the chargemaster to which those discounts apply as well as other contract terms. A hospital with a higher chargemaster can have lower rates, *i.e.* higher discounts, and still charge higher prices to MCOs. F 792; CCFF 1803, *in camera*. The evidence shows that Evanston had a higher chargemaster before the merger than Highland Park. F 793; CCFF 1804, *in camera*.

The rates that Respondents' expert calculated for Highland Park and other hospitals are also questionable. These data, which were alleged to show that Highland Park's premerger rates were higher than Evanston Hospital's rates, also show, for example, that Highland Park's rates to United [REDACTED] two of the premier academic institutions in Chicago, and two of the firms that Dr. Baker and Dr. Noether include in their "academic" control group. CCFF 1810-12, *in camera*. The accuracy of this data is surely questionable. *See also* Noether, Tr. 6089-90 (Judge McGuire questions Dr. Noether on how her calculations could show Highland Park's prices were two or three times as high as other hospitals, including teaching hospitals), *in camera*.

⁴⁸ The four MCOs are Humana, Aetna, Blue Cross, and United. CCFF 1807-08, *in camera*.

with the “learning about demand” theory. The premise underlying these “tests” was that if the “learning about demand” theory was correct, Evanston would have been charging prices comparable to “community” hospitals prior to the merger and comparable to “academic” hospitals after the merger.⁴⁹ The claim is that if, post-merger, ENH’s price levels increased toward the “academic” hospital price levels, but did not exceed those prices, then the evidence is consistent with “learning about demand.” A limitation of this “test” is that even if it is passed, it does not eliminate the possibility that ENH obtained market power through the merger and was raising its prices for that reason. Dr. Baker admitted that the pricing pattern of ENH’s prices to Humana, Aetna, and United was also consistent with ENH obtaining market power through the merger with Highland Park. CCF 691.

The “tests” used by Respondents’ experts were constructed in such an arbitrary manner that no conclusions can be drawn from the results. Respondents’ experts constructed a comparison group of hospitals and then compared the post-merger price levels at ENH with the post-merger price levels of the comparison group. However, the “academic” comparison group used was not an appropriate comparison to ENH.

Dr. Noether constructed the control group of hospitals with which she and Dr. Baker tested their “learning about demand” theory. CCF 1816-17, *in camera*. Dr. Noether began with

⁴⁹ ENH charged the same prices at all of its three hospitals. Whether or not price levels at Evanston should appropriately be compared to the “academic” hospital control group used by Respondents’ experts, by any definition, Highland Park was no “academic” hospital. Respondents’ experts never explain why, absent market power, ENH would charge prices as high as those at the “academic” control hospitals for services performed at Highland Park.

an arbitrary group of 20 hospitals.⁵⁰ Dr. Noether's group of 20 excludes hospitals that are geographically closer to the three ENH hospitals than some of the hospitals on her list. CCFF 1826, *in camera*. Dr. Noether excluded hospitals that were mentioned as ENH's competitors, in the ENH documents she cites, but she included other hospitals that were mentioned. CCFF 1827-30. Dr. Noether also included hospitals that were not mentioned in any of the ENH source documents she cites. CCFF 1831-32.

From her list of 20 hospitals, Dr. Noether used arbitrary rules to construct her "academic" and "community" hospital control groups. Dr. Noether used three criteria to separate her hospitals into "community" and "academic" groups, teaching intensity,⁵¹ number of staffed beds,⁵² and the number of different DRGs to which at least four patients a year were assigned.⁵³ CCFF 1835, 1838. There was no basis in economic or healthcare literature for the choices Dr. Noether made. CCFF 1834, 1836-37, 1839-41, *in camera*. Dr. Noether arbitrarily chose the number of DRGs (370) necessary to be included in her "academic" control group in such a way as to put a hospital that had high prices in the "academic" group. The inclusion of this hospital increased the average prices in the "academic" control group she compared to ENH. CCFF

⁵⁰ There were no specific criteria that Dr. Noether used to include the hospitals on this list. CCFF 1823-24.

⁵¹ Dr. Noether required that a hospital have at least .25 residents per bed to be classified in her "academic" group. Noether, Tr. 5995.

⁵² Dr. Noether required that a hospital have at least 300 staffed beds to be classified in her "academic" group. Noether, Tr. 5995.

⁵³ DRGs, Diagnosis Related Groups, are an inpatient disease and treatment classification system created by the Center for Medicare and Medicaid Services. Dr. Noether required that a hospital have 370 different DRGs (in which at least four patients were treated in a year) to be an "academic" hospital. Noether, Tr. 5994.

1841-45, *in camera*.

This procedure left Dr. Noether with control groups that were inappropriate. Dr. Noether excluded hospitals from her original group of 20 hospitals that would have met the criteria for inclusion in her “academic” control group. CCFF 1846-53, *in camera*. Major teaching hospitals – hospitals with post-merger prices lower than those at ENH – were excluded by Dr. Noether from her “academic” control group and included in her “community” control group. CCFF 1854-62, *in camera*. Hospitals that treated, on average, more complex cases than ENH – hospitals with post-merger prices lower than those at ENH – were excluded by Dr. Noether from her “academic” control group and included in her “community” control group.⁵⁴ CCFF 1863-906, *in camera*. In other words, Dr. Noether created artificial groups to which she compared ENH, and biased the results toward a finding that ENH’s prices were below the prices at the “academic” control group.

An examination of the hospitals Dr. Noether did include in her “academic” control group shows that they are not an appropriate control group with which to compare ENH’s prices. F 820; CCFF 1912, *in camera*. There are differences between ENH and the hospitals in Dr. Noether’s control group in terms of range of services, complexity of the services, teaching intensity, and national recognition. CCFF 1913-26, *in camera*. The conclusion that Dr. Noether used an inappropriate control group is supported by the marketplace: MCO executives testified that ENH is not comparable to the hospitals in Dr. Noether’s “academic” control group. CCFF 1927-40.

⁵⁴ Some of these hospitals in her “community” group treated cases that were more complex than those treated in at least one other hospital in her “academic” control group. CCFF 1907-11, *in camera*.

Finally, in the end, ENH failed the “learning about demand” test that Dr. Baker developed.⁵⁵ Dr. Baker’s analysis of four MCOs showed that ENH’s pricing was higher than the pricing at the “academic” control group for two of the MCOs. When asked directly why United, one of the firms to which ENH was charging prices higher than those charged by the “academic” hospitals, would pay higher prices to ENH instead of using the lower-priced academic hospitals, Dr. Baker had no explanation.⁵⁶ Baker, Tr. 4787, *in camera*. The fact that ENH had substantial market power is the obvious reason.

3. “Learning About Demand” Is Implausible

Respondents’ “learning about demand” theory implies that Evanston was not choosing prices so as to maximize its profits before the merger. That is, the “learning about demand” theory, if true, means that Evanston could have raised prices before the merger, and sufficient MCOs would have paid those prices to make the price increase profitable. Thus, according to the theory, MCOs, premerger, were getting hospital services from Evanston at bargain prices. Given the record evidence, however, this state of affairs is implausible.

When a firm is not profit maximizing, it can be expected, in response to market signals, to adjust its prices and output to the profit maximizing position. Yet, Respondents did not present any credible evidence that Evanston saw itself as not profit maximizing before the merger. To the contrary, the evidence is that Evanston fully priced its services according to the

⁵⁵ See, *supra*, note 5 and the evidence cited therein for a discussion of how Dr. Baker attempted to explain this.

⁵⁶ In addition, Dr. Baker calculated that in 2003, United could have [REDACTED] if it had used the hospitals in Dr. Noether’s “community” control group instead of ENH. Dr. Baker had no answer why United did not do that. Baker, Tr. 4784-86, *in camera*.

premerger market conditions, including competition from Highland Park and other hospitals. CCF 1767-76; Hillebrand, Tr. 1731, 1733 (ENH acted equally aggressive in contract negotiations before and after merger); Sirabian, Tr. 5711-16 (Evanston attempted to renegotiate higher rates from MCOs premerger, but MCOs refused). Therefore, Respondents' "learning about demand" theory is too implausible to be a credible explanation of Evanston's post-merger price increases. Instead, the Commission should reject Respondent's theory and find that the most likely ground for price increases is that the merger conferred market power.

B. The Commission Should Disregard Respondents' "Quality Improvement" Defense

Asserting an ill-defined and non-specific "quality of care" defense, ENH asks the Commission to allow this anticompetitive merger to stand. Placed in its proper analytical framework, however, the defense fails. As a threshold matter, the fact of ENH's significantly higher relative price increases stands undisputed. Moreover, there is no evidence that quality at ENH improved relative to other hospitals. ID at 180. As a result, the relative price increases do not require adjustment for quality changes, and because the quality changes do not account for or justify the price increases, there has been anticompetitive harm.

ENH offers its unproven "quality improvements" assertions not to say that the merger was not anticompetitive, but, instead, raises the "quality of care" issue to argue that the quality changes produced benefits that in some unspecified manner "outweighed" the anticompetitive harm. RAB at 62. This argument is erroneous on at least two critical grounds. First, as a practical matter, ENH offers absolutely no quantification of the value of the alleged quality improvements. Rather, it suggests that the Commission engage in a metaphysical exercise to weigh the alleged unquantified quality improvements against the proven, quantified

anticompetitive price increases. This exercise simply cannot be done.

Second, the exercise is unnecessary, and, indeed, antithetical to the proper administration of the antitrust laws because courts correctly dismiss arguments that anticompetitive harm can be offset by other considerations. The antitrust laws reflect a judgment that “ultimately competition will produce not only lower prices, but also better goods and services.” *Nat’l Soc’y of Prof. Engineers v. U.S.*, 435 U.S. 679, 695 (1978); *see also FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 463 (1986) (defendant’s “quality of care” justification is “nothing less than a frontal assault on the basic policy of the Sherman Act”); *U.S. v. Rockford Mem’l Corp.*, 717 F. Supp. 1251, 1289 (N.D. Ill. 1989), *aff’d on other grounds*, 898 F.2d 1278 (7th Cir. 1990) (district court blocks hospital merger because, *inter alia*, hospitals’ intentions to improve quality were “irrelevant” for Section 7 purposes). ENH is not entitled to pre-empt the workings of the market by deciding for itself what is best for consumers or overall economic welfare.

It may be possible that proven, quantifiable quality improvements can justify an otherwise anticompetitive merger, but this merger is not such a case. The *Merger Guidelines* recognize that mergers can sometimes have procompetitive effects, as well as anticompetitive effects, in the form of cost reductions and quality improvements. Section 4 of the *Merger Guidelines* sets out the proper analytical framework for accounting for any such procompetitive effects within the overall competitive effects determination. Specifically, any proven efficiencies in the form of cost reductions or quality improvements must be sufficient in magnitude to “reverse” the anticompetitive effects of the merger so that consumers within the relevant market are no worse off after the merger. *Merger Guidelines* § 4. That is, the analysis does not consider cost reductions or quality improvements as an “offset” against the injury to consumers from the

merger, but rather asks whether such consequences make the merger neutral (or even beneficial) to consumers notwithstanding adverse price effects. Hence, the benefits of any proven cost reductions or quality improvements must accrue with respect to the competitive effects felt by consumers within the relevant market, not to others.

ENH failed to satisfy the criteria required for the Commission to credit the alleged quality improvements within the relevant market. ENH needed to show that its alleged “quality of care” improvements were: (1) merger-specific; (2) cognizable; and (3) sufficient in magnitude to reverse the anticompetitive effects. *Merger Guidelines* § 4; *see also H.J. Heinz*, 246 F.3d at 720-21 (“a rigorous analysis” is required to ensure that the claims “represent more than mere speculation and promises”); *FTC v. Swedish Match*, 131 F.Supp.2d 151, 172 (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).

ENH’s alleged quality improvements must be merger-specific. *Merger Guidelines* § 4. If the alleged quality changes could have practically come about absent the merger, they cannot save the merger from violating Section 7. This follows because, absent the merger, consumers would have similarly obtained the benefit of the quality improvements, but without the anticompetitive increases in price. *Id.*

ENH’s alleged quality improvements must also be cognizable. *Merger Guidelines* § 4. Cognizable claims are ones that are merger-specific and verifiable. That is, the existence of the merger-specific quality improvements must be substantiated using data and information that can be reasonably verified as to accuracy. Absent such verification, there is no way for the Commission to know confidently that the alleged quality improvements actually took place. *Id.*

Finally, to reverse the anticompetitive effects of this merger, ENH must also show that the value to consumers of its alleged quality improvements is at least as great as the harm to consumers from the proven, quantified adverse price increases. *Merger Guidelines* § 4. To make such a showing, ENH must: (1) quantify the dollar value to consumer welfare of the quality changes using data that can be verified; (2) show that at least some of the value of the alleged quality improvements accrued to consumers within the relevant market; and (3) show that the value of the quality improvements accruing to consumers within the relevant market was sufficient to make the welfare of those consumers no worse off because of the merger.⁵⁷

1. ENH Cannot Show 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 practically achieved only through

⁵⁷ The ALJ found only two of Respondent’s alleged quality improvements to be merger-specific – the introduction of the EPIC computer system and the extension of ENH’s academic programs to Highland Park. ID at 190-91. Assuming these two changes are merger-specific and cognizable, they nevertheless do not amount to a benefit that could possibly reverse the anticompetitive harm of the merger. First, the implementation of EPIC constitutes only a computer upgrade to Highland Park. [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED] CCF 2410, *in camera*.

Second, ENH’s academic programs extended to Highland Park after the merger, but not significantly. For example, [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED] CCF 2293, *in camera*. Thus, the ALJ properly found that these changes “do not sufficiently outweigh the merger’s harm to competition and ultimately to consumers.” ID at 192.

the merger.⁵⁸ 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 only offers the false assumption that coincidence proves causation. ENH would have the Commission conclude (as ENH failed to convince ALJ) that because changes to Highland Park’s operations occurred after the merger, those changes were caused by the merger.⁵⁹ RAB at 76-77. 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 by acting alone, or in partnership with

⁵⁸ The AHA incorrectly contends that the ALJ erred in applying a merger specificity standard to his evaluation of Respondents’ alleged quality improvements. AHA, Amicus Brief at 21-25, Dec. 16, 2006. Merger specificity may not be relevant when considering whether quality improvements “explain” the price increases, but, even so, the evidence shows that the quality improvements do not explain Respondents’ price increases. This is because quality either did not significantly improve, or if it did, the changes occurred much later, and in the absence of discussions with MCOs, to provide a credible explanation. The AHA concedes that merger specificity is appropriate to analyze whether quality improvements might reverse anticompetitive harm. AHA at 24-25.

⁵⁹ Contrary to Respondents’ contention, the ALJ did not shift the burden of persuasion onto them by requiring Respondents to bring forth evidence more substantial than assumptions. RAB at 77.

another hospital or through a merger with another hospital.⁶⁰

a. Highland Park’s Premerger Quality of Care Was “Very Good”

Witnesses from Evanston, Highland Park and the MCOs consistently praised Highland Park’s quality of care before the merger as “very good, if not excellent.” F 850-52; *see also* CCFE 2295-2352.⁶¹ Highland Park maintained a high level of care, but recognized its weaknesses and instituted corrective measures. Newton, Tr. 376-401, 409-11. Highland Park impressed Evanston, which saw it as a “strong community hospital,” and deemed Highland Park a worthy merger partner. CX 874 at 5. Indeed, Highland Park offered leading edge and innovative clinical programs before the merger and continually added new services and made ongoing improvements to its services in the years prior to the merger. CCFE 2326-45.

b. Highland Park Had Plans in Place to Further Improve Its Quality of Care

In 1998 and 1999, Highland Park outlined its strategy to improve quality of care further. F 871. In detailed plans, Highland Park identified areas of focus, many of which address the areas that ENH claims are Evanston’s contributions to this merger. The impetus came from knowing that “[t]his highly affluent community expects and demands quality,” and the

⁶⁰ The ALJ correctly found that “Highland Park intended to make improvements, had a history of making improvements, had the economic ability to make improvements, and would have made improvements because to do so was in Highland Park’s economic self interest.” ID at 183 The ALJ further found that the majority of the changes made at Highland Park after the merger were not merger-specific. ID at 182-91; F 869-993. *See also* CCFE 2294-43.

⁶¹ In a 1999 joint submission to the Illinois Health Facilities Planning Board, signed by Messrs. Neaman, Newton and Spaeth, ENH lauded Highland Park for bringing “leading edge and innovative clinical services” to the community and “consistently [being] the first provider in Lake County to develop and offer advanced clinical services.” CX 413 at 7, 16-17.

recognition that while Highland Park “delivers basic services at a very high level” and is perceived as an “excellent community hospital,” Highland Park needed to improve itself to compete against Evanston. CX 1868 at 7, 10. In March of 1999, Highland Park’s Finance Committee committed to invest more than \$100 million over the next four years in improvements. F 872-73.

Natural, self-survival competitive incentives pushed Highland Park to: (1) improve its medical staff, patient outcomes, patient satisfaction, employee morale, technology (including information systems, such as Meditech), equipment, facilities and administration, (2) offer new clinical services, such as heart surgery, and more oncology services, and (3) strengthen the affiliation with Northwestern Memorial to draw upon the latter’s academic and research programs. F 869-70; Newton, Tr. 329-44. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] Romano, Tr. 3158-59, *in camera*.

c. There Was a National Trend toward Improved Quality of Care

As ENH began making changes at Highland Park, the healthcare community was already in the midst of a national movement to further study measures of quality and improve quality of care at hospitals.⁶² Studies by leading medical organizations began surfacing in the late 1990s

⁶² The Advisory Board contends that the ALJ dismissed Respondents’ \$120 million investment in Highland Park because he “concluded that the large expenditures were merely part of an industry-wide trend.” The Advisory Board, Amicus Brief at 2, 9, Dec. 16, 2005. Rather, the ALJ found that premerger Highland Park had budgeted \$108 million for capital spending and other investments through 2003, and that Highland Park’s financial condition would have allowed it to make these improvements. ID at 182-83, 186. For these and other reasons, the ALJ

that guided hospitals on how to improve quality going forward. F 859; CCF 2385-89. The Leapfrog Group recommended use of electronic medical records only in 2000 (after the merger), and ENH's EPIC system became operational only in 2003-2004. CCF 2407, 2453; Neaman, Tr. 1251. [REDACTED]

[REDACTED] CCF 2384; Ankin, Tr. 5078-80; Romano, Tr. 2998-99; Romano, Tr. 3113-14, *in camera*. Highland Park cannot be faulted for not knowing the unknown, nor should ENH be credited for following a trend. Ankin, Tr. 5087; CCF 2402.

d. Highland Park's Financial Health Was Sound

Mr. Stearns, Highland Park's Chairman of the Board, described a sanguine outlook: HPH had "the financial wherewithal to sustain itself. . . [T]here was no urgency to have an alternative [to Evanston] immediately available." CCF 361-62; CX 6305 at 5, 11 (Stearns Dep.). Mr. Stearns added that Highland Park had a "strong balance sheet with an endowment, if you will, of a substantial amount for a community hospital," and had no concern about its "existence, at least for a reasonable period of time" -- "10 years." CX 6305 at 2-5, 10 (Stearns, Dep.).⁶³

In the spring of 1999, Highland Park's Finance Committee approved over \$100 million in new projects through 2003. F 872-73. The Finance Committee "posed the question on the long-

properly concluded that post-merger capital spending of a magnitude similar to that incurred by ENH would have happened even without the merger. ID at 182-83, 186. The Advisory Board also objects to the ALJ's finding of a national trend toward quality improvements. Advisory Board at 4-8. As this section indicates, there is ample support in the record for that proposition.

⁶³ ENH called Kenneth Kaufman, a financial advisor to Highland Park before the merger, to testify about Highland Park's financial viability. Mr. Kaufman cast doubt about Highland Park's future, but he indicated that the time frame was speculative -- "five, ten, 15 years." Kaufman, Tr. 5814-5.

term financial viability of the organization should affiliation discussions [with Evanston] not reach fruition.” CX 1055 at 3. The Finance Committee concluded that the organization “can remain financially strong over the foreseeable future.” CCFF 340, 366. Separately, Highland Park’s finance office concluded that, using a “conservative” model based on “existing cash and investments and cash flow,” the hospital could “generate sufficient cash” to fund the improvements. CX 1903 at 1; F 874.⁶⁴

Highland Park’s financial condition was impressive. At the end of 1999, Highland Park had cash and unrestricted investments of about \$140 million net of debt. CCFF 324. Highland Park could operate fully for 400 days without any revenues. CCFF 309. The cash-on-hand balance was 2.4 times the national average. CX 1912 at 2.

e. Highland Park Would Have Partnered with Other Hospitals

If the merger with Evanston did not occur, Mr. Stearns testified that “we would have continued to pursue other options . . . we had at least some contact with other institutions and we would have pursued those more aggressively had this – the merger with Evanston, not gone through.” CX 6305 at 11-12; CCFF 370, 371. Mr. Stearns did not worry because Highland Park was an “attractive” candidate in an “attractive service area.” CCFF 372.

The likelihood that Highland Park would merge with someone else posed a real threat to Evanston. In the internal discussions about whether to merge with Highland Park, Evanston’s Board recalled that years before and to its immediate south, Skokie Valley Hospital was once a “sleeping dog” community hospital. CCFF 1589; Hillebrand, Tr. 1795. The Rush system of

⁶⁴ In 1999, Highland Park incurred some losses, but its management concluded that new strategies, including growth through new and existing clinical services, would “restore the profitability” of Highland Park. F 874.

hospitals then acquired Skokie Valley and made major investments, and today Skokie Valley is Rush North Shore, a major hospital. Hillebrand, Tr. 1795-97. Evanston's management team cautioned that the same could happen with Highland Park if Evanston did not act -- one of the "key risks of not undertaking [the] merger." CX 84 at 58.

Highland Park also would have improved quality through joint ventures with other hospitals. *See* F 956; CCF 2354-55, 2357-80. In 1997, three years before the merger, Evanston offered to extend its cardiac surgery and oncology programs to Highland Park, offering five different arrangements, each of which Mr. Neaman represented as "viable from our perspective." CX 1865 at 1. Evanston expressed "significant concerns" upon learning that Highland Park simultaneously explored a joint oncology program with Northwestern Memorial. CX 1867 at 1.

In 1999, before they agreed to merge, Evanston and Highland Park contracted to bring cardiac surgery to Highland Park. F 955, 958; CCF 2357. All funding for the program, \$2.9 million, was to come from Highland Park. CCF 2359; CX 2094 at 2. Swedish Covenant successfully runs a cardiac surgery program with ENH today, the terms of which mirror the 1999 agreement between Highland Park and Evanston.⁶⁵ CCF 2363-66, 2372. Such examples demonstrate that joint cardiac surgery programs are viable in the absence of a merger.

2. ENH Cannot Show That Quality of Care In Fact Improved

ENH failed to show that its quality claims are cognizable.⁶⁶ Indeed, ENH did not present

⁶⁵ ENH also runs a successful joint cardiac surgery program with another hospital, Weiss Memorial. CCF 2367-72.

⁶⁶ Respondents contend that the ALJ found "significant" and "verified" quality improvements in sixteen clinical areas at Highland Park (and enhanced by \$120 million in new investments), but this does not accurately reflect the ALJ's findings. RAB at 12, 68; *see also* Amicus Brief of the AHA at 26. At the same time that the ALJ agreed that "significant

a systematic analysis of how the alleged quality improvements at Highland Park compared to other hospitals, nor did it present any reasonably verifiable data showing how the alleged quality improvements improved patient outcomes or patient satisfaction. *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”).

Complaint Counsel’s quality expert, Dr. Romano, conducted the only comprehensive quantitative analysis that measured and compared patient outcomes and patient satisfaction at ENH to a control group of other hospitals, and concluded that there was no evidence that ENH’s quality improved relative to other hospitals.⁶⁷ CCB at 66-75, *in camera*; CCFF 2053-03, *in camera*, 2133-45, *in camera*. Dr. Romano focused on outcomes because it measures “what actually happens to patients in the end as a result of the care process,” *e.g.*, patient mortality.

improvements have been made to Highland Park and that those improvements can be verified,” he also found that the evidence did not show any overall improvement relative to other hospitals. ID at 177. As the ALJ further stated, “improvements were made at Highland Park, but it is not clear that those improvements affected quality” ID at 177. Indeed, this is not surprising because structural measures, which Respondents primarily tout as their “improvements,” are insufficient by themselves to measure quality. They tell us very little about the care that is actually provided to patients. CCFF 2126. Even Dr. Chassin, Respondents’ quality expert, admitted that structural changes are “very remote from the actual outcomes that we like to see delivered.” CCFF 2127.

⁶⁷ Respondents contend that the ALJ should not have considered whether quality improved overall at ENH. RAB at 74-76. Evaluating overall quality, *i.e.* evaluating changes at both hospitals, however, is certainly appropriate because any post-merger deterioration at Evanston would undermine claims that the improvement at Highland Park justifies the merger. ENH’s price increases could not be justified if alleged post-merger improvement at Highland Park was eradicated by an equal deterioration at Evanston. Consideration of overall quality at all three ENH hospitals is also relevant because ENH charged one price for all three hospitals. CCFF 822-32.

Romano, Tr. 2987.⁶⁸ In its ordinary course of providing hospital services, ENH itself relies on outcomes data and patient satisfaction ratings to measure its quality of care. O'Brien, Tr. 3556-57; Rosengart, Tr. 4478; CX 2052 at 44-45; CX 2436 at 3-4.⁶⁹

For example, [REDACTED]
[REDACTED]
[REDACTED] CCFF 2060-61, 2065, 2074, *in camera*; Romano Tr. 3070-72, 3080-85, *in camera*. [REDACTED]
[REDACTED]
[REDACTED] CCFF 2061-64, *in camera* 2074, *in camera*. [REDACTED]
[REDACTED] CCFF 2060-75, *in camera*.
[REDACTED]
[REDACTED]
[REDACTED] CCFF 2078; *see generally* CCFF 2076-86, *in camera*. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

⁶⁸ Respondents' misguided criticisms of Dr. Romano's methodology and dubious applause of their expert, Dr. Chassin (RB at 99-104; RAB at 80-81, fn.23, 24) are addressed at CCRFF 1196-211, *in camera*, 2217-77, *in camera*.

⁶⁹ Respondents' quality expert, Dr. Chassin, and everyone else agree that patient outcomes are "what we all care about." Chassin, Tr. 5153; CCFF 2122-32.

Highland Park's Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") accreditation scores tend to undermine Respondents' claim of structural and process improvement. At the time of the merger, JCAHO evaluated hospitals through on-site visits during which it reviewed approximately 1,200 specific aspects of hospital activities called elements of performance. F 856; CCF 2300. At that time, close to 75% of these elements were structural in nature, and the remaining 25% were process measures. CCF 2300. From 1999 to 2002, Highland Park's JCAHO accreditation score actually declined from 96 to 94.⁷² F 853.

3. ENH Cannot Show That Quality Improvements Reverse the Competitive Harm from This Merger

ENH also failed to show that the value of its alleged quality improvements to consumers within the relevant market was sufficient to reverse the proven, quantified anticompetitive effects of the merger so that consumers are no worse off. Having failed to quantify the alleged quality improvements with verifiable data, ENH necessarily cannot quantify its own purported value to consumers, let alone show that the purported value to consumers within the relevant market was sufficient to make the welfare of those consumers paying higher prices no worse off because of

⁷² In its amicus brief, JCAHO disputes the significance of such decline, arguing that the range of hospital scores are "too narrow" and that the changes of this magnitude do not lend themselves to determine if one hospital has become "substantially better or worse or the same than the other or whether the one hospital has become substantially better or worse or is still the same over time" JCAHO, Amicus Brief at 5-6, Dec. 16, 2005. Instead, only "gross variations" in scores have probative value. *Id.* at 5-6.

Obviously, the JCAHO's introduction of new evidence at this time is inappropriate. The JCAHO's new factual assertions have not been subject to discovery or cross-examination, and thus should not be part of the record. Nevertheless, even if the JCAHO's untested assertions are considered, they merely confirm that the proper conclusion is set forth in the Initial Decision, *i.e.*, that the JCAHO data provide no evidence that after the merger, the quality of care at Highland Park improved in comparison to other hospitals.

the merger. *Merger Guidelines* § 4.

Post-merger contract negotiations between MCOs and ENH never broached the topic of the purported quality improvements at Highland Park. CCFF 2470-96. The MCO witnesses testified that the subject of quality improvements never came up with ENH.⁷³ F 844-47; CCFF 2473, 2476-77, 2479-85. ENH's management conceded that they did not justify the higher prices to MCOs with quality changes at Highland Park. F 842-43; CCFF 2470, 2486, 2489. If the quality changes at Highland Park were so significant, one would have expected ENH to trumpet the changes to its customers in order to justify its price increases. But ENH never did this. F 841-47.

ENH argues that it improved quality exclusively at Highland Park, but it never explains how this justifies the price increases at Evanston and Glenbrook as well. ENH charges one price across all of its hospitals. CCB at 77. As a result, there is no explanation for why health plan enrollees who use Evanston or Glenbrook, but not Highland Park, should have to pay more today than before the merger when there is no claim that quality improved at Evanston or Glenbrook, and in some important clinical areas [REDACTED] the quality of care rendered at Evanston actually *declined*. Romano, Tr. 3007; Holt-Darcy, Tr. 1560-61, *in camera*.

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

⁷³ ENH imposed price increases before the merger had been finalized and well before it could implement any quality changes at Highland Park, most of which did not occur until years after the merger. F 457; CCFF 2444-69. Thus, ENH had few, if any, quality improvements to tout during the initial contract renegotiations with managed care organizations in late 1999 and through early 2000. ID at 179.

this merger and the harm to consumers in the relevant market.⁷⁴ That loss cannot be measured in any meaningful way against the unspecified, non-quantified, speculative “quality improvements” that ENH describes in general terms. ENH must do more than assert changes were made—it must demonstrate that the benefits of the merger outweigh the merger’s anticompetitive effects.⁷⁵

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.* at 274. 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.*⁷⁶ 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).⁷⁷

⁷⁴ The MCO witnesses testified that the price increases they incurred as a result of the merger likely negatively impacted their customers in the form of higher premiums, reduced employee wages and reduced healthcare. Ballengee, Tr. 172, 196-97; Mendonsa, Tr. 483-84; Dorsey, Tr. 1450. 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 483-84.

⁷⁵ The ALJ correctly found that there was “no quantifiable evidence that the improvements at Highland Park enhanced competition and thus benefitted consumer welfare.” ID at 177.

⁷⁶ 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, 2003 FTC LEXIS 120, *62, *64 n.40 (FTC Decision, July 24, 2003).

⁷⁷ Other courts have emphasized the connection between the supposed benefits of particular conduct and competitive effects. In *NCAA v. Board of Regents*, the NCAA’s meritorious goals were not an abstract justification for the anticompetitive conduct; instead, the

V. Respondents Fail to Justify Reversing the Decision of the ALJ

In asking the Commission to reverse the ALJ's decision, Respondents mischaracterize the legal and factual bases on which liability was found. According to Respondents, there should not have been a "presumption" of anticompetitive effects because the relevant market was not "well-defined" and the market share and concentration levels were "far below a monopoly level." RAB at 23. Respondents add that if such a "presumption" exists, they rebutted it. RAB at 23. Respondents' contention might carry more weight had this case turned on a traditional market structure analysis instead of the overwhelming evidence of actual anticompetitive effects establishing a Section 7 violation.

A. Respondents Incorrectly Assert That Complaint Counsel Failed to Establish a Necessary Presumption of Anticompetitive Effects

Respondents' claims regarding the necessity of a "presumption of anticompetitive effects" misses the mark because Complaint Counsel did not rely on any "presumption" to prove liability; rather, Complaint Counsel accepted the burden of showing that this merger has had actual anticompetitive effects. Through the totality of the evidence -- anticompetitive price increases together with documents evincing the merging parties' goal of eliminating competition and customer testimony attributing the anticompetitive effects to the merger -- Complaint

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. 468 U.S. 85, 114-15 (1984). In *Banks v. NCAA*, 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. 746 F.Supp. 850, 862-63 (N.D. Ind. 1990). And, in *U.S. v. Brown University*, 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 . . ." 5 F.3d 658, 677 (3d Cir. 1993).

Counsel showed the actual anticompetitive effects of the merger, thereby rendering irrelevant the need for a “presumption.”

If it were necessary for Complaint Counsel to show a “presumption” of anticompetitive effects, Respondents incorrectly require Complaint Counsel to show a “monopoly” market share to create that presumption. Nowhere in the *Merger Guidelines* is there a requirement that the merged entity possess “monopoly” level market shares. *Merger Guidelines* § 2.211. The only “presumption” arguably relevant to this case is the *Merger Guidelines*’ threshold levels of whether post-merger concentration levels are sufficiently high to “potentially raise significant competitive concerns.” *Merger Guidelines* § 1.51c. As explained previously, this case meets and exceeds the *Merger Guidelines* threshold of a “highly concentrated” market in which mergers are presumed “likely to create or enhance market power.” *Merger Guidelines* § 1.51c. See Section III.C.3.⁷⁸

Setting aside the overwhelming proof of actual anticompetitive effects, Complaint Counsel also demonstrated that the merger took place in well-defined product and geographic markets that allowed ENH to obtain and exercise market power. As discussed previously, the evidence established a relevant product market of general acute care hospital services sold to MCOs and a relevant geographic market consisting of the geographic triangle formed by the

⁷⁸ The cases also do not require “monopoly” market shares to trigger a presumption of anticompetitive effects. *Swedish Match*, 131 F.Supp.2d at 166; see also *U.S. v. Philadelphia National Bank*, 374 U.S. 321, 364 (1963) (“[w]ithout attempting to specify the smallest market share that would still be considered to threaten undue concentration, we are clear that 30% represents that threat”). Absolute market share levels are not required in a unilateral effects case because market shares may “understate the competitive effect of concern” *Merger Guidelines* § 2.211. Even if “monopoly” market shares were required, ENH is a monopolist because this merger increased the HHIs to 10,000. See Section IV.C.3.

three ENH hospitals. *See* Section III.C.1, 2.⁷⁹

B. Respondents Failed to Rebut the *Prima Facie* Case

Respondents further contend that they rebutted the presumption of anticompetitive effects through several different explanations. Complaint Counsel previously debunked the “learning about demand” and “improved quality of care” explanations. *See* Section IV. Respondents now add a new twist to its rebuttal arguments, misleadingly claiming that after the merger ENH became a better competitor in the Chicago area because the merger increased Highland Park’s financial strength, thereby transforming it from a “weak to a formidable competitor.” RAB at 62. First, the merger did not make ENH a better or stronger competitor; rather the merger eliminated Evanston’s competitor. Having achieved market power through the merger, ENH extracted higher prices without concern for losing customers to competitors. Second, as previously discussed, Highland Park was financially sound, and ready, willing and able to compete against Evanston and other hospitals absent the merger. *See* Section IV.B.

VI. Complaint Counsel’s Cross Appeal

Complaint Counsel cross-appeals one discovery ruling and two rulings of the ALJ in the

⁷⁹ Respondents’ related assertions that Evanston and Highland Park were not the “first” and “second” choices among MCOs and the likelihood of “repositioning” by other hospitals are refuted by the testimony of the MCO representatives and the other evidence establishing actual anticompetitive effects. *See* Section III.B. Furthermore, with respect to “repositioning,” there is no evidence of any entry of new facilities offering inpatient general acute care hospital services in the geographic triangle formed by the three ENH hospitals since ENH was formed. It was the location of the three ENH hospitals that led to the creation of market power. *See* Section III.A.2. The fact that hospitals in other part of the city might have added services is irrelevant to addressing the MCOs’ need for a hospital in those North Shore neighborhoods in the triangle formed by the ENH hospitals.

Initial Decision. We address each of these matters separately.

A. The Commission Should Vacate the September 22, 2004, Order Denying Complaint Counsel’s Motion to Compel the Production of Back-Up Tapes

Respondents’ employees routinely drafted and exchanged numerous electronic documents – such as emails, letters and memoranda – both before and after the merger. Respondents, however, refused to produce electronic documents from January 1999 through December 2002, that were stored on “back-up tapes” because the cost of retrieving the documents was purportedly “burdensome.” In an Order dated September 22, 2004, the ALJ denied Complaint Counsel’s motion to compel the production of a sampling of the back-up tapes because the Commission would not assume liability for the costs of retrieving these electronic documents. On appeal, Complaint Counsel asks the Commission to vacate this Order.

By way of background, a company’s computer system typically retains current, or “active” files on a central computer to which the employees have access through their personal computers. In addition, to reduce the risk of loss due to fires or other catastrophes, most companies periodically transfer their active files to “back-up tapes,” which are then stored at a different site. Over time, a system’s active files do not retain a complete set of all documents: a company can change computer systems (like Highland Park did after the merger), and, even if a company retains the same system, documents are routinely deleted from active files either by employees or through the company’s document retention system. Because any document production limited to Respondents’ active computer files was inherently incomplete, Complaint Counsel sought the production of a sampling of Respondents’ back-up tapes from 1999 through 2002.

In the Order denying Complaint Counsel’s motion to compel, the ALJ recognized that the

back-up tapes have “the potential to yield information relevant to the proceedings.”⁸⁰ Still, the ALJ erroneously relied on decisions on discovery motions in litigation filed by private parties, which conditioned the production of electronic materials on the moving party agreeing to bear some or all of the cost of restoring the electronic files on the back-up tapes.⁸¹ Because of the Commission’s budget constraints, the ALJ’s Order effectively precludes the Commission from gaining access to back-up tapes in its enforcement efforts, regardless of their potential value.

The ALJ’s Order is inconsistent with decisions like *Zubalake v. UBS Warburg LLC*, 217 F.R.D. 309, 316 (S.D.N.Y. 2003), on which the ALJ relied. The *Zubalake* court recognized that:

“ . . . the absolute wealth of the parties is not the relevant factor. More important than comparing the relative ability of a party to pay for discovery, the focus should be on the total cost of production *as compared to the resources available to each party.*” 217 F.R.D. at 321 (emphasis added).

Complaint Counsel recognizes that the Order may have little import for this case.

Nevertheless, if it is allowed to stand, the Order erroneously imposes a likely insurmountable burden on the Commission in future investigations and litigation matters. Therefore, Complaint Counsel respectfully asks the Commission to vacate Section III(A) of the September 22, 2004, Order denying the motion to compel the production of the back-up tapes and to clarify, for the benefit of the ALJs, the private litigants and Complaint Counsel in future actions, that the orders on motions to compel the production of such materials should not be conditioned on the Commission’s bearing some or all the costs of production, but instead should be decided exclusively on the basis of the likely probative value of the materials relative to the magnitude of

⁸⁰ September 22, 2004, Order at 2.

⁸¹ September 22, 2004, Order at 3, *citing, e.g., Wiginton v. CB Richard Ellis, Inc.*, 229 F.R.D. 568 (N.D. Ill. 2004).

the litigation and the costs of production.

B. The Commission Should Enter Judgment Against Respondents under Count II

Count II alleges that the merger violated Section 7 of the Clayton Act: Respondents gained market power through the merger inasmuch as they could profitably impose non-transitory price increases that were significantly greater than the contemporaneous price increases implemented by comparison hospitals. Complaint ¶ 30. The ALJ’s findings of fact confirm this violation. The ALJ correctly found there was direct evidence that “ENH exercised its enhanced post-merger market power through elimination of a competitor and obtained post-merger price increases significantly above its premerger prices and substantially larger than price increases obtained by other comparison hospitals.” ID at 200. The ALJ also concluded that “[t]he only viable explanation for Respondents’ higher prices is that the merger gave ENH enhanced market power.” *Id.*

Despite these findings, the ALJ incorrectly ruled that Count II failed as a matter of law because Complaint Counsel failed to prove the relevant markets.⁸² ID at 200-01. The core issue regarding Count II is whether, as an element of a claim under Section 7, a plaintiff must also allege and prove specific relevant product and geographic markets, wholly independent of the probable effects of the merger, when the evidence establishes actual anticompetitive effects as a result of the merger. On appeal, Complaint Counsel asks the Commission to reverse this determination and to enter judgment for Complaint Counsel under Count II.

⁸² Complaint Counsel notes that this portion of the ALJ’s decision was *dicta*; the ALJ specifically held that Count II was moot in light of the Court’s finding of Respondents’ liability under Count I. ID at 201.

As an initial matter, the Commission should evaluate the merits of Count II even if it enters judgment against Respondents under Count I. The Commission's review is *de novo* and there is no prohibition against finding multiple reasons for liability. See *Airline Pilots Ass'n, Int'l v. UAL Corp.*, 897 F.2d 1394, 1397 (7th Cir. 1990) (“[I]t is cases rather than reasons that become moot. Whether a court gives one or ten grounds for its results is not a question to which Article III prescribes an answer.”) Moreover, as the Seventh Circuit noted, “[t]he practical reason [for ruling on alternative grounds] is that the alternative grounds are ripe for decision and deciding them may help a higher or a subsequent court.” *Airline Pilots*, 897 F.2d at 1397.

Direct evidence showing an “actual detrimental effect” can substitute for the presentation of traditional market definition and market share analysis. *FTC v. Libbey, Inc.*, 211 F. Supp.2d 34, 48-49 (D.D.C. 2002). Far from adopting a “novel theory of Clayton 7 liability” in Count II, Complaint Counsel simply built on settled law that direct evidence of actual anticompetitive effects can be the best proof of market definition, market power and anticompetitive impact. See *Indiana Federation of Dentists*, 476 U.S. at 460; *Todd v. Exxon Corp.*, 275 F.3d 191, 206 (2d Cir. 2001) (“an actual adverse effect on competition . . . arguably is more direct evidence of market power than calculations of elusive market share figures”); *Toys “R” Us, Inc. v. FTC*, 221 F.3d 928, 937 (7th Cir. 2000); *Re/Max Int'l, Inc. v. Realty One, Inc.*, 173 F.3d 995, 1016 (6th Cir. 1999); *Rebel Oil Co., Inc. v. Atlantic Richfield Co.*, 51 F.3d 1421, 1434 (9th Cir. 1995). Thus, the Guidelines-based, formal market definition exercise is not required when direct evidence exists. See H. Hovenkamp, *Federal Antitrust Policy: The Law of Competition and Its Practice* at 549-50 § 12.8 (2005) (“Clayton § 7's ‘may substantially lessen competition’ language does not require a given market structure or a given set of proofs about market concentration, firm market

share, entry barriers or anything else. . . . Market structure evidence is the surrogate for bad performance, not the other way around.”⁸³ In other words, as here, when a plaintiff has demonstrated that a merger had anticompetitive effects, in that the merged firm gained market power from the merger, the plaintiff has presented the necessary evidence from which to infer the existence of a cognizable product and geographic market. Nothing more is required.

The decision on which the ALJ relied, *Republic Tobacco Co. v. North Atlantic Trading Co., Inc.*, 381 F.3d 717 (7th Cir. 2004), does not change this conclusion. First, *Republic Tobacco* is a case in which the plaintiff challenged a vertical restraint which, as the Seventh Circuit recognized, “are presumptively legal,” and “[a]s horizontal agreements are generally more suspect than vertical agreements, we must be cautious about importing relaxed standards of proof from horizontal agreement cases into vertical agreement cases.” *Id.* at 736-37. Second, as the *Republic Tobacco* decision recognized, the most stringent interpretation of cases like *Indiana Federation of Dentists* suggests that, when there is direct evidence of market power, proof of only the “rough contours” of a relevant market is all that is necessary. *Id.*

The central question in a retrospective Section 7 merger case is whether anticompetitive effects flowed from the merger. In this case, Complaint Counsel has demonstrated *actual* anticompetitive effects in a “line of commerce” in a “section of the country,” within the meaning of Section 7. Additional structural analysis is not required, and, in any event, Complaint

⁸³ The agencies’ *Merger Guidelines* are more suited for prospective merger evaluations rather than retrospective analyses where actual competitive effects data exist. Indeed, the *Guidelines* are expressly designed for a prospective, “forward-looking inquiry” to be used in determining “whether a merger is likely substantially to lessen competition.” *Merger Guidelines* at §§ 0, 0.1. When a merger has yet to occur, actual real-world competitive effects are not yet discernable, formally defining product and geographic markets may be necessary to evaluate “the *likely potential* competitive effect of a merger.” *Id.* at § 1.5 (emphasis added).

Counsel proved the relevant markets in which this merger harmed competition. *See* Section III.

C. Reply to Respondents' Appeal of the Divestiture Requirement and Cross-Appeal with Respect to the ALJ's Order

Pursuant to well established law, ENH should be required to divest Highland Park to remedy the harm from its unlawful merger and restore competition.⁸⁴ *See* 15 U.S.C. § 21(b); *Chicago Bridge & Iron*, Dkt. No. 9300, Opinion of the Commission at 93; *E.I. du Pont*, 366 U.S. at 326-27; *Ford Motor*, 405 U.S. at 573. In addition to divestiture, the Commission can order ancillary relief. “The relief which can be afforded” from an illegal acquisition “is not limited to the restoration of the status quo ante.” *Ford Motor*, 405 U.S. at 573 n.8. Rather, relief must be directed to that which is “necessary and appropriate in the public interest to eliminate the effects of the acquisition offensive to the statute.” *Id.* (citations omitted). The Commission’s choice of remedy prevails, for it is “well settled that once the government has successfully borne the considerable burden of establishing a violation of law, all doubts as to the remedy are to be resolved in its favor.”⁸⁵ *E.I. du Pont*, 366 U.S. at 334.

⁸⁴ Citing no supporting law, Respondents claim it would be unfair to order divestiture where the Complaint was filed more than four years after the merger and ENH improved quality at Highland Park. RAB at 85-86. But the anticompetitive harm from this unlawful merger has also persisted for more than four years. The Supreme Court has held that divestiture, while drastic, is the “most effective” means to restore premerger competition. *E.I. du Pont*, 366 U.S. at 326. There is no time limit on the FTC’s legal authority to challenge a merger or order divestiture relief, and the purported integration of assets following an illegal merger does not prohibit entry of a divestiture order. *See, e.g., Ekco Products Co.*, 65 F.T.C. 1163 (1964) (divestiture ordered 10 years after illegal acquisition challenged).

⁸⁵ The Commission, as an expert body, has wide latitude, and a reviewing court will not set aside or modify the FTC’s remedial provisions so long as there is a “reasonable relationship” between the remedy and the unlawful conduct at issue. *Atlantic Refining Co. v. FTC*, 381 U.S. 357, 377 (1965); *FTC v. Mandel Bros., Inc.*, 359 U.S. 385, 392 (1959); *FTC v. Ruberoid Co.*, 343 U.S. 470, 473 (1952).

1. Complaint Counsel's Reply to Respondents' Appeal of the Divestiture Requirement

Respondents claim that divestiture is inappropriate because divestiture “would harm patients and their communities” and would not “lead to lower prices.” RAB at 87, 90.

Respondents also argue that alternatives short of divestiture would be adequate. RAB at 91-92.

For the reasons discussed below, Respondents fail to establish by clear and convincing evidence that a “remedy other than full divestiture would adequately redress any violation which is found.”

Fruehauf Corp., 90 F.T.C. 891, 892 n.1 (1977); *Diamond Alkali Co.*, 72 F.T.C. 700, 742 (1967).⁸⁶

a. Divestiture Will Benefit Consumers

Divestiture will not adversely affect the quality of care at Highland Park. Complaint Counsel has established that the majority of post-merger changes made at Highland Park, including physical changes made to the facility as well as organizational changes made to the clinical departments, will remain after a divestiture.⁸⁷ CCRB at 57-60; CCFF 2567-80. To the extent some post-merger changes at Highland Park will not remain in place, Complaint Counsel's medical expert testified that there is no evidence that elimination of those changes

⁸⁶ Several *amicus* briefs filed in support of ENH contain untested, extra-record factual assertions. Complaint Counsel believes that the concerns about divestiture relief expressed in the *amicus* briefs are addressed in the proposed final order and by the Commission's process for approving proposed divestitures, but that the consideration of any unsubstantiated factual assertions in those briefs is unwarranted and prejudicial to this proceeding. See *Amicus Briefs of Am. Hops. Ass'n, Business Roundtable, and City of Highland Park*. See also Complaint Counsel's Response to Motions for Leave to File *Amicus Curiae Briefs*, Dec. 30, 2005.

⁸⁷ Highland Park today exists as a separate hospital fully licensed to offer acute care inpatient hospital services. However, several functions and services were consolidated by ENH post-merger. Accordingly, Complaint Counsel's proposed final order includes requirements designed to assist an acquirer to re-establish functions consolidated in the merger and have access to all of the practices and procedures ENH currently employs at Highland Park.

through a divestiture would harm quality of care. CCF 2578, *in camera*. Accordingly, the ALJ properly held that, based on the record, the quality improvements asserted by Respondents are not merger specific and will not be lost upon divestiture, but rather will continue post-divestiture. F 869-975; ID at 204-05. Moreover, the ALJ concluded that “divestiture . . . could not be deemed to harm consumers as it would eliminate the anticompetitive harm that has been found to exceed any quality benefits.” ID at 204-05. Divestiture can thus be expected to result in an overall net benefit to consumers.⁸⁸

The order proposed by Complaint Counsel contains provisions specifically designed to assure such quality benefits will continue pending, during, and following divestiture.⁸⁹ The Commission’s final order will be bolstered by other third parties interested in assuring that quality of care does not decline or threaten patient safety. Government agencies and third parties, including MCOs who include Highland Park in their networks, have vested interests in seeing

⁸⁸ Highland Park serves the affluent North Shore communities and has an attractive patient base, which, according to record testimony, likely makes it an attractive facility for purchase by an acceptable acquirer. CCF 50, *in camera*; CCF 368-72. There is nothing in the record to suggest that successful divestiture of Highland Park is not achievable in this case, nor is there any basis for the speculation in certain *amicus* briefs that Highland Park will not be acquired by an appropriate hospital operator or multi-hospital system that can restore competition to the market *and* deliver quality services to the local community. The concerns expressed in *amicus* briefs that divestiture would be difficult, costly, or unsuccessful, or would result in a loss of quality at Highland Park, are not supported by the record, are addressed by requirements in the proposed final order, and can be better focused in comments on the specific acquirer and manner of divestiture proposed by ENH. See 16 C.F.R. § 2.41(f) (referring to Commission’s public comment period prior to divestiture approval application).

⁸⁹ For example, Complaint Counsel’s proposed final order contains provisions (1) to ensure the continuation of programs and services instituted at Highland Park since the merger, such as a cardiac surgery program (§ II.A.), (2) to require the divestiture of Highland Park *along with* post-merger improvements (§ II.A.), (3) to encourage the continued employment of staff and management at Highland Park (§ II.G.), and (4) to require Respondents to maintain the assets and operations of Highland Park pending divestiture, including providing sufficient working capital (§ III).

that their constituents receive and that Highland Park maintain a high quality of care. *See, e.g.*, Chassin, Tr. 5156-57; Romano, Tr. 6333-34, *in camera*; Ankin, Tr. 5050-51; Ballengee, Tr. 186; Neary, Tr. 625. With the revisions proposed by Complaint Counsel, the Commission's final order can assure that concerns such as those raised by Respondents, and in *amicus* briefs, are among the factors considered by the Commission as potentially affecting the future competitive viability of Highland Park when evaluating the divestiture.⁹⁰

b. Divestiture Can Be Expected to Restore Competition

Attempting to shift their burden to Complaint Counsel,⁹¹ Respondents speculate that divestiture will not significantly increase competition because ENH discovered after the merger that "its premerger prices were significantly below prices at comparable Chicago-area hospitals." RAB at 90. This "learning about demand" argument boils down to an assertion that restoring an independent competitor to the market through divestiture would be ineffective to discipline the now more "sophisticated" ENH. RAB at 90. Respondents attempt to shoehorn their unsuccessful argument on liability into an equally flawed argument on remedy. The MCO representatives testified that "Highland Park, as an independent, stand alone, premerger entity gave them a valuable alternative with which to restrain Evanston's prices." ID at 206; F 229-32; CCB at 21-28. With the divestiture and the restoration of competition, MCOs will be able to tell ENH that it is not entitled to the prices of major teaching hospitals, and if ENH insists, the

⁹⁰ Concerned members of the public will have an opportunity for input on the qualifications of the acquirer and manner of divestiture proposed by ENH during the comment period pursuant to the divestiture application process. *See* 16 C.F.R. § 2.41(f).

⁹¹ It is *Respondents'* burden to demonstrate by clear and convincing evidence that relief other than divestiture will restore competition and effectively remedy the violation, not Complaint Counsel's to prove divestiture will cause ENH to lower prices. *Fruehauf*, 90 F.T.C. at 892; *Diamond Alkali*, 72 F.T.C. at 742.

MCOs will be able to turn to the new Highland Park and other hospitals offering services comparable to ENH to form viable networks. *See* Section III.

c. Respondents' Proposed Alternative Remedies Are Inadequate

Relief for an illegal merger must be effective to redress the violation and restore competition. *Ford Motor*, 405 U.S. at 573; *E.I. du Pont*, 366 U.S. at 326. The Commission has repeatedly affirmed that “in Section 7 cases, the principal purpose of relief ‘is to restore competition to the state in which it existed prior to, and would have continued to exist but for, the illegal merger.’” *BF Goodrich Co.*, 110 F.T.C. 207, 345 (1988). *See also Olin Corporation*, 113 F.T.C. 400, 619 (1990); *Ekco Products*, 65 F.T.C. at 1216-7. Respondents’ proposed alternative remedies neither restore the competitive *status quo ante* nor prevent continued consumer harm from supra-competitive pricing, and thus fail to satisfy this standard.⁹²

Respondents first propose a “prior notice” order that would obligate ENH to notify the Commission before acquiring any other hospitals in the relevant geographic market. RAB at 92. However, giving notice on future acquisitions fails to solve the problem of the anticompetitive effects of this merger, including the present market conditions that have given rise to the Section

⁹² Certain of the *amicus* briefs challenge the appropriateness of divestiture relief on policy grounds even where, as here, the ALJ concluded the merger was illegal and net competitive harm resulted from the violation. ID at 204. Congress, however, has already struck that policy balance, and the Supreme Court has confirmed that divestiture, even if it imposes costs on the violator, is the preferred remedy. *E.I. du Pont*, 366 U.S. at 327. Enactment of the Hart-Scott-Rodino Act did not alter the public interest determination underlying Section 11(b) of the Clayton Act. 15 U.S.C. §21(b). The legislative history behind the HSR Act reflects Congress’s recognition that blocking unlawful mergers before they occur is preferable to ordering divestiture after the fact, but does *not* reflect a policy reassessment disfavoring post-consummation divestiture in cases such as this one. The test here is whether some lesser remedy will be as effective as divestiture. It is Respondents’ burden to establish that, and they have not done so.

7 violation in this case. ID at 204.

Respondents alternatively suggest an order requiring Evanston and Highland Park to negotiate and maintain separate contracts with health plans. ID at 204. However, the evidence establishes that restoring competition in the market means re-creating two *independent* hospital decision-makers. ID at 206; F 229-32. Respondents' proposal would do nothing more than divide ENH's managed care contracting responsibilities among employees of the same firm. Respondents have failed to show that "non-structural relief could effectively redress the violations at issue in this case."⁹³ ID at 204.

2. Complaint Counsel's Cross-Appeal – The ALJ's Order Should Be Supplemented and Revised To Assure Effective Divestiture Relief That Restores an Independent and Viable Hospital Competitor

The ALJ's Order adopts most of Complaint Counsel's proposed order, but several proposed provisions involving ancillary relief were eliminated. ID at 207. Complaint Counsel cross-appeals the ALJ's elimination of requirements that the Respondents: (1) take actions to assist the acquirer in ensuring the provision or continuation of a cardiac surgery program equivalent to that established and provided post-merger at Highland Park; (2) provide financial incentives for ENH employees to accept job offers from the acquirer; and (3) indemnify and hold harmless any Commission-appointed Monitor or Divestiture Trustee in the performance of official duties. Each of these requirements is necessary to accomplish divestiture relief that is

⁹³ Creating two independent decision-making competitors out of ENH without divestiture would require implementing a complex, long-term injunctive remedy. The Supreme Court stated that 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.

effective to restore a viable, independent hospital competitor to the market.⁹⁴ Complaint Counsel’s proposed order revising the ALJ’s Order is attached as Complaint Counsel’s Proposed Final Order (“CCPFO”).

a. ENH Should Be Required to Assist the Acquirer In Continuing a Cardiac Surgery Program

The Notice of Contemplated Relief contained in the Complaint expressly recognizes that restoration of Highland Park “as a viable, independent competitor in the relevant market” might also require “the ability to offer such services as Highland Park was offering and planning to offer prior to its acquisition by ENH.” Complaint, Docket No. 9315, Notice of Contemplated Relief, ¶ 1. The record establishes such services included a cardiac surgery program.⁹⁵

Accordingly, Complaint Counsel proposed a provision explicitly requiring Respondents to help the acquirer provide or continue a cardiac surgery program equivalent to the post-merger program at Highland Park. The requirement was qualified by a proviso that provided flexibility for the acquirer and the Commission, and exempted Respondents from providing such assistance if Respondents could demonstrate the acquirer did not need assistance or that a cardiac surgery program was not necessary to achieve the purpose of the Order, and if the Commission approved the divestiture without continuation of a cardiac surgery program.

⁹⁴ The ALJ also eliminated the provision in Complaint Counsel’s original proposed order that states the purpose of the divestiture. “Purpose” clauses are in virtually all FTC consent orders requiring divestiture to provide a self-contained test against which a divestiture proposal will be measured, but are not necessary for litigated orders accompanied by a Commission decision that provides guidance for interpreting order requirements and standards for evaluating any divestiture proposed by Respondents. Thus, Complaint Counsel does not cross-appeal the elimination of the purpose clause.

⁹⁵ Highland Park planned to implement a cardiac surgery program without the merger and would have done so in late 1999 or early 2000, had the merger not taken place. F 955. *See also* CCF 2357-73.

The ALJ, however, eliminated this requirement from the ALJ's Order, finding it to be either "beyond the relief necessary to cure the violation or unnecessary," without further explanation. ID at 207. The cardiac surgery requirement is necessary to assure the acquirer's ability to offer this service, but is conditioned by the proviso's terms. Therefore, the Commission should restore this important option to the divestiture requirements in its final order.⁹⁶ The proposed language appears in CCPFO ¶ II.E.

b. ENH Must Provide Financial Incentives to Encourage Staff Continuity Post-Divestiture

The ALJ adopted most of Complaint Counsel's proposed provisions requiring that Respondents provide assistance to the acquirer of Highland Park to recruit and hire staff who are currently employed by ENH. ID at 207. The ALJ agreed these requirements would enable the acquirer to establish an independent, full-service staff and management upon divestiture, which could facilitate the continuation of high-quality hospital care post-divestiture. The ALJ further agreed that Respondents must provide assistance in the transfer of employment from ENH to the acquirer.

Accordingly, the ALJ's Order requires Respondents to identify employees, grant access to files, and grant the acquirer an opportunity to interview ENH employees (ALJ's Order, ¶ II.G.1.). The ALJ's Order also prohibits Respondents from interfering with the acquirer's attempts to recruit and employ any ENH employees or undermining the acquirer's employment of ENH employees (ALJ's Order, ¶ II.G.2.; ¶ II.G.3.). The ALJ, however, eliminated a proposed

⁹⁶ An express obligation would help clarify Respondent's order obligations whether or not a particular acquirer proposed by ENH already has its own cardiac surgery program and requires only transitional assistance from ENH.

requirement that Respondents also provide reasonable financial incentives to current ENH employees to encourage them to accept offers of employment from the acquirer.⁹⁷ ID at 207.

The Commission should restore this requirement. After the merger, Highland Park remained as a separate facility within the ENH system, but many of the hospital's corporate functions, including managed care contracting, information systems, purchasing, and other business operations, were consolidated with the other ENH hospitals. CCFF 2561. Respondents should be required to facilitate continuity in quality of care as Highland Park disentangles from ENH by providing reasonable financial incentives to help the acquirer employ key and experienced staff and management from ENH. The proposed language appears in CCPFO ¶¶ II.H.3.

c. ENH Must Indemnify and Hold Harmless the Monitor and Divestiture Trustee

The ALJ appropriately ordered that the Commission may appoint one or more individuals to monitor Respondents' compliance with the order (ALJ's Order, ¶ V) and to divest the assets in the event that Respondents fail to do so by the Order's deadline (ALJ's Order, ¶ VI). However, the ALJ eliminated the requirement that Respondents indemnify and hold harmless the Monitor and Divestiture Trustee against any losses, claims, damages, liabilities, or expenses arising out of performance of the Monitor's or Divestiture Trustee's duties. ID at 207. Without an indemnification provision, Respondents could pressure the Monitor or Divestiture Trustee with a

⁹⁷ The Commission has approved an incentive provision of this sort on many occasions in both consent and litigated orders. *See, e.g., Chicago Bridge & Iron*, Dkt. No. 9300, 2004 FTC LEXIS 250, *15 (December 21, 2004) (Final Order) ¶ IV.D.3.; *Baxter Int'l Inc. and Wyeth*, Dkt. No. C-4068, 2003 FTC LEXIS 15, *26-27 (Feb. 3, 2003) (Decision and Order) ¶ II.H.4.; *Amgen, Inc. and Immunex Corp.*, Dkt. No. C-4056, 2002 FTC LEXIS 51, *29-31 (Sept. 3, 2002) (Decision and Order) ¶ II.J.

lawsuit or threat of a lawsuit that could affect the performance of official duties. An indemnification provision is necessary to “reduce any adverse incentives of Respondents, which may put the divested business at risk” (ID at 207), and has therefore become a standard requirement in all Commission orders that include the appointment of a Monitor or Divestiture Trustee, including those issued as a result of litigation.⁹⁸ The Commission should therefore restore the standard indemnification requirements in its final order. The proposed language appears in CCPFO ¶ V.B.6. and ¶ VI.C.7.

d. Respondents Should Be Required to “Replace or Restore” Assets Unless This Can Be Shown to be Unnecessary to Achieve the Order’s Purpose

Paragraph II.A. of the ALJ’s Order requires Respondents to divest the Highland Park Hospital Assets and to replace or restore any assets or clinical services that no longer exist. A proviso to Complaint Counsel’s proposed Paragraph II.A. exempted Respondents from this “replace or restore” obligation only if Respondents could demonstrate that the asset or service was “not necessary to achieve the purpose of this Order,” and that the acquirer did not need the asset or service.

The intent of the proviso is to provide the Commission and the acquirer with flexibility and thereby avoid unnecessary efforts by Respondents to replace or restore assets and services. Complaint Counsel’s proposed language – linking the Respondents’ demonstration to achievement of the purpose of the order as well as to the acquirer’s need – is the most direct and effective way to “(1) correct any informational and bargaining imbalance that may exist between

⁹⁸ See, e.g., *Chicago Bridge & Iron*, FTC LEXIS 250 at *9, ¶ II.C.6.; *Baxter Int’l Inc.*, 2003 FTC LEXIS 15 at *38, ¶ V.B.7.; *Amgen, Inc. and Immunex Corp.*, 2002 FTC LEXIS 51 at *48-49, ¶ V.B.7.

Respondents and the prospective acquirer of the divested assets, (2) enhance and expand the competitive viability of the buyer, and (3) reduce any adverse incentives of Respondents, which may put the divested business at risk,” all of which the ALJ recognized is important and necessary. ID at 207.⁹⁹

The ALJ’s Order, however, revised the language of the proviso to ¶ II.A. to relieve Respondents from the obligation to replace or restore assets or services if the Respondents can demonstrate that the termination of such asset or service was “for good cause.” Because the “good cause” standard in the ALJ’s Order may allow a subjective assessment by Respondents of their own needs and interests that might be contrary to the public interest in achievement of the order’s remedial purpose, it could undermine the effectiveness of divestiture relief. The ALJ’s “good cause” standard is also not defined, and undefined and potentially ambiguous terms can undermine enforcement of order obligations.

The Commission should adopt Complaint Counsel’s originally proposed objective test, which exempts Respondents from their “replace or restore” obligation only if, as noted above, Respondents can demonstrate to the Commission’s satisfaction that the asset or service is “not necessary to achieve the purpose of this Order,” and that the acquirer does not need the asset or service. Complaint Counsel’s proposed alternative language appears in the proviso to CCPFO ¶ II.A.

⁹⁹ Citing *Federal Trade Comm’n, A Study of the Commission’s Divestiture Process* (1999) (<http://www.ftc.gov/os/1999/08/divestiture.pdf>).

e. Additional Revisions Are Necessary to Clarify the Divestiture of Intellectual Property

The ALJ generally adopted all of Complaint Counsel’s provisions and definitions relating to intellectual property and its division, whether through an outright transfer or by license. The ALJ made revisions to Complaint Counsel’s original definition of the ENH License and to the original formulation of ¶ II.D., which requires Respondents to grant the license to the acquirer. It appears from these revisions, however, that there is some confusion about the nature of the ENH License.¹⁰⁰ To clarify Respondents’ divestiture obligations with respect to intellectual property, Complaint Counsel proposes slight revisions to several definitions and to the operative provision that establishes the license.

The definition of the Highland Park Hospital Assets is structured to exclude assets that are not located in Highland Park, Illinois, and whose use is shared with other ENH hospitals (ALJ’s Order, ¶ I.O.).¹⁰¹ Intellectual property is included in this definition, which means that any intellectual property exclusively related to Highland Park is part of the asset package transferred outright to the acquirer. The ALJ’s Order will give the acquirer access to the remaining intellectual property by requiring Respondents to grant a license to the acquirer (ALJ’s Order, ¶ II.D.). A license is the most effective method of dividing the non-exclusive intellectual property between a newly divested Highland Park and ENH.

Complaint Counsel proposes to revise the license grant language in ¶ II.D. of the ALJ’s

¹⁰⁰ The ALJ added language referring to the “existing ENH Licenses” (*see* ALJ’s Order, ¶ II.D.), but it is unclear what this means because there are no existing ENH Licenses. Rather, the ENH License will be created at the time of divestiture.

¹⁰¹ Respondents would be required to close the gap between this asset package and the original assets by replacing or restoring any assets or services that no longer exist. *See* ALJ’s Order, ¶ IIA.1., ¶ IIA.2.

Order to eliminate the term “Licensed Intellectual Property” and thereby avoid a redundancy with the term “ENH License.” Removing the term “Licensed Intellectual Property” from ¶ II.D. also requires that it be removed from ¶ I.O.5. of the Order (where the term is defined). Finally, another revision to Paragraph I.O.5. is necessary to clarify that intellectual property *exclusive* to Highland Park must be transferred outright rather than through the license. This would be accomplished by creating separate sub-sections, respectively, for HPH Name and Marks and for Intellectual Property, in the definition of Highland Park Hospital Assets.¹⁰²

The revisions proposed by Complaint Counsel would clarify and better handle the transfer of intellectual property to an acquirer. The provisions that deal with the transfer of intellectual property appear in CCPFO ¶ I.K., ¶ I.O.5., ¶ I.O.6., ¶ I.R., and ¶ II.D.

VII. Conclusion

Complaint Counsel submitted a simple and straightforward case of a merger that resulted in actual anticompetitive effects. Undisputed post-merger pricing data showed significantly higher relative price increases by ENH than other Chicago hospitals. Prices rose, uniquely and persistently, because of the merger. Respondents, in their contemporaneous business documents, admitted the merger’s contribution to those price increases, and MCOs, otherwise in the business of containing hospital costs for their customers, attested to the fact that the merger altered the competitive dynamics and forced them to accept ENH’s demands. These facts are now settled, and make this case comparatively easy to decide.

¹⁰² Because “HPH Name and Marks” is already defined in ¶ I.Q., Complaint Counsel also proposes to remove any references to “HPH Name and Marks” from the definition of “Intellectual Property” in ¶ I.R.

Indeed, Respondents' attempts to portray this case as novel and difficult aside, what makes this case truly unique is its very simplicity. Here, the Commission does not have to investigate demand substitution, delineate markets, and calculate market shares and market concentration in order to arrive at structural proxies from which to predict the competitive effects of the merger. There is an easier and more accurate way of assessing whether the merger lessened competition – the totality of the evidence proving that the merger caused actual anticompetitive effects. Respondents' complaints about the purported infirmities of a market structure analysis in this case is not unlike a criminal defendant, who, despite the eye witnesses who have taken the stand and identified the defendant as the perpetrator, moves to dismiss the prosecution's case because the prosecution introduced no circumstantial evidence.

Respondents offered two different explanations – “quality of care” for Highland Park and “learning about demand” for Evanston – for these extraordinary and unique post-merger price increases. The post-hoc justifications offered by Respondents' experts – neither of which finds any support in the documents, among the MCOs or the data – are neatly tailored in the sense that, from a theoretical standpoint, each has a surface plausibility, so neither could be rejected out of hand. A trial was necessary. As the record from the trial establishes, and as the ALJ concluded, however, those explanations are utterly deficient as a matter of fact (and the “quality of care” claim is insufficient as a matter of law, as well).

The merger between Evanston and Highland Park created market power that manifested itself when ENH raised and then sustained prices above competitive levels to MCOs. The merger therefore violated Section 7 of the Clayton Act because it substantially lessened competition in a “line of commerce” and in a “section of the country,” a conclusion also reached

by the ALJ. Complaint Counsel respectfully requests the Commission to remedy the harm by ordering ENH to divest itself of Highland Park.

Respectfully submitted,

Complaint Counsel

Handwritten signature of Philip M. Eisenstat in cursive script, with a horizontal line drawn underneath the signature.

By: Philip M. Eisenstat

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February 10, 2006

APPENDIX A

COMPLAINT COUNSEL'S PROPOSED FINAL ORDER

**UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION**

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

_____)	
In the matter of)	
)	
Evanston Northwestern Healthcare)	
Corporation,)	Docket No. 9315
a corporation, and)	
)	
ENH Medical Group, Inc.,)	
a corporation.)	
_____)	

ORDER

I.

IT IS HEREBY ORDERED that, as used in this Order, the following definitions shall apply:

- A. “Acquirer” means any Person approved by the Commission to acquire the Highland Park Hospital Assets pursuant to this Order.
- B. “Acquirer Hospital Business” means all activities relating to general acute care inpatient hospital services and other related health care services to be conducted by the Acquirer in connection with the Highland Park Hospital Assets.
- C. “Acute Care Hospital” means a health care facility licensed as a hospital, other than a federally-owned facility, having a duly organized governing body with overall administrative and professional responsibility, and an organized professional staff, that provides 24-hour inpatient care, that may also provide outpatient services, and having as a primary function the provision of General Acute Care Inpatient Hospital Services.
- D. “Commission” means the Federal Trade Commission.
- E. “Direct Cost” means the cost of direct material and direct labor used to provide the

relevant assistance or service.

- F. “Divestiture Agreement” means any agreement between Respondent (or between a Divestiture Trustee appointed pursuant to Paragraph VI. of this Order) and an Acquirer approved by the Commission, and all amendments, exhibits, attachments, agreements, and schedules thereto that have been approved by the Commission, to accomplish the purpose and requirements of this Order.
- G. “Divestiture Trustee” means the Person appointed pursuant to Paragraph VI. of this Order.
- H. “ENH” means Evanston Northwestern Healthcare Corporation, its directors, officers, employees, agents, attorneys, representatives, successors, and assigns; its subsidiaries, divisions, joint ventures, groups, and affiliates controlled by ENH (including, but not limited to, ENH Faculty Practice Associates and ENH Medical Group, Inc.), and the respective directors, officers, employees, agents, attorneys, representatives, successors, and assigns of each. ENH Faculty Practice Associates is an Illinois non-profit corporation that, *inter alia*, employs physicians who primarily serve the patients of ENH, and is the sole shareholder of ENH Medical Group, Inc., an Illinois for-profit corporation.
- I. “ENH Contractor” means any Person that provides physician or other health care services pursuant to a contract with ENH (including, but not limited to, the provision of emergency room, anesthesiology, pathology, or radiology services) in connection with the operation of the Post-Merger Hospital Business at Highland Park Hospital.
- J. “ENH Employee” means any Person employed by ENH in the operation of the Post-Merger Hospital Business, including, but not limited to, any physician employed by ENH Faculty Practice Associates.
- K. “ENH License” means: (i) a worldwide, royalty-free, paid-up, perpetual, irrevocable, transferable, sublicensable, non-exclusive license under all Intellectual Property owned by or licensed to ENH relating to operation of the Post-Merger Hospital Business (that is not included in the Highland Park Hospital Assets) and (ii) such tangible embodiments of the licensed rights (including but not limited to physical and electronic copies) as may be necessary or appropriate to enable the Acquirer to utilize the rights.
- L. “ENH Medical Staff Member” means any physician or other health care professional who: (1) is not an ENH Employee and (2) is a member of the ENH medical staff, including, but not limited to, any ENH Contractor.
- M. “General Acute Care Inpatient Hospital Services” means a broad cluster of basic medical and surgical diagnostic and treatment services for the medical diagnosis, treatment, and care of physically injured or sick persons with short term or episodic health problems or infirmities, that include an overnight stay in the hospital by the patient. General Acute Care Inpatient Hospital Services include what are commonly classified in the industry as

primary, secondary and tertiary services, but exclude: (i) services at hospitals that serve solely military and veterans; (ii) services at outpatient facilities that provide same-day service only; (iii) those specialized services known in the industry as quaternary services; and (iv) psychiatric, substance abuse, and rehabilitation services.

N. “Highland Park Hospital” means the Acute Care Hospital located at 718 Glenview Avenue, Highland Park, Illinois 60035.

O. “Highland Park Hospital Assets” means all of ENH’s right, title, and interest in and to Highland Park Hospital and all related healthcare and other assets, tangible or intangible, business, and properties, including any improvements or additions thereto made subsequent to the Merger, relating to the operation of the Post-Merger Hospital Business in Highland Park, Illinois, including, but not limited to:

1. All real property interests (including fee simple interests and real property leasehold interests), whether or not located on the Highland Park Hospital campus;
2. All personal property, including equipment and machinery;
3. All inventories, stores, and supplies;
4. All rights under any contracts and agreements (*e.g.*, leases, service agreements such as dietary and housekeeping services, supply agreements, procurement contracts), including, but not limited to, all rights to contributions, funds and other provisions for the benefit of Highland Park Hospital pursuant to the Foundation Agreement dated December 16, 1999, between ENH and Highland Park Hospital Foundation (“Foundation Agreement”);
5. All rights and title in and to use of the HPH Name and Marks on a permanent and exclusive basis (even as to ENH);
6. All Intellectual Property;
7. All governmental approvals, consents, licenses, permits, waivers, or other authorizations;
8. All rights under warranties and guarantees, express or implied;
9. All items of prepaid expense; and
10. All books, records, and files (electronic and hard copy).

Provided, however, that the Highland Park Hospital Assets shall not include assets not

located exclusively in Highland Park, Illinois, whose use is shared with or among other ENH Acute Care Hospitals.

- P. "Hospital Provider Contract" means a contract between a Payor and any hospital to provide General Acute Care Inpatient Hospital Services and related healthcare services to enrollees of health plans.
- Q. "HPH Name and Marks" means the name "Highland Park Hospital" and "HPH," and any variation of these names, in connection with the Highland Park Hospital Assets, and all other associated trade names, business names, proprietary names, registered and unregistered trademarks, service marks and applications, domain names, trade dress, copyrights, copyright registrations and applications, in both published works and unpublished works, relating to the Highland Park Hospital Assets.
- R. "Intellectual Property" means, without limitation: (i) all patents, patent applications, and inventions and discoveries that may be patentable; (ii) all know-how, trade secrets, software, technical information, data, registrations, applications for governmental approvals, inventions, processes, best practices (including clinical pathways), formulae, protocols, standards, methods, techniques, designs, quality control practices and information, research and test procedures and information, and safety, environmental and health practices and information; (iii) all confidential or proprietary information, commercial information, management systems, business processes and practices, customer lists, customer information, customer records and files, customer communications, procurement practices and information, supplier qualification and approval practices and information, training materials, sales and marketing materials, customer support materials, advertising and promotional materials; and (iv) all rights in any jurisdiction to limit the use or disclosure of any of the foregoing, and rights to sue and recover damages or obtain injunctive relief for infringement, dilution, misappropriation, violation or breach of any of the foregoing.
- S. "Merger" means the merger of Highland Park Hospital into ENH pursuant to the Agreement and Plan of Merger among Evanston Northwestern Healthcare Corporation, Lakeland Health Services, Inc., and Highland Park Hospital dated as of October 29, 1999, which was consummated on or about January 1, 2000.
- T. "Monitor" means the Person appointed pursuant to Paragraph V. of this Order.
- U. "Payor" means any Person that pays, or arranges for payment, for all or part of any General Acute Care Inpatient Hospital Services for itself or for any other Person. Payor includes any Person that develops, leases, or sells access to networks of Acute Care Hospitals.
- V. "Person" means any individual, partnership, firm, corporation, association, trust, unincorporated organization or other entity or governmental body.

- W. “Post-Merger Hospital Business” means all activities relating to the provision of General Acute Care Inpatient Hospital Services and other related health care services conducted by ENH after the Merger, including, but not limited to, all health care services, including outpatient services, offered at Highland Park Hospital.
- X. “Pre-Merger Highland Park Hospital Business” means all activities relating to the provision of General Acute Care Inpatient Hospital Services and other related healthcare services that Highland Park Hospital was offering prior to the Merger.
- Y. “Respondent” means ENH.
- Z. “Transitional Administrative Services” means administrative assistance with respect to the operation of an Acute Care Hospital and related health care services, including but not limited to assistance relating to billing, accounting, governmental regulation, human resources management, information systems, managed care contracting, and purchasing.
- AA. “Transitional Clinical Services” means clinical assistance and support services with respect to operation of an Acute Care Hospital and related health care services, including but not limited to cardiac surgery, oncology services, and laboratory and pathology services.
- BB. “Transitional Services” means Transitional Administrative Services and Transitional Clinical Services.

II.

IT IS FURTHER ORDERED that:

- A. No later than one hundred eighty (180) days from the date the divestiture requirements of this Order become final, Respondent shall divest and convey the Highland Park Hospital Assets at no minimum price, absolutely and in good faith, to an Acquirer that receives the prior approval of the Commission and in a manner (including an executed divestiture agreement) that receives the prior approval of the Commission. To the extent that:
 - 1. The Highland Park Hospital Assets as of the date the divestiture requirements of this Order become final do not include (i) assets that Respondent acquired on the date of the Merger, (ii) assets that replaced those acquired on the date of the Merger, or (iii) any other assets that Respondent acquired and has used in or that are related to the Post-Merger Hospital Business in Highland Park, Illinois, *then* Respondent shall add to the Highland Park Hospital Assets additional assets (of a quality that meets generally acceptable standards of performance) to replace the assets that no longer exist, are no longer controlled by Respondent, or are no longer located in Highland Park, Illinois;

2. After the Merger and prior to the date the divestiture requirements of this Order become final, Respondent terminated any clinical service, clinical program, support function, or management function (i) performed by the Pre-Merger Highland Park Hospital Business, or (ii) performed by the Post-Merger Hospital Business in Highland Park, Illinois, *then* Respondent shall restore such service, program, or function (of a quality that meets generally acceptable standards of care or performance), no later than the date the Highland Park Hospital Assets are divested, or any other date that receives the prior approval of the Commission.

Provided, however, that Respondent shall not be required to replace any asset or to restore any service, program or function contemplated by Paragraphs II.A.1. or II.A.2. of this Order only if in each instance Respondent can demonstrate to the Commission that such asset, service, program or function is not necessary to achieve the purpose of this Order, and that the Acquirer does not need such asset, service, program or function to effectively operate the Acquirer Hospital Business in a manner consistent with the purpose of this Order, and the Commission approves the divestiture without the replacement or restoration of such asset, service, program or function.

- B. Respondent shall comply with all terms of the Divestiture Agreement approved by the Commission pursuant to this Order, and any breach by Respondent of any term of the Divestiture Agreement shall constitute a violation of this Order.
- C. Respondent shall cooperate with the Acquirer to ensure that the Highland Park Hospital Assets are transferred to the Acquirer as a financially and competitively viable Acute Care Hospital operating as an ongoing business, including but not limited to providing assistance necessary to transfer to the Acquirer all governmental approvals needed to operate the Highland Park Hospital Assets as an Acute Care Hospital.
- D. No later than the date the Highland Park Hospital Assets are divested, ENH shall grant to the Acquirer an ENH License for any use in the Acquirer Hospital Business, and shall take all actions necessary to facilitate the unrestricted use of the ENH License.
- E. Respondent shall take all actions necessary to assist the Acquirer in ensuring the provision or continuation of a cardiac surgery program at Highland Park Hospital that is capable of providing an equivalent standard of care and performance and functioning in substantially the same manner as the cardiac surgery program established and provided at Highland Park Hospital after the Merger. *Provided, however,* that Respondent shall not be required to assist the Acquirer in ensuring the provision or continuation of a cardiac surgery program as contemplated by this Paragraph II.E. only if the Respondent can demonstrate to the Commission that the Acquirer does not need assistance from Respondent in providing or continuing a cardiac surgery program, or that a cardiac surgery program is not necessary to achieve the purpose of this Order, and the Commission approves the divestiture without the provision or continuation of a cardiac

surgery program.

- F. Respondent shall take all actions necessary and shall effect all arrangements in connection with the divestiture of the Highland Park Hospital Assets as will ensure that the Acquirer can conduct the Acquirer Hospital Business in substantially the same manner as Respondent has conducted the Post-Merger Hospital Business at Highland Park Hospital, with an independent full-service medical staff capable of providing General Acute Care Inpatient Hospital Services, and an independent full-service hospital staff and management, including, but not limited to, providing Transitional Services, the opportunity to recruit and employ ENH Employees, and the opportunity to recruit, contract with, and extend medical staff privileges to any ENH Medical Staff Member, including as provided in Paragraphs II.G., II.H., and II .I. of this Order.
- G. At the request of the Acquirer, for a period not to exceed twelve (12) months from the date Respondent divests the Highland Park Hospital Assets, except as otherwise approved by the Commission, and in a manner (including pursuant to an agreement) that receives the prior approval of the Commission:
1. Respondent shall provide Transitional Services to the Acquirer sufficient to enable the Acquirer to conduct the Acquirer Hospital Business in substantially the same manner that Respondent has conducted the Post-Merger Hospital Business at Highland Park Hospital; and
 2. Respondent shall provide the Transitional Services required by this Paragraph II.G. at substantially the same level and quality as such services are provided by Respondent in connection with its operation of the Post-Merger Hospital Business.

Provided, however, that Respondent shall not (i) require the Acquirer to pay compensation for Transitional Services that exceeds the Direct Cost of providing such goods and services, (ii) terminate its obligation to provide Transitional Services because of a material breach by the Acquirer of any agreement to provide such assistance, in the absence of a final order of a court of competent jurisdiction, or (iii) include a term in any agreement to provide Transitional Services that limits the type of damages (such as indirect, special, and consequential damages) that the Acquirer would be entitled to seek in the event of Respondent's breach of such agreement.

- H. Respondent shall allow the Acquirer an opportunity to recruit and employ any ENH Employee in connection with the divestiture of the Highland Park Hospital Assets so as to enable the Acquirer to establish an independent, full-service medical staff, hospital staff and management, including as follows:
1. No later than six (6) weeks before execution of a divestiture agreement, Respondent shall (i) identify each ENH Employee, (ii) allow the Acquirer an

opportunity to interview any ENH Employee, and (iii) allow the Acquirer to inspect the personnel files and other documentation relating to any ENH Employee, to the extent permissible under applicable laws.

2. Respondent shall (i) not offer any incentive to any ENH Employee to decline employment with the Acquirer, (ii) remove any contractual impediments with Respondent that may deter any ENH Employee from accepting employment with the Acquirer, including, but not limited to, any non-compete or confidentiality provisions of employment or other contracts with Respondent that would affect the ability of the ENH Employee to be employed by the Acquirer, and (iii) not otherwise interfere with the recruitment of any ENH Employee by the Acquirer, including, but not limited to, by refusing or threatening to refuse to extend medical staff privileges at any Respondent Acute Care Hospital.
 3. Respondent shall (i) vest all current and accrued pension benefits as of the date of transition of employment with the Acquirer for any ENH Employee who accepts an offer of employment from the Acquirer no later than thirty (30) days from the date Respondent divests the Highland Park Hospital Assets and (ii) provide any ENH Employee to whom the Acquirer has made a written offer of employment with reasonable financial incentives to accept a position with the Acquirer at the time of divestiture of the Highland Park Hospital Assets, including, but not limited to (and subject to Commission approval), payment of an incentive equal to up to six (6) months of such employee's base salary to be paid upon the employee's completion of one (1) year of employment with the Acquirer.
 4. For a period of two (2) years from the date the divestiture of the Highland Park Hospital Assets is completed, Respondent shall not, directly or indirectly, hire or enter into any arrangement for the services of any ENH Employee employed by the Acquirer, unless such ENH Employee's employment has been terminated by the Acquirer; *provided, however*, this Paragraph II.H.4. shall not prohibit Respondent from: (i) advertising for employees in newspapers, trade publications, or other media not targeted specifically at the employees, or (ii) hiring employees who apply for employment with Respondent, as long as such employees were not solicited by Respondent in violation of this Paragraph II.H.4.
- I. Respondent shall allow the Acquirer an unimpeded opportunity to recruit, contract with, and otherwise extend medical staff privileges to any ENH Medical Staff Member in connection with the divestiture of the Highland Park Hospital Assets so as to enable the Acquirer to establish an independent, complete, full-service medical staff, including as follows:
1. No later than the date of execution of a divestiture agreement, Respondent shall (i) identify each ENH Medical Staff Member, (ii) allow the Acquirer an opportunity to interview any ENH Medical Staff Member, and (iii) allow the Acquirer to

inspect the files and other documentation relating to any ENH Medical Staff Member, to the extent permissible under applicable laws.

2. Respondent shall (i) not offer any incentive to any ENH Medical Staff Member to decline to join the Acquirer's medical staff; (ii) remove any contractual impediments with Respondent that may deter any ENH Medical Staff Member from joining the Acquirer's medical staff, including, but not limited to, any non-compete or confidentiality provisions of employment or other contracts with Respondent that would affect the ability of the ENH Medical Staff Members to be recruited by the Acquirer; and (iii) not otherwise interfere with the recruitment of any ENH Medical Staff Member by the Acquirer, including, but not limited to, by refusing or threatening to refuse to extend medical staff privileges at any Respondent Acute Care Hospital.
- J. Except in the course of performing its obligations under this Order, Respondent shall:
1. not provide, disclose, or otherwise make available any trade secrets or any sensitive or proprietary commercial or financial information relating to the Acquirer or the Acquirer Hospital Business to any Person other than the Acquirer, and shall not use such information for any reason or purpose;
 2. disclose trade secrets or any sensitive or proprietary commercial or financial information relating to the Acquirer or the Acquirer Hospital Business to any Person other than the Acquirer (i) only in the manner and to the extent necessary to satisfy its obligations under this Order and (ii) only to Persons who agree in writing to maintain the confidentiality of such information;
 3. enforce the terms of this Paragraph II.J. as to any Person and take such action as is necessary, including training, to cause each such Person to comply with the terms of this Paragraph II.J., including any actions that Respondent would take to protect its own trade secrets or sensitive or proprietary commercial or financial information.
- K. No later than ninety (90) days from the date the Highland Park Hospital Assets are divested, Respondent shall terminate any Hospital Provider Contract negotiated or amended after the Merger that is in effect as of the date the divestiture provisions of this Order become final; *provided, however*, that nothing in this Paragraph II.K. shall preclude Respondent (i) from completing any post-termination obligations relating to any Hospital Provider Contract or (ii) from entering into a new Hospital Provider Contract with any Payor after the current contract has been terminated.

III.

IT IS FURTHER ORDERED that:

- A. From the date this Order becomes final (without regard to the finality of the divestiture requirements herein) until the date the Highland Park Hospital Assets are divested pursuant to this Order, Respondent shall take such actions as are necessary to maintain the viability, marketability, and competitiveness of the Highland Park Hospital Assets and the Post-Merger Hospital Business relating to the Highland Park Hospital Assets. Among other things that may be necessary, Respondent shall:
1. Maintain the operations of the Post-Merger Hospital Business relating to the Highland Park Hospital Assets in the ordinary course of business and in accordance with past practice (including regular repair and maintenance of the Highland Park Hospital Assets).
 2. Use best efforts to maintain and increase sales of the Post-Merger Hospital Business relating to the Highland Park Hospital Assets, and to maintain at budgeted levels for the year 2005 or the current year, whichever are higher, all administrative, technical, and marketing support for the Post-Merger Hospital Business relating to the Highland Park Hospital Assets.
 3. Use best efforts to maintain the current workforce and to retain the services of employees and agents in connection with the Post-Merger Hospital Business relating to the Highland Park Hospital Assets, including payment of bonuses as necessary, and maintain the relations and good will with customers, suppliers, vendors, employees, landlords, creditors, agents, and others having business relationships with the Post-Merger Hospital Business relating to the Highland Park Hospital Assets.
 4. Assure that Respondent's employees with primary responsibility for managing and operating the Post-Merger Hospital Business relating to the Highland Park Hospital Assets are not transferred or reassigned to other areas within Respondent's organization except for transfer bids initiated by employees pursuant to Respondent's regular, established job posting policy.
 5. Provide sufficient working capital to maintain the Post-Merger Hospital Business relating to the Highland Park Hospital Assets as an economically viable and competitive ongoing business and shall not, except as part of a divestiture approved by the Commission pursuant to this Order, remove, sell, lease, assign, transfer, license, pledge for collateral or otherwise dispose of the Highland Park Hospital Assets.
- B. No later than forty five (45) days from the date this Order becomes final, Respondent

shall file a verified written report to the Commission that identifies (i) all assets included in the Highland Park Hospital Assets, (ii) all assets originally acquired or that replace assets originally acquired by Respondent as a result of the Merger, (iii) all assets relating to the Post-Merger Hospital Business in Highland Park, Illinois, that are not included in the Highland Park Hospital Assets, and (iv) all clinical services, support functions, and management functions that ENH discontinued at Highland Park Hospital after the Merger (hereinafter "Accounting").

IV.

IT IS FURTHER ORDERED that no later than ten (10) days from the date this Order becomes final (without regard to the finality of the divestiture requirements herein), Respondent shall provide a copy of this Order and Complaint to each of Respondent's officers, employees, or agents having managerial responsibility for any of Respondent's obligations under Paragraphs II and III of this Order.

V.

IT IS FURTHER ORDERED that:

- A. At any time after this Order becomes final (without regard to the finality of the divestiture requirements herein), the Commission may appoint a Person ("Monitor") to monitor Respondent's compliance with its obligations under this Order, consult with Commission staff and report to the Commission regarding Respondent's compliance with its obligations under this Order.
- B. If a Monitor is appointed pursuant to Paragraph V.A. of this Order, Respondent shall consent to the following terms and conditions regarding the powers, duties, authorities, and responsibilities of the Monitor:
 - 1. The Monitor shall have the power and authority to monitor Respondent's compliance with the terms of this Order, and shall exercise such power and authority and carry out the duties and responsibilities of the Monitor pursuant to the terms of this Order and in a manner consistent with the purposes of this Order and in consultation with the Commission or its staff.
 - 2. Within ten (10) days after appointment of the Monitor, Respondent shall execute an agreement that, subject to the approval of the Commission, confers on the Monitor all the rights and powers necessary to permit the Monitor to monitor Respondent's compliance with the terms of this Order in a manner consistent with the purposes of this Order. If requested by Respondent, the Monitor shall sign a confidentiality agreement prohibiting the use, or disclosure to anyone other than the Commission (or any Person retained by the Monitor pursuant to Paragraph V.B.5. of this Order), of any competitively sensitive or proprietary information

gained as a result of his or her role as Monitor, for any purpose other than performance of the Monitor's duties under this Order.

3. The Monitor's power and duties under this Paragraph V shall terminate three business days after the Monitor has completed his or her final report pursuant to Paragraph V.B.8.(ii), or at such other time as directed by the Commission.
4. Respondent shall cooperate with any Monitor appointed by the Commission in the performance of his or her duties, and shall provide the Monitor with full and complete access to Respondent's books, records, documents, personnel, facilities and technical information relating to compliance with this Order, or to any other relevant information, as the Monitor may reasonably request. Respondent shall cooperate with any reasonable request of the Monitor. Respondent shall take no action to interfere with or impede the Monitor's ability to monitor Respondent's compliance with this Order.
5. The Monitor shall serve, without bond or other security, at the expense of Respondent, on such reasonable and customary terms and conditions as the Commission may set. The Monitor shall have authority to employ, at the expense of Respondent, such consultants, accountants, attorneys and other representatives and assistants as are reasonably necessary to carry out the Monitor's duties and responsibilities. The Monitor shall account for all expenses incurred, including fees for his or her services, subject to the approval of the Commission.
6. Respondent shall indemnify the Monitor and hold the Monitor harmless against any losses, claims, damages, liabilities, or expenses arising out of, or in connection with, the performance of the Monitor's duties, including all reasonable fees of counsel and other expenses incurred in connection with the preparation for, or defense of, any claim, whether or not resulting in any liability, except to the extent that such losses, claims, damages, liabilities, or expenses result from the Monitor's gross negligence or wilful misconduct. For purposes of this Paragraph V.B.6., the term "Monitor" shall include all Persons retained by the Monitor pursuant to Paragraph V.B.5. of this Order.
7. If at any time the Commission determines that the Monitor has ceased to act or failed to act diligently, or is unwilling or unable to continue to serve, the Commission may appoint a substitute to serve as Monitor in the same manner as provided by this Order.
8. The Monitor shall report in writing to the Commission (i) every sixty (60) days from the date this Order becomes final, (ii) no later than thirty (30) days from the date Respondent completes its obligations under this Order, and (iii) at any other time as requested by the staff of the Commission, concerning Respondent's compliance with this Order.

- C. Respondent shall submit the following reports to the Monitor: (i) no later than twenty (20) days after the date the Monitor is appointed by the Commission pursuant to Paragraph V.A., a copy of the Accounting required by Paragraph III.B. of this Order; and (ii) copies of all compliance reports filed with the Commission.
- D. The Commission may on its own initiative or at the request of the Monitor issue such additional orders or directions as may be necessary or appropriate to assure compliance with the requirements of this Order.

VI.

IT IS FURTHER ORDERED that:

- A. If Respondent has not divested, absolutely and in good faith the Highland Park Hospital Assets within the time and manner required by Paragraph II.A. of this Order, the Commission may at any time appoint one or more Persons as Divestiture Trustee to divest the Highland Park Hospital Assets, at no minimum price, in a manner that satisfies the requirements of this Order.
- B. In the event that the Commission or the Attorney General brings an action pursuant to § 5(l) of the Federal Trade Commission Act, 15 U.S.C. § 45(l), or any other statute enforced by the Commission, Respondent shall consent to the appointment of an Divestiture Trustee in such action. Neither the appointment of a Divestiture Trustee nor a decision not to appoint a Divestiture Trustee under this Paragraph VI shall preclude the Commission or the Attorney General from seeking civil penalties or any other relief available to it, including appointment of a court-appointed Divestiture Trustee, pursuant to § 5(l) of the Federal Trade Commission Act, or any other statute enforced by the Commission, for any failure by the Respondent to comply with this Order.
- C. If a Divestiture Trustee is appointed by the Commission or a court pursuant to this Paragraph VI, Respondent shall consent to the following terms and conditions regarding the Divestiture Trustee's powers, duties, authority, and responsibilities:
 - 1. Subject to the prior approval of the Commission, the Divestiture Trustee shall have the exclusive power and authority to effect the divestiture for which he or she has been appointed pursuant to the terms of this Order and in a manner consistent with the purposes of this Order.
 - 2. Within ten (10) days after appointment of the Divestiture Trustee, Respondent shall execute an agreement that, subject to the prior approval of the Commission and, in the case of a court-appointed Divestiture Trustee, of the court, transfers to the Divestiture Trustee all rights and powers necessary to permit the Divestiture Trustee to effect the divestiture for which he or she has been appointed.

3. The Divestiture Trustee shall have twelve (12) months from the date the Commission approves the agreement described in Paragraph VI.C.2. of this Order to accomplish the divestiture, which shall be subject to the prior approval of the Commission. If, however, at the end of the twelve-month period the Divestiture Trustee has submitted a plan of divestiture or believes that divestiture can be achieved within a reasonable time, the divestiture period may be extended by the Commission, or, in the case of a court appointed Divestiture Trustee, by the court.
4. Respondent shall provide the Divestiture Trustee with full and complete access to the personnel, books, records and facilities related to the assets to be divested, or to any other relevant information, as the Divestiture Trustee may request. Respondent shall develop such financial or other information as such Divestiture Trustee may reasonably request and shall cooperate with the Divestiture Trustee. Respondent shall take no action to interfere with or impede the Divestiture Trustee's accomplishment of the divestiture. Any delays in divestiture caused by Respondent shall extend the time for divestiture under this Paragraph in an amount equal to the delay, as determined by the Commission or, for a court-appointed Divestiture Trustee, by the court.
5. The Divestiture Trustee shall use his or her best efforts to negotiate the most favorable price and terms available in each contract that is submitted to the Commission, but shall divest expeditiously at no minimum price. The divestiture shall be made only to an Acquirer that receives the prior approval of the Commission, and the divestiture shall be accomplished only in a manner that receives the prior approval of the Commission; *provided, however*, if the Divestiture Trustee receives bona fide offers from more than one acquiring entity, and if the Commission determines to approve more than one such acquiring entity, the Divestiture Trustee shall divest to the acquiring entity or entities selected by Respondent from among those approved by the Commission; *provided, further*, that Respondent shall select such entity within ten (10) business days of receiving written notification of the Commission's approval.
6. The Divestiture Trustee shall serve, without bond or other security, at the cost and expense of Respondent, on such reasonable and customary terms and conditions as the Commission or a court may set. The Divestiture Trustee shall have the authority to employ, at the cost and expense of Respondent such consultants, accountants, attorneys, investment bankers, business brokers, appraisers, and other representatives and assistants as are necessary to carry out the Divestiture Trustee's duties and responsibilities. The Divestiture Trustee shall account for all monies derived from the divestiture and all expenses incurred. After approval by the Commission and, in the case of a court-appointed Divestiture Trustee, by the court, of the account of the Divestiture Trustee, including fees for his or her services, all remaining monies shall be paid at the direction of the Respondent,

and the Divestiture Trustee's power shall be terminated. The Divestiture Trustee's compensation shall be based at least in significant part on a commission arrangement contingent on the Divestiture Trustee's divesting the assets.

7. Respondent shall indemnify the Divestiture Trustee and hold the Divestiture Trustee harmless against any losses, claims, damages, liabilities, or expenses arising out of, or in connection with, the performance of the Divestiture Trustee's duties, including all reasonable fees of counsel and other expenses incurred in connection with the preparation for, or defense of any claim, whether or not resulting in any liability, except to the extent that such liabilities, losses, damages, claims, or expenses result from gross negligence or willful misconduct by the Divestiture Trustee. For purposes of this Paragraph VI.C.7., the term "Divestiture Trustee" shall include all Persons retained by the Divestiture Trustee pursuant to Paragraph VI.C.6. of this Order.
 8. If the Divestiture Trustee ceases to act or fails to act diligently, the Commission may appoint a substitute Divestiture Trustee in the same manner as provided in this Paragraph VI for appointment of the initial Divestiture Trustee.
 9. The Divestiture Trustee shall have no obligation or authority to operate or maintain the assets to be divested.
 10. The Divestiture Trustee shall report in writing to the Commission every sixty (60) days concerning the Divestiture Trustee's efforts to accomplish the divestiture.
- D. The Commission or, in the case of a court-appointed Divestiture Trustee, the court, may on its own initiative or at the request of the Divestiture Trustee issue such additional orders or directions as may be necessary or appropriate to accomplish the divestiture required by this Order.

VII.

IT IS FURTHER ORDERED that:

- A. Respondent shall file a verified written report with the Commission setting forth in detail the manner and form in which it intends to comply, is complying, and has complied with this Order (i) no later than thirty (30) days from the date this Order becomes final (without regard to the finality of the divestiture requirements herein), and every thirty (30) days thereafter (measured from the date the first report is filed) until the divestiture of the Highland Park Hospital Assets is accomplished, and (ii) thereafter, every sixty (60) days (measured from the date of divestiture) until the date Respondent completes its obligations under this Order; *provided, however*, that Respondent shall also file the report required by this Paragraph VII at any other time as the Commission may require.

- B. Respondent shall include in its compliance reports, among other things required by the Commission, a full description of the efforts being made to comply with the relevant Paragraphs of this Order, a description (when applicable) of all substantive contacts or negotiations relating to the divestiture required by Paragraph II of this Order, the identity of all parties contacted, copies of all written communications to and from such parties, internal documents and communications, and all reports and recommendations concerning the divestiture, the date of divestiture, and a statement that the divestiture has been accomplished in the manner approved by the Commission.

VIII.

IT IS FURTHER ORDERED that Respondent shall notify the Commission at least thirty (30) days prior to (1) any proposed dissolution of Respondent, (2) any proposed acquisition, merger or consolidation of Respondent, or (3) any other change in Respondent that may affect compliance obligations arising out of this Order, including but not limited to assignment, the creation or dissolution of subsidiaries, or any other change in Respondent.

IX.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this Order, and subject to any legally recognized privilege, and upon written request with reasonable notice, Respondent shall permit any duly authorized representative of the Commission:

- A. Access, during office hours and in the presence of counsel, to all facilities and access to inspect and copy all non-privileged books, ledgers, accounts, correspondence, memoranda and other records and documents in the possession or under the control of Respondent relating to any matter contained in this Order; and
- B. Upon five days' notice to Respondent and without restraint or interference from them, to interview their officers, directors, or employees, who may have counsel present, regarding any such matters.

By the Commission.

Donald S. Clark
Secretary

SEAL

ISSUED:

CERTIFICATE OF SERVICE

I hereby certify that on February 10, 2006, I caused the attached “Answering and Cross-Appeal Brief of Complaint Counsel (PUBLIC VERSION)” to be served upon the persons identified below and in the manner indicated:

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Federal Trade Commission
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Chul Pak

COMPLAINT COUNSEL'S CERTIFICATION OF ELECTRONIC COPY

Pursuant to Section 4.2(c)(3) of the Commission's Rule of Practice, 16 C.F.R. § 4.2(c)(3),

I hereby certify that the electronic copy of the Answering and Cross-Appeal Brief of Complaint Counsel (PUBLIC VERSION), filed on February 10, 2006, is a true and correct copy of the paper original.

2/10/06
Date

Chul Pak
Chul Pak
Complaint Counsel