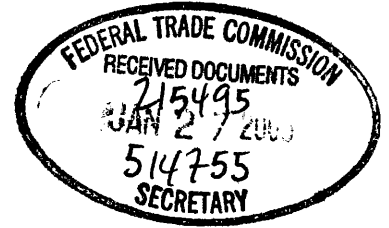


ORIGINAL

PUBLIC VERSION

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



DOCKET NO. 9315

In the Matter of

**EVANSTON NORTHWESTERN
HEALTHCARE CORPORATION**

COMPLAINT COUNSEL'S REVISED PRETRIAL BRIEF

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INTRODUCTION

On January 1, 2000, Evanston Northwestern Healthcare Corporation and Highland Park Hospital merged, forming a billion dollar company with three hospitals that controlled the market for general inpatient acute care hospital services in the Evanston, Illinois area. (CX0501 at ENH JH 004274-4948.) Exercising that market power, the hospitals immediately and successfully renegotiated their contracts with the managed health care companies with which they did business, imposing price increases for hospital services on managed care plans and employers, higher premiums for some enrollees and cancellations of health insurance for others. According to the hospitals' own records, in the first year after the merger, Respondent imposed price increases yielding an unprecedented { [REDACTED] } increase in revenues that was directly attributable to the market power that Respondent commanded due to the merger.

The merger of Evanston Northwestern Healthcare Corporation and Highland Park Hospital "substantially . . . lessen[ed] competition, or . . . tend[ed] to create a monopoly," in violation of section 7 of the Clayton Act, 15 U.S.C. § 18. Therefore, as established in a recent Commission decision involving another consummated merger challenge, the appropriate remedy is the divestiture of the acquired hospital, Highland Park.¹

STATEMENT OF THE CASE

In late 2002, the Commission initiated an investigation of the January 1, 2000, merger of Respondent Evanston Northwestern Healthcare Corporation ("ENH") and Lakeland Health Services, Inc., which owned and operated Highland Park Hospital ("Highland Park"). Before

¹ *In re: Chicago Bridge and Iron Co.*, Docket No. 9300 (January 6, 2005), reproduced at <http://www.ftc.gov/os/adjpro/d9300/050106opionpublicrecordversion9300.pdf>.

2000, ENH operated two acute care hospitals, Evanston Hospital, in Evanston, Illinois, and Glenbrook Hospital, in Glenview, Illinois, which is about ten miles west of Evanston. Highland Park is about ten to twelve miles north of Evanston Hospital and Glenbrook Hospital. Beginning in December 1999, and continuing after the merger was consummated, ENH began exercising the market power it gained through the merger by negotiating contracts on behalf of all three hospitals. Specifically, under the threat of terminating the existing contracts of ENH and Highland Park with managed care companies, { [REDACTED] [REDACTED] [REDACTED] }. (CX000016 at ENH DR 005703.) By raising the prices for hospital services, ENH significantly increased the cost of health care services and health care insurance to its customers.²

Based on this investigation, the Commission issued the Complaint in this action on February 10, 2004.³ In Counts I and II of the Complaint, the Commission alleges that the merger of ENH and Highland Park was anticompetitive and, as relief, seeks the divestiture of Highland Park to restore competition in the delivery of general acute care inpatient hospital services in the Evanston, Illinois area.⁴

² See Feldman, R. *et al.* "The Effect of Premiums on the Small Firm's Decision to Offer Health Insurance," *Journal of Human Resources* 32, 635-58 (1997).

³ <http://www.ftc.gov/os/caselist/0110234/040210emhcomplaint.pdf>.

⁴ Count III of the Complaint alleged that ENH Medical Group, Inc., a company related to Evanston Northwestern Healthcare Corporation, had engaged in price fixing, in violation of section 5 of the FTC Act, 15 U.S.C. § 45. Pursuant to a proposed Consent Agreement between the parties, the Secretary of the Commission withdrew Count III from Adjudication by Order dated January 18, 2005.

The issues before this Court are straightforward. In most recent cases brought under section 7 of the Clayton Act, 15 U.S.C. § 18, the government has challenged a proposed merger *prospectively*, before the merger has been consummated. In such cases, the court necessarily faces the task of attempting to predict *future* competitive effects with respect to a transaction that has not yet taken place. To do so, the parties and the court must use predictive tools that can do no more than provide indirect means of attempting to estimate what is likely to happen in the future.

Because this transaction has been consummated, the task that the Court faces is much simpler. We know what happened after the merger: there was an immediate, substantial price increase. Indeed, this effect is undisputed. At trial, Complaint Counsel's chief expert economist, Dr. Deborah Haas-Wilson, Professor of Economics at Smith College, will testify that ENH's price increases after the merger were significantly greater than the price increases charged by comparison groups of hospitals. As for the Respondent's expert, Dr. Jonathan Baker, he too acknowledges that ENH's price increases were at least { [REDACTED] } percentage points greater than those of comparison hospitals.⁵

The chief debate between the parties therefore turns on how to explain this large price increase at the time of the merger. Complaint Counsel's explanation is the one that ENH's executives gave to their Board at the time of the merger: they were able to extract higher prices because the merger gave them increased market power. This effect was by no means unexpected. Indeed, the evidence will show that for many years preceding the merger, ENH sought to

⁵ { [REDACTED] }
[REDACTED]
[REDACTED].

combine with other local hospitals for the purpose of increasing the prices it was able to charge its customers. Contemporaneous evidence shows that ENH expected that it would exercise enhanced market power as a result of its merger with Highland Park; it set about attempting to implement such price increases even before the merger had formally closed; and its executives reported back that they had succeeded, as a result of the merger, in renegotiating their contracts at substantially higher prices, just as they had expected.

Respondent's explanation of the enormous price increase is substantially more complicated. To begin with, it is not one story but two, because neither of Respondent's explanations can account for the price increases that ENH was able to achieve at *both* Evanston and Highland Park in the wake of the merger. To explain the price increase at Evanston, Respondent has forwarded the "learning about demand" theory, which might more simply be described as an "ignorance" defense. According to this story, ENH did not know that it was charging below-market prices until the time of the merger. Then, based on information that it obtained through the merger regarding Highland Park's pre-merger pricing, it realized that it could actually charge much higher prices for Evanston and, accordingly, it increased its prices at Evanston to ostensibly "competitive" levels.

Obviously this explanation tells us nothing about why prices increased at Highland Park, since it was Highland Park that was the ostensible source of ENH's new "learning." Even as an explanation for the Evanston price increase, however, Respondent's "ignorance" defense fails both as a matter of logic and of fact. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED].

More fundamentally, the record is utterly bereft of contemporaneous evidence that would support this implausible claim. If ENH truly had learned, through its acquisition of Highland Park, that { [REDACTED] [REDACTED] }, one might have expected at least *one* hand-slapping memorandum bemoaning their underperformance and attempting to account for it. More likely, heads would have rolled. But none of the executives who ostensibly failed to maximize prices, despite a decade of searching for ways to do so, lost his job in the wake of the merger. Instead, the evidence shows ENH executives internally exchanging high-fives – and seeking, and obtaining, bonuses from the Board – for having executed a transaction that turned out to be so profitable. When ENH’s executives testify at trial with bowed heads about their simple ignorance in failing to increase prices before the merger, it will be useful to keep those bonuses, and the executives’ prior representations to the Board, in mind.

Respondent’s “ignorance” defense fails for additional reasons, too. For example, the post-merger prices at Evanston far exceeded Highland Park’s pre-merger prices – a most surprising “learning” effect. Nor does the record support the fundamental premise of the “learning” theory, { [REDACTED]

[REDACTED]

[REDACTED]. Finally, and tellingly,

Respondent's expert promulgated a test in his expert report that he claimed could be used to determine whether the "learning" hypothesis were true. Respondent's price increases proceeded to flunk that test, using Respondent's own pricing data.

Respondent's efforts to explain the Highland Park price increase are equally unavailing. Respondent's explanation for price increases at Highland Park is "quality" – that is, there were not true price increases, if one accounts for the improvement in quality that accompanied the jump in prices. This theory provides no real explanation for the Evanston price increases – hence the need for the "learning" theory – because it was Highland Park's delivery of care that seemingly was improved as a result of its affiliation with ENH. Recognizing this, Respondent makes no substantial effort to show quality improvements at ENH, focusing instead on Highland Park.

Again, however, Respondent's explanation fails both as logic and as fact. As a matter of logic, it takes no great experience with hospitals to know that quality improvements do not happen overnight. Indeed, the purported quality improvements that Respondent identifies at Highland Park did not take effect until years after the merger. If Respondent's theory were correct, one would expect to see prices rising in that time frame. In fact, however, the evidence shows prices rising at Highland Park before the ink on the merger documents was even dry. This dramatic gap between the time in which the price increases were implemented, and the ostensible quality improvements that account for them, renders Respondent's quality claim as implausible as its learning story.

Nor do the facts provide any greater support for Respondent's quality claim. To begin with, improvements in quality are not secrets that one keeps from one's customers. If

improvements in the quality of care at Highland Park accounted for Respondent's ability to increase prices dramatically there, one would expect a bevy of documents from ENH to its customers heavily marketing why improvements in care at Highland Park justified agreeing to higher prices for its services. Instead, what the contemporaneous record on this point shows is – silence. Respondent did not attempt to persuade its customers that it was delivering a better service. As Respondent's customers will testify, they agreed to higher prices at Highland Park (and ENH) not because they believed the quality of care had improved there, but for the reason that ENH's executives knew well: the merger had enhanced ENH's market power. ENH was able to extract higher prices simply because it could, not because it was delivering better services.

Finally, as with Respondent's learning theory, the factual assumptions on which Respondent's quality claim is based simply are not there. { [REDACTED]

[REDACTED]

[REDACTED] }.

In short, the evidence at trial will establish that the merger led to a substantial price increase at the merging hospitals, and the contemporaneous evidence shows that ENH and its customers both explained the price increases the same way: they resulted from ENH's enhanced market power as a result of the merger. The remedy for such an anticompetitive merger is straightforward: divestiture of Highland Park. Respondent will argue that this remedy is inappropriate, but a long line of case law, reflected most recently in the Commission's decision in *In re Chicago Bridge and Iron Co.*, Docket No. 9300 (January 6, 2005),⁶ puts this argument to

⁶ <http://www.ftc.gov/os/adjpro/d9300/050106opionpublicrecordversion9300.pdf>.

rest.

In *Chicago Bridge*, an FTC challenge of a consummated merger, the Commission was explicit: “. . . [D]ivestiture is the most appropriate remedy . . .” that can be used to “pry open to competition [the] market[s] that [have] been closed by defendants’ illegal restraints.”⁷ Thus, the Commission’s equitable powers encompass the authority, upon finding a violation of section 7 of the Clayton Act, to “place[] the burden of unscrambling the merger” on the respondent’s shoulders.⁸ The goal of the relief is to “effectively . . . eliminate the tendency of the acquisition condemned by § 7.”⁹ Relying on well established precedent, the Commission concluded that divestiture is the necessary remedy – and it is in the public interest – “to *eliminate the effects* of the acquisition offensive to the statute.” *Id. quoting Ford Motor Co. v. United States*, 405 U.S. 562, 573 n. 8 (1972) (emphasis in original). In short, when the acquiring party has created the problems, “equity necessitates that [it] help solve them.”¹⁰

* * * * *

In this pretrial brief, Complaint Counsel summarizes the evidence that they will present at trial demonstrating that the merger of Evanston Northwestern Healthcare Corporation and Highland Park Hospital violated the antitrust laws. To this end, the brief addresses the following topics:

First, the brief discusses the health care delivery system and why transactions for the sale

⁷ *Id.* at 93, *quoting du Pont, supra*, 366 U.S. at 323.

⁸ *Id.* at 94.

⁹ *Id.* at 102, *quoting du Pont, supra*, 366 U.S. at 331-32.

¹⁰ *Id.* at 94.

and purchase of health care services are different than transactions involving most other goods or services. Specifically, in this case, Complaint Counsel will demonstrate that, although hospital services are delivered to a patient at the direction of a doctor, the managed care plan, as the payer, is properly considered the “customer” in a transaction.

Second, the brief sets forth the factual background of the ENH merger with Highland Park.

Third, in the Argument section, the brief summarizes the legal standards that are used under section 7 of the Clayton Act, and, using two different analytical approaches as set forth in both Counts I and II of the Complaint, explains why the merger of ENH and Highland Park violated section 7 of the Clayton Act.

Next, the brief addresses the affirmative defenses that Respondent will likely offer to rationalize the price increases that it implemented immediately after the merger.

Finally, the brief discusses why the divestiture of Highland Park is the appropriate remedy for this clear violation of section 7 of the Clayton Act, 15 U.S.C. § 18.

BACKGROUND

I. THE HEALTH CARE DELIVERY SYSTEM IN THE UNITED STATES

The United States has an employer-based system of health insurance in which 90 percent of persons with private health insurance¹¹ obtain their insurance through their employer or the

¹¹ This case focuses exclusively on the purchase and sale of general acute care hospital services to individuals insured through private managed care plans, as discussed more fully below.

It does not include other insurance programs such as, in particular, government programs like Medicare or Medicaid. Under Medicare, a federally-sponsored health insurance program for the elderly, the Centers for Medicare and Medicaid Services of the Department of Health and

employer of a family member. Employers provide health insurance to employees either by purchasing insurance coverage from one or more insurance companies or by “self-insuring,” *i.e.*, paying for the health care costs themselves. Even under this latter system, also known as “self-insurance,” the employer typically contracts with an insurance company to administer the self-insurance plan.

In turn, the insurance company is typically responsible for negotiating contracts with a range of health care “providers” – hospitals, doctors, nursing homes, and others – that specify the terms for the provision of care to eligible beneficiaries of the insurance company’s plans. Most importantly, these contracts specify the price that the provider of the health care services will be paid for services that are covered by the contract, whether by the insurance company itself or by the self-insurance plan of an employer that contracts with the insurer.

The Introduction of Managed Care

Health insurance has changed significantly in the past twenty or so years, in ways that substantially affect the antitrust analysis of hospital mergers. Until the early 1980s, most health insurance plans were “indemnity plans.” Under an indemnity plan, an insurer usually contracted with all providers in an area and typically it directly paid hospitals for services using the same formula in all of its contracts. Based on this universal contracting, an enrollee in the plan (and his or her doctor) had virtually complete discretion in choosing the hospital at which to seek

Human Services, unilaterally establishes by statute and regulation a payment system for services. *See* 42 U.S.C. § 1395ww(d). Under Medicaid, a joint federal-state health insurance program for the indigent, the states, with the approval of the federal government, establish by statute and regulations a payment system for services. *See* 42 U.S.C. §§ 1396 *et seq.* Under both programs, the rates are unilaterally established by the government agency and the hospitals do not engage in contract negotiations for the rates they will be paid.

services. Further, in most traditional indemnity plans, the insurer assumed complete liability for any covered medical services furnished by a hospital. The patient usually did not have any liability for the hospital services he or she received except, possibly, for a deductible and a co-payment that were the same regardless of the hospital at which the patient sought services.

As Complaint Counsel's witnesses will testify, today, in contrast the dominant form of private health insurance is "managed care." A managed care plan may use a variety of tools to reduce the total cost of covered services that are furnished to enrollees of the plan, such as a requirement that the enrollee obtain the insurer's prior approval of the procedure or treatment in order for the service to be covered under the insurance plan. However, the one common feature of all managed care plans is that – unlike indemnity insurance – a managed care plan exercises significant discretion in *choosing* the providers with which it contracts.

Using this strategy of "selective contracting," the managed care plan contracts with (and beneficiaries of the managed care plan obtain covered services from) a discrete group of hospitals and physicians, commonly referred to, collectively, as the managed care plan's "network." If an enrollee receives treatment from a hospital in the network, the managed care plan generally will pay most if not all of the hospital's bill for those services. In contrast, if an enrollee receives treatment from a provider outside the network, the enrollee must pay a higher portion (and, sometimes, 100 percent) of the charges for the services.¹²

¹² Managed care insurance plans come in various shapes and sizes. Three of the most common types are health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and point-of-service plans ("POSs"). These types of plans differ from one another along a number of dimensions including: (1) the size and inclusiveness of the provider network; (2) the financial penalty for using providers outside of the network; (3) the referral requirements before seeing a specialist; and (4) the extent of coverage.

An integral component of selective contracting is that a managed care plan no longer enters into a form contract with all hospitals, using a standard payment formula. Instead, the managed care company and each contracting hospital negotiate a price that the managed care plan will pay for the hospital services that the contracting hospital furnishes to enrollees of that managed care plan.¹³ In other words, managed care introduced price competition among hospitals for managed care contracts, and the managed care company – not the doctor or patient – became the hospital’s customer for the purposes of the contract terms under which managed care would be delivered.

With the introduction of price competition, hospitals and managed care plans have begun to use a variety of formulas and methodologies for determining payment rates. While these terms will be included in a glossary that the parties will prepare at the request of the Court, Complaint Counsel and its witnesses will regularly use two specific terms relating to the payment formulas used in managed care contracts that should be brought to the attention of the Court for the purposes of this brief.

One standard and common payment formula is known as a “per diem” formula. Under a

The differences between these types of plans are becoming increasingly difficult to discern, but HMOs traditionally have more restrictive provider networks, larger financial penalties for receiving care outside of the network, gate-keeper requirements, and greater coverage for preventive care. PPO plans tend to have more inclusive provider networks and fewer referral requirements. PPOs also tend to have financial penalties for using providers outside the network although fewer providers tend to be outside the network. POS plans tend to have more restrictive networks, but lower financial penalties for using out-of-network providers.

¹³ For example, a contract may set forth the extent and the procedures for the insurance company to monitor and control the hospital utilization of the managed care plan enrollees, such as whether the insurer must pre-approve, or the details of the billing arrangement and payment mechanics between the hospital and insurance company.

contract that incorporates a “per diem” formula, the managed care plan pays the hospital a negotiated fixed dollar amount for each day of care the hospital furnishes to an enrollee of the plan, regardless of the amount or type of services the hospital actually provides to that patient each day. In general, managed care plans prefer this type of formula because the contractual rate is fixed for the period of the contract, and the likely cost of covered services is relatively easy to project.

Alternatively, there is a formula known as a “discount-off-charges” formula. In a contract using this formula, the managed care plan’s payment to a hospital for the services furnished to an enrollee is based on the hospital’s list prices for its goods or services. Applying this formula, a managed care plan generally pays a hospital a percentage of the list price of each individual item or service that the hospital actually uses in furnishing care to an enrollee of the managed care plan.

Importantly, the individual hospital’s list prices are set forth in what is known in the industry as the hospital’s “charge master.” At ENH, the charge master sets forth ENH’s list prices for approximately {██████} different items that the hospital might use in the provision of inpatient care. (Washa, Tr. 47; Hodges, Tr. at 47; Hillebrand, Tr. at 327.) In general, managed care plans disfavor the use of this formula because it can facilitate the hospital’s ability unilaterally to increase the contract price the managed care plan must pay. (Hodges, Tr. at 130.) In other words, absent some sort of contractual limitations, a contract incorporating a “discount off charges” formula can give the hospital significant control over the prices that the managed care plan actually must pay for services furnished under the contract, because the hospital

typically retains discretion to increase the list prices in its charge master.¹⁴

* * * * *

In sum, managed care has effected a fundamental change in the market for health care services – a change that has important consequences for antitrust analysis. Before managed care, indemnity insurers routinely contracted with all hospitals, and the patient (and his or her doctor) had virtually complete discretion in choosing the hospital at which he or she would seek services. Therefore, under the former system, a hospital competed by trying to attract patients (and their doctors) to seek care at its facility. Now that managed care is in place, however, managed care plans selectively contract with individual hospitals, and the contracting decisions of the managed care company will determine the hospital(s) at which the patient (and his or her doctor) might seek services. Further, under managed care, a hospital now competes with other hospitals for the business of a managed care plan by offering competitive prices that will attract the managed care companies to purchase health care services from that hospital.

II. THE MERGER OF ENH AND HIGHLAND PARK.

Before the 2000 merger, Evanston Northwestern Healthcare Corporation and Lakeland

¹⁴ “Per diems” and “discount off charges” are merely the two dominant pricing formulas in the contracts between a managed care plan and a hospital.

There are other formulas: for example, a managed care plan and a hospital can negotiate fixed rate for all services furnished to a patient for a particular hospital stay. This approach is commonly used for maternity care; the contract will specify one fixed rate for the delivery of a child, together with all necessary care for the mother and baby until discharge, and second fixed rate for a caesarian section, together with all necessary care for the mother and baby until discharge. *E.g.* CX05029 at ENH JL 007485.

Finally, a hospital and the managed care contract may enter a set of contracts concurrently that incorporates each of these formulas, depending on the type of care that is rendered.

000766.) { [REDACTED]

[REDACTED]

[REDACTED]}. (CX01782 at NHN 000873.)

{ [REDACTED]

[REDACTED]}.

(CX01802 at NHN 001092.) As the Network's minutes confirm, "{ [REDACTED]

[REDACTED]}." { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]}. (CX01768 at NHN 000117-18.)

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]}." (CX01802 at NHN001090.) Mark

Neaman, the chief executive officer of ENH, confirmed that Mr. Spaeth's views were the

"{ [REDACTED]}." (CX01802 at NHN 001091.) Mr. Neaman

was blunt: { [REDACTED]

[REDACTED]}." *Id.* (emphasis added).¹⁷

¹⁷ In the end, it is probably better that the Network was never successful: without meaningful operational integration, the Network's joint contracting on behalf of its members would have constituted price-fixing, a violation of section 5 of the FTC Act. *In re: North Texas Specialty Physicians*, Docket No. 9312 (Initial Dec., Nov. 15, 2004) (Chappell, J.) (joint negotiation of managed care contracts by doctors constituted price-fixing in violation of section 5 of the FTC Act); see *New York v. St. Francis Hospital*, 94 F. Supp.2d 399 (S.D.N.Y. 2000)

sustainable pricing through managed care contracting.” (CX00395 at ENH JH 007182.)

As in its other initiatives, ENH again relied on the assistance of Bain & Company, a consulting group that it regularly retained. In preparation for ENH’s discussions with Northwest Community and Highland Park in 1996, Bain presented various tactics for revenue and market share gain. (CX00066 at ENH JH 000329-350.) { [REDACTED]

[REDACTED] }.” (CX00066 at ENH JH 000339.) Nevertheless, the merger discussions fell through. (Neaman, Tr. 169; Stearns, Tr. 64-66.)

C. ENH/Highland Park Merger

As a final effort, ENH and Highland Park decided to merge. (CX00001 at ENH RG 000145; CX00002 at ENH RS 005451; Neaman, Tr. 169; Stearns, Tr. 64-66.) The discussions, which continued through the fall of 1999, ultimately culminated in the ENH-Highland Park merger that closed in January 2000.

The goals of the ENH and Highland Park merger were the same as the Network and NH North: to gain market power through the merger and to increase prices. For example, in a December 1998 meeting between their chief executive officers, ENH presented { [REDACTED]

[REDACTED] }.” (CX00442 at ENH MN 002046.) { [REDACTED] },” ENH aimed to “{ [REDACTED]

[REDACTED] }.” (CX00442 at ENH MN 002047.)

Highland Park shared this “vision.” In a senior Highland Park management meeting in

early 1999, Ronald Spaeth stated that the combined entity would be able { [REDACTED] }
[REDACTED]}. (Spaeth, Tr. at 203, 214.) The minutes to the meeting reflect view that it would be

“{ [REDACTED] }
[REDACTED]
[REDACTED] }.”

As the evidence will show, ENH and Highland Park realized their “vision” through the merger. Managed care organizations viewed the combined ENH-Highland Park entity as “{ [REDACTED] }”. Indeed, not only did the merged { [REDACTED] } managed care companies but, as discussed below, the merger created a monolith that commanded supracompetitive prices.

ENH exercised its enhanced market power through two interrelated business strategies.

Contract Negotiations. Even before the merger was consummated, ENH started demanding higher prices for all three hospitals. As a first step, { [REDACTED] }
[REDACTED]
[REDACTED] }. (Neaman Tr. 327-28; see, e.g., CX05900 at ENHL RB 000022; CX05901 at ENHL RB 002144.) { [REDACTED]

[REDACTED]
[REDACTED] }. (*Id.*)
[REDACTED]
[REDACTED]

Unilateral Price Increases. ENH complemented its contract negotiations by implementing a unilateral set of price increases for the goods and services it used in providing care. As noted above, ENH, like most hospitals, maintains a “charge master,” which is a set of list prices for its goods and services. At the same time ENH insisted on more favorable contracts with the managed care plans, it also increased the list prices for the goods and services that would be sold pursuant to those contracts.

This strategy was possible because, in its contract renegotiations, ENH had forced numerous managed care companies to change the payment formula in their contracts from a per diem formula to a discount off charges formula. As more managed care companies had to agree to pay ENH based on its list price for that good or service, ENH could further increase its real prices by regularly – and unilaterally – increasing its list prices for those goods and services.

At the time of the merger, ENH established a “Chargemaster Transition Team.” (*E.g.*, CX02240 at ENH DS 000035.) The goals of the Team were explicit: “{ [REDACTED]

[REDACTED]}.” (*E.g.*, CX02238 at ENH DS 000311.) To do this, { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]}.

¹⁹ Thus, for example, { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]}.

(CX02240 at ENH DS 000045.)

ENH continued this strategy after the merger. In 2002, ENH implemented a “[REDACTED]”
[REDACTED]
[REDACTED]}. (Hodges, Tr. at 47; Hillebrand, Tr. at 327). In implementing the Project, ENH exhibited little concern about the reactions of the managed care plans with which it contracted. As Mr. Hillebrand testified, he decided that ENH [REDACTED]
[REDACTED]
[REDACTED]}. (Hillebrand, Tr. at 348).
[REDACTED]
[REDACTED]}. (CX00043 at ENH JH 007105.) By April 2002, ENH estimated that, through this single initiative, it had changed the list prices for [REDACTED]
[REDACTED]}. (CX00045 at ENH JH 004956.)

* * * * *

In sum, through these two interrelated strategies – renegotiating its contracts and increasing the list prices on its charge master – ENH successfully charged higher prices that it commanded through the market power it gained in its merger with Highland Park.

ARGUMENT

In Counts I and II of the Complaint, Complaint Counsel sets forth two related but distinct violations of section 7 of the Clayton Act. *See Complaint* at ¶¶ 15-32. Both counts allege that the merger substantially lessened competition as ENH raised prices to managed care plans, that entry by new competitors would not remedy the anticompetitive effects, and that no overriding

efficiencies exist to rescue the merger.

The counts differ, however, with respect to their market allegations. Count I follows the traditional structural approach by laying out specific product and geographic markets as well as alleging a substantial increase in concentration. *See Complaint* at ¶¶ 16-18.

Count II does not elaborately allege the product and geographic markets in which the merger of ENH and Highland Park had anticompetitive effects. Instead, the count alleges that, after the merger, ENH forced managed care companies to pay significantly higher prices for general inpatient acute care hospital services in the Evanston, Illinois area, in violation of section 7 of the Clayton Act. Even without precise market definitions, the allegations in Count II are sufficient to allege that the merger “substantially lessened competition in a line of commerce in a section of the country” in accordance with section 7 of the Clayton Act.

The evidence supports the allegations in each count, and each count makes out a valid and complete section 7 violation. For Count I, the evidence, including the testimony of ENH’s own expert, will establish that the merger led to increasing, and very high levels of market concentration sufficient to constitute a *prima facie* case of illegality. For Count II, the existence of actual anticompetitive effects in this retrospective analysis provides direct proof that the merger was anticompetitive.

The remainder of this Argument proceeds in five parts. Part I addresses some of the underlying legal issues raised in this case, including some of the erroneous analytical methodologies used in past hospital cases. Part II shows that Complaint Counsel should prevail on Count II of the Complaint, because the merger at issue here resulted in ENH gaining substantial market power, and the price increases resulting from the merger were caused by this

increased market power, not ENH's enhanced "learning" or improved "quality." Part III demonstrates that Complaint Counsel also should prevail under Count I of the Complaint, because the enhanced market power actually gained by ENH after the merger is to be expected given a properly defined product and geographic market. Part IV addresses why Respondent's various affirmative defenses fail. Finally, Part V demonstrates that the presumed remedy of divestiture is the appropriate one here.

I. LEGAL STANDARDS UNDER SECTION 7 OF THE CLAYTON ACT

Section 7 of the Clayton Act provides the statutory framework governing mergers and acquisitions. Section 7 prohibits a merger or acquisition between companies "where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or tend to create a monopoly." 15 U.S.C. § 18. The lawfulness of a merger turns upon the transaction's "potential for creating, enhancing, or facilitating the exercise of market power – the ability of one or more firms to raise prices above competitive levels for a significant period of time." *United States v. Archer-Daniels-Midland Company*, 866 F.2d 242, 246 (8th Cir. 1988). See *Horizontal Merger Guidelines* (the "Merger Guidelines") at § 0.1 ("... the Guidelines focus in the one potential source of gain that is of concern under the antitrust laws: market power."); See also *Chicago Bridge, supra* at 5-6 ("... the unifying theme of Section 7 decisional law and economic trading is that mergers should not be permitted to create or enhance market power or to facilitate its exercise"), quoting *Merger Guidelines* at § 0.1.²⁰

²⁰ The *Horizontal Merger Guidelines* are reproduced at <http://www.ftc.gov/bc/docs/horizmer.htm>.

The statute states:

No person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.

As the Commission has explained, mergers can unlawfully enhance market power in three general ways. See *In the Matter of Chicago Bridge & Iron Co.*, Docket No. 9300, at 6 (Dec. 21, 2004) (“*Chicago Bridge*”). First, a merger may create a single dominant monopolist with the ability to maintain prices above competitive levels. Second, a merger may result in a market in which only a few firms compete in selling the product, allowing those firms to exercise market power by explicitly or tacitly coordinating their actions. Third, a merger may result in a single firm that is not a monopolist but still able to exercise market power by itself without coordination or concurrence by other firms in the market. In each of these situations, “the exercise of market power results in lower output and higher prices and a corresponding transfer of wealth from buyers to sellers or a misallocation of resources.” *Chicago Bridge* at 6-7.

A. Market Definition is Only a Tool Used to Predict the Competitive Effects of a Proposed Merger

Where the government challenges a proposed merger before the parties have closed the transaction, the government first must make a *prima facie* case establishing a presumption that the merger will substantially lessen competition, generally by relying upon structural market analysis. See, e.g., *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 715 (D.C. Cir. 2001). Respondent then must rebut this presumption by submitting evidence that the market structure analysis is

inaccurate. If Respondent is successful, the burden of producing additional evidence to demonstrate the likely competitive effects of the merger shifts back to the government.

Much of the structural analysis in cases challenging prospective mergers centers on defining and analyzing 1) the “line of commerce,” or the “relevant product market”; 2) the affected “section of the country,” or the “geographic market”; and 3) the transaction’s probable effect on competition in the relevant markets. *See, e.g., United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 618-23 (1974). In conducting the analyses, the parties, as well as the Commission and the courts, rely upon past cases and the *Merger Guidelines* that were issued by the United States Department of Justice and the Federal Trade Commission on April 2, 1992, as amended. *See, e.g., Chicago Bridge at 7; Heinz*, 246 F.3d at 716. The purpose of the *Merger Guidelines* is to set forth the methodologies the government will use to predict whether two firms, if merged, could raise prices after the merger. To do this, the *Merger Guidelines* focus on whether the merged entities “likely would” raise prices in the future and, if they did, whether buyers “likely would” continue to do business with the merged entities or would do business with other sellers.

Under the *Merger Guidelines*, the agencies and the courts employ indirect measurements to predict the competitive effects of a merger. By necessity, the traditional *Merger Guidelines* analysis focuses on predictive methodologies built upon structural factors, such as concentration levels. *See, e.g., Merger Guidelines at § 1.51*. This is necessary because data regarding the actual competitive effects of a merger are unavailable when the merger has yet to occur. To this end, the *Merger Guidelines* focus on the number of competitors that are in the market, the market shares that each of those competitors has, and the effects that the merger would have on the

market shares and market concentration.

Still, the central touchstone of protecting competition should not be lost in the details of market shares and market concentration. The foundational principle of the *Merger Guidelines* is that “mergers should not be permitted to create or enhance market power or to facilitate its exercise.” *Merger Guidelines* at § 0.1. And as the *Merger Guidelines* set forth, “market power” is “the ability profitably to maintain prices above competitive levels for a significant period of time.” *Merger Guidelines* at § 0.1. Finally, mergers that enhance market power violate section 7 of the Clayton Act and, thus, are illegal.

B. Elaborate Market Definition is Unnecessary Upon a Showing of Actual Anticompetitive Effects.

A key difference between this litigation and most merger lawsuits is that here the challenged merger that is under review already has resulted in anticompetitive effects. This is not a preliminary injunction hearing in which the government must predict the likely competitive effects of a proposed merger. Instead, in this case the challenged merger of ENH and Highland Park occurred some time ago and the Court can assess the actual competitive effects of that merger.

In particular, unlike litigation involving a proposed merger, in this lawsuit, the parties and the Court have access to actual pre- and post-merger pricing data and other terms of sale. As a result, the proxies that are used in evaluating the competitive effects of a proposed merger – including the structural analysis contemplated by the *Merger Guidelines* – are not the only relevant data here. Direct evidence of anticompetitive effects exist and there is no need for “anelaborate market analysis.” *FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 461

(1986).²¹

In *Indiana Federation*, the Supreme Court reasoned that “[P]roof of actual detrimental effects, such as reduction of output,’ can obviate the need for an inquiry into market power, which is but a ‘surrogate for detrimental effects.’” *Id.* at 460-61 (citations omitted). The Court explicitly “conclude[d] that the finding of actual, sustained adverse effects on competition in those areas where . . . dentists predominated, viewed in light of the reality that markets for dental services tend to be relatively localized, is legally sufficient to support a finding that the challenged restraint was unreasonable even in the absence of elaborate market analysis.” *Id.* The Court reasoned:

“The Commission found that, in two localities in the State of Indiana (the Anderson and Lafayette areas), Federation dentists constituted heavy majorities of the practicing dentists and that as a result of the efforts of the Federation, insurers in those areas were, over a period of years, actually unable to obtain compliance with their requests for submissions of x rays. Since the purpose of the inquiries into market definition and market power is to determine whether an arrangement has the potential for genuine adverse effects on competition, ‘proof of actual detrimental effects, such as a reduction in output’ can obviate the need for an inquiry into market power, which is but a ‘surrogate for detrimental effects.’ 7 P. Areeda, *Antitrust Law* ¶ 1511 (1986).” 476 U.S. at 460-61.

Thus, the Court concluded.,

“In this case we concluded that the finding of actual, sustained adverse effects on competition in those areas where IFD dentists predominated, viewed in light of the reality that markets for dental services tend to be relatively localized is legally sufficient to support a finding that the challenged restraint was unreasonable, even in the absence of market analysis.” *Id.*

The federal courts have clearly understood the Supreme Court’s directive. For example,

²¹ On the other hand, post-merger evidence suggesting that the merging parties acted competitively “is entitled to little or no weight” because, after all, the merged parties could avoid section 7 problems “simply by refraining from anticompetitive behavior.” *Chicago Bridge, supra*, at 9, n. 44, quoting *United States v. General Dynamics Corp.*, 415 U.S. 486, 504-05 (1974) and *Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1384 (7th Cir. 1986).

in *Toys “R” Us, Inc. v. FTC*, 221 F.3d 928 (7th Cir. 2000), the Seventh Circuit rejected the defendant’s argument that market power analysis in antitrust cases requires a market definition:

“[Toys “R” Us] seems to think that anticompetitive effects in a market cannot be shown unless the plaintiff, or here the Commission, first proves that it has a large market share. This, however, has things backwards. . . . [T]he share a firm has in a properly defined relevant market is only a way of estimating market power, which is the ultimate consideration. The Supreme Court has made it clear there are two ways of proving market power. One is through direct evidence of anticompetitive effects.” *Id.* at 937.

The Second Circuit endorsed this view in *Todd v. Exxon Corp.*, 275 F.3d 191 (2d Cir. 2001), noting that evidence of an “actual adverse effect on competition . . . arguably is more direct evidence of market power than calculations of elusive market share figures.” *Id.* at 206. And, in a section 7 case, *FTC v. Libbey, Inc.*, 211 F. Supp.2d 34 (D.D.C. 2002), the court recognized that direct evidence showing an “actual detrimental effect” could substitute for the presentation of traditional market definition and market share analysis. *Id.* at 48-49 (quoting *Indiana Federation and Toys “R” Us*). See also *United States v. General Dynamics Corp.*, 415 U.S. 486, 505 n.13 (1974) (“[P]ost merger evidence showing a lessening of competition may constitute an ‘incipiency’ on which to base a divestiture suit”); *Tasty Baking Co. v. Ralston Purina, Inc.*, 653 F. Supp. 1250, 1267 (E.D. Pa. 1987) (“The most recent evidence of defendants’ monopoly power is found in defendants’ post-acquisition pricing decisions.”)²²

²² The Commission’s decision *In the Matter of Schering-Plough Corporation*, Docket No. 9297 (Dec. 18, 2003), is also instructive. In *Schering*, the Commission found that it was unnecessary to define the relevant market to prove an antitrust violation if direct evidence of anticompetitive effects is available. Citing various merger cases as well as the *Merger Guidelines*, the Commission observed that the “traditional way” of establishing an antitrust violation begins with the definition of a relevant market.

However, this approach was “unnecessary” in cases in which the plaintiff alleged and presented direct evidence showing that the challenged activity had anticompetitive effects. As the Commission explained,

As the evidence will show, ENH's merger with Highland Park led to large, sustained supracompetitive price increases of acute care inpatient services sold to managed care organizations, in the Evanston, Illinois area. These price effects are defined, measurable, and certain. Indeed, ENH acknowledges that it did, in fact, raise prices substantially to its customers after the merger. If the direct evidence demonstrates that these undisputed price increases were not attributable to other factors and, therefore could only be attributable to market power, then the tools that are used typically to estimate market power are unnecessary. In particular, in these situations neither the FTC, ENH, nor the Court need engage in the traditional, formal market definition or market analysis. *See infra*, § II.A. (3)(a). The focus of the parties, therefore, should be on the reasons behind the large price increases and whether the reasons are related to market power.

C. **Past Hospital Merger Cases Misdefined the Product and Geographic Markets for the Delivery of General Acute Care Hospital Services**

Complaint Counsel has a sufficient evidentiary basis of actual anticompetitive effects to enable the Court to properly analyze the merger of ENH and Highland Park without an elaborate market definition. Nevertheless, Complaint Counsel is also committed to a long-overdue overhaul of the market analysis of hospital mergers that was first developed by the courts almost thirty years ago, when the individual patient and his or her doctor exercised virtually complete discretion in choosing the hospital at which to seek services. This analysis was developed

“[S]ome in the antitrust community have become so accustomed to the traditional way of proceeding that they forget that this complex market analysis [starting from a definition of the relevant market] provides only an *indirect* indication that trade has been or may be restrained. It is not necessary to weigh all of these factors if a case presents more direct evidence of actual or likely anticompetitive effects.” *Schering* at 16, n.32 (emphasis in original).

before the advent of managed care and selective contracting and today, therefore, these cases – and the analytical framework they used– are obsolete.

1. The Earlier Hospital Merger Cases Did Not Consider the Role of Managed Care in Defining the Geographic Markets

In the mid-1970's, when the indemnity insurance companies contracted with all hospitals and did not play a role in the choice of facilities, the Commission and the courts, in evaluating the merger, examined the practical alternatives of the individual patient (and his or her physician) to seek care at various hospitals. However, the tribunals and the parties even in more recent cases challenging hospital mergers have continued to use this analysis in hospital merger cases.

Historically, in the first cases challenging hospital mergers – that arose well before the advent of managed care – the courts focused on the provision of acute care hospital services to individual patients as the product market and, with this product market in mind, the courts then examined the choice of hospitals by the individual patient and his or her doctor to define the geographic market. The first such case of which Complaint Counsel is aware was nearly thirty years ago. *American Medicorp, Inc. v. Humana Inc.*, 445 F. Supp. 589 (E.D. Pa. 1977). In *American Medicorp*, the court examined under section 7 the competitive effects of Humana's proposed acquisition of American Medicorp, each of which owned and operated about forty hospitals around the country. Without discussion, the *American Medicorp* court concluded that the product market was the "delivery of short term, acute care hospital services to doctors and patients," and it evaluated the merger under the antitrust laws by treating the patient (and his or her doctor) as the buyer of hospital services. *Id.* at 605-06.

The Commission and the courts continued to use this analysis even after managed care

replaced indemnity insurance.²³ In fact, this analysis has been used even after the government and the courts recognized managed care as the principal purchaser of hospital services. In the last hospital merger case litigated by the federal antitrust agencies, *United States v. Long Island Jewish Medical Center*, 983 F. Supp. 121 (E.D.N.Y. 1997), the court expressly determined that there were five categories of “buyers” in transactions involving general acute care hospital services, *see id.* at 134, including managed care plans. Still, to define the geographic market, the *Long Island* court then examined “patient flow” and “patient migration” analysis – *i.e.*, the willingness of individual patients to seek care at hospitals other than the merging facilities -- rather than the willingness of a managed care plan to terminate its business contract with the merging hospitals in favor of other facilities.²⁴

2. The Methodology for Defining Geographic Markets in Past Hospital Cases is Neither Necessary Nor Applicable Here

At trial, Complaint Counsel will present evidence and testimony that will confirm that patient flow analysis is largely irrelevant in defining the geographic markets in the markets in

²³ *E.g.*, *Federal Trade Commission v. Freeman Hospital*, 911 F. Supp. 1213, 1218 (W.D. Mo.) (district court examined “where the patients of the [merging] hospitals come from”), *aff’d*, 69 F.3d 260 (8th Cir. 1995); *United States v. Rockford Mem. Corp.*, 717 F. Supp. 1251 (N.D. Ill. 1989), *aff’d*, 898 F.2d 1278 (7th Cir. 1990) cert denied, 498 U.S. 920 (1990); *Hospital Corporation of America*, 106 F.T.C. 361 (1985)(managed care was emerging, but markets defined on the basis of patient flow); *United States v. Hospital Affiliates International*, 1980-81 CCH Trade Cases ¶ 63,721 (E.D. La. 1980)(merger of psychiatric hospitals); *In re: American Medical International, Inc.*, 104 F.T.C. 1, 196 (1984).

²⁴ *See* 983 F. Supp. at 140-41 (geographic market definition based on finding that “large numbers of . . . residents” go to other hospitals). *See also California v. Sutter Health Systems*, 130 F. Supp.2d 1109, 1120 (N.D. Cal. 2001) (“The basic question to be asked is where can patients practicably go for acute inpatients services”); *United States v. Mercy Health Services*, 902 F. Supp. 968 (N.D. Iowa 1995)(district court recognized the role of managed care as the buyer, but defined the geographic market in terms of the willingness of residents of the area to travel to other hospitals), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997).

which the managed care companies are the buyers of acute care inpatient hospital services. First, as explained above, these prior cases required a geographic market definition to predict the likely competitive effects of a proposed merger. This detailed geographic market definition is unnecessary when, as here, there is direct evidence that the consummated merger has had actual anticompetitive effects.

In any event, the choice among hospitals by individual patients – and, thus, patient flow analysis – is not a good measurement of the dynamics of the transaction between a hospital and a managed care company. As Complaint Counsel’s experts will testify, in the markets in which the managed care companies are the customers for hospital services, the proper product market to evaluate the competitive effects of a merger is general acute care hospital services sold to managed care plans. Thus, geographic market definitions must be based on the managed care company’s decision whether as a practical matter, in order to remain competitive, it must contract with a particular hospital in an area rather than the decision of an individual patient whether to seek care at that hospital.

Furthermore, even to the extent that patients’ choices of hospitals were relevant in defining the geographic market for services sold to managed care companies, the Court should reject the methodology to define geographic markets that the courts have used in past hospital merger cases. In the past, the courts have employed what is known as the “Elzinga-Hogarty” test to define the geographic market for evaluating the competitive effects of a hospital merger.²⁵ However, as Complaint Counsel will prove at trial, the Elzinga-Hogarty test was not properly

²⁵ See Elzinga & Hogarty, *The Problem of Geographic Market Delineation in Antimerger Suits*, 18 Antitrust Bull. 45 (1973).

used in defining geographic markets in hospital merger cases, even in the past.

To use the Elzinga-Hogarty test in past hospital merger cases, the courts have preliminarily designated as the geographic market an area that includes the merging hospitals. Then, to test this assumption, the courts have measured the extent to which people currently commute to obtain hospital services. The courts have reasoned that if some material number of people currently commute into (or out of) the designated area, then an even greater number of patients would commute if the hospitals in that area were to raise their prices. Therefore, the court would conclude that the designated area was too small to be considered a “geographic market” for the purposes of section 7. Based on this conclusion, the courts conducted the same analysis of a slightly larger area, until it identifies an area which is relatively self-contained.²⁶

At trial, however, Dr. Elzinga will testify that the Elzinga-Hogarty test cannot be used in accurately defining the geographic market in a hospital merger case. Specifically, Dr. Elzinga will explain how it is erroneous to use data regarding the past choices of hospitals by one small group of residents to predict the future selection of hospitals by the population of that area as a whole. Also, Dr. Elzinga will explain how, due to health insurance, the prices a hospital charges for its services have little if any impact on the choice of hospitals by a patient. As a result, it is fundamentally erroneous to use the Elzinga-Hogarty test in defining geographic markets in hospital merger cases. In fact, this conclusion is so inescapable that Respondents’ own

²⁶ Tellingly, this methodology has led to the conclusion in some cases that patients are willing to travel up to ninety miles for basic hospital care, *United States v. Mercy Health Services*, 902 F. Supp. 968, 982 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997), which is the equivalent of concluding that a resident of Washington, D.C. would readily travel to Richmond, Virginia, for hospital services. Thus, the use of the Elzinga-Hogarty test has designated implausibly large areas as “geographic markets” in hospital merger cases.

economist, Dr. Monica Noether, apparently has declined to use the test here, at least as a “formal” tool for defining the geographic market.²⁷

In sum, the transformation of the healthcare system – and the change from indemnity insurance to managed care plans – has had significant impact not only on the market for health care services, but also on the proper antitrust analysis of hospital mergers. In the past, the Commission, the courts and the parties have regularly used patient flow analysis in defining the geographic markets for the purposes of evaluating the effects of a proposed hospital merger. Today, however, patient flow analysis – and the formal Elzinga-Hogarty test that was used to conduct this analysis – is outdated. Therefore, to the extent that market definition is necessary when, as here, there is direct evidence of anticompetitive effects of a merger, the past decisions of the Commission and the courts evaluating hospital mergers have little if any relevance to this case, in which the Court must determine the competitive effects of a hospital merger in the markets wherein managed care companies are the buyers of inpatient acute care hospital services.

**II. COUNT II: THE MERGER OF ENH AND HIGHLAND PARK
SUBSTANTIALLY LESSENE COMPETITION IN THE SALE OF GENERAL ACUTE
CARE INPATIENT HOSPITAL SERVICES TO MANAGED CARE PLANS IN THE
EVANSTON, ILLINOIS AREA IN VIOLATION OF SECTION 7 OF THE CLAYTON
ACT**

In this case, as the evidence will show, ENH raised acute inpatient services prices to managed care organizations following its merger with Highland Park. These price increases were substantial, exceeded the increases of comparison hospitals, and continued for a sustained period of time. ENH achieved these increases by exploiting the enhanced market power that it

²⁷ Nevertheless, for reasons that at least until now have been unexplained, Dr. Noether apparently will apply patient flow analysis for the purposes of defining the geographic market and, therefore, Dr. Elzinga’s testimony is relevant to this case.

gained from the merger. The purchasers of ENH's services, the managed care companies, determined that it was more profitable for them to pay the anticompetitive prices that were charged by ENH than to exclude the three ENH hospitals from their networks.

As set forth below, this will be confirmed by the testimony of the representatives of the managed care plans. First, these representatives will testify that, in their view, inpatient acute care hospital services are a distinct service and that outpatient hospital services cannot be substituted for inpatient acute care hospital services marketed to managed care plans. With respect to the geographic market, the managed care plan representatives will testify that, before the merger, they could deter price increases by ENH (or by Highland Park) that were out of line by forming a network that included the other hospital at which it would purchase inpatient services in the Evanston, Illinois area. Thus the product market is general acute care inpatient hospital services sold to managed care plans, and the geographic market is the Evanston, Illinois area.

A. The Merger of ENH and Highland Park Had Anticompetitive Effects

Complaint Counsel will present at trial three different types of evidence to demonstrate that the merger of ENH and Highland Park was anticompetitive. First, executives of the managed care plans – the customers of hospital services in the market – will testify at trial that ENH could and did exploit its post-merger market power, gained through the merger, to extract supracompetitive prices. Second, ENH's contemporaneous business documents confirm that ENH's own executives viewed the merger as anticompetitive, creating market power that ENH readily exercised. Finally, the statistical analysis performed by the FTC's experts (and indeed, ENH's own experts) will show that ENH significantly raised its post-merger prices.

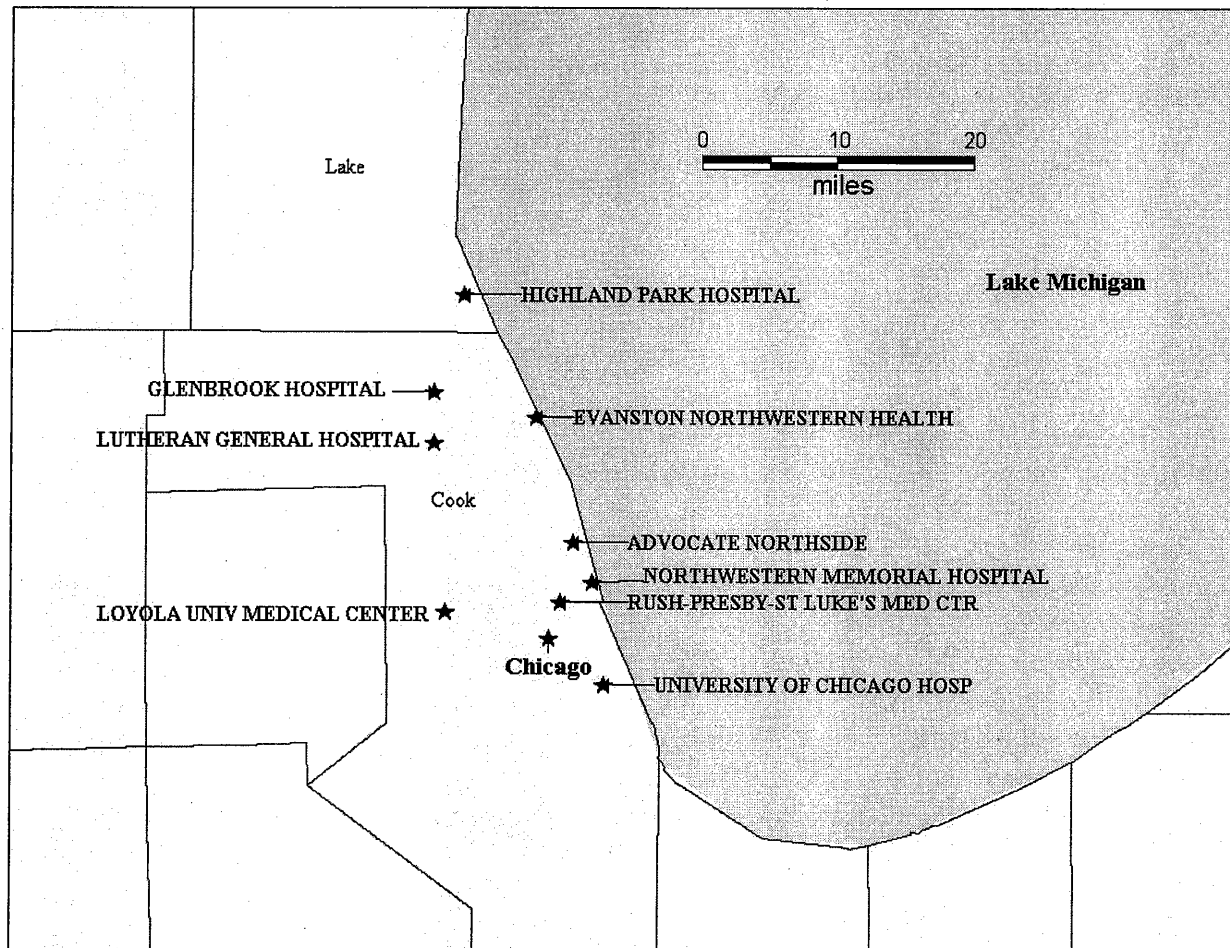
1. Executives of Managed Care Plans Will Testify that the Merger of ENH and Highland Park Was Anticompetitive

The first type of evidence that Complaint Counsel will present is the testimony of executives of the managed care plans that the merger of Evanston Northwestern and Highland Park Hospital gave ENH market power in the Evanston, Illinois area, allowing ENH to impose substantially higher hospital rates on managed care plans.

For a substantial number of employees that reside in the Evanston area, the pair of hospitals that were owned by ENH prior to the merger, on the one hand, and the Highland Park Hospital, on the other, offered the two closest locations where (primary and secondary) inpatient hospital services could be obtained. As a result, prior to the merger, a managed care plan that could include the ENH hospitals and the Highland Park hospital was able to refuse to contract with Highland Park if it demanded a significant price increase – even if this would have resulted in Highland Park dropping out of its network – because the managed care plan could still include the two nearby hospitals owned by ENH prior to the merger. Absent the merger, therefore, this potential exclusion of Highland Park from the network would have prevented the hospital from obtaining an anticompetitive price increase. (By the same reasoning, absent the merger, the managed care plan would have been able to avoid a unilateral anticompetitive price increase by ENH.)

The merger of ENH and Highland Park substantially weakened the bargaining positions of managed care companies vis-à-vis these hospitals, because the merged company negotiated a single contract on behalf of both ENH and Highland Park. Post-merger, a managed care plan had a choice of accepting a price increase for all three of ENH's merged hospitals, or losing all three

hospitals from its network. The loss of all three would have put managed care plans in significantly worse position because their alternative network without the three ENH hospitals was less attractive to the plans' customers. The three hospitals of the merged ENH form a geographic triangle that covers a significant area and includes the most affluent suburbs of Chicago, where employees are likely to put a particular premium on convenience. There are no other hospitals within that triangle, and it is several miles in any direction outside of that triangle to the next hospital. See Map below.



The managed care companies were faced with the stark reality that it was more attractive for them to pay the anticompetitive prices demanded by ENH than to forego contracting with ENH and to lose the business of employers and employees who refused to purchase a plan that excluded the three ENH hospitals. At trial, Complaint Counsel will present the testimony of the representatives of the managed care plans that chose to pay the higher prices demanded by ENH rather than lose business. In fact, the witnesses at trial will include representatives of one managed care company that terminated its negotiations with ENH; tried to market a plan that did not include ENH; but found it was so unprofitable to do so that it reopened its negotiations with ENH and paid the higher prices that ENH demanded.

Complaint Counsel anticipates calling at trial the representatives of managed care companies to testify about ENH's exercise of market power. For the purposes of this brief, we have summarized the testimony of Jane Ballengee, who is PHCS's Regional Director of Network Development.

PHCS operates one of the largest proprietary networks in the country and is among the top networks in the Chicago marketplace. PHCS is not a health care "insurer," in the traditional sense of the word. Instead, PHCS negotiates contracts with hospitals, doctors, and other health care providers for the provision of services, and then sells access to this "network" of providers to managed care plans and employers that have self-insurance plans.

Ms. Ballengee will testify that prior to the merger, { [REDACTED]
[REDACTED]
[REDACTED] }. Pre-merger, with a

few exceptions,²⁸ PHCS had contracts with Evanston and Glenbrook under { [REDACTED] [REDACTED] }. After the merger, however, ENH successfully demanded that PHCS { [REDACTED] [REDACTED] }, and ENH successfully commanded a significant price increase from pre-merger prices.

Finally, Ms. Ballengee will testify that PHCS accepted these price increases only because ENH commanded market power. PHCS had no reasonable alternative to keeping the ENH hospitals in its network. In fact, in response to ENH's demands, { [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] }.

Complaint Counsel anticipates that Ms. Ballengee's testimony will be echoed by representatives of other managed care companies, including Unicare, Aetna, One Health, and United. Additionally, ENH's contracts and correspondence with other managed care companies will demonstrate that, like PHCS, these managed care plans paid higher prices due to ENH's exercise of market power.

2. ENH's Contemporaneous Business Documents Confirm that, Through the Merger, ENH Exercised Market Power

ENH's activities on the other side of the negotiating table confirm the testimony of the

²⁸ For example, under the PHCS contracts, { [REDACTED] [REDACTED] [REDACTED] }. Because this is a fixed rate, like the per diem rate, managed care companies prefer this formula to a discount off charges formula.

managed care plan witnesses. ENH had formulated and was implementing the contracting strategies that had caught the managed care companies by surprise. The intent and success of these tactics are seen in ENH's contemporaneous business documents leading up to and following the close of the merger on January 1, 2000.

ENH's internal documents will demonstrate that, after the merger, it exercised its market power in two different ways. First, in renegotiating its contracts with the managed care companies immediately after the merger, ENH implemented an immediate price increase. Second, ENH then imposed further price hikes by inflating its list prices for its goods and services.

a. ENH Increased Its Prices To Its Managed Care Customers Through the Renegotiations of Contracts

ENH's business records in 2000 reflect management's calculated plan to implement an immediate increase in post-merger prices to its customers. ENH executives reiterated strategies to capitalize on the Highland Park merger in numerous minutes from Board of Directors meetings, internal memoranda, and presentations. In these documents, ENH management also reported the results from these strategies, results which far surpassed their expectations.

Soon after the merger's close, ENH's chief operating officer, Jeffrey Hillebrand, described to the Board's Executive Committee the results of the recently concluded renegotiations { [REDACTED] }. (CX00005 at ENH GW 004073). Tying the success of the renegotiations directly to the merger, Mr. Hillebrand stated, as reported in the minutes, that { [REDACTED] } [REDACTED] }. (CX00005 at ENH GW 004073) (emphasis added).

an overview of the goal of the review, { [REDACTED] }
{ [REDACTED] }. (CX 01970 at PAGE 4). Subsequently, in 2002, ENH unilaterally increased its list prices, which effectively increased the prices that ENH charged to every managed care plan with which it had a discount-off-charges contract. { [REDACTED] }
{ [REDACTED] }. (CX00045 at ENH HJ 004956)

3. Expert Testimony Will Confirm that ENH Raised its Prices Through the Exercise of Market Power Gained Through the Merger

Both Complaint Counsel and ENH will call expert witnesses to testify on their analyses of, for example, actual pricing trends following the merger.³⁰ Both parties' experts will testify that ENH's prices rose substantially after the merger, both in absolute terms and relative to other groups of comparison hospitals. These conclusions strongly support the expected testimony of the representatives of the managed care companies, as well as the statements in ENH's contemporaneous business records.

a. Retrospective Price Studies Show Post-Merger Absolute Prices Increased Substantially

Complaint Counsel's expert economist, Dr. Haas-Wilson, will testify that her analyses of

³⁰ To clarify the terms of the discussion, it is important to understand how both parties' experts use the word, "price." Price can mean the list price of a certain hospital procedure as set forth in the hospital's "charge master." Price can also mean the actual payment for the same procedure calculated pursuant to the particular managed care plan's contract with the hospital.

The parties' experts generally use the term to indicate the payment level, *i.e.*, the amount the managed care plan actually pays the hospital for the service. This revenue-based methodology takes into account the interactions of the contract provisions and the hospital's pricing activities – *e.g.*, the hospital's list price, the formula specified by the contract between the hospital and the managed care plan, any discounts, and the like – to determine the actual payment the managed care plan makes for the services rendered by the hospital.

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED], ENH's price increases exceeded those at comparison hospitals. Finally, for the reasons set forth below in the discussion of quality, claimed quality improvements at ENH do not explain ENH's price increases.

As with the absolute price analysis, Complaint Counsel expects ENH's own experts to testify that they also found that ENH implemented price increases after the merger. Thus, the analyses from both ENH's and Complaint Counsel's experts will show that factors common to all Chicago area hospitals do not explain ENH's relative price increases. Complaint Counsel also expects both sides' experts to acknowledge that changes in case mix and complexity between the different hospital systems also fail to account for ENH's large price increases.

B. Respondent's Efforts to Explain the Price Increases Are Unavailing

Based upon the testimony of the managed care organizations, ENH's contemporaneous business records, and the analyses of the Complaint Counsel's experts, Complaint Counsel will show that ENH took advantage of the enhanced market power from the Highland Park merger to increase prices. Because Respondent must agree that ENH raised post-merger prices to its customers, both in absolute and relative terms, Respondent must develop a case demonstrating that the price increases were due to some cause other than market power.

1. ENH's Price Increases Are Not Attributable to Its "Learning About Demand"

Confronted with their own analyses demonstrating that ENH raised prices substantially after the merger, Complaint Counsel expects that ENH's experts will testify on a post-hoc theory to attempt to explain away the increases at Evanston. (As noted previously, a different explanation is offered for the price increase at Highland Park, which is discussed more fully below.) Respondent's Evanston hypothesis, in a nutshell, is that ENH was ignorant that its pre-merger prices were low and, { [REDACTED] [REDACTED] }. Complaint Counsel anticipates that ENH will claimed { [REDACTED] [REDACTED] }. Complaint Counsel expect ENH's experts to testify that, after "learning about demand," { [REDACTED] [REDACTED] [REDACTED] [REDACTED] }. These six hospitals are heavily involved in teaching, and four of them offer quaternary services – like solid organ transplants -- that ENH does not offer. As the evidence will show, Respondent's post hoc justification suffers from numerous flaws.

First, the ostensible source of ENH's "learning" was Highland Park's contract terms, which ENH discovered during due diligence in the summer and fall of 1999. Yet, { [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] }

[REDACTED]

Second, the factual predicate for the “learning” hypothesis is wrong. [REDACTED]

[REDACTED]

[REDACTED]. Highland Park,

therefore, provided no “lessons” to ENH regarding ENH’s ability to charge higher prices.

Third, Respondent’s experts are wrong in treating the six hospitals as an appropriate comparison group for ENH’s pricing. To make any sort of relevant comparison, ENH’s experts would have to select the comparison hospitals in both a defensible and non-arbitrary manner, so that the selected hospitals were similar to ENH. The evidence will show that neither condition holds. Indeed, as Dr. Haas-Wilson will testify, [REDACTED]

[REDACTED]

[REDACTED]. By Respondent’s own standards, therefore, a

comparison of these hospitals’ prices is inappropriate.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

2. ENH’s Price Increases At Highland Park Were Not Due to Measurable Increases in the Quality of Care

ENH also is going to argue that the Court should ignore the post-merger price increases because ENH purportedly increased the quality of care at one of the three merged hospitals – Highland Park. Any argument that the price increases imposed by ENH were somehow due to an increase in quality of care that Highland Park achieved through the merger however, can be rejected on its face. As the representatives of ENH’s customers will testify, ENH began contract negotiations and imposed higher prices for all three ENH hospitals *before* the merger had even been consummated. Thus, it is illogical for Respondent to claim that the price increases are attributable to indeterminate post-merger quality changes at Highland Park.

In any event, this argument rests on two false premises. *First*, the evidence will show that during the negotiations, neither ENH nor the managed care companies negotiated prices on the basis of quality of care changes that might be undertaken at Highland Park, as they certainly would have done if the price increases were related to perceived quality improvements. *Second*, the evidence does not support Respondent’s proposition that quality of care increased substantially at Highland Park. As measured by data widely-regarded throughout the industry and government for measuring quality of care, patient outcomes did *not* change after the merger.

a. ENH and the Managed Care Plans Did Not Negotiate Prices on the Basis of Indeterminate Quality of Care Changes at Highland Park

There is no evidence that during the post-merger negotiations either ENH or the managed care plans bargained over any quality of care changes ENH may or may not have had in mind for

Highland Park. { [REDACTED] }.

Jeffrey Hillebrand, the chief operating officer of ENH who was personally responsible for the contract negotiations, was blunt in this regard. When asked whether, during the 2000 contract negotiations, anyone told “{ [REDACTED] }.”

(Hillebrand, Tr. at 515.)

Mr. Hillebrand’s testimony will be corroborated by other evidence about the manner in which ENH conducted its contract negotiations. For example, { [REDACTED] }.

{ [REDACTED] }. (O’Brien, Tr. at 19.) Furthermore, there is no written communication between ENH and any of the managed care plans during the course of the contract negotiations regarding the purported improvements in quality of care at Highland Park that supposedly justified ENH’s demands for higher prices.

Representatives of the managed care plans will make the same point. For example, { [REDACTED] }, but that it did not view any quality of care differentials at Highland Park as the justification for the price increases. The representatives of other managed care companies will confirm that they demand high quality from all providers, and that certification by state and federal agencies, and accreditation by the Joint Commission on the Accreditation of Healthcare Organizations, are the best measurable evidence of a high quality

of care. There is no evidence, however, that they considered purely hypothetical changes (since no changes had yet been put in place) in renegotiating contracts with ENH.

The express language of the contracts between the parties bear further proof that any quality of care changes did not form the basis of the bargain. For example, the quality of care language included in the post-merger contract between ENH and One Health remained exactly the same as the language included in the pre-merger contract: the contracts simply required the “{ [REDACTED] [REDACTED] }.” (Compare CX-5061, at ENH JL 008035 with CX-5064 at ENH JL 007953.) No more and no less was required either before or after the merger. In sum, the views of ENH and of the managed care plans, and the contemporaneous documentary evidence, confirm that any quality of care changes at Highland Park was not the basis for the post-merger price increases.

b. The Merger Did Not Yield Cognizable Improvements in Quality of Care

Respondent’s efforts to attribute its price increases to changes in quality of care also are defective because, in reality, there were no cognizable changes in quality of care that would have warranted the price increases that ENH demanded. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED].” (Hillebrand, Tr. at 513 -15.)³¹ As measured by the all-important JCAHO accreditation

³¹ Interestingly, on February 11, 2004, ENH’s Senior Vice President for Quality, Peggy King told Respondent’s chief executive officer, Mark Neaman, { [REDACTED] [REDACTED] }.” Her plan was, for purposes of the “FTC investigation” to

standard, pre-merger quality of care at Highland Park was already “good” and any post-merger changes cannot explain the large price increases absorbed by the managed care plans.

The testimony of Complaint Counsel’s quality of care expert, Dr. Patrick Romano, will

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

Specifically, in order for Respondent to justify the post-merger price increases at ENH that were greater than those at other hospitals, ENH would have to demonstrate that the improvements in the quality of care at Highland Park were so significant, when compared to those other area hospitals, that they justified across the board price hikes not only for Highland Park but for Evanston Hospital and Glenbrook Hospital as well. { [REDACTED]

[REDACTED] }. Indeed, his analysis of the patient outcome data, which is widely-used throughout the industry and by regulatory agencies, shows that patient outcomes did not change at Highland Park from pre-merger levels.

“{ [REDACTED]
[REDACTED]
[REDACTED] }.” CX01200 at ENHE
MN 001785.

Five months later, when asked in her deposition about pre and post merger outcome studies, Ms. King responded that “{ [REDACTED]
[REDACTED] }.” King Tr. at 156. Apparently, Mr. Neaman decided that Ms. King’s February data review had no “utility” for the Commission’s investigation.

In other words, quality of care did not increase after the merger as Respondent alleges.

III. UNDER COUNT I, THE MERGER OF ENH AND HIGHLAND PARK YIELDED A HIGHLY CONCENTRATED MARKET LIKELY TO CREATE OR ENHANCE MARKET POWER

Because this consummated merger resulted in substantial price increases caused by ENH's increased market power, a structural, *Merger Guidelines*-based approach is not necessary to conclude that the merger violated section 7 of the Clayton Act. Nevertheless, applying the *Merger Guidelines*' standards, the evidence, including the testimony of ENH's own experts, will demonstrate that the ENH-Highland Park merger was anticompetitive. Indeed, accepting ENH's experts' proposed geographic and product market definitions, the resulting market concentration measures establish a presumption that the merger is "likely to create or enhance market power or facilitate its exercise." *Merger Guidelines* at § 1.51(c). Furthermore, as the evidence will show, ENH cannot overcome this presumption with counterarguments such as new competitor entry or merger efficiencies.

A. ENH's Inappropriate Product and Geographic Market Definitions

We expect that ENH's expert, Dr. Noether, will contend that the relevant product market includes all acute "hospital-based" health care services. This definition encompasses both inpatient and outpatient services. Generally, "inpatient" services are services that require the patient to stay at least one night at the hospital. "Outpatient" services may be performed at a hospital, but the services do not require an overnight stay. By comparison, the FTC's expert, Dr. Haas-Wilson, will testify that the relevant market should include only inpatient acute care services. In her testimony, Dr. Haas-Wilson will explain why outpatient services are not adequate substitutes for inpatient services from the managed care company's perspective, and

thus, that the relevant product market should not include outpatient services.³²

Complaint Counsel also expects that Dr. Noether will testify that the relevant geographic market includes not only the three ENH facilities but also a limited number of other hospitals.

Even in the most lax application of the *Merger Guidelines*, however, { [REDACTED]

[REDACTED]

[REDACTED] } – in the market in

which ENH’s three hospitals operate. { [REDACTED]

[REDACTED]

[REDACTED].

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED].

³² Besides, the views expressed by Dr. Haas-Wilson were endorsed by the Seventh Circuit in *United States v. Rockford Mem. Hosp.*, 898 F.2d 1278, 1284 (7th Cir. 1990).

B. Under the Merger Guidelines, the Merger With Highland Park Presumptively Gave ENH Market Power

In any event, even Dr. Noether's market concentration analysis leads to the presumption, as articulated by the *Merger Guidelines*, that the merger is presumed to increase market power. Using what we expect to be her proposed product and geographic market definitions— the most favorable market definitions she could develop for Respondent-- we expect Dr. Noether's concentration analysis to reveal that the merger of ENH and Highland Park increased the market's HHI measure by more than 100 points and to a post-merger level greater than 1,800 points. In such a circumstance, the *Merger Guidelines* state that the antitrust agencies will "presume" that the merger created or enhanced market power or facilitated its exercise. *Merger Guidelines* at § 1.51(c). As ENH's behavior shows, this presumption proved to be correct in this case.

Under the *Merger Guidelines*, once the presumption of increased market power is established, the merging parties must introduce specified types of evidence demonstrating certain countervailing factors also set forth in the *Guidelines*. *Merger Guidelines* at § 1.51(c). These factors include likelihood of entry by new competitors, merger efficiencies, or that one of the merging parties was a failing firm that was about to exit the market but for the merger. *Merger Guidelines* at § 2 - § 5.³³

As the evidence will show, none of these factors holds in the merger of ENH and Highland Park. New hospital entry is very difficult and has not occurred despite the substantial

³³ Respondents have dropped the failing company defense, compare First Amended Answer, Eighth Defense (July 12, 2004), with Second Amended Answer; see *Merger Guidelines* § 5, and so Complaint Counsel will not further address this defense.

price increases. There also has been no suggestion by respondent of any merger-specific related efficiencies and, therefore, the Court need not consider countervailing factors in its merger analysis.

As for ENH's learning about demand theory, it would provide no basis for rebutting the presumption of market power under section 1.51 of the *Horizontal Merger Guidelines*. It provides an alternative (but failed) attempt to explain away Respondent's actual price increases, but would provide no basis for rebutting the presumption under the *Merger Guidelines* that the merger would be anticompetitive. The presumption is based on structural factors set forth in the *Merger Guidelines* such as market concentration or likelihood of entry. In order to rebut the increased market power presumption that ENH's own concentration analysis produces, ENH is limited to the structural factors enumerated by the *Merger Guidelines*. The evidence will show that it can offer none.

IV. RESPONDENT'S AFFIRMATIVE DEFENSE WILL FAIL

A. Purported Improvements in Quality of Care Are Not a Cognizable Defense of an Anticompetitive Merger

As set forth in its Fifth Affirmative Defense, ENH argues that even if quality improvements cannot account for its post-merger price increases, the improvements (if any) in the quality of care furnished by ENH at Highland Park provide a basis for the Court to ignore the fact that the merger was anticompetitive. The defense, however, can be rejected for three reasons. First, as noted above, the factual predicate for the defense is missing: the post-merger quality of care improvements at Highland Park are insignificant, at best, and are swamped by the magnitude of the anticompetitive effects of the merger.

Second, as recognized in a case that is on point, a merger that is anticompetitive cannot be justified on the grounds that it is otherwise beneficial to the quality of care provided by one of the merging hospitals. Thus, in *United States v. Rockford Memorial Corp.*, 717 F. Supp. 1251, 1287-89 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990), the district court treated “all its corresponding benefits in quality and community development as irrelevant for the present § 7 inquiry.” *Id.* at 1289. Instead, as the *Rockford* court recognized, the exclusive goal in a section 7 case is to evaluate the merger’s effect on competition. *Id.*

Third, the purported quality of care improvements cannot justify this merger because the Respondent is unable to attribute those improvements to the merger, *cf. FTC v. Cardinal Health*, 12 F. Supp.2d 34, 62 (D.D.C. 1998)(in order to be weighed against anticompetitive effects of a merger, efficiencies must be both verifiable and *directly attributable* to the merger). If benefits can be achieved through other means, those benefits should not be credited in evaluating the net effects of a merger. *Cf. FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1090 (D.D.C. 1997). Here, the facts demonstrate that before the merger, Highland Park could and often did achieve quality improvements on its own, as an independent hospital.

Before the merger, Highland Park had already implemented several quality improvement initiatives. In { [REDACTED]

[REDACTED] }.³⁴ (CX0541 at ENH RS 007987-88; CX0094 at ENH RS 004099-4105.)

34

{ [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }. (CX0541 at ENH RS

Likewise, Highland Park set several quality improvement goals in 1998, many of which were met prior to the merger.³⁵ (CX0091 at ENH RS 004106-17) { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED].

(CX0092 at ENH RS 005749-71; CX0545 at ENH RS 005775.)

In short, the evidence will demonstrate that Highland Park clearly did not require the merger with ENH to carry through with its long-standing commitment to a high quality of care.³⁶

007987-88; CX0094 at ENH RS 004102.)

³⁵ In 1998, Highland Park listed as its future goals: { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]. (CX0091 at ENH RS 004106-17)

³⁶ See also, e.g., CX 00505 at ENH 002093; CX0542 at ENH RS 003561; CX0541 at ENH RS 007988 (in 1997, HPH was one of only five hospitals in Illinois selected as a Lincoln Award winner).

ENH is not claiming a failing firm defense, and its quality of care expert will specifically disclaim the notion that Highland Park lacked the financial wherewithal to improve services. The claimed enhancements amount to items as simple as hiring better nurses, which Highland Park was well capable of doing. Thus, in the absence of evidence that Highland Park could have achieved these advantages only through the merger, the changes in quality of care cannot be credited in determining whether, on balance, the increases in quality of care outweighed the clear anticompetitive effects of the merger.

B. ENH and Highland Park Were Separate Entities When They Merged and, Thus, Their Merger Is Subject to Section 7 of the Clayton Act

In its Second Amended Answer, Respondent also raises what it labels the “*Copperweld*” doctrine. It asserts that, at the time of the merger, ENH and Highland Park were not separate entities and, therefore, their merger is not subject to section 7 of the Clayton Act.

The “*Copperweld*” doctrine gets its name from the decision of the Supreme Court in *Copperweld Corp. v. Independence Tube Co.*, 467 U.S. 752 (1984), in which the Supreme Court concluded that “the coordinated activity of a parent and its wholly-owned subsidiary must be viewed as that of a single enterprise for the purposes of § 1 of the Sherman Act,” *id.* at 771, and therefore, that a parent and its wholly-owned subsidiary could not engage in conduct that would be considered collusive under section 1 of the Sherman Act. Respondent apparently would import this interpretation of section 1 of the Sherman Act to their analysis under section 7 of the Clayton Act – on the grounds that both ENH and Highland Park were members of the dying Northwestern Healthcare Network – even though, in the words of the *Copperweld* Court, the holding in that case was limited “to the narrow issue squarely presented.” *Id.* at 767. Further, to

Complaint Counsel's knowledge, the *Copperweld* decision has never been imported from section 1 of the Sherman Act to cases arising under section 7 of the Clayton Act.

In any event, a brief review of the *Copperweld* decision confirms that it is inapplicable here. As the Supreme Court explained, its conclusion rested solely upon the fact that a parent corporation and its wholly-owned subsidiary have a "complete unity of interest," and that "the parent may assert full control over the subsidiary at any moment that the subsidiary fails to act in the parent's best interest." 467 U.S. at 771-72. Here, in contrast, the Network lacked any real authority to assert "full control" over ENH, Highland Park and the other hospital members of the Network. In fact, as the exhibits show, the member hospitals had complete discretion to assert "full control" over the Network. Thus, the member hospitals elected to dissolve the Network rather than let the Network assert full control over their operations. (CX1833 at NHN 001718-19)

Further, economic reality, not corporate form, dictate whether two or more companies can be treated as two or more legal entities that can engage in an antitrust conspiracy cognizable under section 1 of the Sherman Act.³⁷ Here, economic reality dictates that each of the individual hospitals should be treated as separate entities. As noted above, throughout the life of the Network, the chief complaint of the Network members was that they lacked unity of purpose or a common design. { [REDACTED] [REDACTED] [REDACTED] }." (CX01768 at NHN 000117)

³⁷ *City of Mount Pleasant v. Associated Elec. Coop.*, 838 F.2d 268, 275 (8th Cir. 1988).

later. *United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586 (1957). Therefore, because Respondent's failed Network never engaged in meaningful integration, never operated as a unified entity, and could not exercise control over its members, the *Copperweld* argument is groundless and the merger is subject to section 7 of the Clayton Act.

IV. THE APPROPRIATE REMEDY IS DIVESTITURE OF HIGHLAND PARK

Complaint Counsel stated in its Complaint and Notice of Contemplated Relief that a possible remedy to the lessening of competition would be to order a complete divestiture of Highland Park to a third party. The clear language of Section 11(b) of the Clayton Act mandates that, if there is a violation, the "Commission . . . shall . . . issue and cause to be served on such person an order requiring such person to . . . divest itself of the . . . assets, held." The Supreme Court has held on multiple occasions that divestiture is the presumptive remedy for a merger that violates section 7 of the Clayton Act. *See, Ford Motor Co. v. United States*, 405 U.S. 562, 573 (1972); *United States v. Greater Buffalo Press*, 402 U.S. 549, 556 (1971); *United States v. E.I. du Pont de Nemours Co.*, 366 U.S. 316, 326-27 (1961). As the Court noted in *du Pont*, "Divestiture has been called the most important of antitrust remedies. . . . It should always be in the forefront of a court's mind when a violation of § 7 [of the Clayton Act] has been found." 366 U.S. at 330.

Based upon this clear mandate, the FTC considers divestiture as a standard component of its remedial options. *See, e.g., Hospital Corp. v. FTC*, 807 F.2d 1381, 1393 (7th Cir. 1986) (affirming FTC order requiring merged hospital to divest assets); *Olin Corp.*, 113 F.T.C. 400 (1991) (requiring merged firm to divest assets to restore competition; *Fruehauf Trailer Co.*, 67 F.T.C. 878 (1965) (ordering divestiture of two acquired competitors ten years after merger). As

the judge in *Olin Corp.* explained, “It is axiomatic that the normal remedy in Section 7 cases is the divestiture of what was acquired unlawfully. Indeed, divestiture is the remedy specified in Section 11(b) of the amended Clayton Act.” 113 F.T.C. at 584. Commission precedent holds that “a presumption should favor total divestiture” over partial divestiture, and that “the burden rests with respondent to demonstrate that a remedy other than full divestiture would adequately redress any violation which is found.” *Freuhauf*, 90 F.T.C. 891, 892 n.1 (1977).

The Commission’s recent order in *Chicago Bridge* underscores the FTC’s statutory authority to order the divestiture of all assets obtained in an unlawful merger. After finding a section 7 violation, the Commission noted that the Clayton Act specifically contemplates divestiture as a remedy and that “[m]uch of the case law has echoed this sentiment and found divestiture the most appropriate means for restoring competition lost as a consequence of a merger or acquisition.” *Chicago Bridge* at 93. The Commission ordered the Respondent to form two separate, stand-alone divisions and divest one of them within six months of the final order. *Chicago Bridge* at 94.

ENH may raise objections to such a remedy based upon its integration efforts and the difficulty of unscrambling the merger. Adopting such an approach would severely hamper challenges of consummated mergers. Parties could evade liability under the Clayton Act simply by integrating the merging parties’ assets. In any event, in this case, there is a natural division between ENH and Highland Park. As the evidence will show, both were viable, stand-alone entities prior the merger, and both can continue as stand-alone entities following a divestiture. If the Court finds a section 7 violation from the merger, there is nothing short of a separation of the two hospital systems that could remedy the violation. As the evidence also will show, anything

less would not restore the same level of competition in the inpatient hospital services market in the Chicago northern suburbs.

CONCLUSION

For the foregoing reasons Complaint Counsel will respectfully seek from the Court an order encompassing the following findings and conclusions:

1. The Commission has jurisdiction over the subject matter of this proceeding and over Evanston Northwestern Healthcare Corporation (“ENH”), pursuant to 15 U.S.C. § 18.
2. The effects of the January 1, 2000, merger of ENH and Lakeland Healthcare Services were substantially to lessen competition, or to tend to create a monopoly in a line of commerce in a section of the country, in violation of section 7 of the Clayton Act, 15 U.S.C. § 18.
3. The January 1, 2000, merger of ENH and Lakeland Healthcare Services did not have any pro-competitive effects.
4. The notice of contemplated relief issued with the Complaint in this matter, including the divestiture of Lakeland Healthcare Services and Highland Park Hospital, sets forth provisions appropriate and warranted to remedy Respondent’s unlawful activity.
5. Such other findings of fact, conclusions of law, and other relief as the Court may deem appropriate.

Dated: January 27, 2005

Respectfully submitted,



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CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing documents were served on counsel for the


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Dated: January 27, 2005