UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION

In the Matter of

EVANSTON NORTHWESTERN HEALTHCARE CORP.

Docket No. 9315

COMPLAINT COUNSEL'S PROPOSED FINDINGS OF FACT IN REPLY

(Public Version)

Volume II

(CCRFF 515-964)

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VOLUME II

VII. THE MERGER RESULTED IN NO ANTICOMPETITIVE EFFECTS

A. The Court Should Consider Various Economic Factors In Its Competitive Effects Analysis

515. The economic principles that underlie the Merger Guidelines provide an appropriate framework for analyzing the Merger. (Noether, Tr. 5900, 5903).

Response to Finding No. 515:

The finding is incorrect. The Merger Guidelines do not provide an appropriate framework for analyzing this Merger. The Merger Guidelines provide a framework of analysis to determine "whether a merger is likely substantially to lessen competition." (1992 Horizontal Merger Guidelines, § 0.1). In this case, the Complaint does not allege that the merger between Evanston Hospital and HPH is likely to lessen competition in the future, but that the merger has already lessened competition, and Complaint Counsel has taken on the burden of showing actual competitive effects from the merger. For this process, the analysis contained in the Merger Guidelines is irrelevant. For a consummated merger, such as the Evanston and HPH merger, where pricing data exists, the emphasis is on the analysis of the pricing data, not on an analysis from the Merger Guidelines. (Elzinga, Tr. 2362; Haas-Wilson, Tr. 2467-68; CCFF 1609-1612).

516. The Merger "did not harm competition, neither price or quality; did not lead to the creation of market power for the merged entity; and therefore, there was no exercise of power. To the contrary, consumers benefitted from the merger." (Noether, Tr. 5900).

Response to Finding No. 516:

The finding is incorrect. The merger did harm competition, leading to price increases at ENH after the merger. (*See* CCFF 392-502). {[redacted]} (Baker, Tr.

4618, 4620, *in camera*; Haas-Wilson, Tr. 2637-38, *in camera*).

The merger did lead to the creation of market power, which was then exercised. Respondent's expert even admitted that before the merger, Evanston and HPH both had some market power. (Noether, Tr. 6131-32). The merger on January 1, 2000, between Evanston and HPH enhanced the market power of ENH, the merged entity, and, after the merger, ENH exercised its market power. (Haas-Wilson, Tr. 2657-58).

The statement, "consumers benefitted from the merger," is not supported by any documents or any testimony other than the testimony of Dr. Noether. {[redacted]} (Romano, Tr. 3004-05, 3008; Romano, Tr. 3192, *in camera*. *See also* CCFF 2033-2293). Most notably, Respondent cannot prove that any changes to HPH's quality outweighed the anticompetitive effects of the merger. (Noether Tr. 6181-83).

1. Dr. Haas-Wilson's Analysis Is Based On A Bargaining Theory

517. {[redacted]} (Haas-Wilson, Tr. 2756, *in camera*). {[redacted]} (Haas-Wilson Tr. 2757, *in camera*).

Response to Finding No. 517:

The first sentence of the finding as stated is incorrect, and the cited source does not support what Respondent's finding claims. Dr. Haas-Wilson's competitive effects theory is based on bargaining theory. (Haas-Wilson, Tr. 2469). Bargaining theory is based on a body of economic thought that is well accepted in the economic literature and for which Professor Nash won a Nobel Prize. (Haas-Wilson, Tr. 2469). {[redacted]

[redacted] (Haas-Wilson, Tr. 2756, *in camera*).

518. Dr. Haas-Wilson's bargaining theory is premised on the notion that the Merger led to a reduction in the number of alternative hospitals available to MCOs for network building. According to Dr. Haas-Wilson's bargaining theory, a MCO could have excluded Evanston Hospital from a network before the Merger because that MCO could have used HPH, among other hospitals in the area, as alternatives to Evanston Hospital. But after the Merger, Dr. Haas-Wilson surmises, a MCO could not exclude all three ENH hospitals from a network. According to Dr. Haas-Wilson, therefore, ENH gained market power as a result of the Merger. Without considering the full evidentiary context, Dr. Haas-Wilson purports to prove her theory by demonstrating that ENH's post-Merger prices to MCOs increased more than the prices of competitor hospitals. (Haas-Wilson, Tr. 2472-73; Noether, Tr. 5983).

Response to Finding No. 518:

The finding is incorrect in part, and the cited sources do not say what Respondent's finding claims. First, while Dr. Haas-Wilson stated that before the merger, a managed care organization would have the option of forming a network with Highland Park and other hospitals that excluded Evanston, she never said that after the merger a managed care organization could not exclude all three ENH hospitals from its network. Dr. Haas-Wilson merely made the point that after the merger the option of excluding Evanston and retaining Highland Park was no longer possible. (Haas-Wilson, Tr. 2472-73). This put the managed care organizations in a worse bargaining position relative to ENH after the merger by changing the next best alternative network available to the managed care organization. (Haas-Wilson, Tr. 2476).

The last sentence of this finding is also incorrect. Dr. Haas-Wilson did consider the full evidentiary context in concluding that the merger on January 1, 2000, between Evanston Hospital and Highland Park Hospital enhanced the market power of ENH, the

merged entity, and, after the merger, ENH exercised its market power. (Haas-Wilson, Tr. 2657-58). {[redacted]} (Haas-Wilson, Tr. 2733, *in camera*). {[redacted]} (Haas-Wilson, Tr. 2734, *in camera*).

2. The Pertinent Pricing Analysis Under Dr. Haas-Wilson's Bargaining Theory Has Both Theoretical And Empirical Dimensions

a. As A Theoretical Matter, Complaint Counsel Must Show More Than That ENH's Prices Increased After The Merger

i. Price Changes Alone Are Not Evidence Of Market Power

519. {[redacted]} (Baker, Tr. 4702, 4644, 4649-50, 4653, *in camera*; Haas-Wilson, Tr. 2677, *in camera*; Noether, Tr. 5904).

Response to Finding No. 519:

The finding is incorrect. {[redacted]}

[redacted] (Haas-Wilson, Tr. 2733-34, *in camera*).

520. {[redacted] (Haas-Wilson, Tr. 2828, *in camera*).

Response to Finding No. 520:

The finding is incomplete. {[redacted]

[redacted] (Haas-Wilson, Tr. 2733-34, *in camera*).

ii. Complaint Counsel Must Evaluate And Eliminate Viable Alternative Explanations

521. Before concluding that post-Merger price increases were caused by the gain and exercise of market power, viable alternatives for the price increases must be evaluated and eliminated. (Haas-Wilson, Tr. 2677-78).

Response to Finding No. 521:

The finding is incomplete. The viable alternative explanations that one examines in order to determine whether the price increases are the result of market power must be based on sound economic theory. (CCFF 581-585). In addition to selecting viable alternative explanations that are based on sound economic theory, one must thoroughly evaluate all of the viable alternative explanations. (CCFF 581).

In this case, Dr. Haas-Wilson utilized her expertise in economics, particularly health care economics, in formulating the viable alternative explanations for the price increase at ENH after the merger. Not only did Dr. Haas-Wilson select the potential explanations that, based on sound economic theory, could explain the price increase at ENH after the Merger, but she also employed a systematic and comprehensive methodology to evaluate the potential explanations for the price increase. Dr. Haas-Wilson repeatedly relied upon the economic research and literature on health care as she selected her control groups and conducted her economic pricing analysis. (*See* CCFF 581-741).

In direct contrast to the comprehensive work that Dr. Haas-Wilson performed, the Respondents' experts, Drs. Noether and Baker, rely solely upon the learning about demand explanation, and were incorrect in attributing the price increase at ENH after the merger to that explanation. (*See* CCFF 1763-2031 discussing the fact that the learning about demand excuse is without merit.).

522. If there are credible, benign reasons why prices went up after a merger, then those "explanations would allow you to move forward and conclude that the merger was not anti-competitive, whether you defined a relevant product market or geographic market or not." (Elzinga, Tr. 2404).

Response to Finding No. 522:

Complaint Counsel have no specific response.

523. There are many potential viable alternative explanations for a post-merger price increase including:

(a) {[redacted]} (Haas-Wilson, Tr. 2642 *in camera*; Haas-Wilson, Tr. 2484; Baker, Tr. 4652-53, *in camera*).

(b) {[redacted]} (Haas-Wilson, Tr. 2482-83; Baker,

Tr. 4652, *in camera*).

(c) Changes in regulations. (Haas-Wilson, Tr. 2483).

(d) {[redacted]} (Haas-Wilson, Tr. 2681; Baker, Tr. 4652, *in camera*).

(e) {[redacted]} (Baker, Tr. 4653, *in camera*; Haas-Wilson, Tr. 2682).

(f) {[redacted]} (Baker, Tr. 4650-53 (discussing DX 8044), *in camera*).

(g) Changes in quality at the merging hospitals or other area hospitals. (Haas-Wilson, Tr. 2482-85, 2684). For example, {[redacted]} (Baker, Tr. 4653, *in camera*).

(h) Changes in the mix of customers. (Haas-Wilson, Tr. 2486).

(i) {[redacted]} (Haas-Wilson, Tr. 2585, *in camera*).

(j) Decreases in the price of outpatient services. (Haas-Wilson, Tr. 2487).

(k) Changes in information, also known as "learning about demand." (Haas-Wilson, Tr. 2488).

(l) Changes in a hospital's marketing and advertising program. (Haas-Wilson, Tr. 2683).

(m) Changes in teaching intensity. (Haas-Wilson, Tr. 2486-87).

(n) Payor specific changes. (Haas-Wilson, Tr. 2687-89).

(o) Changes in reputation. (Haas-Wilson, Tr. 2682).

(p) The addition of nicer amenities. (Haas-Wilson, Tr. 2683).

Response to Finding No. 523:

The finding is incomplete. The viable alternative explanations that one examines in order to determine whether the price increases are the result of market power must be based on sound economic theory. (CCFF 581-585. *See also* CCRFF 521).

Some of the subparts in this finding are incorrect. {[redacted]} In a competitive market, a firm that experiences such an idiosyncratic cost increase would not be able to pass along a price increase to its customers because its

customers would just switch to its competitors.

The first cite does not support proposed finding RFF 523(a).

{[redacted]} (Baker, Tr. 4653 (emphasis added), *in camera*).

Respondent cites the wrong page for RFF 523(i). Respondent is also incorrect in categorizing the transcript cite. It is in the public record.

The source cited does not support RFF 523(n). Dr. Haas-Wilson did not consider payor specific changes to be a potential viable alternative explanation for a post-hospital-merger price increase. She "wouldn't want to say anything on (her list of ten possible explanations for a price increase) is just payor related." (Haas-Wilson, Tr. 2687-89).

524. {[redacted]} (Haas-Wilson, Tr. 2744, *in camera*).

Response to Finding No. 524:

The cited source does not say what Respondent's finding claims. {[redacted]} (Haas-Wilson, Tr. 2744, *in camera*).

The proposed finding is irrelevant. *See* CCRFF 521 discussing the fact that the

viable alternative explanations that one examines in order to determine whether the price increases is the result of market power must be based on sound economic theory.

This finding is also irrelevant because none of Respondent's experts considered this to be a possible viable alternative explanation for the price increase at ENH after the merger and therefore, none did any economic analyses on this point. Respondent also does not claim that this accounts for all of the price increase at ENH after the merger.

525. Dr. Haas-Wilson did not put any probability estimates on any of these potential explanations. (Haas-Wilson, Tr. 2678). Nor did she know how much of a chance there would need to be that an alternative explanation explains a price increase for it to be considered "viable." (Haas-Wilson, Tr. 2680).

Response to Finding No. 525:

The finding is irrelevant, incorrect and misleading. Probability estimates are not relevant to potential explanations. There does not need to be a determination of "how much of a chance" there is that an alternative explanation explains a price increase for the explanation to be considered "viable." The appropriate question is whether the potential alternative explanation for the price increase at ENH after the merger is based on sound economic theory. *See* CCRFF 521 discussing the fact that the viable alternative explanations that one examines in order to determine whether the price increases is the result of market power must be based on sound economic theory.

526. {[redacted]} (Haas-Wilson, Tr. 2745-46, 2754, 2755-56, *in camera*).

Response to Finding No. 526:

The finding is irrelevant and incomplete. [redacted] (CCFF 392, 689-692). The only issue remaining on this score is whether the price increases were due to the exercise of market power or some alternative explanation that is based on sound economic theory. An alternative explanation must account for all of the price increases in order for market power to not be part of the explanation, otherwise the price increases are deemed anticompetitive. [redacted] (CCFF 631, 586). [redacted] (Haas-Wilson, Tr. 2615, *in camera*; CFF 632). [redacted] (Haas-Wilson, Tr. 2637 (referring to DX 7024), *in camera*; CFF 693).

527. [redacted] (Baker, Tr. 4649-50, *in camera*).

Response to Finding No. 527:

The cited source does not say what Respondent's proposed finding says. [redacted] (Baker, Tr. 4649-50, *in camera*). [redacted]

[redacted] Moreover, Dr. Baker, who is the sole source for this finding, lacked credibility. (*See* CCFF 1742-1762).

iii. In Particular, Complaint Counsel Must Rule Out "Learning About Demand" To Show That ENH Exercised Market Power As A Result Of The Merger.

528. [redacted] (Baker, Tr. 4654-55, 4699-4700, 4743-44, 4747-48, 4769, *in camera*).

Response to Finding No. 528:

The finding is incorrect for several reasons. [redacted] (Baker, 4752-4755, *in camera*). [redacted] (CCFF 703-725, 1912-1940, *in camera*).

[redacted] (CCFF 696-702, 1797-1809).

{[redacted]

[redacted]} *See* CCRFF 99-104 discussing academic and community hospitals.

In any event, Dr. Baker lacked credibility. (*See* CCFF 1742-1762).

529. {[redacted]}
(Baker, Tr. 4655-56, *in camera*).

Response to Finding No. 529:

The finding is irrelevant. {[redacted]

[redacted]} (Haas-Wilson, Tr. 2732-33 (referring to DX 7046), *in camera*).

(*See, e.g.* CCFF 737).

In any event, Dr. Baker lacked credibility. (*See* CCFF 1742-1762).

530. {[redacted]}
(Baker, Tr. 4757-59, 4761-62, 4812, *in camera*).

Response to Finding No. 530:

The finding is incorrect. {[redacted]

[redacted]}

{[redacted]

[redacted]

[redacted]

(Haas-Wilson, Tr. 2728, *in camera*). {[redacted]

[redacted]} (Haas-Wilson, Tr. 2728 (discussing DX 7062 at 1, *in camera*), *in camera*). {[redacted]

[redacted]} (Haas-Wilson, Tr. 2728 (discussing DX 7062 at 1, *in camera*), *in camera*). In any event, Dr. Baker lacked credibility. (*See* CCFF 1742-1762).

531. {[redacted]} (Noether, Tr. 5970-72; Baker, Tr. 4813-14, *in camera*). In fact, the literature on markets with asymmetric or imperfect information dates back to at least 1961, includes several papers published in well-respected journals, and includes a Nobel Prize in Economics awarded in 2001. (Noether, Tr. 5970-72 (*describing* DX 8108)).

Response to Finding No. 531:

The finding is incorrect. The learning about demand explanation was put forth by the experts hired by ENH in this case. (Haas-Wilson, Tr. 2488). {[redacted]

[redacted]} (Baker, Tr. 4770-71, *in camera*). Dr. Noether also testified that none of the literature she discussed applies theories of imperfect information to hospital mergers. (Noether, Tr. 6143). By Dr. Noether's own admission, the theory of learning about demand is a disequilibrium argument; because Evanston was not well informed about the

demand for its services, the market allegedly was not in equilibrium. (Noether, Tr. 5990). The literature, however, deals with equilibrium market failures caused by asymmetric information. Learning about demand has nothing to do with whether ENH knew more or less about the terms of the transaction than did the customers (the MCOs), which is the asymmetry with which the literature deals. In any event, Dr. Baker lacked credibility. (*See* CCFF 1742-1762).

iv. The Court Should Consider Both Price Levels And Price Changes When Evaluating Whether Price Increases Were The Result Of Market Power From The Merger.

532. {[redacted]} (Noether, Tr. 5989, 5991; Haas-Wilson, Tr. 2823-24, *in camera*).

Response to Finding No. 532:

The finding is incorrect. {[redacted]} (Haas-Wilson, Tr. 2495, CCFF 503-504).

The finding is also incorrect and misleading. {[redacted]} (*See* CCFF 1763-2026).

b. As An Empirical Matter, Complaint Counsel Must Show That ENH's Post-Merger Prices Increases Were The Result Of

Market Power

533. {[redacted]} (Noether, Tr. 6105-06, *in camera*; Baker, Tr. 4671, 4811, *in camera*). This issue is discussed more depth below in Section V.A.2, 3.

Response to Finding No. 533:

The cited sources do not say what Respondent's proposed finding claims. {[redacted]} (Noether, Tr. 6105-06, *in camera*; Baker, Tr. 4671, 4811, *in camera*). The second sentence is not a finding of fact.

The proposed finding is incorrect because Dr. Haas-Wilson examined the possible alternative explanations for the post-merger price increases at ENH, and she concluded that the merger on January 1, 2000, between Evanston Hospital and Highland Park Hospital enhanced the market power of ENH, the merged entity, and that, after the merger, ENH exercised its market power. (Haas-Wilson, Tr. 2657-58). [redacted] (Haas-Wilson, Tr. 2733, *in camera*).

3. This Court Also Should Take Into Account Other Competitive Effects Considerations

534. The Court's competitive effects analysis also should take into account: (1) the vast improvements in quality of care after, and as a result of, the Merger (discussed in Section VIII); (2) the limited barriers to entry into the market and the repositioning of existing market participants to foster competition (discussed in Sections V.B.3.b.; IX.A); and (3) the inability of HPH to remain viable in the long-term due to its financial problems (discussed in Sections

V.B.3.b.; IX.B.1).

Response to Finding No. 534:

Respondent cites no support for this finding. This is contrary to the judge's April 6, 2005, Order on Post Trial Briefs, stating that each proposed finding shall have a valid and correct cite to the record.

B. The Pre-Merger Competitive Landscape Is Inconsistent With Dr. Haas-Wilson's Bargaining Theory

1. This Case Involves A Differentiated Product

535. As discussed in Section VI, hospital services are a differentiated product. (Noether, Tr. 5910, Haas-Wilson, Tr. 2492). They are differentiated on both product and geographic dimensions. (Noether, Tr. 5911).

Response to Finding No. 535:

The finding is too vague to address directly. Complaint Counsel do not disagree that hospital services are a differentiated product. However, without specific citations to what in Section VI Respondent is attempting to include in this finding with the reference "as discussed in Section VI," Complaint Counsel is unable to address the specifics of this finding. Many of the Respondent's proposed findings in Section VI are incorrect, incomplete, or irrelevant. (*See* CCRFF 366-514).

536. Product differentiation has a number of dimensions including: (1) breadth of service, measured by number of DRGs; (2) size, measured by number of beds; and (3) teaching intensity, measured by number of residents and interns per bed. (Noether, Tr. 5911-12).

Response to Finding No. 536:

The finding is incomplete. Hospitals offer differentiated products or services that are differentiated on many characteristics, not just these three. Hospitals are

differentiated geographically (*see* RFF 535), and by other characteristics such as location and reputation. (Haas-Wilson, Tr. 2492).

537. In a differentiated product market, firms that are closer substitutes to each other are more likely to constrain each other's competitive behavior. (Noether, Tr. 5911).

Response to Finding No. 537:

The finding is irrelevant. Hospitals are differentiated on many characteristics. (*See* CCRFF 536). In addition, hospitals compete on two different levels, competition for inclusion in managed care plans (Haas-Wilson, Tr. 2456-57 (discussing DX 7026)), and, once in a managed care plan, competition for patients. (Haas-Wilson, Tr. 2463-64 (discussing DX 7026)). Without knowing the level of competition that is being referred to or the characteristics of hospitals that are being compared to determine whether the hospitals are close substitutes, it is impossible to apply this generalization to this case, and it is therefore irrelevant.

2. Evanston Hospital And HPH Were Not Close Substitutes

a. Evanston Hospital And HPH Were Not Close Substitutes From A Product Perspective

538. Evanston Hospital and HPH were not each other's closest substitutes in product space. (Noether, Tr. 5901; Neaman, Tr. 1306; Spaeth, Tr. 2244). Before the Merger, HPH could not possibly have replaced all of Evanston Hospital's services in a MCO's network because Evanston Hospital was a much larger hospital with an academic affiliation and offered a much broader array of services. (Chan, Tr. 706; Neaman, Tr. 1306-07; Spaeth, Tr. 2285).

Response to Finding No. 538:

The finding is irrelevant and misleading. First, whether or not Evanston and HPH were each other's closest substitutes, before the merger there was substantial overlap in the services offered between Evanston and HPH. {[redacted]

[redacted] (RX 1912 at 44, *in camera*).

Second, in competing for inclusion in managed care plans, it is irrelevant whether HPH could have replaced all of Evanston Hospital's services in a managed care plan's network. Before the merger, Highland Park, *along with other hospitals in a managed care plan's network,* could have replaced all of Evanston's Hospitals services in the managed care organization's network. (Haas-Wilson, Tr. 2472 (emphasis added)).

539. Before the Merger, Evanston Hospital's closest substitutes in product space were other academic/tertiary care facilities such as Dr. Noether's academic control group hospitals. (Noether, Tr. 6160, 6196).

Response to Finding No. 539:

The finding is incomplete and misleading. Prior to the merger with Highland Park, Evanston's closest competitors in product space were hospitals that offered tertiary services. (Noether, Tr. 6160-61). There is no commonly accepted precise definition of tertiary services, but it means more sophisticated services. (Noether, Tr. 6160). Hospitals that offered services that were on average more complex than Evanston include hospitals in Dr. Noether's academic control group as well as hospitals in Dr. Noether's community control group. The following hospitals in Dr. Noether's community hospital control group all offered, on average, more complex services than Evanston: Alexian Brothers Medical Center, Louis A. Weiss Hospital, Northwest Community Hospital, Resurrection Medical Center, Rush North Shore Medical Center, and St. Francis

Hospital. (Noether, Tr. 6168-72 (discussing DX 7130, same document as RX 1912 at 25); CCFF 1867-1869 (Alexian Brothers); CCFF 1873-1875 (Louis A. Weiss Hospital); CCFF 1880-1882 (Northwest Community Hospital); CCFF 1886-1888 (Resurrection Medical Center); CCFF 1892-1894 (Rush North Shore Medical Center); CCFF 1900-1902 (St. Francis Hospital)).

i. Evanston Hospital And HPH Offered A Different Breadth of Services

540. A breadth of service analysis supports Dr. Noether's conclusion that Evanston Hospital and HPH were not "likely to be very close substitutes." (Noether, Tr. 5917).

Response to Finding No. 540:

The finding is irrelevant. A "breadth of service analysis" ignores an important way that Evanston Hospital and HPH were very close substitutes, in that a managed care organization could use one to replace the other in its networks, when done in conjunction with the other hospitals in the networks. The reason for this is that Highland Park and Evanston were competitors in the same section of Chicago's northern suburbs. People in that area could go north to one hospital or south to the other and receive the same level of services. The managed care network needed one of the two hospitals in its network. (Ballengee, Tr. 166). {[redacted]} (Mendonsa, Tr. 516-517 *in camera*). {[redacted]} (Mendonsa, Tr. 517-18 *in camera*). One Health attempted to market a plan without the three ENH hospitals and failed. (*See* CCFF 1133-1162).

541. Dr. Noether used the number of DRGs treated by a hospital to analyze "breadth of services." (Noether, Tr. 5913). Dr. Noether considered the number of DRGs treated at twenty hospitals that compete one way or another with at least one of the merging hospitals. (Noether, Tr. 5913-14). {[redacted]} (RX 1912 at 44, *in camera*).

Response to Finding No. 541:

The finding is incomplete and misleading. Dr. Noether did not use the number of DRGs treated by a hospital, but rather the number of DRGs treated by a hospital more than four times in a given time period. This procedure is arbitrary and potentially misleading. (*See* CCRFF 542).

In addition, the twenty hospitals that Dr. Noether selected were selected in an arbitrary manner. (*See* CCFF 1821-1833).

542. In conducting this analysis, Dr. Noether excluded any DRGs in which a particular hospital treated fewer than four cases in a particular year, because she did not want to credit a hospital with DRGs that were either coding errors or the result of a patient coming into the emergency room being treated until stabilized and then transferred out. (Noether, Tr. 5914-15). Dr. Noether used 1999 data to conduct this analysis because she wanted to look at the breadth of service at the different providers in the market in the period immediately leading up to the Merger. (Noether, Tr. 5913, 5916-17).

Response to Finding No. 542:

The finding is misleading. Dr. Noether's procedure is arbitrary. Dr. Noether testified that she could have used three or five cases instead of four. (Noether, Tr. 5914-15). Yet Dr. Noether's procedure yields anomalous results. If one examines Highland Park, the number of DRGs varies whether the count is made for a calendar year or a fiscal year. (*See* CCFF 1839). Dr. Noether testified only that, if there were four (or three or five) cases coded under a particular DRG, it is possible that the case may be an incorrect coding or could be a case later transferred, not that it was necessarily so. (Noether, Tr.

5914-15). It is possible that Dr. Noether's procedure eliminates procedures from hospitals that they actually perform. Thus, her measure of DRGs is not an accurate view of what hospitals could do in the future, only what they have done in the past, limited to the fact that they actually performed four such procedures in the time period in question.

543. Evanston Hospital treated the fourth most DRGs out of the twenty hospitals that Dr. Noether considered. (Noether, Tr. 5915).

Response to Finding No. 543:

The finding is unsupported as stated. The record evidence does not show how many DRGs Evanston Hospital (or any hospital) treated, only the number of DRGs Evanston Hospital (or any hospital) treated four or more times. (*See* CCRFF 542).

544. HPH provided the fewest number of DRGs out of the twenty hospitals that Dr. Noether considered, providing a little over half the number of DRGs that Evanston Hospital provided. (Noether, Tr. 5916).

Response to Finding No. 544:

The finding is unsupported as stated. The record evidence does not show how many DRGs HPH (or any hospital) treated, only the number of DRGs HPH (or any hospital) treated four or more times. (*See* CCRFF 542).

545. Three hospitals – Loyola, University of Chicago and Advocate Northside – had "slightly more DRGs" than Evanston Hospital. (Noether, Tr. 5917).

Response to Finding No. 545:

The finding is unsupported as stated. The record evidence does not show how many DRGs Loyola, University of Chicago, or Advocate Northside treated, only the number of DRGs Loyola, University of Chicago, and Advocate Northside treated four or more times. (*See* CCRFF 542).

546. Three hospitals – Northwestern Memorial, Advocate Lutheran General and Rush Presbyterian – had slightly fewer DRGs than Evanston Hospital. (Noether, Tr. 5917).

Response to Finding No. 546:

The finding is unsupported as stated. The record evidence does not show how many DRGs Northwestern Memorial, Advocate Lutheran General, or Rush Presbyterian treated, only the number of DRGs Northwestern Memorial, Advocate Lutheran General, and Rush Presbyterian treated four or more times. (*See* CCRFF 542).

547. The number of DRGs at HPH was very similar to the number of DRGs at Lake Forest Hospital and the two Vista Hospitals. (Noether, Tr. 5917).

Response to Finding No. 547:

The finding is unsupported as stated. The record evidence does not show how many DRGs HPH, Lake Forest Hospital, or the two Vista Hospitals treated, only the number of DRGs HPH, Lake Forest Hospital, and the two Vista Hospitals treated four or more times. (*See* CCRFF 542).

548. {[redacted]} (Noether, Tr. 5986; RX 1912 at 44, *in camera* (*describing* DX 8113)). {[redacted]} (Noether, Tr. 5986; RX 1912 at 44, *in camera*). {[redacted]} (Noether, Tr. 5986; RX 1912 at 44, *in camera*).

Response to Finding No. 548:

The finding is unsupported as stated. The record evidence does not show how many DRGs any of the listed hospitals treated, only the number of DRGs the listed hospitals treated four or more times. (*See* CCRFF 542).

549. The difference in terms of breadth of service between Evanston Hospital and HPH

is further evidenced by the fact that Evanston Hospital had tertiary services pre-Merger, while HPH, to a large extent did not. (Haas-Wilson, Tr. 2491). Accordingly, {[redacted]} (Haas-Wilson, Tr. 2551-52, *in camera*).

Response to Finding No. 549:

The finding is incomplete and misleading. While Evanston Hospital was generally recognized as a tertiary hospital (or a "community/tertiary" hospital (CCFF 34)) pre-merger, both Evanston and Highland Park offered many of the same services. All hospitals offer a core of basic primary and secondary services. (Noether, Tr. 6159). {[redacted]} (RX 1912 at 44, *in camera*). Moreover, in at least one important respect, the two hospitals were similar. They were both located in the North Shore suburbs, which was important to managed care plans who wanted to get adequate geographic coverage. (*See* CCRFF 540).

550. In sum, it would have been difficult for MCOs to substitute HPH for Evanston Hospital in their networks before the Merger because HPH did not provide many of the services that Evanston Hospital provided. (Noether, Tr. 5918).

Response to Finding No. 550:

The finding is incorrect. It would not have been difficult for managed care organizations to substitute HPH for Evanston Hospital pre-merger, because the managed care organization would not have been substituting Highland Park for Evanston on a one-for-one basis, but would have been substituting Highland Park and the other hospitals that

were in the managed care organization's network for Evanston. (Haas-Wilson, Tr. 2472; CCRFF 540).

ii. Evanston Hospital And HPH Were Hospitals Of Very Different Sizes

551. Evanston Hospital and HPH were not close substitutes because they were hospitals of very different sizes. (Noether, Tr. 5921).

Response to Finding No. 551:

The finding is irrelevant and misleading. Managed care organizations found that Evanston and Highland Park were close substitutes, in terms of the MCOs offering a network that was attractive to customers along the corridor between Highland Park and Evanston Hospital. A managed care organization could use Highland Park and the other hospitals in its network as a replacement for Evanston Hospital, or Evanston Hospital and the other hospitals in its network as a replacement for Highland Park. (Haas-Wilson, Tr. 2472; CCRFF 540). The difference in size between the two hospitals was never mentioned by the payers as an obstacle to using only one of the hospitals in its network.

552. To look at hospital size, Dr. Noether considered the number of staffed beds for the same twenty hospitals considered in the breadth of service analysis. (Noether, Tr. 5918).

Response to Finding No. 552:

Complaint Counsel have no specific response.

553. Staffed beds are different than licensed beds. (Noether, Tr. 5918-19). Each hospital is licensed to have a certain number of beds, and that number serves as the upper bound on the number of staffed beds. (Noether, Tr. 5919). But often, depending on the demand for their services, hospitals do not actually staff all of the licensed beds. So the staffed beds number is the number of beds that are actually in operation. (Noether, Tr. 5919).

Response to Finding No. 553:

Complaint Counsel have no specific response.

554. Although the Medicare Cost Report data suggests that Advocate Northside had over 650 beds in 1999, based on publicly available information, such as Advocate Northside's website, Dr. Noether concluded that Advocate Northside is really a 507-bed hospital. (Noether, Tr. 5919-20).

Response to Finding No. 554:

Complaint Counsel have no specific response.

555. Evanston Hospital, with 411 staffed beds in 1999, was seventh out of the twenty hospitals that Dr. Noether evaluated in terms of bed size. (Noether, Tr. 5920; RX 1912 at 60).

Response to Finding No. 555:

Complaint Counsel have no specific response.

556. In this regard, Evanston Hospital was most similar to Advocate Lutheran General, Advocate Northside, Rush Presbyterian, Northwestern Memorial, Advocate Lutheran General, University of Chicago and Loyola in terms of bed size. (RX 1912 at 60).

Response to Finding No. 556:

The finding is inconsistent with the cited document and incorrect. {[redacted]} (RX 1912 at 60, (taking the difference between the bed size of ENH and the named hospitals) *in camera*)). {[redacted]}

[redacted] (RX 1912 at 60 ([redacted]) *in camera*).

557. In contrast, HPH, with 157 beds in 1999, was nineteenth out of twenty in terms of bed size. (Noether, Tr. 5920; RX 1912 at 60). In that sense, HPH was most like Condell, with 163 beds in 1999, and Lake Forest Hospital, with 142 beds in 1999. (Noether, Tr. 5920; RX 1912 at 60).

Response to Finding No. 557:

Complaint Counsel have no specific response.

iii. Unlike Evanston Hospital, HPH Had No Teaching Component

558. Evanston Hospital and HPH were not particularly close substitutes pre-Merger given that Evanston Hospital was an academic hospital and HPH merely was a community hospital. (Noether, Tr. 5924).

Response to Finding No. 558:

The cited source does not say what Respondent's finding claims. Dr. Noether does not refer to Evanston Hospital as an "academic hospital," but as a "major teaching hospital." *See* CCRFF 99 for a discussion of the problems of categorizing hospitals.

The finding is irrelevant. Managed care organizations found that Evanston and Highland Park were close substitutes in terms of the MCOs offering a network that was attractive to customers along the North Shore corridor between Highland Park and Evanston Hospital. A managed care organization could use Highland Park and the other hospitals in its network, including teaching or academic hospitals, as a replacement for Evanston Hospital, or Evanston Hospital and the other hospitals in its network as a

replacement for Highland Park. (Haas-Wilson, Tr. 2472; CCRFF 540). The difference between the two hospitals in terms of academic or teaching status was never mentioned by the payers as an obstacle to using only one of the hospitals in its network.

559. MedPAC defines "major teaching hospital" as one that has at least 0.25 medical residents per bed. (Noether, Tr. 5922). The number of residents per bed is an indicator of teaching intensity. (Noether, Tr. 5921). Evanston Hospital, which had .3386 medical residents per bed, satisfied this definition of a major teaching hospital. (Noether, Tr. 5922; RX 1912 at 60). HPH, which had no residents pre-Merger, obviously did not satisfy the definition of a major teaching hospital. (Noether, Tr. 5923; RX 1912 at 60).

Response to Finding No. 559:

Complaint Counsel have no specific response.

b. Evanston Hospital And HPH Were Not Close Substitutes From A Geographic Perspective

560. As discussed in Section VI.B.1, a number of hospitals are closer (both in terms of distance, driving time, service area and physician admission patterns) to Evanston Hospital than HPH. And some hospitals are closer to HPH than Evanston Hospital.

Response to Finding No. 560:

Respondent cites no support for this finding. This is contrary to the judge's April 6, 2005, Order on Post Trial Briefs stating that each proposed finding shall have a valid and correct cite to the record.

The finding is irrelevant both to market definition and to the analysis of anticompetitive effects in this merger case. After a merger has been consummated, an economist can rely on direct evidence to determine that a merger reduced competition. It is not necessary in such a case to prove what the market is and to measure market shares to infer whether the merger reduced competition. Direct evidence includes post-merger pricing behavior, evidence from the merging parties themselves (*i.e.*, how they assessed

the merger), and the assessment of the consequences of the merger by customers in the marketplace. (Elzinga, Tr. 2362; Haas-Wilson, Tr. 2468).

Dr. Haas-Wilson used such direct evidence to reach the conclusion that the merger created or enhanced market power and that ENH exercised that market power. Dr. Haas-Wilson demonstrated a significantly larger post-merger price increase at ENH that at other hospitals in the Chicago area. {[redacted]} (Haas-Wilson, Tr. 2734, *in camera*).

Dr. Haas-Wilson did not have to define relevant markets to reach her conclusion that the merger created or enhanced market power and that ENH exercised that market power, so this and other findings on the pre-merger geographic "closeness" or geographic "competition" are irrelevant. Moreover, Dr. Haas-Wilson explained that having found such a price increase, that itself demonstrates a geographic market, so to the extent that a geographic market must be proven, such findings are also irrelevant to the geographic market issue.

Finally, the location of Evanston Hospital and HPH in the North Shore suburbs of

Chicago made them important hospitals. When they merged, the merger gave ENH market power. The three ENH hospitals formed a geographic triangle that did not contain any other hospitals. This was a very important geographic area due to its demographics. Managed care plans believed that they needed either HPH or Evanston hospital in their network in order to successfully market their plans. After the merger managed care plans believed they had to meet ENH's demands for higher prices. It was irrelevant to the managed care plans that they had other hospitals in their networks outside of the triangle formed by the three ENH hospitals. (*See* CCRFF 562).

The proposed finding ignores the head-to-head competition that follows from Highland Park's and Evanston's geography. A person traveling up the North Shore from Chicago "would stop at Evanston" first and then "Highland Park would be the next hospital." (Holt-Darcy, Tr. 1426). Evanston and Highland Park Hospitals compete for patients from people living in between the two communities. (Holt-Darcy, Tr. 1426; Neary, Tr. at 600-01; CX 1 at 3-5; CX 2 at 7). The North Shore community viewed Evanston and Highland Park as competing hospitals where people on the North Shore could choose either to go north to one or south to the other to receive the same services at the same level. (Ballengee, Tr. at 166, 170-171 ("competitive environment between the two hospitals")). This North Shore area also roughly corresponds to the Evanston-Highland Park Hospital Combined Core Service Area ("CCSA"), which includes the towns of Deerfield, Highland Park, Fort Sheridan, Highwood, Lake Forest, Glencoe, Northbrook, Glenview, Golf, Kenilworth, Techny, Wilmette, Winnetka, Evanston and Skokie. This area spans a densely populated suburban corridor that runs for about 15

miles north-south along the shore of Lake Michigan, and extends roughly ten miles west of the Lake. (CX 348 at 2; CX 360 at 7; CX 359 at 16; CX 84 at 21). Looking at this combined core service area, ENH's core area had a total population of 281,912 (projected growth of -.1%), with an average income of $111,194, and Highland Park's core area had a total population of 128,021 (projected growth of 2.4%), with an average income of $160,133. The most obvious "overlap area" was in Northbrook and Glencoe with 49,912 people (projected growth .7%), and an average income of $153,582. (CX 360 at 12). ENH comprised 44% of the share of this combined core service area. The combined entity had a 55% share of the CCSA. (CX 360 at 13). ENH held the largest share (33%) within Highland Park's (32%) core area with Lake Forest next (9%) (CX 360 at 23).

Ms. Ballengee testified that Highland Park was the "primary alternative" to Evanston because it "sits to the north of these communities. Evanston on the south. There's [*sic*] no hospitals in between and it tends to be a north-south migration of the populace." (Ballengee, Tr. 168). ENH indicated to PHCS that ENH was an entity "controlling all of these communities." (Ballengee, Tr. 176, 177 ("they indicated that they already had the market share for these communities," indicating a 60% market share)). ENH executives told PHCS that eliminating St. Francis, Rush North Shore, and Condell would not justify a lower rate because they were not viewed by ENH as significant competitors. (Ballengee, Tr.181-82). Eliminating the ENH system from the health plan's network would leave a large area that would be "uncovered" from the standpoint of the health plan. (Ballengee, Tr. 181). Other hospitals in PHCS's network,

such as Rush North Shore, Lake Forest and Lutheran General Hospitals, were not considered to be "viable alternatives" to ENH because "there would be a large area that would be not served by the community hospitals." (Ballengee, Tr. 183-84). Ms. Ballengee emphasized that the customers of PHCS "are looking at obviously *wanting to have good hospitals in it to provide good services, they have a breadth of services that they're offering*, and that they have good accessibility to those services *within their communities*." (Ballengee, Tr. 152 (emphasis added)).

In addition, other payors made similar comments. Ms. Foucre testified that consumer preferences mean that "in a heavily populated area, having the hospitals that are in that area in network can be important" and that "there are certain geographies where . . . people who are decision-makers at key employers may reside, and ensuring that we had an adequate network . . . is also important." (Foucre, Tr. 885). Similarly, Mr. Mendonsa of Aetna emphasized that, in the context of developing a hospital network, "[a]ccess is . . . making sure that employees can get to the facilities *that we believe and have determined are the facilities they want to go to.*" (Mendonsa, Tr. 485 (emphasis added)). Mr. Mendonsa testified that people "typically want to go to a hospital in their community" (Mendonsa, Tr. 485), and that, regardless of mileage, {[redacted]} (Mendonsa, Tr. 568, *in camera*). {[redacted]} (Mendonsa, Tr. 516, *in camera*). He also explained that, if there is an employer who has executives living in the area "those things all come into very important play as employers make decisions. {[redacted]

[redacted]

(Mendonsa, Tr. 517, *in camera*). Furthermore, Ms. Holt-Darcy of Unicare testified that "[y]ou want to see *what population that you have, or potentially have, what marketing thinks they need in a particular service area.*" (Holt-Darcy, Tr. 1420 (emphasis added)).

c. Evanston Hospital And HPH Had Much Closer Substitutes Than Each Other

561. The following subsections are intended to supplement the geographic market discussion. (*See* Section VI.B.)

Response to Finding No. 561:

Respondent cites no support for this finding. This is contrary to the judge's April 6, 2005, Order on Post Trial Briefs stating that each proposed finding shall have a valid and correct cite to the record.

i. Evanston Hospital Had Several Closer Substitutes Than HPH

562. As far back as 1996, managed care executives believed that Evanston Hospital had many strong competitors and substitutes. (RX 145 at ENH JH 12083)

Response to Finding No. 562:

Complaint Counsel objects to the reliance on RX 145 at ENH JH 012083, to the extent that it is introduced the truth of the matter asserted therein. The quoted statements in RX 145 attributed to managed care executives are double hearsay, and are inadmissible for the purpose of proving the truth of the matter asserted therein pursuant to Rule 805, F.R.E., and JX1 ¶ 5 (February 10, 2005).

The finding is irrelevant, incomplete, and misleading. The finding is irrelevant for the reasons given in CCRFF 560 above. The finding is incomplete and misleading

because it does not distinguish between first and second stage competition. As explained by Dr. Haas-Wilson, hospitals compete with one another in two distinct ways. In the first way, referred to as "first-stage" competition, hospitals compete for inclusion in managed care plans. It is at this stage of competition that price is determined. In the second way hospitals compete, referred to as "second-stage" competition, hospitals compete for patients once they are in a managed care plan's network. (Haas-Wilson, Tr. 2456, 2463-65). The finding does not distinguish between the two stages of competition and is thus incomplete.

The witnesses cited never said that there were many hospital competitors or substitutes with respect to "first-stage" competition, which is the competitive dynamic by which hospital prices are determined. (Haas-Wilson, Tr. 2456). Far from it. {[redacted]} (CCFF 959-1312, *in camera*). {[redacted]} (*See, e.g.*, Ballengee, Tr. 179-80; Mendonsa, Tr. 520, *in camera*; Foucre, Tr. 901-02). Health plans testified that the three ENH hospitals combined form a triangle of a service or catchment area in which the service areas of the hospitals are contiguous. (Foucre, Tr. 901-902 ("there are no hospitals within that triangle, there are no other facilities"); Foucre, Tr. 901-903 (The area in this triangle is a heavily populated with affluent communities, where corporate decision-makers and prospective customers live); Ballengee, Tr. 168 (

"Highland Park sits to the north of these communities Evanston on the south. There's [*sic*] no hospitals in between and it tends to be a north-south migration of the populace").

ENH told payers after the merger that ENH held power in the contiguous area that its hospitals surrounded. For example, ENH indicated to PHCS that ENH was an entity "controlling all of these communities." (Ballengee, Tr. 176, 177 ("they indicated that they already had the market share for these communities," indicating a 60% market share)). ENH executives told PHCS that eliminating St. Francis, Rush North Shore, and Condell would not justify a lower rate because they were not viewed by ENH as significant competitors. (Ballengee, Tr.181-82). {[redacted]} (CX 129 at 1, *in camera*). Thus, from the health plan perspective, {[redacted]} (Holt-Darcy, Tr. 1561, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1602, *in camera).* [redacted] (Mendonsa, Tr. 543-44, *in camera*). {[redacted]} (Mendonsa, Tr. 542-43, *in camera*).

Eliminating the ENH system from the health plan's network would leave a large area that would be "uncovered" from the standpoint of the health plan. (Ballengee, Tr. 181). Other hospitals in PHCS's network, such as Rush North Shore, Lake Forest and Lutheran General Hospitals, were not considered to be "viable alternatives" to ENH because "there would be a large area that would be not served by the community hospitals." (Ballengee, Tr. 183-84). The access problem was heightened because companies in or near the triangle area include Kraft Foods, Allstate, Sara Lee, and Abbott Laboratories. There are no non-ENH hospitals in this triangle. United Healthcare does not believe it could have a viable network without ENH. (Foucre, Tr. 901-903).

{[redacted]} (Mendonsa, Tr. 517, *in camera*).

(1) Evanston Hospital's Closest Substitutes From A Product Perspective Were Advocate Lutheran General And Northwestern Memorial

563. Evanston Hospital's chief competitors were Advocate Lutheran General and Northwestern Memorial. (Chan, Tr. 706)

Response to Finding No. 563:

The finding is incomplete and misleading for the reasons stated in CCRFF 562 above. Market participants believed that Evanston's "main competitor" was Highland Park. (Neary, Tr. 600-01).

564. Around the time of the Merger, One Health considered Advocate Lutheran General to be one of the main alternatives to ENH. (Neary, Tr. 630-31; Dorsey, Tr. 1480-81). In addition, One Health considered Northwestern Memorial as an alternative to ENH. (Neary, Tr. 631).

Response to Finding No. 564:

The finding is incomplete and misleading for the reasons stated in CCRFF 562 and 563 above. In addition, the finding is misleading and incomplete because it fails to mention One Health's actual post-merger experience. At first, Mr. Neary, in consultation with other One Health management, concluded that One Health could still market its network without the ENH facilities. (Neary, Tr. 615-16). The conclusion that One Health could market its network without the ENH facilities turned out to be incorrect. "After the termination, we immediately started receiving complaints from our sales staff about the termination and making requests of us to try to re-open negotiations with ENH." (Neary, Tr. 617). One Health's sales staff could not market the network without having the ENH hospitals in the network. (Neary, Tr. 618-19). In response to these complaints, One Health re-opened negotiations with ENH in the fall of 2000. (Neary, Tr. 617-18; Hillebrand, Tr. 1708; Dorsey, Tr. 1439, 1441-42, 1456-57; CX 266 at 1). Moreover, the finding ignores the relative importance of the three ENH hospitals and the accessibility they provide to the population living between Evanston, Highland Park and Glenbrook. (Neary, Tr. 600-01).

565. The representative from United testified that Evanston Hospital competes with Advocate Lutheran General. (Foucre, Tr. 942). In United's view, as between Advocate Lutheran General, St. Francis, and Rush North Shore, Advocate Lutheran General, which is perceived as one of the highest quality hospitals in Chicago, is the most comparable facility to Evanston Hospital in type of services, quality of services and size of the facility. (Foucre, Tr. 943-44, 947). United also viewed Northwestern Memorial as Evanston Hospital's competitor for certain services. (Foucre, Tr. 946).

Response to Finding No. 565:

The finding is incomplete and misleading for the reasons stated in CCRFF 562

and 563 above. In addition, the finding is misleading and incomplete because it fails to mention that Ms. Foucre of United testified, "I don't know that I have a mechanism for measuring quality of service or have looked at that." (Foucre, Tr. 942). Ms. Foucre testified that consumer preferences mean that "in a heavily populated area, having the hospitals that are in that area in network can be important" and that "there are certain geographies where . . . people who are decision-makers at key employers may reside, and ensuring that we had an adequate network . . . is also important." (Foucre, Tr. 885). Ms. Foucre testified that the three ENH hospitals combined form a triangle of a service or catchment area in which the service areas of the hospitals are contiguous. (Foucre, Tr. 901-902 ("there are no hospitals within that triangle, there are no other facilities"). The area in this triangle is very heavily populated with very affluent communities, where corporate decision-makers and prospective customers live. (Foucre, Tr. 901-903). United Healthcare does not believe it could have a viable network without ENH. (Foucre, Tr. 901-902, 925-26).

566. The PHCS representative viewed Advocate Lutheran General as a significant competitor for Evanston Hospital before the Merger. (Ballengee, Tr. 211). PHCS still considers Advocate Lutheran General a significant competitor for Evanston. (Ballengee, Tr. 211). For purposes of developing its network and deciding which hospitals to include, the PHCS representative viewed the services and quality at Advocate Lutheran General to be comparable to ENH. (Ballengee, Tr. 191).

Response to Finding No. 566:

The finding is incomplete and misleading for the reasons stated in CCRFF 562 and 563 above. Ms. Ballengee testified that Highland Park was the "primary alternative" to Evanston because it "sits to the north of these communities Evanston on the south.

There's [*sic*] no hospitals in between, and it tends to be a north-south migration of the populace." (Ballengee, Tr. 167-68). ENH indicated to PHCS that ENH was an entity "controlling all of these communities." (Ballengee, Tr. 176, 177 ("they indicated that they already had the market share for these communities" indicating a 60% market share)). ENH executives told PHCS that eliminating St. Francis, Rush North Shore, and Condell would not justify a lower rate because they were not viewed by ENH as significant competitors. (Ballengee, Tr.181-82). Eliminating the ENH system from the health plan's network would leave a large area that would be "uncovered" from the standpoint of the health plan. (Ballengee, Tr. 181). Other hospitals in PHCS's network, such as Rush North Shore, Lake Forest and Lutheran General Hospitals, were not considered to be "viable alternatives" to ENH, because "there would be a large area that would be not served by the community hospitals." (Ballengee, Tr. 183-84). Ms. Ballengee emphasized that the customers of PHCS "are looking at obviously *wanting to have good hospitals in it to provide good services, they have a breadth of services that they're offering*, and that they have good accessibility to those services *within their communities*." (Ballengee, Tr. 152 (emphasis added)).

567. {[redacted]} (Holt-Darcy, Tr. 1596, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1596, *in camera*).

Response to Finding No. 567:

The finding is incomplete and misleading for the reasons stated in CCRFF 562 and 563 above. The finding is also incomplete because it fails to mention that Ms. Holt-

Darcy of Unicare also testified that "[y]ou want to see *what population that you have, or potentially have, what marketing thinks they need in a particular service area.*" (Holt-Darcy, Tr. 1420 (emphasis added)). Ms. Darcy, the Unicare representative, testified that "together they [Evanston and Highland Park] make sort of a triangle of [*sic*] service or catchment area." (Holt-Darcy, Tr. 1425). She testified that "there are other hospitals in those geographies but not necessarily overlap in that sense." (Holt-Darcy, Tr. 1425). "Depending on which way you're traveling you would stop at Evanston and go to Highland Park would be the next hospital." (Holt-Darcy, Tr. 1426). For the people living in between the two hospitals, "you could go to either one equally distant." (Holt-Darcy, Tr. 1426). {[redacted]} (Holt-Darcy, Tr. 1561, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1602, *in camera).*

568. {[redacted]} (Mendonsa, Tr. 561, *in camera*).

Response to Finding No. 568:

The finding is incomplete and misleading for the reasons stated in CCRFF 562 and 563 above. In addition, the finding is incomplete and misleading because Mr. Mendonsa of Aetna emphasized, in the context of developing a hospital network, that "[a]ccess is . . . making sure that employees can get to the facilities *that we believe and have determined are the facilities they want to go to.*" (Mendonsa, Tr. 485 (emphasis added)). Mr. Mendonsa testified that people "typically want to go to a hospital in their

community" (Mendonsa, Tr. 485), and that {[redacted]

[redacted]

[redacted]}

(Mendonsa, Tr. 517, *in camera*). {[redacted]

[redacted]}

(Mendonsa, Tr. 516, *in camera*). {[redacted]

[redacted]

[redacted]

[redacted]

[redacted]} (Mendonsa, Tr. 517, *in camera*).

{[redacted]

[redacted]} (Mendonsa, Tr. 568, *in camera*).

569. {[redacted]} (RX 1351 at BCBSI-ENH 5230, *in camera*). {[redacted]} (RX 1351 at BCBSI-ENH 5230, *in camera*). {[redacted]} (RX 1368 at BCBSI-ENH 5182-83, *in camera*). {[redacted]} (RX 1368 at BCBSI-ENH 5183, *in camera*)

Response to Finding No. 569:

The finding is incomplete and misleading for the reasons stated in CCRFF 562 and 563 above. {[redacted]

[redacted]

[redacted]

[redacted] (*See* RX 1351 at BCBSI-ENH 5228-29, *in camera*). Presentation of "alternatives" in the context of trying to assure access at the time of termination is not the same thing as having a viable marketing alternative for the network as a general matter. ENH did not call Blue Cross to testify even though Respondent listed Blue Cross on its witness list.

For Blue Cross to replace ENH from the network, an entirely different analysis of the health plan's marketing needs would have had to take place. [redacted] (Holt-Darcy, Tr. 1550-53, *in camera*).

[redacted]

[redacted]

(RX 1368 at BCBSI-ENH 5180, *in camera*).

(2) Evanston Hospital's Closest Substitutes From A Geographic Perspective Were St. Francis And Rush North Shore

570. [redacted] (Ballengee, Tr. 212; RX 754 at PHCS 7582, *in camera*; Ballengee, Tr. 263, *in camera*). In addition, PHCS viewed Rush North Shore as a significant competitor to Evanston Hospital. (Ballengee, Tr. 211-12)

Response to Finding No. 570:

The finding is incomplete and misleading for the reasons stated in CCRFF 562 and 563 above. As to the first assertion, Ms. Ballengee did not use the word "alternative." (Ballengee Tr. 212). The second assertion is misleading. Ms. Ballengee testified that "I'm not sure it [Rush North Shore] is. It may be." (Ballengee, Tr. 211) Furthermore, any analysis of the geographic substitutes must take into account that looking at the area between Highland Park and Evanston, there was a not insubstantial group population for whom both hospitals were each other's closest substitutes.

571. One Health saw St. Francis as Evanston Hospital's most significant competitor. (Dorsey, Tr. 1472, 1479; Neary, Tr. 631) In addition, One Health believed that Rush North Shore could be a substitute for Evanston Hospital. (Neary, Tr. 624).

Response to Finding No. 571:

The finding is incomplete and misleading for the reasons stated in CCRFF 562

and 570 above. Moreover, according to One Health, ENH's "main competitor" was HPH, not St. Francis. (Neary, Tr. 600-01).

In addition, the finding is misleading and incomplete because it fails to mention One Health's actual post-merger experience. At first, Mr. Neary, in consultation with other One Health management, concluded that One Health could still market its network without the ENH facilities. (Neary, Tr. 615-16). The conclusion that One Health could market its network without the ENH facilities turned out to be incorrect. "After the termination, we immediately started receiving complaints from our sales staff about the termination and making requests of us to try to re-open negotiations with ENH." (Neary, Tr. 617) One Health's sales staff could not market the network without having the ENH hospitals in network. (Neary, Tr. 618-19). In response to these complaints, One Health re-opened negotiations with ENH in the fall of 2000. Moreover, the finding ignores the relative importance of the three ENH hospitals and the accessibility they provide to the population living between Evanston, Highland Park and Glenbrook. (Neary, Tr. At 600-01).

572. According to the representative from United, Evanston Hospital competes with St. Francis. (Foucre, Tr. 941). In addition, the United representative agreed that, because of their close proximity, Rush North Shore and Evanston Hospital were competitors. (Foucre, Tr. 941).

Response to Finding No. 572:

The finding is incomplete and misleading for the reasons stated in CCRFF 562, 563 and 570. The proposed finding is also misleading in characterizing Ms. Foucre's views as to competition between St Francis, Rush, and Evanston. Ms. Foucre testified that consumer preferences means that "in a heavily populated area, having the hospitals

that are in that area in network can be important" and that "there are certain geographies where . . . people who are decision-makers at key employers may reside, and ensuring that we had an adequate network . . . is also important." (Foucre, Tr. 885). Ms. Foucre testified that the three ENH hospitals combined form a triangle of a service or catchment area in which the service areas of the hospitals are contiguous. (Foucre, Tr. 901-902 ("there are no hospitals within that triangle, there are no other facilities"). The area in this triangle is a very heavily populated with very affluent communities, where corporate decision-makers and prospective customers live. (Foucre, Tr. 901-903). United does not believe it could have a viable network without ENH. (Foucre, Tr. 901-902, 925-26).

573. {[redacted]} (Mendonsa, Tr. 562, *in camera*). {[redacted]} (Mendonsa, Tr. 562, *in camera*).

Response to Finding No. 573:

The finding is incomplete and misleading for the reasons stated in CCRFF 562, 563 and 570 above. This finding is also incomplete and misleading because it reduces the idea of hospital competition to merely mileage rather than how hospitals are viewed by consumers and how they compete to be in a network. For example, Mr. Mendonsa of Aetna emphasized, in the context of developing a hospital network, that "[a]ccess is . . . making sure that employees can get to the facilities *that we believe and have determined are the facilities they want to go to.*" (Mendonsa, Tr. 485 (emphasis added)). Mr. Mendonsa testified that people "typically want to go to a hospital in their community" (Mendonsa, Tr. 485), and that {[redacted]

[redacted] (Mendonsa, Tr. 517, *in camera*). [redacted] (Mendonsa, Tr. 516, *in camera*). [redacted] (Mendonsa, Tr. 517, *in camera*). [redacted] (Mendonsa, Tr. 568, *in camera*).

574. [redacted] (Holt-Darcy, Tr. 1595-96, *in camera*).

Response to Finding No. 574:

The finding is incomplete and misleading for the reasons stated in CCRFF 562, 563 and 570 above. This finding is also incomplete and misleading because it reduces the idea of hospital competition to merely mileage rather than how hospitals are viewed by consumers and how they compete to be in a network. Ms. Holt-Darcy of Unicare, testified that "[y]ou want to see *what population that you have, or potentially have, what marketing thinks they need in a particular service area.*" (Holt-Darcy, Tr. 1420 (emphasis added)). Ms. Holt-Darcy testified that "together they [Evanston and Highland Park] make sort of a triangle of [*sic*] service or catchment area." (Holt-Darcy, Tr. 1425). She testified that "there are other hospitals in those geographies but not necessarily

overlap in that sense." (Holt-Darcy, Tr. 1425). "Depending on which way you're traveling you would stop at Evanston and go to Highland Park would be the next hospital." (Holt-Darcy, Tr. 1426). For the people living in between the two hospitals (Evanston and Highland Park), "you could go to either one equally distant." (Holt-Darcy, Tr. 1426). {[redacted]}. (Holt-Darcy, Tr. 1561, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1602, *in camera).*

575. A 1996 study conducted by Bain revealed that Blue Cross executives viewed St. Francis as a viable substitute for Evanston Hospital. (RX 145 at ENH JH 012083).

Response to Finding No. 575:

Complaint Counsel objects to the reliance on RX 145 at ENH JH 012083, to the extent that it is introduced the truth of the matter asserted therein. The quoted statements in RX 145 attributed to Blue Cross executives are double hearsay, and are inadmissible for the purpose of proving the truth of the matter asserted therein pursuant to Rule 805, F.R.E., and JX1 ¶ 5 (February 10, 2005).

The finding is incomplete and misleading for the reasons stated in CCRFF 562, 563 and 570 above. This finding is also incomplete because it omits a reference to a Blue Cross press release referred to therein that concludes: (1) "18 percent of the increase in hospital costs is driven by rising provider consolidation"; (2) "The research shows every one percent increase in hospital market share due to consolidation leads to an approximate 2 percent increase in inpatient expenditures, and (3) "in practice, it [hospital

consolidation] often gives providers greater market clout to raise prices, which rarely translates into tangible benefits for patients, employers, and society." (RX 1368 at BCBSI-ENH 5180, *in camera*).

576. {[redacted]} (RX 1803 at HFN 515, *in camera*). Indeed, Resurrection documents have recognized Evanston Hospital as a competitor since at least 1995. (RX 119 at 12602, 12631-32).

Response to Finding No. 576:

The finding is misleading and irrelevant for the reasons stated in CCRFF 562, 563 and 570. The first assertion is inadmissible double hearsay. The second assertion is misleading because it relates to a study done by Deloitte & Touche Consulting Group and was not authored or produced by Resurrection Health Care System.

ii. HPH's Closest Substitutes From Both A Product And Geographic Perspective Were Lake Forest Hospital And Condell

577. {[redacted]} (Foucre, Tr. 944; Mendonsa, Tr. 562, *in camera*; Dorsey, Tr. 1472; Ballengee, Tr. 212; Holt-Darcy, Tr. 1595, *in camera*).

Response to Finding No. 577:

The finding is irrelevant for the reasons stated in CCRFF 562, 563 and 570. In addition, the proposed finding is misleading in a general sense. Respondent never asked witnesses whether the hospitals were "substitutes" or to specifically say if they thought that hospitals compete with respect to "first-stage" competition, which is the competitive dynamic by which hospital prices are determined. (Haas-Wilson, Tr. 2456). {[redacted]}

[redacted]

(Mendonsa, Tr. 562, *in camera*). Ms. Ballengee and Mr. Dorsey never testified that Condell was a significant competitor to Highland Park. (Ballengee, Tr. 212; Dorsey, Tr. 1472). Ms. Foucre used the word "primarily." (Foucre, Tr. 944). [redacted] (Holt-Darcy, Tr. 1595, *in camera*).

Respondent's vague questions did not distinguish the first stage at which price is set from "second-stage" competition. As to first-stage competition, which involves contracting between hospitals and health plans to be part of a network. health plan witnesses testified that the relevant area of competition for ENH with respect to participation in health plan networks – the first level of competition – is a triangle adjacent to or contiguous to the three hospital campus that make up ENH. (Newton, Tr. 351-52; Foucre, Tr. 901-903; Ballengee, Tr. 167-68; Holt-Darcy, Tr. 1425-1427; Mendonsa, Tr. 543-44). [redacted] (Ballengee, Tr. 179-80; Neary, Tr. 617; and Mendonsa, Tr. 520, *in camera*).

Second-stage competition is the competition among hospitals for patients based on non-price variables. (Haas-Wilson, Tr. 2463-65). Assertions about the "second stage" of competition (Haas-Wilson, Tr. 2463-65) are offered to suggest that consumers will switch in terms of price, even though that did not happen in this case (Neaman, Tr. 1211-12). Here, ENH never expected any consumer switching in response to the price increase. (Neaman, Tr. 1212; Hillebrand, Tr. 1764-65, 1757-58; Newton, Tr. 367). Dr.

Elzinga alludes to this by calling it the "silent majority fallacy" whereby the assumption is made that patients will travel to more distant facilities in response to a price increase by local hospitals. (CCFF 1674-79). Dr. Elzinga concludes that the decision to select a particular hospital is not driven primarily by the relative prices between hospitals (Elzinga, Tr. 2388-89), and the decision to travel to a more distant hospital is highly personal. (Elzinga, Tr. 2387-88).

578. {[redacted]} (RX 754 at PHCS 7582, *in camera*). {[redacted]} (RX 754 at PHCS 7582, *in camera*).

Response to Finding No. 578:

The finding is misleading and irrelevant for the reasons stated in CCRFF 562, 563 and 570. In addition, respondent's proposed finding is incomplete because the document states that the alternative for Evanston is "questionable." In addition, the proposed finding ignores that Ms. Ballengee testified that Highland Park was the "primary alternative" to Evanston because it "sits to the north of these communities Evanston on the south. There's [*sic*] no hospitals in between and it tends to be a north-south migration of the populace." (Ballengee, Tr. 168). ENH indicated to PHCS that ENH was an entity "controlling all of these communities." (Ballengee, Tr. 176, 177 ("they indicated that they already had the market share for these communities" indicating a 60% market share)). ENH executives told PHCS that eliminating St. Francis, Rush North Shore, and Condell would not justify a lower rate because they were not viewed as significant competitors. (Ballengee, Tr.181-82). Eliminating the ENH system from the health

plan's network would leave a large area that would be "uncovered" from the standpoint of the health plan. (Ballengee, Tr. 181). Other hospitals in PHCS's network, such as Rush North Shore, Lake Forest or Lutheran General Hospitals, were not considered to be "viable alternatives" to ENH because "there would be a large area that would be not served by the community hospitals." (Ballengee, Tr. 183-84). Ms. Ballengee emphasized that the customers of PHCS "are looking at obviously *wanting to have good hospitals in it to provide good services, they have a breadth of services that they're offering*, and that they have good accessibility to those services *within their communities*." (Ballengee, Tr. 152).

579. Terry Chan, who was responsible for managed care contracting for HPH before the Merger and now works for Children's Hospital, viewed Lake Forest Hospital as HPH's closest competitor. (Chan, Tr. 647-48, 652-54, 656-57, 730).

Response to Finding No. 579:

The finding is misleading and irrelevant for the reasons stated in CCRFF 562, 563 and 570.

580. Spaeth also confirmed that, before the Merger, HPH's primary competitor was Lake Forest Hospital. (Spaeth, Tr. 2239). Lake Forest Hospital was HPH's primary competitor because of the major overlap between both hospitals' medical staffs. (Spaeth, Tr. 2163). Over 200 of the same physicians were on both HPH's and Lake Forest Hospital's medical staffs. (Spaeth, Tr. 2163).

Response to Finding No. 580:

The finding is misleading and irrelevant for the reasons stated in CCRFF 562, 563 and 570. The first assertion is incomplete and misleading because Mr. Spaeth admitted that he presented a report to his board of directors at the time of the merger showing that Evanston and Highland Park has a combined share of 55% in their combined core service

area. (Spaeth, Tr. at 2161). He further admitted that according to this report ENH was the most significant competitor in terms of market share in Highland Park's core service area. (Spaeth, Tr. at 2161).

The second assertion is misleading because it fails to disclose that Evanston employs its own physicians. (*See generally* CX 442 at 21-22).

In the couple of years before the merger announcement, and even after the intent to merge was disclosed, Evanston physician referral and admitting patterns were a source of competitive concern to Highland Park Hospital and its physicians, and the merger suppressed a growing competition between Evanston and Highland Park Hospitals. (CX 1 at 3 (Meeting of Evanston and Highland Park physicians and management "Do not 'compete with self' in covered zip codes (e.g., 60-70% market share) such as Evanston, Glenview, Highland Park and Deerfield); CX 2 at 7 (Highland Park Medical Executive Committee at which Evanston management discussed the merger, "This would be an opportunity to join forces and grow together rather than compete with each other'); (CX 1879 at 4 "Stop competing with each other:")).

581. Accordingly, before the Merger, MCOs sometimes played Lake Forest Hospital off of HPH. (Chan, Tr. 747). For instance, certain MCOs offered to exclude Lake Forest Hospital from their networks in exchange for better rates with HPH. (Chan, Tr. 747).

Response to Finding No. 581:

The finding shows that payors engage in selective contracting and that Ms. Chan knew this when she worked for Highland Park.

582. Also before the Merger, HPH negotiated restricted contracts with certain MCOs that excluded Lake Forest Hospital and Condell, but never excluded Evanston Hospital. (Chan, Tr. 728).

Response to Finding No. 582:

The finding shows that payors engage in selective contracting and that Ms. Chan knew this when she worked for Highland Park. In addition, the proposed finding is misleading and incomplete because Ms. Chan did not testify that such a contract never existed, but rather that it was "unlikely" that a payor asked for a lower rate in return for excluding Evanston. She explained that health plans would not want to exclude Evanston because "Evanston's rates were very competitive" and Evanston offered some tertiary care." (Chan, Tr. 747) . In addition, it is worth noting that Ms. Chan complained before the merger was consummated that Evanston signed a hospital contract with Unicare that Highland Park had not signed. (CX 114). She also was not asked whether Highland Park in combination with some other hospital, offering tertiary services could have excluded Evanston.

583. HPH's first contracts with PHCS excluded Lake Forest Hospital. (Chan, Tr. 666-67). And in 1996, HPH's negotiators tried to play themselves off of one of their closest competitors, Condell Hospital, with PHCS. (RX 149 at ENHL TH 141). HPH offered rates to PHCS "contingent on the exclusion of Condell Hospital" from PHCS's network. (RX 149 at ENHL TH 141; RX 148 at ENHL TC 7927).

Response to Finding No. 583:

The finding is misleading and irrelevant for the reasons stated in CCRFF 562, 563 and 570. Complaint counsel notes that Respondent's proposed finding of fact shows that payors engage in selective contracting and that Ms. Chan knew this when she worked for Highland Park. This proposed finding also is misleading to the extent that it might be cited to show that Evanston was not excluded, because Ms. Chan explained that health plans would not want to exclude Evanston because "Evanston's rates were very

competitive" and Evanston offered some tertiary care." (Chan, Tr. 747) .

584. In the 1980s, HPH had an exclusive contract with Blue Cross that excluded Lake Forest Hospital, Condell and Victory Hospital. (Chan, Tr. 737).

Response to Finding No. 584:

The finding is misleading and irrelevant for the reasons stated in CCRFF 562, 563 and 570. Complaint counsel notes that Respondent's proposed finding of fact shows that payors engage in selective contracting and that Ms. Chan knew this when she worked for Highland Park. This proposed finding also is misleading to the extent that it might be cited to show that Evanston was not excluded, because Ms. Chan explained that health plans would not want to exclude Evanston because "Evanston's rates were very competitive" and Evanston offered some tertiary care." (Chan, Tr. 747) .

585. HPH also had a contract with Humana's Premier plan that excluded Lake Forest Hospital and Condell. (RX 331 at ENH JL 2149; Chan, Tr. 726).

Response to Finding No. 585:

The finding is misleading and irrelevant for the reasons stated in CCRFF 562, 563 and 570. Complaint counsel notes that Respondent's proposed finding of fact shows that payors engage in selective contracting and that Ms. Chan knew this when she worked for Highland Park. This proposed finding also is misleading to the extent that it might be cited to show that Evanston was not excluded, because Ms. Chan explained that health plans would not want to exclude Evanston because "Evanston's rates were very competitive" and Evanston offered some tertiary care." (Chan, Tr. 747) .

586. HPH agreed to certain discounts with HFN, with the expectation that it would be given a certain degree of exclusivity in HFN's network. (RX 406).

Response to Finding No. 586:

The finding is misleading and irrelevant for the reasons stated in CCRFF 562, 563 and 570. Complaint counsel notes that Respondent's proposed finding of fact shows that payors engage in selective contracting and that Ms. Chan knew this when she worked for Highland Park. This proposed finding also is misleading to the extent that it might be cited to show that Evanston was not excluded, because Ms. Chan explained that health plans would not want to exclude Evanston because "Evanston's rates were very competitive" and Evanston offered some tertiary care." (Chan, Tr. 747).

587. Finally, Lake Forest Hospital recognized Condell and HPH as its primary competitors. (RX 306 at FTC-LFH 67-69; RX 789 at LFH 811).

Response to Finding No. 587:

The finding is misleading and irrelevant for the reasons stated in CCRFF 562, 563 and 570. Respondent's proposed finding of fact is also incomplete and misleading to the extent that it ignores that Lake Forest analyzed the market as becoming more concentrated with hospitals merging to enhance negotiating leverage with health plans, and more specifically that the HP/Evanston merger was one in which a market dominant firm was created. {[redacted]}

[redacted] (RX 1144 at FTC-LFH 0001953-54, *in camera*).

C. Dr. Haas-Wilson's Bargaining Theory Does Not Take Into Account The Fact That Evanston Hospital And HPH Had Very Different Negotiating Strategies And Contract Rates Before The Merger

588. Dr. Haas-Wilson concedes that the personalities of negotiators can impact the outcome of the bargain between hospitals and MCOs. (Haas-Wilson, Tr. 2745-46). Dr. Haas-Wilson, however, did not conduct any analysis to determine whether the personalities of the negotiators at issue here had an impact on the outcome of negotiations between ENH and MCOs, either before or after the Merger. (Haas-Wilson, Tr. 2745-46).

Response to Finding No. 588:

The finding is irrelevant and misleading. [redacted] (Haas-Wilson, Tr. 2745-46 *in camera*). Following economic theory as a guide, Dr. Haas-Wilson developed a list of ten possible explanations for the large price post-merger price increases at ENH.

(Haas-Wilson, Tr. 2480-81). She did not include personalities of negotiators on the list that could explain the large price increase at ENH. (Haas-Wilson, Tr. 2482-88 (discussing DX 7024).

{[redacted]} (Noether, Tr. 6239-43 *in camera*) {[redacted]} (Noether, Tr. 6240-43 *in camera*).

589. The personalities of the pre-Merger and post-Merger negotiators are relevant to the consideration of the learning about demand theory, as discussed below. (Noether, Tr. 5972-73).

Response to Finding No. 589:

The finding is incorrect. The cited source does not say what Respondent's finding claims. Nowhere in the cited testimony does Dr. Noether discuss the personalities of the pre- and post-merger negotiators. Moreover, the personalities of the negotiators could not explain the large post-merger price increases at ENH. (*See* CCRFF 588).

1. Evanston Hospital And HPH Had Different Pre-Merger Negotiating Strategies

a. HPH Had An Aggressive Pricing Strategy Before The Merger

590. HPH analyzed all of its contracts monthly, regardless of payment methodology. (Chan, Tr. 724-25). Before the Merger, HPH negotiated with MCOs on an annual basis. (Spaeth, Tr. 2174).

Response to Finding No. 590:

Respondent's finding is incomplete because it ignores three key facts. First, pre-merger, Highland Park did not get a new contract every year with each health plan, and some pre-merger contracts stayed in effect for years. (CX 5910 (stipulated in JX 6 to show the complete set of contracts for fifteen health plans over an extended period)). {[redacted]} (RX 1912 at 77 ([redacted]), *in camera*; Baker, Tr. 4745-47, *in camera*; Haas-Wilson, Tr. 2646, *in camera*. *See* CCFF 696-702). {[redacted]} (*See* CCFF 696-702, 848-859, *in camera*). {[redacted]} (Chan, Tr. 819-20, *in camera*). Mr. Spaeth, former CEO of Highland Park, also admitted that Highland Park could not have achieved price increases with health plans prior to the merger. (Spaeth, Tr. 2172-73). Mr. Spaeth knew that Highland Park could not sustain a strategy in which it would lose contracts or be eliminated from a health plan's network. Such a strategy would have proved very difficult for the hospital to stick to. (Spaeth, Tr. 2172-73, 2178).

After the merger, ENH was able to use the more favorable of the Evanston or Highland Park contract rates as a "starting point" in health plan renegotiations *"and then add[ed] a premium to that."* (Hillebrand, Tr. 1856, 1705; Newton, Tr. 364 (emphasis added). *See* CCRFF 591). Mr. Hillebrand admitted that the merged entity was successful in 2000 in negotiating prices above the pre-merger rates of either Evanston or Highland Park for numerous payors. (Hillebrand, Tr. 1705. *See* CX 1991 at 2-3 ({[redacted]}), *in camera*); CX 2070 at 3 (Mr. Hillebrand wrote that ENH's goal will be to receive "superior pricing."); Newton, Tr. 364-65 (ENH negotiators would use its additional leverage to "seek additional price from the health plans" and to "increase the revenue to the combined entity."); CX 67 at 49 (ENH strove to "[j]ustify premium pricing (*i.e.*, above the competitive average."). ENH's successes are amazing considering that, according to Messrs. Neaman and Hillebrand, health plans' bargaining positions increased after the merger. (Neaman, Tr. 960-61, 1269-71; Hillebrand, Tr. 1725-26).

{[redacted]}

[redacted] (Baker, Tr. 4739, *in camera*, Haas-Wilson, Tr. 2729, 2731-32, *in camera*; Holt-Darcy, Tr. 1528, 1561, *in camera*; Foucre, Tr. 890; Ballengee, Tr. 176; Neary, Tr. 602; Neary, Tr. 756, *in camera*; Dorsey, Tr. 1447).

591. Before the Merger, HPH generally would start out negotiations with MCOs by asking for discount-off-charges arrangements. (Chan, Tr. 665).

Response to Finding No. 591:

This finding is incomplete because it leaves out the fact that pre-merger, Highland Park's prices were lower than Evanston's, and that Highland Park pre-merger was unable to raise prices to the level that the combined Highland Park and Evanston could raise prices after the merger. (*See* CCRFF 590).

592. If a per diem with a particular MCO were generating a discount of 20% to 30%, HPH asked for an increase in the per diem. (Chan, Tr. 676). If the contracted rates were generating a larger discount than 30%, HPH would try to restructure the stop-loss provision to reduce the loss to the hospital, and increase the effective discount. (Chan, Tr. 676). HPH believed that any discount larger than 15% was too large. (Chan, Tr. 670).

Response to Finding No. 592:

This finding is incomplete because it leaves out the fact that pre-merger, Evanston's prices were higher than Highland Park's, and that Highland Park pre-merger was unable to raise prices to the level that the combined Highland Park and Evanston could raise prices after the merger. (*See* CCRFF 590).

593. HPH also sent termination letters to MCOs to make them come to the negotiating table. (Chan, Tr. 734-35). HPH had, at various times before the Merger, threatened to terminate MCOs – including Blue Cross's PPO plan, Humana's Premier Plan and HFN's EPO and PPO networks. (Chan, Tr. 725-26; RX 331 at ENH JL 2150; RX 406). HPH never took seriously the possibility of a MCO actually terminating the contract. (Chan, Tr. 666).

Response to Finding No. 593:

This finding is incomplete because it leaves out the fact that pre-merger, Evanston's prices were higher than Highland Park's, and that Highland Park pre-merger was unable to raise prices to the level that the combined Highland Park and Evanston could raise prices after the merger. (*See* CCRFF 590).

594. {[redacted]} (Chan, Tr. 780-81, *in camera*).

Response to Finding No. 594:

This finding is incomplete because it leaves out the fact that pre-merger, Evanston's prices were higher than Highland Park's, and that Highland Park pre-merger was unable to raise prices to the level that the combined Highland Park and Evanston could raise prices after the merger. (*See* CCRFF 590). Moreover, the finding is irrelevant. Without knowing the overall growth of managed care organizations in the Chicago area, and the overall inflation of hospital prices in the Chicago area over the ten-year period from 1988 to 1997, one cannot tell whether this increase in revenue from managed care contracts is meaningful, or has any relationship to the negotiating strategies used by Highland Park. Under indemnity insurance, the customer of the hospital would be the individual patient, in contrast to under managed care, and hospitals did not compete to participate in a health plan's network. (Haas-Wilson, Tr. 2463-66). It was not until the 1990s that managed care plans overtook indemnity insurance and became "the predominant form of commercial health insurance." (Hillebrand, Tr. 1832-33; Haas-Wilson, Tr. 2463-65).

b. Evanston Hospital, In Contrast, Did Not Focus On MCO Negotiations Before The Merger

i. Before 1999, Evanston Hospital Did Not Institute An Aggressive MCO Negotiation Policy

595. In the 1980s, MCO contracting at Evanston Hospital focused on building relationships. (Hillebrand, Tr. 1832). Because, at the time, Evanston Hospital believed that managed care soon would dominate the market, Evanston Hospital's goal was to have a relationship with every new player in the marketplace. (Hillebrand, Tr. 1831-32).

Response to Finding No. 595:

This finding is irrelevant. What Evanston Hospital's motivations were in the 1980s is irrelevant. This case is about Evanston's 2000 merger with Highland Park Hospital. In that regard, the events and motivations leading up to the merger, in which Evanston sought to obtain market power, can be relevant to help interpret the post-merger conduct of ENH (*see, e.g.* CX 1802 at 2-3 (Evanston and Highland Park joined the Northwestern Healthcare Network in the mid-1990s to gain "leverage" and "better pricing" from health plans.); CX 395 at 1-2 (In 1996, Evanston, Highland Park and another hospital pursued a merger that Evanston believed would create an entity that would be "indispensable to the marketplace," and with a higher market share, could "obtain premium sustainable pricing.")). However, events in the remote past have no bearing on this case.

596. In the 1980s, Evanston Hospital's managed care book of business was much smaller. (Hillebrand, Tr. 1832). Consequently, Evanston Hospital did not feel pressured to seek revenue from MCOs during this period. (Hillebrand, Tr. 1832)

Response to Finding No. 596:

This finding is irrelevant. Evanston's book of business with health plans in the 1980s is irrelevant. (*See* CCRFF 595). Traditional indemnity insurance was the dominant form of commercial reimbursement in the 1980s. (Hillebrand, Tr. 1831-32).

Under indemnity insurance, the customer of the hospital would be the individual patient, in contrast to under managed care, and hospitals did not compete to participate in a health plan's network. (Haas-Wilson, Tr. 2465-66). It was not until the 1990s that managed care plans became "the predominant form of commercial health insurance." (Hillebrand, Tr. 1832-33; Haas-Wilson, Tr. 2463-65).

597. Before 1999, Evanston Hospital considered having relationships with MCOs to be of greatest importance because ENH did not want any barriers between itself and a patient or a physician. (Hillebrand, Tr. 1834-35). Evanston Hospital's pre-1999 MCO contracting strategy was reflected in Evanston Hospital's negotiating style. (Hillebrand, Tr. 1835). Evanston Hospital took the position that "it was more important to have the relationship [with the MCO] than anything else." (Hillebrand, Tr. 1835).

Response to Finding No. 597:

Respondent's finding is incomplete. Evanston sought relationships with health plans prior to the merger because Evanston prior to the merger faced competition for inclusion in networks. Prior to the merger, the relationship between Evanston and health plans was determined by the ability of the health plan to exclude Evanston from its network. (Haas-Wilson, Tr. 2470).

In the mid-1990s, Northwestern Healthcare Network members (including Mr. Neaman) recognized that hospital competition meant that "we are 'slicing' each other up in the market." (CX 1768 at 1, 3). As a result, the hospitals in the network were "undercutting each other," a phenomenon that was "apparent to the payors." (CX 1768 at 3). Testimony from Mr. Neaman and Mr. Newton confirms that pre-merger, Evanston and Highland Park were both concerned about being excluded from health plans' network of providers. (Neaman, Tr. 961; Newton, Tr. 303-06). To maintain access to health plan

networks, Evanston and Highland Park lowered their pricing, increased the breadth, depth and quality of their services, and strove to control costs. (Neaman, Tr. 961-62; Newton, Tr. 303-06).

At the same time, Evanston strove to gain "leverage" through the Northwestern Healthcare Network and obtain "better pricing" from health plans. (CX 1802 at 2-3). In 1996, Evanston and Highland Park pursued another merger (with a third hospital) that would make the combined entity "indispensable to the marketplace," and enable the combined entity to "obtain premium sustainable pricing." (CX 395 at 1-2).

{[redacted]} (Ballengee, Tr. 167 (When Evanston and Highland Park were separate entities, PHCS could use one hospital and not the other. "If, in fact, the negotiation and the rates were not going well at one hospital . . ., we had the alternative."); Mendonsa, Tr. 530 ({[redacted]}, *in camera*); Holt-Darcy, Tr. 1518-19 ({[redacted]}, *in camera*).

After the merger, ENH's bargaining position changed, because the merged entity now possessed the market power to impose price increases at will without concern over losing any relationships with health plans. (Neaman, Tr. 1211-12; Hillebrand, Tr. 1764-

65).

598. Before 1999, many of Evanston Hospital's MCO contracts were evergreen, meaning that they renewed automatically. (Hillebrand, Tr. 1835). For a variety of reasons, neither Evanston Hospital nor the MCOs sought to change their terms. (Hillebrand, Tr. 1835). That is, before 1999, Evanston Hospital did not negotiate MCO contracts on a yearly basis. (Hillebrand, Tr. 1835).

Response to Finding No. 598:

Respondent's finding is incomplete. Evanston's ability to renegotiate contracts or achieve more favorable contract terms prior to the merger depended on the health plan's ability to exclude the hospital and turn to alternatives. (Haas-Wilson, Tr. 2470). As shown in CCRFF 597, pre-merger, Evanston was concerned about being excluded from health plans' network of providers prior to the merger. (Neaman, Tr. 961). As a result of Evanston's concern, Evanston competed harder, lowered its pricing, increased the breadth, depth and quality of its services, and strove to control costs to remain in health plan networks. (Neaman, Tr. 961-62. *See* CCRFF 597). In any event, HPH also had some contracts pre-merger that stayed in effect for years. (*See* CX 5910 (stipulated in JX 6 to show the complete set of contracts for fifteen health plans over an extended period)).

599. Even MCOs recognized that, before 1999, Evanston Hospital did not employ a confrontational negotiation strategy. (RX 105). For example, executive Barbara Hill wrote in 1995 to Neaman that "[w]hat went wrong for us with -Advocate relationship was Advocate's 'take it or leave it' negotiating stance. I know your team at Evanston has a friendlier approach!" (RX 105).

Response to Finding No. 599:

Respondent's finding is misleading because it cites to one document (RX 105) regarding one negotiation between Evanston and Aetna and then generalizes for "MCOs"

in general. In any event, Respondent's finding is incomplete because it does not explain why Evanston might not have been able to employ a confrontational negotiating strategy prior to the merger. Prior to the merger, Evanston was concerned about being excluded from health plans' network of providers, and health plans knew that they could build networks without Evanston. (Neaman, Tr. 961. *See* CCRFF 597).

ii. Evanston Hospital's Pre-Merger MCO Contract Negotiator Used A Passive Negotiation Style

(1) Sirabian Was In Charge Of Evanston Hospital's Pre-Merger MCO Negotiations

600. Jack Sirabian, the former Vice President of Business Services, who testified at trial, was responsible for hospital managed care contracting at Evanston Hospital from the time the hospital first got into managed care contracting in approximately 1990 through January 2000. (Sirabian, Tr. 5965, 5697-98).

Response to Finding No. 600:

Complaint counsel have no specific response.

601. When Sirabian first became responsible for managed care contracting, he did not have any experience in contract negotiations. (Sirabian, Tr. 5697).

Response to Finding No. 601:

This finding is irrelevant. Traditional indemnity insurance was the dominant form of commercial reimbursement in the 1980s. (Hillebrand, Tr. 1831-32). Under indemnity insurance, the customer of the hospital would be the individual patient, in contrast to under managed care, and hospitals did not compete to participate in a health plan's network. (Haas-Wilson, Tr. 2463-66). It was not until the 1990s that managed care plans became "the predominant form of commercial health insurance." (Hillebrand, Tr. 1832-33; Haas-Wilson, Tr. 2463-65). In that regard, nobody would be expected to have any

experience with managed care contract negotiations when Mr. Sirabian first became responsible for managed care contracting.

602. During the entire 10-year period in which Sirabian was responsible for managed care contracting at Evanston Hospital, he did not have any support staff helping him with that responsibility. (Sirabian, Tr. 5698). And during this period, Sirabian had responsibilities other than managed care contracting. (Sirabian, Tr. 5699). His main responsibilities were managing the hospital and professional business offices, which involved patient billing and customer service for the hospital and physicians. (Sirabian, Tr. 5699-5700). At no time during the 10-year period in which Sirabian was responsible for managed care contracting at Evanston Hospital was managed care contracting his sole responsibility. (Sirabian, Tr. 5701).

Response to Finding No. 602:

The finding is irrelevant and misleading. There is no evidence that Mr. Sirabian's staff or duties had any adverse impact on Evanston's managed care contracting or on any issue in this litigation.

603. Sirabian reported to Hillebrand in connection with managed care negotiations, but he did not normally report to him about specific contracts. (Sirabian, Tr. 5701).

Response to Finding No. 603:

The finding is irrelevant, incomplete and misleading. There is no evidence that Evanston's reporting structure had any adverse impact on Evanston's managed care contracting or any issue in this litigation. Both Mr. Sirabian and Mr. Hillebrand were effective negotiators prior to the merger. (*See* CCRFF 609).

604. Hillebrand, however, maintained relationships with some of the very large insurers, such as Blue Cross and Humana. (Hillebrand, Tr. 2012). Hillebrand would get involved with face-to-face negotiations with these larger health plans. (Hillebrand, Tr. 1700). Accordingly, Sirabian paid closer attention to Evanston Hospital's contracts with these MCOs. (Sirabian, Tr. 5707).

Response to Finding No. 604:

It is irrelevant which contracts Mr. Sirabian handled pre-merger versus which

contracts Mr. Hillebrand handled pre-merger. Both Mr. Sirabian and Mr. Hillebrand were effective negotiators prior to the merger. (*See* CCRFF 609).

(2) Sirabian's Goal Was To Obtain "Win-Win Contracts"

605. Sirabian's goal in managed care negotiations was to ensure that Evanston Hospital would be included in all of the different MCO networks, and to build those relationships. (Sirabian, Tr. 5700, 5702, 5721).

Response to Finding No. 605:

It is irrelevant that Evanston negotiators may have focused on building relationships with health plans pre-merger. Mr. Sirabian testified that before the merger, he always tried to get the highest price that he could for Evanston. (Sirabian, Tr. 5734). As shown in CCRFF 597, pre-merger, Evanston's concern about the competitive environment and the possibility of being excluded from health plans' network of providers made Evanston compete harder, lower its pricing, increase the breadth, depth and quality of its services, and strive to control costs. (Neaman, Tr. 961-62. *See* CCRFF 597). It was only after the merger that ENH possessed the market power to impose price increases at will without concern over losing any relationships with health plans. (Neaman, Tr. 1211-2; Hillebrand, Tr. 1764-65).

606. Sirabian's negotiating philosophy was "win-win," *i.e.*, that if both the insurance company and the hospital had a contract then both could benefit from a successful relationship. (Sirabian, Tr. 5702). During negotiations with MCOs, Sirabian told the MCOs he was negotiating with a goal that both sides would benefit from the contract. (Sirabian, Tr. 5702-03; RX 97 at ENHL JL 1093).

Response to Finding No. 606:

Respondent's finding is misleading to the extent that it implies that Mr. Sirabian

was not an effective negotiator at Evanston pre-merger. (*See* CCRFF 609). Mr. Sirabian testified that before the merger, he always tried to get the highest price that he could for Evanston. (Sirabian, Tr. 5734). As shown in CCRFF 597, pre-merger, Evanston's concern about the competitive environment and the possibility of being excluded from health plans' network of providers made Evanston compete harder, lower its pricing, increase the breadth, depth and quality of its services, and strive to control costs. (Neaman, Tr. 961-62. *See* CCRFF 597). It was only after the merger that ENH possessed the market power to impose price increases at will without concern over losing any relationships with health plans because the merged entity had achieved its goal of becoming "indispensable" to health plans. (*See* CCRFF 597; Neaman, Tr. 1211-2; Hillebrand, Tr. 1764-65).

607. Consequently, in managed care contract negotiations, Sirabian never attempted to secure aggressive rates from MCOs. (Sirabian, Tr. 5702, 5722, 5733-34). For example, Sirabian wrote to Humana in 1995 that, "[r]ather than counter your proposal with an amount higher than we would expect in order to reach a satisfactory compromise, I will propose a fair and reasonable amount right now which we both can support." (RX 108 at ENHL JL 3173).

Response to Finding No. 607:

The cited sources do not say what Respondent claims. Mr Sirabian never testified that he did not "attemp[t] to secure aggressive rates from MCOs." Rather, Mr. Sirabian testified that, pre-merger, he strategized to secure a rate that was as high as Evanston could get without jeopardizing what he felt would be fair and equitable to the health plan. (Sirabian, Tr. 5733-34. *See* Sirabian, Tr. 5722 (Mr. Sirabian did not want to impose prices that would be "prohibitive for the insurer."); Sirabian, Tr. 5702 (Mr. Sirabian did

not want to "jeopardize the financial health of the insurance company").

Respondent's finding is also incomplete, because it does not explain Evanston's motivation to not "jeopardize" what was fair and equitable to the health plans. Prior to the merger, Evanston knew that it could be excluded from health plans' network of providers if it did not price its services competitively. (Neaman, Tr. 961-62. *See* CCRFF 597). {[redacted]} (CCRFF 597, *in camera*). Respondent's finding is also misleading to the extent that it implies that a negotiator telling a health plan that his offer is "fair and reasonable" actually means that the offer is not aggressive. (RX 108 at ENHL JL 3173; Sirabian, Tr. 5702. *See* CCRFF 609).

608. Although Sirabian used cost information, provided by Evanston Hospital's accounting department, to ensure that the rates being offered exceeded Evanston Hospital's costs, he primarily evaluated whether to accept the rates proposed by a MCO based on gut reaction, and would decide when negotiations were at a point that they could not go any further based on intuition. (Sirabian, Tr. 5704-05).

Response to Finding No. 608:

The finding is incomplete and misleading. Mr. Sirabian testified that prior to the merger, he negotiated prices based upon internal reports and cost information that would cover Evanston's cost and give Evanston a reasonable profit margin. (Sirabian, Tr. 5704-05, 5738).

609. Before the Merger, Evanston Hospital had been worried that taking a tougher stand in negotiations would backfire. (RX 2047 at 34 (Ogden, Dep.)). Part of that was personality; Sirabian was not comfortable taking a tough stand, and "had severely, tragically underestimated how [Evanston Hospital] was positioned in the marketplace to begin with." (RX 2047 at 34 (Ogden Dep.)).

Response to Finding No. 609:

Respondent's finding is misleading. Mr. Neaman testified that he knew that certain Evanston contracts rates were below those received by other hospitals prior to the merger. (*See* Neaman, Tr. 1223 (Mr. Neaman understood that one or more hospitals in the network received higher prices from health plans than Evanston.). *See* CCRFF 597). Evanston could do nothing about it in the in the mid to late 1990s, because Evanston did not have the market power to achieve the price increases at that time. (Hillebrand, Tr. 1725-26; Neaman, Tr. 960-62 (In the 1990's, Evanston senior management believed that the hospital was at a disadvantage during negotiations with health plans.); CX 2037 at 2-3; CX 442 at 4; CX 1566 at 9).

Complaint Counsel disagree with the implication that Mr. Sirabian was not a good negotiator. Mr. Sirabian testified that before the merger, he always tried to get the highest price that he could for Evanston, and that he looked out for the best interest of Evanston. (Sirabian, Tr. 5734, 5739). During pre-merger negotiations with health plans, Mr. Sirabian strategized to secure a rate that was as high as Evanston could get without jeopardizing what he felt would be fair and equitable to the health plan. (Sirabian, Tr. 5733-34. *See* Sirabian, Tr. 5723 (Mr. Sirabian negotiated what he considered to be "fair and reasonable" prices pre-merger with health plans.)). Pre-merger, Mr. Sirabian negotiated prices that would cover Evanston's cost and give Evanston a reasonable profit margin. (Sirabian, Tr. 5738).

ENH senior management also believed that Mr. Sirabian was good at his job. (Sirabian, Tr. 5726-29 (Mr. Sirabian was given more and more responsibility throughout

his tenure at Evanston pre-merger.); Hillebrand, Tr. 1729 (Mr. Hillebrand trusted Mr. Sirabian's judgment and efforts.); Sirabian, Tr. 5754, 5762 (Neither Mr. Hillebrand or Mr. Neaman ever criticized the way that Mr. Sirabian handled managed care contracts in the 1990s.); Sirabian, Tr. 5728 (Messrs. Neaman and Hillebrand always gave Mr. Sirabian positive reviews.)). {[redacted]} (Holt-Darcy, Tr. 1509, *in camera*). Similarly, Ms. Ballengee testified that Mr. Sirabian was an active negotiator. (Ballengee, Tr. 206).

Mr. Hillebrand, the man who oversaw Mr. Sirabian in managed care contracting at Evanston hospital during the 1990s and led the relationships with health plans, is still doing so today, and is also an effective negotiator. (Hillebrand, Tr. 1727-8; Neaman, Tr. 1220-21. *See* Neaman, Tr. 1220 (Mr. Neaman believes that Mr. Hillebrand is an effective negotiator with a good understanding of the marketplace, as well as the relationship between health plans and ENH)). Mr. Hillebrand always tries to "do well" for ENH and has never been criticized for the way that he handled managed care contracting prior to the merger. (Hillebrand, Tr. 1727; Neaman, Tr. 1220. *See* Neaman, Tr. 1220 (Mr. Neaman trusts and relies on Mr. Hillebrand).

610. Chan, who worked with Sirabian (her Evanston Hospital counterpart) just before and after the Merger, did not believe that Sirabian was a tough negotiator. (Chan, Tr. 740-41). {[redacted]} (Haas-Wilson, Tr. 2820, *in camera*; RX 2030, *in camera*).

Response to Finding No. 610:

The cited sources do not say what Respondent claims. {[redacted]

[redacted] (Haas-Wilson, Tr. 2820, *in camera* (emphasis added)). Moreover, Ms. Ballengee herself testified that she did not consider Mr. Sirabian's negotiation style to be benign at all. (Ballengee, Tr. 206). Respondent also overstates what Ms. Chan actually said. (Chan, Tr. 740-41). Ms. Chan testified that Mr. Sirabian was "not as tough a negotiator as some of the other people I know." (Chan, Tr. 740-41).

(3) Sirabian Did Not Threaten Termination As A Means To Obtain Aggressive Rates

611. During contract negotiations, Sirabian rarely threatened to terminate a contract if a MCO refused to agree to his proposed rate. Again, his primary objective was to be included in the network. (Sirabian, Tr. 5702-03, 5752).

Response to Finding No. 611:

The finding is incomplete. Complaint Counsel agree that Evanston was concerned about being excluded from health plan networks prior to the merger. (Sirabian, Tr. 5702-03, 5752; Neaman, Tr. 961-62. *See* CCRFF 597). [redacted] (*See* CCRFF 597, *in camera*; CX 1768 at 3 (Evanston representatives knew prior to the merger that the competitive environment meant that hospitals were "'slicing' each other up in the market" and "undercutting" each other.)). After the merger, ENH no longer had to be concerned about being dropped from health plan networks. (*See* CCRFF 597; Neaman, Tr. 1211-2; Hillebrand, Tr. 1764-65).

612. For example, during the 1990s, the three most difficult payors to negotiate with were Cigna, Aetna, and United because these MCOs were not willing to bring the negotiations to a conclusion. (Sirabian, Tr. 5710, 5715-16). Nevertheless, Sirabian never threatened to terminate any of these contracts. (Sirabian, Tr. 5763-64).

Response to Finding No. 612:

This finding is misleading, it could not be literally true that the MCO's were not willing to bring the negotiations to a conclusion, Evanston did have contracts with these companies, so the negotiations must have been brought to a conclusion. The finding is also inconsistent with Mr. Sirabian's testimony that "with the major groups, the top seven to 10, [Evanston was] always able to come to terms" prior to the merger. (Sirabian, Tr. 5753-54, 5763-64. *See* Hillebrand, Tr. 1725 (Cigna and United were two of the top four providers in the market); CX 2059 at 1 (Aetna represented the fifth largest managed care volume for ENH in the 1990s.)).

(4) Sirabian Let Contracts Lapse And Did Not Initiate Contract Renegotiations

613. During the 1990s, Evanston Hospital's contracts with MCOs typically were 12-months in duration. (Sirabian, Tr. 5701, 5705). After the contracts expired, if new rates were not agreed upon, the current contract would continue to exist until a new rate structure was put in place (*i.e.*, an evergreen contract). (Sirabian, Tr. 5705).

Response to Finding No. 613:

The finding is incomplete and misleading. A contract that automatically renews or continues after the initial term of the contract has ended is not an "expired" contract. (*See, e.g.* CX 215 at 1; CX 5085 at 2). Moreover, the fact that a contract has not been negotiated for a number of months or years does not mean that the hospital is not being reimbursed more as each year passes. {[redacted]

[redacted]

(Hillebrand, Tr. 1711; Ballengee, Tr. 227, *in camera*; Chan, Tr. 667). Once a contract's reimbursement rate is negotiated as a certain percent discount off charges, a hospital can simply raise the rates on its chargemaster to increase its net revenue from health plans. (Newton, Tr. 366). [redacted] (CX 5902 at 1, 3, *in camera*; CX 5199 at 2). According to Mr. Sirabian, it was Evanston's practice throughout the 1990s to review and raise items on its chargemaster every year. (Sirabian, Tr. 5741-42). [redacted] (Neary, Tr. 766-67, *in camera*; Chan, Tr. 785-86, *in camera*). [redacted] (Chan, Tr. 785-86, *in camera*; Neary, Tr. 766-67).

614. Generally, contracts had to be renegotiated 2-3 months before the contract expired. (Sirabian, Tr. 5705). Sirabian was usually responsible for initiating the renegotiations. (Sirabian, Tr. 5705-06). Because rates generally increased with renegotiation as a result of increasing costs and other factors, insurers generally had little incentive to initiate renegotiations. (Sirabian, Tr. 5706).

Response to Finding No. 614:

The finding is incomplete and misleading. It is not necessarily true that "rates generally increased with renegotiation as a result of increasing costs and other factors." {[redacted]} (Chan, Tr. 688-90; CX 30 at 2; Chan, Tr. 716-20, 824-26, *in camera*). In 1996, for example, Mr. Sirabian "suggest[ed] increasing [Evanston's] contractual allowances by 10 million dollars." (CX 2059 at 2). In 1998, Mr. Hillebrand lamented to Evanston's board of directors that the hospital was experiencing "significant reductions in reimbursement" from both Blue Cross and Humana. (CX 2037 at 2-3; Neaman, Tr. 1151-52). {[redacted]} (Chan, Tr. 824-26, *in camera*; Chan, Tr. 716-20; CX 30 at 2)

615. Sirabian's practice, however, was not to initiate renegotiations before the contract term expired for those insurers with which Evanston Hospital had low volumes and that represented a small portion of Evanston Hospital's overall business – including Aetna, Cigna and networks such as One Health. (Sirabian, Tr. 5706-07).

Response to Finding No. 615:

Respondent's finding is incorrect with regard to Aetna and Cigna. According to Mr. Hillebrand, Cigna was one of the top four providers in the market in the 1990s. (Hillebrand, Tr. 1725). Similarly, Aetna represented the fifth largest managed care volume for ENH in the 1990s. (CX 2059 at 1). {[redacted]} (CX 135 at 1-2, *in camera*).

iii. Many Evanston Hospital Contracts Had Not Been Renegotiated In A Number Of Years

616. Before the Merger, Evanston Hospital had not negotiated a new contract with Cigna since 1995. (CX 5013 at 6).

Response to Finding No. 616:

Respondent's finding is misleading to the extent that it attempts to justify ENH's large post-merger price increases as "catch-up" rates. Even if, *arguendo*, ENH did try to update older contracts during the 2000 renegotiations, the rates that the merged entity imposed were far above what would be considered appropriate in that situation. Prior to the merger, Evanston catch-up rates were based in part on increases in the Medical CPI. (*See, e.g,* RX 250 at ENH JL 008241). {[redacted]} (Mendonsa, Tr. 523, *in camera*).

{[redacted]} (Mendonsa, Tr. 523, *in camera*; CX 6279 at 4, *in camera*). {[redacted]} (CX 6279 at 5, *in camera*).

617. In a letter to Sirabian, on December 3, 1999, First Health acknowledged that "Evanston and Glenbrook Hospital rates have not been renegotiated for some period." (RX 695 at FH 8575).

Response to Finding No. 617:

This finding is misleading and incomplete. First, neither the finding nor the

underlying document state what "some period" actually means in terms of time. (RX 695).

{[redacted]} (CX 6279 at 4, *in camera*). {[redacted]} (CX 6279 at 5, *in camera*; Haas-Wilson, Tr. 2537-38, *in camera*). There is no evidence linking price increases of that magnitude to contracts that have not been renegotiated for some period.

618. Before the Merger, Evanston Hospital had not negotiated a new HMO or PPO contract with One Health since 1996. (Neary, Tr. 596; CX-5061; CX-5065).

Response to Finding No. 618:

This finding is misleading and incomplete. {[redacted]} (CX 2085 at 1 (emphasis added), *in camera*; Neary, Tr. 762-63, *in camera*). {[redacted]}

[redacted] (CX 6282 at 5, *in camera*).

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

619. [redacted] (Mendonsa, Tr. 563, *in camera*; CX 5007 at 2 (effective date Nov. 1, 1996); Hillebrand, Tr. 1897).

Response to Finding No. 619:

This finding is misleading and incomplete. [redacted] (Mendonsa, Tr. 533-34, 540 *in camera*. *See* Mendonsa, Tr. 539-40, *in camera*; Mendonsa, Tr. 478 ([redacted])).

[redacted] (CX 6279 at 4-5, *in camera*).

[redacted] (CX 6279 at 18, *in camera*).

620. [redacted]

[redacted] (Holt-Darcy, Tr. 1582, *in camera*; CX 5085 at 1).

Response to Finding No. 620:

This finding is misleading and incomplete. Rush Prudential's 1994 contract rates were so advantageous to Evanston that, five years later, Rush Prudential was still reimbursing Evanston at rates that were higher than many health plans. (CX 74 at 9). In 1999, Rush Prudential paid higher per diems for ICU, medical, and surgical services than Blue Cross/Blue Shield, Aetna, PHCS, United, Preferred, and Cigna. (CX 74 at 9).

After the merger, ENH renegotiated contracts regardless of whether the contracts were old or new. For example, Rush Prudential was acquired by Unicare in 2000. (Holt-Darcy, Tr. 1413). [redacted] (Holt-Darcy, Tr. 1547-48, *in camera*; CX 216 at 1, *in camera*). [redacted] (CX 5075, *in camera*). [redacted] (Holt-Darcy, Tr. 1503, 1597, 1599-1600, *in camera*. *See* RX 250 at ENH JL 008241 (Pre-merger, Evanston catch-up rates were based on increases in the Medical CPI). [redacted]

[redacted] (Holt-Darcy, Tr. 1536, 1539, 1543, 1563, *in camera*; CX 5075 at 17, *in camera*).

[redacted] (Mendonsa, Tr. 523, *in camera*; CX 6279 at 4, *in camera*). [redacted] (CX 6279 at 5, *in camera*; Haas-Wilson, Tr. 2537-38 ([redacted]), *in camera*).

621. At the time of the Merger, Bain brought to ENH's attention that its rates with United Healthcare had not been renegotiated since 1994. (Hillebrand, Tr. 1870; RX 684 at BAIN 73).

Response to Finding No. 621:

Respondent's finding is incomplete. When ENH asked United to send a letter to the FTC claiming that the 2000 "rates reflected a one time 'catch up' increase in ENH's rate," United would not sign or send the letter. (Foucre, Tr. 924-25, 927; CX 6284 at 1).

[redacted] (Mendonsa, Tr. 523, *in camera*; CX 6279 at 4, *in camera*). [redacted]

[redacted] (CX 6279 at 5, *in camera*). {[redacted]

[redacted] (CX 6279 at 19, *in camera*).

622. In negotiations with Preferred Plan in 1995, Sirabian recognized that Evanston Hospital's contract had not been renegotiated in 18 months. (RX 100). And as of May 1997, Evanston Hospital had not negotiated a new contract with Preferred Plan for roughly two years. (RX 250).

Response to Finding No. 622:

The finding is irrelevant. Evanston revisited and renegotiated the Preferred Plan rates in 1997, 1998, and 1999, making a catch-up on the Preferred Plan contract unnecessary at the time of the merger. (CX 5196; CX 5197; CX 5199). [redacted] (CX 6279 at 4, *in camera*). {[redacted] (CX 6279 at 5, *in camera*; Haas-Wilson, Tr. 2537-38, ({[redacted]}), *in camera*).

623. In addition, as seen in Sirabian's June 1995 letter to the Travelers' Insurance Group, a one-year contract was allowed to remain in existence for almost two years without being renegotiated. (RX 98).

Response to Finding No. 623:

This finding is irrelevant. Evanston's practices in 1995 are irrelevant to the issues

of this case.

c. By The Late 1990's, Changing Financial Conditions Put Pressure On Evanston Hospital To Focus On MCO Contract Rates

624. Evanston Hospital experienced financial pressures in the late 1990s from an operating standpoint. (Neaman, Tr. 1314).

Response to Finding No. 624:

The finding is irrelevant and misleading. There has never been any question in this case as to the strong financial status of Evanston Hospital. In a November 1999, Evanston board meeting, Mr. Neaman highlighted that "[o]ver the past five years, Evanston experienced a 70% growth in operating revenue; total operating profits of $121 million; total operating and investment returns of $400 million and growth in our Second Century Fund from $224 to $612 million." (CX 657 at 3).

A summary report presented to the Evanston Board on June 25, 1999 regarding the merger states that ENH's had no debt and a fiscal year 1998 income from operations was $16.7 million (with additional investment income of $59.1 million and an investment balance of $700 million). (CX 84 at 16; *see also* CX 359 at 13 (Presentation to the Executive Committee of the Evanston board of directors)). Its finance committee also noted that the audit report for t he previous fiscal year showed "no material weakness" (CX 874 at 3). Further. Mr. Neaman stated to employees that he expected "great results" in 1999 and that Evanston could expect a $14 million return, which would be well ahead of neighboring hospitals. (CX 1566 at 3).

In any event, Mr. Neaman admitted that the financial pressures of the late 1990s

affected all hospitals to some extent. (Neaman, Tr. 1315). Furthermore, the purported cuts took place before the merger in 1998-99. (Hillebrand, Tr.1837). Because these changes affect all hospitals, it would have been considered by Dr. Haas-Wilson's study. {[redacted]} (Haas-Wilson, Tr. 2483–85, 95, 2542-44, *in camera).* Prices at ENH rose relative to the prices at other hospitals. (CCFF 579). {[redacted]} (Haas-Wilson, Tr. 2562-63, 2565, 2573-74, 2579, 2583, 2586, *in camera*).

625. Evanston Hospital's key sources of financial pressure in the late 1990s were the Balanced Budget Act of 1997 ("Balanced Budget Act"), declining economic returns and decreased payors reimbursement. (Neaman, Tr. 1314, 962-63; Hillebrand, Tr.1837). The pricing pressures from Medicare and the MCOs were both a significant threat to, and an opportunity for, Evanston Hospital. (Neaman, Tr. 1152; CX 2037 at 3).

Response to Finding No. 625:

The finding is irrelevant and misleading as to the effect of the purported cutbacks. Further, Mr. Neaman admitted that the cutbacks affected all hospitals (Neaman, Tr. 1315), and took place before the merger (Hillebrand, Tr.1837).

Because these changes affect all hospitals, it would have been considered by Dr. Haas-Wilson's study. {[redacted]} (Haas-Wilson, Tr. 2483–85, 2495, 2542-44, *in camera).* Prices at ENH rose relative to the prices at other hospitals. (CCFF 579, *in camera*). {[redacted]

[redacted] (Haas-Wilson, Tr. 2562-63, 2565, 2573-74, 2579, 2583, 2586, *in camera*). The finding is also incomplete and misleading because, subsequent legislation restored, in part, reimbursement for various health care providers affected by Balanced Budget Act cuts. [redacted] (RX 1205 at FTC RNSM0000345, *in camera*).

Finally as to pressure from health plans, Complaint Counsel emphasize the importance of Mr. Neaman's testimony regarding managed care contract discussions with Bain cited in the proposed finding. Mr. Neaman stated "we had always had those discussions, so that would include 1998 as well as other time." (Neaman, Tr. 963).

626. Kim Ogden of Bain believed that from, 1993 to 1999, pricing pressures on hospitals persisted from managed care and the Balanced Budget Act. (RX 2047 at 8 (Ogden, Dep.)). Providers thus moved to become more efficient and develop higher quality services. (RX 2047 at 8 (Ogden Dep.)).

Response to Finding No. 626:

The finding is irrelevant and misleading for the reasons stated in response to CCRFF 624 and 625.

i. Evanston Hospital Realized The Adverse Financial Effect Of The Balanced Budget Act Until In Late 1998 And 1999.

627. Congress passed the Balanced Budget Act in 1997 as an effort by the federal government to erase the federal budget deficit. (Neaman, Tr. 1314). The original Balanced Budget Act was intended to cut approximately $100 billion paid to hospitals and doctors through federal programs such as Medicare. (Neaman, Tr. 1314). The Balanced Budget Act and the federal government, however, ultimately reduced payments to hospitals and physicians by $225 billion. (Neaman, Tr. 1314).

Response to Finding No. 627:

The finding is irrelevant because the cited cuts affected the entire industry, and not just ENH alone. Mr. Neaman admitted that the cutbacks affected all hospitals. (Neaman, Tr. 1315). Because these changes affect all hospitals, they would have been considered by Dr. Haas-Wilson's study. [redacted] (Haas-Wilson, Tr. 2483–85, 2495; Haas-Wilson, Tr. 2542-44, *in camera*). [redacted] (CCFF 579, *in camera*). [redacted] (Haas-Wilson, Tr. 2562-63, 2565, 2573-74, 2579, 2583, 2586, *in camera*).

The finding is misleading as to hospital payments because subsequent legislation restored, in part, reimbursement for various health care providers affected by Balanced Budget Act cuts. [redacted] (RX1205 at FTC RNSM0000345, *in camera*).

The finding is irrelevant as to physician payments because payments for physician services are covered by Part B of the Medicare program separate from hospital reimbursement.

628. Academic medical centers were especially threatened by the cuts in the Balanced Budget Act. (H. Jones, Tr. 4178; RX 528 at ENH RS 5507). For instance, in the Summer of 1999, Mt. Sinai Medical Center in Cleveland discontinued its academic programs, Stanford University Hospital cut 15% of its workforce and Henry Ford Hospital in Detroit had its bond

rating reduced. (RX 528 at ENH RS 5507).

Response to Finding No. 628:

Complaint Counsel objects to the reliance on RX 528 at ENH RS 5507, to the extent that it is introduced for the truth of the matter asserted therein. The quoted statements in RX 528 as to what other hospitals were doing are double hearsay, and are inadmissible for the purpose of proving the truth of the matter asserted therein pursuant to Rule 805, F.R.E., and JX1 ¶ 5 (February 10, 2005). This is contrary to the judge's ruling (Tr. 76) that this exhibit cannot be cited for its truth.

The finding is vague and misleading due to the use of the term "academic" medical center without defining how that term is used. (*See* CCRFF 99 for an explanation that the term "academic" hospital has no agreed upon meaning in the industry.)

The finding is irrelevant. The Balanced Budget Act cutbacks affected all hospitals. (Neaman, Tr. 1315). By its own terms the finding claims that the Balanced Budget Act cutbacks affected all "academic" medical centers. {[redacted]} (Haas-Wilson, Tr. 2483–84, 95, 2542-44, *in camera).* Prices at ENH rose relative to the prices at other hospitals. (CCFF 595). {[redacted]} (Haas-Wilson, Tr. 2562-63, 2565, 2573-74, 2579, 2583, 2586, *in camera*).

629. The Balanced Budget Act affected all hospitals to some extent, but Evanston

Hospital was hit harder than most because the Balanced Budget Act disproportionately affected hospitals, like Evanston Hospital, with many clinical service lines, employed physicians, home care, teaching programs and research institutes. (Neaman, Tr. 1315).

Response to Finding No. 629:

This finding regarding the Balanced Budget Act is misleading for the reasons stated in CCRFF 625, 627, and 628. In addition, the finding mischaracterizes the financial status of Evanston. There has never been any question in this case as to the strong financial status of Evanston Hospital. Indeed, in 1999, Evanston had approximately $613 million in a fund to support future activities of the hospital at the time of the merger. (CX 657 at 3). Its finance committee also noted that the audit report for the previous fiscal year showed "no material weakness." (CX 874 at 3). Further, Mr. Neaman stated to employees that he expected "great results" in 1999 and that Evanston could expect a $14 million return, which would be well ahead of neighboring hospitals. (CX 1566 at 3).

630. Beginning in 1998, and for the next five years, the Balanced Budget Act reduced Evanston Hospital's operating revenue by $16 million per year. (Hillebrand, Tr. 1844). Starting in 1998, and for the next five years, the Balanced Budget Act reduced Evanston Hospital's operating income by a total of $80 million. (Hillebrand, Tr. 1845, 1837; Neaman, Tr. 1315-6; RX 518 at ENH GW 2044).

Response to Finding No. 630:

This finding is misleading as to the projected loss of $80 million in revenue over five years. As of April 14, 1999, Evanston projected a Balanced Budget Act impact of just $47.9 million for Evanston. (CX 627 at 3). Later, in its fiscal year 2000/2001 budget assumptions, ENH projected a Balanced Budget Act deduction from revenue of just $2 million while at the same time expecting at least $13.5 million in favorable managed care

payment increases. (CX 25 at 2).

This finding regarding the Balanced Budget Act is misleading for the reasons stated in CCRFF 625, 627, and 628. In addition, the finding mischaracterizes the financial status of Evanston for the reasons stated in CCRFF 624.

631. Evanston Hospital did not realize the full impact of the Balanced Budget Act until late 1998 or early 1999. (Hillebrand, Tr. 1837; RX 462 at ENH RS 5480). 632. By early 1999, HPH was also starting to feel the impact of the Balanced Budget Act's reimbursement cuts. (RX 462 at 2). The impact of the Balanced Budget Act was estimated to be $15 million over five years for Lakeland Health Services. (RX 518 at ENH GW 2044).

Response to Finding No. 631:

This finding regarding the Balanced Budget Act is misleading for the reasons stated in CCRFF 625, 627, and 628. In addition, the finding mischaracterizes the financial status of Evanston for the reasons stated in CCRFF 624.

632. By early 1999, HPH was also starting to feel the impact of the Balanced Budget Act's reimbursement cuts. (RX 462 at 2). The impact of the Balanced Budget Act was estimated to be $15 million over five years for Lakeland Health Services. (RX 518 at ENH GW 2044).

Response to Finding No. 632:

This finding regarding the Balanced Budget Act is misleading for the reasons stated in CCRFF 625, 627, and 628. It is also misleading because as of April 14, 1999, Evanston projected a Balanced Budget Act impact of just $13.3 million for Highland Park between fiscal years 1999 and 2002. (CX 627 at 3).

The finding is also misleading as to the impact of the Balanced Budget Act on Highland Park. Highland Park's President realized that the Balance Budget Act simply meant that the hospital should continue "growing our business success as well as enhanced control of our costs." (CX 99 at 1). Further, he noted that even though there

were payment reductions from Medicare, "the demand for service from patients and medical staff continues unabated." (CX 97 at 1). He pointed out that "[i]n spite of the decline in operating margins, our historical cash flow has generated a strong balance sheet including $242 million of cash and investments through 6/30/98." (CX 97 at 1). He also emphasized that "our ability to absorb short-term declines in operating margins is a recognized asset that the Committee was willing to deploy." (CX 97 at 1).

633. The Balanced Budget Act had a significant negative effect on Evanston Hospital's operating income starting in 1998 and 1999, causing operating income to turn from positive to negative. (CX 6304 at 12 (Livingston, Dep.)).

Response to Finding No. 633:

This finding regarding the Balanced Budget Act is misleading for the reasons stated in CCRFF 625, 627, and 628. In addition, the finding mischaracterizes the financial status of Evanston for the reasons stated in CCRFF 624.

634. Before the Balanced Budget Act was passed, Evanston Hospital's operating income was sufficient to allow Evanston Hospital to avoid using money from its endowment to support its financial well-being. After, and due to, the Balanced Budget Act, however, Evanston Hospital had to use money from its endowment to maintain an acceptable operating income level. (CX 6304 at 12 (Livingston, Dep.)). As of July 2004 (but never before 1998), every year Evanston Hospital would take $20 million from its endowment and place that $20 million into its operating earnings category. (CX 6304 at 12 (Livingston, Dep.)).

Response to Finding No. 634:

The finding is misleading. This finding regarding the Balanced Budget Act is misleading for the reasons stated in CCRFF 625, 627, and 628. In addition, the finding mischaracterizes the financial status of Evanston for the reasons stated in CCRFF 624. Furthermore, the finding misstates Mr. Livington's testimony. Mr. Livingston's testimony on this point was not consistent. He first testified that "we took 4 percent of

some number of our endowment, but a total of $20 million so that - - out of the endowment each year to go into operating earnings. . ." (CX 6304 at 12 (Livingston Dep.)). A few lines further down the page, he testified that "[s]o when you see our earnings of $20 million from operation[s], $10 million of that comes from money that we are now taking out of the endowment." (CX 6304 at 12 (Livingston Dep.)). However, whether it was $10 million or $20 million that was coming out of the endowment, Mr. Livingston made it clear that this was not unusual for a not-for-profit hospital to take some money out of its endowment. ENH's withdrawals were "consistent with what most entities do. Northwestern University does it. Most other not-for-profit hospitals do it. You expect a return of 7, 8, 9 percent. So you take 3, 4, 5 percent out of that for operation." (CX 6304 at 12 (Livingston Dep.)).

635. The money in Evanston Hospital's endowment is invested in various stocks and bonds. (Neaman, Tr. 1316). Evanston Hospital/ENH had a policy of not dipping into the principle of its investments but, instead, uses investment income for specific purposes. (Neaman, Tr. 1316-17). For example, as of February 2005, ENH annually used $20 million of Second Century Fund, an endowment designed to produce investment income, to support free care, research and academic programs. (Hillebrand, Tr. 1843-44). Because the endowment is used to build new business in the absence of operating income, a net decrease in operating income is undesirable. (CX 6304 at 13 (Livingston, Dep.)).

Response to Finding No. 635:

The finding is misleading for the reasons stated in response to CCRFF 624 and 634. Prior to the merger, ENH's Second Century Fund grew dramatically. In a November 1999, Evanston board meeting, Mr. Neaman highlighted that "[o]ver the past five years . . . [Evanston] experienced a 70% growth in operating revenue; total operating profits of $121 million; total operating and investment returns of $400 million and growth

in our Second Century Fund from $224 to $613 million." (CX 657 at 3). In addition, since the merger, the fund has reached nearly a billion dollars. (Hillebrand, Tr. 1843)

636. The Balanced Budget Act also had an impact on MCO reimbursement because many of the MCOs use Medicare fee schedules as a basis for negotiating rates with hospitals. (Neaman, Tr. 1319). In 1997, Medicare, Blue Cross and Humana instituted significant reductions in reimbursements. (CX 2037 at 2; Neaman., Tr. 1151-52).

Response to Finding No. 636:

This finding is irrelevant and misleading because the Medicare fee schedules had no effect whatsoever on health plan reimbursement for inpatient hospital services. The fee schedules referred to by Mr. Neaman relate only to physician pricing and not to hospital reimbursement. It was demonstrated at trial that MCOs use fixed fee reimbursement (e.g., per diem or per case) or discount off charges. (*See* CCFF 170-176, 770-812).

ii. Since the late 1990s, Evanston Hospital/ENH, Along With Other Hospitals, Have Been Under Pressure To Reduce Costs

637. In 1998, Evanston Hospital felt more pressure to cut costs and improve revenue. (Neaman, Tr. 963; H. Jones, Tr. 4108). This feeling was not unique to Evanston Hospital/ENH. {[redacted]} (RX 1393 at ENHL BW 3681, *in camera*; H. Jones, Tr. 4108).

Response to Finding No. 637:

The finding is irrelevant because the cited cuts affected the entire industry, and not just ENH alone. Mr. Neaman admitted that the cutbacks affected all hospitals. (Neaman, Tr. 1315). Mr. Neaman stated "we had always had those discussions [to reexamine its overall strategy], that would include 1998 as well as other time[s]." (Neaman, Tr. 963). Because these changes affect all hospitals, it would have been considered by Dr. Haas-

Wilson's study. {[redacted]} (Haas-Wilson, Tr. 2483–85, 95, 2542-44, *in camera*). {[redacted]} (CCFF 579, *in camera*). {[redacted]} (Haas-Wilson, Tr. 2562-63, 2565, 2573-74, 2579, 2583, 2586, *in camera*).

638. {[redacted]} (RX 1205 at FTC-RNSMC 361, *in camera*). {[redacted]} (RX 1205 at FTC-RNSMC 361, *in camera*).

Response to Finding No. 638:

This finding is misleading for the reasons stated in CCRFF 625, 627, and 628. Because these changes affect all hospitals, it would have been considered by Dr. Haas-Wilson's study. {[redacted]} (Haas-Wilson, Tr. 2483–85, 2495; Haas-Wilson, Tr. 2542-44, *in camera*). {[redacted]} (CCFF 579, *in camera*). {[redacted]} (Haas-Wilson, Tr. 2562-63, 2565, 2573-74, 2579, 2583, 2586, *in camera*).

639. {[redacted]}

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

Response to Finding No. 639:

This finding is misleading for the reasons stated in CCRFF 625, 627, and 628.

640. MCOs such as Unicare also recognized that hospitals faced increasing costs caused by increased health care demand and HIPAA. (RX 1189 at ENHL JL 14125).

Response to Finding No. 640:

This finding is misleading for the reasons stated in CCRFF 625, 627, and 628.

iii. By The Late 1990s, Evanston Hospital No Longer Could Rely As Heavily On Its Investment Income

Response to Finding No. 641:

641. In 1990, Evanston Hospital created the Second Century Fund, an endowment designed to produce investment income. (Hillebrand, Tr. 1843). From 1990 until the late 1990s, Evanston Hospital did very well in investment income and achieved its targeted financial returns. (Hillebrand, Tr. 1835-36).

The finding is incomplete and misleading. Complaint Counsel agree with the finding that ENH did well with its endowment, but the finding is incomplete because it does not spell out the full picture of ENH's financial gains prior to the merger. In a November 1999, Evanston board meeting, Mr. Neaman highlighted that "[o]ver the past five years, Evanston experienced a 70% growth in operating revenue; total operating profits of $121 million; total operating and investment returns of $400 million and growth in our Second Century Fund from $224 to $612 million." (CX 657 at 3).

A summary report presented to the Evanston Board on June 25, 1999 regarding the merger states that ENH's had no debt and a fiscal year 1998 income from operations was $16.7 million (with additional investment income of $59.1 million and an investment

balance of $700 million). (CX 84 at 16; *see also* CX 359 at 13 (Presentation to the Executive Committee of the Evanston board of directors). Its finance committee also noted that the audit report for t he previous fiscal year showed "no material weakness" (CX 874 at 3). Further, Mr. Neaman stated to employees that he expected "great results" in 1999 and that Evanston could expect a $14 million return, which would be well ahead of neighboring hospitals. (CX 1566 at 3).

Indeed, there has never been any question in this case as to the strong financial status of Evanston Hospital. Indeed, in 1999, Evanston had approximately $613 million dollars in a fund to support future activities of the hospital at the time of the merger. (CX 657 at 3). Its finance committee also noted that the audit report for the previous fiscal year showed "no material weakness" (CX 874 at 3). Further. Mr. Neaman stated to employees that he expected "great results" in 1999 and that Evanston could expect a $14 million return, which would be well ahead of neighboring hospitals. (CX 1566 at 3).

642. Before the late 1990s, Evanston Hospital management and the Evanston Hospital Board felt that the managed care pricing levels were sufficient as long as Evanston Hospital was able to get a 2% return from operations over the Medical Consumer Price Index. (Hillebrand, Tr. 1836).

Response to Finding No. 642:

This finding is incomplete and misleading because Evanston's returns pre and post-merger were well in excess the board's approved budget and any expected measure of return. Before the merger, in a September 29, 1999 speech to employees, Mr. Neaman stated that "our operating results show some $14 million, or 2% operating income return in 1999. This is down from the previous year, but in excess of budget, and certainly

substantially ahead of any of our neighboring institutions." He characterized this as "great results." (CX 1566 at 3). After the merger, in a May 17, 2000, letter from Mr. Neaman to Lester Knight, III, ENH board chairman, Mr. Neaman emphasized that the net revenues were well in excess of any targeted return "[i]n FY 2000, the Board-approved operating budget was $4 million net income from operations. We are now forecasting $18 million in net income for FY 2000 from operations alone. (CX 373 at 1 (emphasis added). Mr. Neaman goes on to connect the excess income with the merger:

> How could we *boldly achieve these operating returns of at least $15 million per year (well in excess of the capital maintenance factor)* when we started FY 2000 at $4 million and 70% of the hospitals in this market are losing money from operations?? Simply stated these are the favorable results rolling forward of our $26 million (to-date) economic improvements via the merger integration.

(CX 373 at 1, 6 (emphasis added)) Mr. Neaman estimated that ENH's "Return on Sales" for various business units was as high as 33% for cardiac surgery, 40% for the emergency room, 40% for radiology and diagnostics, and 45% for GI units. (CX 373 at 7).

643. In 1990s, investment income grew between 10-20% per year. (Neaman, Tr. 1317). As the 1990s progressed, however, Evanston Hospital was not able to maintain 10-20% annual returns on its investment income. (Neaman, Tr. 1317).

Response to Finding No. 643:

The finding is misleading as to Evanston's experience in the late 1990s and its expectations regarding investment income. In a November 1999, Evanston board meeting, Mr. Neaman highlighted that "[o]ver the past five years . . . [Evanston] experienced a 70% growth in operating revenue; total operating profits of $121 million; total operating and investment returns of $400 million and growth in our Second Century Fund from $224 to $613 million." (CX 657 at 3).

As to Evanston's future expectations, an Evanston presentation to Standard and Poor's, Strategic and Capital Structure Review, dated December 7, 1999, states as a goal "*maintain very strong capital structure* (over $1 billion in cash and investments"). (RX 704 at ENH HJ 001612, 001616 (emphasis added)). The November 1999, Evanston board of directors meeting states that "over the past five years" Evanston's total growth in the Second Century Fund from $244 to $613 million. (CX 657 at 3).

644. Evanston Hospital was experiencing a decline in "Net Non-Operating Revenue," the majority of which is investment income. (H. Jones, Tr. 4107; RX 514 at FTC-KHA 1665). Evanston Hospital's non-operating income decreased from $71 million in 1997 to $59 million in 1998 and was projected to level off at approximately $45 million for the next three years before gradually increasing in 2002-2004. (H. Jones, Tr. 4107-08; RX 514 at FTC-KHA 1665).

Response to Finding No. 644:

The finding is misleading as to Evanston's experience and expectations regarding investment income. In a November 1999, Evanston board meeting, Mr. Neaman highlighted that "[o]ver the past five years . . . [Evanston] experienced a 70% growth in operating revenue; total operating profits of $121 million; total operating and investment returns of $400 million and growth in our Second Century Fund from $224 to $613 million." (CX 657 at 3).

Evanston's December 7, 1999, Presentation to Standard and Poor's, Strategic and Capital Structure Review, states as a goal "*maintain very strong capital structure* (over $1 billion in cash and investments"). (RX 704 ar ENH HJ 001612, 001616). A summary report presented to the Evanston Board on June 25, 1999 regarding the merger states that ENH had no debt and a fiscal year 1998 income from operations of $16.7 million (with additional investment income of $59.1 million and an investment balance of

$700 million). (CX 84 at 16; *see also* CX 359 at 13 (Presentation to the Executive Committee of the Evanston board of directors). Furthermore, Mr. Livington testified that $10 or $20 million from the investment income was used for operating income. (CX 6304 at 12 (Livingston Dep.); CCRFF 634). If investment income fell to $45 million a year, that would more than cover the money used for operating income and still allow for the growth of principal.

In any event, in every year through 2004 there was projected at least $8 million operating revenue in excess of expenditures and more than $50 million in revenue over expenses. (RX 514 at FTC-KHA 1665)

645. Although Evanston Hospital initially projected fairly stable non-operating revenue into the future, by the late 1990s, Evanston Hospital suffered significant deterioration in investment returns as Evanston Hospital's income from investments quickly decreased because of poor returns from the stock market. (Hillebrand, Tr. 1837; CX 6304 at 12 (Livingston, Dep.); H. Jones, Tr. 4108; RX 514 at FTC-KHA 1665).

Response to Finding No. 645:

The finding is misleading as to Evanston's experience and expectations regarding investment income. In a November 1999 Evanston board meeting, Mr. Neaman highlighted that "[o]ver the past five years . . . [Evanston] experienced a 70% growth in operating revenue; total operating profits of $121 million; total operating and investment returns of $400 million and growth in our Second Century Fund from $224 to $613 million." (CX 657 at 3).

As to expectations regarding investment income, Evanston's December 7, 1999, Presentation to Standard and Poor's, Strategic and Capital Structure Review, states as a goal "*maintain very strong capital structure* (over $1 billion in cash and investments").

(RX 704 ar ENH HJ 001616). A summary report presented to the Evanston Board on June 25, 1999 regarding the merger states that ENH had no debt and a fiscal year 1998 income from operations of $16.7 million (with additional investment income of $59.1 million and an investment balance of $700 million). (CX 84 at 16. *See also* CX 359 at 13 (Presentation to the Executive Committee of the Evanston board of directors).

Evanston's finance committee also noted that the audit report for the previous fiscal year showed "no material weakness." (CX 874 at 3). Furthermore, Mr. Neaman stated to employees that he expected "great results" in 1999 and that Evanston could expect a $14 million return, which would be well ahead of neighboring hospitals. (CX 1566 at 3). According to an Illinois government report, the second highest net income of the hospitals in the state of Illinois for the period 1996-1999 and ranked highest among the hospitals in solvency ratio and investment income. (CX 2389 at 7, 12, 40).

In any event, in every year through 2004 there was projected at least $8 million operating revenue in excess of expenditures and more than $50 million in revenue over expenses. (RX 514 at FTC-KHA 1665).

2. Evanston Hospital And HPH Had Different Negotiated MCO Contract Rates Before The Merger

646. As discussed in Section , the different negotiating styles of Evanston Hospital and HPH led to different negotiated MCO contract rates before the Merger.

Response to Finding No. 646:

Respondent cites no support for this finding. This is contrary to the Judge's April 6, 2005, Order on Post-Trial Briefs, stating that each proposed finding shall have a valid and correct cite to the record.

D. Dr. Haas-Wilson's Bargaining Theory Does Not Eliminate All Viable Alternative Explanations For ENH's Post-Merger Price Increases, Such As Learning About Demand

1. "Price" Can Be Defined In Several Ways

647. There are several different ways to think about price. (Noether, Tr. 5988).

Response to Finding No. 647:

Complaint Counsel have no specific response.

a. Charges

648. Price could be thought of as a hospital's charges. Every hospital or hospital system has a chargemaster, which provides a list price that a hospital charges for each component of the products and services provided by the hospital or hospital system. (Hillebrand, Tr. 1710-11, 1716; Porn, Tr. 5646).

Response to Finding No. 648:

The finding is irrelevant and misleading. {[redacted]} (Noether, Tr. 5906; Baker, Tr. 4632, *in camera*; Haas-Wilson, Tr. 2456-57). When a managed care organization contracts to include a hospital in its networks, the managed care organization does not pay the hospital's charges or chargemaster prices, but instead negotiated prices. (Haas-Wilson, Tr. 2496-97, 2500).

649. In most cases, however, chargemaster prices do not reflect the actual prices paid by patients or MCOs. (Hillebrand, Tr. 1710-11, 1716).

Response to Finding No. 649:

The cited source does not say what Respondent's finding claims. The cite only refers to managed care plans, not individual patents. (Hillebrand, Tr. 1710-11). It is true that chargemaster prices do not reflect the actual prices paid by managed care plans who

have negotiated contract prices, however individual patients, who are not covered by a health insurance plan that negotiates discounts will expect to pay the list or chargemaster prices if they simply walk into a hospital. (*See* CCFF 179).

b. Contract Rates

650. Another way to think about price is to consider the rates contained in the contracts between hospitals and MCOs, or "contract rates." (Noether, Tr. 5988).

Response to Finding No. 650:

The finding is misleading. {[redacted]} (Haas-Wilson, Tr. 2645). {[redacted]} (Haas-Wilson, Tr. 2647). To the extent that the contract rates are rates per day, that can be misleading when hospitals find ways of treating conditions that reduce the length of the stay. The right way to analyze the price to the buyer is to look at the entire hospital stay. (Baker, Tr. 4629).

Moreover, there is no single in-patient "contract rate" in a typical contract. Rather there will be a number of different rates for different types of inpatient services that a hospital will offer, such as different rates for general medical surgical, intensive care, maternity, etc. (*See e.g.,* CX 5070 at 28; CX 5001 at 4, 6, 8).

651. {[redacted]}, which is discussed in more depth below. (Baker, Tr. 4807-08, *in camera*).

Response to Finding No. 651:

The finding is incorrect. Learning about HPH contract rates would tell Evanston Hospital little about how the actual hospital prices compare. About 1/3 of the contracts between HPH and managed care organizations had contract rates that were higher than the rates at Evanston. (Sirabian, Tr. 5717). Yet when Dr. Noether compared the prices charged by HPH and Evanston Hospital pre-merger to four managed care companies, Aetna, Blue Cross, Humana, and United, Dr. Noether found that the prices at Evanston were higher than the prices at Highland Park for each of the five ways that Dr. Noether calculated the prices. (Haas-Wilson, Tr. 2646 (discussing DX 7047, *in camera*), *in camera*).

652. The claims data produced by certain MCOs during discovery include information on the patient, at what hospital the patient received care, the date of admission, the date of discharge, and in many cases the diagnosis, age and gender of the patient. Importantly, this data also includes the amount that the MCO reimbursed the hospital for the care of the patient. (Haas-Wilson, Tr. 2496).

Response to Finding No. 652:

Complaint Counsel have no specific response.

653. {[redacted]} (Baker, Tr. 4807-08, *in camera*; Haas-Wilson, Tr. 2496).

Response to Finding No. 653:

The finding is incorrect. {[redacted]}

[redacted] (Haas-Wilson, Tr. 2647-48, *in camera*). {[redacted]

[redacted]

[redacted]} (Baker, Tr. 4629, *in camera*). Furthermore, the citation to Dr. Haas-Wilson does not support this finding.

c. Reimbursement Rates

654. Another way to think about "price" is to consider the actual amount paid to a hospital through a managed care contract relationship, or the "reimbursement amount." (Noether, Tr. 5988). This amount combines the amount paid by the MCO with the amount paid directly by the patient. (Noether, Tr. 5988).

Response to Finding No. 654:

Complaint Counsel have no specific response.

655. It is possible to calculate imperfect reimbursement amounts from some of the claims data provided by the MCOs in discovery. (Noether, Tr. 5988-89).

Response to Finding No. 655:

The finding is misleading. The claims data is "like finding gold" to an empirical healthcare economist. (Haas-Wilson, Tr. 2497). The claims data has information on the actual payment made by the hospital, it has information on a patient level, and it has information on many hospitals in the Chicago area so that one can test statistically whether the price increases at ENH were greater than price increases at other hospitals. (Haas-Wilson, Tr. 2496-97). {[redacted]

[redacted]

[redacted]

[redacted] (Haas-Wilson, Tr. 2616, 2619-23, *in camera*; Baker, Tr. 4642, 4800, *in camera*).

2. The Factual Evidence Is Consistent With The Learning About Demand Alternative Explanation For The Price Increases At Issue

a. Coincident With The Merger, ENH Learned That It Was "Leaving Money On The Table" Through Proper Due Diligence

656. HPH and Evanston Hospital shared their pre-Merger contract rates during the Merger due diligence. (Chan, Tr. 712).

Response to Finding No. 656:

Complaint Counsel have no response.

657. One of Chan's responsibilities on the contracting team, from HPH's side, was to compare HPH's rates with MCOs to Evanston's rates. (Chan, Tr. 659-60, 714). When Chan first saw Evanston's charges, she felt they were low as compared to HPH. (Chan, Tr. 739).

Response to Finding No. 657:

As an initial matter, Respondent's finding on Evanston's "low" pre-merger rates relative to HPH is irrelevant to the question of exercise of market power. Whatever the rates of Evanston or Highland Park were prior to the merger, after the merger, ENH demanded (and generally achieved) the higher of the two contract rates plus a premium. (*See* CCFF 848-903). ENH also demanded (and received) the same rate for all three of its facilities. (*See* CCFF 822-847). Thus, both Evanston and HPH post-merger were able to escalate rates for individual contracts up from pre-merger levels, supporting the conclusion that the combined entity was exercising market power that was unavailable to each hospital pre-merger. ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCFF 1313-1328).

Respondent's finding as it deals with Ms. Chan's comparison of HPH and Evanston pre-merger contracts also is misleading and incomplete. Ms. Chan's comparison did not factor in critical components of the actual price or reimbursement per case and so did not accurately capture the true charges.

{ } (Haas-Wilson, Tr. 2645, *in camera*). { } (Haas-Wilson, Tr. 2645, *in camera*). { } (Haas-Wilson, Tr. 2647, *in camera*).

(Haas-Wilson, Tr. 2647-48, *in camera*). { } (*See* CX 1373 at 14, *in camera* { }.

In addition, the contention that Evanston had lower prices is contradicted by

Respondent's own experts' analysis. {[redacted]} (*See* CCFF 1805-1808).

Finally, if in some instances Evanston had lower prices than HPH pre-merger for certain health plans, volume differentials is part of the explanation. Evanston had significantly greater volume than HPH. (*See, e.g.*, RX 757 at 1 (Evanston's volume from CCN pre-merger was "four times as high as CCN's volume at HPH."). {[redacted]} (Hillebrand, Tr. 1761; Chan, Tr. 843-44, *in camera*; Dorsey, Tr. 1474-75; Ballengee, Tr. 160-62 (PHCS would have expected to receive lower rates at Evanston prior to the merger because PHCS sent more dollars to Evanston than Highland Park.)).

658. {[redacted]} (Chan, Tr. 660, 662-63, 711-12; RX 620 at ENHL TC 17809, *in camera*). Chan found that the discounts at Evanston Hospital were substantially larger than HPH's discounts. (Chan, Tr. 739, 711-13, 715-16). {[redacted]} (RX 620 at ENHL TC 17810, *in camera*; Chan, Tr. 714-17).

Response to Finding No. 658:

Respondent's finding is misleading and incomplete. The level of discounts in a contract is just one component of the actual price or reimbursement per case. Without complete information on, for example, ENH's chargemaster, a full and accurate comparison of actual reimbursement is impossible. (*See* CCRFF 657). {[redacted]}

[redacted] (RX 620 at ENHL TC 17809, *in camera*).

659. {[redacted]} (RX 663 at ENHL TC 16939, *in camera*; Chan, Tr. 671; Chan, Tr. 852-53, *in camera*).

Response to Finding No. 659:

Respondent's finding is misleading and incomplete. The level of discounts in a contract is just one component of the actual price or reimbursement per case. Without complete information on, for example, ENH's chargemaster, a full and accurate comparison of actual reimbursement is impossible. (*See* CCRFF 657).

660. {[redacted]} (RX 663, at ENHL TC 16939, *in camera*; Chan, Tr. 853-54, *in camera*).

Response to Finding No. 660:

Respondent's finding is misleading and incomplete. The level of discounts in a contract is just one component of the actual price or reimbursement per case. Without complete information on, for example, ENH's chargemaster, a full and accurate comparison of actual reimbursement is impossible. (*See* CCRFF 657).

661. {[redacted]} (RX 620 at ENHL TC 17811, *in camera*). {[redacted]} (RX 620 at ENHL TC 17811, *in camera*; Chan, Tr. 716-17).

Response to Finding No. 661:

Respondent's finding is misleading and incomplete. The level of discounts in a contract is just one component of the actual price or reimbursement per case. Without complete information on, for example, ENH's chargemaster, a full and accurate comparison of actual reimbursement is impossible. (*See* CCRFF 657).

662. A week after writing her first memo, Chan wrote another memo to Gilbert and Newton on September 30, 1999, comparing the rates of HPH and Evanston Hospital's contracts on a contract-by-contract basis. (RX 625 at ENH JL 8293). {[redacted]} (Chan, Tr. 825, *in camera*).

Response to Finding No. 662:

Respondent's finding is misleading and incomplete. The level of discounts in a contract is just one component of the actual price or reimbursement per case. Without complete information on, for example, ENH's chargemaster, a full and accurate comparison of actual reimbursement is impossible. (*See* CCRFF 657).

663. Chan found that Evanston Hospital's effective discount for inpatient services was 54.11%, while HPH's effective discount was only 38.78%. (RX 625 at ENH JL 8294). HPH would have received over $5 million less in revenue for inpatient services for the year if it applied Evanston Hospital's rates. (RX 625 at ENH JL 8294; Chan, Tr. 723). For outpatient services, HPH would have received $2.881 million less in revenue for the year if it applied Evanston Hospital's rates, and just under $8 million less in revenue for the year overall if inpatient and outpatient services were combined. (RX 625 at ENH JL 8294; Chan, Tr. 722-24). This figure was based on 80% of HPH's managed care contracts. (RX 625 at ENH JL 8294; Chan, Tr. 724). If the remaining 20% of HPH's contracts were also examined, HPH may have lost even more revenue. (Chan, Tr. 724).

Response to Finding No. 663:

Respondent's finding is misleading and incomplete. The level of discounts in a contract is just one component of the actual price or reimbursement per case. Without complete information on, for example, ENH's chargemaster, a full and accurate

comparison of actual reimbursement is impossible. (*See* CCRFF 657).

664. Chan also examined individual MCO rates with the hospitals, and found that PHCS had a much larger effective discount with Evanston Hospital, 51.98%, than with HPH, 17%. (RX 625 at ENH JL 8294; Chan, Tr. 718-19). Chan also found that there was a significant difference between Evanston Hospital's effective discount with United, 60.59%, and HPH's effective discount with United, 15%. (RX 625 at ENH JL 8294; Chan, Tr. 719-20).

Response to Finding No. 664:

Respondent's finding is misleading and incomplete. The level of discounts in a contract is just one component of the actual price or reimbursement per case. Without complete information on, for example, ENH's chargemaster, a full and accurate comparison of actual reimbursement is impossible. (*See* CCRFF 657).

665. In the Highland Park Healthcare Board of Directors meeting on October 22, 1999, Chan and Gilbert reported that "applying ENH's hospital contract rates to [HPH] would reduce [HPH's] annual net revenue from managed care payors by approximately $8,000,000." (RX 674 at ENHL TC 17915).

Response to Finding No. 665:

Respondent's finding is misleading and incomplete. The level of discounts in a contract is just one component of the actual price or reimbursement per case. Without complete information on, for example, ENH's chargemaster, a full and accurate comparison of actual reimbursement is impossible. (*See* CCRFF 657).

666. {[redacted]} (RX 663 at ENHL TC 16939, *in camera*).

Response to Finding No. 666:

Respondent's finding is misleading and incomplete. The level of discounts in a

contract is just one component of the actual price or reimbursement per case. Without complete information on, for example, ENH's chargemaster, a full and accurate comparison of actual reimbursement is impossible. (*See* CCRFF 657).

667. Evanston Hospital's negotiator, Sirabian was surprised to learn that HPH was getting higher rates than Evanston Hospital. (Sirabian, Tr. 5717-18). For example, Sirabian was surprised to learn that HPH had higher rates with United. (Sirabian, Tr. 5763)

Response to Finding No. 667:

Respondent's finding is incomplete. Mr. Sirabian was aware years prior to the merger that Evanston's rates with United were below Evanston's costs. (Sirabian, Tr. 5712). He testified that he notified United negotiators that United's rates were lower than Evanston's rates as compared to other health plans with whom Evanston contracted. (Sirabian, Tr. 5712).

668. Sirabian expected all of Evanston Hospital's rates to be higher than HPH's rates because Evanston Hospital was an academic institution and HPH was a community hospital, and the types and quality of care provided by the two organizations were very different. (Sirabian, Tr. 5718).

Response to Finding No. 668:

The cited source does not say what Respondent's finding claims. Mr. Sirabian does not use the term "academic" institution, but rather "teaching" institution. The terms are not synonymous, and not everyone in the industry uses the terms in the same way. (*See* CCRFF 99). Respondent's finding is incomplete and misleading. The conclusion that Evanston had lower rates than HPH pre-merger is contradicted by other record evidence. (*See* CCRFF 657).

669. Even Spaeth was surprised to learn that HPH had better rates on the majority of MCO contracts. He assumed that an academic medical center with highly sophisticated care like

Evanston Hospital would have better rates than a community hospital like HPH. (Spaeth, Tr. 2297).

Response to Finding No. 669:

Respondent's finding is incomplete and misleading. The conclusion that Evanston had lower rates than HPH pre-merger is contradicted by other record evidence. (*See* CCRFF 657).

b. At The Time Of The Merger, Evanston Hospital Learned About The Demand For Its Services Through Bain's Consulting Services

670. Bain & Co. ("Bain") was a consulting firm hired by Evanston Hospital, in part, to give advice to Evanston Hospital's management regarding contract negotiations. (Chan, Tr. 652). Evanston Hospital specifically engaged Bain for help with the Merger in the Fall of 1999. (Neaman, Tr. 1159). Bain provided advice and analysis pertaining to the Merger and was paid about $1 million for this work. (Neaman, Tr. 1148; Hillebrand, Tr. 1800).

Response to Finding No. 670:

Complaint counsel have no specific response.

671. Kim Ogden, an operating Vice President at Bain, was responsible for overseeing the merger related work done by Bain. (RX 2047 at 6 (Ogden, Dep.). Ogden did not testify live at trial, but portions of her deposition testimony were admitted into evidence. Ogden did not work for Bain at the time of her deposition. Presently, she works in an unpaid position running a non-profit organization. (RX 2047 at 2 (Ogden, Dep.).

Response to Finding No. 671:

Complaint Counsel have no specific response.

672. Bain examined Evanston Hospital's and HPH's managed care contracts in October and November 1999. (Hillebrand, Tr. 1849, 1851; RX 652).

Response to Finding No. 672:

Complaint Counsel have no specific response.

673. Bain had a kick-off meeting with Evanston Hospital management to talk about

what benefits may result from the Merger and where Bain should focus its efforts. As a result of the meeting, two projects became a priority for Bain: (1) a review of Evanston Hospital's service lines became a priority because Evanston Hospital was in the process of planning its capital expenditures; and (2) a review of Evanston Hospital's contracts also became a top priority in light of the discovery that several of Evanston Hospital's contracts had expired. (RX 2047 at 10 (Ogden, Dep.)).

Response to Finding No. 673:

Complaint Counsel have no specific response.

674. Bain believed that the Merger provided Evanston Hospital with opportunities to expand its geographic reach, add new services, consolidate existing services to improve quality, develop centers of excellence, eliminate duplicate costs, engage in benchmarking and relieve Evanston Hospital's capacity constraints through capital investments at HPH. (RX 2047 at 8-9, 14 (Ogden, Dep.)).

Response to Finding No. 674:

Respondent's finding is incomplete. Bain also focused on the additional leverage that would be achieved through unified contracting between Evanston and Highland Park. Bain advised ENH that the "merger provides the opportunity to . . . negotiate contracts with payors from a stronger position." (CX 2072 at 1). The focus of Bain's merger work was "growing net income by leveraging contracting and service line opportunities created by the Highland Park merger." (CX 74 at 3).

Bain consistently advised ENH that ENH's "negotiating leverage [with health plans] should increase with increased scale." Thus, ENH should "leverage HP" to "maximize scale benefits." (CX 74 at 22). Bain counseled that "the addition of Highland Park will substantially improve ENH's leverage." (CX 74 at 19). According to Bain, ENH had "significant leverage" with health plans because the combined ENH/Highland Park entity would be the largest in admissions volume in the Chicago area. (CX 74 at

15). Bain calculated that post-merger, ENH had attained a 55% market share. (CX 1607 at 5). ENH understood that Bain's use of the term "leverage" incorporated the concept of bargaining power in contract negotiations with health plans. (Hillebrand, Tr. 1801-02).

675. As to the benchmarking opportunities presented by the Merger, Evanston Hospital believed that HPH was not a well-run hospital, and there was an opportunity to share Evanston Hospital's best practices with HPH to improve both quality and costs. (RX 2047 at 9 (Ogden, Dep.)). The best examples of areas where Evanston Hospital could enhance HPH's capabilities included obstetrics, cardiac care and oncology. (RX 2047 at 14 (Ogden, Dep.)).

Response to Finding No. 675:

Respondent's finding that "HPH was not a well-run hospital" is contradicted by other record evidence. Highland Park was a good hospital prior to the merger. (*See* CCFF 2295-2323). The quality of care at HPH up until the year 2000 was "very good, if not excellent." (Newton, Tr. 376). The hospital was well-respected in the community and considered by many to be one of the "finest community hospitals in the country." (Newton, Tr. 301; *see also* Spaeth, Tr. 2095). Pre-merger, HPH had a "very good" obstetrics program. (*See* CCFF 2331). HPH also had decided to develop a cardiac surgery program and was actively pursuing a joint cancer care program with other hospitals, including Evanston, all before the merger. (*See* CCFF 2357-2373, 2374-2380).

676. After Bain completed its "Initial Review," Evanston Hospital organized teams under Hillebrand's guidance to begin the negotiating process with various MCOs. (Hillebrand, Tr. 1851).

Response to Finding No. 676:

Complaint Counsel have no specific response.

i. Bain Advised ENH That HPH Had More Favorable MCO Contracts

677. Until 1999, Evanston Hospital management believed that it was "getting good rates." (RX 2047 at 61 (Ogden, Dep.)). But Bain advised ENH that HPH's contract rates "were just better." (RX 2047 at 11 (Ogden, Dep.)). HPH had much higher per diems than Evanston Hospital, and HPH "negotiated structurally better." (RX 2047 at 11 (Ogden, Dep.)). HPH was doing a much better job than Evanston Hospital on the contracting side.

Response to Finding No. 677:

Respondent's finding is misleading and incomplete to the extent that it implies that HPH generally had better contracts than Evanston pre-merger. According to Jack Sirabian, Evanston's contract negotiator, for only about one third of the 35 or 40 contracts between health plans and Highland Park were the contract rates at Highland Park higher than the rates for Evanston. (Sirabian, Tr. 5717). In addition, record evidence contradicts the contention that HPH generally had better contracts. (*See* CCRFF 657).

678. In contrast, Sirabian had a "very loose style," was not organized and was "not on top of contracting at all." (RX 2047 at 11 (Ogden, Dep.)). This was "highlighted by what [ENH] learned about Highland Park's contracting." (RX 2047 at 11 (Ogden, Dep.)).

Response to Finding No. 678:

Respondent's finding is contradicted by other record evidence. Both Jack Sirabian and Jeff Hillebrand, who were in charge of health plan negotiations, were recognized for doing effective jobs. (Sirabian, Tr. 5728; Neaman, Tr. 1220). During the period in which Mr. Sirabian was responsible for contracting, he received positive evaluations from both Mr. Neaman and Mr. Hillebrand for his work at Evanston. (Sirabian, Tr. 5728).

Mr. Hillebrand had and still has general oversight and supervisory responsibility for health plan contracting. (Hillebrand, Tr. 1701-02; Neaman, Tr. 1220). Mr. Neaman believed Mr. Hillebrand to be an effective negotiator, with a good understanding of the

marketplace and ENH's relationships with health plans. Mr. Neaman never criticized Mr. Hillebrand about ENH's pre-merger contracts with health plans. (Neaman, Tr. 1220).

679. Strikingly, in 8 out of the 13 contracts that Bain compared in a November 1999 presentation, HPH had more favorable contract terms than Evanston Hospital. (Hillebrand, Tr. 1803; CX 75 at 6). Bain completed a side-by-side comparison of Evanston Hospital's and HPH's hospital contracts and found that, "[i]n general, HPH generates more revenue per case on a [case-mix] adjusted basis" and "higher revenue per day on a [case mix] adjusted basis." (RX 1995 at 8-9).

Response to Finding No. 679:

As an initial matter, Respondent's finding on Evanston's pre-merger rates relative to HPH is irrelevant to the question of exercise of market power. Whatever the rates of Evanston or Highland Park were prior to the merger, after the merger, ENH demanded (and generally achieved) the higher of the two contract rates plus a premium. (*See* CCFF 848-903). ENH also demanded (and received) the same rate for all three of its facilities. (*See* CCFF 822-847). Thus, both Evanston and HPH post-merger were able to escalate rates for individual contracts up from pre-merger levels, supporting the conclusion that the combined entity was exercising market power that was unavailable to each hospital pre-merger. ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCFF 1313-1328).

In addition, the contention that Evanston had lower prices is contradicted by Respondent's own experts' analysis. {[redacted]} (*See* CCFF 1805-1808).

Finally, if in some instances Evanston had lower prices than HPH pre-merger for

certain health plans, volume differentials is part of the explanation. [redacted] (*See, e.g.*, RX 757 at 1 ([redacted]), *in camera*). Hospitals often exchange lower prices for the promise of a greater volume of patients through its doors. (Hillebrand, Tr. 1761; Dorsey, Tr. 1474-75; Ballengee, Tr. 160-62 (PHCS would have expected to receive lower rates at Evanston prior to the merger because PHCS sent more dollars to Evanston than Highland Park.).

680. For example, Bain's analysis revealed that HPH's United contract was roughly two times more favorable than Evanston Hospital's United contract. (RX 684 at BAIN 43; Hillebrand, Tr. 1893). From this information, Hillebrand learned that United was paying Evanston roughly 45-50% of what United was paying HPH. (Hillebrand, Tr. 1869; RX 684 at BAIN 43).

Response to Finding No. 680:

Respondent's finding on Evanston's pre-merger rates relative to HPH is irrelevant to the question of exercise of market power. Post-merger, ENH raised rates to the higher of the HPH or Evanston pre-merger rates plus a premium. (*See* CCFF 848-903). ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCRFF 679).

Respondent's finding is also contradicted by evidence from Dr. Noether, Respondent's expert. [redacted] (Haas-Wilson, Tr. 2646 (discussing DX 7047, *in camera*), *in camera*). [redacted]

[redacted] (Haas-Wilson, Tr. 2646-47 (discussing DX 7047 ([redacted]), *in camera*), *in camera*). [redacted] (CCFF 1805, *in camera*). [redacted] (CCFF 1805, *in camera*). [redacted] (CCFF 1805, *in camera*). (*See also*, CCFF 1806-07 (further describing Dr. Baker's analysis on pre-merger price comparisons for inpatient and outpatient breakdowns)).

681. [redacted] (Hillebrand, Tr. 1870; Neaman, Tr. 1340-41; RX 684 at BAIN 73; Haas-Wilson, Tr. 2851-52, *in camera*). [redacted] (RX 679 at ENHL RG at 4135; Chan Tr. 857-59, *in camera*). Put simply, United was paying Evanston Hospital "less than at a fair rate and less than other comparable institutions." (Hillebrand, Tr. 1872). [redacted]

[redacted] (RX 694 at ENHL TC 8787, *in camera*).

Response to Finding No. 681:

Respondent's finding on Evanston's pre-merger rates relative to HPH is irrelevant to the question of exercise of market power. Post-merger, ENH raised rates to the higher of the HPH or Evanston pre-merger rates plus a premium. ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCRFF 679).

In addition, calculations based on Dr. Noether's and Dr. Baker's materials contradict the contention that Evanston had lower pre-merger prices than HPH for United. (*See* CCRFF 680).

682. Hillebrand was "beyond surprised" by the gap between the rates that HPH was getting from United and what Evanston Hospital was getting from that MCO. (Hillebrand, Tr. 1871). Hillebrand had believed that United was paying Evanston Hospital on par with academic medical centers for many years before 2000. (Hillebrand, Tr. 1871). Up until receiving this advice, Hillebrand believed that Evanston Hospital had better contracts than HPH. (Hillebrand, Tr. 1853).

Response to Finding No. 682:

Respondent's finding on Evanston's pre-merger rates relative to HPH is irrelevant to the question of exercise of market power. Post-merger, ENH raised rates to the higher of the HPH or Evanston pre-merger rates plus a premium. ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCRFF 679).

In addition, calculations based on Dr. Noether's and Dr. Baker's materials contradict the contention that Evanston had lower pre-merger prices than HPH for United. (*See* CCRFF 680).

683. Similarly, Neaman was "shocked that here we were, Evanston, the big . . . teaching place with all of the services running around, and for example, with United, we're

getting half of what a community hospital is." (Neaman, Tr. 1344-45). Specifically, Neaman was "shocked" to learn that HPH had better rates, particularly on the United contract. (Neaman, Tr. 1342).

Response to Finding No. 683:

Respondent's finding on Evanston's pre-merger rates relative to HPH is irrelevant to the question of exercise of market power. Post-merger, ENH raised rates to the higher of the HPH or Evanston pre-merger rates plus a premium. ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCRFF 679).

In addition, calculations based on Dr. Noether's and Dr. Baker's materials contradict the contention that Evanston had lower pre-merger prices than HPH for United. (See CCRFF 680).

684. {[redacted]} (RX 2047 at 61 (Ogden, Dep.); CX 75 at 11; RX 684 at BAIN 48; Neaman, Tr. 1341; Chan, Tr. 860-61, *in camera*). Ogden attended a meeting with United, during which the "woman who was negotiating for United was – seemed very embarrassed when it was raised in the meeting that Highland Park's rates were so much higher than Evanston's. You know the United contract itself was from 1994, . . . the rates. So obviously Evanston was extraordinarily behind because it hadn't been negotiated at all, and she . . . made several comments that suggested she was going to go back and fix this. So there was acknowledgment that . . . some changes need to be made in the rates." (RX 2047 at 31 (Ogden, Dep.)).

Response to Finding No. 684:

Respondent's finding is misleading and incomplete to the extent that it implies that ENH's post-merger price increases to United were completely attributable to a catch-up from the 1994 contract. Prior to negotiations, Bain targeted the United contract as a "1st Priority" contract with "upside revenue potential" for which the merged entity "had enough leverage to improve terms." (CX 75 at 9-10). ENH strategized to use its "55%

market share" and its status as the "preferred provider in the region by a margin of 2X or greater" as bargaining leverage during the negotiations with United. (CX 1607 at 5). According to United, "ENH proposed above market, non-negotiable contract rate increases under threat of system-wide termination." United "recogniz[ed] the strategic importance of ENH's geographic exclusivity," and "was forced to accept the ENH contract proposal." (CX 21 at 5).

{[redacted]} (CX 6279 at 19, *in camera*. *See also* CCFF 672-677, *in camera*). {[redacted]} (Foucre, Tr. 1081-82, *in camera*; CX 2281 at 4, *in camera*). United experienced a number of substantial price increases following the merger but had no option to create alternative networks. (*See* CCFF 999-1015).

685. Bain also advised Evanston Hospital that HPH had higher reimbursement rates with PHCS. (Hillebrand, Tr. 1892). Bain estimated that PHCS's rates with HPH were 30-35% higher than Evanston Hospital's rates. (Hillebrand, Tr. 1893; RX 684 at BAIN 43).

Response to Finding No. 685:

Respondent's finding on Evanston's pre-merger rates relative to HPH is irrelevant to the question of exercise of market power. Post-merger, ENH raised rates to the higher of the HPH or Evanston pre-merger rates plus a premium. ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCRFF 679).

686. {[redacted]} (RX 718 at 6,

in camera; Chan, Tr. 865-66 (*in camera*). {[redacted]} (RX 718 at 6, *in camera*). {[redacted]} (RX 718 at 6, *in camera*).

Response to Finding No. 686:

Respondent's finding on Evanston's pre-merger rates relative to HPH is irrelevant to the question of exercise of market power. Post-merger, ENH raised rates to the higher of the HPH or Evanston pre-merger plus a premium. ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCRFF 679).

PHCS's competitive savings with Evanston pre-merger was also due to the volume of business that PHCS directed to Evanston through its contract. Ms. Ballengee of PHCS testified that PHCS would have expected to receive lower rates at Evanston prior to the merger because PHCS sent more dollars to Evanston than Highland Park. (Ballengee, Tr. 160-62. *See* Hillebrand, Tr. 1761 (Hospitals often exchange lower prices for the promise of a greater volume of patients through its doors)).

687. {[redacted]} (RX 762 at ENHL TC 9917, 9924 *in camera*; RX 2047 at 57 (Ogden, Dep.); CX 67 at 39).

Response to Finding No. 687:

Respondent's finding on Evanston's pre-merger rates relative to HPH is irrelevant to the question of exercise of market power. Post-merger, ENH raised rates to the higher of the HPH or Evanston pre-merger plus a premium. ENH's price increases were

contrary to market trends to hold pricing flat or to discount further. (*See* CCRFF 679).

Respondent's finding is misleading and incomplete to the extent that it implies that ENH's post-merger price increases to PHCS were completely attributable to a catch-up from the original Evanston contract. Prior to negotiations, Bain targeted the PHCS contract as a "1st Priority" contract with "upside revenue potential" for which the merged entity "had enough leverage to improve terms." (CX 75 at 9-10). Bain advised ENH that it had "the required leverage to gain PHCS's agreement to improved terms." This was because PHCS was heavily reliant on the combined ENH/HP entity, with ENH/HP constituting "over 30% of [PHCS's] North Shore admissions." (CX 67 at 39).

Faced with substantial price increase demands during the 2000 renegotiations, PHCS consulted its customers about the possibility of eliminating ENH from its network, but found that customers "made it very clear . . . that they didn't believe that they could have a marketable network . . . without having the new ENH entity in it." (Ballengee, Tr. 180-81, 183-84). After months of negotiation with ENH from December 1999 to early 2000 (*see* CCFF 1036-1084), PHCS accepted a 60% increase in the rates it had to pay under the new contract. (Ballengee, Tr. 179, 196). {[redacted]} (*See* CCFF 1046-1050, 1086, *in camera*).

688. [redacted] (RX 718 at 6-7, *in camera*).

Response to Finding No. 688:

Respondent's finding on Evanston's pre-merger rates relative to HPH is irrelevant

to the question of exercise of market power. Post-merger, ENH raised rates to the higher of the HPH or Evanston pre-merger rates plus a premium. ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCRFF 679).

In addition, Respondent's finding is misleading and incomplete to the extent that it implies that ENH's post-merger price increases to PHCS were completely attributable to a catch-up from the original Evanston contract. Bain recognized that ENH post-merger had greater bargaining strength and advised ENH to use it to extract higher prices. (*See* CCRFF 687).

689. {[redacted]} (RX 762 at ENHL TC 9936, *in camera*).

Response to Finding No. 689:

Respondent's finding on Evanston's pre-merger rates relative to HPH is irrelevant to the question of exercise of market power. Post-merger, ENH raised rates to the higher of the HPH or Evanston pre-merger rates plus a premium. ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCRFF 679).

In addition, calculations based on Dr. Noether's and Dr. Baker's materials contradict the contention that Evanston had lower pre-merger prices than HPH for Aetna. (*See* CCRFF 680).

Finally, Respondent's finding is incomplete and misleading. {[redacted]} (RX 762 at ENHL TC 9936, *in camera*). {[redacted]}

[redacted] (RX 762 at ENHL TC 9936, *in camera*).

690. {[redacted] (RX 762 at ENHL TC 9942, *in camera*). {[redacted] (RX 762 at ENHL TC 9942, *in camera*).

Response to Finding No. 690:

Respondent's finding on Evanston's pre-merger rates relative to HPH is irrelevant to the question of exercise of market power. Post-merger, ENH raised rates to the higher of the HPH or Evanston pre-merger rates plus a premium. ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCRFF 679).

In addition, Respondent's finding is misleading and incomplete. First, for most service in Cigna contracts, a direct comparison between pre-merger Evanston and HPH rates is not possible because of difference in methodologies. (*See* CCRFF 780). Second, where comparisons are possible, Evanston had many other service categories with higher rates than HPH. (*See* CCRFF 780). {[redacted] (RX 762 at ENHL TC 9942, *in camera*).

691. HPH also had higher rates on the Humana PPO/Employers Health contract, but unlike Evanston Hospital, HPH did not have a Humana Staff Medicare or Humana Staff contract. (CX 75 at 6; Hillebrand, Tr. 1804).

Response to Finding No. 691:

Respondent's finding on Evanston's pre-merger rates relative to HPH is irrelevant to the question of exercise of market power. Post-merger, ENH raised rates to the higher

of the HPH or Evanston pre-merger rates plus a premium. ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCRFF 679).

{[redacted]} (*See* CCRFF 680, *in camera*). With regard to the two staff contracts mentioned, Respondent is apparently referring to physician contracts rather than contracts for inpatient hospital services. Moreover, the question of whether or not HPH had a Humana Staff Medicare contract is irrelevant, because Medicare is not included in the relevant market.

692. Evanston Hospital was "not very thoughtful about building in escalators for costs, medical cost increases, et cetera. So I think structurally Highland Park looked like it had just been more thoughtful." (RX 2074 at 11 (Ogden, Dep.); Hillebrand, Tr. 2043).

Response to Finding No. 692:

Respondent's finding on Evanston's pre-merger rates relative to HPH is irrelevant to the question of exercise of market power. Post-merger, ENH raised rates to the higher of the HPH or Evanston pre-merger plus a premium. ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCRFF 679).

In addition, calculations based on Dr. Noether's and Dr. Baker's materials contradict the contention that Evanston had lower pre-merger prices than HPH for a number of major health plans. (*See* CCRFF 680).

693. Evanston Hospital had some contract rates that were more favorable than HPH's contract rates. For example, Bain discovered that pre-merger Evanston Hospital's rates with Blue Cross' PPO were slightly higher than HPH's Blue Cross PPO rates. (Hillebrand, Tr. 1803; CX 75 at 6).

Response to Finding No. 693:

Respondent's finding on Evanston's pre-merger rates relative to HPH (whether higher or lower) is irrelevant to the question of exercise of market power. Post-merger, ENH raised rates to the higher of the HPH or Evanston pre-merger rates plus a premium. ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCRFF 679).

ii. Bain Advised ENH That It Had Expired Or Outdated MCO Contracts

694. Based on its evaluation of Evanston Hospital's contracts, Bain informed Evanston Hospital that it had many expired contracts with terms that varied greatly from contract to contract. (RX 652 at BAIN 9; RX 2047 at 9-11 (Ogden, Dep.)). For example, Bain discovered that the United (Metlife), United (Share), CIGNA PPO and HMO IL/MCNP contracts all had expired. (CX 74 at 20).

Response to Finding No. 694:

Respondent's finding is incomplete and misleading to the extent that it implies that ENH's post-merger price increases were entirely attributable to renegotiating expired contracts. Whatever the rates of Evanston or Highland Park were prior to the merger, after the merger, ENH demanded (and generally achieved) the higher of the two contract rates plus a premium. (*See* CCFF 848-903). ENH also demanded (and received) the same rate for all three of its facilities. (*See* CCFF 822-847). Thus, both Evanston and HPH post-merger were able to escalate rates for individual contracts up from pre-merger levels, supporting the conclusion that the combined entity was exercising market power that was unavailable to each hospital pre-merger. ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCFF 1313-1328).

Respondent's characterization of the United (Share), United (Metlife), Cigna PPO, and HMO IL/MCNP contracts as "expired" is incorrect. As of the time of the merger, these health plans were still reimbursing ENH under the terms of the contracts in question. (CX 74 at 20). It does not follow, therefore, that these contracts were "expired," as Respondent asserts.

695. Neaman and Hillebrand were "just horrified" when they found out that ENH had expired contracts, "so that was absolutely news to them." (RX 2047 at 19 (Ogden, Dep.)).

Response to Finding No. 695:

Respondent's finding is incomplete and misleading to the extent that it implies that ENH's post-merger price increases were entirely attributable to renegotiating expired contracts. ENH was able to obtain the higher of the two contracts pre-merger along with a premium. (*See* CCFF 848-903). This was contrary to market trends and supports the conclusion that the combined entity was exercising market power that was unavailable to them prior to the merger. (*See* CCFF 1313-1328).

696. Hillebrand considered the fact that Evanston Hospital had many expired contracts and no uniform rates among contracts "a call to action" because there seemed to be no apparent rhyme or reason to Evanston Hospital's contracts and contracting strategy. (Hillebrand, Tr. 1850).

Response to Finding No. 696:

Respondent's finding is incomplete and misleading to the extent that it implies that ENH's post-merger price increases were entirely attributable to renegotiating expired contracts. ENH was able to obtain the higher of the two contracts pre-merger along with a premium. (*See* CCFF 848-903). This was contrary to market trends and supports the conclusion that the combined entity was exercising market power that was unavailable to

them prior to the merger. (*See* CCFF 1313-1328). Furthermore, many of Evanston's contracts were "evergreen," with provisions for automatic annual renewal until a new contract was put in place. (*See, e.g.,* CCRFF 858, 878, 613). Also, as shown in CCRFF 694, Evanston's contracts were not "expired," because Evanston was still being reimbursed under these contracts as of the time of the merger. (CCRFF 694).

697. {[redacted]} (RX 762 ENHL TC 924, *in camera*).

Response to Finding No. 697:

Respondent's finding is not supported by the record citation: the bates page cited does not exist in the exhibit.

More generally, Respondent's finding is misleading and incomplete to the extent that it implies that ENH's post-merger price increases were entirely attributable to one-time adjustments on Evanston's contracts. ENH was able to obtain the higher of the two contracts pre-merger along with a premium. (*See* CCFF 848-903). This was contrary to market trends and supports the conclusion that the combined entity was exercising market power that was unavailable to them prior to the merger. (*See* CCFF 1313-1328). In addition, the price increases continued past the 2000 renegotiations. {[redacted]} (Foucre, Tr. 1091, 1096, *in camera*).

Indeed, in 2002, ENH embarked on a strategic pricing project to its chargemaster and ultimately raised its chargemaster's overall pricing by 8.5%. (Porn, Tr. 5685; CX 45

at 8). This 2002 chargemaster price increase resulted in a projected gross charge impact of $102.2 million annually, and a net impact of $20 million to $26 million annually. (Porn, Tr. 5686-85; CX 45 at 8). This increase was also characterized as a "one-time 'catch-up' adjustment." (RX 1170 at DC 2008.)

698. {[redacted]} (RX 762 at ENHL TC 9909, *in camera*). {[redacted]} (RX 762 at ENHL TC 9909, *in camera*). {[redacted]} (RX 762 at ENHL TC 9909, *in camera*).

Response to Finding No. 698:

Respondent's finding on Evanston's pre-merger rates relative to HPH is irrelevant to the question of exercise of market power. Post-merger, ENH raised rates to the higher of the HPH or Evanston pre-merger rates plus a premium. ENH's price increases were contrary to market trends to hold pricing flat or to discount further. (*See* CCRFF 679).

{[redacted]} (RX 762 at ENHL TC 9909, *in camera*).

699. {[redacted]} (RX 762 at ENHL TC 9910, *in camera*). {[redacted]} (RX 762 at ENHL TC 9913, *in camera*). {[redacted]} (RX 762 at ENHL TC 9911, *in camera*). {[redacted]} (RX 762 at ENHL TC 9913, *in camera*). {[redacted]} (RX 705 at ENHL JL 23052; Chan, Tr. 862-863, *in camera*).

Response to Finding No. 699:

Respondent's finding is misleading and incomplete to the extent that it implies that ENH's post-merger price increases were entirely attributable to one-time adjustments on Evanston's contracts. ENH was able to obtain the higher of the two contracts pre-merger along with a premium. (CCFF 848-903). This was contrary to market trends and supports the conclusion that the combined entity was exercising market power that was unavailable to them prior to the merger. (*See* CCFF 1313-1328).

In addition, Respondent's finding on the size of Humana's losses is misleading and incomplete. Included in Bain's analysis are over $6 million in losses associated with the Humana Medicare HMO. (CX 74 at 8; *see also* RX 762 at ENHL TC 9911 ({ }), *in camera*). These losses were much greater than the approximately $2 million in losses for the commercial HMO product. (CX 74 at 8). At issue in this case are commercial insurance customers, not Medicare.

700. { } (Haas-Wilson, Tr. 2849-51, *in camera*).

Response to Finding No. 700:

Respondent's finding is incomplete and misleading. { } (Haas-Wilson, Tr. 2851, *in camera* (emphasis added). Regardless of whether Evanston was pricing below competitive levels before the merger or not, after the merger, ENH's price levels were above competitive levels, even those of the major teaching hospitals in the Chicago area,

which ENH claims are its competitors. (*See* CCFF 1952-1965 (discussing how ENH flunked its own learning about demand test)). However, the fact remains that ENH's competitors are not the major teaching hospitals in the Chicago area. (*See* CCRFF 1059).

iii. Bain Advised ENH That It Was Under-Market As Compared To Its Peer Academic Hospitals

701. According to Bain, Evanston Hospital had a good position in the market before the Merger, but it had not negotiated MCO contract rates based on that position. (RX 2047 at 34 (Ogden, Dep.)). As a result, Evanston Hospital was "very far behind in the marketplace, and that seemed to be supported by the reactions of payors." (RX 2047 at 31 (Ogden, Dep.)).

Response to Finding No. 701:

Respondent's finding is incomplete and misleading. Despite the supposed importance of ENH's changes in negotiating strategy in late 1999, there are no contemporaneous business records mentioning ENH's alleged goal to price at the level of academic hospitals. (*See* Hillebrand, Tr. 2051-61 (acknowledging that Bain's contracting strategy recommendations did not describe pricing at academic hospital levels)). Nowhere in Bain's contracting strategy documents did Bain mention that ENH should price at "academic' hospitals' levels. Nowhere did Bain make any pricing comparisons between ENH and any other hospital except Highland Park. (*See* CX 74 (October 1999 Initial Review); CX 75 (November 1999 Project Review); CX 1998 (January 2000 Project Review); CX 67 (February 2000 Final Project Review)). Mr. Neaman did not recall Bain making any recommendations that ENH's price should be at the level of other types of hospitals besides Highland Park. Mr. Neaman did not recall any comparisons made by Bain in the context of its 1999-2000 contracting recommendations comparing ENH to other hospitals besides Highland Park. (Neaman, Tr. 1386-87).

702. In a November 1999 presentation by Bain, Evanston Hospital learned, generally speaking, that other academic hospitals similar to Evanston Hospital were getting much higher prices than Evanston Hospital. (Neaman, Tr. 1345).

Response to Finding No. 702:

Respondent's finding is incomplete and misleading. There are no contemporaneous business records mentioning ENH's alleged goal to price at the level of academic hospitals. (*See* CCRFF 701).

Because Bain did not use the term "academic hospital" in its presentations to ENH management, one cannot tell what hospitals are meant to be included in that term. Different industry participants use different criteria and terminology to classify hospitals. (*See* CCRFF 99).

In any event, even on Respondent's own terms, Evanston's pre-merger and ENH's post-merger charges were comparable to or higher than sophisticated hospitals in the area that Dr. Noether classified as in the relevant geographic market. These hospitals included a major teaching hospital, St. Francis and hospitals that treat cases as complex on average as ENH, including Rush North Shore, Resurrection, and St. Francis. (*See* CCFF 1858-1906).

Thus, St. Francis met the MedPAC criteria for a major teaching hospital and was identified as a teaching hospital in a 1999 ENH competitive analysis. (*See* CCFF 1858-1860). Resurrection Medical Center and Rush North Shore Medical Center treated, on average, more complex cases than ENH, as did St. Francis. (*See* CCFF 1863-1866, 1886-1906). {[redacted]}

[redacted] (RX 1912 at 149, 152, *in camera*). [redacted]

[redacted] (RX 1912 at 149, 152, *in camera*).

703. Initially, Hillebrand was skeptical of Bain's report, but once he was convinced that Bain's data was accurate, he felt embarrassed to find out ENH was not priced with its peer group of hospitals. (Hillebrand, Tr. 1853-54; RX 2047 at 30 (Ogden, Dep.)). Hillebrand inferred from Bain's presentation that if ENH was being paid much less than HPH, a community hospital, then ENH had to be faring worse than its peer academic medical centers. (Hillebrand, Tr. 1853-54).

Response to Finding No. 703:

Respondent's finding is incomplete and misleading. There are no contemporaneous business records mentioning ENH's alleged goal to price at the level of academic hospitals. (*See* CCRFF 701). Mr. Hillebrand specifically acknowledged this fact. (Hillebrand, Tr. 2051-61).

iv. Bain Advised ENH On MCO Contract Renegotiations

(1) Bain Advised ENH On A Post-Merger Negotiation Strategy

704. In the November 1999 presentation, Bain prioritized contracts for renegotiation – dividing them into first and second priorities. (CX 75 at 9). Bain suggested that Evanston Hospital begin renegotiating the expired contracts first. (RX 2047 at 30 (Ogden, Dep.); CX 75 at 9). Bain identified the Humana, United, HMO Illinois and PHCS contracts all as first priority contracts to renegotiated. (CX 75 at 10).

Response to Finding No. 704:

Respondent's finding on the division of priority contracts is incomplete. One of the factors in analyzing which contracts to renegotiate was also the degree of "leverage to improve terms." (CX 75 at 9). Bain recommended to delay renegotiation for those contracts were there was "insufficient leverage to improve terms." (CX 75 at 9).

705. Bain's contracting advice from the Summer of 1999 through 2000 was not tied specifically to the Merger. (Hillebrand, Tr. 1847; RX 2047 at 24-25 (Ogden, Dep.)). Bain advised Evanston Hospital/ENH to seek higher rates regardless of whether the Merger was consummated. (Neaman, Tr. 1347).

Response to Finding No. 705:

Respondent's finding is incomplete and misleading. Bain also focused on the additional leverage that would be achieved through unified contracting between Evanston and Highland Park. Bain advised ENH that the "merger provides the opportunity to . . . negotiate contracts with payors from a stronger position." (CX 2072 at 1). The focus of Bain's merger work was "growing net income by leveraging contracting and service line opportunities created by the Highland Park merger." (CX 74 at 3). The addition of Highland Park's volume was a specific component in Bain's recommendations on contracting strategy. (*See* CCRFF 674).

706. Nevertheless, Bain advised Evanston Hospital that improvements in the quality of service offered as a result of the Merger, if consummated, would have a positive impact on managed care contracting. (RX 2047 at 15 (Ogden, Dep.)).

Response to Finding No. 706:

Respondent's finding is incomplete and misleading. Bain also focused on the additional leverage that would be achieved through unified contracting between Evanston and Highland Park. Bain advised ENH that the "merger provides the opportunity to . . . negotiate contracts with payors from a stronger position." (CX 2072 at 1). The focus of Bain's merger work was "growing net income by leveraging contracting and service line opportunities created by the Highland Park merger." (CX 74 at 3). The addition of Highland Park's volume was a specific component in Bain's recommendations on

contracting strategy. (*See* CCRFF 674).

707. Bain gave specific recommendations for Evanston Hospital's proposal to United, which was the first health plan in the new round of contract negotiations. (Hillebrand, Tr. 1740, 1868-69; Neaman, Tr. 1339). In particular, Bain recommended a "one-time corrective adjustment" given that Evanston Hospital's rates with United had not been renegotiated since 1994. (Hillebrand, Tr. 1870; RX 684 at BAIN 73; RX 2047 at 45 (Ogden, Dep.); CX 1607 at 4).

Response to Finding No. 707:

Respondent's finding is incomplete and misleading to the extent that it implies that Evanston was not aware that United's contract had not been renegotiated since 1994 and that Evanston was not attempting to renegotiate United's contract prior to the merger. Mr. Sirabian was aware years prior to the merger that Evanston's rates with United were below Evanston's costs. (Sirabian, Tr. 5712). He testified that he notified United negotiators that United's rates were lower than Evanston's rates as compared to other health plans with whom Evanston contracted. (Sirabian, Tr. 5712). Mr. Sirabian also testified that he had attempted to renegotiate United's contract starting in 1995 when the contract's initial term had ended but was never successful. (Sirabian, Tr. 5711).

708. The intention was to take the rates Evanston Hospital received from United as a benchmark into the subsequent negotiations with other health plans. (Hillebrand, Tr. 1740-41). The discount-off-charges rates negotiated with United were intended to be the benchmark for future negotiations. (Hillebrand, Tr. 1741). For the smaller payors, the rates negotiated with United would be a minimum threshold. (Hillebrand, Tr. 1741).

Response to Finding No. 708:

Complaint Counsel have no specific response.

709. Evanston Hospital began renegotiating its United contract in October 1999. (Hillebrand, Tr. 1851-52, 1868-69). Bain participated directly in the United negotiations. (Hillebrand, Tr. 1734, 1852, 1869; Neaman, Tr. 1339).

Response to Finding No. 709:

Respondent's finding is incomplete and misleading, because it overstates the involvement of Ms. Ogden and Bain in the 1999 United negotiations. Ms. Ogden admitted that she only attended one negotiation meeting with United, that Bain representatives did not attend the subsequent meetings with United, and that she does not know when ENH and United finalized the United contract. (RX 2047 at 168 (Ogden, Dep.)).

(2) Bain Advised ENH On Negotiation Tactics

710. Bain was tasked, in part, with helping post-Merger ENH develop a new contracting approach and philosophy, specifically to bring more rigor and more data to the contracting process. (Hillebrand, Tr. 1846-47).

Response to Finding No. 710:

Complaint Counsel have no specific response.

711. Before 1999, Bain had recommended that Evanston Hospital engage Bain to teach Evanston Hospital employees how to be more aggressive with MCOs in negotiations. (Neaman, Tr. 1149). Evanston Hospital did not engage Bain to consult on managed care contracting until 1999. (Hillebrand, Tr. 1734-35).

Response to Finding No. 711:

Complaint Counsel have no specific response.

712. In late 1999, Bain again approached Evanston Hospital to offer advice about MCO negotiations. This time, however, Neaman engaged Bain to provide such advice. (Neaman, Tr. 1343-44; Hillebrand, Tr. 1854-55). This led to a fairly major shift in Evanston Hospital's negotiating tactics with health plans starting in mid- to late-1999. (Neaman, Tr. 1217).

Response to Finding No. 712:

Respondent's finding is incomplete. Part of the "major shift" in ENH's negotiating strategy in the months prior to the closing of the merger was incorporating the

additional leverage that would be achieved through unified contracting between Evanston and Highland Park. Bain advised ENH that the "merger provides the opportunity to . . . negotiate contracts with payors from a stronger position." (CX 2072 at 1). The focus of Bain's merger work was "growing net income by leveraging contracting and service line opportunities created by the Highland Park merger." (CX 74 at 3). The addition of Highland Park's volume was a specific component in Bain's recommendations on contracting strategy. (*See* CCRFF 674).

713. Bain made several recommendations regarding contracting strategy. First, Bain recommended that ENH "start by asking for a percent of charges even though [Bain] had no expectation that [ENH] would end up there, but as an opening bid, that was a way for [MCOs] to then respond to [ENH] with per diems, and [ENH] could understand where they were coming from." (RX 2047 at 62 (Ogden, Dep.); Hillebrand, Tr. 1757, 1854-55; RX 684 at BAIN 53).

Response to Finding No. 713:

Complaint Counsel have no specific response.

714. Bain and ENH never discussed whether to terminate negotiations if it did not get a discount-off-charges arrangement. (RX 2047 at 62 (Ogden, Dep.)). Rather, "[t]he full anticipation was that . . . [ENH] would have per diems, and [its] minimal accepted terms were all in terms of per diems." (RX 2047 at 62 (Ogden, Dep.)).

Response to Finding No. 714:

Complaint Counsel have no specific response.

715. Second, Bain suggested that ENH ask for a price higher than what it might ultimately be satisfied with. (RX 2047 at 62 (Ogden, Dep.)). {[redacted]} (Hillebrand, Tr. 1856; RX 2047 at 31 (Ogden, Dep.); RX 718 at 7, *in camera*). {[redacted]} **(RX 718 at 87, *in camera*).** "Targeting 10 percent above the best contract from either hospital" was ENH's "aggressive goal." (RX 2047 at 31 (Ogden, Dep.)).

Response to Finding No. 715:

Respondent's finding is incomplete and misleading to the extent that it implies that ENH generally did not achieve rates at least as good as the better of the HPH and Evanston contracts. In renegotiation contracts following the merger, ENH demanded the higher of the two contract rates plus a premium. (*See* CCFF 848-859). In summarizing the ENH merger integration project, Bain concluded, "In the end, we found that our client [ENH] had significant leverage over payors, and in most cases, were able to achieve terms at or above the best contract currently in existence between the two hospitals." (CX 1991 at 3).

In addition, RX 717 is not in evidence. This is contrary to the Judge's April 6, 2000 Order.

716. Third, Bain encouraged ENH to set minimum contract rate targets. (RX 2047 at 48 (Ogden, Dep.)). {[redacted]} (RX 718 at 6, *in camera*). {[redacted]} (CX 5072, at 23, 29, *in camera*; Chan, Tr. 866, *in camera*).

Response to Finding No. 716:

Respondent's finding is incomplete and misleading to the extent that it implies that ENH generally did not achieve rates at least as good as the better of the HPH and Evanston contracts. (*See* CCRFF 715).

717. Fourth, Bain suggested that ENH adopt a more aggressive, face-to-face negotiating style – including the use of an "internal bad guy" in certain negotiations to demonstrate the seriousness of ENH's requests. (RX 2047 at 51 (Ogden, Dep.)). For example, Bain gave ENH advice on the steps of the United negotiation such as who was going to talk first and what they were going to say. (RX 2047 at 45 (Ogden, Dep.)). From previous negotiations with Sirabian, United knew that Sirabian was a "pushover." Therefore, Bain recommended using

an "internal bad guy" to "show them [United] that we're serious and that we're not just going to take whatever you give us." (RX 2047 at 51 (Ogden, Dep.)).

Response to Finding No. 717:

Respondent's finding on United's characterization of Mr. Sirabian's negotiating style is based on inadmissible hearsay and/or is speculative. In her testimony, Ms. Ogden provided no basis for Respondent to claim that United "knew" that Mr. Sirabian was a pushover. (*See* RX 2047 at 51 (Ogden, Dep.)). There is no indication that United, either directly or through its actions, informed Ms. Ogden of its state of mind.

718. Finally, Bain advised that ENH should talk about what it can "bring to the table," something Evanston Hospital had not been doing. (RX 2047 at 31 (Ogden, Dep.)). Bain helped ENH come up with a clear articulation of who ENH "was and had been for five years and just wasn't getting credit for." (RX 2047 at 31 (Ogden, Dep.)).

Response to Finding No. 718:

Respondent's finding is incomplete to the extent that it implies that Bain's negotiating advice to ENH in what it could "bring to the table" was limited to pre-merger Evanston. Part of the shift in ENH's negotiating strategy in the months prior to the closing of the merger was incorporating the additional leverage that would be achieved through unified contracting between Evanston and Highland Park. Bain advised ENH that the "merger provides the opportunity to . . . negotiate contracts with payors from a stronger position." (CX 2072 at 1). The focus of Bain's merger work was "growing net income by leveraging contracting and service line opportunities created by the Highland Park merger." (CX 74 at 3). The addition of Highland Park's volume was a specific component in Bain's recommendations on contracting strategy. (*See* CCRFF 674).

719. In putting together the contracting strategy, Bain analyzed "payer's economics."

(RX 2047 at 36-37 (Ogden, Dep.); CX 74 at 5). Evanston Hospital had not been "gathering a lot data around what was happening in the marketplace, and we [Bain] believed that that was important to inform, provide a context for these negotiations, . . . we're looking for a big catch-up here." (RX 2047 at 36-37 (Ogden, Dep.)). It was important to understand the MCOs' financial conditions – "[a]re these payers losing money and, therefore, they're going to be really resistant to it, to what we're asking which is a big catch up." (RX 2047 at 37 (Ogden, Dep.)). Bain advised that it was "really just a basic part of any negotiation strategy [to] . . . understand who you are negotiating with, how they are doing." (RX 2047 at 37 (Ogden, Dep.)).

Response to Finding No. 719:

Respondent's finding is misleading to the extent that it implies the "payer economic" analysis did not address bargaining leverage between ENH and the health plan in question. Part of the shift in ENH's negotiating strategy in the months prior to the closing of the merger was incorporating the additional leverage that would be achieved through unified contracting between Evanston and Highland Park. Bain advised ENH that the "merger provides the opportunity to . . . negotiate contracts with payors from a stronger position." (CX 2072 at 1). The focus of Bain's merger work was "growing net income by leveraging contracting and service line opportunities created by the Highland Park merger." (CX 74 at 3). The addition of Highland Park's volume was a specific component in Bain's recommendations on contracting strategy. (*See* CCRFF 674).

Bain provided ENH with "action plans" for individual health care plan negotiations. (*See, e.g.*, CX 1998 at 44, 49). These action plans analyzed the bargaining strength that the combined Evanston-HPH entity had over the health plans in order to obtain better rates. (CX 1998 at 44, 49).

For example, for the PHCS negotiations in early 2000, Bain concluded that ENH could negotiate better terms because "ENH has significant leverage in negotiations with

PHCS as they have strong North Shore presence and need [ENH] in their network." (CX 1998 at 44). Bain advised ENH that it had "the required leverage to gain PHCS's agreement to improved terms." This was because PHCS was heavily reliant on the combined ENH/HP entity, with ENH/HP constituting "over 30% of [PHCS] North Shore admissions." (CX 67 at 39).

By contrast, for the early 2000 negotiations with Blue Cross's HMO (HMO Illinois), Bain concluded that "negotiations will be challenging given their strong strategic position in [Illinois]." (CX 1998 at 49). According to Bain, HMO Illinois at that time had the largest market share of any HMO in Illinois. (CX 1998 at 49). Bain noted that "[t]his negotiation will be challenging because ENH's relative leverage with HMO IL is less than with most payors." (CX 67 at 36).

720. Bain also looked at the "importance of ENH and [HPH] to payers' position." (RX 2047 at 37 (Ogden, Dep.); CX 74 at 5). The goal was to understand how likely it was that a particular MCO would "walk away from the table." (RX 2047 at 37 (Ogden, Dep.)). In "any contract negotiation . . . across any industry, you start with understanding who they are, who you are negotiating with." (RX 2047 at 37 (Ogden, Dep.)). Bain found that ENH was about the same importance . . . across may different MCOs, and it was one of many hospitals that they negotiated with." (RX 2047 at 37 (Ogden, Dep.)). Bain also found that HPH was too small to make a difference to MCOs, *i.e.* the importance of Evanston Hospital to a MCO did not differ from the importance of Evanston Hospital and HPH together to a MCO. (RX 2047 at 38 (Ogden, Dep.)).

Response to Finding No. 720:

Respondent's finding is incomplete. Bain's action plans providing individualized contracting advice analyzed the bargaining strength that the combined Evanston-HPH entity had over the health plans in order to obtain better rates. (*See* CCRFF 719). In addition, according to Bain, ENH had "significant leverage" with health plans because the combined Evanston/Highland Park entity would be the largest in admissions volume in

the Chicago area. (CX 74 at 15). The addition of HPH added an additional third in the total number of admissions to the combined Evanston-HPH entity over Evanston alone. (CX 74 at 15). ENH understood that Bain's use of the term "leverage" incorporated the concept of bargaining power in contract negotiations with health plans. (Hillebrand, Tr. 1801-02).

Furthermore, health plan representatives testified that the addition of HPH created a combined entity with a unified coverage of a critical geographic area. This significantly changed the negotiating dynamic between ENH and the health plans. Ms. Foucre of United testified that United could not terminate its contract with ENH because United "could not have a viable network that would support our sales and growth objectives without the Evanston Northwestern Healthcare system." (Foucre, Tr. 901-902, 925-926; *see also* CCFF 999-1001). Other health plan representatives testified to the same thing: a network without the combined ENH/HPH was not viable. (*See, e.g.*, CCFF 1080-1084 (PHCS experience); CCFF 1152-1162 (One Health experience); CCFF 1204-1210 (Aetna experience); 1281-1288 (Unicare experience)).

721. Bain laid out a template for ENH to use in its contract negotiations "that highlighted that they should be doing an annual review, and the data that they should put together before every negotiation, and then some thoughts on how to conduct the negotiation itself." (RX 2047 at 61 (Ogden, Dep.)). Bain's role was to help ENH with "some of the analysis of the marketplace that would communicate that we had done our homework." (RX 2047 at 45 (Ogden, Dep.)).

Response to Finding No. 721:

Complaint Counsel have no specific response.

722. One of the key strengths Bain brought to the Merger project was its data. (Neaman, Tr. 1165-66). Some of the data Bain used with its Merger project came from public

sources, some from ENH's financial books and the rest from Bain's proprietary data set. (Neaman, Tr. 1219). Because Bain performed work for various insurance companies, the proprietary data set Bain used in connecting with its Merger project contained, in part, information about these companies and their profitability. (Neaman, Tr. 1219).

Response to Finding No. 722:

Complaint Counsel have no specific response.

723. Bain's advice led to a shift by ENH in its negotiating tactics, including a "willingness to lose contracts." (Neaman, Tr. 1218). These changes in strategy were a change for Evanston Hospital because its prior strategy had been to maintain, develop and enhance relationships with MCOs. (Hillebrand, Tr. 1854-55).

Response to Finding No. 723:

Respondent's finding is incomplete. Part of the shift in ENH's negotiating strategy in the months prior to the closing of the merger was incorporating the additional leverage that would be achieved through unified contracting between Evanston and Highland Park. Bain advised ENH that the "merger provides the opportunity to . . . negotiate contracts with payors from a stronger position." (CX 2072 at 1). The focus of Bain's merger work was "growing net income by leveraging contracting and service line opportunities created by the Highland Park merger." (CX 74 at 3). The addition of Highland Park's volume was a specific component in Bain's recommendations on contracting strategy. (*See* CCRFF 674).

In addition, Respondent's finding is misleading to the extent that it implies that Evanston did not attempt to obtain the best rates possible. Due to rising costs and other economic pressures in the mid to late 1990s, Evanston attempted to negotiate more "stringent" and "higher rates" charged to health plans. (Sirabian, Tr. 5744).

Finally, Mr. Sirabian understood that terminating contracts was an option to be

used during negotiations. He did terminate some health plans during his tenure. (Sirabian, Tr. 5750-53).

724. Although Bain's advice led ENH to change its tactics, ENH's bargaining position did not change. (Hillebrand, Tr. 1726, 1733). While Bain thought the Merger provided several benefits to ENH, "[w]e weren't trying to renegotiate based on a changed position because of the merger. We said we need to renegotiate because we don't have a contract. You haven't negotiated with us in five years. Here is who Evanston is, and it really was overwhelmingly a focus on Evanston" and what Bain thought was "fair market value." (RX 2047 at 32 (Ogden, Dep.)).

Response to Finding No. 724:

Respondent's finding is incomplete and misleading. Bain provided its contracting strategy in the context of the merger integration effort, and Bain's advice expressly incorporated the additional leverage that would be achieved through unified contracting between Evanston and Highland Park. Bain advised ENH that the "merger provides the opportunity to . . . negotiate contracts with payors from a stronger position." (CX 2072 at 1). The focus of Bain's merger work was "growing net income by leveraging contracting and service line opportunities created by the Highland Park merger." (CX 74 at 3). The addition of Highland Park's volume was a specific component in Bain's recommendations on contracting strategy. (*See* CCRFF 674).

More fundamentally, the health plan representatives expressly testified that ENH's bargaining position did change after the merger. ENH was able to extract higher rates from health plans because health plans could not afford to have a North Shore geographic hole in their coverage. (*See* CCRFF 720).

725. During the course of examining Evanston Hospital/ENH's contracting tactics in late 1999 and 2000, Neaman expressed his concerns that aggressive tactics might risk losing contracts to the Bain representatives and to ENH's own negotiators. (Neaman, Tr. 1348). In

response to Neaman's concerns that aggressive negotiating tactics might risk the loss of contracts, Bain put together a contingency plan in the event ENH did lose MCO contracts. (Neaman, Tr. 1349).

Response to Finding No. 725:

Complaint Counsel have no specific response.

v. Bain's Advice Paid Off – But The Successful Contract Renegotiations Were Not Due To The Merger

726. Some of ENH's 2000 contract renegotiations resulted in higher prices and, with the exception of one contract, ENH did not lose any contracts as a result of those renegotiations. (Hillebrand, Tr. 1757).

Response to Finding No. 726:

Respondent's finding is misleading and contradicted by the record evidence. According to Mr. Hillebrand, the one contract ENH lost during the 2000 renegotiations was One Health. (Hillebrand, Tr. 1757). One Health did accept ENH's termination in July 2000. (CX 266 at 1). However, soon after the termination, One Health discovered that it was losing membership and could not market a network without ENH. (*See* CCFF 1152-1158). Faced with this lack of viability, One Health re-opened negotiations and surrendered to ENH's pricing demands and contract terms. (*See* CCFF 1159-1177).

727. ENH's ability to get better contract terms after the Merger was, in part, dictated by improvements in the capabilities of the contracting team after the Merger as a result of Bain's recommendations. (RX 2047 at 15 (Ogden, Dep.)).

Response to Finding No. 727:

Respondent's finding is incomplete to the extent that it implies that Respondent's "ability to get better contract terms" post-merger was not attributable to additional bargaining leverage due to the HPH merger. Bain provided its contracting strategy in the

context of the merger integration effort, and Bain's advice expressly incorporated the additional leverage that would be achieved through unified contracting between Evanston and Highland Park. Bain advised ENH that the "merger provides the opportunity to . . . negotiate contracts with payors from a stronger position." (CX 2072 at 1). The focus of Bain's merger work was "growing net income by leveraging contracting and service line opportunities created by the Highland Park merger." (CX 74 at 3). The addition of Highland Park's volume was a specific component in Bain's recommendations on contracting strategy. (*See* CCRFF 674).

In summarizing the ENH merger integration project, Bain concluded, "In the end, we found that our client [ENH] had significant leverage over payors, and in most cases, were able to achieve terms at or above the best contract currently in existence between the two hospitals." (CX 1991 at 3).

728. The Merger thus "provided a catalyst, an opportunity to get serious about some of [the things listed in CX 2072] like reducing costs . . . and that was definitely the case on the contracting side." (RX 2047 at 36 (Ogden, Dep.)). The Merger provided ENH with a good opportunity to renegotiate its outdated and under-market contracts. (RX 2047 at 30 (Ogden, Dep.)).

Response to Finding No. 728:

Respondent's finding is incomplete and misleading to the extent that it implies that Bain did not advise ENH that the post-merger entity had greater bargaining strength and that ENH should take advantage of that increased strength to obtain better rates from health plans. Bain provided its contracting strategy in the context of the merger integration effort, and Bain's advice expressly incorporated the additional leverage that would be achieved through unified contracting between Evanston and Highland Park.

Bain advised ENH that the "merger provides the opportunity to . . . negotiate contracts with payors from a stronger position." (CX 2072 at 1). The focus of Bain's merger work was "growing net income by leveraging contracting and service line opportunities created by the Highland Park merger." (CX 74 at 3). The addition of Highland Park's volume was a specific component in Bain's recommendations on contracting strategy. (*See* CCRFF 674).

729. During these contract negotiations, the Merger was discussed only to the extent that it provided an opening explanation of "why we're sitting down together and here is who is at the table," *i.e.* ENH needed a contract that covered all of the hospitals. (RX 2047 at 33 (Ogden, Dep.)). The Merger was not discussed "in the sense of . . . we're a completely changed entity now." (RX 2047 at 33 (Ogden, Dep.)).

Response to Finding No. 729:

Respondent's finding is irrelevant. Whether or not ENH discussed its increased bargaining strength due to the merger in renegotiation discussions does not take away from the fact that Bain advised ENH that the "merger provides the opportunity to . . . negotiate contracts with payors from a stronger position" and that Bain utilized the increased bargaining strength from the merger to formulate negotiation strategies. (CX 2072 at 1; *see also* CCRFF 674).

In any event, Respondent's finding is contradicted by the record evidence. {[redacted]} (Holt-Darcy, Tr. 1529-30, 1544-45, *in camera*).

730. The broader geographic coverage provided by the Merger impacted ENH's

managed care contracting, except in the sense that "[i]t is easier for payers to administer contracts if they have got one contract versus lots and to know that that contract looks pretty much the same. That is a good thing or was a good thing in the payers' mind." (RX 2047 at 15 (Ogden, Dep.)). She further believed that if Evanston Hospital would have done exactly what Bain had told them to do even without the Merger, then it "would have had the same rates." (RX 2047 at 29 (Ogden, Dep.)).

Response to Finding No. 730:

Respondent's finding relating to the broader geographic coverage is nonsensical as written. If Respondent intended to state that the broader geographic coverage did not impact on ENH's contracting, that finding is contradicted by other record evidence. Testimony from health plan representatives established that the broader geographic coverage of the combined Evanston-HPH entity had a significant impact on the negotiating dynamic. Health plans no longer had the option of combining either Evanston or Highland Park with another hospital to provide coverage for the crucial North Shore area. (*See* CCFF 969, 999-1015, 1030 (United experience); CCFF 1080-1084 (PHCS experience); CCFF 1152-1162 (One Health experience); CCFF 1204-1210 (Aetna experience); CCFF 1281-1288 (Unicare experience)).

In addition, Respondent's finding based on Ms. Ogden's response to a hypothetical situation is speculative. Ms. Ogden is a fact witness, not an expert, and her opinion is an inadmissible extension in expert witness territory.

Finally, the last sentence is not supported by the record citation. Ms. Ogden did not testify that Evanston would have received the same rates even without the merger on the cited portion of her testimony. (RX 2047 at 29 (Ogden, Dep.)).

731. HPH was a "tiny hospital" and the Merger did not change ENH's "position in the marketplace at all." (RX 2047 at 33 (Ogden, Dep.)). Pre-Merger HPH was able to get better

rates because their process was better and they had better people doing the contracting. (RX 2047 at 33 (Ogden, Dep.)). "[T]here was no other reason that they would have had such far superior rates." (RX 2047 at 33 (Ogden, Dep.)). What ENH did on the contracting side post-Merger was to apply "better people and a better process." (RX 2047 at 33 (Ogden, Dep.)).

Response to Finding No. 731:

Respondent's finding that HPH was a "tiny hospital" with no impact upon ENH's position is contradicted by other evidence, including a contemporaneous presentation by Bain. According to Bain, ENH had "significant leverage" with health plans because the combined ENH/Highland Park entity would be the largest in admissions volume in the Chicago area. (CX 74 at 15). According to the presentation, the addition of HPH to Evanston added approximately 10,000 admissions on top of Evanston's 30,000 admissions in 1998, or approximately one-third of Evanston's total admissions for that year. (CX 74 at 15).

Respondent's finding that pre-merger HPH was able to obtain better rates is contradicted by other record evidence that shows that Evanston in fact had higher pre-merger rates. (*See* CCRFF 657).

Respondent's finding on ENH's post-merger contracting methodology is incomplete. ENH also utilized its additional bargaining leverage due to the merger as set forth in Bain's strategy and individual action plans. (*See* CCRFF 674).

Health plans also testified that ENH's bargaining position did change post-merger. Health plans no longer had the option of combining either Evanston or Highland Park with another hospital to provide coverage for the crucial North Shore area. (*See* CCFF 969, 999-1015, 1030 (United experience); CCFF 1080-1084 (PHCS experience); CCFF

1152-1162 (One Health experience); CCFF 1204-1210 (Aetna experience); CCFF 1281-1288 (Unicare experience)).

732. The rates that ENH ended up with after the Merger "were not significantly higher . . . than rates that already existed in the market for a lot of other hospitals." ENH "just played catch up." (RX 2047 at 34 (Ogden, Dep.)).

Response to Finding No. 732:

Respondent's finding is based on inadmissible speculation by Ms. Ogden and is contradicted by record evidence. In her deposition, Ms. Ogden specifically admitted that she did not have knowledge of other Chicago hospitals' rates. (RX 2047 at 34 (Ogden, Dep.)).

In any event, post-merger ENH's prices exceeded those of many hospitals, including hospitals that were teaching facilities or treated cases more complex than those treated at ENH. (*See* CCRFF 702).

733. In the end, "almost all of the upside [in the contract negotiations] – was just from negotiating contracts and doing it in a systematic, data-driven way." (RX 2047 at 24-25 (Ogden, Dep.)). There was also "value from understanding Highland Park's contracts and the process they had gone through in negotiating their contracts, the benchmarking." (RX 2047 at 25 (Ogden, Dep.)). "[A]rmed with that knowledge, . . . Evanston could have absolutely got the same contracting rates they did without Highland Park's . . . volume" and geographic scope. (RX 2047 at 25 (Ogden, Dep.)). "I think Evanston was just so far behind." (RX 2047 at 25 (Ogden, Dep.)).

Response to Finding No. 733:

Respondent's finding on what Evanston could have achieved without the merger is based on Ms. Ogden's response to a hypothetical situation is speculative. Ms. Ogden is a fact witness, not an expert, and her opinion is an inadmissible extension in expert witness territory.

Respondent's finding that the increase in rates was due to process improvements is contradicted by other record evidence. In summarizing the ENH merger integration project, Bain concluded, "In the end, we found that our client [ENH] had significant leverage over payors, and in most cases, were able to achieve terms at or above the best contract currently in existence between the two hospitals." (CX 1991 at 3).

c. Individual MCO Negotiations Are Consistent With The Learning About Demand Theory

734. {[redacted]} (Noether, Tr. 6105-06, *in camera*).

Response to Finding No. 734:

Respondent's finding is incorrect. {[redacted]} (Haas-Wilson, Tr. 2732-33, 2830-31, *in camera*. *See* CCFF 694-738, *in camera*). Dr. Haas-Wilson's pricing analysis led her to conclude that "the merger between Evanston Hospital and Highland Park Hospital enhanced the market power of ENH, and after the merger, January 1, 2000, the merged entity exercised that market power." (Haas-Wilson, Tr. 2451).

735. The individual post-Merger negotiations confirm that the contract rate increases at issue were not anticompetitive. After the Merger, ENH negotiated lower prices than HPH's previous discount-off-charges rates for inpatient services at United's PPO/POS plan, PHCS, CCN, Health Network, Preferred Plan and First Health. (RX 871 at ENH JL 3239).

Response to Finding No. 735:

Respondent's finding is incorrect. No conclusion can be drawn regarding the "prices" of ENH and HPH from simply looking at the effective discounts listed in RX 871 (Respondent's source), because effective discounts are discounts taken off of the hospital's list prices, or chargemaster. Prior to the merger, Evanston Hospital and Highland Park Hospital had their own separate chargemasters. Unless one knows the prices in the chargemaster, one cannot know which discount will yield the highest price. [redacted] (Newton, Tr. 365-66; RX 1687 at ENHL BW 027653, *in camera*).

Further it is impossible that Highland Park's pre-merger prices were higher than ENH's post-merger prices because, as ENH and Highland Park executives testified, ENH used the more favorable of the Evanston or Highland Park contract rates as a *"starting point"* in health plan renegotiations *"and then add[ed] a premium to that."* (Hillebrand, Tr. 1856, 1705; Newton, Tr. 364 (emphasis added). *See* CCRFF 591). [redacted] (Chan, Tr. 819-20, *in camera*; Spaeth, Tr. 2201-02, 2172-73).

[redacted]

[redacted] (CX 6279 at 4, *in camera*). [redacted] (CX 6279 at 5, *in camera*).

Respondent also fails to properly differentiate between "rates" and "prices" in RFF 736. [redacted] (Haas-Wilson, Tr. 2645, *in camera*). [redacted] (Haas-Wilson, Tr. 2645, *in camera*. *See* CCFF 696-702, *in camera*).

736. ENH also negotiated lower prices than HPH's previous discount-off-charges rates for outpatient services at PHCS, CCN, Health Network, Preferred Plan, First Health, and the State of Illinois. (RX 871 at ENH JL 3239).

Response to Finding No. 736:

Neither ENH's nor Highland Park's rates for outpatient services are relevant in this case, because outpatient services are not included in the relevant product market. (Haas-Wilson, Tr. 2660). The relevant product market in this case is the market for "general acute care inpatient services sold to managed care organizations." (Haas-Wilson, Tr. 2451-52). Hospitals offer inpatient and outpatient services, but they are not

demand side or supply side substitutes. (Haas-Wilson, Tr. 2663).

Further, Respondent's finding is incorrect. No conclusion can be drawn regarding the "prices" of ENH and HPH from simply looking at the effective discounts listed in RX 871 (Respondent's source), because effective discounts are discounts taken off of the hospital's list prices, or chargemaster. (*See* CCRFF 735, *in camera*). Pre-merger, Evanston and Highland Park had their own chargemasters. Without knowing the chargemaster, one cannot tell which discount yields the higher price. {[redacted]} (Haas-Wilson, Tr. 2645, *in camera*).

737. Since 2000, ENH has seen price increases with some contracts, price decreases with some contracts, and no pricing changes with other contracts. (Hillebrand, Tr. 1710). The primary MCO negotiations at issue are discussed below.

Response to Finding No. 737:

The cited source does not say what Respondent's finding claims. Mr. Hillebrand testified that, since 2000, ENH has only decreased its prices for the Humana product. (Hillebrand, Tr. 1710). With the exception of the Humana contract, Mr. Hillebrand testified that none of the price increases implemented by ENH in 2000 during contract renegotiations were rescinded. In fact, since 2000, there have been even more price increases to health plans. (Hillebrand, Tr. 1709-10).

i. Aetna

(1) Evanston Hospital's Pre-Merger Contract Rates With Aetna Were Outdated And Undermarket

738. Aetna's relationship with Evanston Hospital before 2000 was not friendly, and Aetna was perceived in the marketplace as being "anti-provider." (Hillebrand, Tr. 1895).

Response to Finding No. 738:

Complaint Counsel note the inherent contradiction in Respondent claiming that Aetna was "anti-provider" in RFF 738, while citing an Aetna document in RFF 599 that claims that there was a friendly relationship between Aetna and Evanston pre-merger. (*See* RFF 599; RX 105 (Aetna executive Barbara Hill wrote in 1995 to Neaman that "[w]hat went wrong for us in the Advocate-Aetna relationship was Advocate's 'take it or leave it' negotiating stance. I know your team at Evanston has a friendlier approach!").

In any event, this finding is irrelevant. This case is about Evanston's 2000 merger with Highland Park Hospital, not about Evanston's judgment of whether particular health plans were "anti-provider" or not. Further, ENH's self-serving testimony regarding the Aetna is not corroborated by contemporaneous documents or un-biased testimony.

739. In 1995, Aetna and Evanston Hospital engaged in contract renegotiations. (RX 84 at ENHL JL 1097). {[redacted]} (Mendonsa, Tr. 556, *in camera*).

Response to Finding No. 739:

Complaint Counsel have no specific response.

740. Evanston's negotiator, Sirabian, had an extremely conciliatory approach to the discussions. For example, Sirabian wrote with regard to rates proposed in 1995: "This represents [ ] a significant adjustment for us and is being offered in recognition of your efforts to satisfy our requirements." (RX 84 at ENHL JL 1097). Sirabian continued by offering to reduce Evanston Hospital's current rates for obstetric services to amounts in place more than two years before the 1995 negotiations. (RX 84 at ENHL JL 1097). Further, Evanston Hospital rolled back its normal delivery and Caesarian section per case rates by 15%. (RX 84 at ENHL JL 1097).

Response to Finding No. 740:

The finding is incomplete and misleading. Pricing pressures from Aetna as well

as other health plans escalated in the 1990s for both Evanston and Highland Park. In 1997, Mr. Neaman wrote that that "[p]ricing pressures, as anticipated five years ago, have continued to grow." (Neaman, Tr. 1151; CX 2037 at 2. *See* Hillebrand, Tr. 1725 (Mr. Hillebrand believes that in the 1990s ENH was at a disadvantage in negotiations with Blue Cross, Humana, and United because of the substantial collective market share of these three payers.)). {[redacted]} (Chan, Tr. 688-90, 716-20; CX 30 at 2; Chan, Tr. 824-26, *in camera*). Testimony from Mr. Neaman confirms that pre-merger, Evanston concern about being excluded from health plans' network of providers meant that the hospital lowered its pricing, increased the breadth, depth and quality of its services, and strove to control costs to remain in health plan networks. (Neaman, Tr. 961-62).

{[redacted]} (Haas-Wilson, Tr. 2472; Ballengee, Tr. 166-67; Mendonsa, Tr. 530, *in camera*; Holt-Darcy, Tr. 1517-9, *in camera*). Thus the specter of being excluded from a network affected the negotiating positions of the hospitals.

{[redacted]} (Chan, Tr. 688-90; CX 30 at 2; Chan, Tr. 824-26, *in camera*). {[redacted]} (Chan, Tr. 688-90; CX

30 at 2; Chan, Tr. 824-26, *in camera*).

741. Additionally, in 1995 Sirabian proposed to increase the discount-off-charges for non-ambulatory surgery outpatient services from 12% to 15%. (RX 84 at ENHL JL 1097). Sirabian concluded that, "[a]s is evident, this represents a substantial reduction in fees for [Evanston Hospital] especially when you consider that we would, under normal circumstances, be asking for higher rates for next year." (RX 84 at ENHL JL 1097).

Response to Finding No. 741:

The finding is incomplete and misleading because it leaves out the context in which Evanston was negotiating with managed care organizations. {[redacted]} (*See* CCRFF 740, *in camera*). Moreover, Evanston's pre-merger outpatient discounts are irrelevant, because outpatient services are not included in the relevant product market. (Haas-Wilson, Tr. 2659-60). {[redacted]} (Ballengee, Tr. 235, *in camera*; Mendonsa, Tr. 524-28, *in camera*. *See* Holt-Darcy, Tr. 1522, *in camera*).

742. Even after Sirabian offered these reductions to Aetna, Aetna continued to negotiate aggressively and later retracted an agreement that Evanston Hospital and Aetna had made verbally. (CX 2045 at 1). In response, Sirabian offered further reductions to Aetna in 1995 in search of a "win-win" relationship between Aetna and Evanston Hospital. (CX 2045 at 1).

Response to Finding No. 742:

The finding is incomplete and misleading because it leaves out the context in which Evanston was negotiating with managed care organizations. {[redacted]}

[redacted]

[redacted] (*See* CCRFF 740, *in camera*).

743. Sirabian offered to reduce existing HMO per diems by 5% and reduce obstetric rates by 10%. (CX 2045 at 1). Further, Sirabian proposed a stop loss provision that was more favorable to Aetna than the existing contract. (CX 2045 at 1). All of these concessions were aimed towards establishing the "win-win" situation with Aetna. (CX 2045 at 1).

Response to Finding No. 743:

The finding is incomplete and misleading because it leaves out the context in which Evanston was negotiating with Managed Care Organizations. [redacted]

[redacted] (*See* CCRFF 740, *in camera*).

744. [redacted] (Mendonsa, Tr. 563, *in camera*; CX 5001 at 2). [redacted] (Mendonsa, Tr. 533-34, 563, *in camera*).

Response to Finding No. 744:

The finding is incomplete and misleading because it leaves out the context in which Evanston was negotiating with Aetna. [redacted]

[redacted] (Mendonsa, Tr. 530, *in camera*. *See* CCRFF 740, *in camera*).

[redacted] (Mendonsa, Tr. 533-34, 540 *in camera*. *See* Mendonsa, Tr. 539-40, *in camera*; Mendonsa, Tr. 478 ([redacted] (*See* CCRFF 754, *in camera*).

[redacted] (For the increases in the chargemaster *see* CCFF 918-924, *in camera*).

Respondent's finding is misleading to the extent that it implies that a contract that is evergreen is necessarily disadvantageous to a provider. According to Ms. Chan, "[i]f the hospital really do [*sic*] not want to change the contract, if they have a really good contract, they would keep it evergreen." (Chan, Tr. 677-78).

745. [redacted] (Noether, Tr. 6095, *in camera*; RX 1912 at 34, *in camera*). [redacted] (Noether, Tr. 6095, *in camera*; RX 1912 at 34, *in camera*). [redacted] (Noether, Tr. 6096, *in camera*).

Response to Finding No. 745:

Respondent's finding is incorrect. Evanston and Highland Park's rates were identical for many service category offerings and very similar for those service categories that were not identical prior to the merger. (*Compare* CX 5001 *and* CX 5007. *See* CCFF 860-869, *in camera*). {[redacted]} (*See* CCRFF 740, *in camera*).

{[redacted]} (*Compare* CX 5001 at 4 *and* CX 5007 at 4; Hillebrand, Tr. 1948-52, *in camera*; Mendonsa, Tr. 550, *in camera*). Similarly, Highland Park and Evanston's pre-merger PPO rates to Aetna for Intensive Care, Coronary Care, OB-C-section and Boarder Baby were also identical. (*Compare* CX 5001 at 8 *and* CX 5007 at 10). For Aetna's POS product, rates at Highland Park and Evanston for Medical, Surgical, Intensive Care Unit, Coronary Care Unit, OB-Normal, OB-C-section, and Boarder Baby did not differ by more than 50 dollars. (*Compare* CX 5001 at 6 *and* CX 5007 at 7). The "discrepancy" in the medical/surgical per diem at Evanston and Highland Park discussed by Respondent above was only 40 dollars pre-merger. (*Compare* CX 5001 at 8 *and* CX 5007 at 10).

{ [redacted] } (*Compare* CX 5001 at 4, CX 5007 at 4 *and* CX 5008 at 5-6, *in camera*).

Evanston and Highland Park pre-merger rates relative to one another prior to the merger are irrelevant, because absent the merger, neither hospital was able to impose the price increases that the merged entity imposed after the merger. (CX 17 at 2 ("As stated previously, none of this could have been achieved by either Evanston or Highland Park alone."); CX 13 at 1 ("Neither Evanston nor Highland Park alone could achieve these results."); Hillebrand, Tr. 1722, 1816-17; *See* CCFF 696-702, *in camera*. *See* CCRFF 590, *in camera*). Post-merger, ENH was able to use the more favorable of the Evanston or Highland Park contract rates as a "starting point" in health plan renegotiations *"and then add[ed] a premium to that."* (Hillebrand, Tr. 1856, 1705; Newton, Tr. 364 (emphasis added). *See* CCRFF 590, *in camera*).

{ [redacted] } (Haas-Wilson, Tr. 2645-47

(discussing DX 7047, *in camera*), *in camera*. *See* Haas-Wilson, Tr. 2645 ({[redacted]}), *in camera*. *See also* CCFF 696-702, *in camera*). {[redacted]} (Baker, Tr. 4745-47, *in camera*).

(2) ENH's Post-Merger Negotiations With Aetna Were Not Anticompetitive

746. {[redacted]} (RX 769 at ENH JL 2817, *in camera*). Aetna noted that it could not "operationalize" the change in tax identification numbers until new agreements were executed. (RX 779 at 1).

Response to Finding No. 746:

Complaint Counsel have no specific response.

747. {[redacted]} (RX 769 at ENH JL 2817, *in camera*). {[redacted]} (RX 769 at ENH JL 2818-19, *in camera*).

Response to Finding No. 747:

The cited source does not say what Respondent's finding claims. {[redacted]} (RX 769, *in camera*). {[redacted]} (*See* CCRFF 745, *in camera*)

748. {[redacted]} (Mendonsa, Tr. 547, *in camera*). {[redacted]}

[redacted] (Mendonsa, Tr. 547, *in camera*).

Response to Finding No. 748:

Complaint Counsel has no specific response.

749. [redacted] (CX 123 at 1; Mendonsa, Tr. 546-47, 531, *in camera*).

Response to Finding No. 749:

Respondent's finding is incomplete. [redacted] (Mendonsa, Tr. 531 (describing CX 123 ([redacted])), *in camera*. *See also* Neaman, Tr. 1211-12; Hillebrand, Tr. 1764-65 (Messrs. Neaman and Hillebrand admitted that they did not believe that ENH's price demands had to change because of any risk that ENH would lose business to other hospitals or that other hospitals would change their prices in response to ENH's prices); Hillebrand, Tr. 1708 (With the exception of One Health for a short period of time, ENH did not lose a single health plan customer after the price increases.)).

750. [redacted] (Hillebrand, Tr. 1896; RX 769 at ENH JL 2818-19, *in camera*; CX 5174 at 11-12, *in camera*). Aetna, however, did not agree to that payment methodology. (Hillebrand, Tr. 1896). [redacted] (Mendonsa, Tr. 524, *in camera*).

Response to Finding No. 750:

Respondent's finding is incomplete. {[redacted]} (CX 5008 at 5-7, *in camera*). {[redacted]} (CX 5008 at 5-7, *in camera*). {[redacted]} (*See* CCRFF 754, *in camera*).

751. {[redacted]} (CX 5008 at 5-6, *in camera*; Hillebrand, Tr. 1896).

Response to Finding No. 751:

Respondent's finding is incomplete. {[redacted]} (CX 5008 at 5-7, *in camera*). {[redacted]} (*See* CCRFF 754, *in camera*).

752. {[redacted]} (RX 855 at ENHL BW 11393, *in camera;* CX 5007 at 5). {[redacted]} (RX 855 at 2, *in camera*). {[redacted]}. (CX 5008 at 7, *in camera*).

Response to Finding No. 752:

Respondent's finding is incomplete. {[redacted]} (*See* CCRFF 754, *in camera*). {[redacted]} (For the increases in the chargemaster *see* CCFF 918-924, *in camera*).

753. {[redacted]} (Mendonsa, Tr. 539, *in camera*; CX 2447, *in camera*; Hillebrand, Tr. 1897; Hillebrand, Tr. 1948, *in camera*). The increase was over a three year period and, after the third year, the rates would remain in place until they are superceded. (Hillebrand, Tr. 1897). {[redacted]} (Noether, Tr. 6097, *in camera*).

Response to Finding No. 753:

Respondent's finding is incomplete and misleading. {[redacted]} (Mendonsa, Tr. 523, *in camera*. *See* Hillebrand, Tr. 1836; RX 250 at ENH JL 008241 (Evanston pre-merger rates were based in part on increases in the Medical CPI); RX 808 at ENH JL 002021 (ENH post-merger yearly rate increases with Blue Cross (but no other health plan) were also based on Medical CPI. *See* CCRFF 777); CX 2085 at 1 (One Health benchmarked price increases against Medical CPI.)). {[redacted]}

[redacted] (Mendonsa, Tr. 533-34, 545, *in camera*). {[redacted]} (Mendonsa, Tr. 540, *in camera*). {[redacted]} (*See* CCRFF 754, *in camera*).

754. {[redacted]} (Mendonsa, Tr. 533-34, 564, *in camera*; Noether, Tr. 6096-97, *in camera*). {[redacted]} (Mendonsa, Tr. 564, *in camera*). {[redacted]} (Mendonsa, Tr. 530, *in camera*).

Response to Finding No. 754:

This finding is incomplete and misstates the record. {[redacted]} (Mendonsa, Tr. 533-34, 540 *in camera*. *See* Mendonsa, Tr. 539-40, *in camera*; Mendonsa, Tr. 478 ({[redacted]})).

[redacted] (Mendonsa, Tr. 518, 520, 530, *in camera*).

[redacted] (Mendonsa, Tr. 570, *in camera*).

[redacted] (Mendonsa, Tr. 530, *in camera*).

[redacted] (Mendonsa, Tr. 518, 520, 530, *in camera*).

[redacted] (CX 6279 at 4-5, *in camera*). [redacted] (CX 6279 at 18, *in camera*). In October 2000, Mr. Neaman reported to ENH's board of directors that the annualized economic value of the new Aetna contract would be $3 million – $2 million more than Bain's February 2000

prediction of what ENH would achieve in increased annual net revenue per year from Aetna. (CX 17 at 7; CX 67 at 32).

755. Overall, the Aetna-ENH negotiations in 2000 were very friendly. (Hillebrand, Tr. 1895-96). {[redacted]} (Mendonsa, Tr. 537, *in camera*). {[redacted]} (Mendonsa, Tr. 566, *in camera*).

Response to Finding No. 755:

The cited source does not say what Respondent's finding claims. {[redacted]} (Mendonsa, Tr. 537, *in camera*). {[redacted]} (Mendonsa, Tr. 537-38, *in camera*).

756. {[redacted]} (Hillebrand, Tr. 1897; Mendonsa, Tr. 556, *in camera*).

Response to Finding No. 756:

{[redacted]} (CX 5008 at 5, *in camera*). {[redacted]}

[redacted] (CX 20 at 1; Administrative Complaint, In the Matter of *Evanston Northwestern Healthcare*, February 10, 2004). {[redacted] (*See* RFF 752, *in camera*). {[redacted] (*see* CCFF 918-924, *in camera*) [redacted]}

ii. Blue Cross

(1) Evanston Hospital Pre-Merger Contract Rates Exceeded HPH's Pre-Merger Contract Rates

757. During the 1990s, Sirabian focused most of his attention on the Humana and Blue Cross contracts. (Sirabian, Tr. 5707). Sirabian made sure that the Humana and Blue Cross contracts were always current and up-to-date because the Humana and Blue Cross contracts represented a substantial portion of ENH's managed care business. (Sirabian, Tr. 5707).

Response to Finding No. 757:

The finding is incomplete and misleading. First, one Blue Cross contract was up for renegotiation in June 1998, but was not renegotiated until 2000. Second, the finding fails to mention that because of the great size of Blue Cross, Evanston and then ENH did not believe it could effectively negotiate with it. (CX 6304 at 16 (Livingston, Dep.)).

758. Since the late 1990s, Evanston Hospital has had an amicable relationship with Blue Cross. (Hillebrand, Tr. 1860). Hillebrand worked closely, and had good relationships, with many of the Blue Cross representatives. (Hillebrand, Tr. 1860).

Response to Finding No. 758:

The finding is incomplete and misleading. Evanston sought a relationship with Blue Cross prior to the merger because Evanston faced pre-merger competition for

inclusion in networks and "pricing pressures" from health plans. (Neaman, Tr. 961; CX 2037 at 2. *See* Hillebrand, Tr. 1725 (Mr. Hillebrand believes that in the 1990s ENH was at a disadvantage in negotiations with Blue Cross, Aetna, and United because of the substantial collective market share of these three payers.). *See also* CCRFF 597). Because of the great size of Blue Cross, Evanston could not effectively bargain with it. (CX 6304 at 16 (Livingston, Dep.)). In 1997, Mr. Neaman lamented to Evanston's board of directors that the hospital was experiencing "significant reductions in reimbursement" from Blue Cross in particular. (CX 2037 at 2-3; Neaman, Tr. 1151-52). {[redacted]} (Chan, Tr. 688-90; CX 30 at 2; Chan, Tr. 824-26, *in camera*).

759. During the 1990s, Blue Cross was always very fair and offered rates such that both sides would mutually benefit. (Sirabian, Tr. 5708).

Response to Finding No. 759:

The finding is incomplete and misleading. {[redacted]} (Haas-Wilson, Tr. 2626, 2728, *in camera*). {[redacted]}

[redacted] (Noether, Tr. 5992-93, 6000; Baker, Tr. 4721, *in camera*) [redacted] (RX 1912 at 61-63, *in camera*).

760. When Sirabian compared Evanston Hospital and HPH's respective contracts with Blue Cross, he learned that Evanston Hospital had better rates with that MCO. (Sirabian, Tr. 5708)

Response to Finding No. 760:

Complaint Counsel have no specific response.

(2) ENH's Post-Merger Negotiations With Blue Cross Were Not Anticompetitive

761. In anticipation of the effective date of the Merger, ENH opened the dialogue with Blue Cross on December 9, 1999. (RX 707). ENH notified Blue Cross that: (1) HPH would be integrated into the same legal entity and tax identification number as ENH; (2) HPH would cease to exist as a separate entity as of the date of the Merger; and, consequently (3) HPH's contract with Blue Cross would be terminated as of December 31, 1999. (RX 707). At the same time, ENH notified Blue Cross that it would initiate efforts to renegotiate the rates and terms of the ENH agreements. (RX 707).

Response to Finding No. 761:

Complaint Counsel have no specific response.

762. Effective January 1, 2000, ENH (including HPH), under its new name, began to provide hospital services to members of HMO Illinois under the rates, terms and conditions of the then-current Provider Agreement between Evanston Hospital and HMO Illinois. (RX 707).

Response to Finding No. 762:

Complaint Counsel have no specific response.

763. In March 2000, ENH initiated a renegotiation with Blue Cross. (Hillebrand, Tr. 1861; RX 707; RX 808 at ENH JL 2019). The contract negotiations were fairly straightforward. (Hillebrand, Tr. 1861).

Response to Finding No. 763:

The finding is incomplete and misleading. Evanston didn't have the ability to effectively negotiate with Blue Cross because of Blue Cross's size. (CX 6304 at 16 (Livingston, Dep.)). Mr. Sirabian testified that, during renegotiations with Blue Cross – a health plan with a dominant market position – the health plan presented a pricing and contract term proposal that "we either accepted or didn't." (Sirabian, Tr. 5731. *See* CCRFF 777).

764. Although ENH notified Blue Cross of its intent to renegotiate its rates under the contract in early December 1999, ENH did not officially open negotiations until March 1, 2000. (RX 707; RX 808 at ENH JL 2019).

Response to Finding No. 764:

Complaint Counsel have no specific response.

765. To ameliorate the risk ENH assumed by proposing per diem and per case rates for HMO Illinois, it proposed a stop loss provision with a $40,000 threshold at 75% of billed charges. (RX 808 at ENH JL 2021).

Response to Finding No. 765:

Complaint Counsel have no specific response.

766. As a result of proposing per diem and case rate terms, ENH's initial proposal to HMO Illinois included a request for an annual adjustment of the Medical CPI rate to cover ENH's increasing annual costs. (RX 808 at ENH JL 2021). ENH proposed a contract term of three years. (RX 808 at ENH JL 2021).

Response to Finding No. 766:

Complaint Counsel have no specific response.

767. During the 2000 negotiation, Blue Cross and ENH discussed trends in Blue Cross's product evolution and which products would be successful in the marketplace. (Hillebrand, Tr. 1862).

Response to Finding No. 767:

Respondent's finding is irrelevant.

768. The ENH-Blue Cross negotiations began with a focus solely on the HMO product, but evolved into a renegotiation of the entire book of business with Blue Cross. (Hillebrand, Tr. 2019).

Response to Finding No. 768:

Complaint Counsel have no specific response.

769. {[redacted]} (RX 823 at ENHL TC 18986, *in camera*).

Response to Finding No. 769:

Complaint Counsel have no specific response.

770. {[redacted]} (RX 823, *in camera*). {[redacted]} (RX 823 at ENHL TC 18986, *in camera*).

Response to Finding No. 770:

Respondent's finding is incomplete. {[redacted]}

(RX 823 at ENHL TC 018987, *in camera*). [redacted]

[redacted]

(*See* CCRFF 777; Haas-Wilson, Tr. 2626, 2728, *in camera*).

771. [redacted] (RX 823 at ENHL TC 18987, *in camera*).

Response to Finding No. 771:

Complaint Counsel have no specific response.

772. [redacted] (RX 877 at ENH JL 6487, *in camera*).

Response to Finding No. 772:

Complaint Counsel have no specific response.

773. [redacted] (RX 877 at ENH JL 6487, *in camera*).

Response to Finding No. 773:

Complaint Counsel have no specific response.

774. [redacted] (RX 319, *in camera*).

Response to Finding No. 774:

Complaint Counsel have no specific response.

775. [redacted] (RX 319, *in camera*). [redacted] (RX 319, *in camera*). [redacted] (RX 319, *in camera*).

Response to Finding No. 775:

Complaint Counsel have no specific response.

776. {[redacted]} (RX 319, *in camera*). {[redacted]} (RX 319, *in camera*). {[redacted]} (RX 319, *in camera*). {[redacted]} (RX 319, *in camera*).

Response to Finding No. 776:

Complaint Counsel have no specific response.

777. {[redacted]} (RX 319, *in camera*). {[redacted]} (RX 319, *in camera*). {[redacted]} (RX 319, *in camera*).

Response to Finding No. 777:

The finding is incomplete and misleading. Post-merger, Blue Cross's size and market power made it impossible for ENH to impose a price increase on Blue Cross that outpaced the price increases at other Chicago hospitals (as ENH did with other health plans).} (Haas-Wilson, Tr. 2626, 2638-2642, 2728, *in camera*). ENH representatives, including Mr. Sirabian, Mr. Hillebrand, Mr. Neaman, and Mr. Livingston, admitted that it was Blue Cross's market power, not "learning about demand," that made it impossible to raise prices to Blue Cross post-merger. (*See, e.g.*, Sirabian, Tr. 5731 (Blue Cross presented a pricing and contract term proposal that "we either accepted or didn't."); Neaman, Tr. 1182-83 (ENH had less opportunity to negotiate successfully with Blue

Cross/Blue Shield than with other health plans because of Blue Cross's size . . . There is little opportunity for ENH to improve its position in negotiations with Blue Cross/Blue Shield); Hillebrand, Tr. 1807 (Blue Cross/Blue Shield is a "dominant player" in Chicago); CX 6304 at 16 (Livingston, Dep.) (Blue Cross/Blue Shield is "such a big player, there is no way [ENH] can have any ability to negotiate with them significantly."); CX 1998 at 49 (According to Bain, the early 2000 negotiations with Blue Cross's HMO (HMO Illinois), would "be challenging given their strong strategic positions in [Illinois].")).

iii. Cigna

(1) Evanston Hospital's Pre-Merger Contract Rates With Cigna Were Outdated And Undermarket

778. As of the Merger, Evanston Hospital had not negotiated a new contract with Cigna since 1995. (CX 5013 at 6).

Response to Finding No. 778:

Respondent's finding is misleading to the extent that it attempts to justify ENH's large post-merger price increases as "catch-up" rates. Even if, *arguendo*, ENH did try to update older contracts during the 2000 renegotiations, the rates that the merged entity imposed were far above what would be considered appropriate in that situation. ENH would not have been able to achieve those price increases absent the merger. (CX 17 at 2 ("As stated previously, none of this could have been achieved by either Evanston or Highland Park alone."); CX 13 at 1 ("Neither Evanston nor Highland Park alone could achieve these results."). *See* CCRFF 616).

779. Evanston Hospital's contracted rate with Cigna's PPO and HMO plans for

inpatient medical and surgical services was $1,270. (CX 5013 at 2, 28). Evanston Hospital's contracted rate with Cigna's PPO and HMO plans for outpatient services was a discount-off-charges of 11%. (CX 5013 at 4, 29).

Response to Finding No. 779:

The finding is misleading. Respondent's finding is misleading to the extent that it attempts to generalize about "Evanston Hospital's rates before the Merger" (*See* RFF 780), from one service category's rates. (*See* CCRFF 780).

780. HPH had not renegotiated a new contract with Cigna since 1993, but its rates were better than Evanston Hospital's rates before the Merger. (CX 5011 at 4). HPH's contracted rate with Cigna's PPO and HMO plans for inpatient medical and surgical services was $1,320. (CX 5011 at 1). HPH's contracted rate with Cigna's PPO and HMO plans for outpatient services was 10% off charges. (CX 5011 at 2).

Response to Finding No. 780:

The cited source does not say what Respondent's finding claims. First, for most service categories in the Cigna contracts, an apples-to-apples rate comparison is not possible, because of differences in pre-merger payment methodology between Highland Park and Evanston pre-merger (per diem at Highland Park versus per case at Evanston). (*Compare* CX 5011 *and* CX 5013). Respondent's finding is also incomplete and misleading. For other service categories in which a comparison is possible, Evanston had a higher rate than Highland Park. For example, Evanston's rates pre-merger were 33.7% higher than Highland Park's for ICU services. (*Compare* CX 5013 at 2 (Evanston's ICU per diem of $1,765) *with* CX 5011 at 1 (Highland Park's ICU per diem of $1,320)). Significantly, post-merger, ENH adopted an ICU rate of $1,942 per day, a rate $177 more than Evanston's pre-merger per diem and $622 more than Highland Park's pre-merger per diem. (*Compare* CX 5015 at 18, CX 5013 at 2, *and* CX 5011 at 1).

781. Before the Merger, {[redacted]} (Chan, Tr. 786, *in camera*). {[redacted]} (CX 1099 at 12, *in camera*). {[redacted]} (Chan, Tr. 818, *in camera*).

Response to Finding No. 781:

Complaint Counsel have no specific response.

(2) ENH's Post-Merger Negotiations With Cigna Were Not Anticompetitive

782. After the Merger, ENH signed a three year contract with Cigna. (CX 5015 at 9). The contract provided for no price increase for the second and third years of the contract. (CX 5015 at 24).

Response to Finding No. 782:

Respondent's finding is incorrect. First, Cigna's post-merger PPO contract was a discount off charges arrangement for all inpatient services. (CX 5015 at 24). {[redacted]} (RX 1687 at ENH BW 027653, *in camera*; Porn, Tr. 5670 (Under a discount off charges contract, the higher the chargemaster list price, the more health plans have to pay to the hospital.)). {[redacted]} (Hillebrand, Tr. 1944, *in camera*; CX 5015 at 18).

783. The post-Merger contract with Cigna used a variety of reimbursement methodologies, including per diem, case rates and discount-off-charges. (CX 5015 at 18-21, 24, 28-30). For Cigna's HMO and "Gatekeeper" products, Cigna negotiated mostly per diem and case rates for inpatient services. (CX 5015 at 18-19, 28-29). For Cigna's PPO product, the parties agreed to a discount-off-charges arrangement for inpatient services. (CX 5015 at 24).

Response to Finding No. 783:

Respondent's finding is incomplete. Because "HMOs tend to have more narrow networks than do PPOs," health plans can normally negotiate lower rates for HMO plans. (Haas-Wilson, Tr. 2460, 2462). {[redacted]}

(Mendonsa, Tr. 479; CX 5015 at 24; Hillebrand, Tr. 1834. *See* Holt-Darcy, Tr. 1543, *in camera* ({[redacted]})).

Respondent's finding is also incomplete. ENH's own negotiator testified that Cigna did poorly and had to pay a lot more to ENH after the 2000 negotiations. (Chan, Tr. 696-697). {[redacted]} (Haas-Wilson, Tr. 2536, *in camera*; CX 6279 at 4, *in camera*). {[redacted]} (CX 6279 at 5, *in camera*; Haas-Wilson, Tr. 2537-38 ({[redacted]}), *in camera*). On July 3, 2000, Mr. Neaman reported to ENH's board of directors that the "successful renegotiation" of the Cigna contract would result in an additional $3 million in additional annualized revenue. (CX 13 at 1,7).

784. On October 9, 2003, ENH and Cigna agreed that the terms and conditions of the post-Merger contract should continue to apply. (RX 1547).

Response to Finding No. 784:

Complaint Counsel have no specific response.

iv. CCN

(1) Evanston Hospital's Pre-Merger Contract Rates With CCN Were Outdated And Undermarket

785. Before the Merger, HPH had a 12% discount-off-charges arrangement for inpatient services and a 5% discount-off-charges arrangement for outpatient services with CCN. (CX 5222 at 1).

Response to Finding No. 785:

Respondent's finding is incomplete. {[redacted]} (*See* Ballengee, Tr. 227, *in camera*; Chan, Tr. 667 ({[redacted]}).

786. {[redacted]} (RX 757 at ENH JL 9731, *in camera*). {[redacted]} (RX 757 at ENH JL 9731, *in camera*).

Response to Finding No. 786:

Respondent's finding is incorrect and misleading. {[redacted]} (*See* CCRFF 785, *in camera*).

(2) ENH's Post-Merger Negotiations With CCN

Were Not Anticompetitive

787. Chan and Sirabian wrote a letter to CCN asking it "to assign HPH's Agreement along with its terms and conditions, rights and obligations to ENH." (RX 689 at ENH JL 4138). CCN, however, did not agree to assign its rates with HPH over to ENH. (RX 781 at ENH JL 6304).

Response to Finding No. 787:

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

788. {[redacted]} (RX 757 at ENH JL 9731, *in camera*). {[redacted]} (RX 757 at ENH JL 9731, *in camera*; RX 834 at ENH JL 3943, *in camera*).

Response to Finding No. 788:

Complaint Counsel have no specific response.

789. {[redacted]} (CX 5235 at 1, *in camera*).

Response to Finding No. 789:

The finding is incomplete. {[redacted]}

(CX 6279 at 4, *in camera*). {[redacted]} (CX 6279 at 5, *in camera*). {[redacted]} (CX 24 at 2, *in camera*).

v. Great West

(1) Evanston Hospital's Pre-Merger Contract Rates With One Health/Great West Were Outdated And Undermarket

790. Before the Merger, HPH had a higher rate than Evanston Hospital. (Neary, Tr. 604-05). Accordingly, {[redacted]} (Noether, Tr. 6102, *in camera*; RX 1912 at 34, *in camera*).

Response to Finding No. 790:

The finding is incomplete and misleading. Not all of Highland Park's negotiated per diem rates were higher than Evanston's prior to the merger. For One Health's PPO product, Evanston negotiated higher rates for pediatric and nursery services than Highland Park. (*Compare* CX 5059 at 17 *and* CX 5065 at 17). For One Health's HMO product, Evanston negotiated higher rates than Highland Park for Medical, Pediatric, ICU, and some nursery services than Highland Park. (*Compare* CX 5058 at 18 and CX 5061 at 18). Because Evanston and Highland Park's pre-merger fixed rate payment methodologies for Obstetric services were different for Evanston and Highland Park (per diem at Evanston and per case at Highland Park), an apples-to-apples comparison of rates is not possible. (*compare* CX 5059 at 17 *and* CX 5065 at 17; CX 5058 at 18 *and* CX 5061 at 18).

791. Evanston Hospital's last pre-Merger contract with Great West was in 1996. (CX 5065 at 4). Evanston Hospital and Great West agreed to a per diem rate of $1250 and $1225 for inpatient medical/surgical services on Great West's PPO and POS products. (CX 5065 at 17).

Response to Finding No. 791:

Complaint Counsel have no specific response.

792. Evanston Hospital's pre-Merger contract also did not have a stop loss provision on either its HMO or its PPO products with Great West, meaning that Evanston Hospital bore the risk that the cost of care for a particular patient would exceed the negotiated rate. (Neary, Tr. 632). Moreover, the contract contained a provision that capped Evanston Hospital's reimbursement: "In no event will Company or Payor pay more than the lesser of the Payment Rate or 80% of Hospital's usual billed charges." (CX 5065 at 16).

Response to Finding No. 792:

Complaint Counsel have no specific response.

793. {[redacted]} (Noether, Tr. 6103, *in camera*; RX 1912 at 34, *in camera*; RX 223 at GW 3988-89, *in camera*).

Response to Finding No. 793:

Respondent's finding is misleading because it attempts to draw an inappropriate comparison between Evanston and hospitals that Dr. Noether includes in her "academic" control group. (Noether, Tr. 6000). It is inappropriate to compare Evanston with those hospitals. (*See* CCFF 1912-1942, *in camera*). {[redacted]} (Neary, Tr. 621;

Dorsey, Tr. 1444 (Evanston is not an academic hospital); Neary, Tr. 622-23; Dorsey, Tr. 1443-44 (Loyola University Medical Center, University of Chicago Hospital, and Northwestern Memorial Hospital are all academic hospitals.); CX 17 at 2 ("As stated previously, none of this could have been achieved by either Evanston or Highland Park alone."); CX 13 at 1 ("Neither Evanston nor Highland Park alone could achieve these results."); Hillebrand, Tr. 1722, 1816-17; *See* CCFF 696-702, *in camera*; Baker, Tr. 4739, *in camera*. *See* CCRFF 590, *in camera*).

One Health believed that Rush North Shore, Condell, and Swedish Covenant were hospitals with services comparable to those offered at Evanston Hospital. (Neary, Tr. 624). {[redacted]} (RX 1912 at 34 ({[redacted]}), *in camera*). In short, One Health testified that Evanston's rates were *not* below market prior to the merger. (Neary, Tr. 644).

794. HPH also had contracts with Great West before the Merger. (Neary, Tr. 596-97). The PPO/POS contract became effective on September, 1996. (CX 5059 at 4). HPH and Great West agreed to a per diem rate of $1375 for inpatient medical services and a per diem rate of $1650 for surgical services, rates that were higher than the rates Evanston Hospital received from Great West at the time. (CX 5059 at 17).

Response to Finding No. 794:

The finding is incomplete and misleading. Many of Highland Park's pre-merger negotiated rates were lower than Evanston's. (*See* CCRFF 790). Respondent's finding is also misleading to the extent it attempts to generalize about Evanston or Highland Park's rates before the merger from a comparison of the hospitals' rates for only two service

categories. (*See* RFF 790).

795. {[redacted]} (RX 261 at ENH JL 7994; Noether, Tr. 6103, *in camera*). {[redacted]} (Noether, Tr. 6104, *in camera*).

Response to Finding No. 795:

The finding is incomplete and therefore misleading. {[redacted]} (RX 261 at ENH JL 7994; Noether, Tr. 6103, *in camera*). {[redacted]}

(2) ENH's Post-Merger Negotiations With Great West Were Not Anticompetitive

796. At or about the time of the Merger, ENH informed Great West that it needed a one-time adjustment to bring its rates up to market. (Neary, Tr. 595, 633). Patrick Neary, formerly of Great West, testified at trial that he "agreed that it had been several years since the contracts had been renegotiated and that it was appropriate to – to increase some of the rates." (Neary, Tr. 608).

Response to Finding No. 796:

Respondent's finding is incomplete. {[redacted]}

[redacted] (CX 2085 at 1 (emphasis added), *in camera*; Neary, Tr. 762-63, *in camera*).

797. Kevin Dorsey, another former Great West employee who testified at trial, did not find ENH's initial proposal "that shocking." (Dorsey, Tr. 1437). He explained: "It is not untypical to receive an initial proposal with a provider more or less shooting for the stars of what they would like to receive." (Dorsey, Tr. 1437-38).

Response to Finding No. 797:

Respondent's finding is incomplete. One Health believed that ENH was "shooting for the stars" with its "extreme" reimbursement request and viewed ENH's proposal as "an opportunity to counter and an opportunity to begin negotiations of a final agreement." (Dorsey, Tr. 1437-38). ENH, however, dismissed One Health's counter-proposal outright. (Neary, Tr. 602).

798. [redacted] (RX 261; RX 837 at ENH JL 4524, *in camera*)

Response to Finding No. 798:

Respondent's finding is inaccurate. [redacted] (RX 261). [redacted] (RX 261). [redacted]

[redacted] (RX 261; RX 837, *in camera*).

799. Accordingly, on May 23, 2000, ENH sent Great West a notice of termination to become effective on August, 31, 2000. (Neary, Tr. 610-11; CX 5062; RX 848). Great West decided to accept the termination and allow the contract to lapse. (Neary, Tr. 611).

Response to Finding No. 799:

Respondent's finding is incomplete. As a final response to ENH's May 23, 2000, termination letter, Patricia Moldovan, the president of One Health's Midwest region placed a call to Jeffrey Hillebrand and explained that "*the price increases were just too high for [One Health] to pass on to the employer groups*." (Dorsey, Tr. 1450 (emphasis added)). At the conclusion of the call, One Health realized that its "last-ditch effort" to "salvage the relationship" had failed and that the termination would proceed. (Dorsey, Tr. 1449-50).

800. Even when Great West was terminated, ENH and Great West had an interim agreement in place. (Hillebrand, Tr. 1898). ENH and Great West negotiated a 10% discount-off-charges interim agreement pertaining to pregnant women in their third trimester. (Neary, Tr. 637).

Response to Finding No. 800:

Respondent's finding is incomplete. Knowing that One Health had no other provider options for those expecting mothers, ENH used its negotiating leverage to *increase* One Health's prices to a 10% discount-off-charges arrangement for those OB services. (Neary, Tr. 620, 637; CX 5063 at 1 (emphasis added)). ENH charged the health plan rates that were even "higher" than contract rates that were in place under the pre-

merger One Health contract. (Neary, Tr. 620, 637; CX 5063 at 1).

801. Great West believed it could still have a sellable network after the termination. (Neary, Tr. 615). At the time Great West accepted the termination, Lake Forest Hospital, Northwest Community, Advocate Lutheran General, Rush North Shore and St. Francis were all part of the Great West network. (Neary, Tr. 611).

Response to Finding No. 801:

Respondent's finding is incomplete. Shortly after the termination of the ENH contract went into effect, Mr. Neary realized that he "was wrong" in thinking that One Health could market and sell a network without the three ENH facilities. (Neary, Tr. 617). The sales staff urged network development management to "try to re-open negotiations with ENH" because One Health was "losing membership" and "losing employer groups" without the three ENH facilities. (Neary, Tr. 617; Dorsey, Tr. 1452). In the months following the termination of the ENH contract, One Health's monthly membership reports also began to reflect a "loss of membership within [the] network." (Dorsey, Tr. 1488).

802. In fact, neither of Complaint Counsel's Great West witnesses could identify a single Great West customer that was lost during the period in which the relationship between Great West and ENH was terminated. (Neary, Tr. 635; Dorsey, Tr. 1469-70, 1481). Neary never saw any letter from any Great West customer complaining about the ENH termination. (Neary, Tr. 635). And Dorsey could not identify any sales that were lost to any specific customer. (Dorsey, Tr. 1481).

Response to Finding No. 802:

Respondent's finding is irrelevant and misleading to the extent that it suggests that One Health did not lose customers during the period of time that ENH was not part of its network. Mr. Dorsey made it clear that in the months following the termination of the ENH contract, One Health's monthly membership reports reflected the "loss of

membership within [the] network." (Dorsey, Tr. 1488).

803. Nor could Neary quantify the revenue purportedly lost by Great West as a result of the termination. (Neary, Tr. 635). Neary could not even testify whether the purportedly lost customers were large or small customers. (Neary, Tr. 635). Neary's only knowledge of lost customers from the termination came from the sales manager, Don Manno. (Neary, Tr. 636) Great West actually demoted Manno in 2001 or 2002. (Neary, Tr. 636-39).

Response to Finding No. 803:

Whether Mr. Neary or Mr. Dorsey could name lost customers or the amount of revenue lost is irrelevant to whether One Health actually lost members after terminating ENH. Mr. Dorsey testified that, in the months following the termination of the ENH contract, One Health's monthly membership reports also began to reflect a "loss of membership within [the] network." (Dorsey, Tr. 1488).

804. {[redacted]} (Noether, Tr. 6104, *in camera*). {[redacted]} (Noether, Tr. 6102, *in camera*).

Response to Finding No. 804:

The finding is incorrect. Market power is the ability to profitably raise prices above competitive levels for a significant period of time. ENH conceded the elements of market power: (1) ENH did not change its pricing strategy for fear that ENH would lose business to other hospitals; (2) ENH did not change its pricing strategy for fear that other hospitals would change their prices in response to ENH's prices (3) ENH has sustained its price increases since 2000 (with the exception of Humana); (4) ENH has imposed numerous additional price increases since 2000; and (5) ENH has not lost a single health plan customer since the merger. (Neaman, Tr. 1211-2; Hillebrand, Tr. 1708-09, 1764-65.

See CCFF 817-903, *in camera*, 918-924, *in camera*, 942-951, *in camera*). {[redacted]} (CX 6282 at 5, *in camera*). {[redacted]} (CX 6282 at 6, *in camera*).

One Health's post-merger "market experiment" exposes ENH's exercise of market power post-merger. (Haas-Wilson, Tr. 2942). Prior to the merger, One Health engaged in selective contracting, which forced hospitals to compete harder for the health plan's business. (Neary, Tr. 587-88). One Health knew that its bargaining strength depended, among other things, on the competitive position of the hospital with which it was negotiating, and the availability of network and non-network-alternatives in the area offering similar services. (Neary, Tr. 589). One Health immediately made the connection between ENH's merger and its own weakened negotiating position because "Evanston had purchased their main competitor," Highland Park. (Neary, Tr. 600-01).

One Health tried to market a network without ENH, but could not do so. (Neary, Tr. 617). Other hospitals in the area, including Lake Forest, Northwest Community, Lutheran General, Rush North Shore and St. Francis, were not adequate substitutes, and One Health lost customers because they did not have the three ENH facilities. (Neary, Tr. 610-11, 617; Dorsey, Tr. 1451-2, 1459, 1488). One Health approached the negotiating table a second time knowing that they "were not in a strong negotiating position" because they "were going back to a . . . hospital system that had terminated with us, and . . . we are going there because our sales staff could not sell the network without having this hospital system in our network." (Neary, Tr. 618-19). One Health "knew that we had to

get a contract with the hospital . . . essentially regardless of what the ultimate price was." (Neary, Tr. 619). {[redacted]} (CX 6282 at 6, *in camera*; *compare* CX 5067 at 15, *in camera*, CX 5059 at 17, *and* CX 5065 at 17; Neary, Tr. 765-66, *in camera*; Hillebrand, Tr. 1944-46, *in camera*; CX 5064 at 17, *in camera*).

805. ENH called Great West asking to reopen negotiations on October 15, 2000. (RX 993 at ENHL JL 22377). Subsequently, Great West returned to the bargaining table and entered into a contract with ENH. (Hillebrand, Tr. 1898). The contractual discount from the pre-Merger HPH contract to the subsequent post-Merger ENH contract did not change at all. (Hillebrand, Tr. 2031).

Response to Finding No. 805:

Respondent's finding is inaccurate, incomplete and misleading. First, according to RX 993 (Respondent's cite), it was Great West representatives, not ENH, that requested that the negotiations resume. (RX 993 at ENHL JL 22377).

Moreover, no conclusion can be drawn regarding pre- or post-merger "prices" from examining contractual discounts, because those discounts are taken off of the hospital's list prices, or chargemaster which were increasing. {[redacted]} (Newton, Tr. 365-66; RX 1687 at ENHL BW 027653, *in camera*). {[redacted]

[redacted] (Neary, Tr. 765, *in camera*). {[redacted]} (Neary, Tr. 765-66, *in camera*; Hillebrand, Tr. 1944, *in camera*; CX 5064 at 17, *in camera*).

Ultimately One Health knew that it was vulnerable to ENH's price demands because "we had to get a contract with the hospital . . . essentially regardless of what the ultimate price was." (Neary, Tr. 619). {[redacted]} (CX 6282 at 5, *in camera*). {[redacted]} (CX 6282 at 6, *in camera*).

806. Great West annoyed ENH in the way it notified customers about the termination. (RX 993 at ENHL JL 22377).

Response to Finding No. 806:

Respondent's finding is irrelevant. This case is about Evanston's 2000 merger with Highland Park Hospital. In that regard, the question of whether Great West annoyed ENH is irrelevant to the issues of this case.

807. As it turned out, Great West could not risk another contentious contract negotiation with ENH. At the same time it was renegotiating with ENH in the Fall of 2000, Great West also faced a difficult negotiation with Lake Forest Hospital, which was assisted by a consulting firm in the negotiation. (Dorsey, Tr. 1484-85). On September 28, 2000, and "[a]fter several months of negotiations," Lake Forest Hospital and its medical group provided Great West with written notice of termination of their contract with Great West effective December 31, 2000.

(RX 949; RX 950).

Response to Finding No. 807:

Respondent's finding is incorrect and irrelevant. First, Messrs. Neary and Dorsey both testified that One Health lost membership and requested a renegotiation with ENH because of complaints specifically related to "the lack of ENH in the network." (Dorsey, Tr. 1452; Neary, Tr. 617). Second, One Health's negotiations with Lake Forest did not influence One Health's 2000 negotiations with ENH. Mr. Dorsey testified that he did not believe that Lake Forest's termination letter meant that One Health was under threat of termination. (Dorsey Tr. 1487).

808. It would have been "very problematic" for Great West to have simultaneously lost ENH and Lake Forest Hospital since Lake Forest Hospital was the primary alternative to HPH. (Dorsey, Tr. 1484).

Response to Finding No. 808:

The finding is incomplete and misleading. While it would have been "problematic" for Great West to simultaneously lose Lake Forest and ENH, *if that had actually "taken affect,"* (Dorsey, Tr. 1484 (emphasis added)), Mr. Dorsey did not believe that One Health was under threat of termination at Lake Forest. (Dorsey Tr. 1487).

vi. HFN

(1) Evanston Hospital's Pre-Merger Contract Rates With HFN Were Outdated And Undermarket

809. Before the Merger, Evanston Hospital's DRG rate for inpatient medical/surgical services with HFN's EPO plan was $5,400 under a contract that dated back to 1996. (CX 5215 at 17).

Response to Finding No. 809:

Respondent's finding is incomplete and misleading. {[redacted]} (RX 1912 at 35, *in camera*). The actual rates for contracts that are structured by DRG case weight are calculated by multiplying the negotiated DRG rate by the Medicare DRG weight factor for each particular inpatient DRG. (*See* CX 5215 at 17; CX 5267 at 17; CX 5304 at 2). Without knowing the case weights or the mix of cases at Evanston or Highland Park prior to the merger, the rates referred to by Respondent are inconclusive as to the reimbursements that either hospital received, or how those reimbursements compared to one another pre-merger. (*See* CX 5215 at 17; CX 5267 at 17; CX 5304 at 2).

810. HPH's DRG case rate for inpatient medical/surgical services with HFN's EPO plan in 1996 was $5,700, higher than Evanston Hospital's rates. (CX 5267 at 17). HPH renegotiated its rate in 1999 to $6,300. (CX 5304 at 2).

Response to Finding No. 810:

Without knowing the case weights or the mix of cases at Evanston or Highland Park prior to the merger, the rates referred to by Respondent are inconclusive as to the reimbursements that either hospital received, or how those reimbursements compared to one another pre-merger. (*See* CCRFF 809).

811. In 1996, both Evanston Hospital and HPH agreed to a 15% discount with HFN for its EPO outpatient medical/surgical services. (CX 5215 at 17; CX 5267 at 17). HPH, however, renegotiated the rate in 1999 to 10%. (CX 5304 at 2).

Response to Finding No. 811:

The finding is irrelevant. Neither ENH's nor Highland Park's rates for outpatient services are relevant in this case, because outpatient services are not included in the relevant product market. (Haas-Wilson, Tr. 2660. *See* CCRFF 736).

812. Before the Merger, Evanston Hospital's DRG case rate for inpatient medical/surgical services with HFN's PPO plan was $5,800 under a contract that dated back to 1996. (CX 5215 at 17). In contrast, HPH's DRG case rate for inpatient medical/surgical services with HFN's EPO plan was $7,000. (CX 5304 at 2).

Response to Finding No. 812:

Without knowing the case weights or the mix of cases at Evanston or Highland Park prior to the merger, the rates referred to by Respondent are inconclusive as to the reimbursements that either hospital received, or how those reimbursements compared to one another pre-merger. (*See* CCRFF 809).

(2) ENH's Post-Merger Negotiations With HFN Were Not Anticompetitive

813. After the Merger, {[redacted]} (CX 5217 at 5, *in camera*). {[redacted]} (RX 270 at ENH-RNSMC 312, *in camera*; RX 281 at NMH 380; RX 1088 at FTC-LFH 1120). Condell negotiated a discount-off-charges contract with HFN in 2002. (RX 1333 at CMC 17620).

Response to Finding No. 813:

Respondent's finding is incomplete. {[redacted]} (CX 5304 at 1; CX 5217 at 5, *in camera*; CX 6279 at 5, *in camera*).

Even if, *arguendo*, other hospitals have discount off charges arrangements with HFN, such arrangements are irrelevant. First, in the years leading up to the merger, there was a movement by health plans towards fixed rate contracts. {[redacted]}

[redacted] (*See* CCRFF 85, *in camera*). Second, ENH was not simply following a trend in shifting HFN to a discount off charges arrangement. ENH moved HFN to a discount off charges arrangement to "better the terms" of its contract with the health plan and ensure that the hospital would be reimbursed based upon its chargemaster list prices. (Newton, Tr. 366; Hillebrand, Tr. 1855. *See* Hillebrand, Tr. 1705-06 (Mr. Hillebrand's "first negotiating step" with health plans in 2000 was to "move to discount off charges."); Porn, Tr. 5670; Chan, Tr. 743-44. *See* CCFF 791). [redacted] (Newton, Tr. 365-66; RX 1687 at ENHL BW 027653, *in camera*. *See* CCFF 884-895, 918-924, *in camera*). With each post-merger chargemaster increase, ENH increased its reimbursement from HFN. (Porn, Tr. 5670; Chan, Tr. 743-44).

vii. Humana

(1) Before The Merger, Evanston Hospital Acquired Humana Physician Office Sites

814. During the 1990s, Humana had the most capitated lives with Evanston Hospital. (Sirabian, Tr. 5709). Evanston Hospital had fair and open discussions with Humana about the requirements of both parties to the contract. (Sirabian, Tr. 5708-09).

Response to Finding No. 814:

Complaint Counsel have no specific response.

815. Until 1998, Evanston Hospital had been reimbursed on per diem, case rate and

discount-off-charges arrangements by Humana for hospital services. (Hillebrand, Tr. 1864).

Response to Finding No. 815:

Respondent's finding is incomplete. {[redacted]} (CX 5025 at 1-2, *in camera*; CX 5027 at 1, *in camera*).

816. In 1998, Evanston Hospital acquired Humana's physician office sites in West Rogers Park, Evanston, Glenview and Buffalo Grove – physician sites adjacent to Evanston Hospital's service area. (Hillebrand, Tr. 1863). Along with the Humana physician offices purchased by Evanston Hospital, ENH Medical Group also acquired about 40 physicians in 1998. (Hillebrand, Tr. 1864).

Response to Finding No. 816:

Respondent's finding is incomplete. ENH viewed buying "additional medical offices strategically located in ENH's market area" as a "strategic benefit[] of the Humana contract." (CX 745 at 1).

817. In lieu of paying an acquisition price for the four Humana centers, Evanston Hospital and Humana negotiated a percent-of-premium agreement with Humana. (Hillebrand, Tr. 1864). Under this capitated contract, payment to Evanston Hospital was a percentage of the premium that Humana collected from its subscribers. (Hillebrand, Tr. 1864-65).

Response to Finding No. 817:

Respondent's finding is incomplete. {[redacted]} (RX 445 at 1, *in camera*).

818. After 1998, because Evanston Hospital was on a percent-of-premium, as opposed to being paid a rate for services, it had assumed dramatically greater risk. (Hillebrand, Tr. 1865). Evanston Hospital was responsible for the cost of care for their principal products, its HMO products. (Hillebrand, Tr. 1865). This contract left Evanston Hospital fully at risk for the care of

Humana's subscribers and was not profitable for Evanston Hospital. (Sirabian, Tr. 5709-10).

Response to Finding No. 818:

The finding is incomplete and misleading. As noted above, in return for these arrangements Evanston acquired physician practices without any acquisition price. (RFF 817). {[redacted]} (CX 5264; 5024 ([redacted]), *in camera*; CX 689 (showing percentages of revenue in each product); CX 74 at 8), and it cites ENH's risk, even though the risk is associated with physician services (CX 5775; CX 1467; *see generally* RX 317) and did not apply to hospital contracting. Thus, the issues raised in the finding are irrelevant because they solely relate to contracting in areas outside of the product market, which is managed care contracting for inpatient acute care hospital services.

Bain's pre-merger analysis of the Humana HMO contracts did not separate hospital and physician side revenue, and it showed much greater losses (over $6 million) for the Humana Medicare HMO than the commercial HMO product (about $2 million). (CX 74 at 8). {[redacted]} (RX 1313 at 1, *in camera*). Even assuming arguendo that the Humana Medicare HMO ran at a loss, the revenues from that contract do not belong in the product market in the first place as they relate to Medicare and not commercial insurance. The finding is also misleading because capitation in both of Humana's Staff Model HMO products was for non-hospital,

physician services (CX 5775; CX 1467; *see generally* RX 317). {[redacted]} (CX 5021, *in camera*; CX 5025, *in camera*; CX 5027, *in camera*; CX 5029; CX 5772; RX 108). As RFF 815 and CCRFF 821 demonstrates, Humana reimbursed Evanston for hospital services through fixed fees both before and after the merger.

819. Evanston Hospital's purchase of the physician sites fundamentally changed its relationship with Humana and played a role in the post-Merger contract negotiations. (Hillebrand, Tr. 1864).

Response to Finding No. 819:

Complaint Counsel have no specific response.

820. Moreover, at the time of Bain's analysis of the managed care contracts, HPH did not participate in all of Humana's products. HPH only participated in Humana's PPO/Employers Health contract. (Hillebrand, Tr. 1804). For that product, HPH had higher pricing than Evanston Hospital. (Hillebrand, Tr. 1804; CX 75 at 6).

Response to Finding No. 820:

Respondent's finding is incorrect, because it generalizes that Highland Park had "higher pricing than Evanston" across the board, when Highland Park only had a higher per diem rate than Evanston in one of three comparable service categories. According to Bain, it was Evanston that had higher rates than Highland Park for Medical/Surgical Intensive and Caesarian Section. Normal delivery rates between the two hospitals were based on different payment methodologies (per diem at Evanston and per case at Highland Park), so a comparison is not possible. (RX 705 at ENHL JL 023056).

821. {[redacted]} (RX 445 at H 17412, *in camera*). {[redacted]

[redacted] (CX 5764-CX 5771, *in camera*; CX 5775, *in camera*; CX 5020-CX 5028, *in camera*). {[redacted]} (RX 82, *in camera*).

Response to Finding No. 821:

Respondent's finding is misleading. Evanston's pre-merger medical/surgical Routine per diem rate was $989. Evanston's Medical/Surgical Intensive per diem rate was $1,403, higher than both Highland Park and Advocate Lutheran General's pre-merger per diem rate. (RX 705 at ENHL JL 023056).

(2) ENH's Post-Merger Negotiations With Humana Were Not Anticompetitive

822. ENH approached Humana in 2000 because the utilization of care was greater than anticipated, and ENH needed to modify the price to account for the increased risk it had assumed. (Hillebrand, Tr. 1865-66).

Response to Finding No. 822:

Respondent's finding is misleading and incomplete because it lumps together commercial and Medicare contracts, and it cites ENH's risk, even though the risk is associated with physician services and did not apply to hospital contracting. (*See* CCRFF 818). ENH also approached Humana because the health plan had been identified as a "1st priority contract" for which ENH had "enough leverage to improve terms." (CX 75 at 9-10). ENH renegotiated the Humana contract because "with the Highland Park merger, ENH offers the largest regional network for more convenient access," and because "ENH is the preferred provider in the region by a margin of 2x or greater." (RX 705 at ENHL JL 023053).

823. ENH did an analysis of the Humana Medicare population in comparison to its general Medicare populations and found that the Humana patients were, older and sicker. (Hillebrand, Tr. 1865-67). The Humana Medicare population had higher uses of services, but in the reimbursement methodology, ENH was exposed for the risk of providing the care to that patient population. (Hillebrand, Tr. 1866-67).

Response to Finding No. 823:

Complaint Counsel have no specific response.

824. The fixed rate methodology of the Humana Medicare contract was such that ENH was losing significant amounts of money in the order of $10 million on that contract alone. (Hillebrand, Tr. 1867). As a result, in 2002, ENH approached Humana to exit the Medicare product, but the two sides were able to renegotiate a new contract to both sides' satisfaction. (Hillebrand, Tr. 1866-67).

Response to Finding No. 824:

The finding is incomplete and misleading. As of the end of 2002, for the hospital contracts, ENH terminated its relationship with the Humana Staff Model Medicare product, and also eliminated its downside risk on the commercial product. (RX 1313 at 1).

825. ENH is constantly renegotiating its contract with Humana. (Hillebrand, Tr. 1866). In fact, in 2002, ENH accepted a price decrease on one of its Humana contracts. (Hillebrand, Tr. 1710).

Response to Finding No. 825:

Complaint Counsel have no specific response.

826. {[redacted]} (RX 1308, *in camera*). {[redacted]} (RX 1308, *in camera*). {[redacted]} (RX 1308, *in camera*).

Response to Finding No. 826:

The finding is irrelevant. {[redacted]}

viii. PHCS

(1) Evanston Hospital's Pre-Merger Contract Rates With PHCS Was Outdated And Undermarket

827. {[redacted]} (Noether, Tr. 6101, *in camera*; RX 1912 at 34, *in camera*).

Response to Finding No. 827:

Respondent's finding is incorrect and misleading. The finding is misleading because comparing hospital contract rates across hospitals does not take into account the effect of volume differences on price (Chan, Tr. 741-42) {[redacted]} (Chan, Tr. 742-744; Haas-Wilson, Tr. 2645-47, *in camera*). Comparing fixed rates across hospitals does not take into account volume or chargemaster differences between the hospitals which could affect the bargaining for rates and the price. This finding is also misleading. {[redacted]} (RX 1912 at 34, *in camera*; Noether, Tr. 6101, *in camera*; CX 5070 at 28, 30). {[redacted]} (*Compare* CX 5070 at 28 *and* CX 5068 at 27, *in camera*).

Prior to the merger, Evanston lowered its price and reduced costs in response to

considerable pricing pressures so that it could stay on health plan networks. (CCRFF 597). Evanston's pre-merger rates to PHCS reflected this competition between Evanston and Highland Park. PHCS knew that "if, in fact, the negotiation and the rates were not going well at one hospital . . . we had the alternative." (Ballengee, Tr. 167). PHCS understood that it could "choose between the two [hospitals] and work them against each other." (Ballengee, Tr. 167). Evanston was concerned about being excluded from health plans' network of providers. (Neaman, Tr. 961. *See* Newton, Tr. 303 (Highland Park was also "routinely concerned" about being excluded from health plan networks pre-merger.)). To maintain access to health plan networks, Evanston lowered its pricing, increased the breadth, depth and quality of its services, and strove to control costs. (Neaman, Tr. 961-62). The "competitive nature of the two hospitals, one with the other" prior to the merger, meant that PHCS was able to get Evanston to lower its proposed rate increases to "4-8 percent" (in contrast to the 60% increase that the merged entity imposed on PHCS post-merger) (Ballengee, Tr. 168-71, 179, 196). {[redacted]} (Ballengee, Tr. 155, 180; Ballengee, Tr. 249, *in camera*).

Ms. Ballengee testified that PHCS would have expected to receive lower rates at Evanston prior to the merger because PHCS sent more dollars to Evanston than Highland Park. (Ballengee, Tr. 160-62). Hospitals often exchange lower prices for the promise of a greater volume of patients through its doors. (Hillebrand, Tr. 1761; Dorsey, Tr. 1474-75).

828. In 1995, PHCS successfully negotiated significant decreases in rates with Evanston Hospital. (RX 107 at GWL 859). PHCS boasted to its carriers that it had increased its net effective inpatient discount by 10% by limiting rate increases to 3%, freezing medical and surgery per diems and increasing both the lesser of discount and stop loss arrangements. (RX 107 at GWL 859).

Response to Finding No. 828:

According to Ms. Ballengee, PHCS was able to attain such discounts and terms prior to the merger because Highland Park and Evanston competed for inclusion in PHCS's network. Ms. Ballengee testified that "if, in fact, the negotiation and the rates were not going well at one hospital . . . we had the alternative." (Ballengee, Tr. 167. *See* CCRFF 827). After the merger, PHCS could no longer "choose between" Evanston and Highland Park or "work them against each other." (Ballengee, Tr. 167). It was only after the merger that ENH could impose a 60% price increase on the health plan. (Ballengee, Tr. 167, 196-97; CX 17 at 2).

829. On the outpatient side, PHCS was equally as successful in squeezing Evanston Hospital's reimbursement. (RX 107 at GWL 859). PHCS bragged to its carriers that it had increased PHCS's net effective discount by 5% through limiting increases in outpatient rates to 3% and changing the lesser of discount provision (described below). (RX 107 at GWL 859).

Response to Finding No. 829:

Neither ENH's nor Highland Park's rates with PHCS for outpatient services are relevant in this case, because outpatient services are not included in the relevant product market. (Haas-Wilson, Tr. 2660. *See* CCRFF 736).

830. The contract between Evanston Hospital and PHCS used discounts-off-charges for some inpatient services since at least 1995. (RX 107 at GWL 859, 870). PHCS utilized a "lessor of discount or per diem of 23 percent" on its 1995 contract. (RX 107 at GWL 859, 870). For inpatient services, the 1995 contract's payment rate is the lesser of: (1) the negotiated rate (per diem or per case, as set forth in or otherwise specified in the contract); or (2) regular billing rates reduced by 23%. (RX 107 at GWL 870). In the absence of a negotiated rate, the 1995

PHCS rates defaulted to a discount-off-charges. (RX 107 at GWL 870).

Response to Finding No. 830:

{[redacted]} (*Compare* CX 5070 at 28, 30 *and* CX 5068 at 27, 29, *in camera*). The discount discussed in RFF 829 was only applicable in situations where it would be more expensive for the health plan to pay the per diem rates. (CX 5070 at 28, 30). However, as Ms. Chan explained, per diem rates in general result in greater discounts "up to 50%" for services than do discount off charges arrangements. According to Ms. Chan, pre-merger, Evanston and Highland Park's fixed rate contracts gave health plans "much higher" discounts than the contracts that were structured in a discount off charges arrangement. (Chan, Tr. 675-76).

831. {[redacted]} (RX 773 at ENH JL 12535, *in camera*).

Response to Finding No. 831:

Respondent's finding is incomplete. Respondent notes the "competitive savings" that Evanston afforded PHCS prior to the merger, but does not note why. As discussed in CCRFF 827, prior to the merger, Evanston was concerned about being excluded from health plan provider networks. It was that concern that resulted in "competitive savings" for health plans such as PHCS. After the merger, ENH possessed the market power to

dismiss any pre-merger concerns that Evanston or Highland Park hospitals may have had and impose a 60% price increase on the health plan. (*See* CCRFF 827). This finding is also misleading for the reasons stated in CCRFF 827. (*See* CCRFF 827).

PHCS's "competitive savings" with Evanston pre-merger was also due to the volume of business that PHCS directed to Evanston through its contract. Ms. Ballengee also testified that PHCS would have expected to receive lower rates at Evanston prior to the merger because PHCS sent more dollars to Evanston than Highland Park. (Ballengee, Tr. 160-62. *See* Hillebrand, Tr. 1761 (Hospitals often exchange lower prices for the promise of a greater volume of patients through its doors)).

832. In fact, HPH's pre-Merger rates were noticeably higher than Evanston Hospital's rates for both inpatient and outpatient services. (Ballengee, Tr. 205). {[redacted]} (CX 5070 at 28; CX 5068 at 27, *in camera*). {[redacted]} (Ballengee, Tr. 268, *in camera*; CX 5070 at 28). [redacted] (Ballengee, Tr. 269, *in camera*; CX 5068 at 27, *in camera*).

Response to Finding No. 832:

Respondent's finding is misleading. Comparing fixed rates across hospitals does not take into account volume or chargemaster differences between the hospitals which could affect the bargaining for rates and the price. (*See* CCRFF 827). Prior to the merger, Evanston's concern over being excluded from health plan provider networks resulted in lower pre-merger rates for health plans. After the merger, ENH possessed the market power to dismiss any pre-merger concerns that Evanston or Highland Park hospitals may have had and impose a 60% price increase on the health plan. (*See*

CCRFF 827). Respondent's finding is also incomplete. PHCS expected to receive lower rates at Evanston prior to the merger because PHCS sent more dollars to Evanston than Highland Park. (Ballengee, Tr. 160-62. *See* Hillebrand, Tr. 1761 (Hospitals often exchange lower prices for the promise of a greater volume of patients through its doors)). Respondent's finding regarding Evanston's pre-merger outpatient rates is irrelevant. Evanston and Highland Park's rates with PHCS for outpatient services are not relevant in this case, because outpatient services are not included in the relevant product market. (Haas-Wilson, Tr. 2660. *See* CCRFF 736).

833. {[redacted]} (RX 279, *in camera*). {[redacted]} (RX 308, *in camera*). {[redacted]} (RX 308, *in camera*).

Response to Finding No. 833:

Respondent's finding is incomplete. PHCS was able to get improved rates in the 1990s because, before the merger, Evanston (and other Chicago Hospitals) responded to health plan pressure to lower prices. That concern resulted in lower pre-merger pricing for health plans. After the merger, ENH possessed the market power to dismiss any pre-merger concerns that Evanston or Highland Park hospitals may have had and impose a 60% price increase on the health plan. (*See* CCRFF 597, 827). Respondent's finding is also incomplete. PHCS expected to receive lower rates at Evanston prior to the merger because PHCS sent more dollars to Evanston than Highland Park. (Ballengee, Tr. 160-62. *See* Hillebrand, Tr. 1761 (Hospitals often exchange lower prices for the promise of a greater volume of patients through its doors). *See* CCRFF 827).

834. {[redacted]} (RX 279, *in camera*). {[redacted]} (RX 308, *in camera*).

Response to Finding No. 834:

Respondent's finding is incomplete. Prior to the merger, Evanston was concerned about being excluded from health plan provider networks. It was that concern that resulted in lower pre-merger pricing for health plans. After the merger, ENH possessed the market power to dismiss any pre-merger concerns that Evanston or Highland Park hospitals may have had and impose a 60% price increase on the health plan. (*See* CCRFF 827). Respondent's finding is also incomplete. PHCS expected to receive lower rates at Evanston prior to the merger because PHCS sent more dollars to Evanston than Highland Park. (Ballengee, Tr. 160-62. *See* Hillebrand, Tr. 1761 (Hospitals often exchange lower prices for the promise of a greater volume of patients through its doors)).

835. {[redacted]} (RX 279, *in camera*; RX 308, *in camera*). {[redacted]} (RX 279, *in camera*; RX 308, *in camera*). {[redacted]} (RX 279, *in camera*; RX 308, *in camera*). {[redacted]} (Ballengee, Tr. 265-66, *in camera*; RX 805, *in camera*).

Response to Finding No. 835:

Respondent cites RX 805, which is not in evidence. Respondent also misstates Ms. Ballengee's testimony. {[redacted]} (Ballengee, Tr. 265-66, *in camera*).

Moreover, it is illogical that PHCS would reimburse ENH at the level of Loyola, Northwestern Memorial, or Rush, since Ms. Ballengee does not consider ENH to be an advanced teaching hospital like these three facilities. (Ballengee, Tr. 189. *See* Ballengee, Tr. 189 (Advanced teaching hospitals are more expensive than tertiary care facilities.)). {[redacted]} (Ballengee, Tr. 267, *in camera*).

Respondent's finding is incomplete. PHCS expected to receive lower rates at Evanston prior to the merger because PHCS sent more dollars to Evanston than Highland Park. (Ballengee, Tr. 160-62. *See* Hillebrand, Tr. 1761 (Hospitals often exchange lower prices for the promise of a greater volume of patients through its doors.)). This finding is also misleading for the reasons stated in CCRFF 827. (*See* CCRFF 827).

Respondent's finding is also incomplete because it ignores the fact that, prior to the merger, Evanston was concerned about being excluded from provider networks. That concern that resulted in lower pre-merger pricing for health plans. After the merger, ENH possessed the market power to dismiss any pre-merger concerns that Evanston or Highland Park hospitals may have had and impose a 60% price increase on the health plan. (*See* CCRFF 827).

836. {[redacted]} (RX 279, *in camera*; RX 308, *in camera*). {[redacted]} (RX 279, *in camera*). {[redacted]} (RX 308, *in camera*).

Response to Finding No. 836:

Respondent's finding is irrelevant. Neither ENH's nor Highland Park's rates with PHCS for outpatient services are relevant in this case, because outpatient services are not included in the relevant product market. (Haas-Wilson, Tr. 2660. *See* CCRFF 736). This finding is also misleading for the reasons stated in CCRFF 827. (CCRFF 827).

837. {[redacted]} (RX 279, *in camera*; RX 308, *in camera*). {[redacted]} (RX 279, *in camera*). {[redacted]} (RX 308, *in camera*).

Response to Finding No. 837:

Respondent's finding is irrelevant. Neither ENH's nor Highland Park's rates with PHCS for outpatient services are relevant in this case, because outpatient services are not included in the relevant product market. (Haas-Wilson, Tr. 2660. *See* CCRFF 736). This finding is also misleading for the reasons stated in CCRFF 827. (CCRFF 827).

838. {[redacted]} (CX 5070 at 9; RX 718 at 7, *in camera*).

Response to Finding No. 838:

Respondent's finding is incorrect. PHCS's contract with Evanston was evergreen, so the contract renewed every twelve months until it was renegotiated. (CX 5070 at 9). It also does not necessarily follow that Evanston would have renegotiated the PHCS contract in 2000 absent the merger.

Respondent's finding is misleading to the extent that it implies that Evanston would have been able to renegotiate PHCS's 2000 contract to contain a 60% price increase without the market power that the hospital system gained through the merger.

During the 2000 negotiations, Mr. Hillebrand informed PHCS that ENH was demanding a price increase because the three hospitals were "now one system" that "controlled the marketplace." (Ballengee, Tr. 176-77, 194). As evidence of ENH's "control" over the marketplace, Mr. Hillebrand cited ENH's 60% market share and told PHCS that the three hospitals combined "already had the market share for these [North Shore] communities." (Ballengee, Tr. 176-77, 194).

(2) ENH's Post-Merger Negotiations With PHCS Were Not Anticompetitive

839. Upon learning of the Merger, PHCS drafted a "significant network change memo" to advise its customers. (RX 712). In this memo, PHCS anticipated ENH's decision to provide notice of termination during contract renegotiation. (RX 712 at PHCS 891). In addition, PHCS advised its customers that it did not anticipate terminating the agreement with ENH, but the potential for termination existed if the parties could not reach mutually acceptable terms. (Ballengee, Tr. 213; RX 712 at PHCS 891).

Response to Finding No. 839:

Respondent's finding is incomplete. PHCS is obligated to inform its clients of possible network changes and of the potential for termination. (Ballengee, Tr. 213-14 ("[W]e must advise PHCS clients of the information.")).

840. On December 1, 1999, Chan sent a letter to Jane Ballengee, who testified at trial, notifying PHCS that HPH would be integrated into the same legal entity and tax identification number as ENH. (CX 171 at 1). Consequently, ENH wanted to assign the contract and rates between PHCS and HPH to the post-Merger entity. (Ballengee, Tr. 174-75; CX 171 at 1-2). ENH was seeking one set of rates for the entire system. (Ballengee, Tr. 176).

Response to Finding No. 840:

Complaint Counsel have no specific response.

841. {[redacted]

[redacted]

(Ballengee, Tr. 232-33, *in camera*; CX 1539 at 2, *in camera*; RX 711). PHCS requested to "begin discussions" regarding the renegotiation of rates that were already two years old at HPH. (RX 711; CX 171 at 5).

Response to Finding No. 841:

Complaint Counsel have no specific response.

842. PHCS notified its customers of ENH's intent to assign HPH's rates on December 14, 1999. (RX 712 at PHCS 891).

Response to Finding No. 842:

Respondent's finding is incomplete. PHCS found that the insurance companies, third party administrators, and direct employers that contracted with PHCS "would not find it acceptable" to redirect enrollees to hospitals outside of the geographic triangle formed by the three ENH facilities. (Ballengee, Tr. 183-84). Those customers "made it very clear . . . that they didn't believe that they could have a marketable network . . . without having the new ENH entity in it." (Ballengee, Tr. 180-81, 183-84).

843. Negotiations between ENH and PHCS then lasted a number of months, from December 1999 through February or March of 2000. (Ballengee, Tr. 173). [redacted] (Ballengee, Tr. 175; RX 718 at 2-5, *in camera*; CX 113 at 1, *in camera;* RX 773 at ENH JL 12536-38, *in camera*; CX 116 at 2, *in camera*; CX 176 at 2, *in camera*).

Response to Finding No. 843:

Respondent's finding is incomplete. [redacted]

(Ballengee, Tr. 175; CX 116 at 1, *in camera*). During the meeting, Mr. Hillebrand demanded higher rates from PHCS because the three hospitals were "now one system"

that "controlled the marketplace." (Ballengee, Tr. 176-77, 194). As evidence of ENH's "control" over the marketplace, Mr. Hillebrand cited ENH's 60% market share figures, and emphasized that the three hospitals combined "already had the market share for these [North Shore] communities." (Ballengee, Tr. 176-77, 194). ENH assured PHCS that all of the other health plans would also have to acquiesce to ENH's pricing demands. (Ballengee, Tr. 176-77 ("these were the rates, everybody was going to do it.")).

Respondent's finding is also incomplete, because it ignores information related to PHCS's internal deliberations. Over the course of these negotiations, PHCS's performed an internal analysis of cost scenarios including and excluding ENH. PHCS's cost analysis showed that "the elimination of Evanston and Highland Park financially would be the best overall in impacting [PHCS's] costs," and that scenarios eliminating other hospitals and keeping the ENH system did not show "as significant" cost savings as eliminating the ENH system altogether. (Ballengee, Tr. 185). As shown in CCRFF 842, however, PHCS customers did not feel that a network without ENH would be marketable.

844. Ballengee offered, in general terms, to exclude certain hospitals from PHCS's network during the contract negotiations with ENH. (Hillebrand, Tr. 1745-47, 1894). However, since PPOs do not have the ability to steer business, Hillebrand was skeptical of that offer. (Hillebrand, Tr. 1746, 1894). Hillebrand later learned that Ballengee did not even have the authority to make such an offer because that approach was not supported by the decision-makers at PHCS. (Hillebrand, Tr. 1894).

Response to Finding No. 844:

Respondent's finding is incomplete. In fact, Mr. Hillebrand rejected PHCS's offer to exclude St. Francis, Rush North Shore, or Condell on the grounds that he did not view these hospitals as "competitors that would be worth any additional rates."

(Ballengee, Tr. 182). Mr. Hillebrand's self-serving testimony regarding Ms. Ballengee's "authority" to make offers is irrelevant to the issues of this case and uncorroborated by documents or testimony.

Neither Mr. Neaman nor Mr. Hillebrand believed that ENH's post-merger price demands had to change because of any risk that ENH would lose business to other hospitals or that other hospitals would change their prices in response to ENH's prices. (Neaman, Tr. 1211-12; Hillebrand, Tr. 1764-65). In fact, ENH did not lose a single health plan customer after the price increases. (Hillebrand, Tr. 1708).

845. {[redacted]} (CX 116 at 1, *in camera*). {[redacted]} (CX 116 at 1, *in camera*).

Response to Finding No. 845:

Complaint Counsel have no specific response.

846. ENH did not negotiate a "take it or leave it" contract with {[redacted]}. {[redacted]} (CX 116 at 2, *in camera*; CX 5072 at 23, 29, *in camera*). {[redacted]} (CX 116 at 2, *in camera*; CX 5072 at 23, *in camera*). {[redacted]}. (CX 5072 at 23, *in camera*; Ballengee, Tr. 258-60, *in camera*).

Response to Finding No. 846:

Respondent's finding is incomplete and misleading. {[redacted]} (Ballengee, Tr. 252, 255, *in camera*; Hillebrand, Tr. 1893; CX 116 at 2, *in*

camera, CX 117 at 1, *in camera*; CX 5072 at 23, *in camera*). After the February meeting, PHCS and ENH came to agreement on rates that were "significantly higher" than what PHCS had been paying pre-merger. (Ballengee, Tr. 179). {[redacted]} (Ballengee, Tr. 268-270, *in camera*. *See* CCRFF 590 (Post-merger, ENH sought the higher of the Evanston or Highland Park rate plus a premium.)).

847. {[redacted]} (CX 116 at 2, *in camera*; CX 5072 at 29, *in camera*). {[redacted]} (CX 116 at 2, *in camera*; CX 5072 at 29, *in camera*). {[redacted]} (Ballengee, Tr. 260, *in camera*; Hillebrand, Tr. 1893; Hillebrand, Tr. 1937, *in camera*; CX 5072 at 18). {[redacted]} (Ballengee, Tr. 260-61, *in camera;* CX 5072 at 18). {[redacted]} (Ballengee, Tr. 260-61, *in camera*; CX 5072 at 18). The escalator clause also required ENH to notify PHCS each year regarding its chargemaster prices. (Hillebrand, Tr. 1995-96). {[redacted]} (Ballengee, Tr. 261, *in camera*). ENH adhered to the terms of its contract with PHCS. (Hillebrand, Tr. 1995-96).

Response to Finding No. 847:

The finding is incomplete and misleading. Regardless of the way Respondents dress it up, the price increase was still very large. {[redacted]} (CX 6279 at 4-5 ({[redacted]}

[redacted]), *in camera*; Haas-Wilson, Tr. 2522, *in camera*; Ballengee, Tr. 196 (60% price increase using PHCS claims data).

848. PHCS calculated that ENH received a post-Merger price increase of 60%. (Ballengee, Tr. 196). That calculation was based on modeling the old and new contracts using data from the PHCS claims database. (Ballengee, Tr. 196). {[redacted]} (Ballengee, Tr. 261-62, *in camera*). {[redacted]} (Ballengee, Tr. 262, *in camera*). {[redacted]} (Ballengee, Tr. 262, *in camera*).

Response to Finding No. 848:

Respondent's finding is incomplete and misleading. {[redacted]} (CX 6279 at 4-5 ({[redacted]}), *in camera*; Haas-Wilson, Tr. 2522, *in camera*; Ballengee, Tr. 196 (60% price increase using PHCS claims data).

ix. Preferred Plan

(1) Evanston Hospital's Pre-Merger Contract Rates With Preferred Plan Were Outdated And Undermarket

849. Before the Merger, Evanston Hospital had a mixed per diem and discount-off-charges arrangement with Preferred Plan, granting Preferred Plan medical/surgical

per diems of $1,397.25, but also including discount-off-charges arrangements for inpatient services at 20% and outpatient services at 15%. (CX 5199 at 2).

Response to Finding No. 849:

Respondent's finding is misleading. The majority of Preferred Plan's pre-merger contract with Evanston was a per diem arrangement. For all service categories listed, such as Medical, Surgical, Obstetrics, Mental Health, ICU, CCU, NICU, and Skilled Nursing service categories, Preferred Plan had a per diem rate. (CX 5199 at 2). Moreover, Preferred Plan's contract was not "outdated" (as Respondent's subheading implies). Evanston revisited and renegotiated the Preferred Plan rates in 1997, 1998, and 1999. (CX 5196; CX 5197; CX 5199).

850. Before the Merger, HPH had a 15% discount-off-charges arrangement for inpatient services and an 8% discount-off-charges arrangement for outpatient services with Preferred Plan. (CX 5183 at 2).

Response to Finding No. 850:

Respondent's finding is incomplete. It is impossible to know that actual rates that health plans paid Highland Park pre-merger from the negotiated contractual discount figure, because the actual chargemaster rates that are being discounted determine the reimbursement rates. (*See* CCRFF 782, 785).

(2) ENH's Post-Merger Negotiations With Preferred Plan Were Not Anticompetitive

851. After the Merger, Preferred Plan agreed to assign HPH's rates to ENH – again, a 15% discount-off-charges for inpatient services and an 8% discount-off-charges for outpatient services. (RX 781 at ENH JL 6304, 6310).

Response to Finding No. 851:

The finding is incomplete. {[redacted]

[redacted] (CX 6279 at 4, *in camera*). {[redacted] (CX 6279 at 5, *in camera*).

852. On May 1, 2000, Preferred Plan and ENH agreed to a new contract that benefited Preferred Plan. This contract included a 20% discount for inpatient services and a 12% discount for outpatient services – discounts that were larger than those Preferred Plan assigned to ENH from HPH after the Merger. (CX 5200 at 2).

Response to Finding No. 852:

Respondent's finding is inaccurate. ENH's post-merger contract with Preferred Plan in no way "benefitted Preferred Plan." Respondent incorrectly assumes that the percent contractual discount is indicative of price changes. As shown in CCRFF 782 and 785, that assumption is not true. {[redacted] (CX 6279 at 4-5, *in camera*. Haas-Wilson, Tr. 2537-38, *in camera* ({[redacted]}). *See* RX 1687 at ENHL BW 027653 ({[redacted]}), *in camera*). Because Preferred Plan's contract is based on a discount off charges payment methodology, the health plan's reimbursement prices continue to increase every time ENH increases its chargemaster.

(*See* CCRFF 93. *See* RX 1687 at ENHL BW 027653 ({[redacted]}), *in camera*).

{[redacted]} (CX 24 at 10, *in camera*). {[redacted]} (CX 24 at 10, *in camera*; RX 1687 at ENHL BW 027653, *in camera*).

x. Unicare

(1) Evanston Hospital's Pre-Merger Contract Rates With Unicare And Rush Prudential Were Outdated And Undermarket

853. Wellpoint, the parent of Unicare, purchased Rush Prudential in 2000. (CX 124 at 1).

Response to Finding No. 853:

Complaint Counsel have no specific response.

854. In September 1999, Evanston Hospital characterized its contract with Rush Prudential as "horrible." (RX 617). Evanston Hospital also noted that it was "very painful working" with Rush Prudential's administrative staff. (RX 617).

Response to Finding No. 854:

Respondent cites the handwriting on RX 617 for its truth. This is contrary to paragraph 4 of the Joint Stipulation Regarding Admissibility of Trial Exhibits dated February 10, 2005, which provides that "all handwriting on documents admitted into evidence is presumed to be inadmissible hearsay and, therefore, not admitted for the truth

of the matter asserted." A party, however, may attempt to admit handwriting into evidence during trial . . ." (JX1 at 1). Respondent did not admit the handwriting into evidence during trial. (*See* Respondent's Admitted Exhibit Index).

855. {[redacted]} (Holt-Darcy, Tr. 1570-71, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1600, *in camera*).

Response to Finding No. 855:

{[redacted]} (Holt-Darcy, Tr. 1570-71, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1522, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1526).

Respondent's finding is incomplete, because it does not explain why Evanston (or Highland Park) would not have asked for that type of arrangement pre-merger. Evanston and Highland Park settled for per diem arrangements with Rush Prudential prior to the merger, because the two hospitals were concerned about being excluded from health plans' network of providers. (Neaman, Tr. 961; Newton, Tr. 303-06; Holt-Darcy, Tr.

1600-01). To maintain access to health plan networks, Evanston and Highland Park had to make its terms and service offerings more attractive to health plans. (Neaman, Tr. 961-62; Newton, Tr. 303-06). {[redacted]} (Holt-Darcy, Tr. 1518-19, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1518-19, *in camera*).

856. Evanston Hospital had an HMO contract with Unicare dating back to 1994. (CX 5085). This contract expired on May 30, 1995, but was renewed annually. (CX 5085 at 2; CX 5091 at 2).

Response to Finding No. 856:

Respondent's finding is inaccurate. Evanston Hospital had an HMO contract with Rush Prudential (not Unicare) that dated back to 1994. (CX 5085). Moreover, Evanston's contract with Unicare did not "expire" on May 30, 1995. According to the contract the "Agreement shall be effective on June 1, 1994 and shall continue until May 30, 1995 and shall *automatically renew* from year to year thereafter upon each and all of the conditions contained herein." (CX 5085 at 2 (emphasis added)).

857. {[redacted]} (Holt-Darcy, Tr. 1599, 1605, *in camera*; CX 216 at 12, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1605, *in camera*). {[redacted]}

[redacted] (Holt-Darcy, Tr. 1548, 1599-1600, *in camera*). [redacted] (Holt-Darcy, Tr. 1549, *in camera*).

Response to Finding No. 857:

Rush Prudential's 1994 contract with Evanston proves that older contracts are not disadvantageous to a provider. According to Ms. Chan, "[i]f the hospital really do [*sic*] not want to change the contract, if they have a very good contract, they would keep it evergreen." (Chan, Tr. 677-78). Prior to the merger, Rush Prudential paid Evanston higher rates than many health plans prior to the merger. (CX 74 at 9). In 1999, Rush Prudential paid higher per diems for ICU, medical, and surgical services than Blue Cross/Blue Shield, Aetna, PHCS, United, Preferred, and Cigna. (CX 74 at 9).

[redacted] (Holt-Darcy, Tr. 1547–48, 1597, 1599-1600, *in camera*; CX 216 at 1, *in camera*). [redacted] (*See* CCRFF 869).

858. [redacted] (CX 216 at 1, 12, *in camera*). And the contract was only scheduled to be in effect for one year. (CX 216 at 9). Accordingly, Evanston Hospital and Unicare would have had to begin negotiations prior to the Summer of 2000 even without the Merger. (CX 216 at 9).

Response to Finding No. 858:

Respondent's finding is incomplete and misleading. [redacted]

[redacted] (Holt-Darcy, Tr. 1547-48, *in camera*; CX 216 at 1, *in camera*).

{[redacted]} (CX 5075, *in camera*. *See* CCRFF 857).

{[redacted]} (CX 5075, *in camera*). {[redacted]}

[redacted]} (*See* RFF 757, *in camera*; CX 1998 at 49).

859. HPH had a PPO contract with Rush Prudential dating back to May 1, 1994. (CX 215 at 1; CX 5076 at 1-2). This contract with Rush Prudential expired on April 30, 1995, but had been successively renewed per the terms of the contract. (CX 215 at 1).

Response to Finding No. 859:

Respondent's finding is inaccurate. Highland Park's contract with Rush Prudential's PPO did not "expire" on April 30, 1995. (CX 215 at 20). According to the contract "the term of this addendum shall be for an initial period of 12 months and *shall continue from year to year thereafter*." (CX 215 at 20 (emphasis added)).

860. In 1998, Rush Prudential sought to contract HPH into its HMO plan. (RX 392). But HPH refused to accept Rush Prudential's "standard terms of the contract." (RX 392).

Response to Finding No. 860:

The finding is incomplete. Highland Park did contract with Rush Prudential for

it's PPO product pre-merger. (*See* CCRFF 859).

861. HPH had no contract with Unicare before the Merger. (CX 114 at 1). Unicare accessed HPH using the CCN or Healthstar Network. (CX 114 at 1). HPH did not sign a contract with Unicare because Unicare was not willing to offer rates comparable to those offered by CCN and Healthstar. (CX 114 at 1).

Response to Finding No. 861

Respondent's finding is incomplete. Health plans could exclude either Highland Park Hospital or Evanston prior to the merger. Unicare chose to exclude Highland Park, but still had a viable network because Evanston provided the necessary coverage in the area. (RFF 861, 856. *See* Holt-Darcy, Tr. 1518-19 ({[redacted]}, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1561, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1528, 1560-61, *in camera*).

(2) ENH's Post-Merger Negotiations With Unicare Were Not Anticompetitive

862. On March 24, 2000, ENH opened contract renegotiations with Unicare. (CX 124 at 1). The contracts had to be renegotiated in part because two mergers took place in early 2000: ENH's merger with HPH and Wellpoint's acquisition of Rush Prudential. (CX 124 at 1).

Response to Finding No. 862:

Respondent's finding is inaccurate. {[redacted]}

(Holt-Darcy, Tr. 1536, 1539, 1543, 1547–48, 1563, 1597, 1599-1600, *in camera*; CX 216 at 1, *in camera*; CX 124 at 1, *in camera*; CX 5075 at 17, *in camera*. *See* CCRFF 863). Alternatively, the fact that two companies affiliate with each other does not mean that ENH had to have one contract for both affiliates. Evanston instead could have maintained separate contracts, just as Evanston did with United prior to the merger. (Hillebrand, Tr. 1870-71).

863. {[redacted]} (Holt-Darcy, Tr. 1503, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1503, *in camera*).

Response to Finding No. 863:

Respondent's finding is incomplete, misstates the record, and is misleading. {[redacted]} (Holt-Darcy, Tr. 1503, 1597, 1599-1600, *in camera* (emphasis added)). {[redacted]}

[redacted] (Holt-Darcy, Tr. 1536, 1539, 1543, 1563, *in camera*; CX 5075 at 17, *in camera*).

{[redacted]} (CX 6279 at 4, *in camera*). {[redacted]} (CX 6279 at 5, *in camera*; Haas-Wilson, Tr. 2537-38 ({[redacted]}), *in camera*).

864. {[redacted]} (Holt-Darcy, Tr. 1579, *in camera*; CX 129 at 1).

Response to Finding No. 864:

{[redacted]} (CX 129 at 1, *in camera*; Holt-Darcy, Tr. 1579, *in camera* (emphasis added)).

{[redacted]}

[redacted] (Holt-Darcy, Tr. 1599-600, *in camera*).

[redacted] (CX 129 at 1, *in camera* (emphasis added)). [redacted] (Holt-Darcy, Tr. 1559-60, *in camera*; CX 129 at 1, *in camera*).

865. [redacted] (Holt-Darcy, Tr. 1527-28, *in camera*; CX 124 at 2, *in camera*). [redacted] (Holt-Darcy, Tr. 1527-28, *in camera*; CX 124 at 2). [redacted] (Holt-Darcy, Tr. 1527, *in camera*).

Response to Finding No. 865:

Respondent's finding is incomplete. [redacted] (Holt-Darcy, Tr. 1527, *in camera*; CX 124 at 1-2, *in camera* (emphasis added)). *See* Holt-Darcy, Tr. 1535 ([redacted]), *in camera*). [redacted] (Holt-Darcy, Tr. 1533-35, *in camera*; CX 124 at 1-2, *in camera*).

[redacted] (CX 216) [redacted] (Holt-Darcy, Tr. 1527, 1535-36, *in camera*; CX 124 at 2-3, *in camera*). [redacted] (Holt-Darcy, Tr. 1527, 1535-36, *in camera*; Hillebrand, Tr. 1944, *in camera*; CX 124 at 2-3, *in camera*). [redacted] (Holt-Darcy, Tr. 1527, 1536, *in camera*; CX 124 at 2-3, *in camera*; CX 5091 at 1).

[redacted] (Holt-Darcy, Tr. 1528, *in camera*). [redacted] (Holt-Darcy, Tr. 1528-29, *in camera*). [redacted] (Holt-Darcy, Tr. 1528-29, *in camera*).

866. In response to Unicare's counteroffer, on June 14, 2000, ENH provided notice of termination of the Unicare hospital contract. (CX 2063 at 1; RX 881). ENH wrote, "[a]s much as we want to continue our contractual relationship with Unicare, we cannot accept the rates as proposed [by Unicare]." (CX 2063 at 1).

Response to Finding No. 866:

Respondent's finding is incomplete. {[redacted]} (Holt-Darcy, Tr. 1551, *in camera*; CX 5907 at 1, *in camera*). {[redacted]} (CX 5907 at 1; *in camera*). {[redacted]} (Holt-Darcy, Tr. 1525, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1563, 1600, *in camera*; CX 5907 at 1, *in camera*). {[redacted]}

867. {[redacted]}

[redacted] (Holt-Darcy, Tr. 1602, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1552, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1540, 1551, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1552, *in camera*).

Response to Finding No. 867:

Respondent's finding is misleading. In first-stage competition, the relative bargaining positions of the hospital and the health plan determine to a large extent the outcome of the negotiation. (Haas-Wilson, Tr. 2469-70). {[redacted]} (Holt-Darcy, Tr. 1529, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1510, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1511, *in camera*. *See* Holt-Darcy, Tr. 1510 ({[redacted]}), *in camera*).

{[redacted]}

[redacted]

(Holt-Darcy, Tr. 1552-53, 1568, *in camera*). {[redacted]

[redacted]}

(Holt-Darcy, Tr. 1552, 1554, *in camera*). {[redacted]

[redacted]} (Holt-Darcy, Tr. 1552-53, *in camera*. *See* Holt-Darcy, Tr. 1602 ({[redacted]

[redacted]}), *in camera*; Holt-Darcy, Tr. 1554 ({[redacted]

[redacted]}), *in camera*).

868. {[redacted]

[redacted]} (Holt-Darcy, Tr. 1567-68, *in camera*). {[redacted]

[redacted]} (Holt-Darcy, Tr. 1567, *in camera*).

Response to Finding No. 868:

{[redacted]

[redacted]} (CCRFF 867, *in camera*).

869. {[redacted]} (CX 5075, *in camera*).

Response to Finding No. 869:

Respondent's finding is incomplete. {[redacted]} (Holt-Darcy, Tr. 1513-14, 1562, *in camera*; CX 5075 at 17, *in camera*). [redacted] (Holt-Darcy, Tr. 1536, 1539, 1543, 1563, *in camera*; CX 5075 at 17, *in camera*). {[redacted]} (CX 5075 at 17, *in camera*. *See* Newton, Tr. 365-66; RX 1687 at ENHL BW 027653, *in camera* ({[redacted]}).

{[redacted]} (CX 6279 at 4, *in camera*). {[redacted]} (CX 6279 at 5, *in camera*. *See* Haas-Wilson, Tr. 2537-38 ({[redacted]}

[redacted] (Holt-Darcy, Tr. 1565, *in camera*).

870. {[redacted]} (Holt-Darcy, Tr. 1535, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1542, *in camera*).

Response to Finding No. 870:

Respondent's finding is inaccurate. {[redacted]} (Holt-Darcy, Tr. 1536-37, 1542, *in camera*).

871. {[redacted]} (Holt-Darcy, Tr. 1582-83, *in camera*; CX 5085 at 1; CX 5075 at 17, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1582, *in camera*; CX 5085 at 1,). {[redacted]} (Holt-Darcy, Tr. 1582, *in camera*; CX 5075 at 17, *in camera*).

Response to Finding No. 871:

{[redacted]}

[redacted] (Holt-Darcy, Tr. 1582-83, *in camera*). Moreover, such a pronouncement could not be made by looking at rates for two service categories in a contract. {[redacted]

[redacted]

[redacted]

[redacted]"(Holt-Darcy, Tr. 1536, 1543, 1563, *in camera*).

{[redacted]

[redacted]

[redacted] (*See* CCRFF 870 ({[redacted]

[redacted]), *in camera*; CCRFF 869 ({[redacted]

[redacted]});

CCRFF 832, *in camera*).

872. {[redacted] (Holt-Darcy, Tr. 1581, *in camera*). {[redacted] (Holt-Darcy, Tr. 1581, *in camera*). {[redacted] (Holt-Darcy, Tr. 1581, *in camera*). {[redacted] (Holt-Darcy, Tr. 1581, *in camera*; CX 5075 at 18, *in camera*).

Response to Finding No. 872:

Respondent's finding is irrelevant. {[redacted]

[redacted]

[redacted]

[redacted] (Holt-Darcy, Tr. 1536-37, 1542, *in camera*).

{[redacted]

[redacted] (*See* CCRFF 869, *in camera*).

873. When compared against Rush Prudential contracts, Unicare also enjoyed improved outpatient rates. The outpatient rates under the 1994 Rush Prudential contracts with HPH were at a 12% discount-off-charges. (CX 5076 at 10; CX 215 at 1). The pre-Merger outpatient discount at Evanston Hospital was 8% off charges. (CX 5085 at 1; CX 5091 at 1). [redacted] (CX 5075 at 17, *in camera*).

Response to Finding No. 873:

The finding is incomplete and misleading. The percentage discount negotiated between ENH and Unicare is not indicative of ENH's actual prices or effective discounts without knowing the chargemaster rates that are being discounted. (CCRFF 782, 785, 832).

874. [redacted] (Noether, Tr. 6104, *in camera*). [redacted] (Noether, Tr. 6104, *in camera*; Holt-Darcy, Tr. 1570-71, *in camera*).

Response to Finding No. 874:

The finding misstates the record. [redacted] (Holt-Darcy, Tr. 1570-71, *in camera*). [redacted]

(Holt-Darcy, Tr. 1522, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1526, *in camera*).

875. {[redacted]} (Holt-Darcy, Tr. 1562-64, *in camera*).

Response to Finding No. 875:

Complaint Counsel have no specific response.

876. {[redacted]} (Holt-Darcy, Tr. 1563-64, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1564, *in camera*). {[redacted]} (Holt-Darcy, Tr. 1564, *in camera*).

Response to Finding No. 876:

{[redacted]} (*See* CCRFF 867, *in camera*).

xi. United

(1) Evanston Hospital's Pre-Merger Contract Rates With United Were Outdated And Undermarket

877. At the time of the Merger, Evanston Hospital's rates with United had been in place for about five years, they were below Evanston Hospital's costs, and they were much lower than Evanston Hospital's rates with other MCOs. (Sirabian, Tr. 5711-12).

Response to Finding No. 877:

Respondent's finding is irrelevant. In first-stage competition, the relative bargaining positions of the hospital and the health plan determine to a large extent the

outcome of the negotiation. (Haas-Wilson, Tr. 2469-70). Because each negotiation is different, United's pre-merger rates relative to other health plans' rates are irrelevant. Respondent's finding is also incomplete, because it does not explain why Evanston would have kept its pricing to United low prior to the merger. As discussed at length in CCRFF 590, Evanston (without the market power obtained through the merger) faced fierce pre-merger competition for inclusion in networks, and the relationship between Evanston and health plans was dictated by the ability of the health plan to exclude Evanston from its network. (Haas-Wilson, Tr. 2470). Pre-merger, Evanston and Highland Park were both concerned about being excluded from health plans' network of providers. (Neaman, Tr. 961; Newton, Tr. 303-06). To maintain access to health plan networks, Evanston and Highland Park lowered their pricing, increased the breadth, depth and quality of their services, and strove to control costs. (Neaman, Tr. 961-62; Newton, Tr. 303-06. *See* CCRFF 590). After the merger, ENH's bargaining position changed, because the merged entity possessed the market power to impose price increases at will without concern over losing any relationships with health plans. (Neaman, Tr. 1211-12; Hillebrand, Tr. 1764-65).

878. The United contract with Evanston Hospital in effect at the time of the Merger expired in the mid-1990s. (Sirabian, Tr. 5711). During the 1990s, United was not willing to work with Evanston Hospital in a fair, honest and open way. United was uncompromising, and Evanston Hospital had a very difficult time trying to present its position to them. (Sirabian, Tr. 5710-11; 5714-15; Hillebrand, Tr. 1868).

Response to Finding No. 878:

Respondent's finding is incorrect, because the United contract was not "expired," as Respondent claims. United's (Chicago HMO's) pre-merger contract with Evanston

states that "[t]his Agreement shall become effective on the date first set forth above in this Agreement; and shall continue in effect from year to year unless terminated by either party as provided hereinafter." (CX 5168 at 7). Also in the record are letters of agreement extending the terms of ENH's contracts with United. (*See, e.g.,* CX 5165).

879. Evanston Hospital had claims issues with United in the mid- to late-1990s that made reimbursement a "mess." (Hillebrand, Tr. 1870-71). Evanston Hospital was commonly paid under the wrong contract terms, by the wrong system, and for the wrong product. (Hillebrand, Tr. 1871). Evanston Hospital's business office literally had people dedicated to claims adjudication and resolution of United claims. (Hillebrand, Tr. 1871). Eventually, Evanston Hospital had to purchase additional software to attempt to resolve those issues. (Hillebrand, Tr. 1871).

Response to Finding No. 879:

Respondent's finding is irrelevant. There is no evidence any claims adjudication or resolution problems between United and ENH affected the prices charged by ENH. Regardless of how difficult it may have been to process payments from United prior to the merger, Evanston and Highland Park each bowed to health plans' demands for favorable terms and conditions in order to remain part of that health plan's network. (*See* CCRFF 590).

880. Before the Merger, United acquired a variety of companies, including Share, Chicago HMO, MetLife and Travelers, each of which had separate payment systems. (Hillebrand, Tr. 1870-71). In July 1998, United requested to consolidate the four hospital agreements in place with Evanston Hospital. (RX 355; Hillebrand, Tr. 1724).

Response to Finding No. 880:

Complaint Counsel have no specific response.

881. Evanston Hospital agreed that the United contracts should be consolidated in July 1998. (RX 356). However, the proposed rate structure was not acceptable and Evanston Hospital presented a counter-proposal. (RX 356). New agreements, however, were not reached during these negotiations, as indicated by the 2000 contract which includes an introductory

paragraph consolidating and superceding the existing contracts held by Share Health Plan, Chicago HMO and Chicago Health Multi Option Insurance. (CX 5174 at 1-2).

Response to Finding No. 881:

Complaint Counsel have no specific response.

882. As early as December 1994, HPH had negotiated discount-off-charges of 15% for nearly all inpatient services with Metropolitan Life Insurance Company, which was acquired by United Healthcare. (CX 5141 at 1-4). HPH had the same contract until the Merger. (CX 5141). For outpatient services under the pre-Merger HPH contract, the percentage of billed charges was 92.5%. (CX 5141 at 5). Emergency room visits were also paid at 92.5% of billed charges. (CX 5141 at 4).

Response to Finding No. 882:

Respondent's finding is incomplete. United contracted with Highland Park Hospital throughout the 1990s under the names of the health plan's affiliates, including MetLife, Metropolitan Life, Chicago HMO, Travelers, and MetraHealth. (CX 5910 at 36-38; Hillebrand, Tr. 1868). {[redacted]} (CX 1099 at 53-55, *in camera*). {[redacted]} (CX 5145 at 2; CX 1099 at 53-54, *in camera*). {[redacted]} (CX 1099 at 55, *in camera*).

(2) ENH's Post-Merger Negotiations With United Were Not Anticompetitive

883. {[redacted]} (Noether, Tr. 6086-87, *in camera*; RX 1912 at 34, *in camera*). {[redacted]} (Noether, Tr. 6086-87, *in camera*; RX 1912 at 34, *in camera*).

Response to Finding No. 883:

Respondent's finding is inaccurate. {[redacted]} (RX 1912 at 34, *in camera*; Noether, Tr. 6086-87, *in camera*; *See, e.g.,* CX 5174 at 11, *in camera*; CX 5070 at 28, 30). {[redacted]} (McGuire, Tr. 6089-90, *in camera*; RX 1912 at 34, *in camera*). {[redacted]}

884. {[redacted]} (Noether, Tr. 6088, *in camera*). {[redacted]}. (Noether, Tr. 6088-89, *in camera*). {[redacted]} (Noether, Tr. 6093, *in camera*; Hillebrand, Tr. 1870; Neaman, Tr. 1340-41; RX 684 at BAIN 73; Haas-Wilson, Tr. 2851-52, *in camera*).

Response to Finding No. 884:

Respondent's cite is inadmissible hearsay as cited. While Ms. Ogden's testimony may have formed the basis for Dr. Noether's opinion, Dr. Noether's recount of Ms. Ogden's deposition testimony is not admissible. {[redacted]}

[redacted] (RX 1912 at 34, *in camera*).

885. After ENH saw HPH's rates with United, Hillebrand felt that United's negotiators had lied to him by giving him the impression that Evanston Hospital was being fairly and appropriately compensated. (Hillebrand, Tr. 1874).

Response to Finding No. 885:

This finding is inconsistent with RFF 182, [redacted] (RFF 182, *in camera*).

886. Jack Sirabian, from ENH, and Ogden, from Bain, handled the 1999 negotiations with United. (Hillebrand, Tr. 1873-74). Jack Gilbert (HPH's former CFO) also participated in the conversations. (Hillebrand, Tr. 1874).

Response to Finding No. 886:

Respondent's finding is incomplete and misleading, however, because it overstates the involvement of Ms. Ogden and Bain in the 1999 United negotiations. Ms. Ogden admitted that she only attended one negotiation meeting with United, that Bain representatives did not attend the subsequent meetings with United, and that she does not know when ENH and United finalized the United contract. (RX 2047 at 168 (Ogden, Dep.)). There is an inconsistency in Respondent claiming that Sirabian was ineffectual with United in RFF 609 and 612, and ENH allowing Mr. Sirabian to oversee the United

renegotiations at the time of the merger. (*See* RFF 609, 612, 886).

887. Jim Watson was the principal contact for United Healthcare during the 1999-2000 negotiations. (Hillebrand, Tr. 1900). {[redacted]} (Foucre, Tr. 1118, *in camera*). {[redacted]} (Foucre, Tr. 1118, *in camera*).

Response to Finding No. 887:

Respondent's finding is inaccurate. Ms. Foucre testified that the United representative primarily responsible for the renegotiation of United's contract with ENH in 2000 was Mary Gilligan (now deceased). (Foucre, Tr. 886-87).

888. In December 1999, United proposed that the parties use the better of the two contracts, either Evanston Hospital's or HPH's, as the basis for the new, post-Merger ENH agreement. (Hillebrand, Tr. 1900-01; CX 111 at 1). HPH's previous contract with United was much better than Evanston Hospital's, at 85% of charges for inpatient services. (CX 5141). Evanston Hospital had per diem contracts before the Merger. (Foucre, Tr. 890).

Response to Finding No. 888:

Respondent's finding is inaccurate. Also CX 111 also does not claim that "HPH's previous contract with United was much better than Evanston's hospital," and such a pronouncement could not be made by looking at one of United's multiple contracts with Highland Park. {[redacted]} (*See* CCRFF 882, *in camera*; CX 1099 at 53-55, *in camera*). Even if, *arguendo*, all of United's pre-merger contracts and rates with Highland Park were based on a discount off charges payment methodology, Respondent's finding is still inaccurate, because there is no way to compare contracts based on discount off charges without knowing the relative chargemasters. (CCRFF 785).

889. {[redacted]} (Foucre, Tr. 1118, *in camera*; CX 5174 at 11-12, *in camera*). {[redacted]} (CX 5174 at 11-12; *in camera*).

Response to Finding No. 889:

Respondent's finding is inaccurate. Ms. Foucre testified that United's 2000 contract with ENH relied *primarily* on a discount off charges payment methodology. (Foucre, Tr. 889).

890. {[redacted]} (CX 5174 at 11-12, *in camera*). {[redacted]} (Foucre, Tr. 1118-19, *in camera*; CX 5174 at 12, *in camera*).

Response to Finding No. 890:

{[redacted]} (CCRFF 785, *in camera*). {[redacted]} (CCRFF 882, *in camera*).

891. ENH proposed the duration of the agreement to be three years. (Hillebrand, Tr. 1901; CX 111 at 4). However, United Healthcare negotiated the initial term to be two years, renewing automatically for successive year terms thereafter. (CX 5174 at 7).

Response to Finding No. 891:

The term of the renegotiated United contract is irrelevant for two reasons. First, the contract that was actually negotiated would automatically renew after the initial term of the arrangement had ended. {[redacted]}

[redacted] (*See* CCRFF 785, *in camera*). In 2002, United knew that the discount off charges arrangements had resulted in higher and higher reimbursements from United as it witnessed "alarmin[g] escalating costs in [ENH's] billed charges" that were "outside of the norms for the market." (Foucre, Tr. 898, 889).

892. [redacted] (CX 5174 at 7; Foucre, Tr. 1087, *in camera*). United, therefore, had foreseen the possibility that ENH's charges could rise and specifically negotiated an appropriate remedy in that event: termination of the contract. (CX 5174 at 7).

Response to Finding No. 892:

The finding is incomplete. In fact, ENH's termination clause with United was no protection against price increases because even after ENH increased its charges more than 6%, United could not terminate ENH and still have a viable network. (Foucre, Tr. 900-01, 925-26).

893. [redacted] (RX 1208 at UHCENH 3378, *in camera*). [redacted] (RX 1208 at UHCENH 3378, *in camera*). [redacted] (RX 1208 at UHCENH 3378, *in camera*). [redacted] (RX 1208 at UHCENH 3378, *in camera*).

Response to Finding No. 893:

[redacted]

[redacted]

(RX 1208 at UHCENH 3378, *in camera.* CCRFF 736).

(3) United And ENH Renegotiated Their 2000 Contract To Accommodate United's Contracting Goals

894. At the end of 2002, United was free to terminate its existing contract with ENH. (Foucre, Tr. 899; CX 5174 at 7). In August 2002, United and ENH began re-negotiations that lasted for nearly two years. (Foucre, Tr. 882; Hillebrand, Tr. 1875).

Response to Finding No. 894:

The finding is incomplete. [redacted] (Foucre, Tr. 899-900, 901-02, 925-26, 931-32; CX 5174 at 7, *in camera*).

895. The renegotiations with ENH began with a meeting in August 2002 between Ms. Foucre and Bill Moeller, CEO of United, conferring with Hillebrand, Joe Golbus, and Jodi Levine. (Foucre, Tr. 892; Hillebrand, Tr. 1875-76). United presented its broad objectives for the negotiations. (Foucre, Tr. 892). ENH discussed its perspective that moving away from discount-off-charges shifts risk to the hospitals and that ENH's view was that United should be responsible for taking risk. (Foucre, Tr. 893).

Response to Finding No. 895:

Respondent's finding is incomplete. United requested the negotiation because, since the 2000 contract, ENH had been an "outlier" hospital with "much higher than the average reimbursement." (Foucre, Tr. 888). The 2000 contract relied primarily on a

discount off charges payment methodology, resulting in higher and higher reimbursements from United as it witnessed "alarmin[g] escalating costs in [ENH's] billed charges" that were "outside of the norms for the market." (Foucre, Tr. 898, 889).

896. When United entered renegotiation talks in August 2002, its objectives were: (1) to move ENH onto its new contract template; (2) to significantly improve the level of fixed rate pricing; and (3) to achieve an overall reduction in the total reimbursement under the contract. (Foucre, Tr. 892). United sent its initial proposal to ENH in October 2002. (Foucre, Tr. 894).

Response to Finding No. 896:

Respondent's finding is incomplete. (*See* CCRFF 895 (explaining United's rationale for requesting these objectives).

897. The two sides met in October 2002. (Foucre, Tr. 894). Present on behalf of United was Foucre, Bill Moeller, Tom Kniery (Vice President of Network Management) and perhaps others. (Foucre, Tr. 894-95; Hillebrand, Tr. 1878). For ENH, Hillebrand, Dr. Golbus and Levine were present. (Hillebrand, Tr. 1878; Foucre, Tr. 895).

Response to Finding No. 897:

Complaint Counsel have no specific response.

898. United shaped the conversation relating to a decrease by asking for reimbursement rates similar to its primary competitor, Blue Cross. (Foucre, Tr. 893). {[redacted]} (Foucre, Tr. 894; Foucre, Tr. 1107, *in camera*; CX 2381, *in camera*).

Response to Finding No. 898:

Respondent's finding is inaccurate. First, Ms. Foucre testified that, to discern whether United's rates were out-of-line with Blue Cross's, United used "external data," "publicly available financial information," and United's own "coordination of benefits" data. (Foucre, Tr. 894-95).

899. ENH did not know how United had derived its data for Blue Cross. (Hillebrand,

Tr. 1880). United never provided ENH with the formula it used to make the calculations. (Hillebrand, Tr. 1880).

Response to Finding No. 899:

First, Mr. Hillebrand's self-serving testimony is not corroborated by documents or Ms. Foucre's testimony. Second, the question of whether or not ENH received a formula from United regarding its Blue Cross data is irrelevant. {[redacted]} (Foucre, Tr. 897; CX 57 at 1, *in camera*). United was told that "there would not be . . . one penny of reduction in [the health plan's] reimbursement to Evanston Northwestern Healthcare." (Foucre, Tr. 897).

Third, how United had derived its data is irrelevant. ENH did not need United to tell ENH what ENH's reimbursement rates to United versus Blue Cross were. ENH maintains all of that information itself.

{[redacted]} (Haas-Wilson, Tr. 2728, *in camera*; RX 1912 at 61-63, *in camera*; Noether, Tr. 6070-74, *in camera*). {[redacted]} (CX 6279 at 19, *in camera*; RX 1687 at ENHL BW 027653, *in camera*). {[redacted]}

[redacted] (*See* CX 135 at 5, 10, 14, *in camera*).

900. United assumed that ENH had a 30% margin on its business with Blue Cross. (Hillebrand, Tr. 1880-81). But United's calculations in that regard simply did not make any sense. (Hillebrand, Tr. 1881).

Response to Finding No. 900:

Mr. Hillebrand's self-serving testimony is not corroborated by documents or Ms. Foucre's testimony. Furthermore, the question of whether or not United's margin on ENH's business with Blue Cross was correct or not is irrelevant. [redacted] (Foucre, Tr. 897. *See* CCRFF 899, *in camera*).

901. United sought a 40% reduction in the reimbursement to be paid to ENH, by proposing a price reduction of $20 million on a book of business at ENH of only $50 million. (Hillebrand, Tr. 1878).

Response to Finding No. 901:

Mr. Hillebrand's self-serving testimony is not corroborated by documents or Ms. Foucre's testimony. [redacted] (CX 6279 at 19, *in camera*; RX 1687 at ENHL BW 027653, *in camera*). [redacted]

[redacted] (CX 6277 at 3, *in camera*).

[redacted] (*See* CCRFF 899, *in camera*. *See* Foucre, Tr. 897 ("There would not be . . . one penny of reduction in [United's] reimbursement to Evanston Northwestern Healthcare.")).

902. Hillebrand felt that United's proposal was demeaning and did not recognize the services and level of care ENH delivered to its patients. (Hillebrand, Tr. 1878). Hillebrand had never before and has never since been presented with a demand of that type. (Hillebrand, Tr. 1878-79).

Response to Finding No. 902:

Mr. Hillebrand's self-serving testimony regarding the 2002 United renegotiation is irrelevant. [redacted] (*See* CCRFF 899, *in camera*.)

903. During the meeting in October 2002, United prepared a document estimating ENH's margin on United's business as compared against other commercial and government payors. (Foucre, Tr. 895-96). United reviewed ENH's financial data, bond filings and other publicly available information in its analysis. (Foucre, Tr. 895). United also used its claims data to assess the performance of the contract. (Foucre, Tr. 896).

Response to Finding No. 903:

Respondent's finding is incomplete, because it fails to note United's results based on its analysis of the data. [redacted] (Foucre, Tr. 894-96, 898; CX 2381 at 1, *in camera*). [redacted] (Foucre, Tr. 1081-82, *in camera*; CX 2381 at 4, *in camera*. *See* CCFF 987-995).

[redacted] (Foucre, Tr. 1082-85, *in camera*; CX 2381 at 4, *in camera*).

[redacted] (Foucre, Tr. 1081, *in camera*). [redacted] (Foucre, Tr. 1081, *in camera*; CX 2381 at 3, *in camera*).

[redacted] (Foucre, Tr. 1096, *in camera*; CX 6277 at 6, *in camera*).

904. ENH analyzed the data presented by United and found that the data was

"nonsensical," invalid, extremely flawed and "junior graduate school level work." (Hillebrand, Tr. 1879, 1881-82; Foucre, Tr. 896). United's data was based on its calculation of revenue and expense profitability for their contract, Medicare, Medicaid and Blue Cross. (Hillebrand, Tr. 1879). The conclusions that United reached, and the basis upon which it did the analysis, simply did not make any sense. (Hillebrand, Tr. 1879). {[redacted]} (Foucre, Tr. 1107, *in camera*).

Response to Finding No. 904:

Respondent's finding is incomplete and misleading. First, Mr. Hillebrand's assessment of the validity of United's data is irrelevant. [redacted] (CX 57 at 1, *in camera*. *See* Foucre, Tr. 896-97 (According to Ms. Foucre, United told ENH that "if there was something that was wrong in [United's] information, [United] would be happy to go through it in more detail," but according to United "*we did not get to that point.*") (emphasis added)). {[redacted]}

(*See* CCRFF 899, *in camera*).

905. For example, United used the wrong case-mix indicator in its data. (Hillebrand, Tr. 1879). United indicated that ENH's case-mix was below 1.0 when, in fact, it was approximately 1.4 at the time. (Hillebrand, Tr. 1879-80). {[redacted]} (RX 424 at UHCENH 3324, *in camera*). {[redacted]} (CX 2381 at 4, *in camera*). United's presentation to ENH also used the wrong average length of stay. (Hillebrand, Tr. 1881).

Response to Finding No 905:

The finding is irrelevant. {[redacted]}

[redacted] (CX 57 at 1, *in camera*. *See* CCRFF 899). Moreover, if ENH were really interested in engaging in dialogue with United, the appropriate case mix indicator would be the case mix indicator of United's business at ENH, which would indicate how complex the cases were that United was paying for at ENH, not the overall case mix indicator of ENH.

906. After ENH contested the validity and pointed out the inaccuracies of United Healthcare's data, the data never again resurfaced during the contract negotiation. (Hillebrand, Tr. 1882).

Response to Finding No. 906:

The finding is incomplete and misleading. As discussed in CCRFF 899, it would not make sense for United to present the data again after the health plan was informed by ENH that "there would not be . . . one penny of reduction in [the health plan's] reimbursement to Evanston Northwestern Healthcare." (Foucre, Tr. 897). [redacted] (*See* CCRFF 899 ([redacted]), *in camera*).

907. Before May 2003, United eased its negotiating position to focus on moving to fixed rate pricing rather than asking for a reduction. (Foucre, Tr. 907-08). [redacted] (Foucre, Tr. 1117-18, *in camera*; RX 1208 at UHCENH 3378, *in camera*).

Response to Finding No. 907:

Respondent's finding is incorrect. [redacted]

[redacted] (Foucre, Tr. 1089-92, *in camera*; CX 6277 at 3, *in camera*).

Respondent's finding is also incomplete, because it ignores the fact United was able to drop Advocate Lutheran General's eight hospitals from its network. (Foucre, Tr. 931-32). Ms. Foucre testified that United could not drop ENH from its network. (Foucre, Tr. 901-02, 925-26).

[redacted] (RX 1912 at 147-52 ([redacted] (RX 1912 at 147-49) [redacted] (RX 1912 at 150-52)), *in camera*). According to Ms. Foucre, ENH is not an academic hospital. (Foucre, Tr. 935-36).

[redacted] (Baker, Tr. 4739, *in camera*; Haas-Wilson, Tr. 2731-32 (discussing DX 7062 at 3, *in camera*), *in camera*).

908. [redacted] (RX 424 at UHCENH 3324, *in camera*). [redacted] (RX 424 at UHCENH

3324, *in camera*; RX 1208 at UHCENH 3378, *in camera*). {[redacted]} (RX 424 at UHCENH 3324). {[redacted]} (RX 1208 at UHCENH 3378, *in camera).*

Response to Finding No 908:

The finding is incomplete and misleading. [redacted] (RX 424 at UHCENH 3324, *in camera*). {[redacted]} (Foucre, Tr. 1116-17, *in camera*. *See* CCRFF 907 ({[redacted]}), *in camera*).

Moreover, it is misleading to compare ENH prices to the prices at Northwestern Memorial and the University of Chicago because they are not comparable to ENH. (*See* CCFF 1912-1940).

909. In January 2003, United identified its self-funded customers that had the largest number of dollars flowing through ENH. (Foucre, Tr. 903). Foucre met with those customers to describe to them the concerns she had regarding the progress of the ENH negotiations. (Foucre, Tr. 903-04). Foucre met with Kraft, LaSalle Bank, Allstate, American Airlines, SBC Communications, WW Grainger and AT&T. (Foucre, Tr. 904). But none of these employers felt adversely affected by the Merger. (Foucre, Tr. 948).

Response to Finding No. 909:

Respondent's finding misstates the record and is misleading. Ms. Foucre testified that she *did not know personally* whether any of United's customers felt adversely affected by the merger. (Foucre, Tr. 948). Moreover, Respondent's finding is inaccurate. Ms. Foucre testified that employer groups such as Kraft felt the impact of ENH's price increases after the merger. Kraft representatives "question[ed] the current reimbursement structure that was at percentage of charges" and "supported [United's] desire for more predictability on fixed rates." (Foucre, Tr. 909). Those representatives were "pretty vocal about their . . . concern about the increasing trend" in ENH's chargemaster rates and the discount off charges structure of the current contract. (Foucre, Tr. 908). Overall, despite having learned of ENH's escalating rates, United's largest employer groups, comprising the "largest number of dollars flowing through Evanston Northwestern Healthcare," informed United that they did not view a network without ENH as a viable alternative (Foucre, Tr. 903, 905).

910. ENH hired Brian Washa as its contract negotiator in June 2003, and this changed the tone of the negotiations. (Hillebrand, Tr. 1885; Foucre, Tr. 912). Washa was now involved in the negotiations from ENH and Kurt Janavitz replaced Greg Mylin from United. (Foucre, Tr. 912; Hillebrand, Tr. 1886). Washa and Janavitz worked together and knew each other from previous experience, and the negotiations took on a different tone. (Foucre, Tr. 912). A fair amount of negotiations occurred between the Summer of 2003 and April of 2004. (Hillebrand, Tr. 1889).

Response to Finding No. 910:

The finding is incomplete. {[redacted]} (*See* CCRFF 911, *in camera*; CCFF 1016-1027).

911. In fact, ENH was considering changing its employee plan to United in July or August 2003. (Foucre, Tr. 913). ENH was looking for alternatives to provide employee benefits to its employees and families. (Foucre, Tr. 914).

Response to Finding No. 911:

The finding is incomplete. ENH only compromised with United after learning of the FTC's scrutiny of the merger. In the Summer/Fall of 2003, during a meeting at ENH to discuss the possible employee-benefit plan, Mr. Hillebrand requested that United representatives "contact the FTC and have a conversation with them about whether–about whether [United] believed that [it] had been . . . financially harmed by the merger of the Evanston hospitals with Highland Park." (Foucre, Tr. 914-15). Mr. Hillebrand also requested that United representatives contact ENH's counsel, Mr. Sibarium, at Winston & Strawn to make a statement that United was "not unreasonably harmed by the merger," and gave Mr. Sibarium's phone number to United representative William Moeller. (Foucre, Tr. 918-19; CX 6283 at 1). Believing that United, in fact, had been financially harmed by the merger, United did not assist ENH or its counsel. (Foucre, Tr. 919, 927).

United representatives and ENH met again on September 2, 2003. (Foucre, Tr. 921). {[redacted]} (Foucre, Tr. 921-23; Hillebrand, Tr. 1928, *in camera*; CX 6284 at 1). Mr. Hillebrand told United representatives that ENH and its attorneys had "taken the liberty of drafting [a] letter pursuant to his conversation that he had had with Bill [Moeller] several weeks earlier." (Foucre, Tr. 923).

Mr. Hillebrand requested that United "consider sending [the] letter or some version of it that [they] were comfortable with" to the Director of the Bureau of Competition at the FTC. (Foucre, Tr. 922-23; CX 6284 at 1). {[redacted]

[redacted] (Foucre, Tr. 921-23; Foucre, Tr. 1101, *in camera*). {[redacted]} (Foucre, Tr. 921-23; Foucre, Tr. 1101, *in camera*; CX 6284 at 1; CX 426 at 1, *in camera*). {[redacted]} (Foucre, Tr. 887-88; CX 5176 at 1, 12, *in camera*; Administrative Complaint, In the Matter of *Evanston Northwestern Healthcare*, February 10, 2004).

Disagreeing with the substance of the September 2, 2003, letter drafted by counsel for ENH, United did not sign it or send it to the FTC. (Foucre, Tr. 924-25, 927).

United did not agree that, "there are numerous alternatives available to consumers besides their three hospitals." (CX 6284 at 1).

United did not agree that "if confronted with . . . a price increase, UHC would drop the ENH hospitals from its network and replace them with competing hospitals." (CX 6284 at 1).

United did not agree that "the new rates reflected a one time 'catch up' increase in ENH's rate, consolidation to one master contract for all products, and did not reflect the creation, possession or exercise of any market power on behalf of the hospitals as a result of the merger." (CX 6284 at 1).

United was not "confident that [United is] not paying 'supracompetitive' prices

for hospital services delivered at Evanston Hospital, Glenbrook Hospital, or Highland Park Hospital." (CX 6284 at 1).

912. {[redacted]} (RX 1319 at 1, *in camera*). {[redacted]} (RX 1319 at UHCENH 3511, *in camera*). {[redacted]} (RX 1319 at UHCENH 3511, *in camera*). {[redacted]} (RX 1527, *in camera*).

Response to Finding No. 912:

The finding is irrelevant. There is no evidence that any payment problems affected the negotiations between United and ENH. {[redacted]} (*See* CCRFF 911, *in camera*).

913. {[redacted]} (RX 1527, *in camera*). {[redacted]} (RX 1527, *in camera*). {[redacted]} (RX 1527, *in camera*). {[redacted]} (RX 1527, *in camera*).

Response to Finding No. 913:

The finding is irrelevant. (*See* CCRFF 912).

914. Since the start of negotiations in 2002, ENH and United had been negotiating one price for all products. (Hillebrand, Tr. 1889-90). However, in January 2004, United asked ENH to develop two prices for the contract. (Hillebrand, Tr. 1889-90). As a result, the parties had to

start over again with negotiations in January 2004. (Hillebrand, Tr. 1889).

Response to Finding No. 914:

Complaint Counsel have no specific response.

915. At about the time that ENH began to recast the pricing into two different structures, ENH became aware that United had terminated with the largest hospital system in Chicago, the Advocate Health System. (Hillebrand, Tr. 1891). The termination was widely covered in the press. (Hillebrand, Tr. 1891).

Response to Finding No. 915:

Complaint Counsel have no specific response.

916. In addition, throughout the early 2000s, the entire Rush System for Health was not in United's network. (Hillebrand, Tr. 1891). Rush North Shore Hospital was added to United's network later, but it was a fairly new relationship between United and Rush North Shore as of January 2004. (Hillebrand, Tr. 1891).

Response to Finding No. 916:

The finding is incomplete. United added Rush North shore to its network in the context of the Rush system, unlike ENH, allowing United to contract with one hospital in the system and not others, and in the context of the Rush system, unlike ENH, charging different prices for different hospitals in the system. (Ballengee, Tr. 163-65; Dorsey, Tr. 1446; Foucre, Tr. 935)

917. {[redacted]} (Foucre, Tr. 1105-06, *in camera*; CX 5176 at 1). {[redacted]} (Foucre, Tr. 1106, *in camera*). {[redacted]} (Foucre, Tr. 882, 887-88; CX 5176, *in camera*).

Response to Finding No. 917:

The finding is incomplete. {[redacted]}

[redacted] (*See* CCRFF 911, *in camera*).

918. Foucre testified that United did not get everything it wanted in the 2004 contract. (Foucre, Tr. 930). {[redacted]} (Foucre, Tr. 1101-02, *in camera*).

Response to Finding No. 918:

The finding is incorrect. United did not "come close" to achieving "a reduction in the total reimbursement under the contract." (Foucre, Tr. 892-93). {[redacted]} (Foucre, Tr. 1103, *in camera*). {[redacted]} (Foucre, Tr. 1103-04, *in camera*). Mr. Hillebrand admitted that the 2004 negotiation with United did not result in an overall price reduction to the health plan. (Hillebrand, Tr. 1890). {[redacted]} (Foucre, Tr. 1103, *in camera*; Foucre, Tr. 931-32).

919. {[redacted]} (Hillebrand, Tr. 1890; CX 5176 at 12; Foucre, Tr. 1106, *in camera*). In fact, ENH was the first provider in the United States to sign United's new template contract. (Hillebrand, Tr. 1890).

Response to Finding No. 919:

The finding is irrelevant. {[redacted]} (Foucre, Tr. 1103, *in camera*). {[redacted]} (Foucre, Tr. 1103-04, *in camera*. *See* CCRFF 918, *in camera*).

920. {[redacted]} (Foucre, Tr. 1102 *in camera*). {[redacted]} (Foucre, Tr. 1102 *in camera*). The 2004 ENH contract with United Healthcare was not a discount-off-charges contract. (Hillebrand, Tr. 2028). Almost all of the rates in the contract are per diems and case rates. (Hillebrand, Tr. 2028).

Response to Finding No. 920:

The finding is irrelevant. {[redacted]} (Foucre, Tr. 1103, *in camera*). {[redacted]} (Foucre, Tr. 1103-04, *in camera*. *See* CCRFF 918, *in camera*).

921. {[redacted]} (Hillebrand, Tr. 1924, *in camera*). {[redacted]} (Foucre, Tr. 1106, *in camera*; CX 5176 at 32-36, *in camera*; Hillebrand, Tr. 1890). {[redacted]} (Foucre, Tr. 1130, *in camera*; CX 5176 at 33, *in camera*). {[redacted]} (Foucre, Tr. 1130, *in camera*; CX 5176 at

35-36, *in camera*). {[redacted]}
(Foucre, Tr. 1106, *in camera;* CX 5176 at 32-36, *in camera*).

Response to Finding No. 921:

The finding is misleading. {[redacted]} (RX 1687 at ENHL BW 027653, *in camera*; Foucre, Tr. 898, 889; Foucre, Tr. 1103-04, *in camera. See* CCRFF 918, *in camera*).

922. United was quite pleased with the results of the new contract with ENH in 2004. (Hillebrand, Tr. 1890-91). ENH also felt that the 2004 contract with United was a fair deal. (Hillebrand, Tr. 1891). Throughout the entire contract process, no one at ENH ever made statements regarding perceiving themselves as having market power. (Foucre, Tr. 948).

Response to Finding No. 922:

With respect to the first sentence, the record citation will only support that Mr. Hillebrand had an understanding that United was pleased, however there is contrary evidence directly from United. {[redacted]} (Foucre, Tr. 1103, *in camera*). {[redacted]} (Foucre, Tr. 1103-04, *in camera. See* CCRFF 918, *in camera*).

With respect to the third sentence, that sentence is irrelevant. Particularly by 2003 and 2004, with an FTC investigation pending, no one would expect ENH to announce to customers that they believed that they had market power.

923. A few months after the contract became effective in June 2004, ENH discovered that United's national template contract had a significant payment compliance issue resulting in underpaid claims and administrative difficulty. (RX 1725 at 1). United was obligated to analyze all of the past claims, identify any underpayments and calculate a prospective remedy to ENH for the mistake. (RX 1725 at 2-3).

Response to Finding No. 923:

The finding is irrelevant.

d. By 2002, ENH Learned That, On A Whole, Its Chargemaster Contained Prices That Were Undermarket

i. Description Of A Chargemaster

924. A charge description master, also known as a CDM or chargemaster, is a line-by-line listing of all of the clinical activities performed at a hospital. (Neaman, Tr. 1349; Porn, Tr. 5638). The chargemaster contains all services provided at a hospital – including inpatient and outpatient services. (Porn, Tr. 5646).

Response to Finding No. 924:

Complaint Counsel have no specific response.

925. The chargemaster represents the list price and not necessarily what will be paid by payors and other customers. (Hillebrand, Tr. 1710-11, 1716; Porn, Tr. 5646). A chargemaster contains thousands of lines of codes, depending on the complexity of the services provided at a hospital. (Porn, Tr. 5647). A hospital that offers complex services would have around 15,000 lines of chargemaster codes, while a community hospital would have fewer. (Porn, Tr. 5647).

Response to Finding No. 925:

Complaint Counsel have no specific response.

926. ENH's chargemaster has 15,000-20,000 line items. (Neaman, Tr. 1349; RX 641 at ENH KG 00627).

Response to Finding No. 926:

Complaint Counsel have no specific response.

927. The chargemaster is a fluid document. (Hillebrand, Tr. 1712). Roughly a hundred changes are made to the chargemaster every month as Medicare issues new codes for new services and changes the terminology for existing services, and as ENH initiates its own new clinical services. (Hillebrand, Tr. 1712, 1989).

Response to Finding No. 927:

Respondent's finding is misleading and incomplete to the extent that it equates a small number of monthly ministerial changes to a larger, more systematic overhaul of the chargemaster pricing structure. In March 2002, ENH engaged Deloitte Consulting to "identify and implement" targeted price increases to ENH's chargemaster. (Porn, Tr. 5668-69; CX 43 at 1). This engagement was known as the "strategic pricing project." (CX 45 at 1). Following the completion of the project, ENH raised over 2,000 chargemaster prices by an average of 31.9%. (Porn, Tr. 5684-85; CX 45 at 8).

ii. ENH Consolidated Its Chargemaster After The Merger

928. To maximize Merger-related cost efficiencies, ENH consolidated its chargemaster with HPH's so the merged entity could have a singular billing system and a singular process for patient registration and other activities. (Hillebrand, Tr. 1710, 1990; RX 864 at ENH HG 1781). A consolidated chargemaster is the best practice for a hospital system. (Porn, Tr. 5646-47).

Response to Finding No. 928:

Respondent's finding relating to why it consolidated HPH's and Evanston's chargemasters is misleading and incomplete. ENH also considered and evaluated the financial impact of equalizing chargemasters across the two entities. In January 2000, ENH's transition team projected the overall increase in gross revenue from harmonizing

chargemasters to be at least $100 million. (CX 2237 at 1; CX 2462 at 1). This was confirmed by subsequent ENH documents. (CX 2238 at 1 (May 2000); CX 2239 at 1 (June 2000); CX 2384 at 2 (July 2000)).

929. ENH did not hire outside consultants to merge its chargemaster with HPH's chargemaster. (Hillebrand, Tr. 1990). ENH had had an internal chargemaster transition team, which Hillebrand headed. (CX 2239; Hillebrand, Tr. 1713, 1990).

Response to Finding No. 929:

Complaint Counsel have no specific response.

930. ENH's "goal" of the 2000 chargemaster transition was to "equalize charges at all three sites." (CX 2239). However, ENH did not increase its chargemaster prices in 2000 above the pre-Merger Evanston Hospital and HPH prices. (Hillebrand, Tr. 1712).

Response to Finding No. 930:

Respondent's finding is incomplete and misleading to the extent that it implies that there was minimal financial impact because it did not raise prices in 2000 over the higher of the two chargemasters. In the transition team report, ENH stated, "The increase [*sic*] gross revenue impact has been calculated at $100,000,000." (CX 2239 at 1).

931. ENH also consolidated the chargemasters by taking the chargemaster list price for an item that existed at one hospital and transferred it over to the other hospital. (CX 2240 at 11; Hillebrand, Tr. 1715). Further, ENH "cleaned up" and streamlined the terminology used both chargemasters. (Hillebrand, Tr. 1711-12).

Response to Finding No. 931:

Complaint Counsel have no specific response.

iii. ENH, With The Assistance Of Deloitte Consulting, Brought Its Chargemaster Up To Market In 2002

932. ENH retained Deloitte Consulting ("Deloitte") to reexamine its chargemaster in the Spring of 2002. (Hillebrand, Tr. 1716; Neaman, Tr. 1349-50).

Response to Finding No. 932:

Complaint Counsel have no specific response.

933. In late 2000, ENH initially hired Deloitte to assist with a revenue cycle analysis of ENH's physician practices. (Hillebrand, Tr. 1990; Porn, Tr. 5641-42). In 2001 and early 2002, Deloitte assisted ENH with a revenue cycle analysis of its hospitals. (Hillebrand, Tr. 1990-91). The last activity Deloitte performed as part of ENH's revenue cycle analysis was to review ENH's chargemaster. (Hillebrand, Tr. 1716, 1990-91; Porn, Tr. 5641).

Response to Finding No. 933:

Complaint Counsel have no specific response.

934. A revenue cycle project involves refining all steps involved in the collection of revenue at a hospital – from scheduling a patient, admitting the patient to the hospital, providing the service, recording the charge, billing the third-party payor and collecting the proper amount. (Porn, Tr. 5638; Hillebrand, Tr. 1991).

Response to Finding No. 934:

Complaint Counsel have no specific response.

935. ENH's hospital chargemaster needed to be updated even without a merger. There were 1901 unique Current Procedural Terminology ("CPT") codes, *i.e.*, the procedures at a hospital, of which 1383 were active. (RX 641 at ENH KG 267; Porn, Tr. 5646-47, 5658). Of the 1901 unique CPT codes, 78 of them were invalid in October 13, 1999. (RX 641 at ENH KG 267). Twenty of the 1383 active unique CPT codes were invalid as of October 13, 1999. (RX 641 at ENH KG 267).

Response to Finding No. 935:

Respondent's finding is irrelevant. Current Procedural Terminology (CPT) is a standardized list of numeric codes that includes a five digit code for each medical service and procedure to allow for standardization of claims processing throughout the health care industry. CPT codes are most commonly used by physicians for billing purposes; sometimes they are also used for outpatient services provided by facilities. Rarely they are used to categorize inpatient services. (Amended Glossary of Terms at 5-6, April 22,

2005). There is no evidence in this case that any of the contracts between ENH and health plans priced inpatient services on the basis of CPT codes. This case involves the pricing of inpatient acute care services (*see* CCFF 218), and whether or not there were invalid CPT codes at some point in time is irrelevant to the issues of this case.

936. In 1999, half of the 1383 active unique CPT codes had multiple pricing points. (RX 641 at ENH KG 267, 271).

Response to Finding No. 936:

Respondent's finding is irrelevant. (*See* CCRFF 935).

937. On its October 13, 1999 preliminary chargemaster review, Deloitte discovered that there were 2010 line items within the hospital chargemaster with a $0 charge. (RX 641 at ENH KG 267). There were 384 unique, active CPTs which carried a $0 charge. (RX 641 at ENH KG 267).

Response to Finding No. 937:

Respondent's finding is irrelevant. (*See* CCRFF 935).

938. Deloitte advised that the "organizational structure and processes related to CDM update and maintenance are not well defined and controlled" in 2001. (RX 1138 at DC 605). Deloitte noted that there was no annual chargemaster review nor a regular, annual review of the hospital fee schedule. (RX 1155 at DC 1982).

Response to Finding No. 938:

Complaint Counsel have no specific response.

939. While ENH "somewhat" had a pricing methodology, it was applied inconsistently and was not tied to market benchmarks. (RX 1155 at DC 1982). Under- and over-pricing were thought to be commonplace within the fee schedule. (RX 1155 at DC 1985). In fact, the majority of prices had not been reviewed in years. (RX 1155 at DC 1985).

Response to Finding No. 939:

Complaint Counsel have no specific response.

940. A chargemaster project involves updating a hospital's chargemaster to include the

most current services available at the hospital. (Porn, Tr. 5638). It is important that a chargemaster properly describe and list the service codes that are provided at a hospital. (Porn, Tr. 5643). The codes are used for billing and cost accounting at a hospital. (Porn, Tr. 5643).

Response to Finding No. 940:

Complaint Counsel have no specific response.

941. Medicare produces annual and quarterly updates which are required to be input into a chargemaster. (Porn, Tr. 5644). In addition, a hospital will regularly add new physicians and new services that need to be accounted for in the chargemaster. (Porn, Tr. 5644).

Response to Finding No. 941:

Complaint Counsel have no specific response.

942. As part of a chargemaster project, Deloitte compares a client hospital's chargemaster to a master list developed by Deloitte over the course of prior engagements, and determines what services need to be added to the chargemaster. (Porn, Tr. 5638). Deloitte has performed chargemaster projects for number of clients. (Porn, Tr. 5638-39).

Response to Finding No. 942:

Complaint Counsel have no specific response.

943. A parallel project Deloitte performs on a chargemaster for its clients all across the country on a regular basis is a chargemaster pricing project. (Porn, Tr. 5645-47). The purpose of a pricing project is to increase a hospital's prices to be competitive in the marketplace. (Porn, Tr. 5645).

Response to Finding No. 943:

Respondent's finding is incomplete and misleading. It is incomplete because it does not describe the relationship between a hospital's chargemaster listings and the effective prices actually charged to the health plans, the hospital's customers. A hospital generally does not charge its customers the prices on its chargemaster. Hospitals have three broad categories of patients: 1) patients whose expenses are paid for by government programs such as Medicare and Medicaid, 2) patients whose expenses are paid for by

commercial insurance (managed care organizations or employers who self-insure), and 3) those who pay nothing or patients who self-insure. (*See* CCFF 152-166). The payment structure differs for each. For Medicare/Medicaid patients, the government determines the prices, which have nothing to do with the hospital's chargemaster. (*See* CCFF 167-169). Managed care organizations enter into contracts that determine what they will pay the hospital so they do not pay the chargemaster rates. (*See* CCFF 170-176). That leaves only self-pay that actually pays the chargemaster rates. (*See* CCFF 177-179).

In this case, the customers in question are the health care plans. Each customer has its own contract with a hospital which will vary in its terms from customer to customer and from hospital to hospital. Setting a hospital's chargemaster at a particular level has nothing to do with keeping a hospital "competitive in the market" for those customers. There are times that managed care organizations will contract with a hospital based on a discount off charges. (*See* CCFF 770-777). In those cases the rates will be related to the chargemaster, but without knowledge of the discount structure, the actual prices paid are unknown. As Mr. Porn of Deloitte specifically emphasized, the chargemaster set "list" prices. Deloitte did not have access to the actual prices that were paid by the health plans. (Porn, Tr. 5666-67).

The finding is misleading, because, given that one does not know how other hospitals are pricing their services, one cannot have a project to price the chargemaster prices to keep "competitive in the market" with respect to unknown prices charged to managed care organization customers.

944. Deloitte compares the prices from a client's chargemaster to comparable

institutions in the marketplace. (Porn, Tr. 5646). Deloitte's selection of comparable hospitals is "somewhat subjective." (Porn, Tr. 5647). Deloitte consults with the clinical departments in a hospital to make sure that the chargemaster definitions being compared with other hospitals are consistent. (Porn, Tr. 5646). Deloitte also determines the overall effect the price changes will have on the institution. (Porn, Tr. 5646).

Response to Finding No. 944:

The finding is incomplete and misleading. (*See* CCRFF 943). Since no one knows what other hospitals are actually charging managed care organizations in the marketplace, it is irrelevant to compare the hospital's chargemaster to comparable institutions' chargemasters.

945. To compare a client's chargemaster prices, Deloitte obtains information from a third-party information clearing house that gathers publicly available pricing information. (Porn, Tr. 5647). The pricing information available from the clearinghouse represents the hospitals' list price – *i.e.*, Deloitte does not have access to the actual prices that may have been paid by MCOs. (Porn, Tr. 5666-67). Deloitte compares the client hospital's chargemaster prices with those from the comparable institutions on a line-by-line basis. (Porn, Tr. 5647).

Response to Finding No. 945:

Complaint Counsel have no specific response.

946. After comparing a client's chargemaster to comparable hospitals, Deloitte will identify those charges that it believes are "under priced" and work with the clinical departments to make sure the comparisons are accurate. (Porn, Tr. 5647-48). Deloitte provides the client hospital with a line-by-line list of the under priced charges and will ultimately suggest that certain prices be increased. (Porn, Tr. 5648).

Response to Finding No. 946:

The finding is incomplete and misleading. (*See* CCRFF 943 and RFF 945). As respondents concede in RFF 945, "Deloitte does not have access to the actual prices that may have been paid by MCOs." (RFF 945) Therefore comparing chargemasters cannot tell which items are "underpriced" to MCOs.

947. In 2001, Deloitte advised ENH that the 2000 chargemaster consolidation could be improved by cleaning up redundancies and errors in the chargemaster. (Porn, Tr. 5643-45; Hillebrand, Tr. 1991). Deloitte advised ENH that it should develop a more rigorous process to better manage the monthly changes that are made to the chargemaster. (Hillebrand, Tr. 1991).

Response to Finding No. 947:

Complaint Counsel have no specific response.

948. During Deloitte's initial projects at the hospital, it identified that ENH's chargemaster was "not up to date." (Porn, Tr. 5643). Deloitte discovered that the ENH chargemaster did not reflect a number of services that were performed at ENH as well as a number of expired or non-current codes. (Porn, Tr. 5641). The chargemaster codes needed to be updated based on annual and quarterly updates that are provided by Medicare. (Porn, Tr. 5643-44).

Response to Finding No. 948:

Complaint Counsel have no specific response.

949. During Deloitte's initial chargemaster update work, it identified that ENH's prices were below market. (Porn, Tr. 5648). Deloitte proposed its pricing project to ENH. (Porn, Tr. 5648). At first, ENH believed that its prices were already competitive and did not see any opportunity from the project. (Porn, Tr. 5648-49). However, after Deloitte presented ENH with its initial findings, ENH agreed to engage Deloitte to perform the pricing project. (Porn, Tr. 5650; RX 1244).

Response to Finding No. 949:

The finding is incomplete and misleading. (*See* CCRFF 943 and RFF 945). Because Deloitte could not tell the actual prices charged managed care organizations it could not tell from comparing chargemasters whether prices charged to managed care organizations were "below market." However, because ENH had converted a number of contracts to discount off charges following the merger with Highland Park, Deloitte, as well as ENH, would know that if the chargemaster were increased, ENH's revenue from managed care organizations would increase. (*See* CCFF 928-35).

950. The purpose of Deloitte's pricing project at ENH was to "increase prices to be competitive in the marketplace." (Porn, Tr. 5645). ENH officially engaged Deloitte to perform the pricing project on March 8, 2002, and the project was completed in approximately 12 weeks. (Porn, Tr. 5650, 5652; RX 1244 at ENH JH 7109). Hillebrand was primarily responsible for hiring Deloitte to work on ENH's chargemaster in 2002. (Neaman, Tr. 1350). Harry Jones, a member of ENH's finance department, worked on the 2002 chargemaster initiative. (Neaman, Tr. 1350; Hillebrand, Tr. 1716; H. Jones, Tr. 4143). Lou Porn, who specializes in providing consulting services to healthcare providers, led the Deloitte team. (Hillebrand, Tr. 1716; Porn, Tr. 5637).

Response to Finding No. 950:

The finding is incomplete and misleading. (*See* CCRFF 943 and RFF 945). Because neither Deloitte, nor ENH knew what other hospitals were charging managed care organizations, they could not target other hospital's prices to remain competitive to managed care organizations. However, because ENH had converted a number of contracts to discount off charges following the merger with Highland Park, Deloitte, as well as ENH would know that if the chargemaster were increased, ENH's revenue from managed care organizations would increase. (*See* CCFF 928-35).

951. Porn's engagements for healthcare providers – including for ENH, Advocate, Children's Memorial and other Chicago area hospitals – involve revenue cycle projects, chargemaster updates, pricing projects, accounts receivable projects and others. (Porn, Tr. 5637-39).

Response to Finding No. 951:

Complaint Counsel have no specific response.

952. Deloitte used a proprietary database to compare ENH's list prices to list prices of other hospitals in the Chicago area. (Hillebrand, Tr. 1716). Deloitte examined ENH's ancillary and diagnostic services, but did not examine routine charges such as room rates. (Hillebrand, Tr. 1994). Deloitte also met with personnel from each of ENH's clinical departments and then compared the prices for individual ancillary and diagnostic services to those of ENH's peer hospital group's prices. (Hillebrand, Tr. 1994).

Response to Finding No. 952:

Complaint Counsel have no specific response.

953. Deloitte selected 10 hospitals as comparable to ENH for purposes of its chargemaster pricing project. (Porn, Tr. 5653-54). The 10-hospital peer group that Deloitte identified included: Loyola University, Advocate Lutheran General, Advocate Illinois Masonic, Resurrection, Northwestern Community, Northwestern Memorial, University of Chicago, Alexian Brothers, Condell and Rush-Presbyterian. (Porn, Tr. 5654; RX 1283 at DC 7). In selecting its peer group, Deloitte performed a subjective evaluation of what it thought were comparable hospitals based on service mix and reputation in the marketplace. (Porn, Tr. 5654-55; Hillebrand, Tr. 1993). Deloitte believed that ENH was comparable to other academic medical centers in the marketplace. (Porn, Tr. 5655).

Response to Finding No. 953:

The contention that ENH was comparable to major academic medical centers in the Chicago area is contradicted by other record evidence. In particular, ENH differs in several central ways from Loyola University, Northwestern Memorial, Rush Presbyterian, and the University of Chicago.

First, ENH's patient mix is very different from the patient mix of these four academic hospitals. (*See* CCFF 705-709). Second, these four hospitals all perform quaternary services, such as solid organ transplants and extensive burn injuries treatment, while ENH does not. (*See* CCFF 710-712). Third, measures of the overall services provided demonstrate that ENH was not similar to these four hospitals. (*See* CCFF 713-18). Fourth, teaching intensity, bed size, and public perception differed substantially between ENH and the other four academic hospitals. (*See* CCFF 719-21). Finally, health plan representatives testified that ENH was an academic hospital and not in the same league as the other four academic facilities. (*See* CCFF 722-27).

954. The initial list of peer hospitals that Deloitte proposed to ENH included Rush North Shore and St. Francis and omitted Rush Presbyterian and Loyola University. (Porn, Tr.

5654-55). ENH modified the proposed list by exchanging Rush North Shore with Rush Presbyterian, and St. Francis with Loyola University. (Porn, Tr. 5655). Porn believed the exchange was made because Rush Presbyterian and Loyola are more comparable due to their status as academic medical centers. (Porn, Tr. 5655).

Response to Finding No. 954:

The contention that Rush Presbyterian and Loyola University hospitals are more comparable to ENH than other hospitals is contradicted by other record evidence. (*See* CCRFF 953).

The contention that Rush Presbyterian and Loyola University hospitals are more comparable to ENH than other hospitals is contradicted by other record evidence. (*See* CCRFF 953). {[redacted]} (CCFF 1863, 1892-94, 1900-02, 1858-59, *in camera*)

955. Deloitte's peer group list also included some non-academic hospitals that offer high-level services, but Deloitte did not perform a technical review of the peer hospitals' case-mix index. (Porn, Tr. 5656). Deloitte also did not know the prices at the peer group hospitals before selecting the list. (Porn, Tr. 5656). Deloitte's selection of the peer hospitals was a subjective selection based on its knowledge of the marketplace. (Porn, Tr. 5657).

Response to Finding No. 955:

Complaint Counsel have no specific response.

956. Deloitte discovered during its chargemaster update project that a number of ENH's "prices were well below the marketplace." (Porn, Tr. 5651, 5653; Hillebrand, Tr. 1993). On average, Deloitte found that ENH's prices were at the 63rd percentile of comparable hospitals, while some charges were below the 50th percentile. (Porn, Tr. 5653; Hillebrand, Tr. 1717, 1993; RX 1244; RX 1283). The percentile is calculated on a line-by-line basis for each code or procedure within the chargemaster. (Porn, Tr. 5658).

Response to Finding No. 956:

The finding is incomplete and misleading. (*See* CCRFF 943 and RFF 945). For

managed care organizations, comparison of hospital chargemasters would not tell one if the prices at ENH were "below the marketplace," since the chargemasters do not report the prices charged in the market to such customers.

957. ENH was surprised at Deloitte's findings because ENH believed that it was competitive in the marketplace. (Porn, Tr. 5658-59). After determining that ENH's prices had a weighted average in the 63rd percentile, Deloitte recommended that ENH increase its prices. (Porn, Tr. 5658).

Response to Finding No. 957:

The finding is incomplete and misleading. (*See* CCRFF 943 and RFF 945). For managed care organizations, comparison of hospital chargemasters would not tell ENH if it was "competitive in the marketplace," since the chargemasters do not report the prices charged in the market to such customers. However, because ENH had converted a number of contracts to discount off charges following the merger with Highland Park, Deloitte, as well as ENH would know that if the chargemaster were increased, ENH's revenue from managed care organizations would increase. (*See* CCFF 928-935).

958. Deloitte recognized that "small across-the-board increases will not recapture the value of the [highly underpriced] services." (RX 1170 at DC 2008). Instead, Deloitte emphasized that a "one-time 'catch-up' adjustment" was required on ENH's chargemaster. (RX 1170 at DC 2008). The main objective of the pricing project was to bring ENH's undervalued hospital prices up to the common-market-based rate. (RX 1244 at ENH JH 7105).

Response to Finding No. 958:

The finding is incomplete and misleading. (*See* CCRFF 943 and RFF 945). For managed care organizations, comparison of hospital chargemasters would not tell ENH if it was "competitive in the marketplace," since the chargemasters do not report the prices charged in the market to such customers. However, because ENH had converted a

number of contracts to discount off charges following the merger with Highland Park, Deloitte, as well as ENH would know that if the chargemaster were increased, ENH's revenue from managed care organizations would increase. (*See* CCFF 928-35).

959. Deloitte's 2002 chargemaster study concluded that an overall 11% increase in ENH's prices was warranted to bring ENH's prices in line with the market. (Hillebrand, Tr. 1993). Thus, Deloitte recommended that ENH move its list prices to either the 80th, 90th or 95th percentile. (Hillebrand, Tr. 1994; Porn, Tr. 5657). In consultation with Deloitte, ENH decided to move its chargemaster prices to the 90th percentile in the market as calculated by Deloitte. (Hillebrand, Tr. 1717, 1994; Porn, Tr. 5657-60). Porn believed that the selection of the 90th percentile was reasonable based on ENH's reputation and prestige. (Porn, Tr. 5657).

Response to Finding No. 959:

The finding is incomplete and misleading. (*See* CCRFF 943 and RFF 945). For managed care organizations, comparison of hospital chargemasters would not tell ENH if it was "competitive in the marketplace," since the chargemasters do not report the prices charged in the market to such customers. However, because ENH had converted a number of contracts to discount off charges following the merger with Highland Park, Deloitte, as well as ENH would know that if the chargemaster were increased, ENH's revenue from managed care organizations would increase.

960. Out of the 14,000 to 15,000 codes within the chargemaster, Deloitte only reviewed approximately 2,400 for possible price increases. (Porn, Tr. 5660; RX 1283 at DC 15). Deloitte did not review increasing pricing on room and board and other related charges. (Porn, Tr. 5660).

Response to Finding No. 960:

Respondent's finding is misleading to the extent that it implies that Deloitte reviewed only a small portion of the gross charges because it only reviewed a minority of codes for potential price increases. Deloitte's pricing analysis covered $473 million in

gross charges, or 43% of total gross patient charges for fiscal year 2001. (RX 1283 at DC 6).

961. Of the 2,400 charges that Deloitte reviewed, only approximately 2,000 charges were actually increased. (Porn, Tr. 5660-61; RX 1283 at DC 15). Deloitte assisted ENH with implementing the price increases on the identified line items. (Porn, Tr. 5660). As a result of implementing the Deloitte recommended chargemaster price increases, ENH's chargemaster was increased a total of 8.5%. (Porn, Tr. 5664).

Response to Finding No. 961:

Respondent's finding relating to the 2,000 price increases is misleading to the extent that it implies that the financial impact was minimal. As Respondent acknowledges, ENH's chargemaster overall was increased a total of 8.5%. (Porn, Tr. 5664). For the approximately 2,000 increases, ENH raised prices an average of 31.9%. (Porn, Tr. 5685; CX 45 at 8). These chargemaster increases resulted in a projected gross charge impact of $102.2 million annually, and a net impact of $20 million (not including self-pay revenue) to $26 million (including self-pay revenue) annually. (Porn, Tr. 5685-86; CX 45 at 8).

962. To Hillebrand's knowledge, MCOs have never requested to see ENH's chargemaster. (Hillebrand, Tr. 1995). Thus, Hillebrand did not anticipate any resistance from the payors to the chargemaster pricing changes because he never before had a conversation with a payor about the chargemaster, and he did not believe that ENH's chargemaster prices were a relevant matter to the payors. (Hillebrand, Tr. 1995). Deloitte also was not aware of any MCO that had issues with the prices increases in the chargemaster. (Porn, Tr. 5665).

Response to Finding No. 962:

Respondent's finding is misleading and incomplete. First, ENH attempted to keep the chargemaster increases quiet. After ENH raised its prices in April 2002, Tom Hodges, ENH's executive vice-president for finance, wrote to ENH managers that "[f]or

a number of reasons we want to be as quiet as possible and there are relatively few people who have seen the scope of the changes." (CX 44 at 1). According to Mr. Hillebrand, for chargemaster increases, "the only notification we make is to Blue Cross." Mr. Hillebrand added, "We should not notify anyone beyond those we have a contractual obligation to do so." (CX 54 at 1).

{[redacted]} (Holt-Darcy, Tr. 1523, *in camera*). {[redacted]} (CX 6279 at 4, *in camera*; Haas-Wilson, Tr. 2537-38, *in camera*). {[redacted]} (CX 6279 at 5, *in camera*; Haas-Wilson, Tr. 2537, *in camera*). {[redacted]} (CX 6279 at 4-5, *in camera*).

Despite these large price increases due to the 2002 chargemaster revision and notwithstanding the attempts to keep the increases quiet, ENH management did not anticipate any problems in implementing the chargemaster price increases nor did management fear that health plans would leave and switch to other hospitals due to the

price increases. (Hillebrand, Tr. 1718-19). {[redacted]} (*See, e.g.*, Foucre, Tr. 1091, 1093, 1096, *in camera*; CX 2381 at 4, *in camera*; CX 6277 at 3, *in camera*), but they needed ENH in their networks. (*See, e.g.*, Foucre, Tr. 903, 905).

963. ENH's 2002 chargemaster initiative had no impact on Medicare reimbursements, and had no relationship to ENH's 2000 MCO contract renegotiations. (Hillebrand, Tr. 1721, 1996).

Response to Finding No. 963:

Respondent's finding is misleading and incomplete as it relates to the connection between the 2002 chargemaster increase and the 2000 contract negotiations. The more discount off charges contracts a healthcare provider has, the more impact a chargemaster increase will have on net revenue realized by the provider. (Porn, Tr. 5670). In post-merger renegotiations with health plans in 2000, ENH strategized "to move to discount off charges as [its] first negotiating step." (Hillebrand, Tr. 1706; Newton, Tr. 366). ENH was successful in moving multiple fixed rate contracts to discount off charges arrangements. (Hillebrand, Tr. 1706). {[redacted]} (Porn, Tr. 5670-71; Chan, Tr. 743-44, *in camera*).

964. Deloitte would have made the same pricing recommendation to ENH even absent the Merger. (Porn, Tr. 5661).

Response to Finding No. 964:

Respondent's finding is irrelevant. The central issue is whether ENH had

sufficient market power to impose a recurring, $20 million annual price increase upon health plans from the chargemaster price increase. As it turned out, ENH did have that power and was successful in imposing the price increases which health plans were forced to accept because they required ENH in their networks. (*See* CCRFF 962).