
**UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION**

In the Matter of

EVANSTON NORTHWESTERN HEALTHCARE CORP.

Docket No. 9315

COMPLAINT COUNSEL'S POST-TRIAL BRIEF

(Public Version)

Federal Trade Commission
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TABLE OF CONTENTS

INTRODUCTION AND SUMMARY1

A. ENH Gained Substantial Market Power Because of the Merger 2

 1. The Direct Evidence of ENH’s Pos-Merger Market Power 2

 2. Post-Merger Market Structure Analysis Supports the Evidence of Anticompetitive Effects 8

B. ENH’s Defenses Are Illusory and Not Substantiated by Credible Evidence 10

 1. “Learning About Demand” 10

 2. “Improving Quality of Care” 11

C. The Appropriate Remedy Is Divestiture of Highland Park 18

ARGUMENT..... 20

I. THE MERGER VIOLATES SECTION 7 OF THE CLAYTON ACT BECAUSE IT CREATED MARKET POWER FOR ENH AND CAUSED ACTUAL ANTICOMPETITIVE EFFECTS 20

 A. Consumers Benefitted from the Pre-Merger Competition Fostered by Health Plans’ Ability to Choose between Evanston and Highland Park 21

 1. Selective Contracting and Bargaining Positions – Competition to Form and Join Hospital Networks Developed by Health Plans 21

 2. Evanston and Highland Park Competed for Inclusion in Networks 24

 3. Highland Park Was Ready, Willing and Able to Compete against Evanston 26

 B. Evanston and Highland Park Sought Ways to Thwart Competition and Gain Market Power 28

 1. “Leverage” through the NH Network 28

 2. “Leverage” through NH North 29

3.	“Leverage” through the Evanston-Highland Park Merger	30
C.	The Merger Gave ENH Market Power	33
1.	Implementing the Price Increases	33
2.	Health Plans Suffered Anticompetitive Effects from the Merger	34
a.	United	35
b.	PHCS	38
c.	One Health	40
d.	Aetna	41
e.	Unicare	42
f.	Other Health Plans	43
3.	ENH’s Documents and Employee Testimony Admit Market Power from the Merger	43
4.	The Only Plausible Explanation for ENH’s Undisputed Higher Price Increases Is ENH’s Market Power from the Merger.....	44
a.	It Is Undisputed that ENH’s Price Increases Were Higher than Other Hospitals’ Price Increases	46
b.	ENH’s Higher Prices Can Only Be Explained by Market Power	48
II.	THE MERGER VIOLATES CLAYTON ACT § 7 BECAUSE IT RESULTS IN A HIGHLY CONCENTRATED MARKET IN WHICH COMPETITION HAS BEEN SUBSTANTIALLY LESSENED	49
A.	Elaborate Market Analysis Is Not Required in This Case	49
B.	The Merger Created a Highly Concentrated Market in which Competition Has Been Substantially Lessened	52
1.	The Relevant Product Market	52
2.	The Relevant Geographic Market	53
3.	The Market Is Highly Concentrated	55
4.	ENH Has Failed to Rebut the Presumption of Anticompetitive Harm	56
C.	Recent Hospital Merger Challenges Are Not Controlling Precedent Here	57

III.	ENH’S “LEARNING ABOUT DEMAND” DEFENSE DOES NOT EXPLAIN AWAY ENH’S MARKET POWER	60
A.	Evanston Did Not Underprice Itself before the Merger	60
B.	The ENH “Control Group” Is Flawed.....	61
1.	The Selective Use of “Academic” Hospitals.....	61
2.	Picking 1 Apple and 6 Oranges as “Academic” Hospitals	62
3.	ENH Flunked Its Own “Learning about Demand” Test	63
IV.	ENH’S “IMPROVED QUALITY OF CARE” DEFENSE DOES NOT SAVE THIS ANTICOMPETITIVE MERGER	66
A.	ENH Failed to Prove that Quality Improved Relative to Other Hospitals.....	66
1.	Insurmountable Flaws in ENH’s Analysis	66
2.	The Quantitative Analysis Shows No Significant Evidence of Quality Improvements Relative to the Control Group Hospitals.....	67
a.	Dr. Romano’s Comprehensive Methodology	68
b.	Heart Care	69
c.	Obstetrics	70
d.	Nursing	71
e.	Exporting Evanston’s “Teaching” Status to Highland Park.....	72
f.	Cancer Care	73
g.	Psychiatric Care	73
3.	ENH Relies on Flawed Qualitative Evidence	74
B.	ENH Cannot Prove that Quality Changes Outweigh the Competitive Harm	75
C.	Highland Park Would Have Improved Quality of Care without the Merger	79
1.	Highland Park’s Pre-Merger Quality of Care Was “Very Good”	79
2.	Highland Park Had Plans in Place to Further Improve Its Quality of Care	80

3.	There Was a National Trend toward Improved Quality of Care	81
4.	Highland Park’s Financial Health Was Sound	81
5.	Highland Park Would Have Partnered with Other Hospitals	82
V.	ENH’S “COPPERWELD” DEFENSE FAILS TO SAVE THE MERGER	83
VI.	THE APPROPRIATE REMEDY IS DIVESTITURE OF HIGHLAND PARK	85
A.	The Clayton Act Requires Divestiture	85
B.	The Proposed Order Would Divest Highland Park with Ancillary Relief	86
1.	Ancillary Relief Is Necessary	87
a.	Intellectual Property License	88
b.	Transitional Services	88
c.	Transfer of Medical Staff and Other Employees	89
d.	Maintenance of Confidential Information	89
e.	Termination of Contracts with Health Plans	90
f.	Monitor and Divestiture Trustee	90
C.	The New Highland Park Will Retain Its High Quality of Care	91
	CONCLUSION	93

TABLE OF AUTHORITIES

CASES

<i>Advocacy Org. for Patients and Providers v. Mercy Health Services</i> , 987 F. Supp. 967 (E.D. Mich. 1997)	57
<i>Atlantic Refining Co. v. FTC</i> , 381 U.S. 357 (1965).....	86
<i>B.F. Goodrich Co.</i> , 1988 FTC LEXIS 16 (1988).....	86
<i>California v. Sutter Health Sys.</i> , 130 F. Supp.2d 1109 (N.D. Cal. 2001).....	57, 58
<i>Chicago Bridge & Iron</i> , Opinion of the Commission, Docket No. 9300 (January 6, 2005).....	19, 52, 90
<i>Chicago Bridge and Iron Co.</i> , Final Order, Docket No. 9300 (January 6, 2005).....	85, 86
<i>Copperweld Corp. v. Independence Tube Co.</i> , 467 U.S. 752 (1984).....	84, 85
<i>Crown Zellerbach Corp.</i> , 54 F.T.C. 769 (1957).....	85
<i>Ekco Products Co.</i> , 65 F.T.C. 1163 (1964).....	85, 86
<i>Ford Motor Co. v. U.S.</i> , 405 U.S. 562 (1972).....	19, 86
<i>FTC v. Bass Bros. Enters., Inc.</i> , 1984 U.S. Dist. LEXIS 16122 (N.D. Ohio 1984).....	56
<i>FTC v. Cardinal Health, Inc.</i> , 12 F.Supp.2d 34 (D.D.C. 1998).....	12, 13, 54, 56
<i>FTC v. Freeman Hosp.</i> , 69 F.3d 260 (8th Cir. 1995).....	57
<i>FTC v. H.J. Heinz Co.</i> , 246 F.3d 708 (D.C. Cir. 2001).....	6, 10, 12, 13, 20, 28, 52, 56, 66, 79
<i>FTC v. Indiana Federation of Dentists</i> , 476 U.S. 447 (1986).....	9, 18, 19, 49, 78, 79, 92
<i>FTC v. Libbey, Inc.</i> , 211 F.Supp.2d 34 (D.D.C. 2002).....	9, 50
<i>FTC v. Mandel Bros., Inc.</i> , 359 U.S. 385 (1959).....	86
<i>FTC v. Ruberoid Co.</i> , 343 U.S. 470 (1952).....	86
<i>FTC v. Staples, Inc.</i> , 970 F. Supp. 1066 (D.D.C. 1997).....	1, 12, 50, 51, 52, 53, 54

<i>FTC v. Swedish Match</i> , 131 F.Supp.2d 151 (D.D.C. 2000).....	52
<i>FTC v. Tenet Health Care Corp.</i> , 186 F.3d 1045 (8th Cir. 1999).....	57
<i>FTC v. Toys “R” Us, Inc.</i> , 221 F.3d 928 (7th Cir. 2000).....	50
<i>FTC v. University Health, Inc.</i> , 938 F.2d 1206 (11th Cir. 1991).....	53
<i>Hosp. Corp. of America</i> , 106 F.T.C. 361 (1985), <i>aff’d</i> , 807 F.2d 1381 (7th Cir. 1986).....	8, 19, 33, 51, 52, 53, 56, 85, 86
<i>Nat’l Soc’y of Prof. Engineers v. U.S.</i> , 435 U.S. 679, 695 (1978).....	18, 78
<i>Olin Corporation</i> , 113 F.T.C. 400 (1990).....	85, 86
<i>Re/Max Int’l, Inc. v. Realty One, Inc.</i> , 173 F.3d 995 (6th Cir. 1999).....	50
<i>Rebel Oil Co., Inc. v. Atlantic Richfield Co.</i> , 51 F.3d 1421 (9th Cir. 1995)	50
<i>RSR Corp.</i> , 88 F.T.C. 800 (1976).....	86
<i>Standard Oil Co. v. FTC</i> , 340 U.S. 231, 248 (1951).....	18
<i>Todd v. Exxon Corp.</i> , 275 F.3d 191 (2d Cir. 2001).....	50
<i>U.S. v. E.I. du Pont de Nemours & Co.</i> , 353 U.S. 586 (1957).....	85
<i>United States v. E.I. du Pont de Nemours and Co.</i> , 366 U.S. 316 (1961).....	85, 86
<i>U.S. v. Long Island Jewish Med. Ctr.</i> , 983 F. Supp. 121 (E.D.N.Y. 1997).....	57, 58
<i>U.S. v. Philadelphia Nat’l Bank</i> , 374 U.S. 321, 371 (1963).....	18, 78
<i>U.S. v. Rockford Mem’l Corp.</i> , 898 F.2d 1278 (7th Cir. 1990).....	9, 50, 53, 79

STATUTES

Clayton Act § 7, 15 U.S.C. § 18.....	6, 8, 9, 20, 33, 49,50, 51, 57, 84, 85
Clayton Act § 11(b), 15 U.S.C. § 21(b).....	85

OTHER AUTHORITIES

Dennis W. Carlton & Jeffrey M. Perloff, <u>Modern Industrial Organization</u> (3rd ed. 2000).....	7
------------------------------------------------------------------------------------------------------	---

H. Hovenkamp, Federal Antitrust Policy: The Law of Competition and Its Practice
(1999)..... 51

U.S. Dep't of Justice and Fed. Trade Comm'n, 1992 Horizontal Merger Guidelines
(1997)..... 1, 3, 8, 9, 10, 12, 13, 20, 52, 53, 54, 55, 56, 66

INTRODUCTION AND SUMMARY

The ultimate question in any merger challenge is whether the merger will give the merged entity the “ability profitably to maintain prices above competitive levels for a significant period of time.”¹ In the vast majority of cases, direct evidence with which to answer the ultimate question is unavailable, which explains why antitrust authorities rarely challenge mergers based on direct evidence of anticompetitive effects. However, when such evidence is available, it is a compelling analytical tool because it directly answers the question of the merger’s impact on competition. *See, e.g., FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1075-6 (D.D.C. 1997).²

This case is the enviable rarity in which, based on scientific tests and data, there is direct evidence of actual anticompetitive effects. The pricing evidence, together with the testimony of industry participants negatively impacted by the merger, and further corroborated by admissions of current and former employees and plain speaking documents, provide every reason to find an antitrust violation because the merger substantially lessened competition in the market for inpatient hospital services in which these firms competed.

Here, as in many Sherman Act cases, we confront overwhelming direct evidence of actual anticompetitive effects. Contrast the totality of this evidence against Respondent’s evidence, which consisted of self-serving statements of people employed or retained by Respondent or affiliated with

¹ U.S. Dep’t of Justice and Fed. Trade Comm’n, 1992 Horizontal Merger Guidelines § 0.1 (Revised 1997) (“*Merger Guidelines*”).

² *Staples* involved a proposed merger between Staples and Office Depot, two competitors in the office supplies superstore market. The pricing evidence showed that each firm’s prices were substantially higher when neither faced competition by the other or any other office supply superstore. *Staples*, 970 F. Supp. at 1075-6. The district court relied on this pricing evidence to decide not only the issue of the relevant product market, but also the likely anticompetitive effects of the merger. *Id.* at 1075-6, 1082 (“Since prices are significantly lower in markets where Staples and Office Depot compete, eliminating this competition with one another would free the parties to charge higher prices in those markets, especially those in which the combined entity would be the sole office superstore.”).

it, and opinions without hard data or quantitative results. Such thinly veiled conjectures cannot substitute for proof, and are insufficient to save this merger.

A. ENH Gained Substantial Market Power Because of the Merger

1. *The Direct Evidence of ENH's Post-Merger Market Power*

ENH itself best described the anticompetitive effects of the merger and why the Court must undo it: absent the merger, “neither Evanston nor Highland Park alone” possessed market power to charge millions more to health plans and ultimately consumers.³ (CX 13 at 1). With the merger, Evanston’s and Highland Park’s decade-long quest for market power came to a successful end. No longer would either face “pricing pressures” from health plans. No longer would both fear exclusion from networks. No longer would they have to compete.

With its new-found market power, ENH raced ahead of other Chicago hospitals in raising prices. There was no Highland Park – or any other hospital for that matter – to keep ENH in check or for health plans to turn to for relief. Dr. Haas-Wilson (Complaint Counsel’s economic expert) and Dr. Baker (one of ENH’s economic experts) both calculated, for the period from 1999 through 2002, by how much ENH’s percentage price increases exceeded the percentage price increases at control group hospitals. So, by way of example, if the control group hospitals increased prices by 5% and ENH by 9%, the experts would refer to that as a 4% increase. Dr. Haas-Wilson found that ENH’s price increases dramatically outpaced its peers.

- { [REDACTED] }
- { [REDACTED] }

³ Throughout this brief, we refer to “ENH” as the post-merger entity Evanston Northwestern Healthcare Corp., which consists of the Evanston, Glenbrook and Highland Park hospitals. Except where noted, we refer to “Evanston” as the pre-merger Evanston and Glenbrook hospitals, and to “Highland Park” as the pre-merger Highland Park Hospital, which was then owned by Lakeland Health Services, Inc.

- [REDACTED]
- [REDACTED]⁴

Both parties agree that ENH's post-merger price increases were greater than the price increases at other Chicago hospitals. [REDACTED]

[REDACTED]
[REDACTED]⁵

The absence of any factual dispute concerning ENH's higher price increases leaves the Court only with the question of what caused the disparity. Complaint Counsel presented four categories of fact evidence. Each set of evidence points decisively in one direction: the merger gave ENH market power and substantially lessened competition.

First, the numbers alone are compelling. [REDACTED]
[REDACTED]

[REDACTED] Dr. Haas-Wilson explored 10 potential explanations for ENH's higher price increases. There was no bias in her analysis. Any of the first nine could have led her to conclude that the merger was not anticompetitive. But none did. The only plausible, data-supported answer for ENH's higher price increases was the market power created by the merger.

Second, ENH directly exercised its newly acquired market power against health plans after the merger. Complaint Counsel called witnesses from five different health plans – ENH called none.

⁴ Compare these numbers with the 5% threshold typically used in the *Merger Guidelines* analysis for the hypothetical monopolist. *Merger Guidelines* § 1.11.

⁵ [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

The witnesses were skilled and knowledgeable negotiators, each competing in an insurance market that mercilessly rewards those who keep costs and prices low and punishes those that fail. When confronted by ENH's demands for higher prices, each health plan had the incentive to look for ways around ENH, including a lower-priced alternative network without ENH, *if practicable*. The fact that they tried but failed is real-life proof of ENH's market power.

Prior to the merger, "selective contracting" required Evanston and Highland Park to compete to get on (or stay on) a health plan's network by offering high quality at a good price. Otherwise, each faced exclusion from the health plan's network. For example, if necessary, health plans could exclude Evanston and still satisfy local customers through a network including Highland Park and other nearby hospitals offering services comparable to Evanston, such as Lutheran General and Rush North Shore. Similarly, health plans could exclude Highland Park and utilize a network consisting of Evanston and other hospitals near Highland Park, such as Lake Forest. Before the merger, health plans did not have to exclude Evanston or Highland Park because they were both pricing competitively.

The availability of alternative network configurations fostered competition by restraining Evanston's and Highland Park's prices while simultaneously inducing each hospital to improve its quality of care and operate more efficiently. Ultimately, consumers benefitted.

With the merger, health plans could no longer choose between networks including either Evanston or Highland Park but excluding the other; the choice became all or nothing. From a business standpoint, the next best alternative network – excluding ENH and relying on hospitals outside the ENH geographic triangle – was untenable, and ultimately ineffective in restraining ENH's prices. This is why ENH's price increases outpaced the control group hospitals.

For example, PHCS, confronted by an unprecedented price increase demand from ENH,

assessed the cost to customers of a network with and without ENH. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } PHCS nonetheless decided it could not compete in selling its products with the lower-priced alternative network that did not have a hospital in ENH's geographic triangle. PHCS acquiesced to ENH's demands.

United also found it difficult to defeat ENH's price increases and to switch to an alternative network that did not have a hospital in ENH's geographic triangle. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } ENH barely budged.⁶

One Health took the bold step of rejecting ENH's higher price demands. One Health then tried to compete with a network of hospitals located outside ENH's geographic triangle. The exercise proved futile. One Health customers found the alternative network inadequate, thereby forcing One Health to return to ENH and its higher prices.

When health plans and employers cannot restrain ENH's price increases by turning to other hospitals that offer lower prices and comparable services (but are located outside of ENH's geographic triangle), and ENH can, in fact, profitably raise prices without losing network placements, that is the essence of market power.

Third, ENH's own business documents speak bluntly and clearly of a decade-long quest for

⁶ During the 2003 contract renegotiations and the pendency of the FTC investigation that five months later would lead to the Complaint in this case, ENH asked United to send a self-serving letter to the FTC stating that the merger was not anticompetitive. (CX 6284 at 1-2). United refused because it would not tell the FTC something that was not true. (Foucre, Tr. 927).

market power that culminated in the Evanston-Highland Park merger. Business documents are highly probative of whether a merger violates Section 7 of the Clayton Act. *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 717 (D.C. Cir. 2001) (“Heinz’s own documents recognize the wholesale competition and anticipate that the merger will end it.”).

- In the mid-1990s, Evanston and Highland Park joined the Northwestern Healthcare Network (“NH Network”) to gain “leverage” and “better pricing” from health plans. (CX 1802 at 2-3).
- 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.” (CX 395 at 1-2).
- Evanston saw the Highland Park merger as the answer to the “pricing pressures” from health plans: “Strengthen negotiation capability with managed care companies through merged entities. Commit with single signature/one voice to marketplace. Make ‘indispensable’ to marketplace.” (CX 442 at 4-5).
- For Evanston, equally important was the risk of “not undertaking [the] merger:” someone else might merge with Highland Park. (CX 84 at 58).
- Highland Park saw the Evanston merger as the way to “push back” health plans and “get the rates back where they ought to be” because “it would be real tough for any of the Fortune 40 companies in this area whose CEOs either use this place or that place to walk from Evanston, Highland Park, Glenbrook and 1700 of their doctors.” (CX 4 at 2).
- Bain, Evanston’s long-trusted consulting firm, recognized the “opportunities created by the Highland Park merger” to raise prices. (CX 74 at 3). Bain wrote that the “addition of Highland Park will substantially improve ENH’s leverage” with health plans. (CX 74 at 19). The upshot would be to obtain and justify “premium pricing (i.e., above the competitive average).” (CX 67 at 49).

ENH’s post-merger documents confirm the pre-merger analysis. In January of 2000, Jeffrey Hillebrand, ENH’s COO, reported to the Board that “*as a result of combining the medical staffs and Hospitals of the merger, the Corporation was able to re-negotiate a managed care contract [United] that resulted in an additional \$3.5 million benefit.*” (CX 5 at 5 (emphasis added)). In memos to the Board, Mark Neaman, ENH’s CEO, praised the \$24 million in higher revenues from renegotiated

contracts with health plans, concluding that “[n]either Evanston nor Highland Park alone could achieve these results.” (CX 13 at 1; CX 17 at 2).

Fourth, the testimony of ENH’s employees echoed the planning documents’ themes that the merger was a vehicle to produce market power. Mark Newton, formerly of Highland Park, ENH and today Swedish Covenant, described the post-merger contracting strategy. He testified that ENH selected the higher rate from Evanston’s and Highland Park’s contracts, and then added a “*premium*.” (Newton, Tr. 364 (emphasis added)). The “premium” represented the “additional negotiating power and leverage” that ENH obtained as a “benefit” of the merger. (Newton, Tr. 365). Terry Chan, who negotiated contracts for Highland Park and then for ENH, added that ENH could increase prices because it had “more leverage” through the merger. (Chan, Tr. 710).

Messrs. Neaman and Hillebrand also conceded the elements of market power. A firm possesses market power if it can price significantly and persistently above competitive levels and not lose so much of its sales to competitors as to make the higher prices unprofitable.⁷ 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. (Neaman, Tr. 1211-2; Hillebrand, Tr. 1764-5). And Messrs. Neaman and Hillebrand were correct: ENH did not lose a single health plan customer after the price increases. (Hillebrand, Tr. 1708).

In late 2000, ENH rewarded executives for the merger with unprecedented bonuses and pay increases worth millions. (Neaman, Tr. 1263-9; CX 31 at 1; CX 2099 at 2-3, 8, 11).

What makes ENH’s pre-merger to post-merger turnaround more remarkable is that it

⁷ “A monopoly sets its price without fear that it will be undercut by a rival firm.” Dennis W. Carlton & Jeffrey M. Perloff, Modern Industrial Organization 87 (3rd ed. 2000).

occurred at a time when, according to Messrs. Neaman and Hillebrand, health plans' bargaining positions increased even more. (Neaman, Tr. 960-1, 1269-71; Hillebrand, Tr. 1725-6). So what changed? ENH's senior management remains the same as before the merger. (Hillebrand, Tr. 1700, 1727-30; Neaman, Tr. 1220-1). The health plans are the same firms that did business with Evanston before the merger. (Hillebrand, Tr. 1723). ENH's negotiating stance remains equally aggressive. (Hillebrand, Tr. 1731, 1733). ENH's negotiators remain equally effective. (Hillebrand, Tr. 1727, 1729; Neaman, Tr. 1220; Sirabian, Tr. 5728, 5733-4, 5738-9, 5744-5, 5754, 5762). The only credible change is the market power ENH gained from the merger.

2. *Post-Merger Market Structure Analysis
Supports the Evidence of Anticompetitive Effects*

The merger laws prohibit mergers that create or enhance market power -- the ability of a firm "to force price above or farther above the competitive level." *Hosp. Corp. of America v. FTC*, 807 F.2d 1381, 1386 (7th Cir. 1986); *Merger Guidelines* § 0.1. Clayton Act Section 7 prohibits a merger "where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or tend to create a monopoly." 15 U.S.C. § 18 (emphasis added).

The direct evidence of actual anticompetitive effects caused by the merger -- ENH's higher price increases relative to the control groups -- corroborated by testimony, admissions and documents from multiple sources, establishes the Section 7 violation. The "effect" of the merger was to substantially lessen competition in a "line of commerce" (general acute-care inpatient hospital services that ENH sold to health plans) in a "section of the country" (the location of the ENH facilities with which health plans contracted). Nothing more need be shown. Indeed, no evidence could be more relevant or more powerful.

The Supreme Court, in the context of the Sherman Act, instructs that evidence of actual

anticompetitive effects obviates the need for any elaborate inquiry into market delineation and market structure. A “finding of actual, sustained adverse effects on competition . . . is legally sufficient to support a finding that the challenged restraint was unreasonable even in the absence of elaborate market analysis.” *FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 461 (1986). The reasoning applies with equal force to merger challenges under the Clayton Act. *U.S. v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1282-1283 (7th Cir. 1990); *FTC v. Libbey, Inc.*, 211 F.Supp.2d 34, 48-49 (D.D.C. 2002).

To the extent that Section 7 of the Clayton Act requires a market structure analysis, the end result is the same: the merger reduced competition substantially. When ENH raised prices significantly after the merger, health plans did not switch to outpatient services nor to hospitals located outside the ENH geographic triangle. This natural experiment proves that (1) the appropriate product market is general acute-care inpatient hospital services sold to health plans (excluding quaternary services), and (2) the appropriate geographic market is the area adjacent or contiguous to the three ENH hospitals.

Evanston’s documents suggest a highly concentrated market post-merger. In 1999, Evanston determined that in the merged entity’s “core service area,” an area a little larger than the geographic triangle formed by the three ENH facilities, the combined share would be 55% (Highland Park 11%; Evanston 44%). (CX 84 at 21). Using Evanston’s figures, the merger increased market concentration under the HHI from 2350 to 3426, an increase of nearly 1000.⁸ These HHI figures represent a “highly concentrated” market in which mergers are “likely to create or enhance market power,” and the burden rests on ENH to rebut the presumption of harm – a burden that ENH cannot

⁸ Using the shares shown in Evanston’s document, the HHI is calculated by summing the squares of the individual shares of all the participants. *Merger Guidelines* § 1.5.

meet. *Merger Guidelines* § 1.51; *H.J. Heinz*, 246 F.3d at 715.

B. ENH's Defenses Are Illusory and Not Substantiated by Credible Evidence

Against these facts of illegal market power, ENH offers two post-hoc arguments. ENH claims that the post-merger price increases are not the result of market power, but rather were caused by ENH "learning about demand." ENH alternatively argues that the price increases can be accounted for by the post-merger "quality of care improvements."

1. *"Learning About Demand"*

According to ENH, pre-merger Evanston did not know that health plans were really willing to pay more for its services. After the merger, Evanston learned, to its surprise, that Highland Park, which offered less complex services, had higher rates on some contracts. This purported epiphany caused ENH to raise prices toward the level at which it believed it truly always belonged -- comparable "academic" hospitals. To demonstrate the truth of the "learning about demand" theory, Dr. Baker, one of ENH's economic experts, claims that the data show that ENH's post-merger prices rose to (but not above) the average price levels of the "academic" hospital control group selected by Dr. Noether, ENH's other economic expert.

The facts tell a story markedly inconsistent with the "learning about demand" assertion.

Evanston had nothing to learn from Highland Park. {

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2645-8,

in camera).

Only Dr. Noether testified that ENH belongs in the same league as “academic” hospitals.

Dr. Noether selected six hospitals with which to compare ENH’s post-merger prices, including the four most expensive hospitals in her data. Her “academic” control group includes ENH even though it does not offer the complex services routinely handled by the “academic” hospitals, and excludes hospitals identified as competitors in ENH’s business documents. By lumping ENH into a supposed cluster of “academic” hospitals, ENH portrays its price increases as simply catching up to its high-end status. The premise, however, that ENH is an “academic” hospital is flawed because disinterested informed observers – health plans that purchase the services of “academic” hospitals – contradict Dr. Noether’s underlying assertion. (*E.g.*, Foucre, Tr. 935-6).

ENH’s conduct is inconsistent with “learning about demand.” If ENH was supposed to have learned about demand, ENH flunked the test Dr. Baker created to prove his theory. Dr. Baker first argued that if “learning about demand” was correct, ENH’s post-merger prices to { [REDACTED] } should rise up to the level of but not exceed the average prices of the “academic” control group. { [REDACTED] } (Baker, Tr. 4739, *in camera*). { [REDACTED] } (Haas-Wilson, Tr. 2728, *in camera*).

2. *“Improving Quality of Care”*

ENH contends that any harm to competition from the merger is outweighed by the post-merger “quality of care improvements” at Highland Park, all of which it claims are “merger specific.”⁹ ENH enumerates a veritable kitchen sink of changes – from valet parking to cardiac

⁹ The claimed benefits of a merger must be “merger specific” to be cognizable as a defense. *H.J. Heinz*, 246 F.3d at 721. “That is, they must be efficiencies that cannot be achieved by either
(continued...)

surgery. ENH's expert, Dr. Chassin, focused principally on two categories of changes – “structural” and “processes.” Structural changes relate to things like the nursing staff, while processes relate to things like diagnostic tests and surgical procedures.

ENH says nothing about quality changes at Evanston or Glenbrook, instead limiting its proof exclusively to Highland Park. Largely missing from Dr. Chassin's work is the measure of quality about which patients likely care the most – outcomes (*e.g.*, mortality rates) and patient satisfaction. Also missing is an explanation of how to value the “improvements” or how to compare them to the price increases. (Chassin, Tr. 5447).

Only “cognizable” benefits – “merger-specific efficiencies that have been verified and do not arise from anticompetitive reductions in output or service” -- are given weight. *Merger Guidelines* § 4. In order to prevail on this defense, ENH must satisfy three elements.¹⁰

First, ENH must show that quality of care, in fact, improved post-merger. ENH must “substantiate” the purported improvements – *quantify* and *verify* their “magnitude.” *Merger Guidelines* § 4; *Staples*, 970 F. Supp. at 1089 (efficiency claims fail if “unreliable” and “unverified”). ENH cannot rely on “mere speculation and promises,” and its proof should be subject to “rigorous” analysis. *H.J. Heinz*, 246 F.3d at 721.

Second, ENH must show that any improvements outweigh the harm to competition. Because

⁹ (...continued)

company alone because, if they can, the merger's asserted benefits can be achieved without the concomitant loss of a competitor.” *Id.* at 722. As set forth in the *Merger Guidelines*, the FTC “will consider only those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects. These are termed *merger-specific efficiencies*.” *Merger Guidelines* § 4 (emphasis in original).

¹⁰ *H.J. Heinz*, 246 F.3d at 720-722; *FTC v. Cardinal Health, Inc.*, 12 F. Supp.2d 34, 61-63 (D.D.C. 1998).

of the actual harm that already has occurred, the benefits ENH claims must be “extraordinary” and of “significant” benefit “to competition, and hence, to consumers.” *H.J. Heinz*, 246 F.3d at 720; see also *Merger Guidelines* § 4 (“The greater the potential adverse competitive effect of a merger . . . the greater must be cognizable efficiencies”).

Third, ENH must show that any improvements are “merger specific.” Courts will not permit mergers to proceed if the benefits can be achieved through alternative means short of a merger. For example, in *H.J. Heinz*, the D.C. Court of Appeals rejected the claim that Heinz could produce better baby food by acquiring Beech-Nut and its recipes. The Court of Appeals reasoned that Heinz, on its own and without the need of a merger, could simply invest more money to make a better tasting product. *H.J. Heinz*, 246 F.3d at 722.

In *Cardinal Health*, the district court rejected the efficiencies defense because “much of the savings anticipated from the mergers could also be achieved through continued competition in the wholesale industry.” *Cardinal Health*, 12 F. Supp.2d at 63. Moreover, if there were efficiencies, “the history of the industry over the past ten years demonstrates the power of competition to lower cost structures and garner efficiencies as well.” *Id.* In the market in which Evanston and Highland Park competed before the merger, “the power of competition” induced by selective contracting achieved lower cost structures and higher quality of care as well.

ENH failed to prove that quality of care did, in fact, improve patient outcomes and satisfaction. For all the anecdotal speculation ENH put into the record about the array of changes implemented at Highland Park since the merger, ENH did not present any meaningful analysis that patients actually benefitted from those changes through improved outcomes or patient satisfaction. ENH also failed to show how the quality changes compared to what was happening at other hospitals. This is a critical flaw because starting in the late 1990s, there has been a nationwide trend

of improved quality, with one major study finding an average per state inpatient improvement rate of 12% through 2001. (Romano, Tr. 3000-1): As a result, ENH cannot distinguish between improvements unique to Highland Park and the merger, or simply part of an overall trend toward better medicine that did not require Highland Park to merge with Evanston.

Complaint Counsel's quality expert, Dr. Romano, conducted the only quantitative analysis in this case that compares the quality changes to other hospitals in Chicago. To test ENH's claim of improved quality, Dr. Romano examined patient outcomes and patient satisfaction at Highland Park and Evanston in the clinical areas highlighted by ENH at trial. Using standard scientific techniques and the available data, Dr. Romano found there was no evidence of quality improvements compared to the peer group.

ENH failed to prove that the benefits outweigh the harm. Since it chose to charge one anticompetitive price regardless of which hospital a health plan utilized, to prevail on its defense, ENH must show that quality improved throughout all three hospitals. In its Second Amended Answer, ENH alleged that the "merger of Highland Park into ENH facilitated significant improvements in the quality of patient care *throughout the ENH system* that outweigh any alleged anticompetitive effects." (Second Amended Answer at 21 (emphasis added)). But at trial, ENH explicitly limited its quality evidence to only one of the three ENH hospitals, Highland Park. ENH has effectively admitted that it cannot meet its own affirmative defense.

Having excluded two-thirds of the relevant hospitals from its proof and having failed to prove that the changes at Highland Park improved quality relative to other hospitals, ENH offers no methodology or mechanism by which to value the quality changes against the price increases. [REDACTED]

[REDACTED]

[REDACTED]

████████████████████ } (CX 6279 at 19, *in camera*). Nor can ENH answer whether \$100 charged to a health plan reflects \$51 in market power and \$49 in quality improvements. ENH also cannot answer whether \$100 charged to a health plan for quality improvements would have been \$50 for the same improvements but for ENH's market power.

ENH's anticompetitive price increases impacted consumers in the form of higher premiums, higher deductibles, higher co-pays and for some, loss of health benefits entirely. (Ballengee, Tr. 196-7; Mendonsa, 483-4). Moreover, the higher prices had to be paid regardless of how little enrollees utilized Highland Park because ENH charged one price for all three hospitals. (Foucre, Tr. 890-1). Thus, even if it had proved a benefit to some consumers, ENH cannot prove that those benefits outweigh the harm to the consumers who paid higher premiums, could not afford medical care anymore, or never received treatment at Highland Park.

ENH offers neither a measurement nor a valuation method to help the Court assess the truth of its claim that the merger's benefits outweigh the harm. The balancing task is hard enough, but having put forth no number, proving that the scale tips in its favor is impossible. This failure of proof, of course, is not the Court's problem, it is solely ENH's problem.

Health plans are in the business of weighing quality. Health plans will pay more to select hospitals that offer more complex services and with reputations for higher quality. (Ballengee, Tr. 163-4). However, in this case, health plans had no opportunity to decide whether the purported quality changes were worth the higher prices.

First, ENH moved forward with price increases before any quality improvements could have been implemented. For example, in November of 1999, before the merger was finalized, Evanston planned to demand higher prices from United. (RX 679 at ENHL RG 004136). On January 6, 2000, only six days after the merger was finalized, Mr. Hillebrand reported to the ENH Board that "as a

result of combining the medical staffs and Hospitals,” ENH had renegotiated the United contract, which would result in an additional \$3.5 million in annual revenues. (CX 5 at 5). The “price increase for the contract was effective January 1, 2000.” (CX 5 at 5). No quality changes occurred this quickly, and some, such as the EPIC system, did not become operational until 2003-2004. (Neaman, Tr. 1251).

Second, if the changes implemented at Highland Park truly improved quality and justified higher prices, ENH would be expected to trumpet the changes to its customers. But the topic of quality changes simply never came up. (*E.g.*, Neary, Tr. 624). Mr. Hillebrand admitted that he did not tell health plans that the higher prices were justified by quality changes. (Hillebrand, Tr. 1784). Mr. Neaman admitted that he never saw any documents correlating the higher prices with the quality changes at Highland Park. (Neaman, Tr. 1241-2). Even after implementing the changes, ENH did not advertise them to health plans. (Ballengee, Tr. 188, 200-3).

On the negative side of the ledger are the undisputed higher prices ENH charged health plans after the merger. But ENH offers nothing for the positive side of the ledger. Since ENH cannot show that *all* the price increase is offset by quality improvements, the “quality of care improvement” defense cannot save the merger.

The quality changes were not “merger specific.” To be sure, some changes benefitted Highland Park -- *e.g.*, opening a cardiac surgery program. But the relevant antitrust question is whether Highland Park could have achieved the same results without engaging in a merger that gave the new firm market power. The answer is yes.

In 1999, before agreeing to the merger, Highland Park was ready to invest more than \$100 million to further improve its quality of care -- investments directed at, among other things, (1) enhancing its core clinical competencies (cardiac surgery, oncology and specialty surgery) by itself

or with other hospitals, (2) strengthening its medical staff with new doctors and nurses as well as enhancing leadership and morale, (3) upgrading technology, equipment and facilities, and (4) increasing patient satisfaction and outcomes so that they would exceed those of competitors and national standards. (CX 545 at 3; CX 1868 at 12-14, 17; CX 1908 at 9-23). Absent the merger, with the need to keep itself attractive relative to Evanston for health plans and patients, Highland Park would have had every incentive to continue improving its quality of care.

Highland Park also had specific plans to expand clinical programs ENH now says resulted from the merger. For example, in 1999, Highland Park agreed with Evanston to develop a joint cardiac surgery program at Highland Park, the same model for the ENH-Swedish Covenant cardiac surgery program today. (CX 2094). Highland Park also had detailed plans to expand multi-disciplinary oncology services alone and with other hospitals.

There was no financial urgency to merge. Neele Stearns, the Board Chairman, testified that Highland Park had the “financial wherewithal to sustain” itself for “10 years,” and “not be under pressure to have to merge with anybody.” (CX 6305 at 2, 4-5, 11 (Stearns, Dep.)). If it had not merged with Evanston, Highland Park “would have continued to pursue other options.” (*Id.* at 11). Being located in an “attractive service area,” Mr. Stearns felt Highland Park would be “attractive to other partnership candidates.” (*Id.* at 12).¹¹

Given the evidence of market power, any doubts must be resolved against the validity of the “quality of care improvements” defense. Courts view with skepticism arguments that a firm should be permitted to acquire market power because the acquisition would have good effects that outweigh

¹¹ To suit its “quality of care improvements” defense, ENH claims that only a merger with Evanston could have achieved the improvements because of its unique geographic proximity to Highland Park. However, ENH also claims that before the merger, Evanston’s geographic proximity to Highland Park did not make them close competitors and that hospitals further away were more significant competitive restraints. ENH cannot have its cake and eat it too.

the harm from market power. “The heart of our national economic policy long has been faith in the value of competition.” *Standard Oil Co. v. FTC*, 340 U.S. 231, 248 (1951). The antitrust laws reflect a judgment that “ultimately competition will produce not only lower prices, but also better goods and services.” *Nat’l Soc’y of Prof. Engineers v. U.S.*, 435 U.S. 679, 695 (1978). “The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain – quality, service, safety and durability – and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers.” *Id.* The same is true in merger analysis. *U.S. v. Philadelphia Nat’l Bank*, 374 U.S. 321, 371 (1963) (prohibiting merger of local banks).

The classic example in the healthcare industry is *Indiana Federation of Dentists*, an FTC Act claim against dentists who engaged in a horizontal restraint impacting health insurers. The dentists claimed that their concern for patients’ “quality of care” justified their conduct. The Supreme Court replied that such a contention was ““nothing less than a frontal assault on the basic policy of the Sherman Act.”” *Id.* at 463 (*quoting Prof’l Engineers*, 435 U.S. at 695). The Supreme Court refused to excuse the dentists’ justification since the health insurers had the same quality of care incentive as the dentists. *Id.* at 463-464 (“[Health plans] are themselves in competition for the patronage of the patients . . . and must satisfy their potential customers not only that they will provide coverage at a reasonable cost, but also that that coverage will be adequate to meet their customers’ dental needs.”).

C. The Appropriate Remedy Is Divestiture of Highland Park

Once a determination is made that a merger violates the Clayton Act, the only course is a complete divestiture: the Clayton Act states that the Commission “*shall*” issue a divestiture order; the Supreme Court, in *Ford Motor Co. v. U.S.*, 405 U.S. 562, 582 (1972), held that the favored

remedy is divestiture; the Court of Appeals for the Seventh Circuit, in *Hosp. Corp. of America*, 807 F.2d at 1393, upheld the FTC's order requiring divestiture of the acquired hospital; and the Commission, in *Chicago Bridge and Iron Co.*, Docket No. 9300 at 93 (January 6, 2005), recently affirmed that in a consummated merger, the acquired entity must be divested.

Against this clear law, ENH suggests that the purported harm from the divestiture will outweigh the benefits. This is unsupported speculation. Highland Park was a fine hospital before the merger and served its community well as a stand-alone entity. There is no credible evidence that Highland Park cannot continue its mission after a divestiture.

To the contrary, numerous parties have the incentive to assure the same level of care at Highland Park after the merger. As suggested in *Indiana Federation of Dentists* and the record in this case, health plans have an equal incentive to see that their customers receive high quality of care at Highland Park. Numerous government agencies and professional associations -- e.g., JCAHO, Medicare, CHRPP -- have oversight responsibility to insure the quality of care. The medical staff can also be counted on to honor their professional obligations to provide excellent care. None of these dedicated healthcare providers will stop doing their jobs just because of a change in Highland Park's ownership.

ARGUMENT

I.

THE MERGER VIOLATES SECTION 7 OF THE CLAYTON ACT BECAUSE IT CREATED MARKET POWER FOR ENH AND CAUSED ACTUAL ANTICOMPETITIVE EFFECTS

Section 7 of the Clayton Act prohibits mergers when the effect of the merger “may be to substantially to lessen competition, or to tend to create a monopoly.” 15 U.S.C. § 18 (2005). “Mergers are motivated by the prospect of financial gains. . . . [The *Merger Guidelines*] focus on the one potential source of gain that is of concern under the antitrust laws: market power. The unifying theme of the [*Merger Guidelines*] is that mergers should not be permitted to create or enhance market power or to facilitate its exercise.” *Merger Guidelines* § 0.1; *see also H.J. Heinz*, 246 F.3d at 713 (“Merger enforcement, like other areas of antitrust, is directed at market power.”). “Market power to a seller is the ability profitably to maintain prices above competitive levels for a significant period of time.” *Merger Guidelines* § 0.1.

The merger between Evanston and Highland Park created market power and ENH exercised that market power through anticompetitive price increases, which of course necessitated reductions in output. This market power contrasts with the pre-merger world, as alluded to by Mr. Neaman’s memo to his Board that the post-merger higher prices could not have been achieved “by either Evanston or Highland Park alone.” (CX 17 at 2).

Proof of these elements – actual significant and persistent anticompetitive effects, solely attributable to market power caused by the merger – constitutes proof of a Section 7 violation in that the “effect” of the merger was “substantially to lessen competition.”

A. Consumers Benefitted from the Pre-Merger Competition Fostered by Health Plans' Ability to Choose between Evanston and Highland Park

1. *Selective Contracting and Bargaining Positions – Competition to Form and Join Hospital Networks Developed by Health Plans*

In the context of managed care, the relevant customers for evaluating a hospital merger are the health plans. The health plans buy hospital services to create “networks;” the health plans then compete among themselves on the basis of the hospital networks they can offer to employers. (Ballengee, Tr. 152). In creating a network, relevant factors include the hospital’s location, reputation for quality and breadth and types of services. (Ballengee, Tr. 152-3; Holt-Darcy, Tr. 1420). Price is important because employers want “cost-effective healthcare.” (Ballengee, Tr. 153). Hospital prices directly impact premiums and health plans’ pricing to employers, which then get passed on to employees. (Ballengee, Tr. 172; Mendonsa, Tr. 483-4).

A hospital’s location plays a critical role. Patients choose hospitals based on, among other things, where their doctors have privileges and the hospital’s accessibility. (Elzinga, Tr. 2389-90). A hospital may be able to increase prices to a health plan if the health plan’s enrollees will not switch to a lower-priced alternative network consisting of more distant hospitals because the enrollees place a high value on the higher-priced hospital’s location. (*Id.*).

Not every hospital gets included in a health plan’s network – each must compete for the health plan’s business (just as each health plan must compete for the employer’s business). The rough and tumble of competition produces winners and losers, but the consumer ultimately benefits because the health plan can “selectively contract” with those hospitals that offer the best mix of services, quality, accessibility and prices. The ability of the health plan to exclude a hospital from its network -- often by substituting another hospital -- is a powerful competition tool, and defines each side’s bargaining position. (Haas-Wilson, Tr. 2470; Noether, Tr. 6189).

The exclusion potential can decrease the hospital's pricing power. One Health contracts with a "subset" of hospitals in an area because "the premise behind a hospital discounting their prices . . . is that they are going to get something in return, and that would be additional membership or patients going to their office or hospital." (Neary, Tr. 587-88). To obtain the benefit of more patients, the hospital must offer a lower price for inclusion in the network.

The credibility of the exclusion threat, and therefore the parties' relative bargaining positions, depends principally on the alternative hospitals (if any) available to the health plan. The more alternatives, *i.e.*, the more competition among hospitals for the health plan's business, the greater the health plan's bargaining position. (Haas-Wilson, Tr. 2470; Noether, Tr. 6191-92). An "alternative" hospital is not simply just another hospital – it must be a good substitute for the reasons that got the rival hospital into the network in the first place: comparable location, services, quality and price. (Ballengee, Tr. 155-6; Neary, Tr. 589).

When good substitutes exist, competition works. For example, in the late 1990s, PHCS was confronted with higher rates from the University of Chicago. (Ballengee, Tr. 155, 189-90). PHCS canvassed its rates with hospitals offering comparable services and location (Northwestern, Loyola and Rush Presbyterian, "advanced teaching hospitals" in Downtown Chicago) and found that the University of Chicago's rates were not in "parity" with the others. (*Id.* at 190). The University of Chicago refused to lower its rates. (*Id.*) Because it had good substitutes, PHCS used its bargaining position to avoid the higher prices and eliminated the University of Chicago from its network. (*Id.* at 189-90).

The health plan's customers -- employers and their employees -- benefit from the greater bargaining position and competition. The first benefit is on hospital prices. The mix of possible exclusion and substitution stir the "natural competitiveness" of hospitals to negotiate better rates.

(Ballengee, Tr. 156). Otherwise, the health plan can turn to the substitute hospitals willing to offer the same services and quality for less money. (Haas-Wilson, Tr. 2470).

Evanston was not immune to the pricing pressures. Evanston admitted that the risk of exclusion from a network and the corresponding loss of patient volume forced it to accept “price decreases.” (Neaman, Tr. 961). In February of 1998, Evanston solicited Bain’s advice about how to deal with the “pricing pressures” and “significant threat” presented by reductions in reimbursement by health plans. (CX 2037 at 2-3).

At Highland Park, health plans reminded executives that “we’ve got other hospitals that will fill that bill, who would be able to be part of the [network], and so if we’re looking for a particular price or a particular term in the contract that [health plans] would find not acceptable, the risk of trying to push that would be that we could be excluded from the [network].” (Newton, Tr. 303). So, while Highland Park wanted 10-12% price increases, it had to settle for 6-8% since it was “replaceable and substitutable” by hospitals like Evanston (and others). (*Id.* at 356-8).¹²

The risk of exclusion has other important pro-competitive dimensions. In order to avoid exclusion, Evanston grew the breadth and depth of its services, grew the quality of its services and strived to improve its cost picture. (Neaman, Tr. 962). Highland Park also focused on its quality of care because “consumers have a general sense of quality and . . . if an institution had a poor image of quality, then they would not be attractive to enrollees, it would not be attractive to consumers.” (Newton, Tr. at 304). Highland Park also stressed operating efficiency and reducing costs. “We would be constantly concerned about the cost profile of the hospital . . . we were not able to manage in the sense of great luxury, so you paid great attention to what is the cost of delivering services,

¹² See also Newton, Tr. 304 (Highland Park felt “constrained” on prices and contract terms); Newton, Tr. 317 (“we did not have that kind of market strength that would allow us to say to a payor or demand from a payor more than above average market increases.”)

because we did not have a lot of the flexibility in terms of just raising prices.” (*Id.* at 305-6, 315-6; CX 1868 at 11 (“The hospital is set on achieving a 16% reduction in cost per adjusted admission . . . in 1998”).

Mr. Stearns, Chairman of the Board, also described the “pressure” on Highland Park: “You adjust to it. There’s pressure exerted by the payors. You deal with it. You try to lower your cost, you try to deliver care more efficiently. It’s there. You just have to cope with it as best you can.” (CX 6305 at 13 (Stearns, Dep.)).

If a good substitute exists, the health plan can credibly threaten to exclude a hospital, but if the substitute is unavailable for any reason, bargaining positions change. The next-best alternative network configuration may not be effective, and the health plan may have to negotiate from a weaker bargaining position. (Haas-Wilson, Tr. 2470-3, 2475-6; Noether, Tr. 6191-2).¹³ In this manner, competition may be lessened by the absorption of a substitute by its rival.

2. *Evanston and Highland Park Competed for Inclusion in Networks*

Prior to the merger, health plans viewed Evanston and Highland Park as substitutes in their network configurations, allowing the plans to avoid unreasonable price increases.¹⁴ The key to the competition between the two hospitals was their geographic location, straddling the affluent North Shore from the town of Evanston north through the town of Highland Park.

For example, PHCS “knew that we had an alternative facility that we could market within our network if, in fact, the rates were not considered to be appropriate.” (Ballengee, Tr. 166).

Basically we viewed Highland Park and Evanston as competitors....
The people would choose either to go north to one or south to the

¹³ Complaint Counsel discusses selective contracting and bargaining positions in its proposed Findings of Fact (“CCFF”) at 192-283.

¹⁴ Complaint Counsel discusses pre-merger competition at CCFF 245-254, 284-301.

other. They could go either way and receive the same services at the same level. So, it was pretty well assumed that we could have one or the other hospital in the network. . . . It allowed us to feel comfortable in working the negotiation off that way, feeling that if, in fact, the negotiation and the rates were not going well at one hospital, that we had the alternative. We could choose between the two and work them against each other . . . We felt that we could eliminate [Evanston] from the network and utilize Highland Park as the alternative hospital.

(*Id.* 166-7). Throughout the 1990s, PHCS was able to keep Evanston’s price increases to low single-digits because there was a “competitive environment between [Evanston and Highland Park] and that we could trade off one for the other.” (*Id.* at 168-70).

One Health considered Highland Park to be Evanston’s “main competitor” or “next nearest competitor” since both drew patients from the “same general population” and offered “comparable” services. (Neary, Tr. 600-2). { [REDACTED] }
{ [REDACTED] } (Mendonsa, Tr. 530, *in camera*). { [REDACTED] }
{ [REDACTED] } (*Id.* at 569, *in camera*).

UniCare voiced the same theme. { [REDACTED] }
{ [REDACTED] }
{ [REDACTED] } (Holt-Darcy, Tr. 1518-9, *in camera*). { [REDACTED] }
{ [REDACTED] }
{ [REDACTED] } (*Id.* at 1517-8, *in camera*).

Selective contracting (or hospital substitutability) played a central role in ENH’s business planning. Mr. Neaman was concerned that Evanston would be excluded from a health plan’s network of providers. (Neaman, Tr. 961). In response, Mr. Neaman admitted that Evanston

developed strategies to improve quality of care and its cost structure. (*Id.* at 962).

At Highland Park, management informed the Board of the “key environmental variables” confronting it and “where competition was going to be coming from.” (Newton, Tr. 326). Highland Park saw that competition existed for “participation in payer plans,” and it “did not want to be excluded from any plans.” (CX 1868 at 3; Newton, Tr. 324). Within Highland Park’s core service area, the competition for network participation would come “mainly from Lake Forest *and Evanston.*” (CX 1868 at 3 (emphasis supplied); Newton, Tr. 324-5). The competition from Evanston and others was “strong and focused, forcing [Highland Park] to pursue a defensive position.” (CX 1868 at 3). As health plans continued to “seek to lower the prices of health care,” the competition for network placement and the “stronger” power of health plans presented “reimbursement challenges” for Highland Park. (CX 1868 at 3; Newton, Tr. 326).

As Highland Park and Evanston pursued merger discussions, both sides acknowledged that the desire to merge was driven in significant part by the opportunity to “join forces and grow together rather than compete with each other.” (CX 2 at 7; *see also* CX 442 at 5 (“Do not ‘compete with self’ in covered markets (e.g., 60-70% market share) such as Evanston, Glenview, Highland Park and Deerfield.”); CX 1879 at 3-4 (“Competition and Signals” . . . “Stop competing with each other.”); CX 4 at 1 (“Everybody progresses to see the community benefit that would be derived *as well as the economic benefit of not being out there doing battle with one another in what will be a common battle ground* if you want to call it that.”) (emphasis added)).

3. *Highland Park Was Ready, Willing and Able to Compete against Evanston*

Absent the merger, Highland Park would have remained an aggressive competitor that health plans could continue to rely on for their network configurations to restrain Evanston. In the late 1990s, Highland Park pursued strategies to stay independent. (Newton, Tr. 313). Highland Park saw

Evanston as one of the competitors “attempting to achieve a sustainable market advantage” against it. (Newton, Tr. 406-7; CX 92 at 4). To counteract this competition and remain on health plans’ networks, Highland Park “would not be able to get overly aggressive in our pricing requests, because that’s going to essentially correlate to the plans telling us that we’re going to take you out of the [network].” (Newton, Tr. 404; *see also* CX 1869 at 8 (“Does the organization possess the vision and desire to aggressively move market?”)). Going forward, health plans would “continue to seek price concessions,” requiring Highland Park to be “very mindful of our overall level of pricing . . . being very focused on cost-effectiveness . . . ensuring that we have a high quality product presented to the market.” (Newton, Tr. 408).

To further invigorate itself as a competitor, Highland Park approved plans in 1998 and 1999 for developing new clinical services (*e.g.*, cardiac surgery and oncology programs), strengthening the medical staff (physicians and nurses), enhancing quality of care for existing medical services, improving patient outcomes and satisfaction, and updating technology, equipment and facilities. (Newton, Tr. 316, 331-44, 408-411; CX 1868 at 8, 10, 12-14, 17-19; CX 1869 at 4; CX 1908 at 7, 9, 12-23). In March of 1999, Highland Park authorized plans to invest over \$100 million in new services, facility expansion, construction, capital and information technology over the next four years. (CX 545 at 3).¹⁵

The marketplace created incentives for Evanston and Highland Park, as separate entities, to compete vigorously. Each developed strategic plans to keep prices in check, improve quality of care and operate their business more efficiently. Courts, such as the D.C. Circuit, favor the continuation of such strategies over mergers: “Indeed, those documents [strategic plans] disclose that Heinz

¹⁵ Complaint Counsel discusses Evanston’s and Highland Park’s pre-merger plans to compete as independent hospitals at CCF 245-254, 356-367.

considered three options to end the vigorous wholesale competition with Beech-Nut: two involved innovative measures while the third entailed the acquisition of Beech-Nut. . . . Heinz chose the third, and least pro-competitive, of the options.” *H.J. Heinz*, 246 F.3d at 717.

B. Evanston and Highland Park Sought Ways to Thwart Competition and Gain Market Power

Evanston bemoaned the “pricing pressures” from health plans. (CX 19 at 1). Highland Park felt it was “under pressure” because health plans “negotiated hard and were successful in imposing pressure” on it. (CX 6305 at 10 (Stearns, Dep.)). Throughout the 1990s, Evanston perceived the health plans to have greater clout and bargaining power, forcing it to accept lower prices. (Neaman, Tr. 960-1). As price cuts deepened in the late 1990s, Evanston felt even greater pressure to find ways to counteract the trend. (Neaman, Tr. 962-3). In contemporaneous documents relating to three different means of consolidation, Evanston and Highland Park repeatedly spoke of increasing “leverage,” building “negotiating strength,” securing “premium” prices and making itself “indispensable” to health plans -- polite words for market power.¹⁶

1. *“Leverage” through the NH Network*

Founded in 1989 by, among others, Evanston and Highland Park, the Northwestern Healthcare Network (“NH Network”) tried to leverage the market shares of nine independent hospitals into higher prices. (Neaman, Tr. 963-5; CX 1802 at 2-3 (“leverage” is the “absolute heart of what [the NH Network] is about”).¹⁷ However, the NH Network proved ineffective because members could not “stand united,” *i.e.*, they continued to compete against each other for health plan

¹⁶ Complaint Counsel discusses Evanston’s and Highland Park’s pre-merger attempts to create market power at CCFF 1535-1608.

¹⁷ *See also* CX 1802 at 7 (“At a time in the market when the most frequent payor strategy is divide, conquer and decrease provider leverage, it is important for [the NH Network members] to maintain as much market strength and cohesion as possible.”).

business. (Neaman, Tr. 965-6; CX 1802 at 2-3; CX 1768 at 3 (“We are undercutting each other and it is apparent to the payors.”)).

In 1996, the NH Network brought in Bain to help guide strategy. Conveying its perception of how health plans viewed the marketplace, Bain noted a comment relayed by Humana: “It’s trickier [for health plans] to negotiate with providers in the Indianapolis market because hospital networks stick together and comprise such a large proportion of the beds in that area. [Humana’s] bargaining power in Indianapolis is far less than our bargaining power in the Chicago market.” (CX 1860 at 54 (showing combined market shares of independent hospitals in Indianapolis (30%) and Chicago (57%)).¹⁸ Bain advised that “market influence” required “significant share (20-25%) of physician/hospital market,” and that the NH Network should “focus on achieving scale in one quadrant of market.” (CX 1860 at 48, 52).

2. *“Leverage” through NH North*

Following through on Bain’s insights, in 1996, Evanston, Highland Park and Northwest Community Hospital pursued a regional alliance – “NH North.” Like the NH Network, NH North was designed to get better prices and contract terms from health plans. (Neaman, Tr. 1027). Bain identified “key needs” for the alliance, including “market share ‘clout’ (30%-50%).” (CX 393 at 1). Evanston defined its goal in multiple terms: increase “market influence” or “market leverage,” or make “indispensable to the marketplace” in order to “obtain premium sustainable pricing” from health plans. (CX 393 at 14; CX 394 at 2, 3, 13; CX 395 at 1, 2). Regardless of the phrase, the guiding principle remained “no competition” among the hospitals. (CX 393 at 2). The plans for NH North never came to fruition.

¹⁸ Complaint Counsel does not offer Bain’s quotation of Humana’s statement for the truth of the matter asserted, but rather to show the statement was made and its likely effect on the NH Network members, including Evanston and Highland Park.

3. *“Leverage” through the Evanston-Highland Park Merger*

Since their days together in the NH Network, Messrs. Spaeth and Neaman, the CEOs of the merging parties, shared the view that hospitals should “stand united” in order to get “better pricing” and “leverage.” (CX 1802 at 2-3). So when other hospitals continued to compete and health plans reaped the benefits thereof by cutting prices and exerting pricing pressures, Messrs. Spaeth and Neaman looked to each other. (Neaman, Tr. 1035-8). Beginning in late 1997, Messrs. Spaeth and Neaman, and their respective Boards and management, laid out their visions for the merger and its impact on competition. Away from the glare of court scrutiny, the executives spoke candidly, and extolled the supra-competitive prices that would (and did) flow from the market power that the new merged entity would enjoy.

In 1998, Messrs. Neaman and Spaeth wrote about the business environment confronting Evanston and Highland Park. (Neaman, Tr. 1037-8; CX 19 at 1). “Pricing pressures will escalate on [hospitals] from both government and managed care.” (CX 19 at 1). The merger would solve the problem: “Strengthen negotiating positions with managed care through merged entities and one voice. . . . make indispensable to marketplace.” (CX 19 at 1; *see also* CX 442 at 4-5; CX 2 at 7 (“geographic advantages” of merger)). Mr. Neaman told managers and the Board that the merger would “[i]ncrease our leverage, limited as it might be, with the managed care players, and help our negotiating posture.” (CX 1566 at 9; RX 2015 at ENHL MO 003485).

In June of 1999, at a Board meeting to decide whether to merge with Highland Park, Evanston executives identified two key issues. *First*, the combined share of Evanston and Highland Park in their “core service area” would be 55%, or nearly four-times larger than the next hospital (Rush North Shore). (Neaman, Tr. 1059-61; CX 84 at 21; *see also* CX 359 at 16). Bain had advised Evanston (in connection with NH North) that “marketshare clout” required a “30%-50%” share so

the Highland Park merger cleared that hurdle. (CX 393 at 1).

Second, to the extent there was any hesitancy about merging, management reminded the Board of the risk of “*not* undertaking [the] merger.” (CX 84 at 58 (emphasis supplied)). Skokie Valley Community Hospital, located three miles to Evanston’s south, had been a “sleeping dog” competitor until it affiliated with the Rush system of hospitals, at which point Rush renamed it “Rush North Shore,” invested heavily in the hospital, and the former “sleeping dog” awoke to become a new, strong hospital. (Hillebrand, Tr. 1794-7). The point of the story was clear: if Evanston did not act first, the same problem could occur to Evanston’s north, and another hospital system would come in to further strengthen Highland Park. (*Id.* at 1797). Evanston’s Board approved the merger with Highland Park. (CX 514 at 9).

Up the street at Highland Park, management foresaw that a merger with Evanston would build “negotiating strength with payers.” (CX 1869 at 7). The three hospitals would form a triangle among “not only a very affluent but an extremely attractive community . . . These organizations together would have a significant market penetration in these very affluent, attractive communities.” (Newton, Tr. 352). Highland Park saw Evanston, Lake Forest, Northwest Community and Condell as merger candidates, the attractiveness of each turning on “how concentrated could this market be for us.” (CX 1869 at 6; Newton, Tr. 353-4). Merging with Evanston would build the greatest pricing strength with health plans. (Newton, Tr. 349-50).

In the Spring of 1999, Mr. Spaeth and the Highland Park Board convened to discuss the merger. The conversation, taped and transcribed, was brutally honest. (CX 4 at 1). Mr. Spaeth, echoing Mr. Neaman, described the problem (CX 4 at 1-2):

[T]he reality in my view is that we are not looking at a rosie [sic] future economically on this site. Neither are they. We are not looking at the opportunity to control this market individually. The largest again [sic] payors in this arena have consolidated and are big

enough, strong enough, and probably bent on assuring that the physicians who practice here and at Evanston and the institutions don't make a hell of a lot of money. That is the reality and I am not even laying that on the insurers I am laying that on the employers.

The solution was the merger (CX 4 at 2):

[T]here are ways to at least I think to push back on the managed care phenomenon and get the rates back where they ought to be if you are a big enough concerted enough entity which is important enough to the employers in this community. I think it would be real tough for any of the Fortune 40 companies in this area whose CEOs either use this place or that place to walk from Evanston, Highland Park, Glenbrook and 1700 of their doctors.

Another Board member (McDonnell) chimed in with the same theme (CX 4 at 11):

I'll tell you can put in the bank now Dr. and that is that the Fortune 40 are gonna win they have the economic power and as long as we maintain the divided front on the provider side you're gonna get hammered its just economics always work.

Thereafter, Evanston brought in Bain to help capitalize on the merger. Bain, consistent with its prior advice for the NH Network and NH North, highlighted the obvious: "Marketplace Position -- with the Highland Park merger, ENH now commands a 55% market share." (RX 679 at ENHL RG 004136). Bain recognized that the "addition of Highland Park" would "substantially improve ENH's leverage," and recommended that ENH use its "significant leverage" to negotiate higher prices from health plans. (CX 74 at 3, 15, 19, 22).¹⁹ Health plans would have to pay "premium pricing (i.e., above the competitive average)." (CX 67 at 49).

The antitrust laws afford neither solace nor escape from the rigors of competition induced by health plans. In *Hosp. Corp. of America*, the Seventh Circuit upheld an FTC challenge to mergers that would have reduced the number of owners/managers of Chattanooga hospitals. The Court

¹⁹ Bain's monthly contract negotiations reports are at CX 74 (October 29, 1999), CX 75 (November 29, 1999), CX 1998 (January 6, 2000) and CX 67 (February 1, 2000).

recognized that hospitals were under “great pressure” from health plans (and the federal government) to “cut costs.” 807 F.2d at 1389. However, efforts by hospitals to resist this pressure through mergers that confer market power violate the Clayton Act. The “fewer the independent competitors in a hospital market, the easier they will find it . . . to frustrate efforts to control hospital costs.” *Id.* The Court opined that the FTC was entitled to make such efforts by hospitals “less effective by preserving a substantial number of competitors.” *Id.* Congress, through the Clayton Act, established that firms cannot combat pricing pressures by acquiring the market power that shields them from those pressures.

C. The Merger Gave ENH Market Power

In January of 2000, Evanston and Highland Park merged. All of Evanston’s, Highland Park’s and Bain’s predictions about the competitive impact of the merger came to fruition. Prices skyrocketed. Substitute hospitals and alternative network configurations proved unavailing. Bargaining positions changed. ENH won and consumers lost.

1. *Implementing the Price Increases*

ENH decided that all three hospitals would operate under one contract, with one price, and one chagemaster. (CCFF 822-832, 884-895). It did not matter that Glenbrook and Highland Park did not provide the same services as Evanston, even though other multi-hospital firms charge different rates for different hospitals. (CCFF 825-829, 904-917). Thus, the health plan would have to pay for the cost of Highland Park’s new parking garage even for those patients who never went to Highland Park because the health plan needed ENH in the network.

To negotiate its post-merger prices with health plans, ENH then picked the highest rate among Evanston’s and Highland Park’s contracts and added a “premium” on top of that. (Newton, Tr. 364). The “premium” represented one of the “benefits” of the merger to ENH – “the additional

negotiating power and leverage with the payors.” (*Id.* at 365).

ENH also required health plans to convert numerous contracts from fixed rates (per diem or per case) to discount off charges arrangements. (CCFF 813-821). This was a major coup because most health plans had fixed rates with other hospitals, including Evanston and Highland Park. (*See* CCFF 778-789). Fixed rates tend to result in greater discounts -- “up to 50%” -- than discount off charges. (Chan, Tr. 675). Generally, health plans disfavor discount off charges contracts because they give the hospital unilateral pricing power to raise its list prices in its chargemaster. { [REDACTED] [REDACTED] [REDACTED] } (Holt-Darcy, Tr. 1522, *in camera*).

For example, in 2002, health plans could not stop ENH from raising its chargemaster prices, { [REDACTED] } (RX 1687 at ENHL BW 027652, *in camera*). ENH estimated that the higher chargemaster would increase net revenues by \$20-26 million annually. (CX 45 at 8).²⁰ And this price increase required no new negotiations with the health plans. { [REDACTED] } (RX 1687 at ENHL BW 027653, *in camera*).

2. Health Plans Suffered Anticompetitive Effects from the Merger

Complaint Counsel called witnesses from five health plans to describe their post-merger negotiations with ENH. ENH called none, although it listed several in its final witness list. Mr. Neaman conceded that the health plans sent smart, tough negotiators. (Neaman, Tr. 961). These health plans will terminate contracts if hospitals ask for price increases out of line with the market,

²⁰ Complaint Counsel discusses the post-merger changes to the contract terms and the chargemaster at CCFF 822-903, 918-958.

and if reasonable substitute hospitals exist. { [REDACTED] } (Mendonsa, Tr. 544, 568-9, *in camera*). PHCS did the same with the University of Chicago. (Ballengee, Tr. 189-90). Yet, post-merger, ENH obtained price increases that it had never before obtained. (Hillebrand, Tr. 1722). The health plans would call this market power.²¹

a. United

In late 1999, before the merger was even consummated, ENH exerted its new “leverage” with United, the second-largest commercial insurer in Chicago. (Hillebrand, Tr. 1740, 1868). { [REDACTED] } (CX 1607 at 5, *in camera*; CX 75 at 37). { [REDACTED] } (Foucre, Tr. 890; CX 5174 at 11-12, *in camera*). Prices continued to escalate dramatically every year thereafter as ENH raised its chargemaster. (CCFF 980-990, 1004-1008). { [REDACTED] } (CX 6279 at 19, *in camera*).

In August 2002, alarmed that ENH had become an “outlier” hospital with out-of-line prices, United requested that its contract revert back to fixed rates and an overall reduction in prices. (Foucre, Tr. 888, 892). ENH refused to make concessions. (*Id.* at 893). In October 2002, United tried again. { [REDACTED] }

²¹ As indicated by the pricing data, other hospitals did not raise their prices to the same extent as ENH. In discussing the price increases to the health plans, Complaint Counsel does not imply that health plans would have accepted *any* price demanded by ENH. Even a monopolist has limits, and will raise prices until its lost revenues from customers switching to alternatives exceeds its enhanced revenues from those who continue to buy from the monopolist.

[REDACTED]
(CX 2381 at 4, *in camera*; Foucre, Tr. 1085, *in camera*). [REDACTED]
[REDACTED]
[REDACTED] (CX

2381 at 4, *in camera*). These eye-popping numbers did not catch ENH's eye. [REDACTED]
[REDACTED] (CX 57 at 1, *in camera*; Foucre, Tr. 897).

Unable to shake ENH on its own, United asked customers to weigh in -- Kraft, LaSalle Bank, Allstate, American Airlines, SBC Communications and AT&T, some of the largest employers in the area. (Foucre, Tr. 903-5; Foucre, Tr. 1085, *in camera*). [REDACTED]
[REDACTED]
[REDACTED]. (CX 6277 at 3, *in camera*).
[REDACTED]
[REDACTED] (CX 6277 at 4-5, *in camera*;

Foucre, Tr. 1091, 1093, 1096, *in camera*).

Having had no success in lowering ENH's prices, United pursued the more modest goal of asking ENH to stop increasing prices so much. In May of 2003, United and its largest employer groups met with ENH to request more fixed rates and less discount off charges arrangements. (Foucre, Tr. 906-9). Kraft expressed "concern about the increasing trend" in ENH's chargemaster and "desire for more predictability on fixed rates." (Foucre, Tr. 908-9).

Discussions meandered until a meeting on September 2, 2003, approximately five months before the Complaint in this case issued. ENH asked United to send a letter to the FTC in which United would state that the merger "has not had any adverse impact on competition." (Foucre, Tr. 921-5; CX 6284 at 1). [REDACTED]

[REDACTED] } (CX 426 at 1, *in camera*). United disagreed with the substance of the FTC letter and refused to send it. (Foucre, Tr. 927).²² [REDACTED]

[REDACTED] } (Foucre, Tr. 1103-4, *in camera*).

What is telling about the United experience is that the second-largest health plan in Chicago and its huge employer customers incurred significant price increases from ENH – higher than other hospitals – for three years even though cheaper, equally good (if not better) hospitals were in United’s network. { [REDACTED]

[REDACTED] } (CX 5174 at 7, *in camera* (§ 9.2)). It would be in United’s best interests -- like any rational, profit-maximizing firm -- to minimize costs by seeking cheaper sources, *if good substitutes existed*. The fact that United did not go elsewhere, while prices were raised significantly and persistently, proves ENH’s market power.

[REDACTED] } (CX 21 at 5, *in camera*). { [REDACTED]

[REDACTED] } (CX 21 at 5, *in camera*). Even today, with Lake Forest, Rush North Shore, St. Francis and other neighboring hospitals in the network, United still cannot satisfy its customers without

²² United also refused to agree that (1) “[t]here are numerous alternatives available to consumers besides [ENH’s] three hospitals” and (2) that if “confronted with [an anticompetitive] price increase, [United] would drop the ENH hospitals from its network and replace them with competing hospitals.” (CX 6284 at 1; Foucre, Tr. 924-7). As discussed above, United’s own analysis and experience with ENH proved these assertions false.

ENH. (Foucre, Tr. 901-2, 925-6, 931-4).²³

The market dynamic of geographic accessibility was well-understood by ENH. In their 1999 joint submission to an Illinois healthcare agency for approval to extend Evanston's heart surgery program to Highland Park, Evanston and Highland Park explained the very local nature of the market for hospital services (CX 413 at 83):

Last, a concept that is often misunderstood by persons not living in suburban communities is that many suburban residents rarely travel from their general area of residence for shopping, business and health care services. For this reason, many of the anxiety and convenience-related issues related to a resistance to travel for care, that are typically associated with smaller communities, also exist in the suburbs.

b. PHCS

Prior to the merger, PHCS obtained competitive pricing from Evanston and Highland Park because PHCS "could choose between the two and work them against each other." (Ballengee, Tr. 167). That choice was eliminated by the merger, prompting Bain to tell ENH that it has "significant leverage in negotiations with PHCS as they have strong North Shore presence and need us in their network." (CX 1998 at 44). Unsurprisingly, ENH raised prices to PHCS by 60% in 2000 (in contrast to 4-8% increases in prior years). (Ballengee, Tr. 168-9, 196; Haas-Wilson, Tr. 2522-3, *in camera*). { [REDACTED] } (Ballengee, Tr. 251-2, *in camera*, CX 5072 at 23, *in camera*). ENH offered no justification other than that it was "now one system," with "60%" market share, and "controlled the marketplace." (Ballengee, Tr. 176-7, 194).

When previously confronted with unreasonable price increases, PHCS avoided the squeeze by turning to good alternative hospitals in its network. For example, as noted earlier, when the

²³ Complaint Counsel discusses the United negotiations at CCF 961-1030.

University of Chicago demanded higher prices, PHCS found that the other teaching hospitals in Downtown Chicago provided the same level and quality of services and convenient access, all at a lower price. PHCS saved customers money by eliminating the University of Chicago from its network and relying instead on the other teaching hospitals.

PHCS sought to do the same with ENH, but the outcome was vastly different. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Ballengee, Tr. 244-8, *in camera*; CX 46 at 1, *in camera*).

{ [REDACTED]

[REDACTED]

[REDACTED] } (*Id.*, *in camera*).

However, customers did not want to “buy the network if they did not have [ENH in] it.” (Ballengee, Tr. 181, 183-4). “People do not like to drive by a local hospital” not in the network, *e.g.*, ENH, to get to another hospital that is in the network. (*Id.* at 184). Cheaper, comparable hospitals in the network, outside of ENH’s geographic triangle, were insufficient to allow PHCS to avoid ENH’s price increases – through the merger, ENH had become “indispensable.”²⁴

As an inducement to ENH, PHCS also offered to exclude from its network hospitals like St. Francis, Rush North Shore and Condell in return for lower prices. However, ENH viewed these hospitals as insignificant competitors, and refused to budge, except to offer a nominal discount for the exclusion of Lutheran General. (Ballengee, Tr. 181-2; Hillebrand, Tr. 1746-7).

c. One Health

The One Health example provides a clear-cut example of ENH’s exercise of market power.

²⁴ Complaint Counsel discusses the negotiations with PHCS at CCFF 1031-1100.

The facts starkly reveal that ENH was able to raise the market price for hospital networks confronting One Health solely because of the merger.²⁵

With the merger, Evanston acquired its “main competitor” for One Health’s business in the area. (Neary, Tr. 600). One Health knew it was no longer in a “strong negotiating position,” a fact already known to ENH and Bain and incorporated in their plan for a “significant upside potential” in negotiations with One Health. (Neary, Tr. 600; CX 75 at 9-10). { [REDACTED]

[REDACTED]

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

One Health did not acquiesce to ENH’s “excessive” price demands without a fight. (Neary, Tr. 609). In August of 2000, One Health excluded ENH from the One Health hospital network. (Neary, Tr. 610-11). One Health quickly realized its error when customers complained about not having access to ENH. (Dorsey, Tr. 1451-2; Neary, Tr. 617). One Health pointed to Lake Forest, Northwest Community, Lutheran General, Rush North Shore and St. Francis as substitutes, but customers demanded ENH. (Neary, Tr. 611, 617; Dorsey, Tr. 1451-2, 1459). One Health lost customers. (Dorsey, Tr. 1452, 1488; Neary, Tr. 617). In January of 2001, One Health returned to ENH to accede “essentially regardless of what the ultimate price was.” (Neary, Tr. 619; Dorsey, Tr. 1439-42). ENH had its coveted “market influence.”

²⁵ Complaint Counsel discusses the negotiations with One Health at CCF 1101-1177.

d. Aetna

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

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

Bain and ENH had a similar perspective. They targeted Aetna too as having “significant upside potential.” (CX 75 at 9-10). { [REDACTED] }

[REDACTED] } (CX 6279 at 18, *in camera*). { [REDACTED] }
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 539-40, *in camera*).

{ [REDACTED] }
[REDACTED] } (Mendonsa, Tr. 544, 568-9, *in camera*). { [REDACTED] }

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

{ [REDACTED] }
[REDACTED] } (Mendonsa, Tr. 541, *in camera*). { [REDACTED] }

[REDACTED]
[REDACTED]

[REDACTED] } (*Id.* at 568, *in camera*).²⁶

e. Unicare

Before the merger, Unicare had the viable option of configuring a network consisting either of Evanston or Highland Park, together with other nearby hospitals. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Holt-Darcy, Tr. 1518-9, *in camera*).

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Holt-Darcy, Tr. 1503, 1539, 1563, *in camera*).

{ [REDACTED]

[REDACTED]

[REDACTED] } (Holt-Darcy, Tr. 1545, *in camera*). { [REDACTED]

[REDACTED]

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

agreed. { [REDACTED]

(Holt-Darcy, Tr. 1552, 1554, *in camera*). { [REDACTED]

²⁶ Complaint Counsel discusses the negotiations with Aetna at CCFF 1178-1225.

[REDACTED] (Holt-Darcy, Tr. 1602, *in camera*).

Like the other health plans, Unicare acceded to ENH's demands.²⁷

f. Other Health Plans

Although they did not testify at trial, other health plans also suffered anticompetitive effects as a result of the merger. ENH's prices to [REDACTED] [REDACTED] all increased significantly after the merger. (CCFF 1305-1312, *in camera*). [REDACTED] [REDACTED] [REDACTED] (CX 6279 at 19, *in camera*). These health plans would have saved money for their customers by switching to a network configuration of lower-priced hospitals, *if good substitutes existed*. Health plans accepted ENH's higher prices because ENH had market power.

3. *ENH's Documents and Employee Testimony
Admit Market Power from the Merger*

On the other side of the negotiating table, ENH privately touted its new-found market power.²⁸ The link between the merger and ENH's improved bargaining position was unmistakable. Mr. Neaman bluntly wrote that the higher prices and revenues could not have been achieved by "either Evanston or Highland Park alone." (CX 17 at 2; *see also* CX 13 at 1). Mr. Neaman added that the "larger market share created by adding Highland Park Hospital has translated to better managed care contracts." (CX 16 at 1).

Mr. Hillebrand reported to the Board that "as a result of" the merger, ENH successfully negotiated a new deal with United that resulted in an "additional \$3.5 million benefit." (CX 5 at 5).

²⁷ Complaint Counsel discusses the negotiations with Unicare at CCFF 1226-1296.

²⁸ Complaint Counsel discusses ENH's post-merger admissions at CCFF 1346-1608.

Mr. Hillebrand later wrote that through the Highland Park merger, ENH will expand its presence in the marketplace “in order to provide leverage to our market position” with health plans, thereby strengthening ENH’s goal to receive “superior pricing” and to become “indispensable” to health plans. (CX 2070 at 3; Hillebrand, Tr. 1810-12). In another iteration of the same document, management advised the Board that ENH would seek to “protect the ‘core’” -- increase market share in the area from “55% to 60%,” and exert “‘marketplace leadership’ -- leverage with payors.” (CX 68 at 11, 13; Hillebrand, Tr. 1813-6).

It was obvious to the former Highland Park negotiators who joined ENH that the new entity possessed more “leverage” and “power” with health plans than either Evanston or Highland Park alone. (Newton, Tr. 365; Chan, Tr. 709-10). Mr. Newton testified that ENH management never voiced any concern that health plans would walk away because, in his mind, “the health plans really needed this combined entity.” (Newton, Tr. 367).

And it was equally obvious that ENH’s senior management behaved as if the merged entity possessed market power. Messrs. Neaman and Hillebrand authorized price increases to health plans in 2000 and 2002 (and later) with impunity -- unrestrained by worry that ENH would be undercut by any other hospital or fear that health plans would punish ENH by taking business elsewhere. (Hillebrand, Tr. 1751-5, 1757-8, 1764-5; Neaman, Tr. 1211-2).

4. *The Only Plausible Explanation for ENH’s Undisputed Higher Price Increases Is ENH’s Market Power from the Merger*

The comparative pricing data shed more light on an already clear picture of ENH’s market power. Complaint Counsel’s expert, Dr. Haas-Wilson, collected data from “every data source [she] could get her hands on” in order to perform as thorough and accurate an analysis as possible. (Haas-Wilson, Tr. 2495-500). Four independent sources were tapped – health plans, ENH, ENH’s consultant and the State of Illinois Department of Public Health – encompassing data from every health

plan and hospital in Illinois from 1999 through 2002. (*Id.*). { [REDACTED] } (Haas-Wilson, Tr. 2540, *in camera*; CX 6279 at 3-5, 7, *in camera*).²⁹

However, large price increases alone do not mean that the merger gave ENH market power. Dr. Haas-Wilson had to determine whether ENH's price increases were attributable to changes in the marketplace that would affect all hospitals equally. (Haas-Wilson, Tr. 2480-2). { [REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2547-50, *in camera*).³⁰

{ [REDACTED] }
[REDACTED]
[REDACTED] }
(Haas-Wilson, Tr. 2544, 2546-8, *in camera*).

{ [REDACTED] } (Haas-Wilson, Tr. 2581-3, *in camera*; CX 6279 at 9, 11, *in camera*). { [REDACTED]

[REDACTED] }
(CX 6279 at 9, 11, *in camera*). { [REDACTED]

²⁹ { [REDACTED] }
[REDACTED] } (Haas-Wilson, Tr. 2500; Haas-Wilson, Tr. 2552, *in camera*).

³⁰ { [REDACTED] }
[REDACTED] } (Haas-Wilson, Tr. 2548, 2550-2, *in camera*).

[REDACTED] } (Haas-Wilson, Tr. 2482-9; Haas-Wilson, Tr. 2562-3, 2565, 2570, 2579, *in camera*; CX 6279 at 9, 11, *in camera*; CX 6282 at 5, *in camera*).

[REDACTED] } (Haas-Wilson, Tr. 2619-20, *in camera*). [REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2619-20, *in camera*). [REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2625-8, 2631-5, *in camera*; CX 6279 at 18-20, *in camera*; CX 6282 at 6, *in camera*).³¹ [REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2625-8, 2631-5, *in camera*; CX 6279 at 18-20, *in camera*; CX 6282 at 6, *in camera*).

a. It Is Undisputed that ENH's Price Increases Were Higher than Other Hospitals' Price Increases

The pricing analysis conduct by both Complaint Counsel and ENH show significantly higher percentage price increases by ENH than other hospitals. [REDACTED]

[REDACTED] } (CX 6279

³¹ [REDACTED] } (Haas-Wilson, Tr. 2567-9, 2625-6, *in camera*; CX 6279 at 9, 18, *in camera*).

at 18-19, *in camera*; CX 6282 at 6, *in camera*).³² { [REDACTED]

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2500; Haas-Wilson, Tr. 2580, 2633-5,

in camera). { [REDACTED]

[REDACTED]

[REDACTED] } (CX 6279 at 20, *in camera*).³³

{ [REDACTED]

[REDACTED] }

(Baker, Tr. 4617-18, 4620, *in camera*; Haas-Wilson, Tr. 2636-7, *in camera*). { [REDACTED]

[REDACTED] } (Baker, Tr. 4621, 4660-1,

4739-40, *in camera*). { [REDACTED]

[REDACTED] } (Hillebrand, Tr. 1806-7; CX 67 at 36; Haas-

Wilson, Tr. 2625-6, *in camera*). { [REDACTED]

[REDACTED] } (Baker, Tr. 4660-1,

4737-40, *in camera*). { [REDACTED]

[REDACTED] } (Noether, Tr. 6114-5, *in camera*; Baker, Tr. 4647, *in camera*).

b. ENH's Higher Prices Can Only Be Explained by Market Power

³² { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 18-20, *in camera*; CX 6282 at 6, *in camera*). { [REDACTED]
[REDACTED] }
(Haas-Wilson, Tr. 2553-4, *in camera*; CX 6279 at 18-20, *in camera*; CX 6282 at 6, *in camera*).

³³ { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2625-6, *in camera*; CX 6279 at 18, *in camera*).

Dr. Haas-Wilson examined 10 possible explanations for ENH's higher prices.³⁴ Six were ruled out by the pricing analysis – increases in cost, changes in regulation, increases in demand, changes in patient mix, changes in customer mix and changes in teaching intensity – as discussed above. { [REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2610-5, *in camera*; CX 6279 at 17, *in camera*).

Dr. Haas-Wilson next looked for changes in “learning about demand,” but since this explanation was fatally flawed, as discussed below, she dismissed it.

It is theoretically possible that ENH's higher prices could be justified if there had been a corresponding increase in quality of care relative to other hospitals. ENH did not present a credible and comprehensive quantitative analysis to prove this theory. Only Complaint Counsel's expert, Dr. Romano, conducted and presented evidence comparing ENH's post-merger quality of care to other hospitals. Dr. Romano's analysis, as discussed below, found no discernible increase in quality of care, as measured by outcomes and patient satisfaction, compared to other hospitals.³⁵

The only economic explanation for the disparities, corroborated by the business documents and testimony of health plans and ENH employees, was that the merger gave ENH market power. (Haas-Wilson, Tr. 2451).³⁶ ENH's expert, Dr. Noether, conceded that a hospital merger could lead to market power at the same time the hospital learns more about demand for its services (Noether,

³⁴ Dr. Haas-Wilson did not test every conceivable reason for the price increase, just those that were reasonable and supported by sound economic theory.

³⁵ { [REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4799, *in camera*).

³⁶ Complaint Counsel discusses Dr. Haas-Wilson's methodologies, results and opinions at CCF 373-745.

Tr. 6142). { [REDACTED]

[REDACTED] } (Baker, Tr. 4742-3, *in camera*).

II.

THE MERGER VIOLATES CLAYTON ACT § 7 BECAUSE IT RESULTS IN A HIGHLY CONCENTRATED MARKET IN WHICH COMPETITION HAS BEEN SUBSTANTIALLY LESSENERD

A. Elaborate Market Analysis Is Not Required in This Case

Most merger challenges occur before the transaction is consummated -- before anticompetitive effects occur -- and without the aid of data to measure post-merger market power directly. This practical evidentiary problem leaves no choice but to rely on proxies -- market shares and market concentration -- to make a predictive judgment about the merger's likely effect on competition. But this case takes the analysis out of the realm of probabilities. The Court's ability to answer the ultimate question of whether this merger substantially lessened competition is aided by scientific data and direct evidence of actual anticompetitive effects.

If there is direct evidence of anticompetitive effects, "elaborate market analysis" is not required. *Indiana Fed. of Dentists*, 476 U.S. at 460. "Since the purpose of the inquiries into market definition and market power is to determine whether an arrangement has the potential for genuine adverse effects on competition, 'proof of actual detrimental effects . . . can obviate the need for an inquiry into market power, which is but a 'surrogate for detrimental effects.'" *Id.*

The Court of Appeals for the Seventh Circuit declared the same rule of law in *FTC v. Toys "R" Us, Inc.*, 221 F.3d 928, 937 (7th Cir. 2000): "the [market] share a firm has in a properly defined relevant market is only a way of estimating market power, which is the ultimate consideration. . . . there are two ways of proving market power. One is through direct evidence of anticompetitive

effects.” Other Circuits agree.³⁷

Courts will apply the reasoning of Sherman Act cases to Clayton Act merger challenges because “[b]oth statutes as currently understood prevent transactions likely to reduce competition substantially.” *Rockford Memorial*, 898 F.2d at 1282-3 (“A transaction violates section 1 of the Sherman Act if it restrains trade; it violates the Clayton Act if its effect may be substantially to lessen competition. But both statutory formulas require, and have received, judicial interpretation; and the interpretations have, after three quarters of a century, converged.”).

In at least two recent Section 7 cases, courts relied on evidence probative of actual anticompetitive effects as on market structure. *FTC v. Libbey, Inc.*, 211 F. Supp.2d 34, 48-50 (D.D.C. 2002) (new firm would have 4.3% higher costs than incumbent, thereby likely leading to higher post-merger prices); *Staples*, 970 F. Supp. at 1075-76, 1082-3 (pricing data showing defendants’ actual pre-merger competitive pricing deemed “compelling evidence”).

In *Staples*, the district court noted that the “HHI calculations and market concentration evidence” are “not the only indications that a merger between Staples and Office Depot may substantially lessen competition.” *Staples*, 970 F. Supp. 1082. “Much of the evidence already discussed with respect to defining the relevant product market also indicates that the merger would likely have an anti-competitive effect.” *Id.* The actual pricing evidence regarding each defendant’s real-life competitive pricing showed that the merged entity “has the ability to profitably raise prices . . . above competitive levels.” *Id.*

³⁷ *Todd v. Exxon Corp.*, 275 F.3d 191, 206 (2d Cir. 2001); *Re/Max International, Inc. v. Realty One, Inc.*, 173 F.3d 995, 1016 (6th Cir. 1999) (“There are two ways to establish the first element, that is, that the defendant holds monopoly power. The first is by presenting direct evidence showing the exercise of actual control over prices or the actual exclusion of competitors.”); *Rebel Oil Co., Inc. v. Atlantic Richfield Co.*, 51 F.3d 1421, 1434 (9th Cir. 1995) (“Market power may be demonstrated through either of two types of proof. One type of proof is direct evidence of the injurious exercise of market power.”).

Section 7 of the Clayton Act prohibits mergers “where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or tend to create a monopoly.” 15 U.S.C. § 18. Complaint Counsel has proved that this merger caused anticompetitive effects. These effects harmed health plans who purchased general acute-care inpatient hospital services -- an undeniable “line of commerce” -- for access to the three ENH facilities -- an undeniable “section of the country.” An elaborate market analysis beyond this is not required by law or logic. As explained by a leading antitrust scholar on mergers, “[m]arket structure evidence is the surrogate for bad performance, not the other way around.”³⁸

B. The Merger Created a Highly Concentrated Market in which Competition Has Been Substantially Lessened

Applying the traditional market structure analysis to this merger does not change the outcome. The task of proving a Section 7 violation through market structure analysis is actually *less* demanding than the alternative approach of establishing a violation through direct evidence of actual anticompetitive effects. “Section 7 does not require proof that a merger or other acquisition has caused higher prices in the affected market. All that is necessary is that the merger create an appreciable danger of such consequences in the future.” *Hosp. Corp. of America*, 807 F.2d at 1389; *H.J. Heinz*, 246 F.3d at 713 (Congress used the word “may” in Section 7 to indicate that its concern was with “probabilities, not certainties.”). Indeed, the Commission recently found a Section 7 violation in a consummated merger based on market structure analysis, and held that proof of anticompetitive effects was unnecessary. *Chicago Bridge & Iron*, Docket No. 9300 at 90.

³⁸ H. Hovenkamp, *Federal Antitrust Policy: The Law of Competition and Its Practice* at 543 § 12.8 (1999) (“Clayton § 7’s ‘may substantially lessen competition’ language does not require a given market structure or a given set of proofs about market concentration, firm market share, entry barriers or anything else.”).

The market structure analysis begins with the identification of the products and geographic locations that should be considered. The key test in delineating markets is the extent to which changes in price prompt purchasers to substitute to alternative products or sellers of the product located elsewhere. *Staples*, 970 F. Supp at 1074 (product market definition tests the “responsiveness of the sales of one product to price changes of the other”); *Merger Guidelines* §§ 1.11, 1.21. After the relevant markets are defined, changes in market shares and market concentration levels are computed. *Merger Guidelines* §§ 1.4, 1.5. The point of the entire exercise is to make a predictive judgment about whether the structure of the post-merger market is likely to give rise to potential adverse competitive effects. *Merger Guidelines* §§ 0.1, 1.0.³⁹

1. *The Relevant Product Market*

The *Merger Guidelines* delineate a product market by asking whether a hypothetical monopolist of the proposed product market could impose a “small but significant and nontransitory increase in price” (“SSNIP”) and not lose so much of its sales to alternative products that the price increase would be unprofitable. *Merger Guidelines* § 1.11; *FTC v. Swedish Match*, 131 F. Supp.2d 151, 160 (D.D.C. 2000) (relevant question is whether the increase in the price of product B will induce substitution to product A to render product B’s “price increase unprofitable”). The SSNIP test typically uses a 5% price increase. *Merger Guidelines* § 1.11; *Staples*, 970 F. Supp. at 1076 n.8.

Dr. Haas-Wilson testified that the appropriate product market is general acute-care inpatient services sold to health plans. (Haas-Wilson, Tr. 2659). Included in this market are primary, secondary and tertiary inpatient services, and excluded are inpatient quaternary services and outpatient services. (Haas-Wilson, Tr. 2659-61). Negotiations between health plans and hospitals set the price of hospital services, and therefore the sale of inpatient hospital services *to health plans*

³⁹ Complaint Counsel discusses the market structure analysis at CCFF 1609-1728.

is the appropriate product market. (Elzinga, Tr. 2397). ENH's expert, Dr. Noether, agreed that patients and health plans will not substitute outpatient services for inpatient services and vice-versa in response to a SSNIP for inpatient services. (Noether, Tr. 6193-4).⁴⁰

Health plans testified that they did not substitute outpatient services for inpatient services in response to significant inpatient price increases. (E.g., Holt-Darcy, Tr. 1422-3). Mr. Neaman admitted that ENH raised prices for inpatient services without concern that customers would switch to outpatient services. (Neaman, Tr. 1210-12). Before the merger, Highland Park expected to negotiate higher prices on outpatient services – where there is “a little bit easier time” -- but not on inpatient services because of the “restraint on the inpatient side in terms of your ability to negotiate higher prices.” (Newton, Tr. 331; CX 1868 at 11).

Numerous hospital merger cases have concluded that general acute-care inpatient services is a relevant product market. *FTC v. University Health, Inc.*, 938 F.2d 1206, 1210-1211 (11th Cir. 1991); *Rockford Memorial*, 898 F.2d at 1284; *Hosp. Corp. of America*, 807 F.2d at 1388.

2. *The Relevant Geographic Market*

The *Merger Guidelines* delineate a geographic market by asking whether a hypothetical monopolist in the proposed geographic market could impose a SSNIP for the relevant product and not lose so much in sales to firms located outside the geographic market that the price increase would be unprofitable. *Merger Guidelines* § 1.21. A geographic market is that geographic area where customers can “practicably turn for supplies.” *Cardinal Health*, 12 F. Supp.2d at 49; *Staples*, 970

⁴⁰ Outpatient services are also not a functional substitute for inpatient services because a hospital generally will not challenge a physicians' decision that a patient requires inpatient services. (Spaeth, Tr. 2076).

F. Supp. at 1073.⁴¹

Dr. Haas-Wilson testified that the appropriate geographic market is the area adjacent or contiguous to the three ENH hospitals. (Haas-Wilson, Tr. 2667). Both sides agree that the “customer” in the sale of inpatient hospital services is the health plan (as opposed to the individual patient). (Noether, Tr. 5924-5; Haas-Wilson, Tr. 2456-7).

Health plans testified that after the merger, ENH demanded large price increases – well above the 5% SSNIP test. Numerous health plans tried to avoid the price increase through alternative networks that did not include ENH, and One Health went so far as to terminate its contract with ENH. (E.g., Neary, Tr. 610-1; Ballengee, Tr. 185). These health plans had hospitals located near ENH and throughout the North Shore in their networks, but all of them found that they had to accept ENH’s price increases because they could not satisfy employers without ENH in their networks. (E.g., Neary, Tr. 617; Dorsey, Tr. 1451-2, 1459; Foucre, Tr. 901-2, 925-6; Ballengee, Tr. 182-4). These real-life experiments demonstrate that health plans cannot “practicably” turn outside the ENH geographic triangle for substitute hospitals, and that ENH can raise prices by more than a SSNIP without losing so much in sales to hospitals outside its geographic triangle as to make the price increase unprofitable.

⁴¹ *Staples* provides a useful illustration of the way reliable pricing evidence can guide the Court’s analysis. In *Staples*, the relevant product market was a major disputed issue. The FTC contended that the product market should be consumable office supplies sold in office supply superstores. Because office products could be found in any number of different retail outlets, the district court recognized that “it is difficult to overcome the first blush or initial gut reaction of many people” to the FTC’s proposed product market. *Staples*, 970 F. Supp. at 1075. However, upon reviewing the pricing data showing that prices were significantly higher when an office superstore faced no competition from another office superstore, and competition from the likes of Wal-Mart had no impact on office superstore prices, the district court found the data “compelling evidence” that the FTC’s product market was correct. *Id.* at 1075-7. Complaint Counsel submits that the evidence of the health plans’ inability to defeat ENH’s post-merger prices by turning to alternative networks with hospitals outside the ENH geographic triangle is also “compelling evidence” supportive of Complaint Counsel’s geographic market.

Messrs. Neaman and Hillebrand admitted that when they approved price increases after the merger, other hospitals were not factors in their pricing decisions. (Neaman, Tr. 1211-2; Hillebrand, Tr. 1764-5). ENH's admissions further prove that the geographic triangle formed by the three ENH hospitals is a relevant geographic market.

3. *The Market Is Highly Concentrated*

Market concentration is measured by the Herfindahl-Hirschman Index (HHI), which is calculated by summing the squares of the market shares of firms in the relevant markets before and after the merger. *Merger Guidelines* § 1.5. Consideration is given to both post-merger market concentration and the increase in concentration resulting from the merger. *Id.* In the market as defined by Dr. Haas-Wilson, ENH has the only hospitals, giving it a monopoly in the provision of inpatient services sold to health plans. ENH's expert, based on product and geographic markets broader than Complaint Counsel's markets, computed a post-merger HHI of "a little over" 1900, an increase of "about" 300 from pre-merger levels. (Noether, Tr. 5963).

In June of 1999, as part of a presentation to the Board about the proposed merger, Evanston reported the following shares in the combined entity's "core service area:" Evanston 44%; Highland Park 11%; Rush North Shore 14%; Lutheran General 7%; St. Francis 7%; "Downtown Teaching Hospitals" 7%; Lake Forest 3%; and "Other" 7%. (CX 84 at 21). Using ENH's own share figures, the HHI increases by over 1000 points to a post-merger HHI of 3426.⁴²

Whether using Dr. Haas-Wilson's market, Dr. Noether's figures or Evanston's corporate

⁴² Dr. Elzinga's criticism of patient flow analysis confirms that ENH enjoyed greater market power than suggested in its business document. Evanston estimated shares in the merged entity's "core service area," which was based on patient flow data. As Dr. Elzinga testified, however, patient flow analysis inherently yields a geographic area that is bigger than a properly defined antitrust geographic market. Therefore, applying Dr. Elzinga's analysis, ENH's geographic market for antitrust purposes is smaller than the "service area" that ENH uses for business purposes. In turn, ENH's share of the antitrust geographic market is actually larger than 55%.

records, the post-merger HHI level corresponds to a market that is “highly concentrated,” and the merger is “presumed” likely to “create or enhance market power.” *Merger Guidelines* § 1.51. ENH’s share, according to its corporate documents, would be 55%. Courts have barred mergers resulting in similar market shares and market concentrations. *Hosp. Corp. of America*, 807 F.2d at 1384 (merger created second largest firm with market share of 26%); *Cardinal Health*, 12 F. Supp.2d at 53 (post-merger HHI of 2277); *FTC v. Bass Bros. Enters., Inc.*, 1984-1 Trade Cas. (CCH) ¶ 66,041 at 68,609-10 (N.D. Ohio 1984) (post-merger HHI of 2320).

4. *ENH Has Failed to Rebut the Presumption of Anticompetitive Harm*

“Sufficiently large HHI figures establish the FTC’s prima facie case that a merger is anti-competitive.” *H.J. Heinz*, 246 F.3d at 716. The burden then shifts to ENH to rebut the presumption of harm by producing evidence that shows that the market share statistics give an “inaccurate account” of the merger’s probable effect on competition. *Id.* at 715. ENH’s rebuttal evidence must be more than mere argument. *Cardinal Health*, 12 F. Supp.2d at 58.

No new entry by a hospital has occurred in the North Shore area since the merger, thereby eliminating the claim that new competition from outsiders will prevent the merger’s harm to competition. (D. Jones, Tr. 1664). ENH’s only serious “efficiency” claim relates to its quality of care defense, which has been shown to be inadequate to save this merger.

ENH cannot show that the market share and market concentration figures give an “inaccurate account” of the merger’s effects. The large post-merger price increases show that the anticompetitive effects predicted by the market structure analysis are accurate. As a result, the market structure analysis reaches the same conclusion as the direct evidence of anticompetitive effects: the merger violated Section 7 by substantially lessening competition.

C. Recent Hospital Merger Challenges Are Not Controlling Precedent Here

The recent court decisions denying government challenges to hospital mergers do not dictate the outcome of this case. *See, e.g., FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 (8th Cir. 1999); *FTC v. Freeman Hosp.*, 69 F.3d 260 (8th Cir. 1995); *California v. Sutter Health Sys.*, 130 F. Supp.2d 1109 (N.D. Cal. 2001); *U.S. v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121 (E.D.N.Y. 1997); *Advocacy Org. for Patients and Providers v. Mercy Health Services*, 987 F. Supp. 967 (E.D. Mich. 1997). Two fundamental points distinguish the merger between Evanston and Highland Park and these past hospital mergers.

First, whereas the prior government challenges involved prospective hospital mergers, this case is a consummated merger, thereby affording an examination of actual post-merger pricing activity and data that were unavailable in the earlier cases. In contrast to the prior government arguments, Complaint Counsel does not make a predictive judgment about what might happen in the future; we have post-merger data, testimony and documents demonstrating that competition in fact has been harmed. With the benefit of direct evidence of actual anticompetitive effects, this case takes a giant step forward from past merger analysis.

Based on market structure analysis, the opinions in these recent cases predicted that the mergers likely would not lessen competition. Some courts adopted broad market definitions that embraced numerous hospitals as competitors and price constraints to the merged entity. For example, one district court did not block a merger because: “Within 7 miles of LIJ, there are three premier tertiary care hospitals . . . who will be major competitors with the merged entity. The presence of these and other hospitals supplying the same services offered by LIJ/NSM and the ability of managed care plans to turn to these suppliers will, with reasonable certainty, constrain the pricing of the merged entity.” *Long Island Jewish*, 983 F. Supp. at 145.

The perception of patient substitutability underlying the *Long Island Jewish* court’s reasoning

is what drives ENH to claim that it is surrounded by major competitors that restrain its pricing and to which health plans can reasonably turn as alternatives. It is an argument that prevailed in prior prospective merger cases, but, as the post-merger evidence demonstrates, is simply inapposite here. ENH demanded significant price increases after the merger. Health plans sought to defeat the price increases by turning to alternative networks that would not include ENH but would include many hospitals in the North Shore with lower prices and comparable services and quality (e.g., Lutheran General, Rush North Shore, Lake Forest, St. Francis and Northwest Community). The health plans found that they could not satisfy their customers with these alternative networks, and had to accept ENH's higher prices. In other words, contrary to the prediction of courts in prospective mergers like *Long Island Jewish*, all these other hospitals did not restrain ENH.

Second, prior cases also are not controlling here because they employed a geographic market analysis – relying on patient flow data – that has since proven unreliable in hospital mergers as it has become clear that the hospital's customers are health plans that themselves compete by forming hospital networks. Patient flow data dominated the previous cases. *See, e.g., Long Island Jewish*, 983 F. Supp. at 141-2; *Sutter Health*, 130 F. Supp.2d at 1120.

However, in this case, both sides agree that the relevant “customer” is the health plan, and not the patient, because the health plan is the entity that purchases and negotiates the prices of the hospital services. (Haas-Wilson, Tr. 2456-7; Noether, Tr. 5901, 5924-5). Because health care financing is now squarely centered on health plans, the unstated premise of the previous hospital merger cases that patients substitute among hospitals is no longer correct. The proper geographic market inquiry then is on the hospital alternatives available to the health plan in developing its network of providers, and in particular, the willingness of a health plan to terminate its contract with a hospital in favor of more distant hospitals. (Haas-Wilson, Tr. 2479).

Complaint Counsel's expert, Dr. Elzinga, explained why patient flow information is flawed for geographic market analysis, and why his own "Elzinga-Hogarty" test is "inapplicable" to hospital mergers.⁴³ (Elzinga, Tr. 2384-5). The patient flow analysis assumes, incorrectly, that if some patients are willing to travel to distant hospitals, then others will too in response to a change in hospital prices. However, a "silent majority" of patients choose the hospital at which they seek care based on factors unrelated to price. (Elzinga, Tr. 2385-90). By ignoring the "silent majority," patient flow analysis incorrectly indicates "that the market area for hospital services is broader or more extensive geographically than it, in fact, is." (*Id.* at 2393).

Patient flow analysis is also flawed because of the "payor problem." Outside the hospital merger context, the Elzinga-Hogarty test assumed that "the person who makes the choice to consume some product is also the person who pays for that product." (Elzinga, Tr. 2395). Because of health insurance, however, "there's a disconnect between who pays for the product and who consumes the product." (*Id.*). The entity that pays for the hospital service is the health plan and the person who consumes the hospital service is the health plan enrollee. Focusing on patient flow does not "help you define the contours of a relevant geographic market area, because the patients who are moving are not necessarily moving in response to price incentives" -- it is the negotiation between the hospital and the health plan that sets the price, and it is the health plan's decisions -- not the patient's -- that defines the geographic market. (*Id.* at 2395-7).

III.

ENH'S "LEARNING ABOUT DEMAND" DEFENSE

⁴³ The Elzinga-Hogarty analysis is a two-prong test. *First*, one looks at some small hypothetical area to see "where the hospital attracts their patients," asking if the hospital is attracting patients from outside that area. (Elzinga, Tr. 2380-81). *Second*, one examines "where patients within that service area currently go to receive their healthcare," asking if residents are leaving hospitals close to where they live to go somewhere else. (Elzinga, Tr. 2380-81).

DOES NOT EXPLAIN AWAY ENH'S MARKET POWER

ENH contends that its post-merger price increases are not the result of market power from the merger, but rather ENH learning that demand for its services among health plans was actually greater than previously thought.⁴⁴ The “learning about demand” defense fails at three levels.⁴⁵

A. Evanston Did Not Underprice Itself before the Merger

ENH’s expert, Dr. Noether, theorizes that before the merger, Evanston was an “academic” hospital that unknowingly sold its services at bargain prices. (Noether, Tr. 6138). If true, health plans would have known what a bargain Evanston was and taken advantage of it. (Noether, Tr. 6138-40; Hillebrand, Tr. 1751). Dr. Noether conceded that under her theory, at least some health plans would have been willing to pay more for the services that Evanston was selling. (Noether, Tr. 6138-9). For example, if a house is underpriced, buyers would likely try to seize the bargain and ultimately bid up the price to market levels. But this never happened at Evanston. Health plans did not clamor to take advantage of Evanston’s supposedly bargain prices. (Noether, Tr. 6141-2; Sirabian, Tr. 5755-6).

There was nothing for ENH to learn because Evanston’s pre-merger *prices* were, in fact, *higher* than Highland Park’s. { [REDACTED]

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr.

⁴⁴ Complaint Counsel discusses the “learning about demand” excuse at CCF 1763-2031.

⁴⁵ Post-hoc arguments come back to bite if there are too many of them. In its “quality of care improvement” defense, ENH contends that Highland Park was on its last financial leg and could not afford to make necessary quality changes. If it were true that Highland Park had higher rates and, therefore, generated more revenues, how could Highland Park be near financial ruin? On the other hand, if Highland Park had the higher rates and revenues, but chose not to spend on quality and let quality deteriorate, why would Highland Park be financially strapped?

2645-7, *in camera*). { [REDACTED]
[REDACTED] }

((Baker, Tr. 4745-7, *in camera*). The results from ENH's experts confirm the observation by an ENH contract negotiator that Evanston had the higher rates in approximately two-thirds of the 35-40 contracts shared with Highland Park. (Sirabian, Tr. 5717).

B. The ENH "Control Group" Is Flawed

Claiming that price levels, not the price changes Dr. Haas-Wilson looked at, is what is important, ENH's experts compared ENH's post-merger price level with the price levels at a selected comparison group of hospitals.

1. *The Selective Use of "Academic" Hospitals*

ENH relied on Dr. Noether to select the control group of comparison hospitals for "learning about demand." Out of the roughly 80-100 hospitals in the Chicago area, Dr. Noether began with 18 chosen because they were "in some way competitors to Evanston and/or Highland Park." (Noether, Tr. 6149-50). Excluded from the 18 are hospitals identified in ENH business documents and cited by Dr. Noether herself as "best practice competitors" or "core competitors." (Noether, Tr. 6150-2). Included in the 18 are hospitals never listed as a competitor in the business documents upon which Dr. Noether relied. (Noether, Tr. 6153-4).

{ [REDACTED]
[REDACTED] } (Noether, Tr. 5993-5, 6150; Haas-Wilson, Tr. 2549-52, *in camera*). Of the 18, Dr. Noether identified ENH and six other hospitals -- Lutheran General, Advocate Northside, Northwestern Memorial, Rush-Presbyterian, University of Chicago and Loyola -- as meeting her criteria of an "academic" hospital. (Noether, Tr. 5999-6000).

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (RX 1912 at 44, 147, 151, *in camera*; RX 1912 at 25, 60; Noether, Tr. 6169-72). [REDACTED]

[REDACTED] } (RX 1912 at 148-9, 151-2, *in camera*). Dr. Noether's asserted "control group" is, in fact, a biased and fatally flawed sample.

2. *Picking 1 Apple and 6 Oranges as "Academic" Hospitals*

ENH's inclusion in the "academic" hospitals control group cannot withstand scrutiny. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2699-2700, 2702, 2708-9, *in camera*). Mr. Neaman admitted that ENH does not treat severe burn cases (transferred to Loyola) nor liver and kidney transplants (transferred to University of Chicago and Northwestern). (Neaman, Tr. 1378). Health plans uniformly did not cite ENH in their list of advanced teaching or academic hospitals, but did cite most of the other hospitals in Dr. Noether's "academic" control group. (Ballengee, Tr. 188-9; Neary, Tr. 621; Dorsey, Tr. 1443-5; Foucre, Tr. 935-6).⁴⁶ [REDACTED]

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2711-2, *in camera*).

⁴⁶ When PHCS looked to benchmark the University of Chicago's prices in the late 1990s, PHCS did not view Evanston to be in the same league. (Ballengee, Tr. 190).

3. ENH Flunked Its Own "Learning about Demand" Test

ENH asked Dr. Baker to test "learning about demand." { [REDACTED] }
[REDACTED]
[REDACTED] } (Baker, Tr. 4732, *in camera*; RX 2038
at 5, *in camera*).⁴⁷ { [REDACTED] }
[REDACTED]
[REDACTED] } (Baker, Tr. 4732, *in camera*; RX 2038 at 5, *in camera*). { [REDACTED] }
[REDACTED]
[REDACTED] } (Baker, Tr. 4717-8, *in camera*; RX 2038 at 4, *in camera*) (emphasis
supplied). { [REDACTED] }
[REDACTED] } (Baker, Tr. 4621, *in camera*).⁴⁸
[REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4710-2, 4734-6, 4741, *in camera*). { [REDACTED] }
[REDACTED]
[REDACTED] } (Baker, Tr. 4739, *in camera*; Haas-Wilson, Tr. 2728-9, 2731-2, *in*
camera). { [REDACTED] }
[REDACTED] } (RX 2040 at 4, *in camera*). { [REDACTED] }
[REDACTED]
[REDACTED] } (RX 2040 at 4, *in camera*).

⁴⁷ In this section, RX 2038, RX 2039 and RX 2040 are cited only to impeach Dr. Baker.

⁴⁸ { [REDACTED] }
[REDACTED] } (Baker, Tr. 4740, *in camera*).

If the “academic” control group truly represents hospitals comparable to ENH, it would defy business judgment and economic theory for { [REDACTED] } to pay more to ENH when cheaper alternatives exist. Customers would protest, and indeed, as discussed earlier, { [REDACTED] }
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6277 at 3, *in camera*).⁴⁹ The fact that the health plans did not switch to cheaper alternatives not only refutes “learning about demand,” but also proves ENH’s market power.

During the pendency of the FTC’s investigation, ENH made the same “learning about demand” argument directly to United to justify its higher prices. ENH asked United to send a letter to the FTC stating that the higher prices to United did not reflect the exercise of “market power” created by the merger, but rather reflect a “one time ‘catch up’ increase” to account for years of lapses in price adjustments. (CX 6284 at 1). United refused to sign. (Foucre, Tr. 924).

{ [REDACTED] }
[REDACTED]
[REDACTED] } (Baker, Tr. 4732, 4739, *in camera*; RX 2038 at 5, *in camera*). { [REDACTED] }
[REDACTED]
[REDACTED] } (Baker, Tr. 4741, *in camera*; compare RX 2038 at 4, *in camera*, and RX 2039 at 4, *in camera*). Dr. Baker’s revisionism only adds to the infirmity of an already shaky post-hoc rationalization.

{ [REDACTED] }

⁴⁹ PHCS, which had once excluded the University of Chicago from its network in favor of other nearby teaching hospitals, could have done the same with ENH if ENH did not have market power. (Ballengee, Tr. 189-90).

[REDACTED] { [REDACTED]

[REDACTED]

[REDACTED] } (Haas-
Wilson, Tr. 2728, *in camera*).⁵⁰ { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Having failed its own test on three swings, ENH should be called out.

⁵⁰ This trend would be consistent with Mr. Neaman’s own views about ENH’s status. In a November 18, 1999 speech to his Board, Mr. Neaman described Evanston as a “community hospital” and not an “academic” medical center, “per se.” (RX 2015 at ENHL MO 003489).

IV.

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

This merger caused tangible harm to competition -- people pay significantly more of their hard-earned money for access to ENH than before -- so the onus falls on ENH to prove that this merger made every higher premium dollar worth it. Health plans remain unconvinced. Their negotiations with ENH did not broach quality of care, and since then, ENH has not proclaimed momentous quality improvements to assure health plans that the higher prices are justified.

Without customer support, ENH approaches the Court alone but without "cognizable" benefits -- "merger-specific efficiencies that have been verified and do not arise from anticompetitive reductions in output or service." *Merger Guidelines* § 4. ENH does not provide (1) a meaningful measurement or quantification of how much quality, in fact, improved, (2) a means to value any improvements, and (3) to the extent quality improved, a valid reason why Highland Park could not achieve the same results absent the merger, *i.e.*, ENH failed to prove that the claimed benefits were "merger specific." ENH cannot rely on "mere speculation" -- consumers harmed by this merger are entitled to proof the merger created "extraordinary" benefits that were passed on to them. *H.J. Heinz*, 246 F.3d at 720-1.⁵¹

A. ENH Failed to Prove that Quality Improved Relative to Other Hospitals

1. *Insurmountable Flaws in ENH's Analysis*

ENH committed two overriding errors that render it incapable of answering the most basic question: whether quality, in fact, improved as a result of the merger.

⁵¹ Complaint Counsel discusses Dr. Romano's analysis at CCF 2053-2145; Dr. Chassin's analysis at CCF 2149-2163, 2036-2037, 2041-2043; and other "quality of care" issues at CCF 2164-2496.

First, ENH's "quality of care" evidence consisted exclusively of changes at Highland Park, with no data concerning quality at Evanston or Glenbrook, thereby prohibiting ENH from proving its initial claim that its data prove that quality improved "throughout the ENH system" as a result of the merger. (Second Amended Answer at 21; Chassin, Tr. 5446-7).⁵² This is significant because ENH decided to raise rates at and charge one price for all three hospitals, not just Highland Park. (CCFF 822-832). As a result, ENH cannot demonstrate that its price increases at all three hospitals are justified by the quality changes at Highland Park alone.

Second, ENH's expert, Dr. Chassin, admits he did not compare Highland Park's quality of care (or ENH overall) against a control group of hospitals in the Chicago area. (Chassin, Tr. 5448-9). This undermines Dr. Chassin's methodology because the results for Highland Park standing alone are meaningless. 1997 saw the start of a nationwide trend to improve quality of care at hospitals. (Romano, Tr. 2998-3001). Leading medical organizations intensified efforts to study and improve quality, resulting in findings that quality improved across the country since the merger. (Romano, Tr. 2999-3001; Noether, Tr. 6010-12).⁵³ Because quality was improving at all hospitals post-merger, Dr. Chassin's narrow focus cannot inform the Court whether post-merger quality improvements at Highland Park kept up with, fell short of, or exceeded the norm.

2. *The Quantitative Analysis Shows No Significant Evidence of Quality Improvements Relative to the Control Group Hospitals*

Dr. Romano conducted the only comprehensive quantitative analysis that measured ENH's performance against a control group of hospitals, and he found no evidence that patients actually

⁵² In the "quality of care" section of this brief, Complaint Counsel refers to "Evanston" as the post-merger Evanston and Glenbrook hospitals, and to "Highland Park" as the post-merger Highland Park hospital, all three of which are owned by ENH.

⁵³ One study found that quality of care among Medicare beneficiaries nationwide increased 12% between 1998 and 2001. (Romano, Tr. 3000-1).

benefitted. (Romano, Tr. 2991-2, 3008). Dr. Romano focused on outcomes because it measures “what actually happens to patients in the end as a result of the care process,” e.g., patient mortality. (Romano, Tr. 2987). Dr. Chassin conceded that outcomes “is really it’s what we all care about.” (Chassin, Tr. 5153). ENH relies on outcomes as the ultimate measure of its quality of care. (O’Brien, Tr. 3556-7; Rosengart, Tr. 4478 (“Mortality is the critical, most defined – definitive criteria for assessing quality.”)).

{ [REDACTED] }
[REDACTED] } (Romano, Tr. 3098-3107, 3109-11, 3116-7, 3127, 3136, *in camera*). Patient satisfaction surveys are important data that ENH itself relies on to gauge its quality. (CX 2052 at 44-5; CX 2436 at 4; Chassin, Tr. 5433-5).

a. Dr. Romano’s Comprehensive Methodology

Dr. Romano’s analysis focused on the areas of quality changes relied on by ENH for its “quality of care” defense. (Romano, Tr. 3009-10). { [REDACTED] }
[REDACTED] }, Dr. Romano compared outcomes at Highland Park, Evanston and ENH overall against a control group using measures set forth by AHRQ (the Agency for Healthcare Research and Quality) and JCAHO (the Joint Commission on Accreditation of Healthcare Organizations. (Romano, Tr. 3203-7, 3066, *in camera*; Romano, Tr. 6273-4).

{ [REDACTED] }
[REDACTED]
[REDACTED] } (Romano, Tr. 3203-5, *in camera*). { [REDACTED] }
[REDACTED]
[REDACTED] } (Romano, Tr. 3203-4, *in camera*).

b. Heart Care

Dr. Romano studied outcomes data, principally mortality rates, in various categories of treatment for heart conditions, touted by ENH as one of its “quality of care improvement” categories, to see if patients actually benefitted from the changes.

Heart Attack Mortality. { [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3093-5, 3210-2, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3093-5, 3212-3, 6303-4, *in camera*). { [REDACTED]

[REDACTED] } (Romano, Tr.

3093-5, 3215, *in camera*).⁵⁴

Heart Attack Care Processes. { [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3067-9,

3080-1, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3069, 3080-1, *in camera*).

{ [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3070-2, 3080-5, *in camera*). { [REDACTED]

⁵⁴ { [REDACTED]

[REDACTED] }
(Romano, Tr. 3217, *in camera*).

[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3079, *in camera*).⁵⁵

Heart Surgery and Other Heart Procedures. { [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3046, 3049-50, 3217-8, *in camera*). { [REDACTED]

[REDACTED] } (Romano,

Tr. 3046, 3050-1, 3054-5, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3218, *in camera*).⁵⁶

c. Obstetrics

ENH claims it made numerous changes to the structure of the obstetrics and gynecology department at Highland Park, *e.g.*, changes in medical staff leadership, changes in nursing morale and changes to the quality assurance program. { [REDACTED]

[REDACTED]

[REDACTED] } (Romano,

⁵⁵ In one of few instances in which he engaged in a quantitative analysis based on outcomes, Dr. Chassin also found evidence of improvement at Highland Park in the administration of aspirin and beta-blockers, but Dr. Chassin's analysis failed to weigh the post-merger decline in quality at Evanston for these indicators over the same time period. (Chassin, 5267, 5269, 5270-4, 5278-84).

⁵⁶ Using benchmarks from the Society of Thoracic Surgeons and the State of New York, Dr. Chassin found improvements in mortality and complications rates for cardiac surgery at Highland Park post-merger, but again his analysis failed to consider quality declines at Evanston. (Chassin, Tr. 5294-6, 5298-9).

Tr. 3222-3, *in camera*). { [REDACTED] } (Romano,

Tr. 3188-9, 3224, 3226-32, *in camera*).

{ [REDACTED] } (Romano, Tr. 3224, *in camera*). { [REDACTED]

[REDACTED]

{ [REDACTED] } (Romano, Tr. 3226-9, *in camera*). { [REDACTED]

[REDACTED] } (Romano, Tr. 3230-1, *in camera*). { [REDACTED]

[REDACTED] } (Romano, Tr. 3231-2, 3188-9, *in camera*).

{ [REDACTED]

[REDACTED] } (Romano, Tr. 3126-7, *in camera*).

d. Nursing

ENH claims it dramatically improved the nursing culture at Highland Park. { [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3232-5, *in camera*). { [REDACTED]

[REDACTED] } (Romano, Tr. 3232-5, *in camera*). { [REDACTED]

[REDACTED] } (Romano, 3232-5, *in camera*).⁵⁷

With no statistically significant evidence of an improvement in nursing quality, Dr. Romano also studied patient satisfaction ratings. { [REDACTED]

[REDACTED] } (Romano, Tr. 3136-7, *in camera*). By 2001, ENH's quality improvement subcommittee reported that Highland Park's nursing quality, as measured by patient satisfaction, was "well below" the target. (RX 1131 at ENH PL 001251).

e. Exporting Evanston's "Teaching" Status to Highland Park

ENH claims that Highland Park's quality of care improved because Evanston exported its "teaching" programs to Highland Park. { [REDACTED]

[REDACTED] } (Romano, Tr. 3117, *in camera*). He found no evidence that quality improved as claimed by ENH. { [REDACTED]

[REDACTED] } (Romano, Tr. 3122-5, 3218-22, *in camera*). { [REDACTED]

⁵⁷ [REDACTED]

[REDACTED] } (Romano, Tr. 3234-5, *in camera*).

[REDACTED] (Romano, Tr. 3118, *in camera*).

f. Cancer Care

ENH proclaims the extension of the Kellogg Cancer Care Center to Highland Park is another improvement from the merger. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr. 3097-8, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr. 3096-7, *in camera*).

{ [REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr. 3098-9, 3101-3, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr. 3103-5, *in camera*).

g. Psychiatric Care

ENH claims it improved psychiatric services by separating and consolidating adult patients at Evanston and adolescent patients at Highland Park. { [REDACTED]

[REDACTED] (Romano,

Tr. 3115-6, *in camera*). { [REDACTED]

[REDACTED] (Romano, Tr.

3115, *in camera*). { [REDACTED]

██████████ } (Romano, Tr. 3116-7, *in camera*).⁵⁸

The point is not that ENH presented *no* credible evidence in any of all the preceding categories. Rather, for none of those categories is there clear evidence of the sort of significant, verifiable, quantifiable and “merger-specific” improvements that must be shown in order to conceivably outweigh the considerable, verified, quantified and merger-specific anticompetitive effects this merger produced.

3. *ENH Relies on Flawed Qualitative Evidence*

Dr. Chassin identified 16 categories of structure and process changes at Highland Park, 11 of which were implemented even though he saw no problems before the merger. (Chassin, Tr. 5360). ██████████

██████████ } (Romano, Tr. 3010-2; Romano, Tr. 3192, *in camera*). Dr. Chassin concedes that many structural changes are “very remote from the actual outcomes that we like to see delivered.” (Chassin, Tr. 5152). But ENH’s evidence revolves around the “very remote.”

Dr. Chassin’s work consisted largely of interviews, site visits and document reviews. He followed no empirical guides to compare quality of care before and after the merger. (Chassin, Tr. 5469-71). *There are other major flaws in Dr. Chassin’s fact-gathering process.*

Dr. Chassin conducted 34 interviews without using any empirical qualitative survey research methods. (Chassin, Tr. 5162-3, 5473). Many of the interviewees were not with Highland Park before the merger. (Chassin, Tr. 5165). Others were current employees of ENH who may have been reluctant to speak against their employer, particularly with the Chief Operating Officer (Mr. Hillebrand) and litigation counsel in the same room. (Chassin, Tr. 5163; Romano, Tr. 3015-6).

⁵⁸ ENH cites numerous other changes implemented at Highland Park, but the data does not show evidence of improvement in patient satisfaction or outcomes. (CCFF 2133-2148).

Highland Park employees with a perspective contradictory to ENH's litigation stance and were knowledge about Highland Park's pre-merger plans to improve quality of care, such as Mr. Newton, were not interviewed. (Chassin, Tr. 5472-3).

Dr. Chassin also conducted site visits at Highland Park, but their significance diminishes since they were done four years after the merger. (Romano, Tr. 2980, 3020-1). Dr. Chassin cannot opine that quality "improved" if he never saw the baseline. Dr. Chassin readily dismisses patient satisfaction surveys because the interviews were conducted a few weeks after the fact, because "recollection deteriorates and changes dramatically," but he quickly accepts the perceptions of employees about events more than four years ago. (Chassin, Tr. 5470-1, 5250).

B. ENH Cannot Prove that Quality Changes Outweigh the Competitive Harm

In analyzing ENH's defense, it is more relevant to think in terms of what ENH has not done. ENH has (1) failed to verify and prove that quality of care, in fact, improved relative to other hospitals; (2) failed to prove that quality of care improved across all three ENH hospitals; (3) failed to quantify any improvements; and (4) failed to define a mechanism by which to value any quality improvements (Dr. Chassin did not put a dollar value on the quality changes at Highland Park, and { [REDACTED] } (Chassin, Tr. 5447-9; Baker, Tr. 4629, *in camera*)).

There is quantified proof of anticompetitive effects and harm to consumers. Prices rose. People who could have afforded ENH's services at competitive rates were shut out of the market. What does ENH offer that might conceivably counterbalance these harms? Nothing. ENH offers neither proof of a verified and quantifiable benefit nor a reasonable way to value the quality changes. With these numbers, the math is easy: ENH failed to prove that the so-called benefits of the merger outweigh the antitrust injury.

Health plans engage in this cost-benefit balancing. Health plans always keep a hospital's reputation for quality of care in mind during the price negotiations, and will pay more to some hospitals with reputations for higher quality and more sophisticated services and less to others, even when different quality hospitals have common ownership (e.g., the Rush system, the Resurrection system and the Provena system). (Ballengee, Tr. 152-4, 163-4, 189; Foucre, Tr. 890-2; Dorsey, Tr. 1445-6). When they have sufficient quality and do not want to pay more, health plans will drop the more expensive hospital, as PHCS did with the University of Chicago. (Ballengee, Tr. 189-90).⁵⁹ Because quality and price are complex and interdependent, health plans seek the appropriate mix of each, with the ultimate goal of striking a balance and delivering "cost-effective healthcare" to their customers. (Ballengee, Tr. 153).

With ENH and this merger, health plans had no more choice. During the 2000 negotiations, quality improvements at Highland Park were not points of negotiation. (Ballengee, Tr. 187-8; Neary, Tr. 624; Dorsey, Tr. 1447-8, 1450). ENH executives admitted they never discussed internally, nor explained to health plans, that the price increases were necessary for or justified by quality changes. (Hillebrand, Tr. 1784; Newton, Tr. 368).

As quality purportedly improved at Highland Park, ENH failed to alert health plans, some of whom to this day see no change in Highland Park's quality of care since 1999. (Foucre, Tr. 926-7; Ballengee, Tr. 187-8, 202-3). ENH's silence is counterintuitive because if its relative quality had in fact improved, as ENH claims to the Court, one would expect ENH to trumpet the improvement not only to justify the 2000 price increases, but also to demand even higher prices going forward. And if any health plan asked why it had to pay ENH the same or more as "academic" hospitals, again

⁵⁹ This is in contrast to the area surrounding ENH, where Mr. Neaman conceded that good quality hospitals exist, but health plans could not substitute them for ENH because of customers' geographic access concerns. (Neaman, Tr. 1191; Ballengee, Tr. 181, 183-4).

one would expect ENH to proffer improved quality as justification.

During the late-2003 negotiations with United, ENH asked United to tell the FTC that the merger created an “improved and expanded integrated healthcare delivery system that has enhanced the quality of care delivered at each of their hospitals.” (Foucre, Tr. 926-7; CX 6284 at 2). To verify ENH’s claim, United required ENH to provide it with data on “re-admission rates, complication rates, average length of stay [and] other measures of that nature” -- data typically available and of the type relied upon in the industry. (Foucre, Tr. 927). ENH did not provide such data, leaving United in the same position as the Court. (Foucre, Tr. 927). Without proof, United refused to buy into ENH’s argument. (Foucre, Tr. 924).⁶⁰

Health plans also had no choice but to pay one rate for all three hospitals, regardless of their views that Highland Park’s services did not merit prices equal to Evanston’s. { [REDACTED] [REDACTED] [REDACTED] } (Holt-Darcy, Tr. 1560-1, *in camera*). Additionally, health plans, who send three times more patients to Evanston than to Highland Park, incurred higher prices for patients who never utilized Highland Park’s new parking garage and valet parking. (Ballengee, Tr. 160-1 (pre-merger, 80% of PHCS claims dollars went to Evanston; 20% to Highland Park); Chan, Tr. 741-2; O’Brien, Tr. 3514).

Health plans understand that higher hospital prices have a “negative impact” on premiums and “downstream to the employees.” (Ballengee, Tr. 172, 196-7; Mendonsa, Tr. 483-4). Higher hospital prices and premiums can lead to “additional payroll deduction or increased deductibles,

⁶⁰ { [REDACTED] [REDACTED] [REDACTED] } (Mendonsa, Tr. 538, *in camera*; Holt-Darcy, Tr. 1546, *in camera*).

increased co-pays,” and worse, particularly among smaller employers, “dropping coverage altogether and people not having insurance.” (Mendonsa, Tr. 483-4; Dorsey, Tr. 1450 (some employers will forego health benefits for employees because they cannot “afford to continue to pay the high cost in their overall medical cost ratio.”)).

In order to justify higher premiums, health plans would have had to tell their customers that their employees ultimately would benefit via higher quality of care. But we know that ENH did not arm the health plans with such information. (*See, e.g., Foucre, Tr. 926-7*). And there is no significant evidence that, in fact, consumers did receive higher quality of care compared to other hospitals as measured by patient outcomes and patient satisfaction.

This merger has made consumers worse off. Insurance premiums increased. Consumers pay more but, as indicated by Dr. Romano’s work, many experienced no improvement in patient outcomes or satisfaction. Consumers who only utilize Evanston do not benefit from the changes at Highland Park, but must pay more for insurance because ENH insisted on charging one price for all three hospitals. Consumers who lost health benefits coverage because it became too expensive are the worst off – all the post-merger changes at Highland Park are worthless to them. It will not do for ENH to assert that it needed to gain market power in order to increase quality at higher rates for the select group that can afford it while reducing overall output.

These concerns underlie courts’ skepticism of arguments by firms with market power that their merger or conduct will ultimately outweigh the harm to competition. *Society of Prof. Engineers*, 435 U.S. at 695 (“ultimately competition will produce not only lower prices but also better goods and services”); *Philadelphia Nat’l Bank*, 374 U.S. at 371; *Indiana Federation of Dentists*, 476 U.S. at 463 (defendant’s “quality of care” justification is “nothing less than a frontal assault on the basic policy of the Sherman Act”). This reasoning prompted a district court to block

a merger of hospitals and dismiss their quality of care defense: “The court finds the defendants’ intention to create a state-of-the-art tertiary referral center and all its corresponding benefits in quality and community development as irrelevant for the present [Clayton Act § 7] inquiry.” *U.S. v. Rockford Memorial Corp.*, 717 F. Supp. 1251, 1289 (N.D. Ill. 1989), *aff’d on other grounds*, 898 F.2d 1278 (7th Cir. 1990).

C. Highland Park Would Have Improved Quality of Care without the Merger

This merger produced tangible anticompetitive effects, effects that occurred only because of the merger. If the merger is defensible, it must be defended by results that are equally produced by the merger. Thus, to the extent there were quality improvements, ENH must show that they were “merger-specific” to be cognizable as a defense, *i.e.*, the quality improvements could not have been achieved by Highland Park without the merger. *Heinz*, 246 F.3d at 721-2. ENH cannot meet that standard since witnesses agree Highland Park was a good hospital before the merger, its executives and documents spoke of plans to implement changes to further improve its quality, it had the financial wherewithal to pay for the changes and, if it could not improve on its own, numerous other hospitals existed as clinical partners or merger candidates.⁶¹

1. *Highland Park’s Pre-Merger Quality of Care Was “Very Good”*

Witnesses from Evanston, Highland Park and the health plans consistently praised Highland Park’s quality of care before the merger as “very good, if not excellent.” (Newton, Tr. 376; Neaman, Tr. 1306 (“pretty good community hospital”); Ballengee, Tr. 160 (Evanston and Highland Park “were both very good hospitals”); Spaeth, Tr. 2098).⁶² Highland Park maintained a high level of

⁶¹ Complaint Counsel discusses ENH’s “merger specificity” claim at CCFF 2294-2443.

⁶² In a 1999 joint submission to the Illinois Health Facilities Planning Board, signed by Messrs. Neaman, Newton and Spaeth, ENH lauded Highland Park for bringing “leading edge and
(continued...)

care, but recognized its weaknesses and instituted corrective measures. (Newton, Tr. 376-401, 409-11). Highland Park impressed Evanston, which saw it as a “strong community hospital,” and deemed Highland Park a worthy merger partner. (CX 874 at 5). In April of 1999, Highland Park received a preliminary score of 95 from JCAHO, an “exceptional” outcome according to Mr. Neaman – Evanston scored 94. (CX 96 at 1; CX 871 at 4; Neaman, Tr. 1198).

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

In 1998 and 1999, Highland Park outlined its strategy to further improve quality of care. (CX 1868; CX 1908). In detailed plans, Highland Park identified areas of focus, many of which address the areas that Dr. Chassin claims are Evanston’s contributions to this merger. The impetus came from knowing that “[t]his highly affluent community expects and demands quality,” and the recognition that while Highland Park “delivers basic services at a very high level” and is perceived as an “excellent community hospital,” Highland Park needed to improve itself to compete against Evanston. (CX 1868 at 7, 10). In March of 1999, Highland Park’s Board committed to invest more than \$100 million over the next four years. (CX 545 at 3).

Natural, self-survival competitive incentives pushed Highland Park to (1) improve its medical staff, patient outcomes, patient satisfaction, employee morale, technology (including information systems, such as Meditech), equipment, facilities and administration, (2) offer new clinical services, such as heart surgery, and more oncology services, and (3) strengthen affiliation with Northwestern Memorial to draw upon the latter’s academic and research programs. (CX 1868 at 12-14, 17; CX 1908 at 12-22; Newton, Tr. 329-44). { [REDACTED]

[REDACTED]

⁶² (...continued)
innovative clinical services” to the community and “consistently [being] the first provider in Lake County to develop and offer advanced clinical services.” (CX 413 at 7, 16-7).

[REDACTED] } (Romano, Tr. 3158-9, *in camera*).

3. *There Was a National Trend toward Improved Quality of Care*

As ENH began making changes at Highland Park, the healthcare community was already in the midst of a national movement to further study measures of quality and improve quality of care at hospitals. (Romano, Tr. 2998-3002). Studies by leading medical organizations surfaced in late 1999 that guided hospitals on how to improve quality going forward. (Romano, Tr. 2998-9). The Leapfrog Group recommended use of electronic medical records only in 2000, and ENH's EPIC system became operational only in 2003-2004. (Wagner, Tr. 4065-6; RX 1117 at ENH GW 003511; Neaman, Tr. 1251). { [REDACTED]

[REDACTED] } (Ankin, Tr. 5078-80; Romano, Tr. 2998-9; Romano, Tr. 3113-4, *in camera*). Highland Park cannot be faulted for not knowing the unknown, nor should ENH be credited for following a trend. (Ankin, Tr. 5087).

4. *Highland Park's Financial Health Was Sound*

Mr. Stearns, Highland Park's Chairman of the Board, described a sanguine outlook: "We had the financial wherewithal to sustain ourselves. There was no urgency to have an alternative [to Evanston] immediately available." (CX 6305 at 4-5, 11 (Stearns, Dep.)). Mr. Stearns added that Highland Park had a "strong balance sheet with an endowment, if you will, of a substantial amount for a community hospital," and had no concern about its "existence, at least for a reasonable period of time" -- "10 years." (CX 6305 at 2-5, 10 (Stearns, Dep.)).⁶³

⁶³ ENH called Kenneth Kaufman, a financial advisor to Highland Park before the merger, to testify about Highland Park's financial viability. Mr. Kaufman cast doubt about Highland Park's
(continued...)

In the Spring of 1999, Highland Park's Finance Committee approved over \$100 million in new projects through 2003. (CX 1055 at 2; CX 1903-2-3; CX 545 at 3). The Finance Committee "posed the question on the long-term financial viability of the organization should affiliation discussions [with Evanston] not reach fruition." (CX 1055 at 3). The Finance Committee "concluded that the organization can remain financially strong over the foreseeable future." (CX 1055 at 3). Separately, Highland Park's finance office concluded that, using a "conservative" model based on "existing cash and investments and cash flow", the hospital could "generate sufficient cash" to fund the improvements. (CX 1903 at 1).⁶⁴

Highland Park's financial condition was impressive. At the end of 1999, Highland Park had cash and unrestricted investments of about \$140 million net of debt. (CX 693 at 16-7). Highland Park could operate fully for 400 days without any revenues. (Newton, Tr. 428). The cash-on-hand balance was 2.4 times the national average. (CX 1912 at 2).

5. *Highland Park Would Have Partnered with Other Hospitals*

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

The likelihood that Highland Park would merge with someone else posed a real threat to

⁶³ (...continued)

future, but he indicated that the time frame was speculative – "five, ten 15 years." (Kaufman, Tr. 5814-5).

⁶⁴ In 1999, Highland Park incurred losses, but its management concluded that new strategies, including growth through new and existing clinical services, would "restore the profitability" of Highland Park. (CX 545 at 4).

Evanston. In the internal discussions about whether to merge with Highland Park, Evanston's Board recalled that years before and to its immediate south, Skokie Valley Hospital was once a "sleeping dog" community hospital. (Hillebrand, Tr. 1795). The Rush system of hospitals then acquired Skokie Valley, made major investments and today Skokie Valley is Rush North Shore, a major hospital. (Hillebrand, Tr. 1795-7). Evanston's management team cautioned that the same could happen with Highland Park if Evanston did not act -- one of the "key risks of not undertaking [the] merger." (CX 84 at 58).

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

In 1999, before they agreed to merge, Evanston and Highland Park contracted to bring cardiac surgery to Highland Park. (Rosengart, Tr. 4527-9; CX 501 at 41). All funding for the program, \$2.9 million, was to come from Highland Park. (CX 413 at 12; CX 2094 at 2). Swedish Covenant successfully runs a cardiac surgery program with ENH today, the terms of which mirror the 1999 agreement between Highland Park and Evanston. (CX 2073; CX 2094; Rosengart, Tr. 4527-8).

V.

ENH'S "COPPERWELD" DEFENSE FAILS TO SAVE THE MERGER

ENH asserts an affirmative defense based on the notion that the merger is protected by the *Copperweld* doctrine. In *Copperweld Corp. v. Independence Tube Co.*, 467 U.S. 752 (1984), the Supreme Court held that a parent company and its wholly-owned subsidiary, as a single entity, were not capable of conspiring in violation of the Sherman Act. ENH seeks to import the *Copperweld* doctrine into Section 7 of the Clayton Act, arguing that Evanston and Highland Park were nominally a single entity under the NH Network, and therefore, the 2000 merger was between wholly-owned subsidiaries of the NH Network. ENH's assertion is bereft of either factual or legal support.

Under the NH Network agreements, Evanston and Highland Park remained "separate economic actors pursuing separate economic interests," and their merger "suddenly [brought] together economic power that was previously pursuing divergent goals." *Copperweld*, 467 U.S. at 769. The NH Network's documents are rife with express provisions – that Evanston and Highland Park demanded as a condition of their participation in the NH Network – that protected the autonomy of each hospital; that maintained the autonomy of each hospital's medical staff; and that preserved the autonomy of each hospital's management and financial operations. (CX 1777 at 49-50, 72, 77). Further, the NH Network preserved each member hospital's right to withdraw from the NH Network if its business decisions were adverse to that hospital, and restricted the NH Network's authority to fire the executives of any member hospital. (CX 1831 at 9-10, 13).

Thus, unlike the *Copperweld* parent company, the NH Network could not "keep a tight rein" over the individual member hospitals – its purported "subsidiaries" – because the NH Network could not "assert full control at any moment if the [member hospitals] fail[ed] to act in the [NH Network's]

best interests.” *Copperweld*, 467 U.S. at 771-72.⁶⁵

VI.

THE APPROPRIATE REMEDY IS DIVESTITURE OF HIGHLAND PARK

A. The Clayton Act Requires Divestiture

Complaint Counsel has demonstrated that the Highland Park-Evanston merger lessened competition in violation of Section 7 of the Clayton Act. Upon a finding of liability, Section 11(b) of the Clayton Act states that the Commission “shall” order a divestiture of “the stock, or other share capital, or assets held” in violation of Section 7. 15 U.S.C. § 21(b).

The Supreme Court has ruled that “[t]he very words of § 7 suggest that an undoing of the acquisition is a natural remedy.” *United States v. E.I. du Pont de Nemours and Co.*, 366 U.S. 316, 329 (1961). The Supreme Court added that divestiture is “simple, relatively easy to administer, and sure. It should always be in the forefront of a court’s mind when a violation of § 7 has been found.” *Du Pont*, 366 U.S. at 330-1.

Just last year, the Commission ordered a divestiture of the acquired entity following a successful Section 7 challenge to a consummated merger. *Chicago Bridge & Iron*, Docket No. 9300; *see also Olin Corporation*, 113 F.T.C. 400, 619 (1990); *Ekco Products Co.*, 65 F.T.C. 1163, 1228-29 (1964); *Crown Zellerback Corp.*, 54 F.T.C. 769, 808 (1957). Within the healthcare context, the Commission has ordered divestiture of a hospital acquired in violation of Section 7, an order that the Court of Appeals for the Seventh Circuit subsequently upheld. *Hosp. Corp. of America*, 106 F.T.C. 361 (1985), *aff’d*, 807 F.2d 1381 (7th Cir. 1986).

⁶⁵ Even if Evanston and Highland Park actually became a single entity through the NH Network, their merger through the formation of the NH Network is properly the subject of this challenge (and on the same grounds) under Section 7 of the Clayton Act. In *U.S. v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586 (1957), for example, the government successfully invoked Section 7 to challenge a transaction that had occurred some 32 years before the lawsuit was filed.

In addition to divestiture, the Commission has ample authority to order ancillary relief. “The relief which can be afforded” from an illegal acquisition “is not limited to the restoration of the status quo ante.” *Ford Motor Co. v. U.S.*, 405 U.S. 562, 573 n.8 (1972). Rather, relief must be directed to that which is “necessary and appropriate in the public interest to eliminate the effects of the acquisition offensive to the statute.” *Id.* (citations omitted). The Commission’s choice of remedy prevails, for it is “well settled that once the government has successfully borne the considerable burden of establishing a violation of law, all doubts as to the remedy are to be resolved in its favor.” *Du Pont*, 366 U.S. at 334.

The Commission, as an expert body, has wide latitude and a reviewing court will not set aside or modify the FTC’s remedial provisions so long as there is a “reasonable relationship” between the remedy and the unlawful conduct at issue. *Atlantic Refining Co. v. FTC*, 381 U.S. 357, 377 (1965); *FTC v. Mandel Bros., Inc.*, 359 U.S. 385, 392 (1959); *FTC v. Ruberoid Co.*, 343 U.S. 470, 473 (1952). As Judge Posner made clear in affirming the Commission’s decision and divestiture order in a hospital merger challenge, “the Commission has a broad discretion, akin to that of a court of equity, in deciding what relief is necessary to cure a violation of law and ensure against its repetition.” *Hosp. Corp. of America*, 807 F.2d at 1393.⁶⁶

B. The Proposed Order Would Divest Highland Park with Ancillary Relief

⁶⁶ The Commission has a long history of employing its broad remedial authority to provide various types of ancillary relief where divestiture has been ordered. *See e.g.*, *Chicago Bridge & Iron*, Docket No. 9300 (divestiture included additional assets, allocation of customer contracts, facilitation of transfer of employees, provision of technical and administrative assistance, asset maintenance order); *Olin*, 113 F.T.C. at 620 (divestiture included post-merger improvements); *B.F. Goodrich Co.*, 110 F.T.C. 207, 362-3 (1988) (divestiture included post-merger improvements, technology, technical assistance); *Ekco Products*, 65 F.T.C. at 1228-29 (divestiture not only of the acquired assets, but also of assets necessary to reconstitute a competitor); *RSR Corp.*, 88 F.T.C. 800, 892-97 (1976) (divestiture of plants that were not part of the original acquisition).

Following upon well-established law, Complaint Counsel's Proposed Order (the "Proposed Order" or "CCPO") appropriately directs ENH to divest Highland Park, including any additions and improvements made to the hospital since the merger, to an approved acquirer no later than 180 days from the date the order becomes final. (CCPO ¶ II.A.).⁶⁷

The Proposed Order also clarifies what assets should be divested. The Proposed Order requires ENH to replace any assets (that were eliminated without ever being replaced) and to restore any clinical services that no longer exist as of the Proposed Order's date. (CCPO ¶ II.A.). If the acquirer finds that such replacement or restoration is undesirable, then the Proposed Order allows for the assets to be divested without the obligations, upon approval by the Commission. This clarification is necessary to account for post-merger reductions that might affect an acquirer's ability to operate Highland Park as a viable competitor.⁶⁸

The Proposed Order also requires ENH to provide all necessary assistance to ensure the continuation of cardiac surgery at Highland Park. (CCPO ¶ II.E.). This arrangement would continue the current cardiac surgery program at Highland Park in substantially the same manner. ENH currently operates joint cardiac surgery programs through affiliation agreements with Swedish Covenant and Weiss Memorial, both of which are successful.

1. *Ancillary Relief Is Necessary*

After the merger, ENH integrated the two hospital medical staffs, consolidated clinical procedures, and moved some clinical and corporate services to locations other than Highland Park.

⁶⁷ In the "Remedy" section of this brief, Complaint Counsel refers to "Highland Park" as the Highland Park hospital currently owned by ENH for which Complaint Counsel seeks an order of divestiture so that Highland Park will be a stand-alone entity separate from ENH.

⁶⁸ The Proposed Order also requires ENH to cooperate with an acquirer to transfer the hospital assets as an ongoing business, including providing assistance to transfer all necessary governmental approvals. (CCPO ¶ II.C., II.F.).

In view of such changes, the Court should order ancillary relief to assist the acquirer to re-establish the consolidated functions and to have access to all of the practices and procedures that ENH currently employs at Highland Park. This would require provisions that address the use of clinical practices (intellectual property), provision of transitional services, recruitment of key personnel, the confidentiality of information, and appointment of a Monitor to oversee the divestiture. Such relief is important to help insure that the acquirer is able to operate a viable hospital and thereby restore competition to the market. Complaint Counsel's Proposed Order imposes appropriate obligations upon ENH in each of these areas.

a. Intellectual Property License

The Proposed Order's requirement that ENH divest Highland Park in its current condition includes assets in the form of any intellectual property such as best practices, procedures, and methods employed by the hospital. The most effective way of handling the question of dividing these assets between ENH and an acquirer would be for each party to equally share the intellectual property. Thus, Complaint Counsel's Proposed Order requires ENH to grant a non-exclusive license to the acquirer for all intellectual property that ENH currently uses in its hospital business. (CCPO ¶ II.D.) This would allow each hospital to begin the post-divestiture period on the same footing after which each hospital would independently pursue further improvements in its practices and procedures.

b. Transitional Services

The Proposed Order requires ENH to provide the acquirer with certain clinical and administrative services for a transitional period, not to exceed 12 months. (CCPO ¶ II.G.). Although Highland Park Hospital essentially is a full-service stand-alone hospital within the ENH system, a number of services and activities were consolidated with ENH and are now provided through a

centralized effort. It is necessary that ENH continue to provide all such centralized services to HPH for a period of time after the divestiture to allow the acquirer an opportunity to either provide the services itself or to arrange for an alternate supplier. The Proposed Order allows ENH to receive a payment for these transitional services that does not exceed the direct cost of providing them.

c. Transfer of Medical Staff and Other Employees

The Proposed Order requires ENH to facilitate the transfer of employees and medical staff to Highland Park. (CCPO ¶ II.H.-I.) Highland Park already has a nursing staff, support staff, and management who work at the Highland Park location, and there are physicians who already practice primarily at Highland Park. As a practical matter, the effect of the Proposed Order on this issue would be to require ENH to cooperate, and not interfere, with the efforts of the acquirer as it works to fill key management and clinical positions at Highland Park and to recruit physicians to its staff. This will insure that the divested hospital will be able to develop the appropriate managerial and clinical expertise needed to be a viable competitor.

d. Maintenance of Confidential Information

The Proposed Order requires ENH to maintain the confidentiality of all information relating to operation of Highland Park. (CCPO ¶ II.J.) ENH would be prohibited from disclosing or using any proprietary information relating to Highland Park except as needed to fulfill its obligations under the Proposed Order. The Proposed Order limits the extent to which ENH may disseminate the information internally and requires ENH to take the same steps to protect this information as it takes to protect its own trade secrets and proprietary information.

e. Termination of Contracts with Health Plans

The divestiture of Highland Park and appropriate ancillary relief will restore the competition eliminated as a result of the merger. It is also necessary, however, that ENH terminate the contracts with health plans that it negotiated after acquiring market power as a result of the merger. Complaint Counsel's Proposed Order requires ENH to terminate these contracts, but does not preclude ENH and the health plans from negotiating new contracts after terminating the old ones. (CCPO ¶ II.K.) Thus, the divestiture and contract termination requirements will result in negotiation of new contracts, but the negotiation this time will occur within a competitive environment.

f. Monitor and Divestiture Trustee

The Proposed Order provides for the appointment of a Monitor to oversee the divestiture and all transitional activities as well as a Divestiture Trustee if ENH fails to divest the required assets in accordance with the Proposed Order. (CCPO ¶¶ V-VI) Appointment of a Monitor is necessary because "common sense tells us that Respondents' self-interests will be best served by creating less rather than more competition from the divested assets." *Chicago Bridge & Iron*, Docket No. 9300 at 94. The monitor will ensure that an acquirer "receives what it needs to maintain a viable business" and that the "divestiture proceeds smoothly by providing a conduit between the acquirer and [ENH] and promptly notifying the Commission of any problems." *Id.*⁶⁹

⁶⁹ Complaint Counsel's Proposed Order also requires ENH to (1) maintain the viability, marketability, and competitiveness of the Highland Park Assets and (2) identify the assets as well as any changes made since the Merger. (CCPO ¶ III) This is appropriate to avoid deterioration of the assets while awaiting divestiture, which could defeat the purpose of the divestiture. The Proposed Order also imposes other standard provisions relating to order distribution, compliance reporting, notification, and inspection requirements. (CCPO ¶¶ IV, VII-IX)

C. The New Highland Park Will Retain Its High Quality of Care

Divestiture will not adversely affect the quality of care at Highland Park. (See, e.g., Romano, Tr. 3193, *in camera*). { [REDACTED] } (Romano, Tr. 3193, *in camera*). The Proposed Order insures continuity by permitting the acquirer to retain key employees. (CCPO ¶ II.H.)

{ [REDACTED] } (Romano, Tr. 3195-97, *in camera*).

{ [REDACTED] } (Romano, Tr. 3197, *in camera*). { [REDACTED] } (Romano, Tr. 3194-96, *in camera*).

As contemplated in the Proposed Order, the introduction of new clinical pathways to Highland Park after the merger would constitute improvements to its intellectual property and would be included in the asset package and addressed in the license to be granted to the acquirer.

{ [REDACTED] } (Romano, Tr. 3195, *in camera*).

A post-divestiture change in “academic” affiliation of Highland Park also would not affect quality because Highland Park is not really a teaching hospital, but is simply owned by a teaching hospital. { [REDACTED] } (Romano, Tr. 3118, *in camera*).

[REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr. 3196, *in camera*).

There are also outside influences that make it unlikely that the quality of care at Highland Park would decline in any significant manner after divestiture so as to threaten patient safety. Hospital quality of care is carefully monitored and evaluated by government agencies (in connection with licensing and Medicare certification) and other organizations such as JCAHO, the Leapfrog Group, and the health plans themselves.

Among these organizations, JCAHO accredits hospitals and bases its hospital evaluations upon a thorough review of 1,200 elements of performance consisting of both structural and process measures. (Chassin, Tr. 5156-7). [REDACTED]

[REDACTED] (Romano, Tr. 6333-4, *in camera*). In addition, there is evidence that organizations such as the Leapfrog Group have successfully influenced hospitals and encouraged them to improve their quality. (Ankin, Tr. 5050-1). Finally, health plans themselves review JCAHO accreditation and Medicare certification of the hospitals in their networks. (*See e.g.*, Ballengee, Tr. 186; Neary, Tr. 625). As seen in *Indiana Federation of Dentists*, health plans also have an incentive to provide quality services to insure that their customers receive the highest quality of care within a competitive environment. *Indiana Federation of Dentists*, 476 U.S. at 463-64.

CONCLUSION

On the one hand, there are the facts that plainly demonstrate illegal market power – undisputed higher prices, unchallenged testimony of health plans, plain and unambiguous contemporaneous documents, and party admissions from key business people. On the other hand, there are ENH’s legally and factually deficient post-hoc arguments. Weighed against each other, the facts govern. Neither Evanston nor Highland Park *alone* could have raised prices significantly more than other hospitals. The merger substantially lessened competition in violation of Section 7 of the Clayton Act – a conclusion supported by both the direct evidence of actual anticompetitive effects and the highly concentrated structure of the market. The only way to restore competition that will benefit consumers is to order ENH to divest Highland Park.

Respectfully submitted,

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May 27, 2005

CERTIFICATE OF SERVICE

I hereby certify that on May 27, 2005, I caused the attached public version of "Complaint Counsel's Post-Trial Brief" to be served upon the persons identified below and in the manner indicated:

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