IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

FEDERAL TRADE COMMISSION

and

STATE OF ILLINOIS

Plaintiffs,

v.

ADVOCATE HEALTH CARE NETWORK,

ADVOCATE HEALTH AND HOSPITALS CORPORATION,

and

NORTHSHORE UNIVERSITY HEALTHSYSTEM

Defendants.

Case No. 15-cv-11473
Judge Jorge L. Alonso
Mag. Judge Jeffrey Cole

[redacted]

PLAINTIFFS' POST-HEARING BRIEF

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Plaintiffs presented substantial evidence in their preliminary injunction briefs demonstrating that Defendants' proposed merger is likely to substantially lessen competition and that Plaintiffs are likely to succeed on the merits of their Section 7 claim. This Court heard highlights of that evidence during the hearing. Numerous witnesses testified that location matters to patients seeking GAC inpatient hospital services and, therefore, location matters to payers constructing networks to offer their members. Payers explained to the Court that when fewer providers are available to meet the demand for local hospitals, providers can use their increased leverage to demand better terms and higher prices.

In addition to the payer testimony, the Court also heard Dr. Tenn's testimony. Dr. Tenn's expert analyses, grounded in objective data and well-accepted economic theory, are entirely consistent with and bolster the evidentiary record. In particular, Dr. Tenn concluded that:

- patients receiving care at North Shore Area hospitals primarily receive their care close to home, traveling only short distances to the hospital;
- payers must include local hospitals in their networks because patients strongly prefer local hospitals;
- a hypothetical monopolist owning the four NorthShore hospitals and only two Advocate hospitals, Lutheran General and Condell, could impose a small but significant and nontransitory increase in price ("SSNIP");
- an expanded geographic market that includes five non-party hospitals that compete locally with the relevant Advocate and NorthShore hospitals also satisfies the hypothetical monopolist test;
- the merger would dramatically increase concentration and create a dominant hospital system with a 60% market share; and
- the merger would substantially increase the bargaining leverage of the combined entity and enable it to increase prices.

In contrast, Defendants' case consisted almost entirely of the self-serving testimony of their executives. Those executives contradicted themselves, each other, and their own experts.

While they claimed that patients in the Chicago metro area are willing to travel significant distances to receive routine inpatient care, when it came to the merging parties' own facilities, they claimed that it is "not natural" for patients to travel even a few miles from east to west. Dr. McCarthy testified that a hypothetical monopolist would need to own at least twenty geographically dispersed hospitals to impose a small but significant and non-transitory increase in price ("SSNIP"). Yet, he ignored the *Merger Guidelines* and never conducted a SSNIP test for the North Shore Area market or his proposed twenty-hospital market. Contrary to basic economic theory, Dr. McCarthy concluded that an increase in a provider's bargaining leverage would lead to the provider accepting lower reimbursement rates, despite the overwhelming testimony from market participants that the opposite is true.

Defendants also failed to produce sufficient evidence to support their defenses. Defendants' executives testified that the parties are merging to allow them to participate in a new insurance product that they call a high performance network ("HPN") but admit that the HPN already exists. According to Advocate's executives, it is impossible to market the existing HPN to large groups because Advocate has a coverage gap in a narrow strip along Lake Michigan but two payers—Blue Cross Blue Shield of Illinois ("BCBSIL") and United—testified that an Advocate-only HPN is marketable to large groups today. Even if there were a gap in Advocate's coverage of the North Shore Area, there is no evidence that insurers need the merger to fill it.

The merger is also not necessary to extend Advocate's capabilities to NorthShore because NorthShore is every bit as capable as Advocate is today. As Dr. Jha testified, NorthShore performs better than Advocate on a wide range of quality and cost measures. Even if NorthShore has less experience in population health management and risk-based contracting, NorthShore does not need those capabilities to offer high quality, cost-effective care and can

(and inevitably will) obtain those capabilities on its own. Defendants failed to present any evidence demonstrating that the merger is the fastest or cheapest way for NorthShore to develop population health management expertise or transition to full-risk contracting.

In short, the hearing confirmed what Plaintiffs' briefs already showed: the merger is presumptively unlawful, would eliminate competition between Defendants, and would lead to higher prices and reduced quality of care. Defendants' arguments fall well short of the high burden they face given the overwhelming presumption of illegality Plaintiffs have shown.

ARGUMENT

I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS

A. The Relevant Product Market Is General Acute Care Inpatient Hospital Services Sold to Commercial Payers

The relevant product market is GAC inpatient hospital services sold to commercial payers and provided to their insured members ("GAC Services"). At the hearing, Dr. Tenn explained that a hypothetical monopolist of GAC Services could raise prices to commercial insurers by a SSNIP because there are no substitutes for those services.[1] Payers uniformly agree with Dr. Tenn. Ms. Norton testified that Cigna "couldn't have a network that did not include inpatient services" because "at some point, a customer or a patient potentially could need inpatient care."[2] Mr. Hamman agreed that BCBSIL "couldn't have a network that does not include inpatient services."[3] And Defendants' own expert, Dr. McCarthy, rejects the notion that outpatient services should be included in the relevant product market.[4]

[1] Tenn PI Hrg. Tr. at 443:22-444:5.
[2] Norton (Cigna) PI Hrg. Tr. at 79:13-23.
[3] Hamman (HCSC) PI Hrg. Tr. at 155:13-21.
[4] McCarthy PI Hrg. Tr. at 1270:1271:2.

B. The Relevant Geographic Market Is No Broader than the North Shore Area

Plaintiffs' proposed geographic market—the North Shore Area—is grounded in real-world market dynamics and supported by substantial evidence. [redacted]

Payers need local hospitals in their networks because patients overwhelmingly demand access to hospitals close to their homes. In Northwestern's experience, "patients tend to like to stay close to home" when receiving healthcare services.[8] This is particularly true for inpatient services because, as Mr. Dechene testified, "[i]f you're in the hospital, you're staying overnight, you'd like to make it convenient for your family to come visit you."[9] Defendants' executives agree that "[w]hen something is considered routine, [patients] expect to be able to stay within their local health community."[10] The preference for local care is reflected in Defendants'

[5] Beck (United) PI Hrg. Tr. at 1155:1-17; Norton (Cigna) PI Hrg. Tr. at 106:25-107:3; *see also* Dechene (Northwestern) PI Hrg. Tr. at 312:10-18; Plaintiffs' Proposed Findings of Fact ("FoF") at ¶ 11.
[6] Beck (United) PI Hrg. Tr. at 1155:1-23; Hamman (HCSC) PI Hrg. Tr. at 151:2-22; *see also* FoF at ¶ 11.
[7] Beck (United) PI Hrg. Tr. at 1155:11-17; Norton (Cigna) PI Hrg. Tr. at 106:25-107:3.
[8] Dechene (Northwestern) PI Hrg. Tr. at 305:21-23.
[9] Dechene (Northwestern) PI Hrg. Tr. at 312:10-22.
[10] JX00028 Tallarico (Advocate) Dep. Tr. at 271:20-24; *see also* PX02008 Hall (NorthShore) IH Tr. at 187:9-18; PX02022 Weiss (NorthShore) Dep. Tr. at 108:13-24 (Testifying that healthcare is still a local business and there is "a certain distance that individuals are not likely to travel past to get their care").

ordinary course documents,[11] and confirmed by Defendants' experts,[12] by employers,[13] and by payers.[14]

Dr. Tenn's empirical analysis supports this evidence. Dr. Tenn found that three quarters of the patients receiving inpatient care at North Shore Area hospitals travelled less than 20 minutes to the hospital, half of patients travelled less than 12 minutes, and a quarter travelled less than 7 minutes.[15] Dr. McCarthy does not dispute Dr. Tenn's findings.[16]

The evidence presented at the hearing shows that, due to the strong preference for local hospitals, payers could not replace North Shore Area hospitals with hospitals from outside of the area and still offer attractive networks. Ms. Beck testified that United could not market to its members in the northern suburbs a network of only downtown academic medical centers.[17] A network of downtown academic medical centers would also not appeal to BCBSIL members living in the northern suburbs.[18] As Mr. Hamman explained, "[t]ypically people get most routine care close to where they live . . . the requirement of them to travel downtown would not be an attractive option to them."[19] Even a network that included Northwestern Memorial and

[11] PX04069-001 (Advocate) ("We cannot expect patients to travel for routine care"); PX07010-034 (Bain) (NorthShore's hospital system is "still largely a 'local' business.").
[12] *See, e.g.*, JX00027 Steele Dep. Tr. at 25:12-19.
[13] JX00016 Hodge (Albertsons) Dep. Tr. at 134:19-137:22; JX00001 Abrams (Medline) Dep. Tr. at 58:8-12 ("[P]eople tend to go to their local hospital . . . [P]eople that live near Advocate hospitals are going to go to Advocate hospitals because it's close.").
[14] Beck (United) PI Hrg. Tr. at 1130:4-11; Hamman (HCSC) PI Hrg. Tr. at 158:1-2; Norton (Cigna) PI Hrg. Tr. at 93:9-15; JX00019 Maxwell (Humana) Dep. Tr. at 92:23-93:7.
[15] Tenn PI Hrg. Tr. at 455:4-8; PX06000 Tenn Report ¶ 106, Figures 5-6.
[16] McCarthy PI Hrg. Tr. at 1343:23-1344:3.
[17] Beck (United) PI Hrg. Tr. at 1130:4-1131:6.
[18] Hamman (HCSC) PI Hrg. Tr. at 157:21-158:7.
[19] Hamman (HCSC) PI Hrg. Tr. at 158:1-3.

Northwestern Lake Forest would not be attractive to BCBSIL members because "there's too much geography between the two of them."[20]

Cigna's members in the Evanston-Skokie-Glenbrook-Highland Park area also typically seek care in their own communities.[21] That is why Cigna determined that its Local Plus network, which included Northwestern Memorial, would not be viable without local hospitals.[22] Ms. Norton testified that Northwestern Memorial is not a sufficient alternative to North Shore Area hospitals because "it's a much further drive, and there are a lot of our customers that do prefer to receive care within the communities with which they live."[23]

Payers recognize that a network that excludes Advocate and NorthShore hospitals would not be attractive in the northern suburbs. Mr. Levin, the Aon executive whose alleged support for the merger was touted by Dr. Sacks and by Defendants' counsel,[24] testified at his deposition that "if you have neither NorthShore and you have neither Advocate, you have neither in the product, I think very few people would buy it."[25] At the hearing, [redacted]"[26] Likewise, without Advocate and NorthShore, [redacted][27]

[20] Hamman (HCSC) PI Hrg. Tr. at 158:8-14; *see also* Norton (Cigna) PI Hrg. Tr. at 111:3-9 [redacted]
[21] Norton (Cigna) PI Hrg. Tr. at 84:1-8.
[22] Norton (Cigna) PI Hrg. Tr. at 84:18-23.
[23] Norton (Cigna) PI Hrg. Tr. at 93:17-21.
[24] Defendants' Opening PI Hrg. Tr. at 53:8-16; Sacks (Advocate) PI Hrg. Tr. at 1416:8-1417:8.
[25] JX00017 Levin (Aon) Dep. Tr. at 156:3-23.
[26] Beck (United) PI Hrg. Tr. at 1156:9-17.
[27] Norton (Cigna) PI Hrg. Tr. at 109:12-14.

[redacted][28] BCBSIL offers only one product, Blue Choice, that excludes both Advocate and NorthShore.[29] [redacted]

Dr. Tenn's empirical analysis confirms this unrebutted payer testimony. Dr. Tenn employed the *Merger Guidelines*' hypothetical monopolist test ("HMT"), which has been widely adopted by courts. *See, e.g., Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 784-85 (9th Cir. 2015); *F.T.C. v. ProMedica Health Sys., Inc.*, No. 3:11 CV 47, 2011 WL 1219281, at *55 (N.D. Ohio Mar. 29, 2011) (citing *U.S. Dep't of Justice & Fed. Trade Comm'n Horizontal Merger Guidelines* ("*Merger Guidelines*") (2010) § 4.2). Dr. Tenn concluded that a hypothetical monopolist owning the four NorthShore hospitals and two Advocate hospitals, Lutheran General and Condell, could profitably impose a SSNIP.[32] Under the case law and the *Merger Guidelines*, these six hospitals are a relevant geographic market.[33] To be conservative, Dr. Tenn also considered a market, the North Shore Area, which includes five non-party hospitals.[34] Dr. Tenn included these additional hospitals in his candidate market because, in theory, they might satisfy payers' need to have local hospitals in networks marketed

[28] Hamman (HCSC) PI Hrg. Tr. at 187:1-5.
[29] Hamman (HCSC) PI Hrg. Tr. at 168:18-23.
[30] Hamman (HCSC) PI Hrg. Tr. at 168:24-169:2, 186:23-187:5.
[31] Hamman (HCSC) PI Hrg. Tr. at 169:12-22, 186:25-187:1; *see also id.* at 280:16-19.
[32] Tenn PI Hrg. Tr. at 453:3-9, 1631:21-25.
[33] *See* McCarthy PI Hrg. Tr. at 1319:11-1320:12 (testifying that Dr. Tenn "can and should stop right there, according to the Guidelines.").
[34] Adding more hospitals to the market favors Defendants because their collective market shares are lower in the broader market and the broader market is less concentrated.

in the northern suburbs.[35] As Dr. Tenn testified, the eleven hospitals in the North Shore Area also satisfy the HMT and constitute a properly defined geographic market.[36]

C. Defendants' Geographic Market Analysis Is Deeply Flawed

i. Defendants Wrongly Focus on the Decisions of a Minority of Patients

Defendants make the flawed argument that because *some* patients travel from the North Shore Area to Northwestern Memorial or other downtown hospitals, the relevant geographic market must include those hospitals. As Dr. McCarthy wrote in his report, however, the fact that some residents receive care outside of their local area is uninformative about the preferences of the majority of patients who receive care locally.[37] The problem with focusing on the individuals who leave the market for care is so well-known that it has a name: the "silent majority fallacy."[38] It is a fallacy because the decision of some residents to receive inpatient care downtown is not relevant as to the decisions of residents who find travel to the downtown area for healthcare inconvenient. A payer that excludes local hospitals is unattractive to the majority of residents in the northern suburbs even if some of their neighbors receive GAC Services downtown. As payer testimony and Dr. Tenn's analysis shows, a hypothetical monopolist of North Shore Area hospitals would not need to own Northwestern Memorial (or other downtown hospitals) to raise prices by 5%.

Even patients who sometimes receive care downtown may not be interested in a health plan that excludes local hospitals and thereby *requires* them to travel downtown for GAC Services. Ms. Nettesheim of Aetna explained that the commuter "who lives in one place and

[35] Tenn PI Hrg. Tr. at 454:4-12.
[36] Tenn PI Hrg. Tr. at 461:15-18.
[37] DX5000 McCarthy Report ¶ 41; *see also* PX06020 Tenn Rebuttal Report ¶¶ 99-100.
[38] DX5000 McCarthy Report ¶ 41; PX06020 Tenn Rebuttal Report ¶ 100 n. 161.

works in another . . . often receives services at *both* locations."[39] Likewise, Ms. Beck of United agreed that United's members may prefer to receive care *both* near their homes and near work.[40]

Defendants' own executives corroborated payers' testimony that networks must include local hospitals to be marketable. According to Mr. Skogsbergh, payers told Advocate that an Advocate-only network would not be marketable in the northern suburbs because it lacks a presence along the lake.[41] According to Dr. Sacks, it is "not natural" for patients to travel from east to west to reach Advocate's facilities a few miles away.[42] And Mr. Skogsbergh confirmed that Advocate's Illinois Masonic Hospital, which is closer to the North Shore Area than Northwestern Memorial, is too far away to support a commercially viable product in the North Shore Area.[43] This testimony belies Defendants' argument that payers could use downtown academic medical centers as a substitute for all of the local hospitals in the North Shore Area.

ii. Dr. McCarthy Wrongly Focuses on Identifying All Competitors

Dr. McCarthy wrote in his report that under the *Merger Guidelines*, "[t]he basic objective to defining a relevant geographic market is to identify the smallest region over which a hypothetical monopolist could impose and sustain a SSNIP."[44] But he completely ignores the *Merger Guidelines* in his analysis. He never performed the HMT on the eleven-hospital North Shore Area market or on his twenty-hospital market.[45]

Instead of identifying the narrowest market in which a hypothetical monopolist could impose a SSNIP, Dr. McCarthy began (and ended) his analysis by identifying every hospital that

[39] Nettesheim (Aetna) PI Hrg. Tr. at 1169:15-22 (emphasis added).
[40] Beck (United) PI Hrg. Tr. at 1116:6-13.
[41] Skogsbergh (Advocate) PI Hrg. Tr. at 373:19-374:18.
[42] Sacks (Advocate) PI Hrg. Tr. at 1435:21-1436:7.
[43] Skogsbergh (Advocate) PI Hrg. Tr. at 377:12-377:20.
[44] DX5000 McCarthy Report ¶ 38.
[45] McCarthy PI Hrg. Tr. at 1334:13-15; Tenn PI Hrg. Tr. at 1635:11-16.

competes for patients with one of the party-owned hospitals and asserting that each of those hospitals must be included in the market. At the hearing, however, Dr. McCarthy agreed that under the *Merger Guidelines*, a properly defined relevant geographic market often excludes significant competitors of the merging parties.[46] As this Court recognized in its order denying Defendants' *Daubert* motion, the "hypothetical monopolist analysis accounts for competition from all area hospitals, not just those that are included in [a] proposed geographic market." Dkt. No. 334 at 2.

By asking the wrong question – which hospitals compete with Defendants – instead of applying the HMT, Dr. McCarthy defined an absurdly large market, consisting of twenty geographically dispersed hospitals, and testified that the relevant market could be even larger.[47] Dr. McCarthy thus suggested that a hypothetical monopolist controlling a mega-system of nineteen of the twenty hospitals he identified – but not, for example, the University of Chicago Medical Center way down on the south side of the city – would be unable to demand a 5% rate increase from payers seeking to sell insurance products to customers in the northern suburbs. All of the qualitative and quantitative evidence in the record contradicts this conclusion, which is methodologically unsound, and should be rejected.

iii. Defendants' Remaining Arguments Are Not Substantive

Defendants spent an inordinate amount of time at the hearing attacking Dr. Tenn's decision to visually represent the relevant geographic market using a straight line drawing rather than another graphic. As Dr. McCarthy admitted, under the *Merger Guidelines*, a relevant

[46] McCarthy PI Hrg. Tr. at 1320:13-17, 1321:1-4; *see, e.g., Merger Guidelines* § 4 ("[P]roperly defined antitrust markets often exclude some substitutes to which some customers might turn in the face of a price increase even if such substitutes provide alternatives for those customers.").
[47] McCarthy PI Hrg. Tr. at 1334:19-1335:11.

geographic market is properly defined by supplier (e.g., hospital) location.[48] In other words, the relevant geographic market consists of the smallest set of hospitals that a hypothetical monopolist would need to own to sustain a SSNIP. That set of hospitals could be visually represented in any number of ways, including by placing a star for each one on a map, drawing a circle around the eleven hospitals, or drawing a line connecting them.[49] The shape of the line demarking the geographic market is irrelevant to the substantive market definition question of which hospitals a hypothetical monopolist must own to sustain a SSNIP.

iv. *Penn State* Cannot Save Defendants' Flawed Arguments

Defendants may claim support for their flawed geographic market arguments in the recent decision in *FTC, et al. v. Penn State Hershey Medical Center, et al.*, No. 1:15-cv-2362, 2016 WL 2622372 (M.D. Pa. May 9, 2016) but that decision is neither controlling nor persuasive. That case is now on appeal with the Third Circuit because the district court erred in defining the relevant geographic market as one in which "few patients leave . . . and few patients enter." *Penn State*, 2016 WL 2622372, at *4 (relying on *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1267 (N.D. Ill. 1989)). This is the wrong standard as a matter of modern economics. The language quoted in *Penn State* comes from a description of the Elzinga-Hogarty test but that test is widely recognized (including by Dr. McCarthy) as an inappropriate and unreliable method of defining geographic markets in hospital mergers. Pl. Repl Br. at 8-10. Indeed, Professor Elzinga published an article over five years ago explaining that the test is inconsistent with the *Merger Guidelines*' HMT.[50] In litigation concerning the merger of NorthShore's Evanston, Glenbrook, and Highland Park hospitals, Professor Elzinga testified that

[48] McCarthy PI Hrg. Tr. at 1311:13-1313:1; *see also* Dr. Tenn PI Hrg. Tr. at 451:18-452:13.
[49] Tenn PI Hrg. Tr. at 451:5-16, 1633:5-14.
[50] Kenneth G. Elzinga and Anthony W. Swisher, *Limits of the Elzinga-Hogarty Test in Hospital Mergers: The Evanston Case*, 18 ANTITRUST BULLETIN 45 INT'L J. ECON. BUS. 133 (2011).

the test is not appropriate in hospital cases and that its application would lead to an overly broad geographic market.[51]

Instead of assessing how payers negotiate rates with hospitals and conducting the HMT, the *Penn State* court erroneously defined the market based on the area from which one of the hospitals' patients travel. The market definition inquiry prescribed by the *Merger Guidelines*, however, "focuses on the anticipated behavior of buyers and sellers." *See Saint Alphonsus Med. Ctr.*, 778 F.3d at 784. The vast majority of patients are not direct purchasers of health care. Rather, payers negotiate rates with providers and patients buy health insurance from payers. Recognizing these basic market dynamics, the approach Dr. Tenn and Dr. McCarthy adopt "explicitly models the individual decisions of patients seeking healthcare services in conjunction with the bargaining process between hospitals and insurers over the formation of provider networks."[52] As Dr. McCarthy explains in his report, this approach to geographic market definition is "widely considered to be superior to previous approaches that relied on various measures of patient flows in and out of the merging hospitals' service areas to determine the relevant geographic market."[53]

D. The Transaction Is Presumptively Unlawful

Defendants do not dispute that their merger would create an entity controlling 60% of the North Shore Area. The North Shore Area is already a highly concentrated market and the proposed merger would result in an increase in concentration that far exceeds the thresholds set forth in the *Merger Guidelines*. *See* Pl. Br. (Under Seal) at 20-21. Based on this evidence alone, the merger is presumptively unlawful and Plaintiffs have established their prima facie case.

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[51] *In the Matter of Evanston Nw. Healthcare Corp.*, FTC Dkt. No. 9315, 2007 WL 2286195, at *65 (F.T.C. Aug. 6, 2007).
[52] DX5000 McCarthy Report ¶ 39.
[53] DX5000 McCarthy Report ¶ 40.

E. The Presumption is Bolstered by Abundant Evidence of Likely Anticompetitive Effects

Plaintiffs have presented substantial evidence demonstrating that (1) Advocate and NorthShore hospitals are close competitors; and (2) the proposed merger would increase Defendants' bargaining leverage in negotiations with payers enabling it to raise prices.

i. Advocate and NorthShore are Close Competitors

Defendants' ordinary course documents show that they compete head-to-head in the North Shore Area.[54] Payers and employers testified that Advocate and NorthShore hospitals are good substitutes for each other.[55] Cigna's experience is a perfect example of how the direct competition between the parties benefits consumers. Ms. Norton testified that for Cigna's members, "Advocate Lutheran General is the preferred alternative to NorthShore Evanston Hospital and vice-versa."[56] Likewise, "[t]he primary alternative to NorthShore Highland Park Hospital would be Advocate Condell Medical Center."[57] [redacted]

Dr. Tenn's analysis confirms this evidence. Employing a widely-accepted hospital choice model, Dr. Tenn estimated diversions between the parties' hospitals.[60] He concluded that

[54] *See, e.g.*, PX04032-009, 039, 041, 043, 048, 050, 052, 057, 059, 061, 066, 068, 070 (Advocate); PX04041-011, 015 (Advocate); PX05005-005, 009-010, 027-029 (NorthShore); *see also* FoFs ¶¶ 57-62.
[55] JX00001 Abrams (Medline) Dep. Tr. at 66:9-16; JX00026 Stanton (Astellas) Dep. Tr. at 179:7-18; Norton (Cigna) PI Hrg. Tr. at 82:9-20.
[56] Norton (Cigna) PI Hrg. Tr. at 82:9-12.
[57] Norton (Cigna) PI Hrg. Tr. at 82:19-20.
[58] Norton (Cigna) PI Hrg. Tr. at 104:15-105:3.
[59] Norton (Cigna) PI Hrg. Tr. at 104:15-105:3.
[60] Tenn PI Hrg. Tr. at 468:19-22 (stating that the hospital choice model is the "standard approach used to estimate diversion ratios in this area"); McCarthy PI Hrg. Tr. at 1341:2-5 (describing that the hospital choice model is Dr. McCarthy's preferred method to calculate diversions).

there is a significant level of substitution between Advocate and NorthShore hospitals.[61] Dr. McCarthy applied the same approach in his analysis to also conclude that Advocate and NorthShore are "good substitutes for each other."[62]

ii. The Merger Would Increase Defendants' Bargaining Leverage and Lead to Higher Prices

Because payers cannot effectively market networks in the northern suburbs without one of the merging parties' hospital systems, the combined firm would have more bargaining leverage with payers than either firm has separately. Dr. Tenn employed a widely-used measure, called "willingness to pay" or "WTP," to quantify how much the merger would increase Defendants' bargaining leverage.[63] Dr. Tenn's estimated increase in WTP of 7.7% is very close to Dr. McCarthy's calculation of a 7.6% increase and Dr. Eisenstadt's calculation of a 7.2% increase.[64]

Increased provider bargaining leverage leads to higher prices. Every major payer testified that [redacted][65] Even payers that expressed some support for the merger, [redacted]

[61] Tenn PI Hrg. Tr. at 485:2-6.
[62] DX5000 McCarthy Report ¶ 95; McCarthy PI Hrg. Tr. at 1307:17-1308:4.
[63] Tenn PI Hrg. Tr. at 487:21-2.
[64] PX06000 Tenn Report Tbl. 13; McCarthy PI Hrg. Tr. at 1347:3-10; Eisenstadt PI Hrg. Tr. at 1553:13-1554:1.
[65] Norton (Cigna) PI Hrg. Tr. at 106:8-107:3; Beck (United) PI Hrg. Tr. at 1154:7-1155:23; Hamman (HCSC) PI Hrg. Tr. at 151:2-22; PX03004 Maxwell (Humana) Decl. ¶¶ 8-9, 20; PX03014 Bhargava (Aetna) Decl. ¶ 4.
[66] Beck (United) PI Hrg. Tr. at 1154:7-1155:23.
[67] Beck (United) PI Hrg. Tr. at 1154:10-13.

Consistent with the undisputed evidence about market dynamics and the unanimous agreement among the economists in this case that the merger will increase Defendants' bargaining leverage, Dr. Tenn concluded that the merger would lead to higher prices. Dr. Tenn estimated a price increase of 8%, or about $45 million a year, across all six hospitals.[68]

F. Defendants Failed to Rebut the Presumption of Harm

i. Dr. McCarthy's Regression Analysis is Divorced from Reality

Dr. McCarthy explained at the hearing that, "when two hospitals merge, there's a change in the willingness to pay because now it's more valuable to have this hospital in your network."[69] Dr. McCarthy agrees with Dr. Tenn that the merged system would be more valuable to payers than NorthShore and Advocate are as independent entities, and also agrees with Dr. Tenn's calculation of the increase in WTP. But Dr. McCarthy diverges from Dr. Tenn by using a regression analysis to reach the implausible conclusion that an increase in a provider's value to payers leads to lower prices. Dr. McCarthy has no sound explanation for these results, which he admits are unexpected and inconsistent with the bargaining leverage hypothesis.[70]

Dr. McCarthy posited in his report that his implausible results might be caused, in part, by repositioning, or maybe insurer market power, or possibly excess capacity.[71] At the hearing, he speculated that his anomalous results also could be due to some unaccounted cost efficiencies from unspecified past mergers.[72] Aside from these guesses, he had no explanation for, nor did he investigate, what factors caused the negative correlation between price and WTP in his

[68] Tenn PI Hrg. Tr. at 489:24-490:13; PX06000 Tenn Report ¶ 184.
[69] McCarthy PI Hrg. Tr. at 1255:21-25.
[70] McCarthy PI Hrg. Tr. at 1358:17-23; *see* DX5000 McCarthy Report ¶ 100.
[71] DX5000 McCarthy Report ¶¶ 106-107.
[72] McCarthy PI Hrg. Tr. at 1354:9-13.

regression.[73] Nothing in the record supports Dr. McCarthy's bizarre conclusion that eliminating competition causes prices to fall. A fairer interpretation, one that is supported by all evidence in the record, is that his regression is flawed and that, as economic theory predicts, providers can and do use bargaining leverage to obtain better terms and higher rates.

Despite the implausible results, Defendants argue that the only acceptable way to analyze a hospital merger is with Dr. McCarthy's flawed regression analysis. As Dr. Tenn explained, however, there is no single model used to analyze hospital mergers.[74] Defendants cite no authority for the proposition that a plaintiff is required to use a specific merger simulation model or to conduct a regression analysis. *See FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1086 (N.D. Ill. 2012) ("defendants have cited no authority indicating that a merger simulation is required in order to obtain a preliminary injunction").

ii. Outpatient Repositioning Cannot Defeat a Price Increase

Defendants repeatedly point to outpatient facilities Northwestern opened in the NorthShore Area to suggest that repositioning by competitors would defeat any post-merger increase in the price of GAC Services. To counteract competition lost through the merger, "repositioning" must be the "equivalent to new entry" in the GAC Services market.[75] Defendants did not (and cannot) produce any evidence showing that opening *outpatient* facilities, which do not offer inpatient services, is equivalent to opening new *hospitals.*[76]

The competitive impact of Northwestern's outpatient "repositioning" on GAC Services is negligible. Mr. Dechene testified that none of Northwestern's outpatient facilities compete with

[73] McCarthy PI Hrg. Tr. at 1354:14-1355:1.
[74] Tenn PI Hrg. Tr. at 494:1-11, 1647:10-22.
[75] *FTC v. CCC Holdings Inc.*, 605 F.Supp. 2d 26, 57 (D.D.C. 2009).
[76] *See* Hamman (HCSC) PI Hrg. Tr. at 154:22-155:8; Dechene (Northwestern) PI Hrg. Tr. at 309:15-25; Tenn PI Hrg. Tr. at 500:5-25; PX06020 Tenn Rebuttal Report ¶¶ 114-115.

GAC hospitals for inpatient care.[77] And Defendants' ordinary course documents show that inpatient market shares in NorthShore's service area have stayed relatively constant over the years, despite Northwestern's new and expanded outpatient clinics.[78] Northwestern's internal documents show a slight *decrease* from 2010 to 2014 in its inpatient market share in the area where it competes with NorthShore.[79]

Dr. McCarthy acknowledges that Northwestern's repositioning efforts had no impact on the inpatient market from 2010 to 2013.[80] Yet when Dr. McCarthy saw data showing a sudden uptick in diversions from party hospitals to Northwestern Memorial from 2013 to 2014, he assumed that the uptick was a direct result of Northwestern's repositioning efforts.[81] Dr. McCarthy was completely unaware of the real reason for this uptick: a change in the way Northwestern classified HMO patients in 2013.[82] As Dr. Tenn's analysis shows, the rate of diversion between Advocate and NorthShore hospitals has stayed relatively consistent since 2008.[83]

iii. Defendants' Proposed Remedy Would Not Cure the Competitive Harm

Plaintiffs demonstrated in their Motion to Strike (Dkt. No. 418) that Defendants' settlement offer is not a substitute for the intense competition between Advocate and NorthShore that exists today. First, despite Defendants' insistence that the goal of this merger is to grow the combined entity's risk-based contracts, the terms of the offer are limited to "any Fee-For-Service

[77] Dechene (Northwestern) PI Hrg. Tr. at 312:7-9.
[78] *See, e.g.*, PX05101-008 (NorthShore); PX04032-034, 042, 051, 060, 069 (Advocate).
[79] DX1420.0023 (showing that Northwestern Memorial and Lake Forest's share of the Near North Lake and Far North Lake inpatient markets dropped from 9.7% to 9.5% between 2010 and 2014). Northwestern Memorial's share of the market never even reached 5%. *Id.;* Dechene (Northwestern) PI Hrg. Tr. at 314:24-315:20.
[80] McCarthy PI Hrg. Tr. at 1275:5-9.
[81] McCarthy PI Hrg. Tr. at 1275:5-22.
[82] McCarthy PI Hrg. Tr. at 1276:11-1277:21.
[83] PX06000 Tenn Report Tbl. 14.

Contract."[84] Second, the proposed price cap does nothing to encourage Defendants to pass savings onto payers if their costs actually fall. Third, the price cap is only temporary and does nothing to remedy the lost competition when the terms expire. Finally, Defendants' proposal has serious administrability concerns as it would require this Court to remain available for the next seven years to continually monitor their attempts to negotiate prices with payers.[85] This type of court oversight and enforcement is precisely the role the Supreme Court has encouraged courts to avoid. *Pac. Bell Tel. Co. v. Linkline Commcs'ns., Inc.*, 555 U.S. 438, 452 (2009) ("Courts are ill suited to act as central planners, identifying the proper price, quantity, and other terms of dealing.").

II. DEFENDANTS FAILED TO PRESENT SUFFICIENT EVIDENCE TO SUPPORT THEIR DEFENSES

As Plaintiffs have explained, no court has ever relied on alleged consumer benefits or cost savings to approve an otherwise anticompetitive transaction. Pl. Br. (Under Seal) at 33. In this case, Defendants do not come close to establishing the extraordinary efficiencies necessary to overcome the presumption of harm. Rather than make a serious attempt to meet the applicable legal standard, Defendants argued at the hearing that Plaintiffs were improperly "trying to get you to think" that the purported benefits of the HPN are an "efficiencies case" when really they are something "different."[86] Defendants ignore that they themselves characterized the purported benefits of the HPN as "efficiencies" in their Answers to Plaintiffs' Complaint.[87] Regardless of the label, any alleged benefits are appropriately considered as part of Defendants' rebuttal case and must be merger-specific and verifiable to weigh against the competitive harms of the merger.

[84] *See* Defendants' Opposition to Plaintiffs' Motion for a Preliminary Injunction (Under Seal) at 31, 37-38; Dkt. # 320-1 ([Proposed] Final Judgement), at 5.
[85] *See* Dkt. # 320-1 ([Proposed] Final Judgement), at 8.
[86] Defendants' Opening PI Hrg. Tr. at 55:3-15.
[87] *See* Dkt. No. 37 ¶ 63; Dkt. No. 38 ¶ 63.

OSF Healthcare Sys., 852 F. Supp. 2d at 1093 (rejecting arguments based on alleged consumer benefits that were "unsubstantiated, speculative, and not merger-specific."); *see also id.* at 1088 n.16 ("[D]efendants' arguments on efficiency and improved quality appear in their post-hearing brief to be part of their [equities] argument" but "the court finds it more appropriate to consider these arguments as part of defendants' rebuttal case on likelihood of success."). This Court cannot credit any purported consumer benefit of the HPN if it "is unable to declare that these goals would be realized with, and only with, the proposed merger . . . ." *Id.* at 1094.

A. The Merger Is Not Necessary for Any Alleged Consumer Benefit

At the opening of the hearing, Defendants made four assertions about why the merger is necessary to achieve the supposed benefits of the HPN. They argued that the parties: (1) "Must have geographic coverage to serve large employers;" (2) "Must gave [sic] common governance;"(3) "Must control 'leakage' to lower total cost of care;" and, (4) "Must integrate NorthShore into Advocate to extend capabilities in clinical integration, population health and full risk contracts."[88] Defendants failed to present sufficient evidence to support these claims. Instead, the evidence conclusively establishes that any consumer benefits associated with the HPN could be achieved *without* reducing competition.

i. Defendants Failed to Establish That They "Must Have Geographic Coverage to Serve Large Employers"

As Defendants have repeatedly told the Court, the HPN already exists. In its current form, the HPN offers every benefit that Defendants claim will be achieved by the merger:

[redacted]

[88] DDX12,001.0021.

[redacted][89] BCD-A is available on and off the public exchange and [redacted].[90] Whether or not the merger goes forward, the HPN will be available to consumers.

At the beginning of the hearing, Advocate told the court that it has "hit a wall" and cannot expand the membership of the HPN without the merger.[91] For that key point, Defendants rely on the testimony of Mr. Skogsbergh and Dr. Sacks, who claim that some payers told them that an Advocate-only product could not be sold to employers because Advocate has a coverage gap east of I-94.[92] That testimony is not credible.

First, BCBSIL disagrees that a merger is necessary to market the HPN to the employer group market. From the beginning of the negotiations about BCD-A, both BCBSIL and Advocate contemplated that it would be offered to large groups.[93] [redacted] Advocate's internal business documents confirm

[89] Hamman (HCSC) PI Hrg. Tr. at 175:20-25, 176:20-177:20; JX00002 Allegretti (HCSC) Dep. Tr. at 21:1-14; 69:11-20.
[90] Hamman (HCSC) PI Hrg. Tr. at 183:12-15; Sacks (Advocate) PI Hrg. Tr. at 1429:1-22, 1452:5-7.
[91] Defendants' Opening PI Hrg. Tr. at 53:20-54:2.
[92] Skogsbergh (Advocate) PI Hrg. Tr. at 373:19-374:6; Sacks (Advocate) PI Hrg. Tr. at 1434:22-1435:2. To bolster this hearsay testimony, Dr. Sacks referenced a letter (also hearsay) from Mr. Levin at Aon stating that an Advocate-only network does not meet its criteria for geographic coverage but that an Advocate-NorthShore product would meet that criteria. Sacks (Advocate) PI Hrg. Tr. at 1417:17-1418:4; DX1704. Mr. Levin did not testify at the hearing but admitted in his deposition that Dr. Sacks solicited the letter, told him which topics to address, and may have edited the content. JX00017 Levin (Aon) Dep. Tr. at 100:5-20, 101:15-19. Mr. Levin did not do any analysis and did not speak to any employers about their interest in an Advocate-only network. JX00017 Levin (Aon) Dep. Tr. at 112:3-6, 117:18-23.
[93] PX04015-005 (Advocate).
[94] Hamman (HCSC) PI Hrg. Tr. at 183:16-22.
[95] Hamman (HCSC) PI Hrg. Tr. at 183:18-22.

that Advocate and BCBSIL contemplated offering BCD-A on the large group market in 2017.[96] Advocate withdrew from its negotiations with BCBSIL after it learned that BCBSIL was not supporting the merger.[97] [redacted]

Of course consumers would be more interested in an HPN that included NorthShore (at the same price) than one that did not. Because consumers prefer broader networks, the addition of *any* healthcare system would make the HPN more attractive.[103] That does not mean, however, that a merger between Advocate and any competitor(s) would be good for consumers. The evidence here demonstrates that United and BCBS can successfully market Advocate-only HPNs. If Advocate wants more consumers to join those plans, it should compete to attract them rather than eliminate competition.

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[96] PX04200-013 (Advocate).
[97] Sacks (Advocate) PI Hrg. Tr. at 1455:12-21; Hamman (HCSC) PI Hrg. Tr. at 183:16-23.
[98] Hamman (HCSC) PI Hrg. Tr. at 183:24-184:1
[99] Beck (United) PI Hrg. Tr. at 1149:21-23.
[100] Beck (United) PI Hrg. Tr. at 1147:1-7, 1149:12-23.
[101] Beck (United) PI Hrg. Tr. at 1148:9-1149:5.
[102] Beck (United) PI Hrg. Tr. at 1150:3-9.
[103] *See* Hamman (HCSC) PI Hrg. Tr. at 250:11-13.

ii. Defendants Failed to Establish That There Is No Practical Alternative to the Merger to Fill Any Gap in Advocate's Coverage Area

Advocate's ordinary course documents establish that its hospitals already draw patients from the supposed gap area. Both Dr. Sacks and Mr. Skogsbergh admitted as much during the hearing.[104] Yet Dr. Sacks claims that payers told him that an Advocate-only network will not sell to large groups because Advocate lacks outpatient facilities and physician offices east of I-94, (even though such facilities are not necessary for Advocate's hospitals to attract patients from the purported "gap" area).[105] If this were the case, Defendants presumably would have been able to offer empirical analysis or expert opinion demonstrating that, contrary to the testimony of BCBSIL and United, a network must include physician offices east of I-94 to be marketable to large groups. They did not.

Defendants also did not demonstrate that that the merger is necessary for Advocate to acquire outpatient facilities or physician offices in the "gap" area. Both Mr. Neaman and Dr. Golbus testified that Northwestern has successfully opened outpatient facilities and physician offices near NorthShore's hospitals.[106] According to Mr. Neaman, Northwestern has opened 12 to 15 physicians' offices and outpatient clinics in close proximity to NorthShore hospitals in the last few years alone.[107] Dr. McCarthy's report identifies numerous other examples of providers that have successfully opened outpatient facilities in the area.[108]

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[104] Sacks (Advocate) PI Hrg. Tr. at 1445:3-1449:7; Skogsbergh (Advocate) PI Hrg. Tr. at 386:6-388:4; *see also* PX4032-1, 3, 8-9 (Advocate); McCarthy PI Hrg. Tr. at 1298:5-8, 1299:11-14.
[105] Sacks (Advocate) PI Hrg. Tr. at 1483:8-17; *see also* Sacks (Advocate) PI Hrg. Tr. at 1445:3-1449:7; Skogsbergh (Advocate) PI Hrg. Tr. at 386:6-388:4.
[106] Neaman (NorthShore) PI Hrg. Tr. at 668:11-15, 688:23-689:8; Golbus (NorthShore) PI Hrg. Tr. at 771:6-13.
[107] Neaman (NorthShore) PI Hrg. Tr. at 688:23-689:8.
[108] DX5000 McCarthy Report at ¶¶ 58, 81, 82, and Appendix A at 64.

Defendants presented no evidence that some entry barrier prevents Advocate, but not its competitors, from opening outpatient facilities or physician offices in the supposed "gap" area. Dr. Sacks claimed that Advocate tried to open an outpatient imaging facility "some years ago," but the facility failed due to lack of physician referrals,[109] and Mr. Skogsbergh claimed that "Advocate had attempted to put some physician offices and some clinics in that area but have not been very successful," without any further explanation.[110] But, in its representations to the FTC, Advocate stated that the imaging facility, which closed in 2009, "was the *one and only* instance in which Advocate attempted to expand into NorthShore's core service area."[111] Defendants' testimony about an imaging facility that closed seven years ago is insufficient to establish that Advocate is unable to open any outpatient facilities or physician offices in the supposed "gap" area through any practical means other than the merger. *St. Alphonsus Med. Ctr.*, 778 F.3d at 791 n.15 ("[A]fter a plaintiff has made a prima facie case that a merger is anticompetitive, the burden of showing that the claimed efficiencies cannot be attained by practical alternatives . . . is properly part of the defense.") (internal quotations and citations omitted).

iii. Defendants Failed To Establish That They "Must Have Common Governance" or That They "Must Control Leakage"

A merger is not necessary for an insurer to offer an HPN that includes both NorthShore and Advocate. NorthShore and Advocate can participate in narrow network insurance products without merging and already do so today.[112] [redacted]

[redacted]

[109] Sacks (Advocate) PI Hrg. Tr. at 1435:8-14. Defendants have previously represented to the FTC that Advocate closed that facility in 2009. PX04156-021-022 (Advocate).
[110] Skogsbergh (Advocate) PI Hrg. Tr. at 417:22-24.
[111] PX04156-019 (Advocate) (emphasis added).
[112] *See* Golbus (NorthShore) PI Hrg. Tr. at 828:2-5; Jha PI Hrg. Tr. at 914:7-13; Hamman (HCSC) PI Hrg. Tr. at 174:23-175:11, 253:8-10; PX03014 (Aetna) Dec. ¶ 10; PX6001 Jha Report ¶ 58.

[redacted][113] Thus, both Aetna and [redacted] agree that NorthShore could participate in an HPN with Advocate as an independent entity.[114]

Defendants claim that they need to merge to prevent members of the HPN from using other providers, which they call "leakage."[115] Leakage, however, is effectively controlled through plan benefit design.[116] In the BCBSIL HMO, for example, Advocate's leakage is less than 10%.[117] [redacted][118] Pl. Repl. Br. (Under Seal) at 22. Alternatively, as Dr. Jha testified, if the parties are concerned about losing patients to each other or to other healthcare systems, they could improve their services to retain those patients.[119]

iv. Defendants Failed to Establish That They Must Merge to Extend Advocate's Capabilities to NorthShore

NorthShore does not need to merge with Advocate to further develop its population health management ("PHM") capabilities or continue to expand into risk-based contracting ("RBC"). As Mr. Neaman testified at the hearing, NorthShore will continue to seek opportunities to engage in RBC regardless of whether the merger occurs.[120] The market is demanding more PHM and RBC and providers across the region are finding ways to meet that demand.[121] For example, as Ms. Beck testified, United's Optum provides physicians and

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[113] *See* Hamman (HCSC) PI Hrg. Tr. at 174:23-175:19, 177:11-14; PX04200-012 (Advocate).
[114] Nettesheim (Aetna) PI Hrg. Tr. at 1201:18-25, 1202:9-18 [redacted]
[115] Defendants' Opening PI Hrg. Tr. at 52:11-21; Sacks (Advocate) PI Hrg. at 1395:8-23, 1433:11-14
[116] Hamman (HCSC) PI Hrg. Tr. at 166:8-167:7; Jha PI Hrg. Tr. at 992:17-25.
[117] Hamman (HCSC) PI Hrg. Tr. at 166:12-17; *see also* PX04200.
[118] PX07028-003 (Humana); PX07029-005 (Humana).
[119] Jha PI Hrg. Tr. at 992:8-993:10.
[120] Neaman (NorthShore) PI Hrg. Tr. at 625:23-626:1.
[121] Neaman (NorthShore) PI Hrg. Tr. at 626:2-9; DX5000 McCarthy Report Appendix A at 81 [redacted] at 90-91 [redacted]

hospitals with solutions to manage risk and improve quality.[122] Dr. Jha explained that there are a number of organizations that help hospitals improve PHM and expand RBC, including Dr. Steele's xG Health Solutions.[123]

Defendants do not deny that NorthShore can (and will) expand its PHM and RBC capabilities without the merger.[124] Despite Dr. Golbus's claim that "Advocate could be the catalyst" that allows NorthShore to achieve its "objectives over a much shorter period of time" and "with a much less expenditure of resources,"[125] Defendants failed to ask any of their five experts to measure the time or expense necessary for NorthShore to achieve its PHM and RBC objectives independently. Defendants provide no verifiable evidence that the merger would bring results to NorthShore faster or cheaper than a third-party vendor could.[126] As Dr. Jha explained, xG Health Solutions has helped providers achieve results with PHM and RBC within one year.[127] In contrast, it could take two or three years just to get Advocate and NorthShore on the same electronic medical records system.[128]

Because the sharing of best practices like PHM can be accomplished without diminishing competition, it is not a merger-specific consumer benefit. *Rockford Mem'l*, 717 F.Supp. at 1291 ("[T]he standardization of clinical practices does not require a merger."); *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1073 ("[T]he court cannot say that the projected savings from the

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[redacted]).
Beck (United) PI Hrg. Tr. at 1127:17-1128:1.
[123] Jha PI Hrg. Tr. at 903:1-904:7; *see also* JX00027 Steele Dep. Tr. at 106:14-107:1, 109:22-113:4.
[124] Golbus (NorthShore) PI Hrg. Tr. at 812:22-814:1; Neaman (NorthShore) PI Hrg. Tr. at 626:2-9; *see also* Beck (United) PI Hrg. Tr. at 1126:3-6; Jha PI Hrg. Tr. at 895:2-899:8.
[125] Golbus (NorthShore) PI Hrg. Tr. at 805:11-15.
[126] *See, e.g.,* Dudley PI Hrg. Tr at 1609:18-21.
[127] Jha PI Hrg. Tr. at 903:18-24; JX00027 Steele Dep. Tr. at 133:24-134:8, 143:15-25.
[128] Golbus (NorthShore) PI Hrg. Tr. at 742:10-743:20, 745:1-22.

implementation of best practices are certain to occur or that they can only be achieved through the proposed merger"); *see also Saint Alphonsus Med. Ctr. - Nampa, Inc. v. St. Luke's Health Sys., Ltd.*, No. 1:12-CV-00560-BLW, 2014 WL 407446, at *17 (D. Idaho Jan. 24, 2014) (rejecting argument that a merger was essential for the parties to transition from a fee-for-service model of care to an integrated, risk-based health care delivery system).

Moreover, while the Patient Protection and Affordable Care Act ("ACA") encourages providers to communicate and work together, there is no provision of the ACA that requires hospitals to merge or that discourages competition between providers.[129] The ACA specifically states that nothing in the Act "shall be construed to modify, impair or supersede the operation of any of the antitrust laws."[130] In fact, the Final Rule of the ACA recognizes that, "competition in the marketplace benefits Medicare and the Shared Savings Program because it promotes quality of care for Medicare beneficiaries and protects beneficiary access to care . . . . Competition among ACOs can accelerate advancements in quality and efficiency."[131]

B. Defendants' Claimed Efficiencies Are Vague and Unsubstantiated

At the opening of the hearing, Defendants identified the three purported benefits that they claim would outweigh the competitive harm of their merger: (1) "At least $200-500 Million in Price Savings Per Year Directly to Consumers in Chicagoland;" (2) "Higher Quality Health Care and Better Consumer Satisfaction;" and (3) "Net Efficiencies of over $200 Million per year."[132] Defendants failed to present any empirical or verifiable evidence supporting these speculative claims.

[129] Jha PI Hrg. Tr. at 862:23-863:8; PX06001 Jha Report ¶ 20.
[130] 42 U.S.C. §18118(a).
[131] PX06001 Jha Report ¶ 20; *see* Jha PI Hrg. Tr. at 862:25-863:8.
[132] DDX12,001.0047.

i. Defendants' Claimed Price Savings Are Speculative and Unverifiable

The entire basis for the alleged price benefits "to consumers in Chicagoland" is that the merger will result in increased sales of the HPN. Yet while Defendants submitted five expert reports in this case, they failed to ask *any* of these experts to project membership in an Advocate-NorthShore HPN and no membership projections were made in the ordinary course of business by Advocate, [redacted] or [redacted].[133] The only projections supporting the purported "$200 to $500 Million" in price savings is Dr. Sacks' testimony about his "back of the envelope" estimates.[134] These estimates cannot be verified, however, because no document containing this guesswork is included among those listed on Defendants' exhibit list, despite Dr. Sacks having testified that such a document was shared with his counsel.[135]

a. Defendants' Price Assumptions Are Unrealistic and Unsubstantiated

Dr. Sacks assumes that every person who purchases the Advocate-NorthShore HPN on the large group insurance market would save 10% or $1000 per year,[136] but these figures are wholly speculative. None of Advocate's contracts contains a pricing term for an HPN sold to large groups. Advocate's contract with BCBSIL [redacted] and Advocate has not signed agreements with either United or Aetna to offer an HPN at a particular price.[137] Advocate has "pledged" to offer its services at a price that would allow payers to offer the HPN at a 10% discount to the cheapest HMO product but, at this point, the price to consumers is still undecided. Dr. Eisenstadt admitted that claims related to price are not cognizable "because it's

[133] *See* Sacks (Advocate) PI Hrg. Tr. at 1456:16-19; 1461:5-13; [redacted] Ms. Nettesheim testified that she is not familiar with any projections made by Aetna Nettesheim (Aetna) PI Hrg. Tr. at 1203:1-7.
[134] Sacks (Advocate) PI Hrg. Tr. at 1461:9-13.
[135] Sacks (Advocate) PI Hrg. Tr. at 1458:15-17.
[136] Sacks (Advocate) PI Hrg. Tr. at 1426:24-1427:2, 1428:6-10.
[137] Sacks (Advocate) PI Hrg. Tr. at 1453:10-18; 1452:22-24; *see also* Hamman (HCSC) PI Hrg. Tr. 183:16-23.

up to the parties to carry through on their pledge . . . . [I]t's up to them to demonstrate or follow through on the pledge."[138]

Even if a price had been definitively established, Dr. Eisenstadt admits that the price difference between a consumer's previous insurance plan and the HPN is not "savings" because the products are not the same.[139] The HPN is inherently less valuable to consumers because it has fewer providers, and a comparison of health plan prices does not take into consideration non-price qualities such as having more than one in-network hospital.[140] Dr. Eisenstadt attempts to account for this by making arbitrary (and incorrect) assumptions about the loss in value experienced by customers switching to an Advocate-NorthShore HPN, but he admits that his principal benchmark, the Aetna Whole Health network, "would not be a meaningful measurement of the value" to customers.[141] As Dr. Tenn explained, Dr. Eisenstadt's measurements are unreliable and overstate the savings to consumers.[142]

b. Defendants' Membership Projections Are Speculative and Unsubstantiated

The total savings are the product of the quality-adjusted savings, if any, per member and the number of projected members. In an attempt to come up with an estimate of the latter, Dr. Sacks made a series of complex assumptions about the size of the market, the merged system's likely share of that market, and the number of members who would switch from their existing health plans to the HPN.[143] Dr. Sacks provided no evidence supporting any of his assumptions.

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[138] Eisenstadt PI Hrg. Tr. at 1540:13-20.
[139] Eisenstadt PI Hrg. Tr. at 1543:25-1544:17.
[140] Hamman (HCSC) PI Hrg. Tr. at 147:14-148:11, 215:20-216:3; Norton (Cigna) PI Hrg. Tr. at 97:1-5; Nettesheim (Aetna) PI Hrg. Tr. 1204:19-1205:1; JX00002 Allegretti (HCSC) Dep. Tr. at 40:2-8, 75:8-76:24, 77:19-78:4; JX00019 Maxwell (Humana) Dep. Tr. at 88:3-19.
[141] Eisenstadt PI Hrg. Tr. at 1548:16-1549:11, 1548:1-15; *see also* FoF ¶¶ 109-112.
[142] PX06020 Tenn Rebuttal Report ¶¶ 120-127.
[143] *See, e.g.*, Sacks (Advocate) PI Hrg. Tr. at 1460:24-25 ("My assumption is that our market share in the large group market is the same as our overall market share, 22 to 23 percent post-merger"); 1427:24-

Dr. Sacks also incorrectly assumes that Dr. Van Liere's survey results are reliable and predict how many employees would switch to an HPN.[144] They do not. As Dr. Van Liere testified, his survey did not measure how many employers or consumers intended to or would switch to the hypothetical Advocate/NorthShore HPN.[145] The survey "didn't specifically measure purchase intentions."[146] Dr. Sacks also mistakenly equates the percentage of *employers* who are interested in offering the product with the percentage of *individuals* who would purchase the product.[147] Even if one were to rely on Dr. Van Liere's survey as an indicator of employer interest in a hypothetical HPN product, it would be impossible to extrapolate actual enrollment from the survey's results.

c. Defendants Improperly Credit All HPN Membership to the Merger

Dr. Sacks's guesstimate of future enrollment in an Advocate/NorthShore HPN also fails to account for enrollment in the Advocate-only HPN product. According to Dr. Sacks's various unfounded assumptions, the Advocate/NorthShore HPN could attract over a million lives or, it

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1428:4 (assuming provider market share is equivalent to share of covered lives in an insurance market); 1428:4-6 ("If we got 21 percent penetration with a high-performing network product"); 1430:9-11 ("If we're able to save 10 percent either because some of these people moved to the product that's priced 10 percent lower or because of the pricing pressure").

[144] *See* PX06023 Ford Rebuttal Report ¶ 77 (finding that Dr. Van Liere's survey is fatally flawed, and consequently provides no reliable evidence regarding likely interest of employers or employees in the possible Advocate-NorthShore HPN offered by BCBSIL because the survey "[d]id not include a control condition or control group," "[o]mitted material information from the Advocate-NorthShore product description," "[f]ailed to check whether the 'jargon' used to describe the hypothetical Advocate-North[S]hore product was understood by respondents," "[f]ailed to properly screen and identify respondents who were knowledgeable regarding their organizations' current health plans or future decisions," "[i]ncluded leading and biased questions and induced order bias from the failure to rotate key questions and response alternatives," and "[f]ailed to provide any quantitative estimates of the percentages of respondents' businesses or organizations that likely would enroll in the proposed Advocate-NorthShore product, or of the confidence intervals or error rates around such estimates.").

[145] Van Liere PI Hrg Tr. at 1073:14-18, 1083:6-8 ("I'm not offering any opinion that says a specific percent of people would take this product, would buy this product").

[146] Van Liere PI Hrg Tr. at 1100:5.

[147] Sacks (Advocate) PI Hrg. Tr. at 1430:20-21.

could attract as few as 210,000 lives.[148] But Dr. Sacks includes in his estimate consumers who would enroll in an Advocate-only HPN [redacted][149]

Dr. Van Liere's survey similarly inflates interest in an Advocate/NorthShore HPN by failing to gauge interest in an Advocate-only product. Dr. Van Liere admitted that the survey he designed and administered did not even allow one to measure how much individual elements of the hypothetical health plan contributed to the survey respondents' interest, such as whether it is Advocate's participation, NorthShore's participation, or even BCBSIL's participation that contributes to a respondent's stated level of interest.[150]

ii. There Is No Verifiable Evidence That the Merger Will Improve Quality

NorthShore is a well-respected and award-winning healthcare system that offers an exceptionally high quality of care.[151] Defendants are unable to substantiate their claim that combining with Advocate will increase NorthShore's quality of care.

First, as Dr. Jha explained, NorthShore already does as well as or better than Advocate on a wide array of quality measures.[152] For example, NorthShore outperforms Advocate on five out of six readmission measures, three out of five measures of hospital-acquired infections, and a variety of process measures.[153] As to mortality, "Advocate is actually worse than NorthShore on

[148] Sacks (Advocate) PI Hrg. Tr. at 1428:4-6, 1431:4-5.
[149] Eisenstadt PI Hrg. Tr. at 1530:12-19.
[150] Van Liere PI Hrg Tr. at 1070:1-1071:10.
[151] *See, e.g.*, Beck (United) PI Hrg. Tr. at 1125:25-1126:2; Jha PI Hrg. Tr. at 1712:23-1714:8; *see also* Norton (Cigna) PI Hrg. Tr. at 81:22-83:1 (Condell and Lutheran General provide similar levels of quality as NorthShore Highland Park and Evanston).
[152] Jha PI Hrg. Tr. at 856:19-22; 878:2-880:6.
[153] Jha PI Hrg. Tr. at 878:25-880:6; PX06001 Jha Report ¶¶ 144-145, 147, Tables 7b, 7c, 7e, 8 .

every single" measure.[154] There is no empirical evidence that Advocate's model leads to better outcomes for patients who use its healthcare system or better outreach to those who do not.[155]

Second, Defendants have no specific or verifiable integration plan. As Dr. Jha explained, there is significant variation in quality among Advocate's hospitals and applying Advocate's model "doesn't all of a sudden lead to more efficiency, [or] better health outcomes."[156] Even if Advocate's model leads to higher quality care (and there is no evidence that it does), to realize any benefits from the merger, Advocate and NorthShore would have to become clinically integrated.[157] Integrating these two large health systems would be a "very, very hard" process that would take at least two to three years.[158] This is all the more problematic in light of Dr. Golbus's testimony that he has not formed a "detailed plan" regarding the integration, even though he is the one who would be responsible for integrating the physician groups.[159]

iii. There Is No Verifiable Evidence that the Merger Will Lower Costs

Defendants' only evidence of the purported cost reductions that would result from the merger is a declaration from the CFO of NorthShore, Mr. Weiss. As Plaintiffs explained in their Reply, the declaration contains no citations to supporting documentation, no information as to how the savings were calculated, and no reliable basis for the methodology used to calculate the alleged cost savings.[160] Pl. Repl. Br. (Under Seal) at 19-20. The overwhelming majority of claimed savings derive from a category Mr. Weiss calls "All other (tbd)," the specifics of which are "not identified at this point" but could come from "other opportunities" that will only be

[154] Jha PI Hrg. Tr. at 878:2-10; *see also* PX06001 Jha Report ¶¶ 143, 150, Tables 7a, 8.
[155] Jha PI Hrg. Tr. at 1707:1-1709:13; PX06001 Jha Report ¶ 151.
[156] Jha PI Hrg. Tr. at 911:17-25.
[157] Jha PI Hrg. Tr. at 912:3-6.
[158] Jha PI Hrg. Tr. at 912:7-22.
[159] Golbus (NorthShore) PI Hrg. Tr. at 747:11-748:14.
[160] PX06022 Dagen Rebuttal Report ¶ 12.

identified post-closing.[161] Plaintiffs' expert, H. Gabriel Dagen, thus concluded that Defendants' claimed efficiencies are speculative and not verifiable.[162] Despite stating at the beginning of the hearing that "you'll hear testimony about" the $200 million in projected cost-savings, Defendants did not call Mr. Weiss or ask any witness about Mr. Weiss's projections.[163]

III. THE EQUITIES FAVOR PLAINTIFFS

Where, as here, a likelihood of success is demonstrated, the equities weigh in favor of granting a preliminary injunction in order to allow consumers to continue to enjoy the benefits of competition between the parties pending a decision on the merits. The overwhelming public interests favoring a preliminary injunction include, "(i) the public interest in effectively enforcing antitrust laws and (ii) the public interest in ensuring that the FTC has the ability to order effective relief if it succeeds at the merits trial." *FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 86 (D.D.C. 2015); *see also FTC v. H.J. Heinz Co.*, 246 F.3d 708, 726 (D.C. Cir. 2001); *FTC v. Swedish Match*, 131 F. Supp. 2d 151, 173 (D.D.C. 2000). While it would be virtually impossible to "unscramble the eggs" post-merger, a delay would not affect the ability of the merged entity to offer an HPN if they prevailed on the merits. Because any benefits of the HPN would be available after a trial on the merits, those benefits do not weigh against a preliminary injunction. *ProMedica*, 2011 WL 1219281, at *60 ("[I]f the benefits of a merger are available after the trial on the merits, they do not constitute public equities weighing against a preliminary injunction."); *OSF Healthcare*, 852 F. Supp. 2d at 1095 (finding that the equities weigh in favor of an injunction where, "despite their obvious desire to proceed with the merger immediately,

[161] PX02022 Weiss (NorthShore) Dep. Tr. at 69:4-10, 72:2-8; PX06022 Dagen Rebuttal Report ¶ 16.
[162] PX06022 Dagen Rebuttal Report ¶ 5.
[163] Defendants' Opening PI Hrg. Tr. at 58:13-16.

defendants admit that the efficiencies they hope to gain can be achieved whenever the merger is allowed to proceed, even if that does not occur until after the FTC makes its final ruling.").

Dated: May 18, 2016

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 18th day of May, 2016, I filed and served the foregoing on all counsel of record via electronic mail.

/s/ Christopher Caputo

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