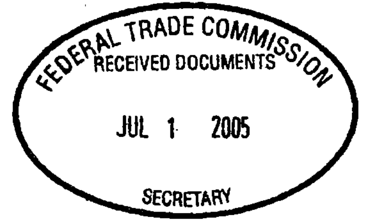

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

In the matter of Evanston Northwestern Healthcare Corporation,	Docket No. 9315 **Public Record**

POST-TRIAL REPLY BRIEF OF RESPONDENT EVANSTON NORTHWESTERN HEALTHCARE CORPORATION

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INTRODUCTION

In its opening brief, Respondent sets forth eight failures of proof warranting entry of judgment for Respondent and dismissal of the Complaint (RPTB[1] at 3-4). Complaint Counsel cites no evidence to overcome those failures, and Respondent stands on the post-trial brief in that regard. Faced with these and other holes in its substantive case, Complaint Counsel repeatedly and improperly endeavors to shift its ultimate burden of persuasion to Respondent. Indeed, Complaint Counsel's brief is structured such that certain issues on which it realizes it cannot meet its burden of persuasion – such as learning about demand and quality – have been improperly characterized as "defenses." In fact, these issues are properly part of Complaint Counsel's burden to establish that the Merger is likely to cause anticompetitive effects. Mindful of the Court's post-trial order regarding briefing, however, we address these points in the confusing order in which they appear in Complaint Counsel's brief.

Complaint Counsel's evidence falls well short of what is needed to establish liability and unwind a fully integrated merger between an academic hospital and a community hospital that is generating extraordinary improvements in the quality of care offered to patients. Relying on incomplete economic analyses, invalid quality assessments, inconsistent lay opinions from self-interested managed care organization (MCO) witnesses, and unreliable testimony from former employees now working for competitors, Complaint Counsel is unable to establish a prima facie merger challenge based on a traditional market structure analysis. *See FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1299 (W.D. Mich. 1996). In addition, the evidence does not support a claim under Complaint Counsel's so called "direct evidence" of anticompetitive effects theory –

[1] Throughout the brief "RPTB" refers to Respondent's Post Trial Brief; "CCFF" refers to Complaint Counsel's Proposed Findings of Fact,"CCPTB" refers to Complaint Counsel's Post Trial Brief, "RFF" refers to Respondent's Proposed Findings of Fact; and "RFF-Reply" refers to Respondent's Reply Findings of Fact..

assuming the validity of such a claim contrary to existing law. Even if Complaint Counsel's hodgepodge of evidence states a claim in the first instance, Complaint Counsel has not come forward with evidence to demonstrate that any alleged anticompetitive effects from the Merger outweigh the pro-competitive quality improvements, as required under *United States v. Baker Hughes*, 908 F.2d 981, 982-83 (D.C. Cir. 1990).

As discussed more fully below, the parties' post-trial submissions reveal *undisputed* facts that weigh heavily in favor of dismissal. These facts include the following:

- Complaint Counsel conducted no independent examination of whether the *levels* of ENH's prices rose above competitive levels after the Merger even though it explicitly argued that the "ultimate question" in this case is whether the Merger gave ENH the ability to profitably maintain prices "above competitive levels for a significant period of time." (CCPTB at 1).

- Complaint Counsel offers no expert opinion regarding the way to evaluate learning about demand. Although Complaint Counsel launches a baseless attack on Professor Baker, not one of the five expert economists Complaint Counsel named on its final witness list offered any expert opinion disagreeing with Prof. Baker's approach.

- Complaint Counsel's expert economist failed to account for a number of other plausible alternative explanations for the post-Merger price increases. (RFF ¶¶ 1053-1064).

- Complaint Counsel offered no comprehensive assessment of changes in quality at HPH and ENH as a result of the Merger. Even so, its expert admitted that certain structure or process changes at HPH likely resulted in quality improvements. (RFF ¶ 1164).

- Complaint Counsel did not call any employer to testify, even though Complaint Counsel maintains – without any evidence to suggest it occurred in this case – that employers and employees bear the ultimate cost of ENH's higher post-Merger prices. (CPTB at 21 CCFF ¶¶ 1338-1343).

SUMMARY OF ARGUMENT

A. Complaint Counsel Has Not Established Direct Evidence of Anticompetitive Effects

Neither the economic analyses, contemporaneous documents, nor trial testimony established direct evidence of anticompetitive effects arising from the ENH/HPH Merger. Contrary to Complaint Counsel's assertions, it failed to prove any of the following points that it concedes it must prove to establish its theory of the case.

1. *Selective Contracting*. There is no credible evidence in this case of wide spread selective contracting in Chicago during the time period that Complaint Counsel alleges prices increased. Indeed, the evidence at trial showed that MCO's sought to contract with all hospitals during the relative period.

2. *Pre-Merger Competition to be in Payor Networks*. Payor after payor admitted that they did not – in fact – play Evanston Hospital and HPH off of one another by threatening to exclude one of them from their networks in an effort to secure better prices pre-Merger. (RFF ¶¶ 974-983). Similarly, there are no payor documents in the case reflecting such pre-Merger competition, and no trial exhibits indicating that payors obtained lower prices from either hospitals as a result of such competition. In fact, substantial evidence confirms that Evanston Hospital and HPH were not close substitutes for each other.

3. *Evanston Hospital/HPH Alternative Hospitals*. Complaint Counsel has not proven that MCOs lack alternatives to Evanston and Highland Park Hospitals. It is uncontroverted that there are at least 18 hospitals closer to Evanston Hospital or HPH than they are to each other. (RPTB at 20-21; RFF ¶¶ 387-390; RFF-Reply ¶ 47, 286, 1697). Nevertheless, Complaint Counsel argues that payors had no alternatives to a merged ENH. (CCPTB at 4-5). The evidence has established, however, that there were numerous alternatives to Evanston Hospital and HPH

prior to the Merger, which continue to exist today. (*See* RFF ¶¶ 387-453). These alternatives could easily substitute in an MCO network, thus belying Complaint Counsel's claims that inclusion of either Evanston Hospital or HPH is critical to the success of a health plan. (RFF ¶¶ 454-460).

4. *Output Has Not Declined.* As referenced above, Complaint Counsel baldly asserts that output necessarily declined as a result of the Merger. (CCPTB at 20). In fact, there is no evidence of any output decline and Complaint Counsel itself even has a proposed finding to the contrary. (CCFF ¶ 1653). Moreover, the evidence at trial established that output at ENH actually increased. (RPTB at 36-38). The absence of a decline in output in the face of a post-Merger price increase is inconsistent with the market power explanation for the price increase. (RFF ¶ 1164).

5. *Alternative Explanations for the Price Increases.* Complaint Counsel claims that its principal economist, Dr. Haas Wilson, excluded all "reasonable" alternative explanations for the price increase that could be supported by economic theory. (CCPTB at n. 34). In fact, she did not even attempt to control for a number of reasonable potential explanations for the price increases, including: idiosyncratic changes at ENH, payor specific factors, and other factors that both she and Dr. Noether recognized as "reasonable" alternative explanations for the price increases. (RFF ¶¶ 1053-1064). This failing alone eviscerates Complaint Counsel's pricing evidence.

6. *Respondent's Documents.* Complaint Counsel's reliance on Evanston Hospital/ENH and HPH documents to establish market power is misguided. As previously explained, ENH CEO, Mark. Neaman's reports on the sequential accomplishments of the Merger and the Bain & Co. ("Bain") documents advising ENH on negotiating strategies are entirely consistent with the

learning about demand explanation for the price increases. Similarly, there are competitively benign explanations for statements and documents relating to the formation of the Northwestern Healthcare Network, the proposed NH North Project, and other matters. At worst, any questionable documents construed in the manner most favorable to Complaint Counsel only go to ENH's intent – a fact that is not relevant in the context of a Section 7 inquiry. *United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586, 589 (1957).

B. Complaint Counsel Has Not Shown that the Merger Will Substantially Lessen Competition Using A Structural Analysis

Complaint Counsel now implicitly recognizes that it must define a relevant market but that it need not conduct an "elaborate market analysis," where it has "direct evidence" of anticompetitive effects. (*See* CCPTB at 49-55). Yet, the cases Complaint Counsel relies on do not stand for the propositions put forward, or are not applicable in a merger setting. (Section II.A.). In the end, Complaint Counsel must define an economically meaningful relevant market – both product and geographic – which it cannot do.

1. *Product Market.* The true product market here includes inpatient and outpatient services, despite Complaint Counsel's insistence that the product market only include inpatient services. (CCPTB at 52-53). Every one of the Complaint Counsel's MCO witnesses – the direct customers in this case – testified that MCOs negotiate for both inpatient acute-care and outpatient hospital services. (*See generally* RFF ¶¶ 366-376; RFF-Reply ¶¶ 1625-1628). As the proper definition of the relevant product market requires the analysis to focus on the product actually being sold to the customer, the relevant product market here must include outpatient services. *Merger Guidelines* § 1.11. Yet, once again, Complaint Counsel only selectively relies on the evidence in this case, ignoring its own witnesses, the MCOs.

2. *Geographic Market.* Complaint Counsel also wants the Court to find that the

geographic market only includes the merging parties – which no Court has ever held – and is contrary to the Merger Guidelines. (CCPTB at 54; Section II.B.2.; *Merger Guidelines* § 1.21). It defines the geographic market by assuming the price increases were anticompetitive in the first instance, which is circular logic. Complaint Counsel ignores the evidence of numerous hospital alternatives to Evanston Hospital and HPH. Under both well settled law and the *Merger Guidelines*, the geographic market here includes numerous other hospitals that compete with ENH. (RFF ¶¶ 409-490).

3. *Concentration Levels*. Finally, even under Respondent's conservatively defined relevant market, post-Merger concentration levels will remain well within a range that courts have found insufficient to give rise to likely anticompetitive effects, and Complaint Counsel cites no case law supporting its contention otherwise. Knowing this, Complaint Counsel makes a lame attempt to rely on an ENH corporate document discussing ENH's "core service area," falsely equating such a limited area with an appropriately defined geographic market. (Section II.B.2.). Again, Complaint Counsel is trying to shift the burden to Respondent where the law does not allow it, and misleadingly cherry-picking evidence which suits its needs. Indeed, Complaint Counsel relies upon merger cases which – unlike the instant case – were based on a coordinated effects theory, a theory which Complaint Counsel's expert economist concedes is not being advanced in this case. (RFF ¶ 517).

C. Complaint Counsel Failed To Reject The Learning about Demand Explanation

Complaint Counsel's primary economic expert, Dr. Deborah Haas-Wilson, recognized the validity of the learning about demand theory, but cursorily contested its application in this case. (RFF ¶ 523(k)). Using Dr. Haas-Wilson's pricing models and statistical analysis, Complaint Counsel attempts to suggest that Evanston Hospital/ENH had nothing to learn from HPH's prices. Dr. Haas-Wilson conceded, however, that she was not aware of a single hospital

or payor who analyzed prices using the models or statistical analysis she employed. (RFF-Reply ¶ 700; RFF ¶ 1027). Moreover, it is undisputed that all parties who were involved in preparing for the MCO negotiations in 2000 were surprised to learn that HPH's pre-Merger contract rates were higher than Evanston Hospital's contract rates for many major contracts. (RFF ¶¶ 656-669, 682-683). Significantly, Complaint Counsel limited its expert analysis to price *changes* even though the only way to reject the learning about demand theory it is by considering price *levels* Complaint Counsel limited its expert analysis to price *changes*. In fact, Complaint Counsel offered absolutely no evidence that ENH's prices were above competitive levels. Indeed, the only proof concerning the level of ENH's prices was offered by Respondent and it demonstrated that

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(*See* RFF ¶¶ 1137-1164).

D. Complaint Counsel Cannot Prove That the Merger Had Anticompetitive Effects in the Face of ENH's Extraordinary Quality Improvements

1. Complaint Counsel seeks to impose artificial factual burdens on Respondent and to evade its own burden of persuasion

Given ENH's overwhelming evidence of quality improvements it made after the merger, Complaint Counsel raises a litany of objections to the Court's consideration of this evidence and again seeks improperly to shift its burden of persuasion to Respondent. Complaint Counsel mistakenly characterizes ENH's evidence of quality improvements as an "efficiency defense" in an effort to escape the fact that such evidence relates directly to Complaint Counsel's acknowledged burden to account for quality improvements in demonstrating that the Merger had anticompetitive effects. Similarly, Complaint Counsel identifies a number of "facts" that it claims Respondent must prove – without legal or logical foundation – before the Court may even consider the quality evidence. Contrary to Complaint Counsel's assertion, for example, there is

no legal basis why the Court should not consider the quality improvements unless Respondent quantifies or values them. Antitrust courts routinely weigh unquantified, and unquantifiable, procompettiive benefits against alleged anticompetitive effects.

2. The quality improvements are relevant in two ways

The evidence of quality improvements in this case are relevant and central to the Court's assessment of the competitive effects of the Merger in two respects. First, to the extent that quality improved at ENH faster than other hospitals during the relevant time period, ENH's quality adjusted prices did not increase as much as its nominal prices, reducing the magnitude of Complaint Counsel's proof of competitive harm.. Second, evidence of ENH's quality improvements are a procompettiive benefit that shifts the burden of production back to Complaint Counsel to come forward with evidence demonstrating that any alleged anticompetitive effects of the Merger outweigh such benefits. In this regard, it is irrelevant whether ENH 's quality improvements outpaced those of other hospitals. All quality improvements are relevant to the analysis so long as they would not have practically occurred as well, as fast, or at all without the Merger.

3. ENH's improvements are cognizable regardless of the campus at which they occurred or which hospital experienced the greater price increase post-Merger

Complaint Counsel's suggestion that quality improvements at HPH are not relevant because post-Merger prices increased more at Evanston Hospital is specious. ENH is an integrated healthcare delivery system. Thus, quality improvements at HPH are a benefit to the entire ENH system. So long as the Merger resulted in quality improvements at HPH and there is no credible evidence of off-setting quality declines at Evanston or Glenbrook Hospital, then any improvement at HPH would be an improvement to the ENH system. ENH's pricing as an integrated system after the Merger merely continues the practice it began when it built

Glenbrook Hospital from the ground up in the 1970s.

4. ENH made merger specific improvements relative to other hospitals

Complaint Counsel would have the Court believe that an illusory nationwide trend – a supposed rising tide of healthcare improvement – somehow would have improved HPH's services regardless of the Merger. However, the evidence showed that HPH lagged behind other Illinois hospitals in its use of life-saving medical therapies for heart attack patients before the Merger. After the Merger, HPH improved in its use of these therapies to the level of Evanston Hospital, surpassing the performance of all hospitals in Illinois, which failed to equal Evanston Hospital's performance. (RX 2043). Apparently, the "nationwide trend" overlooked other Illinois hospitals with respect to caring for heart attack patients. Further, the improvements in quality at HPH did stand the test of comparison against peer groups, and the use of drug therapies for heart attack patients, cardiac surgery mortality and complications, and Cesarean section rate are but a few examples of HPH's favorable performance relative to either regional or national peer-group hospitals. ENH improvements relative to other hospitals also included areas such as electronic medical records, intensivists, an OB/GYN preoperative surgical review program, and many others. HPH did not have the financial means, administrative structure, or organizational will to make such changes.

5. ENH Used Superior Methods to Assess Quality

Complaint Counsel suggests that its expert provided the only quantitative analysis of quality based on numbers crunched from hospital billing data – so-called administrative data. However, such a myopic focus on outcomes, predicated almost exclusively on administrative data and without regard to the validity or adequacy of the tools chosen to measure those outcomes, overlooks the tangible improvements in quality at HPH that were made possible by

the Merger. Respondents offered evidence of structural and process improvements at HPH, as well as patient outcomes, relying on valid measures based on quantitative as well as qualitative data when such data were available. Further, Respondent quantified the value of the improvements at HPH, establishing an investment of over $120 million in a relatively short time frame which yielded real improvements at HPH, such as the introduction of comprehensive electronic medical records, state-of-the art diagnostic equipment for oncology patients, and a modern interventional cardiology laboratory. Indeed, it is hardly "anecdotal speculation" that a HPH resident with a heart attack is now substantially better off after the Merger by virtue of having life-saving interventions readily available in his local hospital, or, that mothers giving birth at HPH are now better off post-Merger by having their births attended by a full-time obstetrician at night. Complaint Counsel discounts the importance of improved local access to sophisticated healthcare made available to Highland Park residents through the Merger.

E. Even If The Court Found A Violation of Section 7, It Should Not Order Divestiture

In the event that the Court were to find a violation of Section 7, the remedy should be tailored to address the competitive concerns without threatening to undo the quality improvements arising from the Merger. Divestiture is a "drastic" remedy, and the case law is clear that it need not be ordered. *United States v. Crowel, Collier & MacMillan, Inc.*, 361 F. Supp. 903, 991 (S.D.N.Y. 1973); *In the Matter of Retail Credit Co.*, 92 FTC 1, 1978 FTC LEXIS 246 at *258-59 (July 7, 1978); (RPTB at 123-126). Complaint Counsel's proposed remedy recognizes that divestiture threatens quality improvements. It purports to require, for example, that ENH continue to support the cardiac surgery program at HPH after divestiture to ensure that it provides care "in substantially the same manner," as that provided under ENH's ownership. (CCPTB at 87). The proposal itself is inconsistent with the facts in the record which

demonstrate that the cardiac surgery program under ENH's complete control at HPH has achieved better mortality rates – in fact zero mortality for the past two years – than ENH's joint venture programs at Weiss and Swedish Covenant Hospital. (Rosengart, Tr. 4502-05; RFF ¶ 1643). Complaint Counsel's proposed order may be wishful thinking, but it is inconsistent with the evidence in the case and with common sense. Should the Court be inclined to find liability, Respondent would urge it to consider the alternative remedies set forth in our post-trial brief. (RPTB at 124-126).

ARGUMENT

I. THE MERGER DID NOT CREATE MARKET POWER FOR ENH IN VIOLATION OF SECTION 7 OF THE CLAYTON ACT

Complaint Counsel attempts to build its case on payor testimony, Respondent's documents, and analyses of ENH's price changes. The record evidence demonstrates that (i) the payor witnesses contradicted themselves and their contemporaneous documents and actions, (ii) Complaint Counsel miscites Respondent's documents and (iii) Complaint Counsel's price change analyses are flawed.

A. Payors Did Not Selectively Contract with Hospitals Prior to the Merger

The first building block in Complaint Counsel's case is the concept that managed care organizations ("MCOs")[2] in the Chicago market selectively contract with area hospitals – i.e. they contract only with a "subset" of hospitals and thereby influence the price they are charged by threatening to use an alternate or "substitute" hospital if the price offered is too high.[3] (*See* CCPTB at 21-24). Complaint Counsel claims that MCOs in Chicago had used these methods against HPH and Evanston Hospital, but were unable to after the Merger. (CCPTB at 21-26). To the contrary, the evidence solidly shows that Chicago area payors (1) do *not* selectively contract, but rather seek to contract with every hospital in Chicago,[4] (2) do *not* play area hospitals off one another, and (3) did *not* use Evanston Hospital and HPH as "substitutes" pre-Merger in an effort to influence pricing. (RFF ¶¶ 480-81, 538-559).

1. Payors did not selectively contract with area hospitals

The goal of the MCOs was not to contract selectively with only a "subset" of hospitals,

[2] The term "MCO" and "payor" are used interchangeably.

[3] Complaint Counsel defines a "substitute" hospital as one with "comparable location, services, quality, and price." (*See* CCPTB at 22).

[4] *See* Noether, Tr. 5981 (selective contracting has not historically played a major role in managed care in the Chicago area); *see also* RFF ¶¶ 76, 974-983.

but rather to contract with almost all area hospitals. For example,

REDACTED (Holt-Darcy, Tr. 1584, *in camera*; RFF ¶ 994; RFF-Reply ¶ 195). Out of approximately 100 hospitals in the Chicago area,

REDACTED Holt-Darcy, Tr. 1583, *in camera*; RFF-Reply ¶ 238), and Aetna had 88 of the hospitals in its network. (Mendonsa Tr. 484; RFF ¶ 455; RFF-Reply ¶ 226). Similarly, United had 98 hospitals in its Chicago-area network. (Foucre, Tr. 881; RFF ¶ 178; RFF-Reply ¶ 243). Indeed, at trial the payor witnesses admitted that they do *not* threaten to exclude area hospitals and substitute alternatives. For example:

- **REDACTED** (Mendonsa, Tr. 562-63, *in camera*; RFF ¶ 977; RFF-Reply ¶ 1202).
- **REDACTED** (Holt-Darcy, Tr. 1594, *in camera*; RFF 978; RFF-Reply ¶ 260, 1230).
- Great West/One Health testified that exclusion of competitor hospitals has "never been a negotiating strategy." (Dorsey, Tr. 1470-1471; RFF ¶ 979).

Complaint Counsel can therefore not establish the foundational premise for its case.

2. Evanston and HPH did not compete for inclusion in payor networks

As shown, managed care payors do not attempt to obtain a better price through "selective contracting." This applied to HPH and Evanston Hospital as well. Payors never threatened to exclude either Evanston Hospital or HPH during pre-Merger negotiations with either hospital in order to obtain a lower price. (RFF ¶¶ 974-983; RFF-Reply ¶¶ 99, 1032-1033). The reason for this is simple; before the Merger Evanston Hospital and HPH were not comparable in services or quality. (RFF-Reply ¶¶ 290-292). Evanston Hospital, an academic medical center, and HPH, a community hospital, were in different service lines and were not considered by the payors to be

"substitutes" or alternatives for each other. (*See* RFF ¶¶ 30-43, 475-481).[5] For instance:

- PHCS recognized that pre-Merger HPH was a "community hospital" while Evanston Hospital was an "advanced teaching" facility with a "higher level of services" and affiliated with Northwestern Medical School. (Ballengee, Tr. 159, 212; RX 107 at GWL 859; RFF-Reply ¶¶ 296, 722).

- **REDACTED** (Foucre, Tr. 1112, *in camera*; RFF-Reply ¶¶ 1939-1940).

- **REDACTED** (Holt-Darcy, Tr. 1505-1506, *in camera*; RFF ¶ 30-41; RFF-Reply ¶ 290).

Therefore, under Complaint Counsel's definition, Evanston Hospital and HPH were not good "alternatives" to each other. (CCPTB at 22; *see* RFF ¶¶ 30-43, 47-49, 481; RFF-Reply ¶¶ 47-48, 57, 1417, 1473-74).[6] Even Complaint Counsel's proposed findings support this. (*See* CCFF ¶¶ 1798-1799). Further, Complaint Counsel's expert economist agreed that Evanston Hospital and HPH were not each other's next-best substitutes. (Haas-Wilson, Tr. 2799).

Complaint Counsel's only support is lay opinion testimony from MCOs that is contradicted by contemporaneous documents and trial testimony. (CCPTB at 24-25). Jane Ballengee (PHCS) asserted that she believed Evanston Hospital was the only viable alternative to HPH and vice versa (CCPTB at 24-25); her testimony, however, is directly contradicted by statements prepared by PHCS at the time of the Merger. A letter from PHCS executives –

[5] Complaint Counsel's managed care witnesses further recognized that a teaching hospital is also more expensive and generally receives higher rates from a MCO. **REDACTED** (RFF ¶ 103; RFF-Reply ¶ 1130). (RFF ¶ 103).

[6] For example, HPH did not offer cardiac surgery and did not have a fully developed oncology program comparable to Evanston Hospital's Kellogg Cancer Care Center. (CX 6305 (Stearns, Dep. at 108)). Since Evanston Hospital offered cardiac surgery and advanced oncological care, but HPH did not, the hospitals could not compete with respect to many services. (CX 6305 at 19 (Stearns, Dep.)).

including Ballengee – to its customers, dated December 14, 1999, states:

> While [PHCS] do[es] not anticipate the termination of [Evanston and Highland Park], the potential for termination exists if we cannot reach mutually agreeable terms. In case of a termination, there are other contracted providers *within the same geographical area* as that of Highland Park Hospital and Evanston Northwestern Healthcare. Those facilities are St. Francis Hospital (Evanston, IL), Lake Forest Hospital (Lake Forest, IL), Lutheran General Hospital (Park Ridge, IL), Rush North Shore Medical Center (Skokie, IL), and Holy Family Medical Center (Des Plaines, IL).

(RX 712 at PHCS 891 (emphasis added); *see also* RFF ¶ 457; RFF-Reply ¶ 296). At trial, Ballengee admitted that St. Francis was just three miles down the road from Evanston Hospital, and that Rush North Shore was a "significant competitor" to Evanston Hospital. (Ballengee, Tr. 212; RFF ¶ 570; RFF-Reply ¶ 284). Similarly, United Healthcare ("United") identified Advocate Lutheran General as "the most comparable facility from type of services, quality of services, [and] size of facility" to Evanston Hospital. (Foucre, Tr. 944; RFF ¶ 565; RFF-Reply ¶ 978).

The evidence at trial established that payors had numerous alternatives to Evanston Hospital and HPH prior to the Merger, which continue to exist today.[7] (*See* RFF ¶¶ 387-453). These alternatives could easily substitute for ENH in an MCO network, belying Complaint Counsel's claims that inclusion of either Evanston Hospital or HPH is critical to the success of a health plan. (RFF ¶¶ 454-460).

Complaint Counsel admits that pre-Merger payors could exclude Evanston Hospital and construct an appropriate network with HPH, "Lutheran General and Rush North Shore." (CCPTB at 4). Payors also identified St. Francis Hospital as a viable pre-Merger network alternative to Evanston Hospital: **REDACTED**

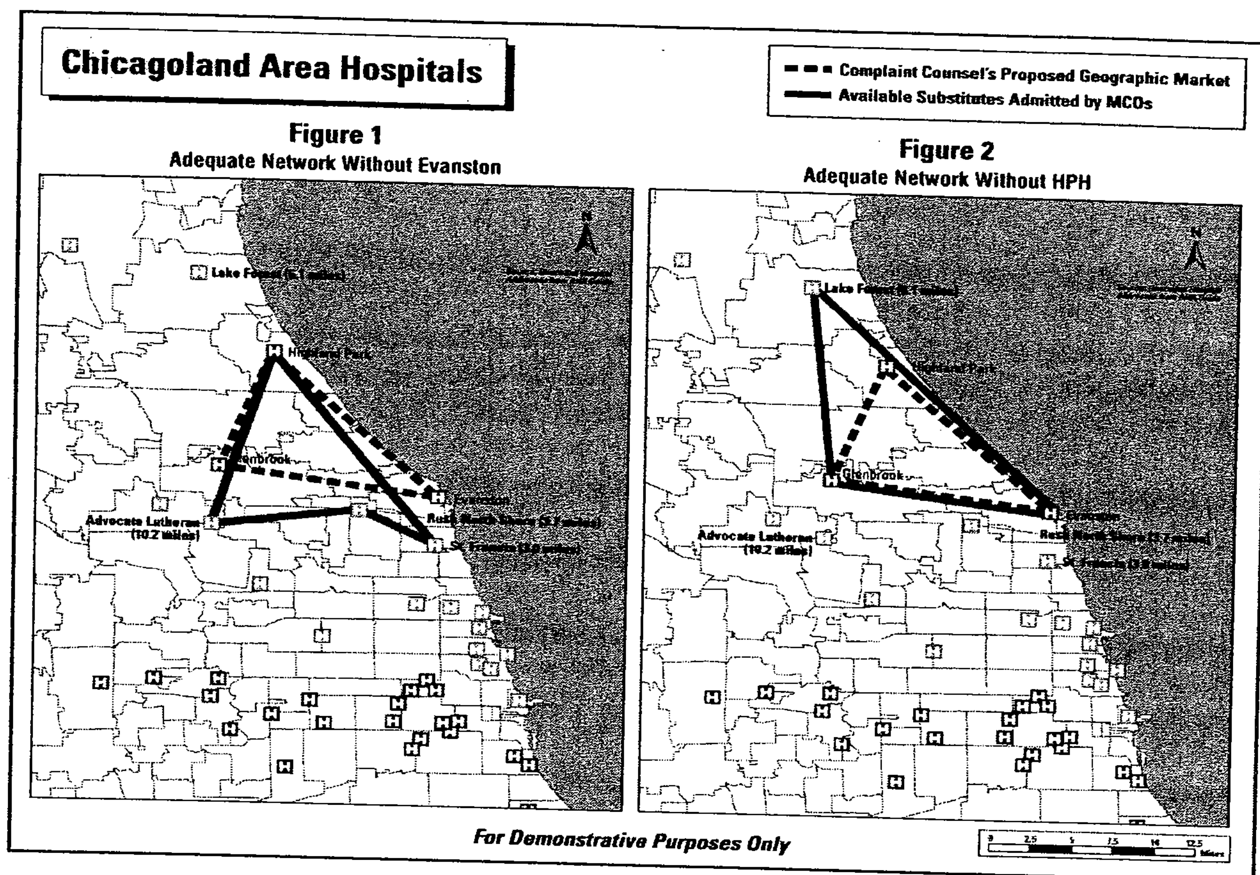
[7] The evidence established that there are at least 18 hospitals closer to Evanston Hospital or HPH than they are to each other. (RPTB at 20-21; RFF ¶¶ 387-390; RFF-Reply ¶¶ 47, 286, 1697).

REDACTED

REDACTED CCFF ¶ 1298, citing Holt-Darcy, Tr. 1518-1519, *in camera*; Ballengee, Tr. 212; RFF-Reply ¶¶ 1082, 1298, 1706).[8] Complaint Counsel further admits that payors could exclude HPH but keep Evanston Hospital and build a network by including "other hospitals near Highland Park, such as Lake Forest." (CCPTB at 4).

As illustrated on the maps below, Complaint Counsel's admissions undermine its theory in this case. Complaint Counsel admits that pre-Merger Advocate Lutheran General, Rush North Shore, and St. Francis were acceptable network substitutes on the Southern leg of a geographic triangle (See Figure 1); it also admits that Lake Forest was an acceptable substitute to HPH on the North end of the triangle. (See Figure 2). In order to maintain its theory that, after the Merger, payors are unable to construct a network without ENH, Complaint Counsel is forced to argue that Lake Forest Hospital - a mere six miles away - is no longer an acceptable substitute to HPH when Evanston Hospital is not in the network. Such an argument is specious in light of MCO testimony identifying Lake Forest Hospital as the primary alternative to HPH before the Merger. (RFF ¶ 577).

[8] HPH and Evanston Hospital are 13.7 miles (27 minutes) from each other. On the other hand, Saint Francis is 3 miles (8 minutes), Rush North Shore is 3.7 miles (9 minutes) and Lutheran General is 10.2 miles (21 minutes) from Evanston Hospital. Lake Forest is 6.1 miles (13 minutes) from HPH. (RFF ¶¶ 387-390).



Tellingly, there is no evidence in the record that any MCO attempted to sell or market one of these alternate networks during the pre- or post-Merger time periods.[9] As a result, Complaint Counsel's claim that the Merger between Evanston Hospital and HPH deprived payors of needed geographic coverage over the North Shore simply lacks any support.[10]

3. HPH was not ready, willing or able to compete in the Chicago marketplace

At trial, Respondent presented testimony from six witnesses – the HPH Chairman of the Board, HPH President, a third party independent financial consultant hired by HPH, a certified public accountant directing the due diligence, Evanston Hospital's Chairman of the Board, and

[9] As discussed further below, payor testimony speculating that such alternate networks are unworkable is unsupported lay opinion. (*See* Section I.C, *infra*).

[10] Complaint Counsel has steadfastly refused to articulate what about the ENH triangle is so critical that it renders hospitals just a few miles down the road incapable of serving as effective alternatives. (*See* RFF-Reply ¶ 285). The

an economic expert – all of whom concluded that prior to the Merger HPH was in financial decline and could no longer compete effectively in the Chicago hospital market. (*See* RFF ¶¶ 2298-2413; RFF-Reply ¶¶ 302-372). At the time of the Merger, HPH was not making any money, it was supporting its negative operating margin with investment earnings, its debt capacity was severely constrained, and it lacked sufficient capital to make needed improvements in its facility. (RFF ¶¶ 2319-2386). In short, the finances of the hospital were "insufficient to meet the competitive challenges of the Chicago marketplace" where other hospitals were investing substantial sums to upgrade their facilities. (Kaufman, Tr. 5807, RFF ¶ 2365; RFF-Reply ¶¶ 309, 325).

Complaint Counsel attempts to rely on HPH's strategic "plans" as evidence of its pre-Merger financial strength. The optimistic statements contained within these strategy documents were not realistic predictions of HPH's economic future, as demonstrated by the independent, third-party witnesses who were responsible for reviewing HPH's financial records. (RFF ¶¶ 2381-2386; RFF-Reply ¶¶ 254, 335-351, 356). Ken Kaufman, an independent financial consultant hired by HPH before the Merger, reviewed the same strategic plans upon which Complaint Counsel now relies and found that the future funds allocated by HPH were "not going to begin to get at the problems" occurring at HPH. (Kaufman, Tr. 5826; RFF ¶ 2381; RFF-Reply ¶¶ 341, 367).[11]

Complaint Counsel also cites to the unreliable and uninformed testimony of Mark Newton, a former vice president of "business affairs" at HPH, who left the hospital soon after the

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lack of evidence as to *why* payors allegedly need either Evanston Hospital or HPH speaks volumes about Complaint Counsel's entire case.

[11] Complaint Counsel awkwardly cites to *FTC v. H.J. Heinz Co.* for the proposition that HPH could have become competitive on its own. 246 F.3d 708, 717 (D.C. Cir. 2001); CCPTB at 27-28. As demonstrated at trial, that is simply not the case.

Merger and is now Chief Executive Officer of a competitor.[12] (CCPTB at 26-27, Newton, Tr. 279, Spaeth, Tr. 2282-2283, Hillebrand, Tr. 2028-2029). Newton was not responsible for financial issues at HPH, but rather relied on the advice of Kaufman, who disagreed with the financial plans. (Newton, Tr. 436-437). Respondent respectfully submits that Newton's lay opinion testimony, which covers nearly every topic in this case, is inherently unreliable and should be viewed with extreme skepticism.[13] (RFF-Reply ¶ 1465).

B. Respondent's Documents are not Evidence of Market Power

Complaint Counsel relies on Respondent's documents as purported admissions of ENH's intent to acquire market power. (CCPTB at 28-32). As an initial matter, intent is not an element of a Section 7 claim. *See United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586, 589 (1957) (finding that intent is not an element of a Section 7 claim).[14] (*See also* RFF-Reply ¶ 1536). In any event, as discussed below, the probative value of Respondent's documents is minimal because they do not mean what Complaint Counsel contends.

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[12] As discussed in greater detail below, the testimony of market participants, such as competitors and MCOs, is unreliable. *See California v. Sutter Health Sys.*, 84 F. Supp.2d 1057, 1076 (N.D. Cal. 2000) (discounting competitor testimony because "the perception of market participants is afforded *considerably less weight* than quantitative data addressing the practical alternatives available to patients") (emphasis added); *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 n.14 (8th Cir. 1999) (stating that "[a]lthough the witnesses may have testified truthfully as to their present intentions, market participants are not always in the best position to assess the market long term") (*citing Bathke v. Casey's Gen. Stores, Inc.*, 64 F.3d 340, 345 (8th Cir. 1995)).

[13] Complaint Counsel relies on the prejudiced testimony of Mark Newton on nearly every topic imaginable, including HPH's market position, finances, clinical quality of care, patient satisfaction, negotiating tactics, managed care contracts, information technology and others. (*See* CCPTB at 23, 33, 44, 79-80). As demonstrated at trial, Newton lacks the knowledge, experience, foundation, and expertise to comment on nearly every one of these topics. Newton was not responsible for clinical quality of care at HPH, does not have a medical or nursing degree, did not have responsibility for information technology, did not have any involvement in the credentialing of physicians, did not have responsibility for financial matters, did not have primary responsibility for merger strategy, was excluded from most merger discussions, and was not responsible for managed care contracting. (Spaeth, Tr. 2283-2284, Newton, Tr. 436, 452-453, 471, 512-513; RFF-Reply ¶ 1465).

[14] The Merger is either capable of reducing competition or it is not, regardless of the parties' desires. *See* Richard A. Posner, Antitrust Law 214-215 (2d ed. 2001) (noting that, in the context of predatory pricing, "[a]ny doctrine that relies upon proof of intent is going to be applied erratically at best" because the availability of such evidence "is often a function of luck and of the defendant's legal sophistication, not of the underlying reality" and therefore a firm "whose executives lack [sensitivity to the antitrust issues] will often create rich evidence of [improper] intent simply by a clumsy choice of words to describe innocent behavior").

1. The term "leverage" is benign

The term "leverage" was generally employed by Bain Consulting ("Bain"), which was hired by Evanston Hospital to assist in revamping its contracting strategy in all areas ranging from managed care payors to equipment suppliers and vendors. (*See* RFF ¶¶ 670-733; RFF-Reply ¶¶ 1036, 1517). As explained by Kim Odgen, the Bain partner responsible for the engagement, Evanston Hospital did not have an effective managed care contracting strategy and consequently was seriously under-pricing itself. (RFF ¶¶ 677-725; RFF-Reply ¶¶ 1779, 1782). In advising Evanston Hospital on new negotiating strategies and techniques, Bain advised that it "should recognize its position and not be afraid to ask to be paid fair market value" for its services. (RX 2047 at 39-40 (Ogden, Dep.); RFF ¶ 996; RFF-Reply ¶ 1518). This advice was extended to ENH's negotiations in all areas, including those with medical equipment vendors as well as MCOs. (RFF ¶¶ 998). Complaint Counsel's fixation on the word "leverage" reflects its misunderstanding of the context in which it was used; it certainly is not proof of an exercise of market power. (*See* RFF ¶¶ 995-1000; RFF-Reply ¶¶ 1361, 1407, 1450, 1517).

2. Complaint Counsel's comparison of market share numbers is misleading

Complaint Counsel attempts to portray ENH as conducting a decade-long quest to obtain market power. (CCPTB at 29-32). Complaint Counsel's reliance on ENH's documents for this claim is misplaced and disingenuous for three reasons.

The "markets" referenced in the various documents cited by Complaint Counsel refer to different patient populations. Thus, the "20-25%" market share that is contained in several Northwestern Healthcare Network ("NHN") documents, including a 1996 document cited by Complaint Counsel, is based on a "Chicago-area" market. (CCPTB at 29; CX 1860 at 11, 13, 48). (*See also* RX 357 at JH 10386; CX 1860 at 11; Neaman Tr. 994) (20-25% market share estimate on the "total covered lives in the [Chicago] metropolitan area (approximately 2.0

million people)). The document referencing a "55%" market share, on the other hand, refers to admissions originating from people living within ENH's 20 zip code "core service area." (CX 359 at 16).

Moreover, the documents do not calculate market share under a method relevant to antitrust analysis. The "market share" that is of concern to antitrust analysis is a firm's share of output within a relevant market that takes into account the forces that constrain the behavior of that firm (or group of firms).[15] The "market share" referenced in the documents cited by Complaint Counsel is not ENH's share of output in the relevant antitrust market, but rather the percentage of admissions ENH receives of the total admissions that originate from a defined patient population (e.g., 20 zip codes around ENH).[16]

Complaint Counsel then misleadingly compares these NHN documents to market share statistics contained in documents relating to the NH North proposed alliance. (CCPTB at 29, CX 393 at 1). The NH North documents cited by Complaint Counsel, which purportedly described Bain's advice to achieve 30-50% market share, was based on a "70 Zip Code Area" that includes over 40 townships – nearly every Northern and Northwest suburb in the Chicago metropolitan

[15] *See U.S. v. Rockford Mem. Corp.*, 898 F.2d 1278, 1283 (7th Cir. 1990) (explaining that the relevant market share is calculated by dividing the output of the defendants by the total output of the suppliers to which a group of customers can turn – i.e. the output of the relevant "market"). *See also Merger Guidelines* § 1.41 ("The Agency normally will calculate market shares for all firms (or plants) identified as market participants in Section 1.3 based on the total sales or capacity currently devoted to the relevant market...")

[16] The information contained in these documents is a cruder, and much less accurate, form of patient flow data, which Complaint Counsel later criticizes as not being appropriate for the basis of determining a relevant market or market share. (CCPTB at 59; CCFF ¶¶ 1661-1684). Moreover, these data are unscientific, unverified and not corroborated by other facts in the case. Respondent's expert, on the other hand, utilized patient travel patterns as only one means of defining a geographic market and then based market share figures on the output of the firms located within that market.

area. (CX 394 at 5; RFF-Reply ¶ 1576).[17] The NHN documents, however, based their market share references on the entire "Chicago area." In attempting to create a history that shows ENH's alleged desire for increasing market share, Complaint Counsel never informs the Court of the differing "markets" referenced in these documents. Moreover, the NHN documents were written in the context of competing with other Chicago area *networks*, such as Advocate Healthcare, rather than a single hospital in a limited geographic region.

Complaint Counsel next leaps to documents that supposedly reference ENH as having a 55% market share after the Merger. Complaint Counsel's discussion makes no reference to the "market" upon which this figure is based, which is actually ENH's "core service area." (CCPTB at 30-32, CX 84 at 21, CX 359 at 16). ENH continuously employs several methods to analyze the geographic origin of its patients. (*See* RX 1429 ENHE F16 4561; Neaman, Tr. 1055, 1307-1308; RFF ¶¶ 499-507; RFF-Reply ¶¶ 49, 57). The most common analysis examines the "service area" of the hospital, which covers a geographic area of approximately 50-52 zip codes, includes 15-16 competitor hospitals, and is where approximately 80-85% of ENH's patients live.[18] (RFF ¶¶ 502-507). From time to time, however, ENH conducts such an analysis using a much smaller geographic area referred to as the "core service area." (Neaman, Tr. 1055). This area includes the 20 zip codes closest to the hospitals and represents only approximately 50% of ENH's total business. (RFF ¶ 502; RFF-Reply ¶¶ 49, 57).[19] Therefore, of the admissions

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[17] As depicted on the map contained within CX 394, the "70 Zip Code Area" contained 40 townships including the towns of Rogers Park, Lincolnwood, Evanston, Skokie, Morton Grove, Wilmette, Winnetka, Kenilworth, Glenview, Northbrook, Glencoe, Des Plaines, Mount Prospect, Arlington Heights, Schaumburg, Bartlett, Palatine, Arlington Heights, Prospect Heights, Wheeling, Buffalo Grove, Deerfield, Lincolnshire, Vernon Hills, Lake Zurich, Barrington, Highland Park, Highwood, Ft. Sheridan, Lake Forest, Lake Bluff, Libertyville, Mundelein, Wauconda, Round Lake, Grayslake, Gurnee, Waukegan, North Chicago. (CX 394 at 5; RFF-Reply ¶ 1576).

[18] ENH has calculated that approximately 16-17% of the admissions generated by patients residing in the "service area" were at ENH. (RFF ¶ 507; RFF-Reply ¶¶ 59, 63).

[19] The townships included in the "core service area" are Evanston, Skokie, Wilmette, Kenilworth, Glenview, Winnetka, Glencoe, Northbrook, Highland Park, Deerfield, Lake Forest, Highwood, and Ft. Sheridan. (CX 84 at 21).

generated by people living within this limited area, ENH believes that it received approximately 55%. (CX 84 at 21; CX 359 at 16). In addition, ENH could not survive on only half of its revenue, and Complaint Counsel offered no evidence that such a narrow geographic area is a meaningful relevant "market" for antitrust purposes. (*See* RPTB at 20-28). Thus, the "market share" figures cited by Complaint Counsel are of little probative value. (RFF ¶¶ 499-507; RFF-Reply ¶¶ 49, 57).

Finally, Complaint Counsel disingenuously uses documents relating to different times and purposes to argue: "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*." (CCPTB at 30-31, citing CX 393 at 1 (emphasis added)). As shown above, the Bain advice in connection with NH North referred to a "70 zip code area," while the market share numbers that Complaint Counsel claims "cleared that hurdle" were based on ENH's "20 zip code area." (CX 394 at 5; CX 393; CX 84 at 21; Neaman, Tr. 1055). This distortion of market share statistics is blatantly misleading and is a desperate attempt to mold innocuous documents around a failing theory.[20]

3. The term "Indispensable" referred to HPH's desire to increase its quality

Complaint Counsel also cites to documents referring to ENH as "indispensable" as proof of ENH's intent to obtain market power.[21] (CCPTB at 29-30). The plain meaning and context

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[20] A further example occurs in Complaint Counsel's references to Mark Neaman's use of the term "market share" in CX 16. (CCPTB at 43, citing CX 16). Once again, the "market share" referenced by Mr. Neaman are not meaningful for antitrust purposes.

[21] Complaint Counsel cites documents authored by Neaman that it claims "alluded" to market power. (*See* CCPTB at 20, CX 17). If the isolated statement cited by Complaint Counsel is read within the context of the entire document, it is clear that the memo was an effort by Neaman, as the CEO of the organization, to thank everyone who participated in the merger integration for their "leadership, support, and encouragement with our collective merger integration efforts." (CX 17 at GW 1144). The accomplishments that could not have been done "alone" included ten major goals, such as "full functional merger of Board, Management, Employees, and Medical Staff," full integration of all business functions, "[r]edevelopment of HPH site" including the addition of new services and facilities, cost improvements, and numerous other activities that were done as part of a team – rather than "alone."

in which the term is used shows that "indispensable" is actually a proxy for quality. (CCPTB at 28; RFF ¶ 1001; RFF-Reply ¶¶ 1459, 1539). It is clear that HPH hoped to become "indispensable" to the market by improving its quality of care, something encouraged rather than prohibited by the antitrust laws. (RFF-Reply ¶¶ 1539, 1569). For example, the Lakeland Finance Committee's August 18, 1998, Managed Care Review stated that one of HPH's goals was to "[i]ncrease patient satisfaction and patient loyalty to the hospital and the physicians making [Highland Park Healthcare, Inc.] indispensable to any major player in the managed care market." (RX 367 at ENH DR 4205). The testimony and documentary evidence presented at trial demonstrated that the goal of the Merger was to protect the Highland Park community asset and improve the quality of care at HPH. (RFF ¶¶ 270-297; RFF-Reply ¶¶ 1370, 1459).

Accordingly, Complaint Counsel's claims of market power cannot be supported by a collage of out of context statements. Moreover, Complaint Counsel's citation to *Hospital Corporation of America v. FTC* ("*HCA*") for the proposition that the FTC is entitled to preserve the number of "independent competitors in a hospital market" is inapposite. 807 F.2d 1381, 1389 (7th Cir. 1986). In *HCA*, the Seventh Circuit found that the respondents would end up owning or managing "5 of the 11 hospitals" in the entire Chattanooga area. *Id.* at 1384. In contrast, there are over 100 hospitals in the Chicago area, and over 47 hospitals within 30 miles of ENH.[22] The Merger at issue in this case only joined a minute ratio of hospitals compared to *HCA*.

C. The Facts Established that ENH's Price Increases Were Not the Result of Market Power

ENH's post-Merger prices did rise, but only because they were previously below-market

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(CX 17 at GW 1146). Complaint Counsel's attempt to transform a morale and teambuilding memo into a nefarious indication of alleged market power is simply inconsistent with the plain reading of the document.

and ENH learned of the demand for its services coincident with the Merger. Thus, its price increases were not anticompetitive; instead, the Merger actually benefited consumers as a result of the multi-million dollar improvements made in the quality of care at HPH.

1. ENH upheld its commitment to integrate HPH into the ENH system

Immediately after the Merger was consummated, ENH began the task of integrating a declining HPH into its system. Making good on its promise to the HPH community, ENH strove to create an "integrated delivery system" that would deliver the same quality of services across all three ENH hospitals. (RFF ¶¶ 7-29; 303-310; RFF-Reply ¶ 1381). As a fully integrated system, ENH operates under one contract, with one price, and one chargemaster. (RFF-Reply ¶¶ 824, 908). Evanston and Glenbrook Hospitals had operated as an integrated entity since Glenbrook Hospital opened its doors in 1977 with no complaints from MCOs. (RFF ¶ 308; RFF-Reply ¶¶ 822-30). To operate HPH differently than the other ENH hospitals would have been inconsistent with ENH's mission and the commitments it made to the Highland Park community under the Merger agreement. (RFF ¶¶ 259-269; RFF-Reply ¶¶ 823-824).

One step on the road to becoming an integrated system was renegotiation of managed care contracts for all three ENH hospitals. In preparing for the renegotiations, ENH compared the reimbursement rates that were in effect for Evanston Hospital and HPH prior to the Merger. To the shock and dismay of Evanston Hospital executives, HPH had better contract rates on the majority of its managed care contracts, despite the broader range and greater sophistication of services provided at Evanston Hospital. (RFF ¶¶ 677-693; RFF-Reply ¶¶ 755, 758). Realizing its rates were below market, ENH sought the higher of the two rates in its negotiations with MCOs. (RFF-Reply ¶ 834). Where HPH had better contract rates it was only natural that ENH,

[22] The evidence established 30 miles as the distance consumers are willing to travel for hospital stays. (Holt-Darcy, Tr. 1420; RFF ¶¶ 387-390, 400; RFF-Reply ¶ 240).

an academic teaching hospital, would request reimbursement equal to at least the rates charged by HPH, a community hospital. (RFF-Reply ¶¶ 1387, 1777). ENH immediately used the increases it received to begin improving the quality of services at HPH.[23]

2. Negotiating discount-off-charges contracts is not evidence of market power

The fact that ENH negotiated discount-off-charges contracts is not proof of market power. As part of its renewed contracting strategy, ENH was advised by Bain to begin all negotiations by requesting discount-off-charges contracts. (RFF ¶ 713; RFF-Reply ¶ 900). ENH merely used this as a starting point in negotiations; it did not refuse to enter into other types of contracts. (RFF ¶¶ 713-714). In fact, several MCOs continue to have per diem contracts with ENH, including **REDACTED** (*See* RFF ¶¶ 750-751, 846, 870-871, 889; RFF-Reply ¶¶ 798, 1087).

Complaint Counsel erroneously claims that the shift to discount contracts "was a major coup [for ENH] because most health plans had fixed rates with other hospitals." (CCPTB at 34). As demonstrated at trial, however, **REDACTED** (RFF ¶¶ 82-91; RFF-Reply ¶ 910).

For example, **REDACTED** (RFF ¶ 84; RFF-Reply ¶ 782). In addition, (RFF ¶ 85).

[23] Complaint Counsel again cites to Newton regarding ENH's pricing decisions after the Merger. (CCPTB at 31-32). As shown above, however, he was not primarily responsible for managed care contracting, was excluded from most merger discussions, and left immediately after the Merger to work for a competitor hospital. (Spaeth, Tr. 2283-2284, Newton, Tr. 436, 452-453, 471, 512-513; RFF-Reply ¶ 1465). Newton simply had no knowledge of ENH's post-Merger contract renegotiation practices and, as stated earlier, his lay opinion testimony should be viewed with caution.

One of the supposed evils of a discount-off-charges contract is that there is almost no limit on how much a hospital can charge because it can increase its chargemaster prices at will. (CCPTB at 34). That is contrary to the evidence. (RFF ¶¶ 87-90).

REDACTED

(RFF ¶ 87-89; RFF-Reply ¶¶ 809, 897). For example, MCOs have easily protected themselves by negotiating escalator clauses, which limit the rate increases a hospital can impose. (RFF ¶¶ 87-90).

REDACTED

(CX 5072 at 18-19, *in camera*; Ballengee, Tr. 260-261, *in camera*; RFF-Reply ¶¶ 1047, 1050).

3. MCOs were not forced to pay more because of the Merger

The evidence presented at trial demonstrated that MCOs had numerous alternatives to ENH. The fact that payors did not terminate their contracts with ENH and turn to these available alternatives proves that ENH's post-Merger prices were competitive. At trial, the MCOs claimed to be harmed by the Merger, but their testimony was either (1) contradicted by their own contemporaneous documents and actions, or (2) lacked foundation.

a. United

i. United admitted that the 1999-2000 contract updated significantly undermarket rates

The evidence regarding ENH's 1999-2000 contract with United is undisputed.[24] During the re-negotiation of the contract,

REDACTED

[24] Complaint Counsel failed to call any witnesses from United involved in the 1999-2000 contract renegotiation.
REDACTED
Foucre, Tr. 1118, *in camera*; RFF ¶ 887; RFF-Reply ¶ 757).

REDACTED (RFF ¶ 684; RFF-Reply ¶ 962). United also admitted to being "embarrassed" by the fact that it had higher rates with HPH than it did with Evanston Hospital. (RX 2047 at 31 (Ogden, Dep.), RFF ¶ 684).

REDACTED

(Noether, Tr. 6086-6088, *in camera*; RFF ¶¶ 680, 883; RFF-Reply ¶¶ 755, 883). Bain advised ENH that the

REDACTED

(RFF ¶ 681; RFF-Reply ¶¶ 962-755). Further, United itself proposed that ENH "should use the better of [the two] existing contracts" as the terms of the new post-Merger contract. (CX 111 at 1; RFF ¶ 888; RFF-Reply ¶ 836, 967). Based on this evidence alone, it is clear that the post-Merger United contract was not the result of market power.

ii. United used the FTC investigation to assist its negotiations

Complaint Counsel cannot dispute the fairness of the 2000 contract and therefore attempts to mischaracterize subsequent negotiations between the parties. (CCPTB at 35-37).[25] In 2002, United began playing both sides of this litigation by working diligently to portray itself as a victim to FTC staff, while simultaneously conducting contract negotiations with ENH. (RFF-Reply ¶ 986).

REDACTED

(RFF-Reply ¶ 967). **REDACTED**

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[25] In 2002, United created inaccurate and misleading data in an effort to pressure ENH to accept a new contract. **REDACTED** (Foucre, Tr. 1078-1079, 1099, 1107, *in camera*; CX 2381 *in camera*; RFF ¶ 898). United planned to enter the re-negotiations with ENH and use this data to demonstrate that ENH's rates with United were well above those it had with other payors. (RFF-Reply ¶ 987). United's plan backfired. As demonstrated at trial, United's data contained major flaws. (Hillebrand, Tr. 1879; RFF ¶ 904; RFF-Reply ¶ 983, 991). Some of the flaws were intentional efforts to misrepresent the facts. For example, CX 2381 at 4, *in camera*; RFF ¶ 905; RFF-Reply ¶ 958, 987). **REDACTED** (RX 424 at 1, *in camera*; **REDACTED** after which it was never referenced again. (Foucre, Tr. 1107, *in camera*, Hillebrand, Tr. 1882; RFF ¶ 906; RFF-Reply ¶ 1983).

REDACTED

CCPTB at 36; citing Foucre, Tr. 908-909; CX 6277, *in camera*). There is no such evidence in the record. (RFF-Reply ¶ 1013). This testimony was permitted over Respondent's objection, but only for the perception of the witness and "not for the truth" of the matter asserted. (Foucre, Tr. 906; RFF-Reply ¶ 1013). Complaint Counsel now cites this testimony as truth of employer opinion. (CCPTB at 36). Complaint Counsel failed to call Kraft or any other employer at trial and is now attempting to circumvent the rules of evidence and use inadmissible hearsay testimony from a payor witness to fill a noticeable hole in its failing theories. This attempt should be given no weight.

iii. United offered to assist ENH in the FTC investigation

In an attempt to further influence negotiations, United curiously offered to assist ENH with the ongoing FTC investigation –

REDACTED

(Foucre, Tr. 1110-1111, 1976 *in camera;* CX 21, *in camera*; RFF-Reply ¶¶ 986, 1017).

REDACTED

(Hillebrand, Tr. 1886-1887; Hillebrand, Tr. 1924-1927, *in camera;* CX 6283, *in camera*).

REDACTED

(Hillebrand, Tr. 1887; Hillebrand, Tr. 1928, *in camera*; CX 6284, *in camera*).

REDACTED

(Foucre, Tr. 922-923; CCPTB at 36; Hillebrand, Tr. 1887; Hillebrand, Tr. 1928, *in camera*; CX 6284; RFF-Reply ¶¶ 1019, 1793).

iv. ENH and United agreed to a new contract in 2004

After negotiating for two years, United and ENH agreed to a new contract in 2004 that satisfied the goals of both parties. (RFF ¶¶ 917-922; RFF-Reply ¶ 985).

REDACTED

(RFF ¶¶ 917-921).

REDACTED

(Foucre, Tr. 1101-1103, *in camera*; RFF ¶¶ 918-921).

v. Exclusion of other area hospitals contributed to United's need to contract with ENH

United's refusal to "go elsewhere" for cheaper rates does not prove that it was forced to submit to ENH's market power because of a lack of alternatives, as Complaint Counsel claims. (CCPTB at 37).[28] Rather, it has more to do with the nature of United's negotiations with other hospital systems. For example, in 2000, United terminated all Rush System hospitals – including Rush North Shore – from its network and did not re-contract with the system, despite coming to terms with Rush North Shore in late 2003. (Foucre, Tr. 932-933; RFF ¶ 916). In addition, United terminated the Advocate Health System – which includes Advocate Lutheran General, ENH's closest substitute (CCFF ¶¶ 717, 1919) – after a public pricing dispute in 2002. (Foucre, Tr. 934; RFF ¶ 915; RFF-Reply ¶ 1000). Any reduction in alternatives, therefore, was due to United's independent contracting decisions and was not a result of the Merger.

b. PHCS

PHCS claimed to be harmed by the Merger because it could no longer "chose between [Evanston Hospital or HPH] and work them against each other." (Ballengee, Tr. 167). However,

Ballengee's allegations are contradicted by her own actions. As discussed above, PHCS had already identified numerous acceptable alternatives to ENH, including St. Francis, Lake Forest Hospital, Advocate Lutheran General, Rush North Shore, and Holy Family. (RX 712 at PHCS 891; *see also* RFF ¶ 457). Moreover, Ballengee admitted that no one at PHCS ever explicitly used the existence of HPH in negotiations with Evanston Hospital or vice versa. (Ballengee, Tr. 170; RFF ¶ 975). PHCS specifically classified Evanston Hospital as an "advanced teaching" facility, while HPH was a community hospital. (RFF-Reply ¶ 1927). As such, efforts to play them against each other would be pointless. (Ballengee, Tr. 159, 212; RX 107 at GWL 859; RFF-Reply ¶ 296).

Ballengee further claims that PHCS "customers and employers would not want to buy the [PHCS] network if it did not have the Evanston entity as part of it." (Ballengee, Tr. 181). At trial, however, Ballengee could not identify any of these supposed customers and admitted that PHCS actually "attempt[s] to eliminate the customer from the actual dollar and cent valuation" of contract negotiations. (Ballengee, Tr. 180-181, 210).[29] Moreover, her entire testimony concerning the requirements for a successful network lacks foundation. First, she never had a job in marketing provider networks. (Ballengee, Tr. 204; RFF-Reply ¶ 1080). Second, because PHCS never even attempted to market a network without ENH, Ballengee could not know that a network without ENH would not be successful. Complaint Counsel elected not to call any employers at trial and is now improperly attempting to have Ballengee speak on their behalf.

Evanston Hospital's prices to PHCS increased because it entered into post-Merger contract renegotiations with PHCS knowing that its pre-Merger contract rates were 30 to 35%

[28] Foucre admitted that she was not aware of anyone at ENH ever making statements indicating it had market power. (Foucre, Tr. 948; RFF ¶ 922).

below those being paid to HPH. (RFF ¶ 685; RFF-Reply ¶¶ 758, 1034). Ballengee agreed that the rates at HPH were higher than the rates at Evanston Hospital. (Ballengee, Tr. 203). Therefore, the justification for the price increase is clear: Evanston Hospital was being paid below market rates.[30]

Notwithstanding its claim that ENH's ability to negotiate discount-off-charges illustrates its market power, Complaint Counsel's discussion of the post-Merger contract with PHCS failed to note that it REDACTED (Ballengee, Tr. 252, *in camera*; Hillebrand, Tr. 1893). (Ballengee, Tr. 258-260, *in camera*; CX 5072 at 23, *in camera*; RFF ¶ 846; RFF-Reply 1086). Moreover, with respect to those portions of the contract that are REDACTED (Ballengee, Tr. 260-261, *in camera*; CX 5072 at 18, *in camera*; Hillebrand, Tr. 1937, *in camera*).[31]

c. One Health

ENH's post-Merger contract negotiations with Great West resulted in a rate increase from

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29 REDACTED , (Ballengee, Tr. 265-266, *in camera*; RX 805, *in camera*; RFF ¶ 835).

30 Ballengee claims that she was REDACTED , but cannot provide any actual evidence to support this claim. (CCPTB at 38). Ballengee claims to have calculated the figure based on the PHCS claims database. (Ballengee, Tr. 196). REDACTED (Ballengee, Tr. 261-262, *in camera*; RFF-Reply ¶ 1093). and it should therefore be disregarded. (Ballengee, Tr. 262, *in camera*).

31 Complaint Counsel also claims that ENH's alleged rejection of Ballengee's offer to exclude some of ENH's competitors from PHCS's network during the post-Merger contract negotiations was evidence of market power. (Hillebrand, Tr. 1745, 1894). The evidence demonstrated that Ballengee did not have the authority to make the original offer because PHCS (a PPO plan) lacked the ability to steer patients. (Hillebrand, Tr. 1894; RFF-Reply ¶¶ 1076-1078). The evidence showed that ENH considered Ballengee's offer but countered that it would also need to exclude Advocate Lutheran General. (Hillebrand, Tr. 1746-1747). Negotiations involving contract terms that Ballengee could not offer, and PHCS was never going to accept, are not evidence of market power.

an outdated contract that had not been negotiated since 1996 and from rates that were admittedly considerably lower than HPH's pre-Merger rates. (Neary, Tr. 633; RFF-Reply ¶¶ 1105, 1112). ENH requested a one-time adjustment to bring its rates up to market levels, to which One Health responded by terminating ENH from its hospital network. (Neary Tr. 610-611, 634). However, since negotiations were ongoing, the parties maintained an interim agreement that covered some One Health customers. (Hillebrand, Tr. 1898; Neary, Tr. 619-620, 637; RFF-Reply ¶¶ 1146-1147). The parties eventually executed a new agreement that contained rates that were very similar to those in the pre-Merger contract between One Health and HPH. (Hillebrand, Tr. 1898, 2031).

REDACTED

(Neary, Tr. 772, *in camera*; RFF-Reply ¶ 1166).

Similar to the situation with United above, One Health's willingness to renegotiate with ENH was not the result of any alleged market power, but rather One Health's negotiations with other area hospitals. On September 29, 2000, One Health received a letter from Lake Forest Hospital terminating its contract "[a]fter several months of negotiations." (RX 950; RFF-Reply ¶¶ 1160-1161). Kevin Dorsey admitted that it would have been very problematic to lose both HPH and Lake Forest Hospital. (Dorsey, Tr. 1484; RFF ¶¶ 807-808). The willingness to renegotiate with ENH was not the result of market power, but rather the independent termination issued by Lake Forest Hospital – One Health's admitted primary alternative to HPH.[32] (Dorsey, Tr. 1484; RX 950; RFF-Reply ¶¶ 1160-1161).

Despite not calling any employers to testify, Complaint Counsel asserts that One Health

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[32] Complaint Counsel called two witnesses, Patrick Neary and Kevin Dorsey, to testify on behalf of Great West/One Health. Although Neary claimed that after the Merger One Health's negotiating position with ENH was weakened because Evanston Hospital acquired HPH, its "main competitor," Dorsey testified that Lake Forest, not Evanston Hospital, was the primary alternative to HPH. (CCPTB at 40; Neary, Tr. 600; Dorsey, Tr. 1484; RFF ¶ 808).

returned to the negotiating table with ENH because "customers complained about not having access to ENH" and "customers demanded ENH." (CCPTB at 40). Neither Neary nor Dorsey could identify any sales that were lost to any customers. The only customer that even raised a question about leaving the Great West network was an automobile dealership located in the North Shore, which never actually moved its business away from Great West. (Neary, Tr. 635; Dorsey, Tr. 1481; RFF-Reply ¶ 1152).

d. Aetna

ENH's post-Merger negotiations with Aetna resulted in a fair rate increase

REDACTED

(Mendonsa, Tr. 563, *in camera*; CX 5007 at 2, *in camera*).

REDACTED (RFF ¶ 754; RFF-Reply ¶ 1187). The post-Merger negotiations resulted in a **REDACTED** **REDACTED** (Mendonsa, Tr. 539, 559, *in camera;* Hillebrand, Tr. 1948, *in camera*; Hillebrand, Tr. 1895-1897).[33]

REDACTED (RFF ¶¶ 750-751; RFF-Reply ¶ 1197). After negotiating for approximately 30 minutes, **REDACTED** , jotted the terms down on a sheet of paper, and shook hands in agreement. (Hillebrand, Tr. 1895-1896; Mendonsa, Tr. 559, *in camera*; CX 2447, *in camera*; CX 5008 at 5-6, *in camera*).

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[33] **REDACTED** (CCPTB at 41). The facts are that Mendonsa only had three years of contracting experience. Mendonsa did not participate in contracting prior to 1997 when he was transferred from Connecticut to Chicago. (Mendonsa, Tr. 475-477). With respect to ENH, Mendonsa only participated in the 2000 negotiations and **REDACTED** (Mendonsa, Tr. 556, *in camera*; RFF-Reply ¶¶ 766, 1178). Furthermore, since Mendonsa's position changed in 2000 and he is no longer responsible for contracting, the breadth of his entire contracting experience spans a mere three years. (Mendonsa, Tr. 485-486; RFF-Reply ¶ 1215). Consistent with the trial record, Complaint Counsel's statement should be revised to state that *in his three years of experience,* **REDACTED** (Mendonsa, Tr. 556, *in camera).*

(Mendonsa, Tr. 559, *in camera*;

REDACTED

RFF-Reply ¶¶ 1197, 1203).

REDACTED

(Mendonsa, Tr. 558, *in camera*; RFF ¶ 411). Complaint Counsel's attempt to characterize as market power a 30 minute negotiation where both parties compromised and ended with a friendly handshake strains credibility.[34]

e. Unicare

Unicare claims that after the Merger it could not **REDACTED** of its customers. (CCPTB at 42, citing Holt-Darcy, Tr. 1518-1519, *in camera*). Lenore Holt-Darcy's biased lay opinion testimony is contradicted by her own definition of **REDACTED** (Holt-Darcy, Tr. 1518-1519; RFF-Reply ¶¶ 1266, 1299). Holt-Darcy testified at trial that Unicare's goal was simply to ensure customers had access to a hospital within a 30 mile area:

> Q: Let's just briefly put a definition behind each of those. When you say you look at geographic need, how do you do that?
>
> A: You want to see what population that you have or potentially have, what marketing things that they need in a particular services area. *You want to make sure that members have access to the hospital within 30 miles of where they live or where they work* so that you have sufficient access to meet standards that the plans put together.
>
> Q: So when you said you look at access, is that what you were referring to?
>
> A: Correct.

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[34] **REDACTED** (Mendonsa, Tr. 566, *in camera*).

(Holt-Darcy, Tr. 1420) (emphasis added). The Merger hardly altered the alternatives available to meet Unicare's "access" standards. (Holt-Darcy, Tr. 1420; CCPTB at 42; RFF-Reply ¶¶ 295, 1299). The evidence showed that

REDACTED

(RFF ¶¶ 387-390).

REDACTED

(RFF ¶ 389). As shown above, Holt-Darcy admitted that

REDACTED

(Holt-Darcy, Tr. 1518-1519, *in camera*; RFF-Reply ¶ 1266, 1297-1298).

Unicare's claim that

REDACTED

(CCPTB at 42 (emphasis added); RFF-Reply ¶ 1246). Evanston and Glenbrook hospitals had operated under one rate and one contract since Glenbrook opened its doors in 1977. (RFF ¶ 308). Further, several other Chicago-area health systems have begun contracting on a system-wide basis. (RFF ¶¶ 187-189; RFF-Reply ¶ 910). Neither Unicare nor any other payor complained about the joint contracting arrangement until they testified at trial.

f. Other health plans

In a total of five sentences, which rely on a mere five proposed findings, Complaint Counsel asserts that at least six other MCOs were victims of ENH's alleged post-Merger market power. (CCPTB at 43; CCFF ¶¶ 1305-1310). Complaint Counsel failed to call any witnesses from these companies, which includes ENH's two largest customers, Blue Cross and Humana. The uncontroverted record evidence shows that none of these health plans were the victims of

alleged market power. (*See* RFF ¶¶ 757-777 (Blue Cross), RFF ¶¶ 788-784 (Cigna), RFF ¶¶ 785-789 (CCN), RFF ¶¶ 809-813 (HFN), RFF ¶¶ 814-826 (Humana), RFF ¶¶ 849-852 (Preferred Plan)).

Humana, ENH's second largest payor, was not called to testify at trial by Complaint Counsel because its price increase was related to an independent business transaction between Humana and ENH. (RFF ¶¶ 814-826; RFF-Reply ¶ 1307). In 1998, ENH acquired four physician office buildings and 40 physicians from Humana. (RFF ¶ 816). Rather than pay for the acquisition of these offices and physicians, Humana and ENH negotiated a capitated contract to cover the cost of the buildings and physicians over a period of time. (RFF ¶ 817). The post-Merger negotiations with Humana took into account outstanding payments under this independent business deal, which Complaint Counsel's economic expert admitted she failed to consider in analyzing the price increase. (RFF ¶ 1023; RFF-Reply ¶ 482). Therefore, any alleged price increase to Humana had no connection to the Merger.

ENH's negotiations with other payors were also not the result of market power. Blue Cross' post-Merger contract with ENH resulted in a small price increase because its pre-Merger contract with Evanston Hospital was one of the few that actually paid higher rates to Evanston Hospital than it did to HPH. (RFF ¶¶ 757-777). Evanston Hospital's pre-Merger contact with Cigna had not been updated since 1995 and contained rates that were below HPH's rates. (RFF ¶¶ 778-781). Cigna and ENH successfully renegotiated a new contract that included a hybrid of reimbursement methodologies, including per diems, case rates, and discount off charges. (RFF ¶¶ 782-784; RFF-Reply ¶ 871). Similarly, Evanston Hospital's pre-Merger contracts with both CCN and HFN were significantly undermarket as compared to HPH's pre-Merger contract. (RFF ¶¶ 785-786, 809-812). Following the Merger, CCN and ENH agreed on a contract that

contained key rates that were originally proposed by CCN during the negotiation. (RFF ¶¶ 787-789). Finally, Preferred Plan agreed to assign HPH's pre-merger rates to Evanston Hospital at the time of the Merger, and in 2000, negotiated a new contract that actually reduced the rates. (RFF ¶¶ 849-852; RFF-Reply ¶ 1310).

4. Complaint Counsel cannot prove its case based on the testimony of the payor witnesses called at trial

As discussed above, Complaint Counsel attempts to direct this Court's attention away from the evidence that it does not have – i.e. evidence of anticompetitive price levels – and prove its theory that the Merger caused competitive harm based on the biased and contradicted opinions of MCO witnesses.[35] Ignoring ENH's two largest MCO customers, Complaint Counsel called as witnesses several small payors who either had no firsthand knowledge of post-Merger negotiations, provided testimony that was contracted by statements made at the time of the Merger, or introduced biased lay opinion testimony that lacked foundation. As noted in prior hospital merger cases, the testimony of MCOs is "suspect" and should be given little weight. *See FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999) (reversing district court's injunction of hospital merger and rejecting reliance on managed care testimony). In *FTC v. Butterworth Health Corp.*, the court rejected evidence provided by managed care companies regarding price increases because the concerns of managed care companies "are hardly the sort of benefit the antitrust laws are designed to protect." 946 F. Supp. 1285, 1299 (W.D. Mich. 1996). The court in *Butterworth* stated:

> In the real world, hospitals are in the business of saving lives, and managed care organizations are in the business of saving dollars. Managed care organizations' interest in maintaining a competitive edge cannot be allowed to trump either hospitals' conscientious

[35] **REDACTED**

(Baker, Tr. 4697, *in camera*; RFF ¶ 1047).

> endeavors to continue to provide comprehensive, high quality health care in this rapidly evolving field, or the consuming public's right to receive the same.

Id. at 1302.[36]

Rather than focus on the testimony of MCO witnesses who were "not disinterested,"[37] the *Butterworth* court noted that the lack of testimony from *employers* represented a significant hole in the government's case. *Id.* Similar to *Butterworth*, Complaint Counsel in this matter has failed to present this Court with any evidence from area employers. No employers were called to testify at trial, nor did Complaint Counsel seek to admit into evidence any documents or testimony from employers, any surveys of employers' views or even bring to trial a benefits consultant who advises area employers.

This failure to rely on employer testimony is a critical hole in Complaint Counsel's case. While the parties agree that the direct customers in this case are MCOs, the evidence demonstrated that payors pass their costs along to self-insured employers. (RFF ¶ 121 (60% of Aetna's business is self-insured); RFF ¶ 144 (90% of Great West's business is self-insured); RFF ¶ 176 (75% of United's business is self-insured)). Thus, Complaint Counsel lacks any testimony from the party that truly bears the cost. (RFF-Reply ¶¶ 1057, 1080). Complaint Counsel's use of MCO testimony as a proxy for employers they chose not to call is a misrepresentation of the trial record, and has no probative value.

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[36] *See FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 145 (D.D.C. 2004) (Stating that "antitrust authorities do not accord great weight to the subjective views of customers in the market."); *FTC v. Owens-Illinois, Inc.*, 681 F. Supp. 27, 38 (D.D.C.), *vacated as moot*, 850 F.2d 694 (D.C.Cir. 1988) ("opinions of purchasers must be viewed in light of their actual behavior"); *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1131 (N.D. Cal. 2004); *see also* 2A Areeda, et al., *Antitrust Law* ¶ 538b, at 239 ("[l]east reliable [evidence] is 'subjective' testimony by customers ... Though not irrelevant, such statements are often unreliable."); *see also Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406, 1410 (7th Cir. 1995) (finding that while managed care HMO's "incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible.").

D. ENH's price increases were explained at trial

Complaint Counsel's conclusion that ENH's price increases provide direct evidence of its market power is wrong for several reasons. First, price increases alone are not direct evidence of market power and Complaint Counsel has not shown the additional proof necessary to reach this conclusion. (RPTB at 35-40; RFF-Reply ¶ 467). Second, Complaint Counsel has not even considered, much less eliminated, plausible alternative explanations for ENH's relative price increases. (RPTB at 38-40; RFF-Reply ¶ 392). Third, the methodology employed by Complaint Counsel's primary expert is fatally flawed, both in terms of the data used to determine the magnitude of the price increases, as well as in ignoring numerous variables that would affect the results. (*Id.*)

1. Complaint Counsel failed to put forth "Direct Evidence" of market power

Direct proof of market power cannot be based on evidence of price increases alone, but must be accompanied by proof that the price increased above a competitive level and can be sustained at that level over a period of time, or is associated with a reduction of output. (*See* RPTB at 35-36). Complaint Counsel failed to provide evidence of either.

Instead, Complaint Counsel offered Dr. Haas-Wilson's "difference-in-differences" analysis, which shows only that ENH's prices increased more than other hospitals' prices increased, a fact which is not disputed in this case. This analysis cannot show the cause of the price increase except by carefully eliminating all other explanations. (RFF ¶¶ 521-523; RFF-Reply ¶¶ 392, 510). Dr. Haas-Wilson's results are only relevant if Complaint Counsel can show that these increases ultimately resulted in prices that were above the competitive level for comparable hospitals. Complaint Counsel offered no such proof.

[37] This Court has already found that MCOs have an "interest" in this litigation. *See* Order Denying Non-Party Great-West Healthcare's Motion For Cost Reimbursement at 3 (July 7, 2004) (Attachment A) (finding Great-West

Dr. Haas-Wilson neither examined the competitive price levels following ENH's increases, nor did she show that the resulting prices were out of line with those of competitor hospitals. Likewise, Dr. Haas-Wilson never examined price levels *before* the Merger to determine whether ENH's pre-merger prices were at, or below, the level of its competitors. Consequently, Complaint Counsel offered no proof that ENH's post-Merger prices were above a competitive level and thus a product of market power. As shown at trial, ENH had significantly misunderstood the demand for its services and was pricing below its competition before the Merger and simply raised its prices to competitive levels following the Merger. (*See* Sections III.A-B, *infra*; RPTB at 41-54; RFF ¶¶ 1148-1149).

Moreover, Complaint Counsel admits, and the trial established, that output was never reduced after the Merger. (CCFF ¶ 1653; RFF ¶ 1164; RPTB at 37-38). Accordingly, ENH's price increases were demonstrably not a result of market power. Finally, market power requires durability, which "depends largely on the ability of existing firms to quickly increase their own output in response to a contraction by the defendant." *Rebel Oil* 51 F.3d at 1441. (S*ee* RPTB at 58-59). Complaint Counsel's post-trial brief is virtually silent on the issue of entry, notwithstanding the fact that it affirmatively pleads the existence of entry barriers in its Complaint. (*See* Compl. ¶¶ 19-23). Respondent, on the other hand, demonstrated that expansion and re-positioning are possible and have been occurring aggressively, and that regulatory barriers to entry will ease significantly in the near future. (RPTB at 58-59; RFF ¶¶ 390(a)-(b), 434, 2290-2291, 2280-2282, 2293-2297).

2. Complaint Counsel's price increase analysis fails to prove that the Merger provided ENH with market power

Without a price level analysis, Complaint Counsel attempts to prove market power

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"has an interest in the outcome" of this case).

indirectly – by ruling out every alternative explanation for the price increases, except for market power, that was "reasonable and supported by sound economic theory." (CCPTB at 48 n.34). Complaint Counsel failed in that attempt because its expert never adequately considered or ruled out plausible explanations for the price increases, particularly "learning about demand."[38] (RFF ¶¶ 315, 519-520). Dr. Haas-Wilson considered only selective portions of the payor testimony and relied only upon the factual evidence that was helpful to her conclusion without considering the entire context of often contradictory evidence. (RFF-Reply ¶¶ 742, 980-981).

Furthermore,

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(RFF ¶ 1057); (ii) payor-specific factors (RFF ¶¶ 523(d), 523(e), 523(l), 523(n), 523(p), 1023); or (iii) other factors that can generally impact the outcome of the bargain between MCOs and hospitals that do not reflect market power. (RFF ¶¶ 526, 1021-1022; RPTB at 38-41). Critically, as discussed below, Complaint Counsel never properly controlled or accounted for the dramatic quality improvements brought about as a result of the Merger, which Complaint Counsel acknowledged it must do before evidence of price increases could be used to prove market power. (Compl. ¶¶ 24, 28; RFF ¶¶ 523(g), 1162-1163).

REDACTED **REDACTED**

[39] (RPTB at 47; RFF ¶¶ 1003-1004, 1156, 1161). By ignoring all of these

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[38] Dr. Haas-Wilson admitted that learning about demand it is both a plausible economic theory and that relative price increases resulting from it are not anticompetitive. (RFF ¶ 1063; *see also* RFF ¶ 523(k); RPTB at 40-41).

[39] **REDACTED** (Baker, Tr. 4645-4646, *in camera*).

relevant factors, it is not possible to conclude that ENH's price increases were caused by market power.

3. Complaint Counsel's price increase analysis was shown to be flawed

Complaint Counsel has taken several liberties with respect to describing the magnitude of the increases. Desperate to make its point, Complaint Counsel starts by "cherry-picking" price increases for individual payors, despite its assertion throughout this entire case that the customers in this case are all of the Chicago area payors.[40] (*See* Section III.C.1, *infra*). Even where Complaint Counsel does discuss the payors as a group, its analysis is flawed and based on data from the Illinois Department of Public Health, which contain no measure of actual payments made by managed care payors. (RPTB at 47-48; RFF ¶¶ 1016; RFF-Reply ¶¶ 395, 397, 501, 524). Furthermore, the control groups cobbled together by Dr. Haas-Wilson are overbroad and contain a wide mix of hospitals with many characteristics that are not similar to those of ENH, and are therefore not a reliable "control" against which price increases at ENH can be compared. (*See* Section II.B, *infra*; RPTB at 47; RFF ¶¶ 1032-1045 RFF-Reply ¶¶ 508, 512-518).

Complaint Counsel has therefore failed to show, directly or indirectly, that ENH's price increases were evidence of market power.[41]

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[40] One example of Complaint Counsel's selectivity in payor evidence is its insistence throughout the brief that ENH's dealings with Blue Cross Blue Shield be ignored. BCBS, one of the payors not called by Complaint Counsel at trial, is the largest health plan in the area and a significant part of the group of payors that Complaint Counsel alleges was harmed by the Merger. (RFF ¶¶ 126-127). And yet, because the evidence with respect to BCBS does not support Complaint Counsel's allegations, it would rather focus on individual data from select payors, and simply ignore any contrary evidence.

[41] Complaint Counsel distorts Prof. Baker's testimony in claiming that he "conceded" that the pattern of the price increase is consistent with ENH gaining market power. (CCPTB at 49). The trial record is clear that Prof. Baker testified that price increases *could* be consistent with the exercise of market power, but that the facts of this case demonstrate that market power does not explain the price increases. (RFF ¶ 519; RFF-Reply ¶ 691). Rather, the price increases here are consistent with learning about demand. (RPTB at 53-54; Section III, *infra*; RFF ¶¶ 1148-1155).

II. COMPLAINT COUNSEL HAS NOT SHOWN THAT THE MERGER WILL SUBSTANTIALLY LESSEN COMPETITION WITHIN A RELEVANT MARKET

Rather than continuing to support a position that is clearly unsupportable, Complaint Counsel appears to have abandoned Count II of its Complaint.[42] In its post-trial brief, Complaint Counsel makes no distinction between Count I and Count II. Rather, Complaint Counsel now contends that it need not conduct an "elaborate market analysis" because it may back into a market definition using its purported "direct evidence" of anticompetitive effects. (*See* CCPTB at 49-55). Like Count II, Complaint Counsel's new position is also legally unsupportable.

With the premise that it need not engage in any meaningful market analysis, Complaint Counsel argues that because ENH was able to achieve price increases, ENH must have had market power. Complaint Counsel thus concludes that the relevant market must be limited to just the merging parties. Complaint Counsel's circular argument regarding the manner in which a relevant market must be defined, and its application here, is fatally flawed for two primary reasons. Specifically, its approach to market definition is without legal support and its proposed relevant markets are inconsistent with the evidence, economic theory and the law.

A. There Must be a Meaningful Market Analysis in a Section 7 Case

Complaint Counsel attempts to support its minimalist approach to market definition here by relying on irrelevant (and misunderstood) Sherman Act cases and on a misinterpretation of two Section 7 cases. As explained below, neither set of cases allows Complaint Counsel to abrogate its responsibility to define a relevant market in a meaningful way.

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[42] The only substantive difference between Counts I and II of the Complaint is that Count I alleged relevant product and geographic markets while Count II explicitly made no reference to a relevant market. (*Compare* Comp. ¶¶ 15-27 *with* ¶ 28-32). In support of Count II, Complaint Counsel stated that "it is unnecessary to define a product or geographic market for the purposes of a claim under Section 7 of the Clayton Act." (Compl. Counsel Interrog. Answers at 33 (included as Attachment C to Respondent's Post-Trial Brief); *see also* RPTB at 15). In its Proposed Conclusions of Law, however, Complaint Counsel explicitly recognizes the need for defining the market by claiming, under Count II, that "[t]he Merger had anticompetitive effects in the relevant market." (Complaint

1. The Sherman Act cases cited by Complaint Counsel are irrelevant and unavailing

In its brief, Complaint Counsel heavily cites *Indiana Federation of Dentists* and *Toys R Us* (both Sherman Act cases), without accounting for, or even acknowledging, the two principle factors that render these cases inapplicable to the present case. *Toys "R" Us, Inc. v. FTC*, 221 F.3d 928 (7th Cir. 2000); *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986). (CCPTB at 49-50). First, the statutory schemes of the Sherman Act and Section 7 of the Clayton Act are different – the explicit language of Section 7 requires proof that future competitive harm is likely within a "line of commerce" and within "any section of the country." 15 U.S.C. § 18. The Supreme Court has consistently interpreted Section 7 to require a determination of the relevant market. (*See* RPTB at 31-34 and cases cited in n. 16). As the Supreme Court stated, "[d]etermination of the relevant product and geographic markets is 'a necessary predicate' to deciding whether a merger contravenes the Clayton Act." *United States v. Marine Bancorporation*, 418 U.S. 602, 618 (1974). The provisions of the Sherman Act have no such requirement.[43] 15 U.S.C. §§ 1, 2.

Second, the Sherman Act cases cited by Complaint Counsel require plaintiffs to define a relevant market even when they attempt to prove market power or anticompetitive effects directly. As the Seventh Circuit stated, direct proof of allegedly anticompetitive effects "is

Counsel's Proposed Conclusions of Law ¶ 19). Because Complaint Counsel is no longer supporting Count II, it should be dismissed.

[43] Complaint Counsel tries to hold up *United States v. Rockford Memorial Corp.* for the proposition that it can import wholesale Section 1 cases into a merger context. In *Rockford,* the court noted that the standards for what is ultimately considered anticompetitive under Section 1 and under Section 7 are essentially the same. 898 F.2d at 1282. This reasoning simply illustrates that both statutes are complements in attempting to proscribe anticompetitive conduct. The court in *Rockford,* however, did not change the jurisdictional scope of these sections or the individual, statutory elements of proof for each. Thus, Section 7 still requires that Complaint Counsel show that the Merger will substantially lessen competition within relevant geographic and product markets. Moreover, Complaint Counsel's attempt to read Section 1 caselaw into a Section 7 case backfires if its aim is to avoid definition of a relevant market. In *Rockford*, a relevant market was actually defined, and as discussed below, the

virtually meaningless if it is entirely unmoored from at least a rough definition of a product and geographic market." *Republic Tobacco Co. v. N. Atl. Trading Co.*, 381 F.3d 717, 737 (7th Cir. 2004). The *Republic* court further explained that the two cases cited by Complaint Counsel, *FTC v. Indiana Federation of Dentists* and *FTC v. Toys "R" Us, Inc.*, do not support a plaintiff's ability to abrogate market definition:[44]

> [N]either *Toys "R" Us* nor *Indiana Federation of Dentists* allows an antitrust plaintiff to dispense entirely with market definition. Rather, these cases stand for the proposition that *if a plaintiff can show the rough contours of a relevant market*, and show that *the defendant commands a substantial share of the market*, then direct evidence of anticompetitive effects can establish the defendant's market power in lieu of the usual showing of a precisely defined relevant market and a monopoly market share.

Id. (emphasis added) (footnote omitted).[45]

2. The Section 7 cases cited by Complaint Counsel do not support it

Complaint Counsel is no more effective in teasing support for its novel theory from the two Section 7 cases it cites – *FTC v. Libbey* and *FTC v. Staples*. (*See* CCPTB at 50-51). In *Libbey*, the court actually did undertake an analysis of the relevant market and engaged in a market share analysis. *FTC v. Libbey, Inc.*, 211 F. Supp. 2d 34, 45 (D.D.C. 2002) ("first step in

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Seventh Circuit has since held that a relevant market definition is required even in Section 1 cases. *See e.g., Republic Tobacco Co. v. N. Atl. Trading Co., Inc.* 381 F.3d 717, 737 (7th Cir. 2004).

[44] The other Sherman Act cases presented by Complaint Counsel in its post-trial brief are similarly unavailing. *See Todd v. Exxon Corp.*, 275 F.3d 191, 199, 206-207 (2d Cir. 2001) (the plaintiff had both defined a relevant market and indicated the defendant's market share; court merely held that direct effects are one way of showing anticompetitive effects *within a relevant market* and not that a plaintiff may eschew market definition entirely); *Re/Max Int'l, Inc. v. Realty One, Inc.*, 173 F.3d 995, 1018 (6th Cir. 1999) (court held that monopoly power is shown by direct evidence of actual control over prices or the actual exclusion of competitors, neither of which was proven here). Complaint Counsel cites to *Rebel Oil* for support, yet the case proves exactly how Complaint Counsel misreads the Sherman Act cases. *Rebel Oil Co. v. Atl. Richfield Co.*, 51 F.3d 1421, 1434 (9th Cir. 1995). The *Rebel Oil* court made clear that in a Section 1 case, market power may be proven "directly" by showing restricted output and supracompetitive prices. *Id.* at 1434. Complaint Counsel has proven neither here.

[45] The Seventh Circuit also noted that in both *Toys "R" Us* and *Indiana Federation of Dentists* the product and geographic markets were not seriously disputed, nor was the substantial nature of the defendant's market share. *Id.* Under those circumstances, the court held that it might be sufficient to allow the inference of market power from direct evidence of anticompetitive effects. *Id.* On the facts of *Republic Tobacco*, however, the Seventh Circuit

evaluating whether a merger violates Section 7 of the Clayton Act is to define the relevant product market"), 50-52 (noting *Libbey's* market share of 72%, a post-merger HHI of 5251, and questioning the viability of a potential entrant). The introduction of "direct effects" evidence did not eliminate the need for market definition and market share analysis; rather, such evidence simply served as one piece of evidence that demonstrated the potential competitive effect of the transaction within the defined market.[46] *Id.* at 50.

Similarly, *Staples* does not hold that evidence of price increases substitutes for defining a relevant market.[47] *FTC v. Staples, Inc.*, 970 F. Supp. 1066 (D.D.C. 1997). First, the "pricing evidence" in *Staples* included evidence of price levels – the merging parties' prices were higher in markets with more office superstores than in markets with fewer office superstores – not mere evidence of price increases that cannot be attributed to market power.[48] *Id.* at 1075-1077. Second, the pricing evidence in *Staples* involved a comprehensive comparison of prices across numerous geographic markets, as opposed to the relative paucity of data available here.[49] *Id.*

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declined to consider this type of proof where the relevant geographic market was in dispute and where the plaintiff had not presented sufficient evidence to support its proposed market definition. *Id.*

[46] Furthermore, *Libbey* was decided on a motion for a preliminary injunction, under which the standard of proof for the government is lower than where, as here, the ultimate determination of legality is at issue. The court granted the injunction because it found that the FTC's concerns were "plausible" and established a "prima facie case," even though it explicitly noted that "[t]he Court is not convinced that the acquisition as presented will in fact violate the antitrust laws." 211 F. Supp. at 50.

[47] Complaint Counsel's misguided reliance on *Staples* is ironic. One of Respondent's experts, Prof. Baker, was Director of the FTC's Bureau of Economics at the time the *Staples* case was brought and personally oversaw the building of the economic evidence against the merger. Complaint Counsel also designated one of the economists who testified in *Staples*, Dr. Orley Ashenfelter, but ultimately did not call him to offer any testimony to rebut Dr. Bakers's analysis. Complaint Counsel never even attempted to elicit support for its interpretation of *Staples* from either witness.

[48] As explained in Respondent's post-trial brief, Complaint Counsel did not control for all alternative explanations for the price increases, nor did it prove that ENH increased its price above competitive levels or that its price increases were accompanied by a reduction in output. (RPTB at 36-54).

[49] The evidence in *Staples* included price comparisons involving different market structures across many time periods and across many geographic markets. 970 F. Supp. at 1073, 1075-1077. The large number of comparisons in the data made it possible to accurately observe the consequences of a change in market structure by controlling for explanations for price changes. In contrast, the purported price evidence in this case involves only one merger at one time in one market and neither Complaint Counsel nor its expert successfully controlled for non-market power various explanations the for that sole comparison in the data.

Third, the pricing evidence in *Staples* was actually used *to define* the relevant product market. *Id.* at 1075-1076, 1080. After defining the product market (the geographic markets were undisputed), the court considered the parties' market shares and HHIs within that market to conclude that there would be a lessening of competition after the merger. *Id.* at 1081. While the court acknowledged that the price evidence used to determine the relevant product market was consistent with the price data that suggested a future anticompetitive effect, it did not hold that the pricing data obviated the need to prove a relevant market. *Id.* at 1082.

B. Complaint Counsel Fails to Define an Economically Meaningful Relevant Market

The Supreme Court has mandated an approach to market definition that requires identifying (a) those products that have a "reasonable interchangeability of use" and (b) the geographic area "in which the seller operates, and to which the purchaser can practicably turn for supplies." *See Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962) and *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 359 (1963); *see also Merger Guidelines* §§ 1.11, 1.21.

Ignoring the Supreme Court and its own *Merger Guidelines*, Complaint Counsel attempts to bootstrap proof of a relevant market from ENH's relative price increases with no additional market analysis, inappropriately reasoning that because MCOs agreed to those prices, the relevant market must be limited to ENH itself. (CCPTB at 51-55). This type of flawed reasoning would suggest that *all* price increases are anticompetitive. In approaching market definition with this circular logic, Complaint Counsel has simply assumed that the MCOs agreed to the higher prices because they had no choice, rather than because the prices were competitive, appropriate for hospitals with improved quality or for any other reason. Complaint Counsel thus assumes its preferred answer – that the Merger is anticompetitive – in the question it is seeking to answer – whether the appropriate definition of the relevant market permits a conclusion that

the Merger will likely cause competitive harm. (*See also* RPTB at 29-30).[50] In contrast, defining the relevant market according to the principles laid down by the Supreme Court reveals that the relevant market extends beyond Complaint Counsel's result-oriented boundaries in both product and geographic dimensions.

1. The relevant product market in this case includes inpatient and outpatient services

In its brief Complaint Counsel devotes one page to its discussion of the product market and simply defines a product market comprised of general acute-care inpatient services sold to health plans, which includes primary, secondary and tertiary services, but excludes quaternary inpatient services, as well as outpatient services. (CCPTB at 52).[51] Complaint Counsel supports this claim with a two-fold argument. First, the prices of the hospital services are set in negotiations between the hospitals and the MCOs. Second, in response to an increase in price, MCOs do not substitute inpatient services for outpatient services, or vice versa. (CCPTB at 52-53).

A proper definition of the relevant product market requires the analysis to focus on the product actually being sold to the customer, or in this case, the group of services that are purchased by the MCOs. (*Merger Guidelines* § 1.11; RFF ¶¶ 366, 369-376; RFF-Reply ¶¶ 1613, 1625). Complaint Counsel is correct that the prices of hospital services are determined in

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[50] As explained in Respondent's post-trial brief, Complaint Counsel has not proven that ENH's relative price increases were anticompetitive. (RPTB at 34-60). Without the initial assumption that ENH's relative price increases are anticompetitive, however, Complaint Counsel's market definition crumbles.

[51] This definition has undergone some metamorphosis. The Complaint defined the product market as acute-care inpatient services, and explicitly excluded "sophisticated services known in the industry as tertiary services that include such services as open heart surgery and transplants." (Compl. ¶ 16). A class of services referred to as "quaternary" was never mentioned or recognized. After its expert stated that tertiary services were included in the product market, Complaint Counsel revised its market definition to include tertiary services, but excluded quaternary services (purportedly including transplants). (RFF ¶¶ 382, 1087; CCPTB at 52). There is no accepted definition of what constitutes quaternary services; indeed, Complaint Counsel's expert defined quaternary at trial as including burn treatment and transplants while her book considers transplants to be a tertiary service. (RFF ¶¶ 1086-

negotiations between hospitals and MCOs. The evidence presented at trial demonstrated that MCOs purchase a bundle of products that includes inpatient and outpatient services. (*See* RPTB at 16-18). Further, the payors trade-off prices on inpatient and outpatient services as part of the negotiation.[52] (RFF ¶¶ 369-376; RFF-Reply ¶ 1629; RPTB at 16-18).

Complaint Counsel further argues that the product market must exclude outpatient services because they are not substitutable with inpatient services. Substitutability between patient services is irrelevant – indeed, if substitutability between patient services was the standard, hospital cases would involve hundreds of product markets because individual inpatient services are not substitutable for each other. *See, e.g., Sutter* 130 F. Supp. 2d 1109, 1119 ("for example, one cannot substitute a tonsillectomy for heart bypass surgery"). (*See* RPTB at 16-18 (a product market may include a number of different products that are not substitutable in and of themselves)).[53] As demonstrated above, hospitals' primary customers negotiate for all acute-care hospital services, including both inpatient and outpatient services. (*See generally* RFF ¶¶ 366-376; RFF-Reply ¶¶ 1625-1628).[54]

1087; RFF-Reply ¶ 1629). Moreover, other witnesses indicated that certain services provided by ENH, such as cardioangenesis, should also be considered quaternary. (RFF ¶ 16; RFF-Reply ¶ 291).

[52] Complaint Counsel cites testimony by one of its experts, Prof. Elzinga, to support its contention that the product market is "the sale of inpatient hospital services to health plans ...." (CCPTB at 52-53). Prof. Elzinga said no such thing. By his own testimony, Prof. Elzinga never offered an expert opinion as to the appropriate market definition in this case. (*See* Elzinga, Tr. 2353-2357). In responding to the Court's question about where price competition occurs, Prof. Elzinga simply testified that the price of hospital services is set by negotiations between health plans and hospitals and that these "hospital services," in his view, would be the product market. (*See* Elzinga, Tr. 2397). Prof. Elzinga never made a distinction between inpatient and outpatient services or even used those terms. (*See* Elzinga, Tr. 2397).

[53] The combination of these services can be analogized to the sale of a car to the ultimate consumer. The car itself is made up of different components, such as a chassis, engine, wheels, and so on, which are not substitutable for each other on an individual basis. When looking at the interaction between the consumer and the dealer, however, the market is the sale of whole cars, irrespective of whether the individual components are substitutable. In the present case, the MCOs want the whole car – all of a hospital's services, including outpatient – and are not looking to pick and choose individual parts. (RFF ¶¶ 369-376; RFF-Reply ¶¶ 1625-1628).

[54] Such a conclusion is not inconsistent with the analysis applied in previous hospital merger cases. *See United States. v. Rockford Mem'l Corp.* 898 F.2d 1278 (7th Cir. 1990); *FTC v. Butterworth Health Corp.* 946 F. Supp. 1285 (W.D. Mich. 1996); *Santa Cruz Med. Clinic v. Dominican Santa Cruz Hosp.*,1995 WL 853037 (N.D. Cal. Sept. 7, 1995). As Complaint Counsel repeatedly notes, the analysis in these cases focused on patients as the primary

2. Complaint Counsel has not properly defined a geographic market

No Court has ever held that the relevant geographic market in a hospital merger case includes only the merging parties.[55] Respondent respectfully urges that this Court not be the first to do so.

The standard for defining a geographic market is clear – it is the "area of effective competition ... in which the seller operates, and to which the purchaser can practicably turn for supplies." *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 359 (1963) (citations omitted). The FTC's own *Merger Guidelines* begin the process of defining a geographic market by engaging in a process called the "hypothetical monopolist" test. This test identities the firms that are the "next-best substitute[s] for production at the merging firm's location" and continues to add such firms until the collection of firms in the geographic market, if viewed as a single entity, would profitably raise price above the competitive level. *Merger Guidelines* § 1.21.

Complaint Counsel defines the geographic market to include only the merging parties because MCOs purportedly could not market their provider networks without the ENH hospitals and thus "cannot 'practicably' turn outside the ENH geographic triangle for substitute hospitals...." (CCPTB at 54). This is the same argument Complaint Counsel advanced for why ENH's relative price increases were necessarily anticompetitive. As demonstrated above, and in Respondent's post-trial brief, the evidence simply does not support Complaint Counsel's

customers and took into account their needs and interactions with hospitals in defining the relevant product market to include only inpatient services. As discussed in this section, looking at these same factors in a market where MCOs are the direct customers would compel the inclusion of outpatient services in the relevant product market.

[55] *Cf. Tenet Health Care Corp.*, 186 F.3d at 1053-1054 ("The FTC's contention that the merged hospitals would have eighty-four percent of the market for inpatient primary and secondary services within a contrived market area that stops just short of including a regional hospital (Missouri Delta in Sikeston) that is closer to many patients than the Poplar Bluff hospitals, strikes us as absurd.") Given that Dr. Haas-Wilson's geographic market suffers from the exact same deficiency, it is not suprising that Complaint Counsel fails to cite its own expert's testimony on this point. (RPTB at 19-20; RFF ¶¶ 491, 498).

contention that MCOs were held hostage by ENH.[56] (*See* RPTB at 18-20, 54-57).

Focusing instead on a review of the record evidence, and applying the principles articulated by the courts and in the *Merger Guidelines,* the geographic market here clearly includes numerous hospitals that compete with ENH and which are viable alternatives for MCOs in building and marketing their health plans. (RFF ¶¶ 409-490). Factors such as geographic proximity, patient travel patterns, physician admitting patterns and market participant's views on competition are particularly relevant in making this determination.[57] (RFF ¶¶ 392, 395, 406, 461, 474, 485; *see also* Respondent's Proposed Conclusions of Law ¶¶ 14-17). Examining each of these elements in depth, Dr. Noether found that, at the very least, the participants in the relevant geographic market should also include Rush North Shore, St. Francis, Advocate Lutheran General, Resurrection, Lake Forest Hospital and Condell and may well include additional hospitals. (RFF ¶ 488; RPTB at 23).

Finally, as stated above, there is no affirmative legal support for its contention that the geographic market is limited to the merging hospitals. Instead, Complaint Counsel disregards recent hospital merger cases decided in favor of the hospitals when arguing its geographic market, yet cites older hospital merger cases in support of its product market. (*See* CCPTB at 53, 57-59). Complaint Counsel's conclusion – that focusing on the MCO as the direct customer renders evidence of patient preferences meaningless – is erroneous and ignores the record

[56] As discussed above, the payor testimony regarding this issue is wholly self-serving and contradicts itself in a number of places. (*See* Section I.C.3, *supra*).

[57] Complaint Counsel never considered any of these factors, nor did it ever satisfy the *Merger Guidelines* requirement that a candidate geographic market be expanded by including each merging party's next best substitute. In particular, Complaint Counsel did not seek to show that Evanston Hospital and HPH were each other's next best substitutes prior to the Merger. (RFF ¶ 968). Evanston Hospital and HPH were, in fact, objectively different hospitals. Prior to the Merger, Evanston Hospital was an academic teaching hospital while HPH was a community hospital. (RFF ¶¶ 30, 41-43, 481). Each competed more closely with other hospitals than with each other in a number of dimensions, and there are numerous other hospitals that are geographically closer to either Evanston Hospital or HPH than these hospitals are to each other. (RFF ¶¶ 384, 389-390, 408, 463-464, 468-469, 473, 561-587).

evidence.[58] The evidence showed that MCOs take patient preferences into account when building their networks.[59] This evidence cannot be ignored when much of it comes from Complaint Counsel's own witnesses. Thus, disregarding cases whose market definition is based on the very facts that Complaint Counsel's designated "customer," the MCO, considers when purchasing the relevant product is irrational.[60]

C. A Proper Market Structure Analysis Fails to Show That the Merger Will Cause Competitive Harm

Even the most narrow properly-defined relevant market produces only modest concentration figures.[61] The concentration level here does not entitle Complaint Counsel to a presumption of competitive harm and Complaint Counsel cites no case law supporting its contention that it does.[62] Complaint Counsel also fails to recognize that structural market

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[58] *See* RFF ¶¶ 385-386; RFF-Reply ¶¶ 1669-1673. Complaint Counsel's "silent majority" problem is irrelevant here because it never introduced any evidence that the patient data in this case represents only a minority of the patients affected and that a "majority" of the patients would not turn to alternatives if faced with an anticompetitive price increase. (CCPTB at 59). Moreover, many of the recent hospital merger cases that Complaint Counsel is running away from recognized this potential dilemma and explicitly used patient flow analysis only as a starting point before proceeding with a "dynamic" analysis of where patients would turn in the event of an anticompetitive price increase. *Sutter*, 130 F. Supp. 2d at 1124-1132; *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 978 (N.D. Iowa 1995) *vac. & remanded for mootness,* 107 F.3d 632 (8th Cir 1997). This is the precise analysis advocated by the Supreme Court and Prof. Elzinga himself. *Philadelphia Nat'l Bank*, 374 U.S. at 359; CCFF ¶ 1664.

[59] This was established by the testimony of Complaint Counsel's own witnesses. (RPTB at 22-23; RFF ¶¶ 383-391; RFF-Reply ¶¶ 1646, 1669).

[60] Complaint Counsel inaccurately attempts to distinguish *United States v. Long Island Jewish Med. Ctr.* in its brief, claiming that patient flow dominated that case and "it has become clear that the hospital's customers are health plans that themselves compete by forming hospital networks." (CCPTB at 58). 983 F. Supp. 121, 140 (E.D.N.Y. 1997). What Complaint Counsel fails to note is that the court in *Long Island Jewish Med. Ctr.* explicitly identified the MCOs as customer of the hospitals and noted that patient preferences are important in the formation of a hospital network. *Id.* at 134, 141. In the context of this discussion, the court then relied on patient origins and travel patterns to define the relevant geographic markets. *Id.* at 141-142. Moreover, Complaint Counsel itself cites to patients' desires and preferences several times in its brief, demonstrating that such preferences do affect the correct definition of the relevant market.

[61] That market, proposed by Respondent's expert, is purposely conservative and does not include several hospitals that exert a competitive restraint on ENH. (RPTB at 23; RFF ¶¶ 488-489; RFF-Reply ¶ 1724).

[62] Indeed, mergers producing concentration measurements higher than those suggested by Complaint Counsel have been allowed by courts. *See e.g., United States v. Baker-Hughes Inc.*, 908 F.2d 981, 983 n.3 (D.C.Cir. 1990) (the acquisition *approved* by the D.C. Circuit Court in *Baker-Hughes* "increased the HHI ... from 2878 to 4303"); *Butterworth*, 946 F. Supp. at 1294 (market shares of 47-65% and uncontested testimony showing post-merger HHI figures ranging from 2767 to 4521, with a delta of 1064 and 1889).

statistics cannot solely be relied upon in predicting competitive harm in a differentiated product market under a unilateral effects theory.[63] The case law that Complaint Counsel does cite all hinged on a coordinated effects theory, a theory that Complaint Counsel's expert concedes is not being advanced in this case.[64] (RFF ¶ 517).

Now, for the first time, Complaint Counsel appears to rely on an ENH corporate document that discusses ENH's "core service area"[65] to support its geographic market.[66] While this produces high HHI figures, it also produces an erroneous and misleading definition of the geographic market. As explained above, this is not appropriate. (*See* Section I.B.2).

Finally, these HHI statistics give an "inaccurate account" of the Merger's probable effects on competition.[67] The evidence shows that: (i) the quality of care at HPH has improved,

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[63] Economists have reiterated this point. As Gregory J. Werden, another of Complaint Counsel's designated experts who did not testify at trial, wrote, "Structural policy is particularly ill suited to differentiated products mergers." Gregory J. Werden, *Simulating Unilateral Competitive Effects from Differentiated Products Mergers*, Antitrust, Spring 1997 at 27; *see also,* Carl Shapiro, *Mergers with Differentiated Products*, Antitrust, Spring 1996 at 23 ("And, to assess unilateral effects most accurately, it is highly desirable to go beyond industry concentration measures to look directly at the extent of competition between the merging brands."). Moreover, the *Merger Guidelines* themselves recognize that "market shares alone may overstate the competitive effects of concern when, for example, the relevant products are less similar in their attributes to one another than to other products in the relevant market." *Merger Guidelines* § 2.211. The "safe harbor" regions articulated in Section 1.5 of the Guidelines only lead to a useful measure of competitive effect in such a case "if each product's market share is reflective of not only its relative appeal as a first choice to consumers of the merging firms' products but also its relative appeal as a second choice." *Merger Guidelines* § 2.211.

[64] *See Hosp. Corp. of America*, 807 F.2d at 1387; *Cardinal Health*, 12 F. Supp. 2d at 65; *FTC v. Bass Bros. Enters., Inc.*, 1984-1 Trade Cas. (CCH) ¶ 66,041, 1984 WL 355, at *25 (N.D. Ohio 1984). In addition, Complaint Counsel's brief makes the misleading claim that the merger in *Cardinal Health* was barred based on a post-merger HHI of only 2277. That case actually involved simultaneous acquisitions of two separate businesses which, combined, created a post-merger HHI of 3079. (CCPTB at 56, *citing FTC v. Cardinal Health*, 12 F. Supp. 2d 34, 53 (D.D.C. 1998)).

[65] Besides conflating the terms "core service area" and "service area" in footnote 42 of its brief to bolster its case, Complaint Counsel disingenuously claims that ENH's share of the *core service area* is an underestimation of its share of the geographic market. Complaint Counsel cites to Prof. Elzinga's testimony for the point, despite the fact that he never testified about ENH's service areas or the relevant geographic market in this case. As discussed above (Section I.B.2), the core service area is not an appropriate measure of an antitrust relevant geographic market nor are "market shares" therein indicative of competitive conditions.

[66] *See* RPTB at 19 n.6 for a history of Complaint Counsel's struggle to find a favorable geographic market definition.

[67] Complaint Counsel's implication that showing new entry is the only way to rebut a prima facie case is misguided. As the court noted in *Baker Hughes*, "the Supreme Court has never indicated that a defendant seeking to rebut a prima facie case is restricted to producing evidence of ease of entry. Indeed, in numerous cases, defendants have relied entirely on non-entry factors in successfully rebutting a prima facie case." 908 F.2d at 984.

and is continuing to improve, dramatically (RFF ¶¶ 1226-2216); (ii) there are currently several hospitals both within and outside of the relevant geographic market that are viable alternatives to ENH and which exercise a constraint on ENH's pricing (RFF ¶¶ 383-490); and (iii) existing hospitals have been repositioning to expand their existing services and add new ones (RFF ¶¶ 2289-2297; *see* RPTB at 20-28, 56-59, 67-107). Accordingly, Complaint Counsel has failed to carry its ultimate burden of persuasion. *Baker Hughes,* 908 F.2d at 983. (*See also* RPTB at 58-107).

III. THE EVIDENCE DEMONSTRATES THAT ENH'S RELATIVE PRICE INCREASES WERE ENTIRELY CONSISTENT WITH LEARNING ABOUT DEMAND

As explained more thoroughly in Respondent's post-trial brief, and as Complaint Counsel concedes, before Complaint Counsel can use evidence of relative price increases as proof of competitive harm, it must first disprove all other plausible, non-market power based explanations for the increases. (RPTB at 38-40; CCPTB at 3, 48; RFF ¶ 521). The evidence at trial established overwhelmingly that before the Merger Evanston Hospital priced its services below what MCOs were willing to pay and that it learned of this fact coincident with the Merger. (RFF ¶¶ 656-703). When ENH raised its prices after the Merger more than other area hospitals raised their prices, it was due to a better understanding of its undermarket pre-Merger rates ("learning about demand") and not because of market power gained from the Merger.[68] (RFF ¶¶ 704-964).

[68] Pursuant to the Court's Order, ENH is responding to Complaint Counsel's argument in the order in which it was presented in Complaint Counsel's post-trial brief. The proper placement of a discussion of "learning about demand," however, would be where Complaint Counsel discusses its "direct evidence" of competitive harm. As Dr. Haas-Wilson admitted, learning about demand is an economically plausible explanation for ENH's price increases. (RFF ¶ 523(k)). As such, Complaint Counsel concedes that it must account for learning about demand before ENH's price increases can be used as evidence of the Merger's anticompetitive effects. (CCPTB at 3, 48). Complaint Counsel is therefore mischaracterizing learning about demand when it describes it as a "defense." (CPTB at 10, 59-60). Complaint Counsel is simply attempting again to shift its burden to ENH.

A. The Evidence Demonstrates that Evanston Hospital's Prices Were Below-Market Prior to the Merger

Complaint Counsel's contention that Evanston Hospital's prices before the Merger were not below the market ignores the record evidence, reliable economic analyses and ultimately, the admissions of its own witnesses. As briefly outlined below, and described more thoroughly in Respondent's opening submissions (RPTB at 40-54; RFF ¶¶ 656-893, 1110-1155), virtually all of the evidence in this case confirms that the pre-Merger prices at Evanston Hospital were below-market for comparable academic teaching institutions. Such evidence includes:

- Evanston Hospital's historical negotiating style, which was not aggressive and which sought to curry favor with MCOs rather than obtain the best price possible. (RFF ¶¶ 600-612). Consequently, its pre-Merger contract rates were below those of HPH and its contracts were not regularly updated or renegotiated as were other hospitals' contracts. (RFF ¶¶ 613-623, 677-700).

- Analyses conducted by Bain, Terry Chan and the MCOs confirmed that Evanston Hospital's prices for many large payors were below HPH before the Merger, and hence below competitive levels. (RFF ¶¶ 656-669, 677-700).

- Mendonsa from Aetna admitted that

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  RFF ¶ 754; *see also* RFF ¶¶ 744-745, 747).

- Neary of Great West testified that it had been years since Evanston Hospital renegotiated a contract and it was due for price increases. (RFF ¶ 796; *see also* RFF ¶¶ 791-795).

- Ballengee of PHCS admitted that,

  REDACTED

  its rates were noticeably lower than HPH's. (RFF ¶¶ 831-832; *see also* RFF ¶¶ 833-837).

- According to Holt-Darcy of Unicare,

  REDACTED

  (RFF ¶¶ 863-864).

- The testimony of Fource, United's representative at trial, as well as its own internal documents, demonstrated that

  REDACTED

  (RFF ¶¶ 907-908).

- **REDACTED**

  (*See* RFF ¶¶ 1118-1136).

- **REDACTED** **REDACTED** (RFF ¶¶ 1111, 1113-1114, 1148).[69]

- **REDACTED** (RFF ¶ 1150; CCFF ¶¶ 717, 1919).

Complaint Counsel's response to all of this evidence is to theorize that if Evanston Hospital's prices were really below-market, MCOs would have recognized the bargain and "taken advantage of it … [to] ultimately bid up the price to market levels." (CCPTB at 60). The fallacy of this argument is obvious. Unlike Complaint Counsel's example of an underpriced house, access to Evanston Hospital's services was not subject to auction where payors bid against each other for the right to be the payor with exclusive access. Evantson Hospital sold access to all payors simultaneously. The payors indeed took advantage of the situation, benefiting as long as possible from Evanston Hospital's undermarket prices and history of

[69] Prof. Baker's examination utilized regression analysis to construct predicted, estimated prices. Because the outpatient data did not include adequate information on individual services that were necessary for the regression framework, his analysis was based on inpatient data alone. (RFF ¶¶ 1145, 1147). Prof. Baker's methodology also did not provide him with a means of controlling for certain limitations of the data, such as the missing baby problem. (RFF ¶ 1146). Dr. Noether's analysis, on the other hand, allowed her to use actual prices, inpatient and outpatient data, and provided a means for controlling for the missing baby problem. (RFF ¶¶ 1103-1109). Notwithstanding these differences in approach, both experts found that ENH prices were substantially below

neglecting outdated contracts.

The evidence upon which Complaint Counsel relies, the economic analyses of the claims data conducted by Dr. Haas-Wilson, does not prove Complaint Counsel's point for two reasons.[70] First, the calculation of "price" in these analyses has absolutely no relevance to the manner in which price is calculated by hospitals and MCOs when negotiating contracts.[71] Dr. Haas-Wilson admitted that the methodologies she employed for this purpose resulted in a calculation of "price" that was never actually used in any MCO contract. (RFF-Reply ¶ 700). All of the ways in which price is analyzed by hospitals and MCOs, including claims modeling – i.e. applying new contract rates to past patient cases to determine the change in reimbursement as a result of new contract rates – confirmed that HPH's prices prior to the Merger were higher than Evanston Hospital's. (RFF ¶¶ 656-69, 677-700; RFF-Reply ¶ 700).

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(RX 1912 at 34, *in camera*).

Second, the claims data upon which all expert analyses are based have limitations that affect any pricing analysis.[72] (RPTB at 47-48; RFF ¶¶ 1013-1015, 1103, 1105, 1146; RFF-Reply ¶¶ 470, 536, 673). Every analysis that attempted to control for data limitations demonstrates that

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academic hospitals levels pre-merger, and rose to those levels coincident with merger, consistent with the learning about demand explanation. (RFF ¶¶ 1111, 1113-1114, 1148).

[70] Complaint Counsel erroneously attributes these analyses to Dr. Noether, yet the record citation reveals that Complaint Counsel is referring to its own expert's analysis of Dr. Noether's *backup material*. (RFF-Reply ¶¶ 700-701).

[71] The five methodologies for calculating price used by Dr. Haas-Wilson were (i) price per DRG weight, (ii) price per inpatient equivalent case, (iii) price per inpatient equivalent patient day, (iv) price per inpatient equivalent DRG weight, and (v) price per adjusted case. (RFF-Reply ¶¶ 700-701).

[72] For instance, the data for some of the payors contain far fewer newborns than mothers ("missing baby problem"), a fact which Dr. Haas-Wilson ignored in her analysis. (RFF ¶ 1103). As a result, the price for the mother sometimes includes the cost of caring for the baby and sometimes does not, and the data do not permit separate identification of each situation.

Evanston Hospital's prices were at the same level or below HPH's prices, and thus below competitive levels. (RFF ¶¶ 1013, 1014, 1116; RFF-Reply ¶¶ 700-1805).[73]

B. Respondent's Price Level Analyses Demonstrated that ENH's Post-Merger Price Increases are Consistent with Learning About Demand

Although not its burden, ENH demonstrated that because it had recently learned about the demand for its services, it increased its prices, coincident with the Merger, from below-market to competitive levels. It did not gain, or exercise, market power as a result of the Merger. (*See generally* RFF ¶¶ 528-532, 647-923, 1065-1155). Complaint Counsel's only substantive response to ENH's price level analyses is to attack the selection process and criteria Dr. Noether employed for the control groups.[74] Complaint Counsel contends, without evidentiary support, that she cherry-picked the hospitals that would yield results most favorable to ENH. The record evidence is that Dr. Noether utilized reasoned judgment and objective criteria in determining the composition of the control groups. (RFF ¶¶ 1065-1096; RFF-Reply ¶¶ 703-727).

Contrary to Complaint Counsel's suggestion, Dr. Noether's control groups were not designed with a pre-set conclusion.[75] During the selection process and in identifying the criteria

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[73] Amazingly, Complaint Counsel contends that Evanston Hospital's former negotiator, Jack Sirabian, observed that Evanston Hospital had higher rates in approximately two-thirds of the 35-40 contracts it shared with HPH. (CCPTB at 61). That is wrong and a perversion of his testimony. Sirabian simply testified that in about one-third of the contracts he reviewed, HPH had higher rates. (RFF ¶ 667; RFF-Reply ¶ 1801). That does not translate to Evanston Hospital having higher prices in the other two-thirds; Evanston Hospital's prices may well have been equal to HPH's in those contracts, which would mean that Evanston Hospital was under-priced, given its superior quality and breadth of services. (RFF ¶ 528). Moreover, Sirabian was discussing contracts in a vacuum. There is no testimony as to which payors provided HPH with the higher rates. If the one-third related to payors with most of the patient volume, Evanston Hospital's prices would be demonstrably lower than HPH's. Indeed, the evidence established that Evanston Hospital's rates with some of the largest MCOs by patient volume – e.g., United, PHCS, Aetna, and Cigna – were lower, and sometimes much lower, than HPH's before the Merger. (RFF ¶¶ 680-690; RFF-Reply ¶ 1801).

[74] In its opening submission, Respondent fully explained Dr. Noether's selection process. (RPTB at 49-50; RFF ¶¶ 1065-1077).

[75] Complaint Counsel claims that Dr. Noether included Loyola and Rush Presbyterian even though those hospitals are "never listed as a competitor in the business documents upon which Dr. Noether relied." CCPTB at 61. Once again, Complaint Counsel distorts the testimony. Dr. Noether merely claimed she could not recall at that moment what documents she reviewed that supported Loyal and Rush Presbyterian's inclusion in the control group. In fact, Dr. Noether had reviewed a Northwestern Memorial document (RX 1316) that lists both Loyola and Rush

to be used, Dr. Noether never knew the prices of any of the hospitals. (RFF ¶ 1077; RFF-Reply ¶¶ 1819, 1823, 1842). As Dr. Noether explained, her objective was to have a control group that includes a large enough sample of good comparison hospitals, but there was no need to include every comparison hospital. (RFF ¶ 1075; RPP-Reply ¶¶ 1823, 1950).[76] Moreover, Complaint Counsel takes Dr. Noether to task for failing to include three hospitals: MacNeal, Christ and University of Illinois. There is no evidence, however, that these hospitals were less expensive than the hospitals in the control group such that their exclusion could even potentially bias matters. The selection process for the control group was based on objective and meaningful criteria and was not, and could not be, biased.

Complaint Counsel next criticizes ENH's academic control group because it claims that ENH does not "routinely" provide "quaternary" services as do other members of the group. (CCPTB at 62). Once again, the facts undermine the criticism. First, there is no standard definition of quaternary services.[77] Thus, for example, ENH's provision of cardio angiogenesis is considered by some to be a quaternary-level service. (RFF ¶ 16; RFF-Reply ¶ 291). Second, the other hospitals in the academic control group do not "routinely" provide quaternary services; such services constitute well under 1% of the cases handled by these hospitals (RFF ¶¶ 1088-1089; RFF-Reply ¶ 712) and are not a basis for meaningfully distinguishing ENH from them.

Presbyterian, along with ENH, as academic/tertiary competitors of Northwestern Memorial. This document was reviewed and relied upon in composing the control groups. (RFF ¶ 1074; RFF-Reply ¶ 1819).

[76] In fact, including too many hospitals in the control group runs the risk of including hospitals that are not good comparisons and which would experience different demand and cost conditions from the subject hospital. (RFF ¶¶ 1035-1036; RFF-Reply ¶¶ 1823, 1950). The risk of invalidating the control group's usefulness by including too many hospitals in the control group is greater than the risk of having too few hospitals. (RFF ¶ 1036; RFF-Reply ¶¶ 1823, 1950). On the other hand, Dr. Haas-Wilson included every hospital in Chicago in the control group for her price change analysis, whether or not it bore any resemblance to ENH. (RFF ¶ 1037). Including all Chicago hospitals is far more arbitrary, and biased, than including fewer, but objectively comparable, hospitals. (RFF-Reply ¶ 1821).

[77] At trial, Dr. Haas-Wilson even contradicted her own book in trying to define quaternary services. (RFF ¶¶ 1086-1087; RFF-Reply ¶ 710).

Third, Complaint Counsel identifies severe burn cases as being a quaternary service. The evidence at trial established that Evanston Hospital provided burn treatment services for years and only stopped providing such services because demand dried up as people become more savvy about fire protection. (RFF ¶ 1090; RFF-Reply ¶ 712). Finally, the composition of the control group, as well as ENH's classification as a major academic hospital, was consistent with the views of the various market participants, including area hospitals, consultants, and the MCOs themselves. (RFF ¶¶ 1073-1074, 1078-1079).[78]

C. The Analyses of Drs. Noether and Baker Confirmed that ENH's Relative Price Increases are Consistent with Learning About Its Demand

ENH's price level analyses demonstrate that ENH's relative price increases are consistent with learning about demand. (RFF ¶¶ 1110-1136, 1148-1155; RFF-Reply ¶¶ 1952, 1959, 1981). Complaint Counsel's only response is to point to a few instances where ENH's prices to an individual payor is above the average price for the academic control group. As demonstrated below, Complaint Counsel has done nothing to undermine the validity of Respondent's price level analyses.

1. ENH properly analyzes price levels across all payors

Examining the prices of all payors together is appropriate when conducting price level analyses here because (a) the Complaint identified the relevant market as "hospital services sold to private payers" (Compl. ¶ 16)[79] and (b) the antitrust laws are designed to protect competition,

[78] In fact, although Complaint Counsel claims that PHCS did not view ENH as an academic hospital, its representative admitted that prior to the Merger HPH was a community hospital, while Evanston had a higher level of services and was a teaching hospital affiliated with Northwestern Medical School. (Ballengee, Tr. 159; RFF-Reply ¶¶ 296, 722).

[79] The Complaint also identified the anticompetitive effect of the Merger as reducing competition in that market and enabling "EHN [sic] to raise its prices to private payers above the prices that the hospitals would have charged absent the merger." (Compl. ¶¶ 27, 32).

not any specific competitor or customer.[80] As Drs. Noether and Baker explained, examining price levels for any individual payor is a poor proxy for determining whether competition as a whole was diminished by the gain and exercise of market power. (RFF ¶¶ 1109, 1143; RFF-Reply ¶¶ 1952, 1955, 1960, 1964). Not one of Complaint Counsel's five economic experts ever testified, at deposition or trial, that examining price levels across all payors is the wrong method of analysis.

Moreover, even viewing the analyses payor by payor reveals that ENH's post-Merger prices are consistent with learning about demand. (RFF ¶¶ 1118-1136, 1151-1155). In response, Complaint Counsel simplistically argues that if ENH was truly an academic hospital, it would "defy business judgment and economic theory" for **REDACTED** to pay ENH more than the other hospitals in the academic control group. (CCPTB at 64).[81] According to this argument, payors would be compelled to drop all but the cheapest hospital in the group, a position that lacks any support. In fact, **REDACTED** routinely pays some academic hospitals more than others (and those differences change from year to year). (RFF ¶¶ 1133, 1154; RFF-Reply ¶¶ 1755-1756, 1960). The fact of the matter is that ENH's prices rose from the level of a community hospital before the Merger towards the level of an academic hospital afterwards.

[80] *Brown Shoe v. United States*, 370 U.S. 294, 344 (1962) ("It is competition, not competitors, that the [Clayton] Act protects."). Indeed, single-firm markets are disfavored by the courts. *Jayco Sys., Inc. v. Savin Bus. Machs. Corp.*, 777 F.2d 306, 319, n.43 (5th Cir. 1985) ("[O]ne purchaser in a market of competing purchasers cannot constitute a relevant geographic market, absent exceptional market conditions.") (citations omitted); *cf. Collins v. Assoc. Pathologists, Ltd.*, 844 F.2d 473, 480 n.5 (7th Cir. 1988) ("[W]e have reason to doubt whether the relevant market can be sliced so small as to embrace only a single hospital.") (citation omitted); *Brader v. Allegheny Gen. Hosp.*, 64 F.3d 869, 877-878 (3d Cir. 1995) ("[E]very court that has addressed this issue has held or suggested that, absent an allegation that the hospital is the only one serving a particular area or offers a unique set of services, a physician may not limit the relevant geographic market to a single hospital.").

[81] Complaint Counsel cites CX 6277 for the proposition that United and Kraft could see that ENH's prices were higher than other academic hospitals. As discussed above, this document contains erroneous conclusions drawn from inaccurate data. (*See* Section I.C.3(a), *supra*; *see also* RFF-Reply ¶¶ 992).

(RFF ¶¶ 1110-1014; RFF-Reply ¶ 1981).[82]

REDACTED (RFF ¶ 1127).

Complaint Counsel's argument also fails generally to take into account the factors that affect the prices charged to any given payor, and in particular REDACTED, including:

- REDACTED (RFF ¶ 528).

- REDACTED (RFF ¶¶ 1133, 1143).

- MCOs want to have virtually every hospital in their networks and would therefore not exclude ENH even if its prices were higher in any given year. (RFF ¶¶ 989-994; RFF-Reply ¶¶ 138, 218).

- REDACTED[83] (RFF ¶ 1012).

- United reached a price agreement very quickly and without much analysis, partly because the negotiator was "embarrassed" about misleading ENH in the past and wanted to preserve their future relationship. (RFF ¶¶ 684, 884).

- REDACTED (RFF ¶ 1154; RFF-Reply ¶¶ 1755-1756, 1960).

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[82] Complaint Counsel does not cite to Dr. Noether's analysis for its claim that ENH's prices flunked Prof. Baker's test. Nevertheless, Dr. Noether's analysis does reveal that ENH's prices to United exceeded the academic average for two years. As Dr. Noether explained, the observation does not affect her conclusion that ENH's relative price increases are more consistent with learning about demand because (i) individual payor prices are irrelevant; (ii) examining prices in a given year is worthless as managed care contracts are generally multi-year, and MCOs negotiate with payers for contract rates at different times making it misleading to compare at a single year rather than looking at the general pattern; and (iii) ENH's prices during those years were still lower than both the University of Chicago and Rush Presbyterian. (RFF ¶ 1133).

[83] REDACTED (RFF ¶ 1012).

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(RFF ¶ 1029, 1128; RFF-Reply ¶ 690).[84]

Accordingly, the appropriate way to conduct a price level analysis in this case is to view the prices of all payors together.

2. Complaint Counsel's attack on Prof. Baker is factually wrong and a sideline diversion

Complaint Counsel impermissibly cites to Prof. Baker's original report.[85] In any event, the conclusion it draws from the report is incorrect and does nothing to undermine learning about demand as an explanation for ENH's relative price increases.

a. Prof. Baker's price level analyses always focused on the prices charged to all payors together

As Prof. Baker explained, post-Merger prices that rise towards, but not above (in any statistically significant way), the average price charged by the academic hospital control group would corroborate the other factual evidence that ENH's relative price increases are consistent with learning about demand. (RFF ¶ 1138; RFF-Reply ¶¶ 1745-1746, 1955). As he testified, Prof. Baker's examination of price levels in this case has at all times remained focused on whether ENH's prices rose above the average price of the academic control group for all payors together.[86] (RFF ¶¶ 1138, 1142; RFF-Reply ¶¶ 1745-1746, 1759, 1761, 1955, 1957).

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[84] For example, in the case of Humana, capitated contracts played a large role in the negotiations. ENH was losing money on their capitated contracts with Humana – in the order of **REDACTED** – and got out of those contracts beginning in 2003. (RFF ¶¶ 699, 824, 1128; RFF-Reply ¶ 690). One would expect that a hospital would get paid relatively more on its fee-for-service contracts with a particular payor when the capitated arrangements with that payor result in losses.

[85] As explained below, Complaint Counsel refers to the original report for the truth despite this Court's order that the report be used for impeachment purposes only. (CCPTB 63-65).

[86] Indeed, Prof. Baker explicitly noted in his original report that ENH's prices to United rose above the academic average for 2003. Nevertheless, he still concluded in that report that his analysis of price levels was consistent with learning about demand because an examination of price levels across all payors is the appropriate way to conduct

After an error in one step of his methodology was pointed out, Prof. Baker corrected his analysis. That analysis still demonstrates that ENH increased its prices only up to, or below, the average price charged by the academic hospitals, consistent with ENH learning about demand.[87] (RFF ¶¶ 1148-1150, 1155; RFF-Reply ¶¶ 1762, 1952, 1959). Prof. Baker also clarified and articulated his theory and its implementation in his supplemented report.[88] (RFF-Reply ¶¶ 1750, 1752, 1759, 1955).

Complaint Counsel's brief resorts to an unfounded *ad hominem* attack on Prof. Baker, which asserts that he "restated his theory to fit the new facts" (CCPTB at 63), "changed his standards by eliminating the inquiry into 'individual payors,'[89] limiting his new test to the 'average overall'"[90] (CCPTB at 64) and that he

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(CCFF ¶ 1762, *in camera*). None of these claims has any support. Not one of its

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the analysis and that analysis demonstrated that ENH's prices did not rise above the academic average. (RFF-Reply ¶¶ 1747, 1954-1955).

[87] Prof. Baker did not altogether ignore the levels for individual payors. Rather, he concluded that each changed in a manner consistent with the documentary and testimonial evidence of how much ENH learned about that payor's demand. (RFF ¶¶ 530, 1151-1154; RFF-Reply ¶¶ 1942, 1967).

[88] At trial, Complaint Counsel repeatedly attempted to get Prof. Baker to testify that the articulation in his original report was his "real test" and that he changed the wording in his supplemental report to fit the "new facts." Unsuccessful in these attempts, Complaint Counsel resorted to reading the original report in the record and asking Prof. Baker simply if he wrote what was being read to him. (Baker, Tr. 4715-4722, *in camera*). This Court subsequently ruled that only certain excerpts from Prof. Baker's original and supplemented report are admitted, and purely for impeachment, not for the truth. Order Denying Complaint Counsel's Motion for Admission of Portions of Dr. Baker's Expert Reports Into Evidence ("Order Denying CC's Motion") at 2 (May 10, 2005) (Attachment B).

[89] In support of its claim that Prof. Baker "believed the test should focus" on individual payors (CCPTB at 63), Complaint Counsel cites Prof. Baker's original report. It thus cites to the original report for its truth in violation of this Court's Order. Order Denying CC's Motion at 2 (Attachment B). In a footnote, Complaint Counsel disingenuously claims that it cites to the exhibits containing Prof. Baker's report only for impeachment purposes. However, it cites to the exhibits themselves to support claims of what Prof. Baker actually "believed" his "test" to be, and cites for the same purpose transcript pages where Prof. Baker merely confirms what he wrote in his first report. (CCPTB at 63-64). Complaint Counsel's violation of this Court's order demonstrates its desperation.

[90] Prof. Baker explained that in practice, in this case, it was only appropriate to test for limits on how much ENH's average prices would be expected to increase on an overall basis because data limitations and the idiosyncratic nature of the negotiations render a comparison of prices to any single payor a poor proxy for market-wide effects of market power. (RFF ¶¶ 1142-1143; RFF-Reply ¶¶ 1745-1746, 1759, 1761, 1955, 1957). Accordingly, he never relied on individual payor prices to make market-wide analyses, either in his original or supplemented report.

five retained experts took issue with Prof. Baker's analysis of price levels across all payors.[91] Prof. Baker's bottom-line approach never changed, and both Complaint Counsel and its experts know it.[92] Prof. Baker is one of the leading antitrust economists and theorists today and has served with dedication and commitment in several government positions and on several government panels, including as senior staff of the President's Council of Economic Advisers. (RFF ¶¶ 354-356, 360-361). Prof. Baker is also a former Director of the FTC's own Bureau of Economics and recently served for two years as an unpaid consultant to the FTC on merger policy. (RFF ¶¶ 357-359; RFF-Reply ¶ 1742). To attack his credibility by claiming that he "changed his standards" and "modified his expert opinions to … support his client's position in this case" is specious.

b. ENH raised prices because it learned about the demand for its services, coincident with the Merger

Even putting aside Prof. Baker's price level analyses, the record evidence here establishes that ENH's price increases were not caused by ENH obtaining market power through the Merger. For instance, Dr. Noether conducted a distinct analysis, using both inpatient and outpatient data combined, which independently demonstrated that ENH's price increases are consistent with learning about demand and not market power. (RPTB at 49-51; RFF ¶¶ 1110-1136).

The remaining factual record also supports learning about demand as an explanation for

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[91] Complaint Counsel's experts were entitled to rebut Prof. Baker's supplemented report and certainly could have taken issue with his focus on price levels across all payors. Not one did. In fact, the only rebuttal submitted by an expert concerned technical aspects of Prof. Baker's econometrics and that expert, who was deposed, testified to Prof. Baker's integrity, reputation, and that Prof. Baker's correction of his mistake was proper and laudable. He was not called by Complaint Counsel at trial.

[92] At no time did Prof. Baker ever hide the results of price level comparisons to payors individually. Prof. Baker has always openly discussed those results and accounted for them in reaching his conclusions. Such transparency belies Complaint Counsel's contention that Prof. Baker changed his theory to fit "new facts." Indeed, Prof. Baker's reporting of the United results in his original report show there were no "new facts" to force him to change theories. (RFF-Reply ¶¶ 1747, 1954-1955).

ENH's relative price increases. (RPTB at 41-45; RFF ¶¶ 656-964; Section I.C, *supra*). Indeed, contrary to Complaint Counsel's argument,[93] ENH's experience with Blue Cross proves the point. Blue Cross did not receive a relative price increase from ENH after the Merger because Evanston Hospital's pre-Merger prices to Blue Cross were above HPH's pre-Merger prices.[94] ENH therefore learned nothing about Blue Cross' willingness to pay for its services and consequently was unable to obtain a relative price increase. (RFF ¶¶ 1120-1124; RFF-Reply ¶¶ 729, 731-732, 1942, 1967). This is not surprising because, before the Merger, Evanston Hospital paid more attention to negotiations with Blue Cross, its largest payor, than it did to any of the other payors. (RFF ¶ 757). ENH attempted to negotiate price increases from Blue Cross, employing the negotiating techniques it learned from Bain. When these techniques proved unsuccessful, however, ENH had no data to present to Blue Cross to back up its request for relatively higher prices because its pre-Merger prices were higher than HPH's. (RFF ¶¶ 760, 769-770). It therefore received no such price increases. With other payors, however, it was a different story. For those other payors, Evanston Hospital's pre-Merger contracted rates were, at varying degrees, lower than HPH's and it was able to present that data to the payor. (*See, e.g.*, RFF ¶ 747, 787, 790, 796, 820, 836, 840, 851, 864, 883-884). That is "learning about demand." If the Merger truly gave ENH market power because payors could not exclude it from their

[93] As described above, Complaint Counsel's attempt to spin the Blue Cross experience fails. Moreover, Complaint Counsel lacks any factual support for its proposition. In its post-trial brief, Complaint Counsel cites as support Dr. Haas-Wilson's testimony; however, that testimony involves her comments on Prof. Baker's supplemented report and this Court has ruled that all such testimony is stricken from the record. (Haas-Wilson, Tr. 2938; *see* RFF-Reply ¶ 729 for a full explanation).

[94] Ironically, Complaint Counsel implies that Dr. Baker improperly excluded data from One Health yet suggests that ENH's price analyses should exclude data from Blue Cross because Blue Cross did not receive a price increase. (*See* CCPTB at 47, 63, 65). The fact of the matter is that ENH's experts utilized all usable data. (RFF ¶¶ 1097-1101). One Health's data did not include any pre-Merger claims data and obviously could not be used in an analysis comparing prices before and after the Merger. (RFF ¶ 1098). Additionally, its data did not include the patients' payment portion and was thus incomplete. Using such data would be mixing apples and oranges. (RFF ¶ 1098). Blue Cross' data was usable and therefore included in the analysis. To do otherwise, as Complaint Counsel appears to advocate, would be result-oriented and unprincipled.

networks (CCPTB at 4), then ENH should have been able to exercise market power against Blue Cross as well and obtain price increases, regardless of Blue Cross' size.[95] (RFF ¶ 1049; RFF-Reply ¶¶ 576, 579, 732, 1942).

IV. COMPLAINT COUNSEL CANNOT ESTABLISH THAT THE MERGER IS LIKELY TO CAUSE ANTI-COMPETITIVE EFFECTS THAT OUTWEIGH THE ACTUAL AND DRAMATIC QUALITY IMPROVEMENTS

If the Court agrees that Complaint Counsel failed to demonstrate that the Merger is likely to result in anticompetitive effects, the Court need not assess ENH's substantial evidence of quality care improvements it has made since the Merger. Only if the Court were to conclude that some portion of the nominal post-Merger price increases could not be explained by learning about demand (or anything else besides market power) would it then need to assess the competitive significance of the substantial improvements in ENH's quality of care as a result of the Merger. Respondent respectfully submits that such an assessment would demonstrate that the Merger does not violate Section 7.

A. Complaint Counsel Distorts the Framework for Analyzing the Quality Improvements in This Case and Ignores Substantial Evidence

In its post-trial brief, Complaint Counsel seeks to improperly shift its burden of persuasion regarding improvements in ENH's quality of care to Respondent and concocts artificial factual hurdles that it claims Respondent must overcome or face defeat. Specifically, Complaint Counsel erroneously claims that ENH committed two "overriding errors" in its quality case: (1) its evidence of quality improvements focused "exclusively" on HPH and (2) ENH did not benchmark its quality improvements against other hospitals. Neither claim is correct. Additionally, Complaint Counsel wrongly asserts that ENH must quantify its quality

[95] As explained in Respondent's post-trial brief, Complaint Counsel has still not ruled out several other explanations for the relative price increases and its post-trial brief does not even attempt to address those alternative explanations. (*See* RPTB at 38-40; RFF ¶¶ 523(a)-(p), 526, 1021-1023).

improvements and prove that they are "significant" and "extraordinary," and that ENH's quality must not have improved because ENH allegedly never "touted" its quality improvements to payors. (CCPTB at 75-79). Complaint Counsel's errors are compounded by a profound failure to explain how – and even whether – these issues fit into the ultimate determination of the Merger's likely competitive effects. Complaint Counsel's argument demonstrates a fundamental lack of understanding that there are two distinct ways that the evidence of ENH's quality improvements impacts the competitive effects analysis in this case, and much of what it erroneously claims ENH should have to prove is wholly irrelevant to one or the other (or both).

The fact that quality at ENH increased as a result of the Merger: (1) reduces ENH's quality-adjusted prices and the resulting increase in its prices after the Merger; and (2) constitutes a procompetitive benefit that must be considered in weighing the ultimate competitive effects of the Merger. With respect to ENH's quality-adjusted prices, because Complaint Counsel's proof of competitive harm is based on its *relative* price increases, the only thing that ENH must show is that quality improved at ENH more than other area hospitals. To include quality improvements in the weighing of competitive effects, Respondent need only show that the improvements were Merger-specific. The other factual hurdles Complaint Counsel wants ENH to jump through are entirely irrelevant to the role of quality in this case.

1. ENH's quality improvements translate to lower post-Merger quality-adjusted prices

The core of Complaint Counsel's competitive effects case is that ENH's prices increased more than those of other hospitals.

REDACTED

REDACTED ;[96] (RPTB at 46-47; RFF ¶ 1156, 1158, 1162). ENH's relative quality-adjusted price increases may therefore be *de minimis*, or even zero – Complaint Counsel has not established otherwise – depriving Complaint Counsel of its alleged proof of competitive harm.[97]

ENH established at trial that the quality of care offered at post-Merger HPH compares favorably to other hospitals, and that it improved proportionately faster than at other area hospitals.[98] (RFF ¶¶ 2205-2216; RFF-Reply ¶ 2034). For example, it is undisputed that HPH's rates of administration of aspirin and beta blockers on admission and discharge to heart attack patients – highly valid process measures – went from below the State of Illinois hospital average pre-Merger to above the State of Illinois average post-Merger.[99] (RFF ¶¶ 1490-1504). It is also undisputed that ENH is a leader in the area of electronic medical records, HPH is one of only a handful of Illinois hospitals that has an intensivist program (as defined by Leapfrog), HPH is the only area hospital with a preoperative gynecological surgical review program, and HPH is one of only a handful of hospitals in Chicago that utilizes advanced cardiac surgical techniques, such as bloodless surgery and complex vein harvesting. (RFF ¶¶ 1640, 1642, 2105-2120, 2480-2482). Additionally, the Merger allowed HPH to adopt new stenting technology far ahead of other cardiac programs in Chicago and add oncology services, such as multidisciplinary, site-specific

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[96] Complaint Counsel acknowledged that it must prove that ENH's quality of care did not improve before evidence of ENH's relative price increases entitles it to a presumption of competitive harm. (*See* Compl. ¶¶ 24, 28 (alleging that the increase in rates ENH charged to private payors for general acute care inpatient hospital services "*without a corresponding improvement in quality of care*, further reflects the market power exercised by the hospitals after the merger") (emphasis added); RFF ¶ 523(g)).

[97] In any event, the evidence established that Complaint Counsel did not account for learning about demand or several other plausible explanations for ENH's relative price increases, whatever their true magnitude.

[98] Complaint Counsel's argument that ENH did not prove that ENH's quality increases relative to other hospitals is based on a gross mischaracterization of Dr. Chassin's testimony. Dr. Chassin testified only that he was not aware of which hospitals Complaint Counsel was referring to in its question. (Chassin, Tr. 5448).

[99] Evanston Hospital's performance on these same measures was also superior to that of other Illinois hospitals during the pre- and post-Merger periods. (RFF ¶ 2205).

oncology conferences to discuss patient treatment and on-site coordinated and ancillary support services, that are rarely found in community hospitals. (RFF ¶¶ 1642, 2476-2479).

2. ENH's quality improvements are a procompetitive effect of the Merger

Evidence of improved quality is relevant as a cognizable procompetitive benefit of the Merger that must be considered if Complaint Counsel succeeded in establishing a presumption of likely competitive harm.[100] (*See* RPTB at 68-71). Indeed, that is agreed to by economists on both sides of this case because quality is one of the dimensions on which hospitals compete. (RFF ¶¶ 323, 325, 329, 523(g)).

As the present Chairman of the FTC explained:

> [R]ightly understood, efficiencies and entry analysis are integral parts of the competitive effects analysis. In this regard, it is somewhat inaccurate to think of an "efficiency defense," for example. That suggests that efficiencies are a defense against otherwise adverse *competitive* effects. Instead, within an integrated analysis, efficiencies should be properly considered as one of the determinants of competitive effects.

Remarks by Deborah Platt Majoras, Chairman, The Federal Trade Commission, ABA Antitrust Section Fall Forum (November 18, 2004), *Looking Forward: Merger and Other Policy Initiatives at the FTC*. Thus, proof of ENH's quality improvements should be considered in the weighing of competitive effects under the burden-shifting paradigm established in previous merger cases, regardless of whether it meets some alleged heightened standard of proof necessary for an "efficiencies defense." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054

[100] In attempting to argue that quality has little or no value in measuring competitive effects, Complaint Counsel cites *Society of Professional Engineers* and *Indiana Federation of Dentists*. Both cases are inapposite. The "quality" defenses raised in each case were attempts to justify inter-competitor agreements restricting the flow of critical information to purchasers and were based on the faulty presumption that consumer choices in a competitive market were unwise or dangerous. *Nat'l Soc. of Prof'l Eng'rs*, 435 U.S. at 696; *Indiana Fed'n of Dentists*, 476 U.S. at 463. The direct "benefits" involved in these cases accrued to the companies and did not enhance consumer welfare. The quality improvements brought about by the Merger, however, are qualitatively different from the alleged quality benefits urged by defendants in those Sherman § 1 cases. Far from limiting information or consumer choice, the

(8th Cir. 1999); *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 151 (D.D.C. 2004); *see Baker Hughes*, 908 F.2d at 982-983. The only showing ENH must make in this regard is that these procompetitive benefits are Merger-specific – i.e., but for the Merger, these quality improvements would not have existed.[101] Contrary to Complaint Counsel's unsupported arguments, ENH need not quantify the improvements or prove that they are extraordinary.[102] (*See* Section IV.A.4, *infra*). Evidence of improved quality therefore undermines or rebuts the initial presumption of competitive harm, if any, that was established by Complaint Counsel. Once that burden of *production* has been met, the burden shifts to Complaint Counsel to produce additional evidence of anticompetitive effects in order to carry its burden of *persuasion* that the Merger will, on balance, harm competition in violation of Section 7. The ultimate burden of proving that the Merger will likely cause a net anticompetitive effect, and hence a violation of Section 7, rests "at all times" with Complaint Counsel. *Baker Hughes*, 908 F.2d at 983.

As discussed below and in Respondent's post-trial brief, ENH has more than met its obligation, presenting substantial evidence of quality improvements in 16 different areas as a result of the Merger. (*See* RPTB at 74-99).

3. Quality improved throughout the system

Complaint Counsel's assertion that ENH must show that quality improved at each of the

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quality improvements resulting from the Merger increase consumer options in health care delivery and offer demonstrable and immediate benefits directly to consumers, enhancing consumer welfare.

[101] Section 4 of the *Merger Guidelines* explains: "The Agency 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 ... Only alternatives that are practical in the business situation faced by the merging firms will be considered in making this determination; the Agency will not insist upon a less restrictive alternative that is merely theoretical."

[102] Complaint Counsel has misconstrued the *Staples* decision as requiring that Respondent quantify the magnitude of its improvement in quality. *Staples* creates no such burden. Rather, it simply holds that, like all rebuttal evidence in Section 7 cases, "the defendants must simply rebut the presumption that the merger will substantially lessen competition by showing that the Commission's evidence gives an inaccurate prediction of the proposed acquisition's probable effect." *FTC v. Staples*, 970 F. Supp. 1066, 1089 (D.D.C. 1997).

three ENH hospitals misses the point.[103] Complaint Counsel's assumed anticompetitive effect is an increase in the systemwide prices of ENH; therefore, the only relevant consideration – both for purposes of quality adjusted prices and weighing procompetitive benefits – is whether quality improved across the ENH system as a whole. The evidence establishes that although it is comprised of three hospitals, ENH is one completely integrated system with one Medicare identification number, one professional staff for all three hospitals, clinically integrated departments overseen by a single department chairman, and central decision-making.[104] (RFF ¶¶ 7, 11-12, 1442). As an integrated system, any quality improvements to HPH resulted in a net gain in quality for the ENH system as a whole unless there were Merger-related declines in quality at Glenbrook or Evanston Hospitals. While ENH has offered overwhelming evidence of post-Merger quality improvements at HPH (*see* RPTB at 74-107), Complaint Counsel has offered no evidence that quality declined at Glenbrook or Evanston Hospitals as a result of the Merger which would offset these improvements. (RFF-Reply ¶¶ 2032, 2060, 2067).

Although not required, ENH nevertheless presented evidence at trial that it improved the quality at all three hospitals. For example, ENH introduced clinical data such as NRMI process measures that demonstrated a substantial improvement in heart attack care at both Evanston Hospital and HPH after the Merger, and other clinical data showing lower cardiac surgery complication rates. (RFF-Reply ¶¶ 2035-2036). It further showed that even the administrative data Complaint Counsel relies on demonstrates improvement throughout the ENH system. Such

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[103] Complaint Counsel's argument is based on a fundamental misinterpretation of ENH's Second Amended Answer, which alleged that the "merger of Highland Park and ENH facilitated significant improvements in the quality of patient care throughout the ENH system that outweigh any anticompetitive effects." (CCPTB at 14). Respondent did not, in its Answer and the Amendments thereto, expressly assume any burdens of proof with respect to any defense. (RFF-Reply ¶ 2032). Additionally, although Complaint Counsel construes the words "throughout the ENH system" to mean at each ENH hospital, they actually refer to the ENH system as a whole.

[104] There is nothing remarkable about the fact that ENH sought one price for all three hospitals. Firms that produce one product in multiple plants (*e.g.*, two different auto assembly lines for the same vehicle) do not routinely charge different prices based on the location of production. ENH is no different.

evidence includes NPIC data showing a favorable post-Merger Cesarean section trend at ENH that has been consistently lower than the national average; Solucient data showing substantial decreases in the median performance of risk-adjusted mortality at ENH as a whole from 2001 to 2004; and Solucient data showing that in 2004 ENH as a whole outperformed the top 100 teaching hospitals by 11.4 percent in Solucient's risk-adjusted patient safety index. (RFF-Reply ¶ 2032). These improvements culminated with ENH receiving the 2005 Leapfrog Award for being the top hospital system in Illinois. (RFF ¶ 2196). This national recognition from independent groups that monitor healthcare quality confirms the increased post-Merger quality of the ENH system as a whole. (RFF ¶¶ 2189-2200). In addition to the clinical and administrative data, ENH introduced evidence of service improvements, including rationalized psychiatric care and the installation of Epic and a new lab computer throughout the ENH system. (RFF ¶¶ 1850, 2004, 2026, 2044, 2175, 2178).[105]

4. ENH produced evidence of the value of its quality improvements

Complaint Counsel has not put forth any valid reason why ENH must attach a dollar value to such procompetitive benefits before the Court may take this evidence into account when deciding whether the Merger violates Section 7.[106] Courts routinely balance interests that are not

[105] Epic is a prime example of the network effects of the Merger. The value of Epic in enhancing patient safety and improving patient outcomes is proportional to the number of participants, sites of care, and providers of care. (RFF ¶¶ 2523-2524). Even Dr. Romano conceded that the Merger enhanced the value of Epic to the entire ENH community and raised the quality of care throughout the entire system by having HPH and its physicians use the same Epic database. (RFF ¶ 2003-2004, 2525).

[106] Complaint Counsel claims that Respondent must show that its quality improvements were "extraordinary" or "significant," improperly relying on *Heinz* as its sole support. Requiring such a heightened standard is antithetical to an integrated analysis of the competitive effects in this case, and the *Heinz* decision does not support its application here. In *Heinz*, the court faced a pre-consummation merger with extraordinary market concentration levels (HHI of 4775), and the defendants could not, as a practical matter, produce *actual* evidence of efficiencies. *FTC v. H.J. Heinz*, 246 F.3d 708, 721 (D.C. Cir. 2001). Under these circumstances, the court demanded hard evidence of the expected efficiencies, not "mere speculation and promises." *Id.* Here, the Merger is complete and the Court has proof of *actual* and overwhelming evidence of the Merger's substantial pro-competitive benefits. Indeed, the ability to save the lives of heart attack patients by performing interventional procedures at HPH, for example, rather than having to transfer the patient to a different hospital, is a "significant" benefit to those patients.

quantified or quantifiable.[107] Here, the Court is weighing the interests of consumers in higher quality and life-saving healthcare against allegedly higher prices.

Despite not being legally required to do so, ENH has nonetheless given the Court sufficient evidence of the value of its post-Merger improvements to weigh against any alleged anticompetitive effects. For example, it is undisputed that ENH spent over $120 million in improvements at HPH since the Merger.[108] (RFF ¶ 1518; RFF-Reply ¶ 2041).

Moreover, Complaint Counsel wrongly implies that the value of any quality improvements must be expressed in monetary terms. (CCPTB at 14-15). For example, Complaint Counsel faults ENH for not being able to answer whether $100 charged to health plans reflects $49 in quality improvements. (CCPTB at 14-15). Value, however, can be expressed in several ways. ENH presented testimony that the quality improvements at HPH saved lives. Dr. Ankin recounted a specific example of a heart attack patient at HPH who was too unstable to transfer, but was successfully treated as a result of the new cardiac surgery program instituted by ENH at HPH after the Merger. (RFF ¶ 1706). Prior to the Merger, HPH patients died under similar circumstances because HPH lacked those vital life-saving services. (RFF ¶ 1706).

5. Quality improved whether or not the payors were informed

Complaint Counsel's argument that ENH's quality must not have improved because ENH never attempted to use quality as a means to "justify" the higher prices during negotiations is a

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[107] *See e.g., United States v. Brown Univ.*, 5 F.3d 658, 674-675, 678 (3rd Cir. 1993) (considering enhanced quality of education and promoting of socio-economic diversity within the student body); *Katz v. Georgetown*, 246 F.3d 685, 687 (D.C. Cir. 2001) (balancing public interest concerns in the context of a preliminary injunction); *Banks v. NCAA*, 746 F. Supp. 850, 861 (N.D. Ind. 1990) (preserving integrity and quality of amateur sports considered a procompetitive benefit) (listing similar cases).

[108] Throughout the trial, Complaint Counsel attempted to portray ENH executives as greedy individuals who boasted about ENH's financial gains as a result of the Merger. Any gains ENH realized from the Merger were offset by the fact that it poured $120 million into HPH and has plans to spend an additional $45 million on HPH. (RFF ¶ 1518).

red herring.[109] Quality improved at ENH (and payors benefited from those improvements) regardless of whether they discussed it during negotiations. As Prof. Baker explained, "if the sticker price on the Hershey Bar stays at $1 but the bar gets bigger, the buyer of that Hershey Bar ... is better off even if the buyer hasn't noticed that the bar is bigger." (RFF ¶ 1160).

Moreover, despite Complaint Counsel's representation to the contrary, ENH *did* inform MCOs that ENH intended to provide quality improvements to HPH. Simultaneous with the execution of the Letter of Intent, on June 30, 1999, Evanston Hospital and HPH sent a press release to MCOs, area employers, elected officials, and the press describing the goals of the Merger: "The merger will result in significant additional investments in clinical services at the Highland Park Hospital campus.... Our intent is to strengthen Highland Park Hospital's capabilities in key clinical growth areas such as oncology, cardiac services, obstetrics, fertility, home health, behavioral health." (RFF ¶ 268; RFF-Reply ¶ 26). The press release listed specific projects such as the Kellogg Cancer Care Center. (RFF ¶ 268; RFF-Reply ¶ 26). Additionally, Hillebrand testified that he discussed the initiation of cardiac surgery at HPH during meetings with MCOs.[110] (RFF-Reply ¶ 26).

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[109] Complaint Counsel's assertion that some payors see no change in HPH's quality of care since 1999 is meaningless. (CCPTB at 76). None of the payors have any training in measuring hospital quality, and there is no evidence that they performed any investigation into HPH's quality pre- or post-Merger. Additionally, for the reasons set forth in Section IV.B, *infra*, Ballengee, one of the payors cited by Complaint Counsel, has absolutely no foundation for opining on HPH's quality of care.

[110] Complaint Counsel erroneously asserts that in 2003, United "required ENH to provide it with data" to verify ENH's claims of quality improvements, but that ENH failed to do so. (CCPTB at 80). The record testimony does not support that assertion. Foucre never testified that United requested any information from ENH. Instead, she testified as to what information United generally would look at to determine increases in quality. (Foucre, Tr. 927). Moreover, Complaint Counsel cites Holt-Darcy and Mendonsa for the proposition that ENH did not claim its price increases were related to quality of care. (CCPTB at 80 n. 60). Holt-Darcy testified only that she could not recall a conversation, and Mendonsa testified that improvements may have been part of the negotiation but he was "not sure what an 'improvement in quality' means necessarily." (Mendonsa, Tr. 537-538; Holt-Darcy, Tr. 1547).

B. Complaint Counsel's Efforts to Refute Respondent's Overwhelming Evidence of Dramatic Post-Merger Improvements in the Quality Of Healthcare at HPH Fall Short

Unable to dispute that ENH made innumerable changes at HPH after the Merger, Complaint Counsel instead argues, based entirely on Dr. Romano's "quantitative analysis," that there is no evidence that the changes benefited patients through improved outcomes and patient satisfaction. (CCPTB at 13-14, 67-74). Complaint Counsel's argument fails for several reasons. First, quality of healthcare is measured by means other than outcomes and patient satisfaction. These other means may be more reliable and more valid under the circumstances. Second, Dr. Romano's analysis suffers from several fatal defects. Third, Complaint Counsel's efforts to find flaws with Dr. Chassin's well-accepted methodology fall short. Stripped of Dr. Romano's flawed analysis, Complaint Counsel is left with nothing to rebut ENH's overwhelming evidence that quality improved at HPH after the Merger.

1. Outcomes Alone and Patient Satisfaction Data Are Not Accepted Measures of Quality

Complaint Counsel argues, without explanation, that the only valid measures of quality are patient outcomes and patient satisfaction. (CCPTB at 13, 67-68). This position is not supported by Dr. Romano's or Dr. Chassin's testimony, and it is contrary to the manner in which agencies like JCAHO assess quality.[111]

Indeed, Dr. Romano testified that no single measure or indicator of quality, such as outcomes, would be a definitive source of information about quality. (Romano, Tr. 3250). Complaint Counsel misleadingly quotes Dr. Chassin out of context to support its position that outcomes alone are a proper measure of quality. (CCPTB at 68). The full quote explains that outcomes have severe problems which prevent reliance solely on them to measure quality.

(Chassin, Tr. at 5153-5154).[112] While outcomes are of obvious importance to patients, Dr. Romano agreed that they have inherent weaknesses that can limit their utility as measures of quality: certain outcomes may not be under a provider's control; some outcomes occur so rarely that they are not useful as quality measures; some outcomes are so delayed after treatment that they cannot be used to assess whether quality changed as a result of a merger; and the sample size for certain procedures is too small to perform any reliable analysis of the outcomes.[113] (RFF ¶¶ 1178-1183). In order for outcome measures to be useful as quality measures, they must be tied to some process of care or something that can be changed in order to produce the desired health outcome. (RFF ¶¶ 1189, 2106).

Third-party organizations in the field of healthcare quality, such as JCAHO, have recognized the difficulty in relying on outcome data to measure quality. (RFF ¶ 1184). JCAHO convenes a series of expert panels to help identify appropriate quality measures for use in the accreditation process. (RFF ¶ 1185). Of the more than 1,200 elements JCAHO considers, not one is an outcome measure.[114] (RFF ¶¶ 1184-1186).

Tellingly, Dr. Romano determined that ENH made quality improvements at post-Merger HPH in several areas without relying on any outcome or patient satisfaction data at all. These areas include obstetrics and gynecology, interventional cardiology, emergency services,

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[111] For a complete discussion of the proper approach to measuring quality, see Respondent's Brief at 72-74 and RFF ¶¶ 1165-1186.

[112] Complaint Counsel also misleadingly quotes Dr. Rosengart about the importance of outcomes. While he did testify that mortality is the most definitive criteria for assessing quality, he was speaking only in reference to cardiac surgery. (RFF ¶ 1608).

[113] Additionally, Dr. Romano conceded that there are structural aspects of quality that cannot be outcome tested because of ethical considerations. (RFF ¶ 1194). One would not, for example, take a working defibrillator out of an emergency room to test the effect on patient outcomes. (RFF ¶ 1195). Accordingly, in areas where it is not possible ethically to conduct outcome tests following a particular structural improvement, Dr. Romano cannot say whether improvements made by ENH have or have not led to better outcomes. (Chassin, Tr. 5152). The absence of such data does not, however, preclude a finding of quality improvements based on structural or process improvements.

[114] Although Complaint Counsel asserts that JCAHO will soon incorporate outcome measures (CCPTB at 92), nowhere do they say which ones or whether Dr. Romano used those indicators.

radiology, intensivists, and electronic medical records. (Romano, Tr. 3289-3290, 3308, 3317-3318, 3327, 3329, 3389-3390; RFF ¶¶ 2219, 1231, 1292; RFF-Reply ¶¶ 2059, 2091). Thus, it is possible to measure healthcare quality without reliance on outcome or patient satisfaction data.

Contrary to Complaint Counsel's suggestion, ENH and Dr. Chassin did not ignore outcomes as measures of quality. ENH relied on outcome data when such data was reliable. For example, ENH presented evidence of HPH's zero mortality rate (from clinical data) for coronary artery bypass graft ("CABG") procedures in the last 2 and 1/2 years and additional evidence showing that its mortality rates compared favorably to national benchmarks. (RFF ¶¶ 1609-1616).

2. Dr. Romano's Methodology and Analysis Are Fatally Flawed

Even if outcome and patient satisfaction data alone were sufficient to measure quality, numerous flaws in Dr. Romano's methodology and analysis undermine the credibility of his conclusions.

a. Dr. Romano did not perform a comprehensive analysis of the quality of care at HPH

Dr. Romano admitted that he did not perform a comprehensive analysis of the quality of care at HPH, which likely would have included interviews with the hospital staff and a site visit (both of which Dr. Chassin performed).[115] (Romano Tr. 3244-3245, RFF ¶¶ 1203-1207; RFF ¶ 2219). Moreover, Dr. Romano cherry-picked those factors that supported Complaint Counsel's position, while ignoring others that did not. Examples of this include:

- concluding that quality did not improve based on the AHRQ indicators, when the JCAHO measures showed just the opposite. (CCPTB at 69, 71)

[115] The ability of Dr. Romano to analyze the quality changes at HPH post-Merger is further called into question by his admission that he was not qualified to evaluate the importance of certain improvements made by ENH, such as the purchase of new laboratory equipment. (Romano, Tr. at 3316).

- relying on parts of the Rhea & Kaiser patient satisfaction survey, but disregarding the authors' conclusion that HPH patients who used a particular service since the Merger feel that there were strong improvements. (Romano, Tr. 3363)

- looking at or relying on small subset of indicators in a given area. (CCPTB at 70-71; Romano, Tr. 3222-3223, 3232-3235, *in camera*).

b. The outcome measures Dr. Romano selected are not valid or reliable measures of quality in this case

Dr. Romano's analysis is also inadequate because a significant majority of the outcome measures he relied upon – the AHRQ quality indicators – lack validity as measures of quality.[116] (RPTB at 102-103; RFF-Reply ¶¶ 2105-2106). There is no evidence of construct validity for processes of care for 7 out of 8 of the indicators that Dr. Romano used to assess complication rates at ENH and several of the mortality indicators lack validity at the provider (i.e., hospital) level. (RFF-Reply ¶¶ 2105-2106, 2058; RX 2004 at 58). Thus, the indicators that Dr. Romano used, because they lack published evidence of construct validity for processes of care, and because they are based on flawed administrative data, cannot be used as proof of quality problems. (RFF-Reply ¶ 2106). Although the developers of the AHRQ indicators cautioned that further investigation by other methods, such as chart review, was required, Dr. Romano made no attempt to confirm the accuracy of his analyses by other methods. (RFF ¶ 2246; RFF-Reply ¶ 2105). Moreover, the different and often contradictory results Dr. Romano obtained depending upon the quality measure used – AHRQ or JCAHO – further calls into question any conclusions made by Dr. Romano based on the use of the AHRQ indicators. (CCPTB at 69).

c. Dr. Romano relied on flawed administrative data in performing his outcome analysis

Dr. Romano's outcome analysis is further flawed because it is based on flawed

administrative data, which is used primarily for hospital reimbursement and billing purposes and reporting to government agencies. (RFF ¶¶ 2221-2222).

Dr. Romano conceded that administrative data, including the State of Illinois administrative data he used in this case, suffers from numerous deficiencies that limit its utility in measuring quality. (Romano, Tr. 3258-74, RFF ¶¶ 2117, 2229, 2232-2236). These limitations are critical because they do not permit one to adequately risk-adjust the outcomes. (RFF-Reply ¶ 2117). Risk-adjustment is very difficult to do, and even Dr. Haas-Wilson admitted in her book that current risk adjustment methods are "quite limited" and may "not be able to distinguish accurately between hospitals providing high quality and those providing poor quality." (RFF ¶ 1182; Haas-Wilson, Tr. 2926-2929). Risk-adjustment requires detailed clinical data about precisely how sick the patient is and what other conditions the patient brings with her or him to the hospital – information that is generally lacking in administrative data. (RFF ¶ 1182). Without such information, it is not possible to determine whether the hospital's care has contributed to improving the outcome.[117] (RFF ¶ 1182).

As a result of these and other problems with administrative data noted by Dr. Chassin (see RFF ¶¶ 2225-2239), hospital leaders remain skeptical about the usefulness and validity of outcome comparisons based on administrative data. (Romano, Tr. 3264-65, RFF ¶ 2238). Accordingly, Dr. Romano's disproportionate reliance on such data casts doubt on the reliability and validity of his outcome analysis.

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[116] Dr. Romano knew that the AHRQ measures lacked validity as quality measures because he led the literature review component of the project to assemble evidence regarding the validity of the AHRQ measures. (CCFF ¶ 2051).

[117] Different risk-adjustment methods also may lead to different results, as evidenced by Dr. Romano's contradictory results using the AHRQ and JCAHO measures. (CCPTB at 69).

d. Dr. Romano's difference-in-difference methodology is fatally flawed

Another flaw in Dr. Romano's outcome analysis is his use of a technique called difference-in-differences to compare changes in outcomes between the pre- and post-Merger periods at ENH.[118] This technique has serious limitations, particularly as Dr. Romano applied it in this case, which can cause the better performing hospital to look worse than the control hospitals. (RFF-Reply ¶ 2104).

One of the most important limitations of Dr. Romano's use of this approach is that it is basically a "before and after" test that fails to take trends into account. (RFF-Reply ¶ 2104). For example, if quality was declining pre-Merger and the Merger reversed the trend, but quality remained below pre-Merger levels, the difference-in-differences analysis may indicate a decline in quality even though there has been a positive change. (RFF-Reply ¶ 2104).

A second limitation is the "close to zero problem." (RFF-Reply ¶ 2104). This problem arises when one hospital has a rate for some condition that is close to zero, for example 0.3%, but the control group hospital has a higher rate during the pre-Merger period, such as 1.0%. (RFF-Reply ¶ 2104). If the control group hospital drops by more than 0.3% – for example from 1.0% to 0.5% – the one hospital will always look worse in comparison using Dr. Romano's approach because it cannot drop by a corresponding amount. (RFF-Reply ¶ 2104).

A third limitation of Dr. Romano's analysis is that he compared actual changes in percentage points by the subject hospitals rather than the relative magnitude of those percentage changes. (RFF-Reply ¶ 2104). Whereas a 2 percentage point change in the mortality of a control hospital might only be a 25% drop in its actual mortality, the same 2 percentage point

[118] Neither Complaint Counsel nor Dr. Romano cite a single article, case study, government report, or any other peer reviewed literature in which this method was used to measure changes in a hospital's quality over time.

change in mortality for the subject hospital may represent a 70% drop in its mortality.[119] (RFF-Reply ¶ 2104).

e. The patient satisfaction data Dr. Romano relied on is not a valid or reliable measure of quality in this case

Dr. Romano conceded that the Press Ganey data he relied on suffers from numerous deficiencies that prevent any meaningful conclusions from being drawn about patient satisfaction.[120] These deficiencies include:

- the representativeness of the sample could not be evaluated;
- many of the patients utilizing a service were not included in the surveys;
- low response rates – estimated at 20% – which significantly increases the possibility of biased results and is too low to allow for valid conclusions;
- not enough data was available; and
- much of the data relates to amenities, such as courtesy of the custodial staff and hospital food quality, that are not measures of clinical quality.

(RFF ¶¶ 2249, 2256-2258, 2267, 2272-2275; RFF-Reply ¶ 2134).[121] Dr. Haas-Wilson has written that there is "at best a weak relationship between patient satisfaction and clinical measures of quality." Deborah Hass-Wilson, Managed Care and Monopoly Power: The Antitrust Challenge 54 (2003). Unsurprisingly, Dr. Romano has never published an article in a peer-reviewed journal drawing conclusions on quality of care based on unrepresentative samples

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[119] An additional weakness of Dr. Romano's difference-in-differences method is that it is based upon administrative data from AHRQ's indicators, which lack validity as outcome measures. (RFF-Reply ¶¶ 2104, 2059).

[120] Complaint Counsel tries to inflate the significance of patient satisfaction data by asserting that ENH relies on such surveys to gauge its quality. (CCPTB at 68). This is misleading. While ENH uses patient satisfaction surveys, in part because JCHAO requires it to, Mark Neaman explained that such surveys do not reflect clinical care or clinical outcomes. (RFF ¶ 2250).

[121] Dr. Romano also relied on a single marketing survey conducted by Rhea & Kaiser. (RFF ¶ 2248). He conceded that the survey did not provide any information on the population surveyed and the sample sizes were very small – as low as 24 users for maternity services. (RFF ¶ 2270). Accordingly, he acknowledged that one would have to be cautious about drawing conclusions from the study. (RFF ¶ 2269). Additionally, the Rhea & Kaiser survey was not timely, asking patients about their perceptions of care that occurred up to two years earlier. (RFF ¶ 2271). It is well

from patient satisfaction surveys. (RFF ¶ 2261).

f. Complaint Counsel's discussion of specific service areas demonstrates the flaws in Dr. Romano's analysis

Complaint Counsel's discussion of specific service areas in pages 69-74 of its brief highlights the flaws in Dr. Romano's methodology and analysis.

i. Heart care

Heart Attack Mortality. Complaint Counsel dismisses the JCAHO measure, which showed improvement in heart attack mortality rates, by relegating it to a footnote. (CCPTB at 69 n. 54). Yet the JCAHO measure is more reliable than the AHRQ indicators Dr. Romano used. (RFF-Reply ¶¶ 2060-2061). **REDACTED**

(RFF-Reply ¶ 2062).

Heart Attack Care Processes. Complaint Counsel concedes that HPH's performance increased compared to the control group.[122] (CCPTB at 69). Complaint Counsel's argument that performance deteriorated at Evanston is a red herring. The evidence showed that Evanston outperformed Illinois hospitals both pre- and post-Merger on all of these measures,[123] and

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(RFF ¶¶ 1493-1494, 1496-1497, 1500-1502, 1504; RFF-Reply ¶ 2060, 2074). Dr. Romano's conclusion of no overall improvement at ENH

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established in patient satisfaction literature that patients' impressions of their care experience must be taken within a few weeks of that experience, or their recollection deteriorates and changes dramatically. (RFF ¶ 2271).

[122] It is undisputed that HPH's performance on heart attack process measures, such as the provision of aspirin and beta blockers upon arrival and discharge, went from below the Illinois hospital average pre-Merger to above it post-Merger. (RFF ¶¶ 1490-1504; RFF-Reply ¶ 2060).

[123] Evanston Hospital's **REDACTED** (RFF ¶ 1501).

must be further discounted as a result of his admitted failure to balance the alleged relative changes in performance at HPH and Evanston. (CCPTB at 69-70).

Heart Surgery and Other Procedures. Complaint Counsel focuses solely on Evanston, while completely ignoring the exemplary mortality rates at post-Merger HPH. (RFF ¶¶ 1609-1616). Moreover, Complaint Counsel wholly misrepresents the evidence concerning cardiac surgical complications. (CCPTB at 70). The evidence showed that HPH's major cardiac surgical complication rate was lower than the national benchmark,

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and ENH's minor complication rate was also very good.[124] (RFF-Reply ¶¶ 2033, 2079).

ii. Obstetrics and gynecology

Complaint Counsel argues that the changes in obstetrics and gynecology did not benefit patients based on Dr. Romano's analysis of a handful indicators, most of which lack validity for measuring quality, and which Dr. Romano himself acknowledged are not comprehensive and overlook many important processes of care. (RFF-Reply ¶¶ 2090, 2107). These indicators also are not sufficient to permit broad generalizations over the entire service area because they all relate to the delivering of babies and do not address other important changes in this service area, such as the addition of a preoperative gynecological surgical review program, the elimination of inappropriate labor and delivery and gynecologic practices, and the disciplining of problem physicians.[125] (RFF ¶¶ 1269-1275, 1301-1303, 1311-1314; RFF-Reply ¶ 2205).

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[124] Additional evidence of improvements in heart attack care at HPH after the Merger include the dramatic increase in the transfers of heart attack patients to HPH directly after the Merger and a concomitant reduction in transfers out. (RFF ¶¶ 1655-1660). The introduction of cardiac surgery and interventional cardiology at HPH increased output by increasing HPH's ability to care for heart attack patients. (RFF ¶¶ 1566, 1606-1607, 1655-1660).

[125] **REDACTED** (RFF ¶ 1297, *in camera*). **REDACTED** (RFF ¶ 1297; RFF-Reply ¶ 2221).

Moreover, Complaint Counsel ignores evidence of improvements under Dr. Romano's own analysis. It glosses over the fact that

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(RFF-Reply ¶ 2089, *in camera*). Complaint Counsel also ignores evidence that ENH as a whole had lower rates for operative vaginal delivery and Cesarean section throughout the pre- and post-Merger periods relative to the benchmark of hospitals at the national level reported in NPIC. (RFF-Reply ¶ 2089).

Finally, neonatal mortality occurs so rarely in the low risk obstetric services offered by HPH that its utility as a measure of quality is questionable. (RFF-Reply ¶ 2093).[126] Moreover, Dr. Chassin did not examine neonatal mortality because he could not find risk-adjusted data that allowed him to track pre- and post-Merger quality in a meaningful way. (RFF-Reply ¶ 2093).

iii. Nursing

Dr. Romano's testimony about nursing services highlights the contradictory and inconclusive nature of his opinions on quality improvements in this case. Dr. Romano relied upon only four different AHRQ patient safety indicators to find no evidence of improvement in nursing services. (CCPTB at 71). These four indicators cannot measure the numerous improvements in nursing skills, staffing, culture, training, and acumen at post-Merger HPH. (RFF ¶¶ 1338-1413). Additionally, the problems with these indicators as definitive measures of quality are discussed in Section IV.B.2.b.

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(CCPTB at 71-72; Romano, Tr. 3232-3235, *in camera*).

REDACTED (RFF ¶ 1231, *in camera*).

iv. Exporting Evanston's "teaching" status to Highland Park

ENH does not contend that quality improved at HPH simply because it "owns" HPH, as Complaint Counsel represents. (CCPTB at 72). Rather, as set forth at page 93 of Respondent's post-trial brief, ENH took affirmative steps to bring its academic focus to HPH, which raised the skill level of the physicians practicing there.

The benefits of this academic focus are borne out by improved patient care in numerous areas at HPH post-Merger. Dr. Romano, however, focused on mortality rates in only four areas. (CCPTB at 72). Not only is this improper, but the evidence does not support his conclusion. As discussed in Respondent's post trial brief at pages 94-95, heart care is a prime example of an area in which quality improved markedly after the Merger. Additionally, Dr. Romano's own measures showed that **REDACTED**

Romano, Tr. 3218-3221, *in camera*).

v. Cancer care

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(CCPTB at 73; Romano, Tr. 3097-8, *in camera*; RFF ¶ 1763). Outcomes are a particularly poor means of assessing quality of care in oncology, where many patients are terminally ill and the outcome is beyond the physician's control. (RFF ¶ 1183).

The oncology patient satisfaction surveys relied on by Dr. Romano illustrate why patient

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[126] To the extent this indicator is relevant, Dr. Romano found improvement at ENH post-Merger. **REDACTED**

satisfaction data is an inappropriate measure of quality in this case. The Kellogg Cancer Care Center is an *outpatient* facility, yet **REDACTED**

[127] (RFF ¶ 2272; RFF-Reply ¶¶ 2140-2141; 2257). As a result, the data does not capture patient satisfaction from the vast majority of the patients who use the facility. (RFF ¶¶ 2272, 2275; RFF-Reply ¶¶ 2140-2141, 2257).

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. (Romano, Tr. 3101-3103, *in camera*). The Rhea & Kaiser survey is equally unreliable because of the extremely small sample size – only 26 oncology patients. (RFF ¶ 2270; RFF-Reply ¶ 2142).

vi. Psychiatric care

Dr. Romano's conclusions on psychiatric care ignore the vast expansion of specialized adolescent psychiatric services at HPH.

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(Romano, Tr. 3115, *in camera*). In reality, while adult services were no longer offered at HPH, the rationalization of psychiatric services allowed post-Merger HPH to (a) offer a broader variety of treatment options and specialized services to adolescent patients than either Evanston or pre-Merger HPH could, and (b) extend the

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REDACTED (RFF-Reply ¶ 2091).

[127] Improvements in the quality of outpatient services should be counted in the analysis of the competitive effects of the Merger because they are part of the proper relevant market of all acute care hospital-based services, as defined by Dr. Noether. However, improvements in the quality of outpatient services are relevant even under Dr. Haas-Wilson's more limited relevant product market, which excludes outpatient services, because the benefits of those services accrue to the MCOs, which purchase inpatient and outpatient services in the same contract. Moreover, outpatient services are inextricably linked to quality improvements in inpatient services. (RFF ¶¶ 326-328).

age range of adolescents who could be treated in the HPH unit. (RFF ¶ 2175, 2182; RFF-Reply ¶ 2283).[128]

Dr. Romano's patient satisfaction analysis again demonstrates the problems with using such data.

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(Romano, Tr. 3116-3117, *in camera* (discussing DX 441 at 107); RFF ¶ 2172). This means that, at best, Dr. Romano analyzed only 2 or 3 quarters of Press Ganey data in forming his opinion.

3. Complaint Counsel's effort to find flaws with Dr. Chassin's more comprehensive and well-accepted methodology falls short

Having ignored all qualitative evidence despite its widespread use by third-party organizations and state licensing agencies such as JCAHO, ACOG, and CHRPP that measure quality, Complaint Counsel unsuccessfully tries to find flaws in the qualitative methods employed by Dr. Chassin. (RFF ¶¶ 1203, 1209; RFF-Reply ¶ 2161).

Contrary to Complaint Counsel's contention, Dr. Chassin used only valid outcome measures based upon clinical data, as well as valid structure and process measures. Moreover, he carefully selected only valid structural measures of quality – such as physician coverage – that have been shown to increase the likelihood of desired health outcomes. (Chassin, Tr. 5586).

Complaint Counsel's criticisms of Dr. Chassin's interviews are baseless. Dr. Chassin alone selected all 34 of the interview subjects and prepared a set of structured interview questions to ask of each individual. (RFF-Reply ¶ 2151; RFF ¶ 1206). The interviewees included several independent physicians based at HPH who were not employed by ENH and HPH physicians who have since left HPH. (RFF-Reply ¶¶ 2153, 2161). Dr. Chassin also

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[128] Dr. Romano admitted that all things being equal, he would prefer sending his own child to a dedicated adolescent unit. (Romano, Tr. 3313-3114).

conducted informal interviews without ENH administrators or counsel present.[129] (RFF ¶¶ 1205-1206). Several of the subjects had worked at HPH prior to the Merger and were intimately familiar with its quality, while others conducted in-depth assessments of HPH shortly after the Merger. (RFF ¶¶ 1797-1799, 1372, 1870, 1969). Significantly, several of the interviewees also testified at trial, allowing this Court to assess their candor and credibility for itself.

Finally, the fact that the interviews took place four years after the Merger is inapposite. Dr. Chassin actively sought out additional information available from contemporaneous documents and third party assessments of quality in an effort to corroborate the information obtained in interviews. (RFF-Reply ¶¶ 2112, 2161; RFF ¶ 1208). Moreover, there is a substantial difference in the reliability of the recollection of a patient who spent a few days or hours in a hospital while ill several months earlier and the recollection of a doctor or administrator who has worked for years on a daily basis in the same place and who was personally involved in and/or affected by the changes that took place.

4. Complaint Counsel has no credible evidence to rebut ENH's evidence of quality improvements at HPH after the Merger

The disparity in the quality evidence is striking. Outside of Dr. Romano's flawed analysis, Complaint Counsel has offered no evidence to rebut ENH's 13 fact witnesses who gave firsthand accounts of the quality improvements at HPH or the objective evidence of quality improvements from third-party organizations responsible for monitoring hospital quality, such as Solucient, HealthGrades, Leapfrog, and Consumer's Digest. For the reasons stated in Respondent's opening brief at page 107, Mark Newton's testimony, upon which Complaint Counsel relies, simply is not credible,[130] nor is the testimony of payors. Jane Ballangee, for

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[129] Further, Hillebrand, for example, was present for only a couple of Dr. Chassin's 34 formal interviews. (RFF-Reply ¶ 2155).

[130] *See also*, Section I.A.3.

example, was unaware of the addition of cardiac surgery, invasive cardiology, intensivists, and the Kellogg Cancer Care Center; the expansion of the emergency room coverage; the addition of new high-end equipment such as a PET scanner; or the implementation of Epic at ENH. (Ballengee, Tr. 201-03). As a result, she has absolutely no basis to make any statements about whether HPH's post-Merger quality did or did not improve.

C. HPH Could Not Have Achieved the Same Results Without the Merger

Complaint Counsel argues that any quality improvements at HPH were not "merger-specific" based on the untenable position that HPH had no pre-Merger quality issues, and that HPH had both the money and the ability to make the necessary improvements. The reality, as demonstrated by the evidence at trial, is that ENH improved the quality at HPH much faster and to a much higher level than HPH could have absent the Merger.

1. HPH had specific quality issues

Complaint Counsel argument that HPH was a good hospital before the Merger is irrelevant. (CCPTB at 79-80). Even if this were true generally, HPH was old and outdated, and it had serious issues with its physical plant and in the areas of

REDACTED .[131] (RFF ¶¶ 1249-1275, 1344-1384, 1420-1441, 1464-1468, 1526-1548, 2450). What matters is that ENH improved quality of care at HPH after the Merger.

2. HPH lacked the financial capacity to implement quality improvements

Complaint Counsel's main support for its illusory argument that HPH would have

[131] Complaint Counsel emphasizes HPH's 1999 preliminary JCAHO score of 95 as evidence of HPH's pre-Merger quality. (CCPTB at 80). It is disingenuous for Complaint Counsel to trumpet this score as evidence of HPH's pre-Merger quality while at the same time criticizing the very methods (interviews and site visits) by which it was determined. Moreover, a score of 95 is not exceptional. In 1999, Chicago hospitals commonly received JCAHO scores in the mid-90s. (RFF ¶ 1521; RFF-Reply ¶ 2301). In part as a result of the frequency of such high scores, JCAHO revised its accreditation process. (RFF ¶ 1521; RFF-Reply ¶ 2301).

improved the quality of care without the Merger are HPH's 1998 and 1999 strategic plans to invest millions of dollars into HPH. (CCPTB at 80). In making this argument, Complaint Counsel grossly misrepresents HPH's financial health. Rather than being "impressive," HPH's financial condition was declining so rapidly in the late 1990s that it lacked the wherewithal to make any meaningful quality improvements or expand its services in ways that would allow it to compete effectively in the Chicago marketplace.[132] (*See* RPTB at 61-65).

3. HPH's culture and leadership structure prevented it from implementing essential quality improvements

HPH also lacked the culture and leadership structure that was essential to making many of the post-Merger quality improvements. (RFF ¶¶ 2453-2458). Thus, even if Dr. Romano is correct that strengthening quality assurance and quality improvement programs is not "rocket science," the fact is that HPH did not make the necessary changes prior to the Merger.

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. Moreover, Dr. Chassin singled out quality assurance as an area in which HPH's pre-Merger organizational structure hindered quality, and in which ENH's addition of strong departmental leadership was necessary to correct the problems. (RFF ¶¶ 1429-1434, 1442-1457, 1452-1453).

4. Complaint Counsel's argument that there was a national trend toward improved healthcare is both misleading and flawed

Complaint Counsel's argument that after the Merger, the healthcare community was moving to improve the quality of care at hospitals, is a red herring.

Complaint Counsel points to a nationwide increase in the quality of care for Medicare

[132] There is no question that due to its declining financial condition, HPH could never have made the $120 million in capital investments that ENH made post-Merger. (RFF ¶ 2452).

beneficiaries.[133] (CCPTB at 67 n. 53). The study showed, however, that healthcare quality in Illinois was significantly below the nationwide average, ranking 47th among the 50 states in 1998-1999 and 46th in 2000-2001. (Romano, Tr. 3001).

Moreover, knowing what to do and being able to do it are two different things. Although the benefits of electronic medical records have been well-known for years, no community hospital has deployed an enterprise grade electronic medical record system such as Epic, and the majority of community hospitals still do not have computerized physician order entry.[134] (RFF ¶¶ 2118-2120, 2211). Additionally, it is undisputed that ENH is a leader in the area of electronic medical records, and not simply a follower of a trend.[135] (RFF ¶¶ 2110-2117, 2208-2210).

Complaint Counsel's citation to Dr. Ankin is misleading. (CCPTB at 81). Evanston and Glenbrook Hospitals had intensivist programs 3 or 4 years before the Merger; HPH added intensivist coverage only after the Merger. (RFF ¶¶ 1686, 1690). Despite studies recognizing the benefits of intensivist programs to patient care, only 6 of 37 hospitals responding to a survey published by the Leapfrog group in 2005 had intensivist coverage, and three of those hospitals were the ENH hospitals.[136] (RFF ¶¶ 1687-1689, 1721). The lack of Illinois hospitals with electronic medical records such as Epic and intensivist programs shows that quality improvement efforts are not nearly as universal as Complaint Counsel suggests.

Finally, Complaint Counsel overstates the importance of the increased nationwide focus

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[133] Medicare is not part of the relevant market in this case.

[134] Complaint Counsel notes that ENH's Epic system did not become operational until 2003-2004. The process for deploying Epic began, however, as soon as ENH signed the license agreement in the summer of 2001. (RFF ¶¶ 2026, 2027-2042).

[135] Epic is a shining example of HPH improving more and faster than it could have without the Merger. As Dr. Chassin noted, the depth and speed with which ENH was able to completely engage its three campuses, including physicians and non-physicians, in the roll-out of Epic produced a much greater improvement in quality in a much shorter period of time than most, if not all, other implementations of an electronic medical record. (RFF ¶ 2109).

[136] Indeed, Rush North Shore declined to institute an intensivist program despite Dr. Ankin's recommendation because it could not afford it. (RFF ¶ 1720).

on the quality of healthcare. Dr. Noether, relying on a 2004 or 2005 study by the Institute of Medicine, determined that in spite of this attention, evidence of widespread quality improvements were lacking. (Noether, Tr. 6010-6016).

5. HPH could not have improved as much through joint ventures

Complaint Counsel's argument that HPH could have improved quality through joint ventures with other hospitals fails because the oncology joint venture was only in preliminary discussions and far from a certainty, and the evidence at trial established that a cardiac surgery joint venture could never have achieved the level of quality that the HPH program now enjoys.[137]

a. HPH did not have any plans to enter into a joint oncology program with another institution

Although HPH explored an oncology joint venture in 1997, these efforts never advanced beyond the discussion stage, and there is no evidence as to how the venture would have been structured, what services would have been offered, and what the level of quality would have been. What is certain is that ENH raised HPH from a community oncology program to an academic teaching program that offered multidisciplinary and specialty services, research trials, complex procedures and treatments, and equipment not usually found in community hospitals. (RFF ¶¶ 1722-1726, 1779-1782, 1787-1788).

b. The Merger is essential to achieving the high level of quality of ENH's cardiac surgery program

Even if HPH could have entered into a joint venture with ENH for cardiac surgery, like Swedish Covenant, both objective data and testimony from Dr. Rosengart, who has personal

[137] The cardiac surgery joint venture also was not as much of a certainty as Complaint Counsel represents. CX 501, which Complaint Counsel cites as evidence that Evanston and HPH "had contracted to bring cardiac surgery to HPH," (CCPTB at 83), is the Agreement and Plan of Merger, which provides that the "surviving corporation" shall establish a cardiac surgery program at HPH. (CX 501 at 41). The surviving corporation refers to the merged entity. (CX 501 at 2). Thus, the Merger Agreement clearly contemplates that cardiac surgery would be extended to HPH by the merged entity, rather than by joint venture. (CX 501 at 41).

knowledge of both the HPH and Swedish Covenant programs, establish that a joint venture would not produce the level of quality in cardiac care that patients at HPH enjoy today.

The outcome data favored by Complaint Counsel shows that HPH's mortality rate is lower than Swedish Covenant's and compares favorably to the best cardiac surgery centers in the country. (RFF ¶¶ 1609, 1611). Cardiac patients at Swedish Covenant also have longer hospital stays than HPH patients, and the cost per case at Swedish Covenant is higher. (RFF ¶ 1644).

Additionally, HPH's cardiac surgery program offers several additional benefits to patients that are lacking in the joint venture with Swedish Covenant, including the performance of cutting edge procedures such as bloodless surgery, access to private and government funded research, quicker adoption of new technologies, and improved access to state-of-the-art medical technology. (RFF ¶¶ 1637-1642, 1645). The integration, common infrastructure, and complete control over the HPH's cardiac surgery program resulting from the Merger is essential to achieving all of these benefits. (RFF ¶¶ 1637-1639, 1641-1642).

The Merger is also necessary for HPH to meet minimum volume requirements necessary for a high quality cardiac surgery program. (RFF ¶ 2492). Dr. Romano conceded that if HPH worked as a stand-alone program like Swedish Covenant and Weiss, independent of ENH, the volume of procedures would fall below the suggested criteria for quality. (RFF ¶ 2493).

D. Complaint Counsel Has Not Shown that the Anticompetitive Effects of the Merger Outweigh Its Pro-Competitive Benefits

The dramatic quality improvements at ENH as a result of the Merger – the product of over $120 million in investments – manifestly outweigh any purported anticompetitive effect the Merger is likely to cause. Complaint Counsel now contends, for the first time, that "[p]eople who could have afforded ENH's services at competitive rates were shut out of the market." (CCPTB at 78). Complaint Counsel trumpets a parade of horribles that *can* result from higher

prices – higher premiums for employees, increased deductibles, increased co-pays, employers dropping coverage altogether, and consumers losing insurance coverage.[138] (CCPTB at 77-78). This argument is nothing more than bald speculation. Complaint Counsel has not produced a single shred of evidence proving that such consequences *actually resulted* from the Merger. Neither Complaint Counsel's experts nor the payors quantified the amount that premiums were affected, if at all, by ENH's higher prices.[139] Additionally, Complaint Counsel did not introduce any employer testimony to discuss whether its healthcare costs rose, whether any additional costs were passed on to employees because of ENH's higher prices, or whether they dropped insurance coverage altogether.[140] Nor did Complaint Counsel present any evidence of a single individual who lost health insurance coverage as a result of higher prices after the Merger. It would be wrong to undo the significant and life-saving quality improvements that resulted from the Merger on the basis of mere speculation.[141]

Complaint Counsel also contends that output was reduced after the Merger. That is absolutely false. Not only does it offer absolutely no evidence to support its claim, but it admits in its findings that output did *not* decrease (CCFF ¶ 1653). The record evidence shows that, with the addition of new and expanded services at HPH after the Merger, output at ENH increased.

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[138] Complaint Counsel awkwardly placed this argument, which concerns its alleged proof of competitive harm, in the section relating to ENH's quality improvements. Pursuant to the Court's Order, ENH is responding to the argument in the order it is found.

[139] Moreover, no expert for Complaint Counsel analyzed the amount of any reduction in premium that would be necessary for an MCO to market a plan to employers without a post-Merger ENH. (Hass-Wilson, Tr., 2765-2766, *in camera*) (RFF-Reply 1097).

[140] As explained in Section I.C.3. above, Complaint Counsel's proxy for employer evidence is inadmissible lay opinion testimony by payor witnesses that lacked any foundation.

[141] Moreover, MCOs and employers have mechanisms to avoid passing any cost increases onto consumers. MCOs can create incentives for employees to use lower cost providers rather than pass on cost increases to employers. For instance, some MCOs have created "tiered" networks, which are broad networks in the aggregate that provide financial incentives for employees to use a limited subset of the network providers that have relatively lower negotiated rates. (RFF-Reply ¶ 145). Employers also have vehicles available to them to control total insurance costs. In a cafeteria plan, for example, employees pay a higher out-of-pocket fee to access a more expensive provider, and a lower out-of-pocket fee to access a less expensive provider. (RFF-Reply ¶ 145).

(RPTB at 37-38; RFF ¶ 1164, 1566, 1606-1607, 1655-1660). Post-Merger increases in prices and output are consistent with an increase in quality and inconsistent with an increase in market power. (RFF ¶ 1164).

For all of these reasons, Complaint Counsel failed to satisfy its burden of proving that any anticompetitive effects the Merger may produce outweigh the pro-competitive benefits of the Merger. It thus failed its ultimate burden of persuasion. *Baker Hughes*, 908 F.2d at 938.

V. THE MERGER COULD NOT VIOLATE SECTION 7

Complaint Counsel's discussion of Respondent's so-called "Copperweld defense" misses the point. Prior to the merger, the membership interests of both Evanston Hospital and HPH were held by a single entity, the parent network NHN. (RFF ¶¶ 198, 207) Therefore, as discussed in Respondent's post-trial brief, Complaint Counsel has not actually proved a fundamental element of Section 7 liability – an acquisition by one "person" of another. 15 U.S.C. §18(a) (2005) ("[n]o person . . . shall acquire, directly or indirectly, the whole or any part of the stock or other share capital . . . [or] the whole or any part of the assets *of another person* ...") (emphasis added). RPTB at 110-113. This analysis is confirmed by the HSR Act and the advice the parties received from the FTC's Pre-Merger Notification Office. RPTB at 111-112; RFF ¶¶ 298-300.[142]

Consequently, Respondent's defense does not hinge on the applicability of the so-called *Copperweld* doctrine, which recognized that a parent and its wholly-owned subsidiary are not capable of conspiring, and are deemed to have a unity of interest, as a matter of law. *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 777 (1984). *See also Am.*

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[142] Complaint Counsel claims that even if the Merger is not subject to Section 7, the formation of NHN is still subject to challenge. CCPTB at 85, n. 65. Whether or not that is true is irrelevant, since the formation of NHN was not challenged here and was never the subject of Complaint Counsel's action. *See* Compl. ¶¶ 12-14 (defining the Merger as the 1/1/2000 merger between HPH's parent and Evanston Hospital).

Chiropractic Ass'n v. Trigon Healthcare, 367 F.3d 212, 223 (4th Cir. 2004); *Siegel Transfer, Inc. v. Carrier Express, Inc.* 54 F.3d 1125, 1131-1132 (3rd Cir. 1995).[143] Nevertheless, Respondent's defense is entirely consistent with the *Copperweld* doctrine. No matter how much Complaint Counsel criticizes NHN's management of the network, it cannot escape the basic fact that, legally, Evanston Hospital and HPH were part of the same "person" for purposes of Section 7.[144] Consequently, Complaint Counsel has not shown that the Merger involved two separate, legal entities – e.g., that Evanston Hospital acquired "the assets of another person." Thus, Section 7 does not apply and Complaint Counsel's claim fails as a matter of law.

VI. THERE ARE ALTERNATIVE REMEDIES TO DIVESTITURE THAT ARE MORE APPROPRIATE EVEN ASSUMING, FOR THE SAKE OF ARGUMENT, THAT THE MERGER VIOLATED SECTION 7

A. The Clayton Act Does Not Require Divestiture

This Court should never need to reach the issue of remedy because, as discussed above, Complaint Counsel has not met its burden of proving that the Merger violated Section 7. However, if the Court were to find a violation, it has significant discretion in fashioning appropriate relief, like here, where there are more appropriate alternative remedies that will maintain the benefits that the Merger brought to consumers.[145]

The Supreme Court has specifically rejected the notion that courts of equity are required

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[143] The courts have extended the *Copperweld* doctrine to two wholly-owned subsidiaries of a common parent. *See* RPTB at 112, n. 58.

[144] See RFF ¶¶ 208-212, 217, 222-223 and RPTB at 113 for a more complete discussion of NHN's ownership of, and powers relative to, Evanston Hospital and HPH.

[145] If the Court were inclined to fence-in ENH for any past violation of Section 7, a prior notification order would be a much more appropriate remedy than divestiture. If the Court were to find an ongoing violation of Section 7 that will continue into the future, a narrowly crafted conduct remedy requiring Evanston Hospital and HPH to negotiate and maintain separate managed care contracts at the request of the MCOs would be more suitable than divestiture. Complaint Counsel has charged that, "ENH's request to shift three hospitals to the same contract with the same rates allowed it to maximize the profitability of the consolidation of the [HPH] and Evanston contracts." (CCFF ¶¶ 917, 1303). While Respondent has shown that consolidation of the contracts was a step to achieve an integrated hospital system – which the other hospital systems are not – if the Court were to find otherwise, this remedy proposed by

to order divestiture, reasoning that "Congress would not be deemed to have restricted the broad remedial powers of courts of equity without explicit language doing so in terms, or some other strong indication of intent." *du Pont* 366 U.S. 316, 331 n.9 (1961).[146] Indeed, the Commission itself has acknowledged that divestiture is not required. *In the Matter of Retail Credit Comp.*, 92 FTC 1, 1978 FTC LEXIS 246, at *258-259 (July 7, 1978) ("This is not to say that divestiture is an automatic sanction, mechanically invoked in merger cases"); *In re National Tea Co.*, 69 FTC 226, 1966 FTC LEXIS 41, at *88 (Mar. 4, 1966) ("At least we think it appropriate, in the circumstances of this case, to give those natural forces of competition a chance to correct the imbalances in those markets before turning to the more stringent remedy of divestiture"); *see also* RPTB at 123-126.

Complaint Counsel also seems to be arguing that its decision to pursue the remedy of divestiture has come from the Commission itself, and thus should receive deference from the Court. (CCPTB at 86). However, the Commission has done nothing of the sort – all it has done is authorize Complaint Counsel to file a complaint. As such, Complaint Counsel's request for divestiture should receive no deference from the Court, and in fact, must be shown to be the most appropriate remedy. Divesture is a "drastic" remedy that "cannot be had on assumptions." *United States v. Crowell, Collier & MacMillan, Inc.*, 361 F. Supp. 983, 991 (S.D.N.Y. 1973). Complaint Counsel has offered no evidence, including economic expert testimony, which demonstrates that divestiture would be the most effective remedy to restore competition allegedly lost through the Merger. (*See* RPTB at 114-115).

Respondent should alleviate the concerns of Complaint Counsel. For a complete discussion of alternative remedies, *see* RPTB at 123-26.

[146] The Court offered no opinion as to whether administrative agencies were limited only to the remedy of divestiture, and no Court has held that the only available remedy to the FTC, if a Section 7 violation is found, is divestiture.

B. The Quality of Healthcare Provided By HPH Would Unquestionably Be Impaired as a Result of Divestiture

This case is distinguishable from the typical divestiture because the benefits of the Merger are important, life-saving improvements in the quality of healthcare. *See Olin*, 113 FTC at 330-331 ("there is no indication in this record that a divestiture order may bring about a loss of substantial efficiencies or other important benefits to the consumer"). In the prior divestiture cases cited by Complaint Counsel, the only implications from divestiture were financial: *CB&I*, Dkt. No. 9300, at 1 (Jan. 6, 2005) (storage tanks for liquified gas); *Olin Corp.*, 113 FTC 400 (1990) (swimming pool chemicals); *Ekco Products Co.*, 65 FTC 1163 (1964) (meat handling equipment); *Crown Zellerback Corp.*, 54 FTC 769 (1957) (paper products). In none of those cases were people's lives and well-being at stake. Even the healthcare case that Complaint Counsel cites, *HCA*, is totally inapposite, as there was no claim that there would be any clinical improvements in quality. 106 F.T.C. 361 (1985). Instead, the acquisition, which involved administrative management of for-profit hospitals, was entirely for financial gain. *Id.* at *33-*36.

Conversely, ENH, a non-profit hospital, has done much more than simply manage HPH – it exported Evanston Hospital's collaborative and multidisciplinary culture to HPH, which was necessary to achieve the vast majority of HPH's improvements. (RFF ¶¶ 2453-2458). ENH also has spent over $120 million on capital improvements at HPH after the Merger and has plans to spend an additional $45 million on HPH. (RFF ¶ 1518). These changes have benefited the community as a whole, greatly improved the clinical quality at HPH, and saved lives. (RPTB at 74-99; RFF ¶¶ 1706, 2446-2482, 2523, 2525).

As set forth in Respondent's post-trial brief at pages 116-120, many of the most important improvements in patient care resulting from the Merger, including improved physician

and nursing skills, improved clinical protocols, cardiac surgery, interventional cardiology, and Epic, would be eroded and eliminated upon divestiture of HPH.[147] (*See also* RFF ¶¶ 1232, 2483-2532; RFF-Reply ¶¶ 2567, 2570, 2576). Divestiture would also sever the integration of the medical staffs, thereby depriving HPH of the intensity and scope of academic activities, research partnerships, multidisciplinary care conferences, and case consultations from which its patients now benefit. (RFF ¶¶ 2514-2518; RFF-Reply ¶¶ 2578-2579). The integrated relationship between ENH and HPH is essential to maintaining these quality improvements, as well as the significant improvements in quality improvement and assurance processes depend on the continued benefit of the integrated relationship between HPH and ENH via the Merger.[148] (RFF ¶ 2484). The consequences to patients from these losses would be dramatic and felt throughout the ENH community.

Complaint Counsel contends that the quality of healthcare at HPH would not decline because HPH is monitored or evaluated by outside entities such as Leapfrog, health plans, and JCAHO. This contention is unfounded and unsupported by the evidence. First, such entities monitored or evaluated HPH prior to the Merger, yet HPH still had serious quality issues that threatened patient care. (*See* Section IV.C.1, *supra*). Second, outside bodies such as Leapfrog have no direct authority to effectuate change. Reporting to Leapfrog is on a voluntary basis, and compliance with Leapfrog directives is not strong (only 37 hospitals across Illinois reported to Leapfrog, while there are at least 100 hospitals just in the greater Chicago area). (RFF ¶¶ 116,

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[147] Complaint Counsel relies on mere guesses and speculation by Dr. Romano to suggest that HPH would maintain the quality improvements brought to it by the Merger. Dr. Romano admits that he has not visited the hospitals, interviewed any of the doctors or staff, or has done any analysis of HPH's financial ability to make quality changes prior to the Merger. (RFF ¶¶ 1203, 1209; RFF-Reply ¶ 2041). Mere guesswork should not be enough to order divestiture when there is actual evidence showing that divestiture would destroy the quality of care improvements that the Merger created, thereby harm patients. (RFF ¶¶ 2483-2532).

[148] For example, exposure to subspecialists with advanced clinical knowledge is critical to continuing quality improvement and, upon divestiture, HPH's exposure to the substantial subspecialty expertise of ENH providers would end. (RFF ¶¶ 2486).

1721). The lack of intensivist programs in Illinois hospitals – only six of the 37 reporting hospitals in Illinois have installed such a program in spite of Leapfrog's recommendation – exemplifies the problem. (RFF ¶ 1721). Third, MCOs only consider quality as "background information," and contrary to Complaint Counsel's assertion, only have an incentive to provide coverage that "will be *adequate* to meet their customers' [] needs." *Indiana Fed'n of Dentists*, 476 U.S. at 463 (emphasis added); RFF-Reply ¶¶ 2473-2477, 2479, 2485.[149] Finally, JACHO scores are general and imprecise measures of quality not suited to assure continual advancements in care. (RFF ¶¶ 1520-1522). This is evidenced by the fact that HPH received a 95 from JCAHO prior to the Merger, but not months later was in jeopardy of losing its Medicare accreditation as a result of significant deficiencies found by the Illinois Department of Public Health and HCFA. (RFF ¶¶ 1513-1514, 1522, 1526-1535).

C. The Ancillary Relief Requested By Complaint Counsel Demonstrates that Divestiture is Not the Proper Remedy

Complaint Counsel also requests ancillary relief. (CCPTB at 86-90). In requesting ancillary relief, Complaint Counsel is talking out of both sides of its mouth.[150] It argues in the competitive effects section, that before the Merger, HPH's financial health was strong and could be a competitive stand-alone hospital; then in the remedy section, it requires an approved acquirer. (CCPTB at 19, 81-82, 87). It argues in the quality section that HPH could have improved quality on its own or with another hospital; then in the remedy section it requires that ENH provide substantial support in maintaining the quality gains at HPH. (CCPTB at 79-83, 87-

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[149] *See also Blue Cross & Blue Shield United of Wisconsin*, 65 F.3d at 1410 (finding that while managed care HMO's "incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible.").

[150] One of Complaint Counsel's provisions requires ENH to terminate all of its contracts that it negotiated with MCOs after the Merger, and negotiate new contracts. Yet, there is no reason to expect ENH's "new" negotiated prices to be any lower than its existing prices, because ENH learned about the true demand for its services

89).[151] Complaint Counsel cannot have it both ways. If HPH could be a strong stand-alone hospital on its own, and maintain the quality improvements that ENH brought to it, then the ancillary relief requested would simply be punishing ENH, which is not the purpose of an antitrust remedy. *E.I. du Pont de Nemours & Co.*, 366 U.S. at 326 ("[c]ourts are *not* authorized in civil proceedings to punish antitrust violators, and relief must not be punitive.") (emphasis added); *Brunswick Corp. v. Pueblo Bowl-o-Mat, Inc.*, 429 U.S. 477, 485-486 (1977) (same). Instead, by requesting this ancillary relief, Complaint Counsel is tacitly admitting that the evidence has shown otherwise – that HPH was flailing financially before the Merger, and could not have made the quality improvements brought to it because of the Merger on its own. (RFF ¶¶ 2446-2482). This admission should make any remedy unwarranted, because Complaint Counsel has failed to carry its burden of proving that any purported anticompetitive effects of the Merger outweigh the dramatic improvements in quality.

Complaint Counsel also offers no criteria to select an acquirer of HPH, yet argues that a mystery acquirer, with some assistance from ENH, could maintain the quality improvements made at HPH, like the cardiac surgery program, Epic, clinical pathways, and the recruitment of high-caliber physicians and hospital administrators. (CCPTB at 87-90). However, no matter the acquirer, it is unlikely that there are any that could maintain the quality levels achieved by ENH. Such an entity would have to be in the same general geographic

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coincident with the Merger. (RPTB at 40-54, 121-122; RFF ¶¶ 2533-2534). As such, Complaint Counsel's requested relief would have no effect on prices in the market.

[151] Complaint Counsel would require ENH to continue HPH's cardiac surgery program "in substantially the same manner," and points to the joint cardiac programs that ENH currently operates at Swedish Covenant and Weiss Memorial. (CCPTB at 87). However, Dr. Rosengart, the division head of Cardiothoracic Surgery at ENH, found that overall, the quality of cardiac surgery performed at ENH (Evanston Hospital and HPH) is higher than the quality of cardiac surgery performed at the affiliated sites, Swedish Covenant Hospital and Weiss Hospital. (Rosengart, Tr. 4504; RFF ¶¶ 1587, 1636-1639). Further, although the mortality rates at Swedish Covenant are within acceptable limits, HPH has had much better outcomes, with 0 mortality for CABG patients in the last two and a half years. (Rosengart, Tr. 4502-05; see also RFF ¶ 1643). Thus, it would be impossible through a joint venture for ENH to operate HPH's cardiac surgery program "in substantially the same manner."

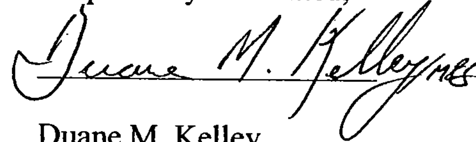
proximity to HPH, with a similar full-time medical management structure, with similarly high-quality programs, with a collaborative culture similar to ENH's, and with the financial capacity to invest in HPH at a level comparable to that demonstrated by ENH. (RFF ¶¶ 1447, 2452, 2456, 2458). None of the area hospitals possesses all of these characteristics, and because of that, none of the ancillary relief requested by Complaint Counsel can maintain the quality improvements made at HPH.

CONCLUSION

For the foregoing reasons, judgment should be entered in favor of Respondents and all counts of the Complaint should be dismissed with prejudice.

July 1, 2005

Respectfully Submitted,



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CERTIFICATE OF SERVICE

I hereby certify that on July 1, 2005, copies of the **Post-Trial Reply Brief Of Respondent Evanston Northwestern Healthcare Corporation (Public Version)** were served (unless otherwise indicated) by messenger on:

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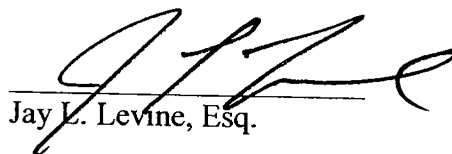


Jay L. Levine, Esq.

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

In the Matter of EVANSTON NORTHWESTERN HEALTHCARE CORPORATION, and ENH MEDICAL GROUP, INC., Respondents.	)))))))))))	Docket No. 9315

ORDER DENYING NON-PARTY GREAT-WEST HEALTHCARE'S MOTION FOR COST REIMBURSEMENT

I.

On May 21, 2004, non-party Great-West Healthcare of Illinois, Inc. ("Great-West Healthcare") filed a motion to extend the time in which to seek cost reimbursement and move to limit the subpoena *duces tecum* served on it by Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc. ("Respondents"), seeking an extension until June 4, 2004.

On June 3, 2004, Great-West Healthcare filed a Motion for Cost Reimbursement ("Motion"). On June 14, 2004, Respondents filed an opposition to the motion ("Opposition"). On June 16, 2004, Great-West Healthcare filed a motion for leave to file a reply. On June 25, Great-West Healthcare filed an amended motion for leave to file a reply and on the same date filed their reply brief ("Reply").

Great-West Healthcare's Motion to extend time in which to seek cost reimbursement and move to limit the subpoena *duces tecum* is **GRANTED**. Great-West Healthcare's Amended Motion for leave to file a Reply is **GRANTED**. For the reasons set forth below, Great-West Healthcare's Motion for Cost Reimbursement is **DENIED**.

II.

Great-West Healthcare moves for cost reimbursement with respect to personnel costs of up to $50,000 associated with locating and producing documents in compliance with the subpoena *duces tecum* served upon it by Respondents, arguing that such reimbursement is required by the 1991 amendments to Rule 45 of the Federal Rules of Civil Procedure.

Attachment A

Respondents assert that controlling authority holds that subpoenaed third parties, such as Great-West Healthcare, with a potential interest in the administrative litigation are, at most, entitled to reimbursement of copying costs – costs which Respondents have already agreed to pay.

III.

Pursuant to Rule 3.31(d), the "Administrative Law Judge may deny discovery or make any order which justice requires to protect a party or other person from annoyance, embarrassment, oppression, or undue burden or expense, or to prevent undue delay in the proceeding." 16 C.F.R. 3.31(d). Great-West Healthcare does not argue that the requested discovery is objectionable under Rule 3.31(d), but rather argues that the Federal Rules of Civil Procedure "requires the court to protect non-part[ies] by requiring the party seeking discovery to bear enough of the expense of complying with a subpoena so that compliance with the subpoena does not impose significant expense on the non-party." Reply at 2.

Federal Rule of Civil Procedure 45(c)(2)(B) provides that where a party issuing a subpoena moves to compel production of documents, the Court "shall protect any person who is not a party . . . from significant expense resulting from the inspection and copying commanded." Courts have noted that "this rule does not impose the entire burden on the requesting party; in fact 'a non-party can be required to bear some or all of its expenses where the equities of a particular case demand it.'" *Propulsid Products Liability Litigation*, 2003 WL 22174137, *2 (E.D. La. 2003) (quoting *In re Exxon Valdez*, 142 F.R.D. 380, 383 (D.D.C. 1992)). In addition, the non-party is entitled only to reimbursement for his reasonable costs. *Broussard v. Lemons*, 186 F.R.D. 396, 398 (W.D. La. 1999).

Great West Healthcare relies primarily on *Linder v. Calero-Portocarrero*, 251 F.3d 178 (D.C. Cir. 2001), which discusses amendments to Rule 45 made in 1991. The D.C. Circuit in *Linder* stated:

> There are relatively few reported cases applying the new Rule 45. *In re The Exxon Valdez*, 142 F.R.D. 380 (D.D.C.1992), described the 1991 amendment as representing "a clear change from old Rule 45(b), which gave district courts *discretion* to condition the enforcement of subpoenas on the petitioners paying for the costs of production." *Id.* at 383. The court thought "'protection from significant expense' does not mean that the requesting party necessarily must bear the *entire* cost of compliance.... There is no indication that [the amendment] intended to overrule prior Rule 45 case law, under which a non-party can be required to bear some or all of its expenses where the equities of a particular case demand it." *Id.* The district court here considered the factors mentioned in *Exxon Valdez* and in pre-1991 cases dealing with cost shifting: "whether the non-party actually has an interest in the outcome of the case, whether the non-party can more readily bear its costs than the requesting party, and whether the litigation is of public

importance." *Linder*, 180 F.R.D. at 177; *Linder*, 183 F.R.D. at 322.

Linder, 251 F.3d at 182 (emphasis in original). The D.C. Circuit thus affirmed the district court's decision which was based on the consideration of equitable factors. *Id.*

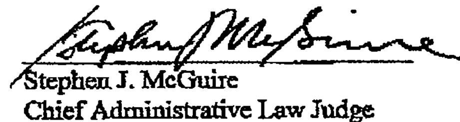
Neither the D.C. Circuit decision in *Linder*, nor the district court decisions in that case, alter the traditional factors that may be considered before costs are shifted to the party issuing the subpoena. *Linder*, 251 F.3d at 182-83; *Linder*, 180 F.R.D. at 177; *Linder*, 183 F.R.D. at 322. Specifically, whether the non-party has an interest in the outcome of the litigation and whether the litigation is of public importance are both factors to be considered. *Exxon Valdez*, 142 F.R.D. at 383.

In the instant case, the Respondents are charged in the Complaint with violating Section 5 of the FTC Act when it "negotiated an increase in the price for One Health's HMO . . . and . . . PPO" which are now known as Great-West Healthcare. Complaint, ¶ 43(e). Thus, Great-West Healthcare has an interest in the outcome. Great-West Healthcare, which is not subject to a motion to compel, has not demonstrated sufficient reason in this case to depart from the settled rule that "[s]ome burden on subpoenaed parties is to be expected and is necessary in furtherance of the agency's legitimate inquiry and the public interest." *Federal Trade Commission v. Dresser Indus., Inc.*, 1977 U.S. Dist. LEXIS 16178, *13 (D.D.C. 1977); *see also In re Rambus Inc.*, 2002 WL 31868184 (2002).

IV.

For the reasons set forth above, Great-West Healthcare's Motion for Costs is **DENIED**.

ORDERED:



Stephen J. McGuire
Chief Administrative Law Judge

Date: July 7, 2004

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

In the Matter of EVANSTON NORTHWESTERN HEALTHCARE CORPORATION, and ENH MEDICAL GROUP, INC., Respondents.	)	Docket No. 9315

ORDER DENYING COMPLAINT COUNSEL'S MOTION FOR THE ADMISSION OF PORTIONS OF DR. BAKER'S EXPERT REPORTS INTO EVIDENCE

On April 21, 2005, Complaint Counsel filed a motion seeking to have portions of the reports filed by Respondent's expert, Dr. Jonathan Baker, admitted into evidence ("Motion"). On April 25, 2005, Evanston Northwestern Healthcare Corporation ("Respondent") filed its opposition ("Opposition"). This issue was previously briefed by the parties on March 25, 2005. *See* Complaint Counsel's Motion for the Admission of Portions of Dr. Jonathan Baker's Expert Reports into Evidence and Respondent's Brief on Admissibility of Expert Reports as a Party Admission.

Complaint Counsel contends that the excerpts of Baker's expert reports are admissible for the truth of the matter asserted and should be admitted as a party admission under Federal Rule of Evidence 801(d)(2). Motion at 4-6. Respondent argues that Baker's expert reports constitute inadmissible hearsay, not party admissions, and that, in the alternative, Respondents should have the right to offer portions of Complaint Counsel's expert reports and depositions into evidence as party admissions. Opposition at 5-10.

Expert reports are hearsay and not admissible, as the parties were advised at the final pretrial conference. Trial Transcript (Tr.) at 6 ("[A]s a rule, we do not enter expert reports in the record. They are hearsay."); Tr. at 7 ("expert reports are hearsay"). In accord with the circuit court decisions in *Kirk v. Raymark Indus., Inc.*, 61 F.3d 147 (3rd Cir. 1995) and *Potts v. Sam's Wholesale Club*, 108 F.3d 1388, 1997 US LEXIS 5355 (10th Cir. 1997) (unpublished opinion), Baker's reports are not admissible pursuant to Rule 801(d). In addition, unlike the expert in *Glendale Fed. Bank v. United States*, 39 Fed. Cl. 422 (Ct. Fed. Cl. 1997), by the time trial began, Baker had identified an error in his initial report and issued a supplemental report correcting the error. *See* Motion at 2; Opposition at 3. Therefore, *Glendale* is not persuasive.

Attachment B

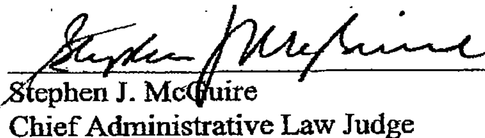
On March 28, 2005, the Court ruled that the relevant portions of Baker's report would be admitted "for purposes of impeachment" and to "the extent that they impeach only." Tr. at 5113, 5114. The parties were allowed an opportunity to confer in an attempt to reach an agreement on whether Baker's reports would be admitted under Rule 801 for the truth of the matter asserted. Tr. at 5115-16. On March 29, 2005, the Court stated:

> [W]hat I said yesterday . . . was that I would allow the first expert report of Dr. Baker to come in for impeachment purposes only. It is my understanding that counsel was going to confer, and if they could reach some agreement regarding . . . whether statements in the expert report could be offered for the truth of the matter asserted, then I would entertain [the] agreements. I haven't heard from counsel, so as we stand today, those statements may only be used for impeachment purposes.

Tr. at 5551-52.

Complaint Counsel's motion does not provide any support for reconsideration of this ruling. Specifically, Complaint Counsel's motion does not indicate that there has been an intervening change in controlling law; new evidence is available; or there is a need to correct clear error or manifest injustice. There is no agreement between the parties. In addition, Complaint Counsel was not limited in its use of Baker's report in cross examination. Thus, the Court's ruling that the relevant portions of Baker's expert reports are admissible for impeachment purposes only and not for the truth of the matter asserted will stand. Accordingly, Complaint Counsel's motion is **DENIED**.

ORDERED:



Stephen J. McGuire
Chief Administrative Law Judge

Date: May 10, 2005