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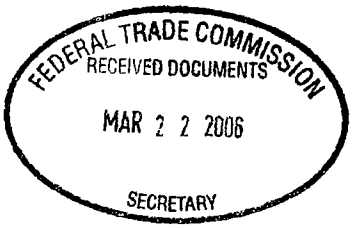

IN THE MATTER OF
EVANSTON NORTHWESTERN HEALTHCARE CORPORATION
AND
ENH MEDICAL GROUP, INC.

RESPONDENT'S BRIEF IN REPLY AND OPPOSITION TO CROSS-APPEAL

PUBLIC VERSION

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The following abbreviations and citation forms are used:

CCAB	Complaint Counsel's Appeal Brief
CCFF	Complaint Counsel's Proposed Finding of Fact
CCPTB	Complaint Counsel's Post Trial Brief
CCRB	Complaint Counsel's Reply Brief
CX	Complaint Counsel's Exhibit
ID	Initial Decision
IDF	Initial Decision Finding of Fact
RAB	Respondent's Appeal Brief
RB	Respondent's Post Trial Brief
Respondent	Evanston Northwestern Healthcare Corp. and ENH Medical Group, Inc.*
RFF	Respondent's Proposed Finding of Fact
RFF-Reply	Respondent's Proposed Reply Finding of Fact
RRB	Respondent's Reply Brief
RX	Respondent's Exhibit
{Text in bold and brackets}	*In Camera* Protected Information**

* Since the Commission's May 17, 2005, Decision and Order resolved all claims against ENH Medical Group, ENH has been identified by the singular term "Respondent" throughout the litigation before the ALJ. ENH acknowledges that the Commission's January 5, 2006, Order denying the removal of ENH Medical Group from the caption dictates that this case continues to have two Respondents, however, ENH respectfully continues to use the singular term "Respondent" in order to maintain consistency across its briefing.

** In accordance with 16 CFR 3.45(e), any references to information that has been granted in camera protection in this case have been identified with brackets and bold typeface. Attached to this brief are copies of the ALJ's in camera orders (Attachment A), pages from the brief containing in camera references (Attachment B), and a list of parties who should be notified in the event the Commission intends to disclose any in camera information in its final decision (Attachment C).

INTRODUCTION AND SUMMARY

Recognizing that it cannot defend the reasoning of the Administrative Law Judge ("ALJ"), Complaint Counsel now urges an alternative rationale for affirming the breakup of a successful hospital merger—a merger that has already produced enormous benefits for patients from Highland Park and the surrounding community. That rationale, while certainly "simple" (CCAB87), is based on a legal and economic theory that is as erroneous as it is unprecedented. The Commission should therefore reject that theory, which Complaint Counsel has devised to achieve *even more* relief in a case that has been settled in substantial part, and in which the facts have proven far different than the allegations on which a divided Commission voted to issue the complaint.

The heart of Complaint Counsel's case is the notion that the Commission can infer that the merger gave Evanston Northwestern Healthcare ("ENH") unilateral market power from the fact that its prices increased after the merger, even with *no* loss of output and *no* evidence that pre-merger prices were at the market level (*i.e.*, the fully-informed competitive level) or that post-merger prices exceeded that level. This is the obvious basis for Complaint Counsel's appeal of the dismissal of Count II. But the same notion is also at the heart of Complaint Counsel's market structure analysis, which, unlike the ALJ's approach, uses the post-merger price increases as the basis for defining the relevant market to include *only* the three ENH hospitals.

For all its "simplicity" (CCAB88), Complaint Counsel's theory is utterly wrong as a matter of both economics and law. As a matter of economics, the theory

assumes that, absent market power, prices are always at the fully-informed competitive level. But that assumption is false. As Judge Posner and many other respected scholars have recognized, accurate information about costs and prices is often costly and difficult to obtain, particularly in a highly complex and differentiated market like hospital services. *See, e.g.*, Richard A. Posner, ANTITRUST LAW 160 (2d Ed. 2001). Moreover, as the economic experts testified, and Complaint Counsel's "bargaining theory" implicitly recognizes, prices in a market characterized by long-term contracts may well differ from the current "market" price because of delays and the idiosyncrasies of individual negotiations.

Thus, as a matter of sound economics, one cannot assume, as Complaint Counsel does, that a firm's pre-merger prices were at market levels, and on that basis infer that a post-merger price increase reliably establishes that the merger may have produced market power. Such reasoning is economic nonsense. For the same reasons, post-merger price increases are at best circumstantial evidence of market power, not the "actual" evidence that Complaint Counsel claims. CCAB5.

This is undoubtedly why Complaint Counsel has failed to find a single administrative or judicial decision that supports its central theory. The few antitrust opinions that recognize even the possibility of unilateral market power short of monopoly have correctly held that a showing of unilateral market power requires more than higher prices. Those decisions require a showing that (a) the merging firms are viewed as the first and second choices by (b) customers accounting for significant sales in the relevant market, *and* (c) that other market participants would be unable to "reposition" themselves

with sufficient speed to prevent the merged firm from raising prices above competitive levels if it attempted to do so. That is the rule articulated in the Commission's decision in *Donnelley*, in the *Merger Guidelines* §2.21, and in pertinent court decisions. *In re R.R. Donnelley*, 120 F.T.C. 36, 195 (1995); *see United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1117-18 (N.D. Cal. 2004); *New York v. Kraft Gen. Foods*, 926 F. Supp. 321, 365-66 (S.D.N.Y. 1995). Complaint Counsel's disregard of these controlling authorities is a tacit admission that the only way it can win this case is for the Commission to make a sea change in the law of unilateral effects.

As shown below in Section I, the evidence cited by Complaint Counsel not only fails to satisfy the requirements of its own legally unsupported "bargaining theory," it also fails to satisfy the *Donnelley* requirements. Complaint Counsel has introduced none of the kinds of evidence recognized in the *Merger Guidelines* as establishing "consumers' actual first and second product choices" such as "marketing surveys, information from bidding structures or normal course of business documents from industry participants." *U.S. Dep't of Justice and Fed. Trade Comm'n Horizontal Merger Guidelines* §2.211, n. 22 (1997). Instead, Complaint Counsel offers uncorroborated testimony from managed care organization ("MCO") witnesses in an attempt to show that a few of ENH's many MCO customers viewed pre-merger Evanston Hospital ("Evanston") and Highland Park Hospital ("HPH") as first and second choices. But upon examination, the cited testimony shows no such thing. And Complaint Counsel's economic expert, Dr. Haas-Wilson, offered no opinion on whether Evanston and HPH

were next best substitutes for use in any MCO network. Haas-Wilson, Tr. 2772, *in camera*.

Moreover, MCO witnesses, contemporaneous documents and expert testimony all confirm that Evanston and HPH were very different from each other before the merger, and that *each* had much closer competitors in both product and geographic space. As *Donnelley* makes clear, the "closeness" of the merging firms is "the primary factor determining the market power that will be created by a merger in a differentiated product setting." 120 F.T.C. at 196.

Beyond this, Complaint Counsel makes no effort to show that these MCO customers account for a significant share of the relevant sales (the second *Donnelley* requirement), much less that the many other hospitals in the Chicago area—or even in the area immediately surrounding the ENH hospitals—could not reposition themselves to accommodate ENH's customers in the event ENH attempted to exercise unilateral market power (the third requirement). Complaint Counsel simply ignores the substantial evidence showing that competing hospitals have repositioned themselves and would continue to do so to increase their attractiveness to sophisticated MCOs, employers, and patients and thus prevent ENH from achieving or exercising unilateral market power.

Indeed, as Judge McGuire concluded from the evidence, it is "highly probable" that other hospitals in the relevant market "would have the ability to constrain prices at ENH, either now or in the future, and could be utilized by managed care organizations to create alternate hospital networks." ID144,147,149. Complaint Counsel has no persuasive response to this finding. And none of the other evidence on which

Complaint Counsel relies, including out-of-context snippets from ENH's internal documents and the supposed pattern of price increases after the merger, satisfies the *Donnelley* requirements.

On the central issue of unilateral market power, then, this is indeed a "simple and straightforward case" (CCAB87), but not for the reason Complaint Counsel asserts. It is simple because Complaint Counsel has failed to satisfy the requirements established by the Commission and the courts for demonstrating that a merger has produced or is likely to produce unilateral market power.

Moreover, although ENH has no burden of proof on the issue, Complaint Counsel has failed to overcome ENH's showing that its post-merger price increases not only were far smaller than Complaint Counsel claims (which are in turn far smaller than alleged in the complaint), but also were the result of bargaining idiosyncrasies as well as ENH's learning that its pre-merger prices were far below the market. By itself, *Complaint Counsel's failure to present any evidence rebutting ENH's evidence that its pre-merger prices were below market levels*—which, again ENH has no burden to show—knocks the legs out from under Complaint Counsel's theory that market power can be established in this case based on post-merger price increases. And if that were not enough, the fact that ENH's *output did not decline* flatly forecloses Complaint Counsel's conclusion that the modest post-merger price increases resulted from market power. *See, e.g.*, Posner, ANTITRUST LAW, at 9-12.

Section II refutes Complaint Counsel's circular attempt to define the relevant market by working backward from ENH's post-merger prices. Given that the

price changes do not reflect an exercise of market power in the first instance, they cannot be used to define relevant markets. And Complaint Counsel nowhere comes to grips with ENH's showing that 18 hospitals are closer to the merged hospitals than they are to each other, a direct refutation of Complaint Counsel's gerrymandered market definition. Section II also rebuts Complaint Counsel's argument that the ALJ erred in dismissing Count II which, as noted above, has no basis in economics or the law.

As shown in Section III, Complaint Counsel offers no serious response to Respondent's showing that the merger produced substantial competitive benefits that are more than sufficient to outweigh any speculative competitive risks. One of those benefits was a financially strengthened HPH. As shown in Respondent's opening brief (RAB63-68), HPH's financial health was steadily deteriorating in the years before the merger, and it could not have continued to operate at a loss, service its substantial debt, and still make the upgrades necessary to compete in the face of repositioning by competitors. Complaint Counsel disagrees on the basis of speculative plans and proposed budgets from a *two-month* period in March and April of 1999. Yet Complaint Counsel (consistent with its "simple" approach) ignores the compelling, contemporaneous financial evidence of HPH's "significant operating shortfalls relative to budget reflected in [among other things, its] June and preliminary July 1999 income statements." RFF2330; RX592A at ENHRS880.

Complaint Counsel's attack on Respondent's quality-of-care evidence is equally simplistic and unfounded. Complaint Counsel does not dispute that, after the acquisition, ENH put a stop to unnecessary medical procedures and other inappropriate

practices that were endemic at HPH. *See* RAB77-81. Beyond that, although the ALJ found that ENH had made more than $120 million in "significant," "verified" quality improvements, Complaint Counsel, like the ALJ, attempts to place on Respondent the burden of proving a negative, namely, that the many quality improvements that ENH implemented and financed at HPH would *not* have occurred absent the merger. ID177-78. But Complaint Counsel cites no legal authority requiring that a defendant prove a negative to establish that quality improvements implemented and financed by the acquiring company were merger-specific.

Nowhere, moreover, does Complaint Counsel refute the simple arithmetic in Respondent's opening brief—based on HPH's pre-merger calculations and independent auditors' due diligence studies—which shows that HPH simply *could not afford* many of the improvements it needed to compete effectively with other area hospitals. And despite speculating that HPH would have made quality improvements without the merger, nowhere does Complaint Counsel attempt to show that those improvements would have occurred *as fast or as well* without the merger, or how HPH could obtain the additional $45 million that ENH has committed for other improvements in the near term.

Ultimately—again, consistent with its "simple" approach—Complaint Counsel argues that quality improvements that did not occur contemporaneously with price changes should simply be ignored. CCAB11. But under settled law, Complaint Counsel always bears the burden to demonstrate that any *prospective* anticompetitive effects of the merger outweigh the merger's likely future benefits. *United States v. Baker*

Hughes Inc., 908 F.2d 981, 983 (D.C. Cir. 1990). Accordingly, all quality improvements accomplished to date and likely to be achieved in the foreseeable future must be considered in assessing the overall competitive effects of the merger. And when those improvements are considered, there can be no doubt that the merger is likely to enhance rather than lessen competition.

Finally, as shown in Section IV, Complaint Counsel has failed to demonstrate the propriety of its proposed divestiture (and of the "ancillary" relief that the ALJ rejected), even if the merger violated Section 7. As Respondent showed in its opening brief, this case is a classic illustration of Judge Posner's observation that "[s]tructural remedies such as divestiture are slow, costly, frequently ineffectual, and sometimes anticompetitive." Posner, ANTITRUST LAW at 268; *accord* Frank H. Easterbrook, *The Limits of Antitrust*, 63 TEX. L. REV. 1, 3 (1984). This merger occurred more than six years ago, in a rapidly changing market, and has produced healthcare improvements of life-and-death importance for patients. Complaint Counsel has done nothing to show that divestiture is justified under governing equitable principles, especially in light of available alternatives, including the substantial relief to which ENH has already agreed. Nor has Complaint Counsel justified the harm that divestiture would inflict on HPH—a charitable not-for-profit organization—which, along with ENH's other hospital campuses, has just been named one of the top fifteen teaching hospitals in the Nation. *See* "Solucient Announces The 100 Top National Hospitals for 2005" *available at* http://www.100tophospitals.com. For these reasons, and others explained in the

amicus curiae filing of Highland Park, the community that will be most affected by the decision here, the public interest would be badly disserved by divestiture.

Complaint Counsel's only proposed solution is to require that ENH allow a potential acquirer of HPH to hire any of ENH's key employees that it wishes—with an enormous signing bonus *paid by ENH*. But there is no evidence that a "white knight" is waiting in the wings and, as shown below, the most likely candidates would be ineligible to play that role. And even if a white knight could be found, Complaint Counsel's draconian bonus proposal would threaten patient care and service quality at ENH's other two hospitals. From the standpoint of patients and other consumers, Complaint Counsel's cure would be far worse than the purported disease.

In sum, this really is a "simple and straightforward case" (CCAB87), just as Complaint Counsel says. But that is only because Complaint Counsel's theories have no basis in law, economics, or the facts of this case. The alleged harm from the merger is speculative at best, whereas the harm that divestiture would impose upon patients and the North Shore community is virtually certain. *See, e.g.*, Easterbrook, *supra,* at 15-16 ("errors on the side of excusing questionable practices are preferable" to the risk of condemning a "beneficial arrangement"); Herbert Hovenkamp, ANTITRUST ENTERPRISE 47 (2005)("The basic rule should be nonintervention unless the court is confident that it has identified anticompetitive conduct and can apply an effective remedy"). This case is therefore controlled by the principle that every would-be doctor learns at the beginning of medical school: "First, do no harm."

ARGUMENT

I. COMPLAINT COUNSEL'S PRICING AND OTHER NON-STRUCTURAL EVIDENCE DOES NOT MEET ITS BURDEN OF ESTABLISHING ANTICOMPETITIVE UNILATERAL EFFECTS UNDER ESTABLISHED STANDARDS.

Complaint Counsel concedes (CCAB35; Pak, Tr. 6537) that this merger does not raise concerns about increased *collusion* (i.e., coordinated effects) in the relevant market, which is Section 7's principal focus. RAB35-36; *accord FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 45, n.8 (D.D.C. 1998). Indeed, Judge Posner and others have suggested that, "in the ordinary merger case, involving moderate market shares, the legal inquiry should be directed to the probable effect of the merger (if any) in facilitating collusion; *it is unlikely to have a substantial effect on the unilateral market power of the resulting firm.*" William A. Landes & Richard A. Posner, *Market Power in Antitrust Cases*, 94 Harv. L. Rev. 937, 974 (1981)(emphasis added); *accord* Posner, ANTITRUST LAW at 124, 138. Nonetheless, Complaint Counsel does not even acknowledge, much less satisfy, the three requirements cited above for a showing of unilateral effects under *Donnelley* and other pertinent decisions. *Donnelley*, 120 F.T.C. at 195; *see Oracle*, 331 F. Supp. 2d at 1117-18; *Merger Guidelines* §2.21.

Unable to meet these requirements, Complaint Counsel maintains that it need not satisfy the traditional requirements for a Section 7 case because, in its view, ENH's post-merger price changes are sufficient evidence of "actual" anticompetitive effects. CCAB5. But neither law nor economic theory supports an inference of market power based on evidence that the merged firm's prices rose more than at other firms in

the industry. RFF315-17,519-20. As shown below, Complaint Counsel's bargaining theory—the heart of its economic case—simply ignores the legal standards for establishing unilateral anticompetitive effects. Neither the MCO testimony, the pricing evidence, nor the negotiating history between ENH and MCOs satisfies the *Donnelley* requirements or, indeed, the requirements of the bargaining theory Complaint Counsel espouses.

A. Complaint Counsel's "Bargaining Theory" Does Not Meet The Legal Standard For Establishing Unilateral Anticompetitive Effects.

One version of Complaint Counsel's bargaining theory maintains that the merger increased ENH's bargaining strength because it "eliminated a hospital competitor from the bargaining table in the relevant market for selling hospital services to MCO's, thereby giving ENH the means to raise prices." CCAB22, n.23. Complaint Counsel argues that this asserted "increase in bargaining strength" produces "the anticompetitive effects that makes this merger unlawful." *Id.* But Complaint Counsel's expert, Dr. Haas-Wilson, neither measured this increase in bargaining strength nor suggested any way to do so. RFF970; Haas-Wilson, Tr. 2759-60, *in camera.* And she admitted that, unlike the unilateral effects standards in *Donnelley* and the *Guidelines,* her bargaining theory does not depend on "there being a significant share of sales in the market accounted for by managed care insurers who view Evanston and Highland Park as next best substitutes for the purpose of network building." Haas-Wilson, Tr. 2772, *in camera*; *compare Guidelines* §2.21.

On its face, this variation of Complaint Counsel's bargaining theory would condemn virtually every horizontal merger, and therefore cannot be correct. Although all firms in a differentiated product market have, by definition, a limited degree of market power, the mere fact that a merger of competing firms reduces the number of choices available to purchasers does not create the kind of market power that has ever been a concern of antitrust law. Posner, ANTITRUST LAW at 81 (2d Ed. 2001); Noether, Tr. 6131.

In a second version of its bargaining theory, Complaint Counsel argues that when MCOs were evaluating alternative networks, Evanston and HPH were their "first and second choices" because of their appeal to persons residing in certain neighborhoods between HPH and Evanston. CCAB21, n.21. In addition to the fact that it addresses only one of the elements articulated in *Donnelley*, this was not the bargaining theory that Dr. Haas-Wilson or any other witness presented at trial. Indeed, Dr. Haas-Wilson offered no analysis or opinion on whether Evanston and HPH were first and second choices for the purpose of including them in the network of any MCO. Haas-Wilson, Tr. 2772, *in camera*. Similarly, Complaint Counsel does not specify which neighborhoods have residents who would prefer Evanston or HPH, does not specify which hospital was such residents' first and second choice, does not explain how one can glean from these residents' purported preferences the MCOs' preferences for the two hospitals, and offers

no means by which to determine the closeness of other substitute hospitals to the merging firms.[1]

In short, neither version of Complaint Counsel's shifting bargaining theory satisfies the *Donnelley* requirements. Neither variant satisfies the requirement that sales into the relevant market be accounted for by a "significant share" of customers who regard the products of the merging firms as their first and second choices. And neither variant satisfies the requirement that other hospitals would not reposition to replace any lost competition. For these reasons, the bargaining theory cannot—as a matter of law—satisfy Complaint Counsel's burden to show that the merger caused anticompetitive unilateral effects.

B. Complaint Counsel's MCO Evidence Does Not Satisfy Its Burden To Prove That The Merger Gave ENH Unilateral Market Power.

None of Complaint Counsel's other evidence establishes *any* of the three elements required under *Donnelley* to demonstrate that the merger resulted in unilateral anticompetitive effects: (1) that "consumers [] regard[ed] the products of the merging firms as their first and second choices"; (2) that such consumers accounted for a "significant share of sales" in the market; and (3) that "repositioning"—i.e., supply by other firms of "products sufficiently similar to the products controlled by the merging firms"—is unlikely. *Donnelley*, 120 F.T.C. at 195; *Oracle*, 331 F. Supp. 2d at 1117-18;

[1] Indeed, Complaint Counsel has not even attempted to demonstrate that the merging hospitals' alleged status as "first and second choices" for inclusion in *alternative networks* can ever satisfy the first *Donnelley* element, especially where the network contains numerous other hospitals providing similar products or services. CCAB21; ID144,149; RAB27-32.

Merger Guidelines §2.21. This section of the brief addresses Complaint Counsel's non-price evidence, while the next sections address Complaint Counsel's pricing and negotiation evidence.

1. Complaint Counsel Has Failed To Carry Its Burden Of Establishing That *Any* Customers Regarded Evanston and HPH As Their First And Second Choices.

Although Complaint Counsel claims that a couple of MCO witnesses (of the nearly 40 MCOs that had Evanston and HPH in their networks) said they viewed Evanston and HPH as first and second choices before the merger, this testimony is inadequate to establish that *any* customers regarded Evanston and HPH that way. CCAB21; Sirabian, Tr. 5700-01.

First, Complaint Counsel's argument conveniently disregards overwhelming evidence that Evanston and HPH, in both product and geographic space, were vastly different hospitals before the merger, and therefore *were not and could not have been viewed as first and second choices* by a significant number of customers. RAB40-43, RFF538-59. Every MCO witness who addressed the issue identified hospitals other than Evanston and HPH as closer competitors and better substitutes for each hospital. RFF564-74. For example, the MCOs consistently recognized that Evanston's closest competitors in product space were Advocate Lutheran General and Northwestern Memorial, while HPH's closest competitors in product space were Lake Forest and Condell. RFF41,563-69,577-87. Even the ALJ recognized that Evanston and HPH were "different in a number of dimensions" before the merger. IDF784-85.

The witnesses also established that other hospitals were better geographic substitutes for Evanston and HPH than they were for each other. Every MCO witness confirmed that St. Francis and Rush North Shore were within minutes of and were alternatives to Evanston. RFF389(a)-(b),455-59,570-74.

Similarly, every MCO witness confirmed that Lake Forest was closer to HPH than HPH is to Evanston (IDF21,266; RFF577), and contemporaneous documents corroborated that Lake Forest was a "viable" alternative to HPH in any MCO network. RFF578. The MCOs, moreover, universally assessed Condell as a "significant" or primary alternative to HPH. RFF577; Neary, Tr. 631. One MCO witness put it best when she stated that HPH, Lake Forest, and Condell were **(REDACTED)**

Holt-Darcy, Tr. 1595, *in camera.*

Yet another of Complaint Counsel's witnesses emphasized that, in choosing a hospital, where people work is just as important as where they live. *See* RFF460 (MCO must provide members with "access to the hospital within 30 miles of where they *live or where they work.*")(emphasis added); *see also* CCAB21, n.20. All this evidence flatly forecloses Complaint Counsel's suggestion that Evanston and HPH were the first and second choices for any significant group of customers.

Second, even if the Commission ignored all this evidence, the testimony cited by Complaint Counsel is facially insufficient to satisfy *Donnelley's* first element. For example, Complaint Counsel, like the ALJ, asserts that Jane Ballengee (PHCS) testified that Evanston and HPH were each other's main alternatives and that it was necessary to include one of them to create a network. CCAB21; IDF229. But Ms.

Ballengee *never* testified that Evanston and HPH were her first and second choices. She testified (without support or foundation) that she believed it was "pretty well assumed" that PHCS "could have one or the other hospital" and that their separate existence made her "feel comfortable" in case PHCS did not find the rates "to be appropriate." Ballengee, Tr. 166-67. Because an MCO would obviously feel more "comfortable" with more alternatives in any negotiation, this statement cannot establish that Evanston and HPH were first and second choices even for PHCS.[2] Nor did PHCS (or any other MCO) act as though it viewed Evanston and HPH as close substitutes, such as playing them off each other in negotiations. *See* RFF974-83.

Complaint Counsel relies upon another MCO witness from One Health—representing less than 1% of ENH's entire MCO business—who identified HPH as a "primary" or "main" competitor of Evanston. IDF232; Neary, Tr. 631. But even this witness did not state that Evanston and HPH were first and second choices.[3] And any such implication was foreclosed by a second witness from the same company, who worked as the supervisor of the first witness and identified another hospital—Lake Forest—as the most significant competitor to HPH. Dorsey, Tr. 1472.

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[2] Moreover, Ms. Ballengee's trial testimony is undermined by a document PHCS sent to its clients *at the time of the merger* advising that "[i]n case of a termination [by Evanston and HPH], there are other contract providers within the same geographical area" as the merging hospitals. RX712 at PHCS891; RFF457; RRB14-15. Further, she **(REDACTED)** and never had any responsibility for marketing health plans to customers. Ballengee, Tr. 204, 257, *in camera.*

[3] This witness, moreover, never had responsibility for sales, advertising, or marketing of One Health's products, and was not involved in negotiating pre-merger contracts with any of the ENH hospitals. Neary, Tr. 629-31.

Complaint Counsel is also wrong in suggesting that the merging parties' status as first and second choices can be inferred from testimony that HPH and Evanston were important or even "necessary" parts of MCOs' Chicago networks. *See* CCAB25-31. Chicago-area MCOs have on average 87 hospitals in their networks. *See* IDF163-65; RFF145,178. They obviously view *all* the hospitals in their networks as important, or else they would not go to the trouble of including them. Thus, Evanston and HPH could be viewed as important or necessary to a network, along with many other hospitals, and still not be the first and second choices of MCOs or their customers. Indeed, these same MCOs may have believed that Evanston and HPH were necessary to their networks primarily because the MCOs had independently terminated the merging hospitals' admitted primary alternatives, including Advocate Lutheran General, Rush, and Lake Forest. *See infra* section I.E.4; RFF565,807-08,915-16; RFF-Reply1190,1209.

Third, even if some MCO testimony could somehow be interpreted to mean what Complaint Counsel takes it to mean, it would still not be sufficiently reliable. Customers have an obvious financial stake in the outcome of the litigation. *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054, n.14 (8th Cir. 1999). Such "self interested" testimony expressing "subjective views" is therefore unpersuasive and deserves little weight. *Oracle*, 331 F. Supp. 2d at 1167; *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 145 (D.D.C. 2004). Indeed, leading antitrust commentators recognize that the "*least* reliable [evidence] is 'subjective' testimony by customers...." Phillip E. Areeda & Herbert Hovenkamp, ANTITRUST LAW, ¶538b at 239 (2d ed. 2002)(emphasis added). Accordingly, in this regard this case is analogous to *Oracle*, in which the court found that

"[a]lthough these witnesses speculated on that subject, their speculation was not backed up by serious analysis that they had themselves performed or evidence they presented. . . . [U]nsubstantiated customer apprehensions do not substitute for hard evidence." *Oracle*, 331 F. Supp. 2d at 1130-31.

Fourth, Complaint Counsel presented no other evidence corroborating its view that Evanston and HPH were first and second choices for any group of customers:

- Employers' Views. Complaint Counsel neither called any employers as witnesses nor offered any surveys demonstrating that employers viewed Evanston and HPH as close substitutes, much less their first and second choices, even though much of the MCOs' business was with self-insured employers, the parties actually affected by any premium increase. RFF121,132,144,152,158-59,176; IDF188-89.
- "Triangle" Residents' Views. While its brief focused on residents living somewhere between the three ENH hospitals, Complaint Counsel offered no survey of the hospital preferences of individuals in any neighborhoods in the "triangle," nor did it even identify those neighborhoods in which it maintains the MCOs viewed Evanston and HPH as first and second choices for inclusion in their network. In fact, the only consumer survey in evidence is from Lake Forest Hospital which shows that consumers are willing to travel 35 minutes for an overnight hospital stay. RAB31; RFF400; ID142; IDF257.
- Patient Flow Data. Ignoring the 18 hospitals that are closer to Evanston or HPH than these are to each other, Complaint Counsel failed to present any evidence of travel patterns, and in fact treats such evidence as irrelevant. *See* CCAB16, n.14.
- Marketing Efforts. Complaint Counsel pointed to no corroborating evidence that MCOs actually tried and failed to design and sell any alternative network without ENH to any particular employer.
- Premium Analysis. Complaint Counsel's experts conducted no analysis of the amount of any premium reduction they would need to sell employers a plan without ENH. RFF986.

Such real-world evidence of MCOs' conduct, which is vastly more probative than vague opinion testimony of isolated MCO witnesses, is lacking here. *Oracle*, 331 F. Supp. 2d at

1167; *Merger Guidelines* §2.211, n.22. For all these reasons, the evidence did not establish that Evanston and HPH were first and second choices for any MCOs or other customers.[4]

2. MCO Testimony Does Not Establish That Customers Who Might Have Regarded Evanston and HPH As First and Second Choices Accounted For A Significant Share Of The Market.

Even if Complaint Counsel could establish that some customers viewed Evanston and HPH as first and second choices, it has failed to carry its burden of establishing that those customers accounted for a "significant share" of the pertinent market. *Donnelley*, 120 F.T.C. at 195; *Oracle*, 331 F. Supp. 2d at 1117-18; *Merger Guidelines* §2.21. It is undisputed that *all* MCOs accounted for only 45% percent of ENH's revenues (RFF14) and that the vast majority of that MCO business came from payors who did not testify, such as Blue Cross, Humana and CIGNA. RFF127; RX1995 at 1.

Indeed, Complaint Counsel's five MCO witnesses accounted for only six of ENH's 35-40 MCO contracts and less than (REDACTED) of ENH's revenues. CCRB22, n.21; RFF13-14; RX1995 at 1, *in camera*. Moreover, as explained above, Complaint Counsel and the ALJ identified only two of these MCOs—PHCS and One Health—as even arguably viewing Evanston and HPH as first and second choices. Those MCOs account for, at most, 5 percent of Evanston's and HPH's business. RFF143; RX1995 at 1. And

[4] Because data on product attributes and relative product appeal do not show that a significant share of MCOs regard Evanston and HPH as first and second choices, and because ENH's market share (properly defined) is below thirty-five percent, Complaint Counsel cannot rely on market share data as evidence of relative preferences. *See Merger Guidelines* §2.211; RAB38.

they therefore account for only a minuscule percentage of any properly defined market. *See* RAB27-33.

In short, whatever a "significant share" of sales may mean, this subset of purchasers is far too small to satisfy the second *Donnelley* requirement. *See Donnelley*, 120 F.T.C. at 195; *Oracle*, 331 F. Supp. 2d at 1117.

3. Complaint Counsel Has Failed To Establish That Repositioning By Other Hospitals Would Not Likely Preclude ENH From Exercising Market Power.

Nor has Complaint Counsel satisfied the third *Donnelley* requirement by demonstrating that other hospitals would be unwilling to reposition in response to an attempt by ENH to exercise market power. It is not Respondent's burden to demonstrate a likelihood of repositioning. It is, rather, Complaint Counsel's burden to establish that other area hospitals likely would *not* reposition in response to an attempted exercise of market power. *Donnelley*, 120 F.T.C. at 195; *see Oracle,* 331 F. Supp. at 1117-18; *Kraft,* 926 F. Supp. at 365-66; *Merger Guidelines* §2.21. And Complaint Counsel has wholly failed to satisfy that burden.

In the face of numerous, recent examples of other hospitals aggressively expanding their capacity and service, Complaint Counsel's only response is that such examples did not include new *facilities* within the "triangle." RAB44; CCAB69, n.79. But that is irrelevant. Complaint Counsel does not dispute that there are 18 hospitals closer to Evanston or HPH than those two are to each other. RAB29. It also does not dispute that there are at least 47 hospitals within 30 miles of at least one of the ENH hospitals that would satisfy the MCOs' geographic needs (RFF387-90), and that could

and likely would reposition to handle the business that ENH would sacrifice if it attempted unilaterally to raise its prices above competitive levels. RFF2278-97. And it offers no serious response to the ALJ's finding that the MCOs already have ample alternatives to Evanston and HPH and could construct alternative networks. ID144,147,149 ("It is highly probable that the four non-ENH hospitals in the geographic market would have the ability to constrain prices at ENH, either now or in the future, and could be utilized by managed care organizations to create alternate hospital networks.")

The evidence, moreover, establishes that hospitals outside of Complaint Counsel's "triangle" already compete with ENH and would only need to expand capacity or offer additional services to constrain an anticompetitive price increase. ID144,147,149; RAB27-29. Indeed, it is because of such repositioning that pre-merger HPH faced a future of declining competitive significance in this dynamic environment. *See* RFF2298-2413. Examples of such repositioning include Northwestern Memorial's building a state-of-the-art women's hospital that has drawn a substantial number of obstetrics patients from the northern suburbs; Condell's adding a new women's center, expanded OB and ER facilities, and cardiac surgery capability; and Lake Forest's constructing a new Center for Women's Health and expanding its medical/surgical department. RFF417-27,431-34,2290-97; RX1206 at FTC-LFH0002170.

Complaint Counsel's witness from the Illinois Health Facilities Planning Board cited numerous other examples of recent hospital repositioning. *See* RFF2278-97; D. Jones, Tr. 1681-84. All this has occurred within the current Illinois Certificate of

Need ("CON") regime, the expected expiration of which (in 2006) will only further accelerate repositioning and new entry. RFF2281-82.

This evidence, supporting and supported by the ALJ's finding of alternatives, squarely forecloses a ruling in Complaint Counsel's favor on this essential element of its case, even as it rebuts Complaint Counsel's entire "bargaining" analysis.

C. The Post-Merger Price Increases Cannot Establish Unilateral Market Power.

Unable to satisfy the *Donnelley* requirements for proving unilateral market power, Complaint Counsel rests its case principally upon post-merger price increases. In essence, it *assumes* that the price increases were anticompetitive and therefore argues that MCOs had no alternative but to pay them. But this circular reasoning does not withstand scrutiny. Established law dictates, and Complaint Counsel admits, that market power cannot be established based upon a price increase alone. CCAB32; *see* RFF315-17,519-20; *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406, 1411-12 (7th Cir. 1995)(applying principle to medical care). And it is equally true that unilateral market power cannot be established simply on the basis of expert testimony purporting to exclude "possible explanations other than market power." CCAB34. *Donnelley*—a post-consummation case—and the *Guidelines* provide the legal framework for determining whether a merger is likely to or did create unilateral market power. And price changes and attempts to exclude "alternative explanations" are relevant only within the *Donnelley* framework.

But even if unilateral market power could be established simply on the basis of price changes, Complaint Counsel's approach falls woefully short as a matter of economic theory. First, it failed to prove a reduction in output. Second, it failed to prove that pre-merger prices were at market levels or that post-merger prices exceeded competitive levels. And third, it failed to show how the pattern of price increases can be explained by its own bargaining theory. Moreover, although Respondent bears no burden to justify the price increases at issue here—which proved to be at most 9-10% above those of other hospitals rather than the astronomical increases alleged in the complaint (*see infra* section I.E.1)—Respondent has offered contemporaneous documents, eyewitness testimony, and expert analysis demonstrating that the price increases were caused by factors other than market power.

1. Complaint Counsel's Acknowledged Failure To Prove A Reduction In Output Precludes A Finding Of Actual Anticompetitive Effects Based Upon Price Increases.

Complaint Counsel has admitted that it cannot show any reduction in output, but now attempts to cover this flaw by summarily claiming that one "would expect" ENH to lose "few, if any, patients" if it exercised market power.[5] CCAB19, n.18. Complaint Counsel does not dispute, however, that a price increase can be evidence of market power only where it is accompanied by a reduction in output.

[5] Complaint Counsel's assumption that the "payor problem," *i.e.*, insensitivity of employers and patients to hospital prices, prevents a reduction in patients served by a hospital exercising market power is unfounded. In Chicago, a significant percentage of MCO business is self-insured, meaning that MCO customers directly bear the cost of increased hospital prices. RFF121 (60% of Aetna's business was self-insured in 2000); 131 (CCN 100%); 144 (Great West 90%); 146 (HFN provides only network services); 156 (PHCS is not an insurance company); 176 (United 75%).

Forsyth v. Humana, 114 F.3d 1467, 1476 (9th Cir. 1997); *Hospital Corp. of America v. FTC*, 807 F.2d at 1381, 1386 (7th Cir. 1986)(hereinafter "*HCA*"); *FTC v. PPG Indus.*, 798 F.2d at 1500, 1503 (D.D.C. 1986); *see* RAB36-37. As Judge Posner has noted, and as Complaint Counsel and its expert previously acknowledged, "monopoly pricing . . . results when firms create an *artificial scarcity* of their product and thereby drive its level under competition." Posner, ANTITRUST LAW at 2 (emphasis added); *see also* 9,13; *accord* CCRB19-20; Elzinga, Tr. 2403; *see also* Noether, Tr. 6217-18. Thus, Complaint Counsel's failure to prove a reduction in output undermines any attempt to rely upon price increases to show that a merger increased market power.

Complaint Counsel not only failed to present evidence of output reduction, it actually acknowledged that ENH experienced *no* reduction in patient admissions. CCFF1653. Evidence of price increases *without* a decline in output is much more consistent with the hypothesis that ENH improved its understanding of the market and/or its quality than with the contrary hypothesis that it exercised market power. Noether, Tr. 6217-18.

2. Complaint Counsel's Failure To Prove That Pre-Merger Prices Were At Market Levels, Or That Post-Merger Prices Exceeded Competitive Levels, Is Fatal To Its Price-Increase Argument.

Similarly fatal is Complaint Counsel's failure to prove either that pre-merger prices were at or above market levels, or that post-merger prices exceeded competitive levels. As the Commission put it in *Donnelley,* "the ultimate issue under Section 7 is whether the challenged acquisition likely will enable the merging firm, acting

unilaterally or collectively with other firms, to increase prices *above competitive price levels*." *Donnelley*, 120 F.T.C. at 151 (emphasis added) (citing *HCA*, 807 F.2d at 1386). And Complaint Counsel concedes that under the *Merger Guidelines* "market power to a seller is the ability profitably to maintain prices *above competitive levels* for a significant period of time." CCAB13; *Merger Guidelines* §0.1. Yet Complaint Counsel offers no evidence that ENH's pre-merger prices were at market levels or that ENH's post-merger prices exceeded competitive levels. In fact, the ALJ found, and Complaint Counsel has conceded, that it "did not attempt to compare ENH's prices to a competitive level." CCAB32, n.32; ID155.

Dr. Haas-Wilson's price change analysis, moreover, failed to account for many aspects of product differentiation that may affect some hospitals' prices (including ENH) in a different way than others in her control group, such as differences in costs, marketing strategies, advertising, negotiating idiosyncrasies and other factors. RFF523,1021-23,1057. Indeed, Dr. Haas-Wilson admitted that she did not exclude all reasonable alternative explanations for the price increases, given the acknowledged product differentiation in the market. RFF1021-23.

Complaint Counsel thus urges the Commission to condemn a merger based on its asserted "actual" effect of enhancing market power, but not to look at whether the alleged effects meet the definition of market power used in *Donnelley*, the *Guidelines* and the case law. The Commission should reject that indefensible position.

3. Complaint Counsel's Bargaining Theory Cannot Explain The Pattern Of Price Increases And Is Based Upon Unreliable Analysis.

Even if the Commission were inclined to overrule *Donnelley* and replace it with something akin to Complaint Counsel's "bargaining theory," that change would not help Complaint Counsel here.

First, the evidence linking that theory to the facts here is not reliable enough to support a finding of liability. As in federal court, the proponent of expert testimony in an administrative proceeding must demonstrate the reliability of the expert's methods and opinions so that the agency's ultimate decision can "be supported by substantial evidence." *Donahue v. Barnhart*, 279 F. 3d 441, 446 (7th Cir. 2002); *see also In re Telebrands Corp.*, No. 9313 at 22, n.32 (Op. of the FTC Comm'n)(Sept. 23, 2005), (while *Daubert* and *Kumho* do not apply directly to agency proceedings "[t]he Commission nonetheless is guided by the spirit of *Daubert* and *Kumho* in making a determination as to the admissibility of expert testimony.")(citations omitted). Here, Complaint Counsel failed to satisfy one of the important *Daubert* requirements by failing to offer an economic model that could test the bargaining theory advanced by Dr. Haas-Wilson. CCAB1,19-20.

For example, Complaint Counsel baldly asserts that "if the value and marketability of an MCO's network would be greatly diminished by not including a particular hospital, that hospital will be able to negotiate higher prices with the MCO." CCAB19-20. Yet Complaint Counsel offered no framework for analyzing any link between the value of an MCO network (with or without ENH) and hospital prices. And

Dr. Haas-Wilson, who was unfamiliar with much of the trial testimony of the MCO witnesses (*see* Haas-Wilson, Tr. 2440,2776-94), did not conduct any analysis of the amount by which any MCO would need to reduce its premium to market a network without Evanston and/or HPH either before or after the merger. Haas-Wilson, Tr. 2764-66, *in camera*. Her testimony, therefore, would be inadmissible in court, and it is entitled to no weight in these proceedings.

Second, Complaint Counsel has failed to rescue Dr. Haas-Wilson's analysis from another fundamental defect, namely, that her bargaining theory is inconsistent with the pattern of actual price changes after the merger. Contrary to Complaint Counsel's assertion (CCAB21, n.22), Dr. Haas-Wilson squarely admitted at trial that "increasing the size of the managed care insurer would increase the bargaining position of that managed care insurer relative to the hospital," making clear that this was her "general view" on hospital/MCO bargaining dynamics. Haas-Wilson, Tr. 2747. In addition, Dr. Haas-Wilson claimed to have relied on an economics article to explain "how bargaining theory can be used to understand the dynamics of hospital competition" and theorized that "the more important a hospital is to [MCO] revenues, the greater the hospital's bargaining leverage and thus the higher the resultant negotiated hospital price." Haas-Wilson, Tr. 2475-76.[6] If this theory were true, the larger the MCO, the more important its business

[6] Dr. Haas-Wilson's reliance on an article by Town and Vistnes in an attempt to explain her bargaining theory is misplaced. *See* Robert Town and Gregory Vistnes, "Hospital Competition and HMO Networks," 20 *Journal of Health Econ.* 733-34 (2001); RFF966. First, Dr. Haas-Wilson did not consider plan-specific factors such as the impact of mergers among MCOs. RFF853,867,1023; *see, e.g.,* RFF816-17,819 (MCO sale of physician practices), RFF1021 (personalities of negotiators), RFF1022 (patient loyalty). Second, she performed no analysis on

will be to a hospital, and thus the *lower* the price increase the hospital would be able to obtain relative to the increase it could obtain from smaller MCOs.

Yet Dr. Haas-Wilson's relative price change analysis is flatly inconsistent with this implication of Complaint Counsel's own bargaining theory. RAB52-53; RFF1050. Contrary to the theory, it is undisputed that (REDACTED) a larger MCO with greater bargaining power over ENH, received *larger* post-merger price increases than the smaller MCO(REDACTED)RAB52-53; RFF125,143,170,1050-52. This inconsistency between theory and results confirms that the post-merger price increases were caused by something other than an increase in ENH's bargaining power.

A further discrepancy between Complaint Counsel's theory and market reality is that at least one payor, (REDACTED) did not receive *any relative price increase* at ENH. RFF1049. This fact directly contradicts a key tenet of Complaint Counsel's bargaining theory—that an increase in ENH's bargaining power would cause prices to rise for all payors. Neither Complaint Counsel nor its expert has accounted for this inconsistency, which is similarly fatal to its "bargaining" argument.

D. Evidence Regarding Negotiations With MCOs And Respondent's Internal Discussions About The Merger Do Not Establish Unilateral Market Power Under *Donnelley*.

Complaint Counsel also relies on evidence about ENH's post-merger negotiations with MCOs—particularly ENH's effort to move from a per diem method to

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the cost of reconfiguring MCO networks. Haas-Wilson, Tr. 2762-66, *in camera*. Third, Complaint Counsel focuses solely on geographic differentiation (CCAB21), ignoring the fact that Evanston and HPH were in dramatically different product dimensions before the merger. RAB6-9,40-42. Each of these is recognized by Town and Vistnes as necessary to the bargaining theory analysis, but were ignored by Complaint Counsel.

a discount-off-charges method—and on internal documents discussing the possible impact of a merger on those negotiations. CCAB10-12,22-31. Here again, this evidence does not satisfy the legal requirements for a showing of unilateral market power, and does not establish market power under any plausible economic theory.

1. Negotiating Changes In Payment Methodologies To A Discount-Off-Charges Method Does Not Indicate Market Power.

Complaint Counsel's argument that the negotiation of discount-off-charges contracts with some MCOs following the merger reflects unilateral market power is meritless. CCAB11-12,18, n.17. That evidence has nothing to do with the three *Donnelley* requirements. And it is undisputed that MCO/hospital contracts are the products of complex negotiations (RFF182-83), that discounts-off-charges are one of many payment methodologies commonly used in hospital contracts, and that a change to this methodology may result in a *decrease* in MCO payments. RFF82,86,920-21. Moreover, although Respondent does not bear the burden of proof, for at least four reasons, the evidence precludes a finding that these changes in contract methodology are connected to market power.

First, there is ample evidence that Evanston could have obtained discount-off-charges provisions before the merger and thus these changes cannot be the product of market power caused by the merger.[7] *See* Holt-Darcy, Tr. 1571, *in camera*; RFF874.

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7 **(REDACTED)** RFF85,591,658-66,677. Contemporaneously, Bain advised ENH to seek a discount-off-charges reimbursement methodology as a negotiation tactic to help secure more favorable per diem rates. RFF713,716.

(REDACTED)

RFF84,86; *see also* RFF-Reply789.

(REDACTED)

Mendonsa, Tr. 558, *in camera*; Ballengee, Tr. 270-71, *in camera*; RFF-Reply1233.

Second, some payors, such as **(REDACTED)**, simply rejected ENH's request for discount-off-charges contracts during the 2000 negotiations and obtained **(REDACTED)** instead. IDF438-39. Other payors such as **(REDACTED)** negotiated discount-off-charges contracts on some plans or services, but per diem and per case rates for others. RFF889; CX5064 at 17, *in camera*; RFF-Reply1113; IDF418. Thus, Evanston did not unilaterally impose such terms on payors.

Third, MCOs can and often do negotiate a variety of other provisions in their contracts to protect themselves from unanticipated charge increases resulting from discount-off-charges contracts. Examples include escalator clauses, which increase the percentage discount as charges rise (IDF177; RFF89,847), and contract termination if the hospital increases its chargemaster by more than a fixed percentage. IDF397; RFF94,892. Moreover, Complaint Counsel has not refuted and in fact, has conceded, that MCOs are large, sophisticated customers with a variety of tools to resist any anticompetitive pricing. RAB45-47; CCAB26.

Fourth, discount-off-charges is, and has always been, the standard reimbursement method for outpatient services. RFF91. **(REDACTED)**

(REDACTED) RFF-Reply799,1108; CX5008 at 6, *in camera*; CX5059 at 18; CX5064 at 18, *in camera*; CX5065 at 19; CX5067 at 16, *in camera*; CX5072 at 29, *in camera*; CX5075 at 17, *in camera*; CX5174 at 12, *in camera*. Complaint Counsel does not and cannot claim that hospitals throughout Chicago have market power in outpatient services because they are reimbursed on a discount-off-charges methodology, and the same goes for inpatient services.

2. ENH's Internal Discussions Do Not Show That The Merger Gave ENH Unilateral Market Power Or That Post-Merger Price Increases Resulted From Market Power.

Complaint Counsel's continued reliance on ENH's internal business records also does not help it prove that the price increases resulted from merger-related market power under the *Donnelley* standards. The documents do not even arguably show that Evanston and HPH were the first and second choices (or even close substitutes) for any group of customers; that these customers accounted for purchases of a significant share of hospital-based services in the relevant market; or that other hospitals would not reposition in response to an anticompetitive price increase.

In all events, Complaint Counsel has grossly misinterpreted these documents. For example, Complaint Counsel continues to argue that one group of documents confirms that Evanston and HPH sought to end competition between each other. CCAB9,24 (citing CX2 at 7; CX1879 at 4). But the undisputed evidence shows that these documents refer to competition between Evanston and HPH's respective *physician* staffs. Spaeth, Tr. 2209,2213 (stating that "the framework [of the documents]

was physicians of both institutions. All of these issues are physician issues."); RFF-Reply47,57,1351,1356,1588. And any competitive concerns about the physician negotiations with MCOs have already been resolved by the Commission's consent order. RAB61. These documents do not contain a single reference to the two hospitals competing for inclusion in MCO networks or suggest that the merger would end that competition. Yet Complaint Counsel inserts the word "[hospital]" throughout its brief, apparently to create the false impression that the documents concern hospital competition. CCAB24.

Moreover, although the merging parties did believe that the merger would "strengthen negotiating positions with managed care," as Complaint Counsel claims, that was *only* because of the potential for improved quality and improved cost efficiencies. CCAB9,24 (citing CX19 at 1); RFF-Reply1352,1356,1361,1369,1407,1584; Spaeth, Tr. 2303. Bain understood this and concluded that the "merger provides the opportunity to reduce costs, refocus activities at the three hospitals, shift activity from overcrowded Evanston Hospital and negotiate contracts with payors from a stronger position." CCAB24 (citing CX2072 at 1); RFF-Reply1516. ENH's CEO, moreover, used these quality and cost benefits as the basis for informing his board that the improved revenues and significant cost savings ($12 million) were achieved through the combined knowledge and resources of the two organizations. CX17 at 1-2; RRB23, n.21; *see also* RFF-Reply4,744-45,1337,1365-79. And it was for these reasons that ENH personnel touted the two hospitals' new-found "interdependence." CX13; CX16; RFF-Reply1373,1376-77. In short, although intent is irrelevant, these documents do not begin

to prove that the parties *intended* to achieve market power, much less that the merger actually produced that result. *See* RAB59-62.[8]

E. The Evidence Shows That The Post-Merger Price Increases Resulted From Other Factors.

Finally, although ENH is under no obligation to establish an alternative explanation for the post-merger price increases, ENH has done so. As shown below, moreover, Complaint Counsel has failed to undermine Respondent's showing that the post-merger price increases were far smaller than the Commission thought when it issued the complaint, and indeed far smaller than Complaint Counsel claimed at trial. Complaint Counsel has also failed to come to grips with Respondent's showing that ENH was able to raise its prices only because it learned, contemporaneously with the merger, that its existing rates were far below the market, and moved to adjust prices to market-clearing levels in its subsequent negotiations with MCOs.

1. As Complaint Counsel Concedes, The Relevant Price Increases, Properly Measured, Are Far Smaller Than The Commission Thought When It Issued The Complaint.

Complaint Counsel concedes that absolute price increases—such as those alleged in the complaint—have no competitive significance. CCAB32; RFF-Reply392. Rather, according to Complaint Counsel, the most meaningful measure of price changes

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[8] Complaint Counsel also misleadingly argues that the Northwestern Healthcare Network ("NHN") and the proposed sub-regional merger "NH North" were examples of ENH's intent to increase its bargaining power. CCAB8. However, Complaint Counsel fails to explain that NHN received Hart-Scott-Rodino ("H.S.R.") approval and was created, not to obtain market power, but in anticipation of the arrival of MCO capitation contracts, a trend that never materialized in Chicago. RFF202-04,210,228,2535-37. Contrary to Complaint Counsel's suggestions, NHN and the proposed NH North were concerned largely with improving the quality of care delivered to the greater Chicago area. RFF201,233-39.

in this case is the aggregate "relative" price change across all MCOs rather than changes on a payor-by-payor basis. Yet it was an ENH witness, Professor Jonathan Baker, former Director of the Bureau of Economics, who conducted the only analysis of average relative price changes across all payors. RFF1024-26. And Prof. Baker's calculations show that the actual size of the aggregate relative price increases in Complaint Counsel's market is no more than 9-10%. IDF689-90; RFF1004. If anything, Prof. Baker's pricing analysis overstates the amount of the actual price increases.[9] *See* RAB58, n.13; RFF1156,1161. Complaint Counsel offered no expert rebuttal to Prof. Baker's price changes analysis.

On appeal, Complaint Counsel suggests for the first time that its experts found a (REDACTED) relative price increase. CCAB31-32. But this conflicts with the assertion in its post-trial brief that its expert, Dr. Haas-Wilson, "found that ENH's price increases were at least **(REDACTED)** " than at other hospitals she used for comparative purposes. CCPTB3. And, buried in footnotes, Complaint Counsel confesses that its latest inflated figure is wrong (CCAB32, n.31), and that the relevant average price increases are substantially lower. CCAB1, n.2.[10] In all events, none of

[9] The ALJ found "a number of problems with the [MCO] data that made the measure of price certainly less than fully accurate." IDF470; Noether, Tr. 6051, *in camera*. In addition, the results were not quality-adjusted. RFF1162.

[10] Although the ALJ relied upon Dr. Haas-Wilson's analysis, mistakenly believing that her conclusions were based on four different datasets, IDF469, Complaint Counsel now concedes that two of those datasets did not include information about other hospitals and are therefore of no value in measuring relative price changes. CCAB32, n.31; IDF614. Moreover, Dr. Haas-Wilson offered aggregate price increase estimates based on only one set of data, the Illinois Department of Public Health ("IDPH") dataset, which contains only charges—essentially "list

these figures approaches the outlandish price increases Complaint Counsel alleged in the complaint. *See* Compl. ¶31.

2. Complaint Counsel Has Failed To Undermine Respondent's Showing That ENH's Pre-Merger Prices Were Significantly Below Market Levels.

Complaint Counsel has likewise failed to undermine the extensive evidence showing that ENH was able to raise prices after the merger only because it learned, at about the same time, that its pre-merger prices were well below market levels. *See* RAB 48-52.

First, Complaint Counsel's assertion that Respondent's explanation is "unconfirmed by any contemporaneous business documents" is simply wrong. CCAB3, 45. At every stage of this litigation, Respondent has presented contemporaneous business documents and testimony from its MCO customers confirming this. RB41-45; RRB56-59; RAB17,49-52. For example, in November 1999, Bain informed Evanston management that HPH had more favorable contract terms than Evanston in the majority of the major contracts Bain examined. RFF679; CX75 at 6; Hillebrand, Tr. 1803. Other third parties, including both HPH's CFO and lead negotiator, came to the same conclusion, specifically finding that "applying ENH's hospital contract rates to [HPH]

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prices"—and are poorly suited to this purpose. CCAB32, n.31, RFF-Reply396; IDF574,576-78; CCFF375.

The (REDACTED) figure cited by Complaint Counsel is based on IDPH data for "all patients," including Medicare and Medicaid patients. RFF-Reply402-03; CCFF396; IDF580. Yet the all patient group is hardly representative of the MCO customers at issue here, thus further indicating that Dr. Haas-Wilson's IDPH analysis was seriously flawed. IDF580,586-87,602-03; RFF-Reply402-03.

would *reduce* [HPH's] annual net revenue from managed care payors by approximately $8,000,000." RFF665; RX674 at ENHLTC17915 (emphasis added).[11]

Second, Complaint Counsel's assertion that ENH could not have learned anything about pricing from HPH is false. CCAB45-46. While it is true that an MCO's payments to any hospital depend upon a complex calculation based on all the contract terms, and are therefore difficult to calculate from those terms alone, the unrefuted contemporaneous evidence proves that both Evanston and Bain concluded that Evanston's contracts were by-and-large less favorable than HPH's. RAB50; RFF656-93; IDF395,411,422,436. Complaint Counsel concedes this fact for "at least some MCOs," (CCAB46, n.47), but more importantly, the MCOs themselves shared this view. For example, the United representative was "embarrassed" when Evanston learned of the difference between the pre-merger Evanston and HPH rates. RFF684,888.[12]

Complaint Counsel also asserts that, by gaining access to HPH's pricing information, Evanston would not have learned how to price "like an academic hospital." But that misses the point. CCAB45. The evidence demonstrated that ENH, a large, sophisticated teaching hospital, had less favorable MCO contracts than HPH, a community hospital. RFF41,658-66,679. Evanston, knowing it was an academic

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[11] Contrary to Complaint Counsel's charge (CCAB46, n.47), Respondent has not attempted to establish a relationship between Evanston and HPH net prices on the basis of word-play. Respondent has tried to use the term "rate" to refer to the hospitals' net charges for their services, not to the "rate of discount" applicable to chargemaster prices.

[12] Complaint Counsel points to ENH's alleged acknowledgement that its "post-merger pricing decisions were not constrained" by area competitors or customers (CCAB26, n.28), but that was only because ENH had learned that its rates were significantly under-market and therefore could be increased without losing customers. RAB49-50; RFF656-93.

hospital and that such hospitals typically have higher cost structures and rates than community hospitals, concluded on that basis that its prices were below market levels. *See* Neaman, Tr. 1344-45; Hillebrand, Tr. 1853-54.

Third, Complaint Counsel's conclusion that this explanation for the price increases is implausible because it "implies that Evanston was not choosing prices so as to maximize its profits before the merger" is not supported by economic theory or the evidence. CCAB50. As discussed in more detail in Respondent's opening brief, there are sound economic reasons why firms may price below the full-information competitive level and, contrary to Complaint Counsel's assertions (CCAB50-51), Respondent presented ample evidence that ENH was pricing below that level.[13] RAB48-50.

3. Economic Analyses Confirm that ENH's Post-Merger Prices Did Not Exceed Market Levels.

Having failed to carry *its* burden to prove that post-merger prices exceeded competitive levels, Complaint Counsel criticizes the pricing analysis presented by Respondent's distinguished economists—Dr. Noether and Prof. Baker. Using different methodologies, they concluded that ENH's prices did not exceed competitive levels (RAB53-55) and that the pattern of price increases was more consistent with the

[13] As Judge Posner has noted, "information is costly to acquire, [and] customers [and sellers] do not always have good information about the competitive alternatives facing them." Posner, ANTITRUST LAW at 160. Thus, a firm with limited information may sometimes price below the market level, and if it learns more about competitive conditions, it would be expected to raise prices to that level. Indeed, when a price is "below the market-clearing level," even a large price increase might simply bring a seller "nearer to the level of prices that would have prevailed under conditions of perfect information and perfect competition." *Id.* at 163.

"learning about demand" explanation than with Complaint Counsel's bargaining theory (RAB52-55).[14] Complaint Counsel's criticisms of their work are misplaced.

First, although Complaint Counsel mounts an extensive attack on Dr. Noether's academic control group, there is no evidence that the inclusion in that group of any or all of the hospitals identified in Complaint Counsel's brief would have changed the conclusion that ENH's prices did not exceed competitive levels. Accordingly the dispute about the control groups is immaterial.[15] Moreover, as a matter of economic practice, a control group does not need to be all-inclusive, only representative and the risk of error from including too many hospitals is greater than the risk from including too few. Reply-RFF1823; *see also* Baker, Tr. 4780-81. Furthermore, any doubts about the academic control group are dispelled by the fact that ENH's inpatient prices never exceeded those of **(REDACTED)**

[14] Complaint Counsel misleadingly asserts that Prof. Baker admitted ENH's price increases "to Humana, Aetna, and United was also consistent with ENH obtaining market power through the merger." CCAB47. In fact, Prof. Baker noted that if viewed in a vacuum, the price increases could be consistent with such an explanation, but he repeatedly testified that all plausible alternative explanations must be eliminated before a conclusion of market power could be reached and that one must analyze price levels as well as price changes to reach sound conclusions. After appropriate testing, Prof. Baker concluded that ENH's prices were in fact consistent with its having learned more about market conditions, and not the presence of market power. RFF-Reply691.

[15] Nor is there any evidence that Dr. Noether's selection of hospitals for her control groups was biased or "arbitrary." CCAB47; RFF1065-96; RFF-Reply703-27. Indeed, Dr. Noether did not know the prices of the various hospitals before selecting them for inclusion in her control groups. RFF-Reply1823. Moreover, Dr. Noether used three objective criteria to identify academic hospitals: (1) size; (2) teaching intensity (0.25 residents per bed); and (3) breadth of service. RFF1066-70. Both size and teaching intensity are recognized by major industry organizations and/or government bodies as indicators of academic hospital status. RFF1069-70. And if the third criterion were dropped entirely, the identity of the academic control group hospitals would remain unchanged. RX1912 at 60; RFF1066; *see generally* RB60-62.

(REDACTED) RFF564-69,1150; IDF276,280,322; ID145-46.

Second, Complaint Counsel argues that pre-merger HPH was "no academic hospital" and that, as a consequence, prices paid for services at HPH should not be at academic levels. CCAB47, n.49. But that argument simply reinforces two of Respondent's principal contentions: (1) that Evanston and HPH could not have been close substitutes for one another in any MCO network pre-merger and (2) that ENH has dramatically upgraded HPH's services since the merger. RAB9-10,40-43,63-84. There is no disputing that, after the merger, ENH brought the benefits of its academic model of clinical practice and management to HPH and, in so doing, added an array of new service lines and complex procedures not commonly found in community hospitals. RAB68-84; ID177-78. For all these reasons, Dr. Noether properly compared ENH's post-merger prices, which are the same at all three ENH campuses, to the academic group.[16]

Third, Complaint Counsel also ignores the evidence when it argues that ENH's pricing was actually higher than the "academic" control group for two of the MCOs. CCAB4,50. Both Dr. Noether and Prof. Baker explained that the relevant comparison for examining whether ENH's prices rose above competitive levels was the *average* price of the academic control group for all payors, rather than a comparison on a payor-by-payor basis. RFF1138,1142; RFF-Reply1745-46,1759,1955,1957. None of

[16] Complaint Counsel's reliance on MCO contract negotiators to criticize Dr. Noether's control groups (CCAB49) is flawed. Those personnel have no medical training and often were not even aware of the most obvious physical improvements to the HPH campus, such as construction of the four story ambulatory care center. *See* RFF1559-61; Ballengee, Tr. 201-03; Neary, Tr. 639-40.

Complaint Counsel's economic experts disagreed.[17] When prices are examined across all payors, both Dr. Noether's and Prof. Baker's analyses demonstrate that ENH's prices did *not* rise above the academic average. RFF1111,1138,1144-49.[18]

Complaint Counsel also ignores the fact that the prices charged by hospitals to MCOs result from the give-and-take of negotiations and the particular mix of patients that use a hospital in a particular year. RFF1133,1143. Because contract negotiations take place under conditions of imperfect information, it would not be surprising for a

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[17] Complaint Counsel did not even call its designated rebuttal econometrician, Prof. Ashenfelter, to dispute Prof. Baker's analysis. After an academic exchange with Prof. Ashenfelter about econometric methods during discovery, Prof. Baker filed a supplemented expert report that corrected one step of his earlier empirical work and avoided an error made by Prof. Ashenfelter. Baker, Tr. 4683-84. The results in Prof. Baker's supplemented report, about which he testified at trial, were unchallengeable on technical grounds, leaving Prof. Ashenfelter with no reason to testify. Indeed, Complaint Counsel had ample time to submit supplemented rebuttal reports in response to Prof. Baker's, but elected not to do so. Complaint Counsel's unsuccessful attempt to convert the back and forth between academic economists who care foremost about analyzing the data correctly into a credibility issue is discussed more fully in Respondent's Post-Trial Reply Brief. RRB65-67.

[18] Even on a payor-by-payor basis, Dr. Noether's analysis found that ENH's prices were below the academic hospital average for all payors except (REDACTED) in certain years, under certain data specifications. RFF1110-36. Similarly, Prof. Baker found that ENH's prices were below the academic hospital average for all payors except (REDACTED) in certain years. RFF1148-55. These payor-by-payor variances, though not analytically significant, are easily explained. First, the data provided by (REDACTED) was so fraught with problems that it would have been defensible to drop this data from the analysis entirely. RFF1012. Second, when properly calculated, ENH's prices for (REDACTED) only exceeded the academic hospital average in one year. RFF-Reply733, Baker, Tr., 4682-83, *in camera*. Third, both of these payors faced idiosyncratic circumstances that impacted their contract negotiations with ENH. RFF684,888,1154. (REDACTED) pre-merger contract prices for ENH were embarrassingly lower than HPH's); Foucre, Tr. 931-32 (REDACTED) had recently excluded several large hospital systems from its network making ENH more critical); RFF816-17,819 (Humana had recently sold its physician practices to ENH).

particular hospital's prices to a particular payor, in a particular year, to overshoot or undershoot the fully-informed competitive level. RFF1133,1143.[19]

4. Complaint Counsel Has Failed To Undermine The Evidence That Post-Merger Price Increases Resulted Not From Market Power, But From The Idiosyncrasies Of Bargaining And ENH's Increased Understanding Of The Market.

As explained in Respondent's opening brief, the evidence showed that the post-merger price increases here resulted from benign bargaining idiosyncrasies along with ENH's increased understanding of the market. Although the MCOs themselves acknowledged that every negotiation is different and both sides engaged in the usual give-and-take, Complaint Counsel ignores the idiosyncrasies of each negotiation and simply assumes that any price increase is the result of market power. RFF182-83,523-26,604-15,910. Moreover, Complaint Counsel's expert admitted that her analysis did not take into account these idiosyncratic differences in the bargaining process. RFF588-89.

United Healthcare. The evidence demonstrated, for example, that ENH's contract discussions with United resulted in market rates for both parties. United's pre-merger contract rates with Evanston were far below its contract rates with HPH. RFF658,664,680-84; CX75 at 8. Accordingly, not only was ENH "shocked" and

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[19] Complaint Counsel suggests that if ENH were an academic hospital, it would not make sense for certain payors to pay ENH more than other hospitals in the academic control group. In fact, payors, such as (REDACTED) routinely pay some hospitals more than others and those differences change from negotiation to negotiation. RFF1133,1154; RFF-Reply1755-56,1960; *see also* RRB64 (more detailed description of factors that may lead an MCO to pay more for one hospital than another).

In all events, academic hospitals are not perfect substitutes for one another and, therefore, would not be expected to have identical prices in a competitive market. RFF368,535-37; *see also Oracle*, 331 F. Supp. 2d at 1113-18.

"beyond surprised" when it learned this information, but United's negotiators admitted the disparity and were "very embarrassed" that Evanston's contracts were so far behind the market. RFF682-84. Yet Complaint Counsel ignores contemporaneous evidence that *United* offered to "utilize the better of [Evanston or HPH's] existing contracts" as the basis for the new contract. CX111 at 1; Hillebrand, Tr.1900-01; RFF888.

Moreover, Contrary to Complaint Counsel's contention that ENH proposed **(REDACTED)** the evidence showed that not only was ENH's proposal based on United's existing contract with HPH, but United was successful in negotiating downward several significant provisions of the final agreement. CCAB26; CX111 at 1; RFF888; RFF-Reply967. Complaint Counsel also ignores the admission by United's witness that United's own customers never felt adversely affected by the merger. Foucre, Tr. 948.

Complaint Counsel also misleadingly uses a document that was shown to be inaccurate at trial, to claim that ENH's rates **(REDACTED)** and erroneously suggests that ENH's post-merger rates exceeded those of **(REDACTED)** CCAB27. In fact,

(REDACTED)

RFF-Reply991-

92; *see also* RFF898-906.[20] United's internal documents—not those manipulated as part of a sales pitch—tell a different story and show that ENH was priced significantly below **(REDACTED)** for hospital services, and well below **(REDACTED)** RFF908; RFF-Reply991.

Complaint Counsel also disregards the fact that United's negotiating position was substantially affected by its independent decision to terminate contracts with Rush and Advocate Lutheran—the two closest competitors and alternatives to Evanston. Foucre, Tr. 941; RFF456,565,915-16; RFF-Reply1000. Based on this fact alone, Complaint Counsel cannot credibly claim that United's alleged lack of substitutes was caused by the merger.

PHCS. Complaint Counsel's argument regarding PHCS likewise rests on unsupported hypotheticals, impeached lay opinion, and unsubstantiated generalizations. CCAB28. Complaint Counsel alleges that ENH raised prices to PHCS by 60% even though PHCS admitted that **(REDACTED)**

RFF848; CCAB28. Indeed,

(REDACTED)

RFF848; Ballengee, Tr. 261-62, *in camera*.

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[20] The single document (CX21) on which Complaint Counsel relies (CCAB26) is not a contemporaneous document, but was specifically prepared for Complaint Counsel during its investigation and misstates even the most basic facts. RFF-Reply967; *see also* RFF-Reply986. When asked about the document, the United witness, Jillian Foucre, **(REDACTED)** Foucre, Tr. 1111-12, *in camera*. Moreover, **(REDACTED)** RFF887.

Complaint Counsel also continues to ignore the most important PHCS document: its statement to its customers at the time of the merger that "[i]n 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)." RX712 at PHCS891; RFF457. This document convincingly refutes PHCS' lay opinion testimony.

Aetna. Complaint Counsel also attempts to misconstrue the "very friendly" negotiations with Aetna, which **(REDACTED)**

RFF755; RFF-Reply1196-97. The evidence with respect to the Aetna negotiations is clear:

(REDACTED)

RFF744-45,750-54.

(REDACTED)

RFF754.

(REDACTED)

CCAB30; RFF 753.

Complaint Counsel also misleadingly suggests that Aetna thought an alternative network was "inadequate." CCAB30. Yet

(REDACTED)

RFF-Reply1190,1209. Therefore, it is not surprising that Aetna was uncertain about offering a network without both Evanston and **(REDACTED)** —but again, this had nothing to do with the merger.

One Health/Great West. Even though One Health is the smallest payor in this case (1% of ENH's revenue), Complaint Counsel called two witnesses from that company who *both* conceded that One Health had several alternatives to ENH. RFF458. Moreover, One Health's witnesses conceded that "it had been several years since the contracts had been renegotiated and it was appropriate to [] increase some of the rates." RFF796. One Health's testimony that ENH's post-merger rate proposal "wasn't that shocking" is consistent with the fact that the post-merger discount-off-charges contract was exactly the same as at pre-merger HPH. Dorsey, Tr.1437-38; RFF805.

As with United and Aetna, One Health was also facing an independent termination from the admitted closest competitor to HPH, Lake Forest Hospital. RFF807-08. Complaint Counsel overlooks this key fact, which explains One Health's post-merger negotiating behavior and cannot be connected to the merger.[21]

[21] Complaint Counsel misleadingly claims that One Health "tried to market" a network without ENH but failed because it "began losing members." CCAB29. Neither Complaint Counsel nor One Health presented any evidence of its alleged efforts to "market" a network without ENH,

Unicare. Complaint Counsel's argument about the Unicare negotiations is also misleading, but for a different reason: Complaint Counsel fails to mention that, at the time of the ENH merger, Unicare was itself merging with Rush Prudential, another MCO operating in Chicago. RFF862.

(REDACTED) RFF867.

(REDACTED)

Holt-Darcy, Tr. 1567-68, *in camera*; RFF868.

Despite admitting the availability of alternatives, Unicare elected to continue its network because of internal issues, not as a result of any alleged market power.[22] RFF867; RFF-Reply1266,1297-98. This idiosyncrasy affected the positioning of the parties during the negotiations and obviously has nothing to do with the Evanston/HPH merger.[23]

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and Complaint Counsel ignores the testimony from One Health witnesses who could not identify a single customer lost as a result of the ENH termination. RFF802.

[22] Complaint Counsel erroneously cites Unicare as an example of an MCO that created a "viable" pre-merger network without one of the merging hospitals. CCAB25, n.27. In fact, both Evanston and HPH were part of Unicare's pre-merger network through a contract with other MCOs, CCN and Healthstar Network. CX114 at 1; RFF861.

[23] Complaint Counsel has no data or expert analysis to support its claim that Unicare received an **(REDACTED)** price increase. CCAB30-31; RFF1099. In reality,

(REDACTED) RFF870-73.

(REDACTED)

Holt-Darcy, Tr. 1542, *in camera*; RFF870.

(REDACTED)

RFF871.

II. THE MARKET STRUCTURE EVIDENCE REFUTES THE ARGUMENT THAT THE MERGER MATERIALLY ENHANCED MARKET POWER AND PRODUCED ANTICOMPETITIVE EFFECTS.

Departing from its previous briefs and the ALJ's decision, Complaint Counsel has abandoned any serious structural analysis under Count I in favor of its novel theory of "actual" competitive effects. In so doing, Complaint Counsel appears to have forgotten the importance of market shares to a unilateral effects analysis. *Donnelley* requires that customers who regard the merging parties' products as their first and second choices account for a significant "share" of sales "in the market" (*Donnelley*, 120 F.T.C. at 195), and those shares obviously cannot be measured without defining the relevant market. Complaint Counsel, moreover, is unable to point to any case that has found liability on a unilateral effects theory unless the merged firms had a share of the market far larger than those found by the ALJ here.[24] RAB35-38. That is no doubt why Complaint Counsel has resurrected its theory, properly rejected by the ALJ, that the relevant market consists of the "triangle" containing only the three ENH hospitals, and why, as an alternative, it erroneously urges the Commission to ignore market shares altogether in favor of the merger's so-called "actual" effects. CCAB5.

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[24] In that regard, while Complaint Counsel argues that a firm need not have a "monopoly" share (CCAB41, n.41), it does not address the authority cited in Respondent's opening brief. And the cases it does cite—*Philadelphia National Bank* and *Swedish Match*—are inapposite. CCAB68, n.78. *Philadelphia National Bank* was decided on the basis of coordinated effects, while in *Swedish Match*, a unilateral effects case, the share of the merged firm was 60%, nearly double that of the closest competitor. *See United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 363-64 (1963); *FTC v. Swedish Match*, 131 F. Supp. 2d 151, 166 (D.D.C. 2000). Complaint Counsel cannot point to any case in which a firm with less than a dominant market share in a well-defined market was found to have market power under a unilateral effects theory.

A. Complaint Counsel's Market Definition Analysis Is Circular And Incapable Of Establishing An Increase In Market Power Or A Causal Link Between Market Power and Post-Merger Price Increases.

Complaint Counsel's attempt to define a relevant market on the basis of its interpretation of ENH's price increases is flawed for three reasons. *See* CCAB72-75. First, it is entirely circular and therefore provides no additional information about the existence of market power—which is, after all, the whole purpose of defining markets and measuring market shares. Complaint Counsel's approach simply *assumes* that a post-merger price increase reflects an exercise of market power, and uses this assumption to define a relevant market that consists only of the firm whose prices increased. RFF495. Complaint Counsel offers no statistical or other objective evidence to support its narrow market definition, and relies instead on uncorroborated and self-serving statements from MCO witnesses, often contradicted by their own and other market participants' contemporaneous documents and testimony. *See supra* section I.B.1. Complaint Counsel's entire structural case is thus a tautology that bears no relationship to the legal framework set out in *Donnelley*, the *Guidelines*, or pertinent court decisions. *See* RAB39-45; *see supra* section I.B. (citing MCO testimony and *Donnelley* requirements).

Second, contrary to Complaint Counsel's arguments (CCAB1, n.2), its approach finds no support in the *Guidelines'* analysis of "small but significant and non-transitory price increases." Under Complaint Counsel's theory, a successful post-merger increase above the five percent level "typically used" in the *Guidelines* shows that the

merger produced market power within *some* relevant market. *Id.* As a matter of simple economics, however, that reasoning has no validity unless one first proves that post-merger prices exceeded the fully-informed competitive level by at least five percent. *See Merger Guidelines* §§0.1-1.2. As shown previously, Complaint Counsel has not even attempted to make such a showing. *See supra* section I.C.2. [25]

Third, while Complaint Counsel acknowledges a link between patient preferences and MCO hospital choices (CCAB21, n.21), its market analysis ignores patients and instead seeks to define a geographic market on the basis of abstract *MCO* preferences divorced from the preferences of their customers and members (employees or patients).

Complaint Counsel also offers no support, even in the alternative, for the ALJ's narrow definition of the relevant market. Complaint Counsel does not dispute that a rigorous analysis considering all relevant factors, such as geographic proximity, travel times, physician admitting patterns and market participants' views, would yield a broad geographic market that should include as many as 18 other hospitals (RAB29-32), but at least the nine hospitals identified in Dr. Noether's conservative "minimum" market. RAB33. Nor does Complaint Counsel attempt to defend the ALJ's misreading of the Lake Forest Hospital survey, which would support a geographic market of all 47 hospitals within a 35 minute drive, including downtown teaching hospitals. RAB31-32.

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[25] Complaint Counsel's citation to *Staples* (CCAB39, n.40) is irrelevant for this reason as well. (CCAB38-39). Complaint Counsel also reasons that if other hospitals with lower prices than ENH were in the relevant market, MCOs would have dropped ENH. CCAB39, n.39. But the evidence showed that during the relevant period consumers favored broad networks (RFF58) and that there was relatively little selective contracting. RFF75-76; RRB12-13.

Indeed, given that Complaint Counsel now concedes that tertiary services are part of the relevant product market—a major change from the complaint issued by the Commission—the broader geographic market must logically include the major downtown hospitals that are within a 35-minute drive of Evanston and HPH. *See United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 141-42 (E.D.N.Y. 1997). This conclusion is also mandated by Landes and Posner's showing that even "fringe sellers" should be included in the relevant market if a market-share analysis is used to assess market power. *See* Landes & Posner, *supra* at 963-68.[26]

In the end, Complaint Counsel seeks to avoid these weaknesses in its structural case by disregarding decades of decisions requiring it to prove a relevant market. As explained below, the Commission should reject this novel argument.

B. Response to Cross-Appeal: Complaint Counsel's Theory Of Liability Under Count II Is Fundamentally Flawed As A Matter Of Law And Policy and Its Cross-Appeal On That Point Should Be Denied.

In its cross-appeal, Complaint Counsel acknowledges that the core issue regarding Count II is whether a plaintiff must allege and prove specific relevant product and geographic markets as an element of a Section 7 claim. CCAB72. As the Supreme Court has explained, relevant market definition is a "*necessary* predicate to a finding of a

[26] The only remaining dispute with respect to the product market is whether to include hospital-based outpatient services. It is undisputed that MCOs contract for the *entire* bundle of inpatient and outpatient services that hospitals provide, and use these contracts to market hospital "networks" or plans. Complaint Counsel readily admits that inpatient and outpatient services are usually negotiated in a single transaction and that they are traded off in rate negotiations. CCAB38. Its argument that outpatient services are not part of the product market because they are also offered by non-hospital providers is thus incorrect. CCAB37-38. Moreover, outpatient services continue to grow and currently represent over 45% of ENH's total services. RFF74.

violation of the Clayton Act" because it provides a framework within which to analyze the alleged anticompetitive effects of a merger, even where the government brings a challenge years after the merger was consummated. *United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586, 593 (1957)(substantial lessening of competition "*can be determined only in terms of the market affected.*") (emphasis added). The Commission has also required proof of a relevant market in post-consummation challenges. *Donnelley*, 120 F.T.C at 151-52; *In re Chicago Bridge & Iron*, No. 9300 at 7 (Op. of the FTC Comm'n)(Jan. 6, 2005)(following *Guidelines* approach to market definition). There is no doubt that Complaint Counsel must allege, define, and prove a relevant market as part of a Section 7 case. *See* RB 31-34; RRB 45-49.

The cases relied on by Complaint Counsel—one Section 7 case and several Sherman Act cases—do not support its attempted rewriting of Section 7 jurisprudence. In *Libbey*, a preliminary injunction case under Section 7, the court analyzed the relevant market and calculated shares. *FTC v. Libbey, Inc.*, 211 F. Supp. 2d 34, 45 (D.D.C. 1997)("first step" in evaluating merger under Section 7 is to define the relevant product market). Rather than eliminate the need to prove a relevant market, the direct evidence in that case simply served as one factor in analyzing the merger's competitive effect within the defined market. *Id.* at 50. *Libbey* thus does not support Complaint Counsel's attempt to avoid defining a relevant market.

Nor do any of the Sherman Act cases hold that direct evidence of anticompetitive effects can substitute for proof of a relevant market in a Clayton Act merger case. The statutory schemes of the Sherman Act and Section 7 of the Clayton Act

differ in that the language of Section 7 requires proof that future competitive harm is likely within a particular "line of commerce" and within "any section of the country." 15 U.S.C. § 18. *See* RB31-34. The Sherman Act has no such requirement. According to the Clayton Act's legislative history, moreover, Congress viewed a properly defined relevant market as a necessary element of a Section 7 claim. *See, e.g.*, S. Rep. 81-1775, at 5 (1950).

Even in the Sherman Act context, the Seventh Circuit has explained that direct proof of anticompetitive effects "is virtually meaningless if it is entirely unmoored from at least a rough definition of a product and geographic market." *Republic Tobacco Co. v. North Atlantic Trading Co.*, 381 F.3d 717, 737 (7th Cir. 2004). And the *Republic* court noted that two of the cases relied on by Complaint Counsel, *Indiana Federation of Dentists* and *Toys "R" Us, Inc.*, do not support a plaintiff's ability to dispense with market definition.[27] *Id.* Complaint Counsel's effort to distinguish *Republic* as a vertical (rather than horizontal) restraint case is misguided because the Seventh Circuit's analysis did not rest on that distinction. Accordingly, nothing in the Sherman Act cases excuses

[27] The other Sherman Act cases cited by Complaint Counsel are similarly inapposite. In *Todd v. Exxon Corp.*, the plaintiff had both defined a relevant market and established the defendant's market share; the court merely held that direct effects are one way of showing anticompetitive effects *within a relevant market,* not that a plaintiff may eschew market definition entirely. 275 F.3d 191, 199, 206-07 (2d Cir. 2001). Similarly, in *Re/Max Int'l, Inc. v. Realty One, Inc.*, the 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. 173 F.3d 995, 1018 (6th Cir. 1999). Similarly, *Rebel Oil Co. v. Atl. Richfield Co.*, made clear that in a Section 1 case, market power may be proven "directly" by showing restricted output and supracompetitive prices. 51 F.3d 1421, 1434 (9th Cir. 1995). Again, Complaint Counsel has proven neither here. *Supra* section I.C.

Complaint Counsel from its statutory obligation—confirmed by a half century of precedent—to allege and prove a relevant market in a Section 7 case.

III. COMPLAINT COUNSEL HAS NOT OVERCOME RESPONDENT'S SHOWING THAT THE MERGER PRODUCED SIGNIFICANT COMPETITIVE BENEFITS THAT OUTWEIGH ANY COMPETITIVE RISKS.

Having failed to show that the merger lessened competition, Complaint Counsel also has failed to undermine Respondent's showing that the merger produced substantial competitive benefits by making HPH financially stronger than before the merger and by enhancing quality, particularly at the HPH campus.

A. Complaint Counsel Has Not Undermined Respondent's Showing That The Merger Increased HPH's Financial Strength And Made It A More Potent Competitor.

Complaint Counsel's cursory treatment of HPH's pre-merger financial condition creates a fictional story of a hospital that was "ready, willing and able to compete" in the Chicago market. CCAB69. But HPH's financial records, and witnesses (including its financial consultant) with first-hand knowledge of HPH's finances, confirm that HPH was in serious financial decline before the merger, and that its pre-merger financial projections and plans were pie-in-the-sky hopes that it could never have realized on its own. RAB64-68.

In urging a contrary conclusion, Complaint Counsel relies principally on anecdotal and speculative testimony along with rosy strategic plans and proposed budgets from a two-month period (March-April 1999) when management was seeking a merger partner. CCAB58-59. Yet Complaint Counsel ignores contemporaneous financial

evidence of HPH's "significant operating shortfalls relative to budget reflected in the June and preliminary July 1999 income statements." RFF2330; RX592A at ENHRS880; Spaeth, Tr. 2305. It also ignores the September 15, 1999, merger due diligence report prepared by Evanston's independent auditors, Ernst & Young, which found that HPH had a negative net margin for the first six months of 1999 that was approximately $4.7 million lower than what HPH had budgeted for that period. RFF2329; RX609 at EY19; H. Jones, Tr. 4121-22. Complaint Counsel also disregards the final pre-merger financial report from HPH's internal Finance Committee on December 2, 1999, which showed that the hospital simply could not meet its earlier plans and budgets because the "Hospital's operating margin for the 10 months ended October 31, 1999 was [negative] ($5,050,000) which is 455.6% unfavorable to budget." RFF2334; RX2013 at ENHRS6102; *see also* RFF2335; RX2013 at ENHRS6097; Spaeth, Tr. 2306-07. This is why, in December 1999, HPH's CEO told his board that HPH did not have a "rosy" financial future absent the merger—hardly the "sanguine [financial] outlook" that Complaint Counsel claims. CCAB58; RFF2334; Spaeth, Tr. 2307-8; *see also* RAB64-68.

Nor is there any basis for Complaint Counsel's assertion that HPH's cash-on-hand demonstrated that its "financial condition was impressive." CCAB59. Despite good intentions, HPH was unable to satisfy its basic financial needs, let alone pay for necessary expansion and improvement. RAB64-65,67. As Respondent showed in its opening brief, based on HPH's actual financials, the hospital had insufficient capital to cover its operating losses and service its debt if it made even minimal quality

improvement investments. RAB67. Complaint Counsel does not dispute this simple arithmetic. RAB67.

In sum, when one looks at all the evidence, not just speculative plans discussed in the two-month period highlighted by Complaint Counsel, it is clear that HPH's financial "downward spiral" was quickly making HPH competitively insignificant in the Chicago hospital market. *See* H. Jones, Tr. 4157; RFF46. Merging with Evanston not only reversed this downward trend, but made HPH a stronger competitor. *See United States v. Syufy Enters.*, 903 F.2d 659, 673, n.24 (9th Cir. 1990)(finding that "[i]n a competitive market...the ability to buy out competitors who are merely ailing may well promote market efficiency, enhance consumer welfare and foster competition"). As the people of Highland Park aptly put it: "Prior to the merger, Highland Park Hospital was a community hospital that provided only a basic set of general primary and secondary services, lacked the financial resources and patient volume to provide more complex services, and faced a number of administrative problems. Today, the hospital has an academic affiliation and provides several tertiary-level services at state-of-the-art facilities. These improvements would not have occurred if not for the merger and the dedication and investment in the community made by ENH." City of Highland Park's *Amicus* Br. at 1 (Dec. 16, 2005).

B. Complaint Counsel Has Not Undermined Respondent's Showing That The Merger Produced Significant, Verified Quality Improvements.

Nor has Complaint Counsel rebutted Respondent's showing, confirmed by that same *amicus* brief, that through an investment of more than $120 million and

countless hours of management effort, the merger produced significant, verified quality improvements, particularly at HPH. RAB3-4,68-81. Complaint Counsel dismisses this evidence on three grounds. First, Complaint Counsel attempts to shift the burden of proof, claiming that "*ENH* . . . must demonstrate that the benefits of the merger outweigh the merger's anticompetitive effects." CCAB66 (emphasis added). Second, relying upon Dr. Romano's discredited testimony, Complaint Counsel argues that HPH's quality improvements cannot be verified. Finally, Complaint Counsel speculates that HPH would have provided the same quality of care as it does today without the merger and, therefore, suggests that the Commission ignore the verified improvements on the grounds that they were not "merger-specific." CCAB53. None of these arguments has merit.

1. Complaint Counsel Improperly Attempts To Shift *Its* Burden Of Proving That The Merger Was Anticompetitive Under The "Totality Of The Circumstances."

As to the burden of proof, Complaint Counsel concedes that "quality improvements can justify an otherwise anticompetitive merger" under certain circumstances (CCAB52), and does not dispute that verified quality improvements in this case should be analyzed as procompetitive effects of the merger. RAB70; RB69-71; CCAB52-53. However, relying upon a line of cases dealing with speculative "efficiencies" from proposed mergers, Complaint Counsel erroneously asserts that Respondent has the burden of proving that the merger's quality benefits outweigh any anticompetitive effects. CCAB52-53; *see also* RB68-71. Ironically, having argued that evidence of post-merger price changes should be presumed attributable to the merger

unless Respondent proves otherwise, it now argues that quality improvements should *not* be presumed attributable to the merger unless Respondent proves they were.

This "heads we win, tails you lose" approach to merger enforcement cannot be squared with *Baker Hughes*, which rejected the government's attempt to impose a heightened burden on a merger defendant. *See Baker Hughes, Inc.*, 908 F.2d at 983; *see also* RAB76-77. Enhanced quality, quite aside from its role as a potential efficiency defense, is a cognizable procompetitive effect that must be considered in a Section 7 merger analysis because quality improvements are a substantial benefit to consumers and, ultimately, reflect a form of improved competition. RFF325-26; *Tenet Health Care Corp.*, 186 F.3d at 1054; *see also* RAB70-71.[28] RB68-71; RAB70, n.18. Economists retained by both Respondent and Complaint Counsel agreed that quality is one of the dimensions on which hospitals compete. RFF325-26,523(g). Accordingly, proof of ENH's post-merger quality improvements must be considered when weighing competitive effects under the burden-shifting paradigm established in previous merger cases. *See Tenet Health Care Corp.*, 186 F.3d at 1054; *Arch Coal, Inc.*, 329 F. Supp. 2d at 151; *see also Baker Hughes*, 908 F.2d at 985-86.[29] And unlike an efficiency defense,

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[28] For that reason, contrary to Complaint Counsel's repeated assertions (e.g., CCAB51-56), the Commission's review of quality in this case is not governed by section 4 of the *Guidelines*, which deals only with "efficiencies" defenses. And even where quality improvements are treated as "efficiencies," the defendant can use post-merger quality improvements to rebut the government's *prima facie* case. *See In re Adventist Health Sys./West*, 117 F.T.C. 224, 311-14 (1994)(concurring opinion of Commissioners Owen and Yao); *Butterworth Health Corp.*, 946 F. Supp. 1285, 1300-01 (W.D. Mich. 1996); *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 146-47.

[29] Complaint Counsel's reliance on *National Society of Professional Engineers* and *Indiana Federation of Dentists* is misplaced. CCAB52. The "quality" defenses raised in those Sherman §1 cases involved attempts to justify agreements among competitors restricting the flow of information to purchasers and were based on the faulty presumption that consumer choices in a

such competitive effects are *not* something on which the merging parties have the burden of proof, much less something that must be proven by quantifying the "dollar value to consumer welfare." CCAB54.

Accordingly, because Respondent has met its burden of *production* on this issue, the ultimate burden of *persuasion* shifts back to Complaint Counsel to show that the merger will, on balance, harm competition. *Baker Hughes*, 908 F.2d at 983. Complaint Counsel, however, has not satisfied its burden to show that the merger was anticompetitive under the "totality of the circumstances," *Baker Hughes*, 908 F.2d at 983-84, which must include, as we now show, the significant quality benefits brought to the Highland Park community after the merger. *See* American Hospital Association ("AHA") *Amicus* Br. at 30 (Dec. 16, 2005)(Complaint Counsel did not meet its burden of showing that the price increases were anticompetitive because it did not adjust prices for quality improvements).

2. Complaint Counsel Failed To Rebut Respondent's Showing Of Substantial And Verified Quality Improvements After The Merger.

To demonstrate the "significant" and "verified" quality improvements found by the ALJ in 16 clinical areas at HPH, Respondent presented testimony from 13

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competitive market were unwise or dangerous. *Nat'l Soc. of Prof'l Eng'rs v. United States*, 435 U.S. 679, 696 (1978); *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447, 463-64 (1986). The direct "benefits" involved in those cases accrued to the conspirators and did not enhance consumer welfare. Similarly, in *Rockford,* the district court was concerned with speculative efficiencies in a proposed merger. *United States v. Rockford,* 717 F. Supp. 1251, 1288-89 (N.D. Ill. 1989). The quality improvements in this case, however, directly enhance consumer welfare and improve competition. *See, e.g.*, *United States v. Carilion Health Sys.*, 707 F. Supp. 840, 846 (W.D. Va. 1989)(finding, *inter alia*, that the hospital merger would improve the quality of healthcare and strengthen competition).

clinical fact witnesses, a quality expert, and an economist, as well as numerous documents, all confirming ENH's quality enhancements to HPH after the merger. ID177-78; RAB68-84. Complaint Counsel attempts to escape this mountain of evidence by suggesting that such improvements do not count unless they can be measured by a narrow set of indicators based entirely on "administrative" data collected for billing purposes.[30] But that unduly narrow approach is not valid from either a legal or a clinical perspective.

a. Complaint Counsel's Narrow View Of How To Measure Quality Has No Basis in Law.

Consistent with case law (cited above) recognizing that quality improvements are procompetitive benefits, Respondent introduced evidence directed at three measures of quality that are widely employed by healthcare organizations and state governing bodies: structural improvements (e.g., facilities and staffing), processes of care (e.g., prescribing medication), and outcomes (e.g., mortality). RFF1171-74. Applying these well-established criteria, Respondent demonstrated substantial

[30] These quality improvements are also relevant to the pricing analysis. Because ENH improved quality after the merger, the observed post-merger price increases overstate the true quality-adjusted prices. Since the rate of these improvements exceeded those at similar hospitals, the relative price increases at HPH are also overstated. RFF1156,1158,1161; *see also* RB47.

Complaint Counsel attempts to discredit this conclusion by claiming that ENH neither "advertised" nor "informed" MCOs of those improvements. CCAB13. The evidence refutes this allegation. For example, when the merger was announced, the parties widely distributed press releases to area employers, elected officials, MCOs and the press describing the goals of the merger, including the parties' determination to increase quality at HPH. RFF259,268; RX563 at ENHTH1568-76; RX564; Hillebrand, Tr. 1857-58. Because the evidence demonstrated that MCOs do not track nor even acknowledge quality of care improvements, and because the members of the Highland Park community were clearly aware of the planned improvements, Complaint Counsel's claim that MCOs were unaware is not only questionable but also irrelevant. *See* City of Highland Park's *Amicus* Br. at 3 (Dec. 16, 2005); Ballengee, Tr. 201-03; Neary, Tr. 639-40.

improvements in physician staffing, access to high-quality physicians through an academic affiliation with Evanston, improved managerial structure, significant upgrades to HPH's patient facilities, and acquisitions of state-of-the-art diagnostic and therapeutic equipment. RFF1199,1610,1621-22.

According to Complaint Counsel, however, only a narrow set of factors—specifically, patient satisfaction surveys and outcomes estimated using administrative data—are relevant. CCAB61-63. But as the evidence showed, such "outcome" measures have a number of limitations that can make them highly misleading. Some outcomes occur too rarely or may be manifested too long after the care is delivered to be useful in assessing quality of care. RFF1180,1334-37. Other outcomes may be influenced by factors, such as preexisting medical conditions, that are independent of the care provided. For these and other reasons, outcomes must be reliably risk-adjusted, which requires detailed clinical data. RFF1179-83.

Given these inherent weaknesses in using outcomes to measure changes in hospital quality, the Commission has looked to structural and process-oriented measures such as the ability to attract highly qualified management, physicians, specialists and nurses, as well as the ability to purchase necessary equipment. *Adventist Health Sys./West*, 117 F.T.C. at 314 (concurring opinion of Commissioners Owen and Yao). Courts have also recognized these and other quality enhancements, such as integrated delivery and tertiary care, *Tenet Health Care Corp.*, 186 F.3d at 1054, and upgrading existing hospital facilities. *Butterworth Health Corp.*, 946 F. Supp. at 1301.

Respondent's method of showing quality improvements is consistent with this precedent. RFF1199,1226-32.[31] Indeed, the evidence in this post-consummation case is much stronger than the evidence presented in the cases described above, almost all of which involved mere *plans* of *future* quality improvements from mergers that had yet to be consummated. *See, e.g., Tenet Health Care Corp.*, 186 F.3d at 1048 (plan to employ more specialists); *Carilion Health Sys.*, 707 F. Supp. at 845 (plan to consolidate services). By contrast, the record here demonstrates *actual* quality improvements that have been implemented continually from the date of the merger in 2000 through today. ID177; RAB72-73; RFF1228-30. Accordingly, unlike the typical pre-consummation case, the Commission need not speculate as to if, when, or how quickly post-merger quality improvements were implemented at HPH. This is why the ALJ correctly found that ENH demonstrated "that significant improvements have been made to Highland Park and that those improvements can be verified." ID177.

b. Complaint Counsel Offered No Credible, Objective Clinical Assessment Of Quality Changes at HPH.

Regardless of the pertinent legal standard, Complaint Counsel's evidence is flawed from a clinical perspective, is replete with factual inaccuracies, and omits undisputed evidence that HPH's quality improved in the wake of the merger.[32] RAB72;

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[31] Complaint Counsel's heavy reliance on outcome measures fails to recognize that a structural improvement, such as replacing a broken cardiac defibrillator in an emergency room, is a quality improvement. RFF1195. Respondent demonstrated numerous structural quality improvements that would not necessarily be reflected in outcome data—including, among other things, enhanced physician staffing and the deployment of Epic. RFF1172,1192,1195,1292,1333,2004.

[32] Complaint Counsel erroneously relies on HPH's Joint Commission on Accreditation of Healthcare Organizations ("JCAHO" or "Joint Commission") accreditation score in an effort to discredit HPH's post-merger improvements. CCAB64. Joint Commission scores, however,

RFF1483-1504,1622. First, Complaint Counsel asserts that its quality expert—Dr. Patrick Romano—conducted the only "comprehensive" analysis of quality at ENH. CCAB61. This is false. Dr. Romano's conclusions were predicated almost exclusively on narrow outcome indicators utilizing unreliable administrative data that lacked clinical validity, and most failed to reach the minimum threshold of statistical significance. RFF1203-04,1209,2219,2245,2247. Complaint Counsel's characterization of his analysis as "comprehensive" is ironic in light of Dr. Romano's admission that a comprehensive analysis would have required him to conduct staff interviews and an on-site tour of ENH's facilities. RFF1203,2219. Unlike Respondent's expert, Dr. Chassin, who conducted two site visits and formally interviewed 34 key physicians, nurses and administrative leaders (RFF1204-05), Dr. Romano conducted no such inquiries. Dr. Romano's superficial analysis, moreover, ignored the substantial improvements in the structure and processes of care at HPH. RB78-79; RFF1228-30,1276-78,1444,1516, 1688-90,1891-95,1922,1955-63. Such narrow approaches to analyzing quality have been previously rejected, and should be rejected here. *See Butterworth Health Corp.*, 946 F. Supp. at 1300-01 (recognizing the "striking disparity in quality between the comprehensive studies done by defendants' experts [including site visits and interviews], and the FTC's expert's critical analysis.").

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established only a *minimum level* needed to maintain HPH's eligibility for Medicare reimbursement. ID181; RB85; RRB92, n.31; RFF1519-25,1530-35; RFF-Reply2128,2301,2319. The Joint Commission itself, as *amicus*, clarified that its grid scores cited by the ALJ and Complaint Counsel are not an appropriate method for evaluating changes in HPH's quality over time. *See* JCAHO *Amicus* Br. at 4 (Dec. 16, 2005); *see also* AHA *Amicus* Br. at 27 (Dec. 16, 2005)(noting JCAHO scores would not reflect a variety of innovative improvements in quality).

Second, the methods and data that Dr. Romano employed make his opinions facially suspect. For example, Dr. Romano relied disproportionately on administrative data that contained few valid measures of quality of care. RFF2221-22,2225-26,2238-44; *see also* RB81-82. Indeed, Dr. Romano conceded that the administrative data he used suffered from numerous deficiencies that limited its utility in measuring quality. Romano, Tr. 3258-74; RFF2229,2232-36; RFF-Reply2117. Moreover, a majority of the outcome indicators relied on by Dr. Romano were created by the Agency for Healthcare Research and Quality ("AHRQ") and lack validity as measures of quality because there is no evidence that they are related to a process or structure of hospital care. RFF1189-90,2230-31,2245-46; RFF-Reply2058,2105-06; RB102-03. Dr. Romano's reliance on these administrative data was improper because they were designed as a first-round quality screen, not as definitive measures, a fact candidly recognized by AHRQ. RFF2223,2246; RX2004 at 29; *see also* RFF-Reply2105.[33]

Finally, no valid conclusions can be drawn from Complaint Counsel's use of patient satisfaction surveys because of significant methodological weaknesses in the available data and how they are collected. RFF2249,2256-61,2267,2272-77; RFF-Reply2134; RB84-85. For example, the ALJ properly found that the surveys have only a 20% response rate, which makes it impossible to draw reliable conclusions from them. IDF867-68; ID181; RFF2256-61.

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[33] ENH has received several quality awards (Top 100 Hospitals) from independent organizations that base their rankings in part on AHRQ data. RFF 2189-93 The fact that ENH has been named a Top 100 hospital for over 10 years running further undermines Dr. Romano's findings. RFF3.

c. There Is No Evidence Of A Decline In Quality At Evanston And Glenbrook After The Merger.

Complaint Counsel also argues that quality of care at Evanston "actually declined" after the merger, but this argument has no basis in the record. CCAB61, n.67, 65. First, Dr. Romano's observation about quality changes at Evanston was based, in part, on one **(REDACTED)** the results of which were contradicted by another, superior measure. RFF-Reply2061-62. Moreover, even if there was a temporary decline in some heart attack care process measures at Evanston, it was unrelated to the merger and quickly returned to its pre-merger levels. RFF-Reply2058.

Second, Dr. Romano did not offer an opinion that any such decline was linked to the merger. He merely offered a "hypothesis" about a diversion in resources from Evanston to HPH and failed to offer any credible evidence in support of this hypothesis. RFF1506,2204; RFF-Reply2067. Third, Complaint Counsel places undue reliance on the testimony of Ms. Holt-Darcy of Unicare, who admitted that she had no basis to assess quality. CCAB65; Holt-Darcy, Tr. 1590-93, *in camera*. And, Dr. Chassin, after conducting a comprehensive quality assessment, found no independent evidence of declines in quality of care at Evanston as a result of the merger. RFF1198,2203.

Finally, even if quality did decline in isolated areas (which it did not), any such reductions were at best *de minimus* and thus do not undermine the overall weight of the post-merger quality improvements. For example, the evidence established that

(REDACTED)

RFF1483-1504; RFF-Reply 2064.

This directly disproves Complaint Counsel's false suggestion that Evanston's performance in the use of heart-attack medication deteriorated after the merger. CCAB65.

3. The Evidence Demonstrates That ENH's Substantial and Verified Quality Improvements at HPH Were Merger-Specific.

Nor is there any basis for Complaint Counsel's speculation that the extensive quality improvements, which the ALJ found were both "substantial" and "verified," would have occurred without the merger. CCAB60, n.66; ID177-78. Although some improvements took years of advance planning, other drastic quality enhancements—such as improvements in physician discipline, nursing, governance, obstetrics, clinical pathways and heart surgery—were made quickly and efficiently. *See* RAB12-16,68-81; *see also* RFF1389,1393,1395-96,1478,1558,1565. ENH also invested more than $120 million in HPH and has committed another $45 million. ID178; RFF1518. Given Respondent's evidence showing substantial quality improvements at HPH following the merger, the burden has shifted to Complaint Counsel under *Baker Hughes* to *disprove* merger specificity by showing that HPH would have made these same quality improvements as fast and as well without the merger. RAB76-77; *Baker Hughes*, 908 F.2d at 983; *see also Merger Guidelines* §4. As demonstrated below, Complaint Counsel has not, and cannot, meet this burden.

a. HPH Strategic Plans Were Unreliable And Speculative.

Complaint Counsel's view of HPH as a high-quality, financially robust institution is belied by the evidence that HPH was financially unable (*see* section III.A., *supra*) and otherwise unwilling to address substantial quality problems in key clinical areas as a stand-alone hospital. RFF1226-27,1249-55. Pre-merger HPH suffered from critical deficiencies in obstetrics, physical plant and facilities, physician staffing, quality assurance, medical staff relationships, and nursing skills. RFF1252-55,1338-40,1795,1872,1878-82,1911-19,2376. Documentary evidence from independent third parties such as the American College of Obstetricians and Gynecologists ("ACOG"), Chicago Risk Pooling Project ("CHRPP"), and IDPH, confirm these deficiencies. RFF1239,1252-55,1266-68,1526-28. Even putting aside HPH's financial woes, the evidence shows that HPH's management had no track record of implementing even simple quality improvements that could have saved patient's lives,

(REDACTED)

(RFF1482-1504, *in camera*), much less taking appropriate disciplinary action against problematic physicians. RFF1271-73,1416. Complaint Counsel's blanket assertion that HPH's quality of care was "very good" pre-merger (CCAB56) thus ignores uncontroverted evidence that these pre-merger quality problems created unnecessary risks to patient safety. RFF1233,1249-50,1296-97,1420-28,1539.

The evidence demonstrated, moreover, that re-investment in the physical plant, clinical integration with an advanced teaching institution, and a wholesale change in clinical culture and management structure were necessary to achieve these

improvements. RFF272-84,1228,1230,2453-58. There is no reliable evidence that pre-merger HPH was able or willing to take these steps.

Complaint Counsel's contrary position is based on the anecdotal and unsubstantiated testimony of one witness—HPH's former VP of business development, Mark Newton. CCAB56. But Mr. Newton had no responsibility for the quality of HPH's clinical services. RFF310. And his testimony is unreliable given that, at the time he testified, he was the CEO of an ENH competitor, Swedish Covenant Hospital, with an obvious interest in challenging a merger that makes ENH a stronger competitor. RFF310; Newton, Tr. 434.

b. Any Suggestion That HPH Could Have Risen To Its Present Quality Level Through Joint Ventures Is Wholly Speculative.

Complaint Counsel also speculates that HPH could have used joint ventures to remedy its safety issues and improve its quality to HPH's current level. CCAB60. But that unsupported assertion flies in the face of the evidence. Witnesses testified repeatedly that HPH's pre-merger joint ventures were unsuccessful and, in fact, hospital joint ventures have typically failed. RFF1636-42,1793-95,2461-69. Moreover, HPH never had a pre-merger joint venture with respect to oncology and, therefore, Complaint Counsel's speculation about possible oncology partnerships with HPH is misguided and should be afforded no weight.

Contrary to Complaint Counsel's assertion (CCAB60), there is reason to doubt that the Illinois Health Facilities Planning Board would have approved a cardiac surgery program at HPH absent the merger. Although the parties had been in contact

with the Board throughout much of 1999, it did not issue a Certificate of Need for the program until November, a month after the merger agreement was executed. CX501 at 16; Newton, Tr. 423. Moreover, HPH's own projected cardiac surgery volumes as a stand-alone program were low, and HPH suffered from clinical deficiencies that rendered it unprepared to undertake such a program absent the merger. Rosengart, Tr. 4521; RFF1582.

Complaint Counsel's speculation on this point should be disregarded for another reason as well: the uncontested evidence showed that ENH's fully integrated cardiac surgery program at HPH is higher quality (**(REDACTED)**) than the ENH joint programs operating through affiliation or joint venture at Weiss Memorial Hospital and Swedish Covenant Hospital. RFF1643,2460-62. This is because of ENH's lack of control over all aspects of care at the joint venture partner hospitals. RFF1601-02,1629,2460-62. ENH's own post-merger experiences with joint ventures thus shows that the merger itself was essential to achieving the high-quality cardiac surgery program at HPH. RFF1636-42,1645.

Finally, there is no reason to speculate about what HPH could have potentially done by joint venture in light of the actual evidence of the merger's benefits. As former Chairman Muris instructed:

> There is no reason to weigh equally the merger's actual benefits with the potential benefits of a joint venture that never occurred. Any number of factors—the possibility that the joint venture would not have occurred, that it would have failed before achieving any benefits, or that the benefits would have taken longer to achieve—render the benefits in the hypothesized "but for" world more conjectural.

In re Genzyme Corp., No. 021 0026 at 18 (Jan. 13, 2004) (Statement of Chairman Timothy J. Muris).

c. The Record Demonstrates That HPH Improved Much Faster Than Its Peers After The Merger.

Complaint Counsel further speculates that HPH would have been swept into a purported "national movement" to improve healthcare quality absent the merger. CCAB57-58. But Complaint Counsel's speculation regarding a "nationwide trend" was predicated on a single study of quality that was misread by Complaint Counsel's quality expert and never received into evidence. RAB80, n.23; IDF859; *see also* RB93-95.

Moreover, Complaint Counsel's evidence for the idea that ENH was merely following a trend toward improved quality focuses almost exclusively on physician testimony related to the intensivist program. CCAB58. However, implementation of the intensivist program at HPH is actually evidence that ENH was ahead of any purported trend and that HPH patients benefited as a result. Evanston had an intensivist program at least three years before the merger; HPH did not. RFF1677,1686. Yet today, HPH is one of only six hospitals in Illinois (three of which are the ENH hospitals) that the Leapfrog Group recognizes as having an intensivist program. RFF1721. Similarly, electronic medical record systems such as Epic remain rare in community hospitals, five years after the Leapfrog Group's recommendations. RFF2473-75.[34]

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[34] Advanced electronic medical record systems ("EMRs") produce significant benefits in both patient safety and efficiency and, if widely adopted, are estimated to save billions of dollars annually. Richard Hillestad, et al., *Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs*, 24 HEALTH AFFAIRS 1103, 1107-1116 (2005).

Accordingly, Complaint Counsel's unsupported speculation about an ill-defined national trend is entitled to no weight in light of actual evidence that HPH attained improvements faster and more efficiently than it would have without the merger.

IV. COMPLAINT COUNSEL HAS NOT MET ITS BURDEN OF JUSTIFYING THE EXTREME REMEDY OF DIVESTITURE, MUCH LESS ITS PROPOSED ANCILLARY RELIEF.

Even assuming liability, Complaint Counsel has failed to meet its burden of justifying divestiture, much less the draconian "ancillary" relief for which it argues in its cross-appeal. As Respondent thoroughly demonstrated in its opening brief, this case is a classic illustration of Judge Posner's recent observation that "[s]tructural remedies such as divestiture are . . . slow, costly, frequently ineffectual, and sometimes anticompetitive." Posner, ANTITRUST LAW at 268. Ignoring such concerns, Complaint Counsel urges the Commission to break up an extremely successful integrated hospital system *more than six years after the system was created*, with no analysis showing that such a radical measure is "designed to protect the public interest." *United States v. E.I. du Pont de Nemours,* 366 U.S. 316, 326 (1961). Indeed, Complaint Counsel offers nothing to show that the divestiture remedy it seeks—including punitive ancillary relief—is justified under governing equitable principles, particularly in light of available alternatives (including the substantial relief to which ENH has already agreed) and the deleterious effects the proposed additional relief would have on quality and consumer welfare.

A. Complaint Counsel Has Failed To Show That Any Anticompetitive Effects Cannot Be Remedied Through Less Intrusive Alternative Remedies, Including The Remedy To Which ENH Has Already Agreed.

Complaint Counsel's argument for divestiture is misguided for at least three reasons.

First, it rests upon a misunderstanding of the pertinent legal standard. Complaint Counsel's bald assertion that its "choice of remedy prevails," without any need for record support and careful analysis, is wrong as a matter of law. CCAB75. Although the Supreme Court in the context of a stock acquisition noted in *du Pont* that "doubts as to the remedy" should be resolved in favor of the Government after it proves a violation, that principle operates only in the context of a fact-specific analysis of market realities and the perceived violation. *E.I. du Pont de Nemours*, 366 U.S. at 334. Indeed, *du Pont* makes clear that "[t]he key to the whole question of an antitrust remedy is...the discovery of measures effective to restore competition," and the Commission has a duty to scrutinize any proposed remedy to ensure that it would vindicate (and not undermine) the purposes of the statute. *Id.* at 326. Moreover, any such remedy must accomplish this end "with as little injury as possible to the interest of the general public." *Id.* at 327-28 (citations omitted). However effective a proposed remedy might be to redress a Section 7 violation, "[c]ourts are not authorized in civil proceedings to punish antitrust violators, and relief must not be punitive." *Id.* at 326. Thus, far from giving Complaint Counsel *carte blanche* to name its remedy, the Court has noted that "[t]he court or agency charged with [the] choice of remedy has a heavy responsibility to *tailor the remedy to the*

particular facts of each case so as to best effectuate the remedial objectives." *Gilbertville Trucking Co. v. United States*, 371 U.S. 115, 130 (1962)(emphasis added).

Nor is it true, as Complaint Counsel asserts, that divestiture is the automatic, or even "the preferred remedy" for a Section 7 violation. CCAB79, n.92. Complaint Counsel has no response to the controlling authority to the contrary cited in ENH's opening brief. RAB84-86. *See E.I. du Pont de Nemours*, 366 U.S. at 328, n.9 (rejecting argument that divestiture is required whenever Section 7 is violated); *In the Matter of Retail Credit Co.*, 92 FTC 1, 1978 FTC LEXIS 246, at *259 (July 7, 1978) ("[D]ivestiture is [not] an automatic sanction, mechanically invoked in merger cases.").[35] Although *du Pont* states that the government will not be denied divestiture solely because such a remedy will result in economic hardship, it also makes clear that a necessary predicate for divestiture is that "other measures will not be effective to redress a violation." *E.I. du Pont de Nemours,* 366 U.S. at 327. Under this precedent, divestiture is more a last resort than a "preferred" remedy.

Instead, the critical issue in fashioning antitrust remedies is the public interest. *See id.* at 326. And here again, Complaint Counsel ignores the substantial policy reasons that require restraint in the imposition of divestiture orders. For example,

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[35] *See also In the Matter of Ekco Prods. Co.*, 65 FTC 1163, 1964 FTC LEXIS 115, at *126-27 (June 30, 1964) (divestiture may be "impracticable or inadequate, or impose unjustifiable hardship—which underscores the importance of the Commission's having a range of alternatives in its arsenal of remedies"); *FTC v. Staples, Inc.* 970 F. Supp. 1066, 1091 (D.D.C. 1997) (often "'[u]nscrambling the eggs' after the fact is not a realistic option"). As Chairman Majoras has noted, both the FTC and DOJ "today strive for flexibility, above all, in crafting merger remedies in particular transactions." Deborah Platt Majoras, Chairman, Fed. Trade Comm'n, ABA Antitrust Section Fall Forum at 7 (Nov. 18, 2004).

when Congress passed the H.S.R. Act, it specifically noted that "[u]nscrambling the merger, and restoring the acquired firm to its former status as an independent competitor is difficult at best, and frequently impossible." H.R. Rep. No. 94-1373, at 8 (1976). Recognizing the extraordinary disruption caused by divestiture, courts have cautioned that this remedy should *not* be ordered without "convincing reasons why that remedy is necessary to prevent the continued violations of the antitrust laws." *Switzer Bros., Inc., v. Locklin*, 297 F.2d 39, 49 (7th Cir. 1961); *see also Timken Roller Bearing Co. v. United States*, 341 U.S. 593, 601-05 (1951)(Reed, J., concurring)(divestiture is "not to be used indiscriminately" where "less harsh" methods are available); *United States v. Microsoft Corp.*, 253 F.3d 34, 107 (D.D.C. 2001)("structural relief" such as divestiture requires "a clearer indication of a significant causal connection between the conduct and creation or maintenance of the market power" than is required to support a less disruptive remedy); Posner, ANTITRUST LAW at 268. As these authorities demonstrate, it cannot be presumed that divestiture automatically serves the public interest.

Complaint Counsel also errs in arguing that divestiture is automatic unless ENH proves by clear and convincing evidence that it is not the appropriate remedy. CCAB76. Here again, Complaint Counsel has not cited a single decision from the Supreme Court or the Seventh Circuit suggesting that the burden shifts to the defendant to *disprove* the propriety of divestiture by clear and convincing evidence.[36] Thus, before

[36] In *du Pont*, the government challenged du Pont's acquisition of only a portion of GM's voting securities. 366 U.S. at 318. Divestiture created no difficulties in that case because, unlike here, the assets of du Pont and GM had not been commingled. Nor do the decisions of the Commission support Complaint Counsel's arguments. In *Freuhauf*, the Commission addressed

divestiture is be ordered in this case, Complaint Counsel should have demonstrated that such relief vindicates the public interest, promotes competition, and is not punitive. *See E. I. du Pont de Nemours*, 366 U.S. at 326-27. As Respondent showed in its opening brief, the evidence here overwhelmingly points *against* divestiture, and Complaint Counsel has failed to rebut that evidence.

Second, Complaint Counsel gives short shrift to the non-structural remedies proposed by Respondent. *See* CCAB79-80. As one commentator has noted, "[n]on-structural remedies often are more appropriate to cure competitive problems because such relief does not disrupt a merger's efficiencies and benefits to the parties and to the consumers." Scott A. Sher, *Closed But Not Forgotten: Government Review of Consummated Mergers Under Section 7 of the Clayton Act*, 45 Santa Clara L. Rev. 41, 91-92 (2004). Moreover, the essence of equity jurisdiction is the tribunal's ability "to mould each decree to the necessities of the particular case." *Hecht Co. v. Bowles*, 321 U.S. 321, 329 (1944).

Here, assuming liability, Respondent's proposals easily fit "the necessities of th[is] particular case," especially when one considers the rapidly changing hospital landscape in Chicago. RFF2280-82,2289-97; *see* Posner, ANTITRUST LAW at 111 ("Often by the time a divestiture decree is entered or can be carried out, the industry has so changed as to make such a decree an irrelevance"). That is certainly true, for example,

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only whether an "arbitrarily created sub-entity, with no prior market history" would be preferable to divestiture. *In re Freuhauf*, 90 F.T.C. 891, 892, n.1 (1977). And the Commission has never subsequently cited the "clear and convincing" dictum from *Diamond Akili Corp.*, 72 F.T.C. 740, No. 8572 (Oct. 2, 1967).

with respect to Respondent's suggestion that it give the Commission advance notice of any future acquisitions. Such a requirement would ensure that any future acquisitions that ENH may pursue would be reviewed by Commission staff prior to consummation. Such a remedy would not interfere with the present competitive market conditions or destroy the quality improvements that now benefit consumers.

The same is true of Respondent's suggestion that a narrow conduct remedy could be crafted requiring Evanston and HPH to maintain and negotiate separate contracts, not to make one contract contingent on the other, and to have separate negotiators. This practice is already employed by other Chicago hospital systems and has proven workable. RFF189. To the extent the Commission feels this system would not create sufficient "independence" between the two hospitals, that issue could be addressed by requiring a firewall that would prohibit exchange of any confidential pricing or negotiating information.[37] In many other cases, both the Commission and the Antitrust Division have accepted firewalls as a viable alternative to divestiture. *See, e.g., In re The Boeing Co.*, 2000 FTC LEXIS 178, Dkt. No. C-3992 (Dec. 29, 2000); *In re Merck & Co., Inc*, 1999 FTC LEXIS 18, Dkt No. C-3853 (Feb. 18, 1999); *United States v. Lehman Bros. Holdings, Inc. & L-3 Communications Holdings, Inc.*, Civil No. 98 00796 Slip Op. at 5-6 (D.D.C. July 13, 1998); *In re Gen. Motors Corp.*, 1984 FTC LEXIS 68, at *30-32 (Apr. 11, 1984). Moreover, this remedy would redress any claimed anticompetitive

[37] To preserve the quality benefits of integration, ENH and HPH should be allowed to share information on revenues and costs as well as physicians, nurses, medical equipment, and quality. A firewall remedy that went beyond managed care prices and negotiating information would eliminate the value of the ENH integrated healthcare system.

concerns—by allowing an MCO to choose, if it desired, one of the ENH hospitals over another—without losing the quality improvements created by the merger.

Third, Complaint Counsel's argument ignores the fact that the Commission has *already* achieved substantial relief as a result of its complaint and the ensuing settlement of a large part of this case prior to trial. The complaint alleged that "ENH required private payers to accept its terms for both hospital and physician services or face termination of both hospital and physician contracts." Compl. ¶¶3,34. This conduct has been stopped by the consent order prohibiting joint negotiations between ENH and the ENH Medical Group. Thus, the Commission has already resolved the principal issue presented by the merger. Complaint Counsel has failed to demonstrate that additional relief is necessary.

B. ENH Showed, Supported By Several *Amici*, That Divestiture Would Be Inequitable.

Complaint Counsel has also failed to rebut Respondent's showing that divestiture at this late date would be highly inequitable. For example, as established by several physicians who worked directly in the hospitals, and by Respondent's quality expert, Dr. Chassin, a divested HPH would lose many of the benefits it has received from the merger, including electronic patient medical records, academic affiliation, clinical integration, cardiac surgery, interventional cardiology, improved physician and nursing skills, and new clinical protocols. ID205; RFF1232,2483-2532; RFF-Reply 2567,2570, 2576. These are tangible quality improvements, the loss of which would erode HPH's quality gains and, ultimately, harm consumers. The Commission should heed the

testimony of physicians who work in these hospitals every day and who understand the improvements that integration has brought to HPH and the Highland Park community as well as what would be lost if HPH were divested. Despite extensive discovery, Complaint Counsel could not find one doctor who would testify that a divested HPH would serve the community as well as the integrated HPH.

A number of HPH's clinical improvements, moreover, are closely interrelated such that the loss of one service would necessarily diminish and, in some cases, destroy related services. For example, future patients in HPH's cardiac surgery program could be at great risk if divestiture were ordered. Although Complaint Counsel claims that this risk could be ameliorated through a joint venture (CCAB60), it is uncontroverted that mortality rates and length of stay following cardiac bypass surgery are better at HPH than at the sites where ENH has joint ventures. RFF1643-44; *see supra* Section III.B.3.b. Indeed, **(REDACTED)** RFF1611. Moreover, the head of ENH's Cardiothoracic Surgery Department testified that, because of a lack of integration between ENH and the affiliated programs at Swedish Covenant Hospital and Weiss Memorial Hospital, the ENH cardiac surgery program could not extend to those hospitals its most advanced surgical techniques—techniques that are practiced at HPH—because of safety concerns. RFF1636-46.

In short, the high-quality results achieved by the HPH cardiac surgery program are dependent on integration which gives ENH full control of post-operative care and administrative decisions. RFF2463-68. HPH cannot achieve the same high-

quality results either through a joint venture or by a partnership with a more distant hospital. RFF1628-29,2462.

Further, the loss of the cardiac surgery program would mean the end of HPH's percutaneous coronary intervention ("PCI") program, which could not be sustained because elective PCIs could not be done at HPH without onsite cardiac surgical backup. RFF2498-99. The loss of the PCI program, in turn, would result in increased transfers of heart attack patients out of HPH, further endangering patient safety. RFF2506-10.

Concerns about divestiture have been voiced not only by ENH doctors, but by *amici*, including the town of Highland Park itself, the AHA, and the Business Roundtable. These *amici* represent broad segments of the public which are rightfully concerned that divestiture would harm the public interest. The Commission should consider the opinions of the doctors who work in the ENH hospitals and the public these doctors serve, before ordering the harsh remedy of divestiture. As the Commission has previously held, "due regard should be given to the preservation of ... important benefits to the consumer in the choice of an appropriate remedy." *Retail Credit Co.*, 1978 FTC LEXIS at *259.

Divestiture would also be inequitable in light of the four-year delay between the merger and the challenge. *See* CCAB75, n.84. Complaint Counsel cites only one case, *Ecko Products Co.*, 65 F.T.C. 1163 (1964)—a case decided long before the passage of the H.S.R. Act—for the proposition that the FTC can challenge a merger long after the acquisition. Given the H.S.R. review and the extraordinarily long delay

before this merger was challenged, equity dictates that Respondent should not be divested. Congress enacted the H.S.R. Act in part to prevent the need for punitive post-consummation divestitures that not only disrupt ongoing businesses but are often "detrimental to customers." *See* Sher, *supra* at 81 (citing H.R. Rep. No. 94-1373, at 11 (1976)); *see also* Easterbrook, *supra* at 3 ("[S]uits against mergers more often than not have attacked combinations that increased efficiency.")

Divestiture would be especially inequitable if the Commission adopts Complaint Counsel's novel unilateral effects theory as a basis for liability. As explained earlier, that theory would require the Commission to jettison important aspects of its unilateral effects analysis that have been settled since *Donnelley* and the adoption of the 1992 *Merger Guidelines*. To impose the drastic remedy of divestiture on the basis of a new theory like that advanced by Complaint Counsel here would be retroactive and thus inequitable. *See generally Chevron v. Huson*, 404 U.S. 97, 106-07 (1971)("Where a decision of this Court could produce substantial inequitable results if applied retroactively, there is ample basis in our cases for avoiding the 'injustice or hardship' by a holding of nonretroactivity."); *Chowaniec v. Arlington Park Race Track, Ltd.*, 934 F.2d 128, 130 (7th Cir. 1991)(same). If the Commission decides to adopt that theory in this case, it should make its ruling prospective only.

Finally, there is a significant risk that a divestiture would not be viable. As one of Complaint Counsel's own experts has explained elsewhere, in many cases "restoration to premerger status might dictate an outmoded firm with no chance of survival." Kenneth G. Elzinga, *The Antimerger Law: Pyrrhic Victories?*, 12 J. L. &

Econ. 43, 59 (1969). Complaint Counsel has presented no evidence of purchasers waiting in the wings and willing to continue ENH's commitment to improving HPH. Before the merger, HPH approached numerous hospital systems, all of which rejected a merger or partnership with HPH. RFF2312. The hospital systems in the Chicago area (Advocate, Rush, and Resurrection) that arguably have the ability to support a divested HPH each falls within the geographic market identified by the ALJ and therefore cannot be potential acquirers because the acquisition would create the same competitive problems alleged in this proceeding. ID143-46. Further, the City of Highland Park's *Amicus* Brief has expressly indicated that a not-for-profit organization with no religious affiliation is a "necessary attribute[]" of any merger partner. *See* City of Highland Park's *Amicus* Br. at 12-13 (Dec. 16, 2005); *see also* RFF2311. A Commission Order imposing a remedy that has been identified by the community as harmful would create an alarming precedent.[38]

C. Response to Cross-Appeal: Complaint Counsel's Proposed Ancillary Relief Cannot Preserve The Benefits Of The Merger, Is Unlawful In Any Event, And Tacitly Admits That The Merger Produced Substantial Quality Improvements.

Nor is there any merit to Complaint Counsel's proposed ancillary relief in this case. Any ancillary relief "must be directed to that which is *necessary and appropriate in the public interest to eliminate the effects of the acquisition offensive to*

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[38] Complaint Counsel also fails to offer any evidence that divestiture would lead to lower prices by either ENH or HPH. As one witness put it,

(REDACTED)

Baker, Tr. 4656, *in camera*.

the statute." *Ford Motor Co. v. United States,* 405 U.S. 562, 573, n.8 (1972)(emphasis added). Complaint Counsel's proposals do not meet that standard.

First, the ancillary relief that Complaint Counsel requests—imposing expensive affirmative obligations on ENH for the benefit of a divested HPH—does not address any of the effects of the acquisition purportedly offensive to the statute. HPH was an ailing hospital before the merger. RFF1249-75,1344-84,1420-41,1464-68,1512-48,1677-85,1729-49,1802-26,1872-90,2129-32; *see also* RFF2298-2413. After the merger, ENH recruited top physicians to HPH and created a state-of-the-art cardiac surgery program. RAB12-16,68-81. Complaint Counsel does not claim that these actions by ENH were anticompetitive. Thus, if divestiture were ordered, forcing ENH to maintain the state-of-the-art cardiac unit at HPH, or helping HPH recruit and retain physicians, would do nothing to remedy any purported Section 7 violation. It would simply penalize ENH, or commandeer it in the interest of social engineering (*i.e.*, forcing one hospital to subsidize another), neither of which is permitted under the antitrust laws. *See e.g.*, *E.I. du Pont De Nemours*, 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); *New York v. Microsoft Corp.*, 224 F. Supp. 2d 76, 189 (D.D.C. 2002)("The Court's role is to end the illegal conduct and to make every effort to protect against conduct of the same type or class, not to engineer a particular market outcome"); *Olympia Equip. Leasing Co. v. W. Union Tel. Co.,* 797 F.2d 370, 377-78 (7th Cir. 1986)(there is "no right under antitrust law to take a free ride on [a] competitor[]").

Second, the proposed ancillary relief will not preserve the merger's benefits. Integration is essential to HPH's quality. For instance, as described above, HPH's cardiac surgery program will work at the optimal level only under an integrated system. Prior experience with cardiac surgery programs operated by joint ventures demonstrates that such programs will not produce the same high-quality results. RFF2459-69.

Moreover, it is unlikely that any purchaser could maintain the quality levels achieved by ENH, even with the proposed ancillary relief requested. As Dr. Chassin testified, such an entity would have to be in the same general geographic proximity to HPH, with a similar full-time medical management structure, with similarly high-quality programs, with an academic affiliation, 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. RFF2459-71. None of the area hospitals that might avoid serious antitrust concerns also possesses all of these characteristics.

Nor can the same high-quality be maintained by "[g]overnment agencies and third parties, including MCOs," as Complaint Counsel contends. CCAB77-78. Government agencies are concerned only with minimum quality requirements, and even when such entities monitored or evaluated HPH prior to the merger, they found that HPH had serious quality issues that threatened patient care. RFF1249-75,1344-84,1420-41,1464-68,1526-48,2450. Moreover, outside bodies such as Leapfrog have no direct authority to effectuate change. RFF1689,1721,2014. And MCOs consider quality only as "background information," and have an incentive to provide coverage that will be

merely "*adequate* to meet their customers' [] needs." *Indiana Fed'n of Dentists*, 476 U.S. at 463 (emphasis added); RFF-Reply2471-80.

Also, some of the "ancillary" relief proposed by Complaint Counsel could seriously undermine Evanston's strength as a competitor—such as the proposal to make Evanston pay six months salary to anyone to whom an acquirer makes a written offer. CCAB82-83. The ALJ properly found that this was well beyond what is necessary and appropriate to eliminate the effects of the acquisition. ID207. And although Complaint Counsel argues that such provisions have been used in the past, it has failed to carry its burden of showing a "need for a special protective provision." *Coca-Cola Co.*, 91 F.T.C. 517, 1978 WL 206107, at *81 (Apr. 7, 1978); *Papercraft Corp. v. FTC*, 472 F.2d 927, 931 (7th Cir. 1973). Without such a showing, this ancillary relief is nothing more than punishment, which the antitrust laws forbid, *see e.g.*, *E.I. du Pont de Nemours*, 366 U.S. 326, and which could threaten ENH's own continued vitality.

Finally, Complaint Counsel's request for ancillary relief "to ensure the continuation of programs and services instituted at Highland Park *since* the merger" (CCAB77, n.8,9) (emphasis added), is an admission that ENH's improvements in quality at HPH are real and verified *and* that the merger was necessary to produce those benefits. If these improvements would have occurred without the merger (as Complaint Counsel argues), there is no reason they cannot be maintained by HPH acting on its own. Thus, if Complaint Counsel is right on the merits, it cannot possibly show the required "need for a special protective provision."

V. RESPONSE TO CROSS-APPEAL: THE ALJ'S DISCOVERY ORDER CONCERNING BACKUP TAPES SHOULD BE AFFIRMED.

The Commission should also reject Complaint Counsel's cross-appeal seeking to overturn the ALJ's decision denying additional discovery of Respondent's email backup data tapes. Before trial, Complaint Counsel moved to compel Respondent to spend more than $1 million and countless attorney hours to produce information from three dozen electronic backup tapes. The ALJ's refusal to impose such an undue, and unprecedented, discovery obligation is subject to considerable deference on appeal and should be affirmed. *See, e.g.*, *In re Hoechst Celanese Corp.*, 1990 FTC LEXIS 152, at *2 (May 25, 1990); *In re Gen. Foods Corp.*, 1980 FTC LEXIS 112, at *2-3 (Feb. 15, 1980); *see also* Resp't Opp'n Compl. Counsel's Mot. Compel (Sept. 2, 2004) (incorporated here by reference).

Complaint Counsel does not contend that the financial burden of backup tape discovery here is outweighed by the "likely benefit" of such electronic discovery—the pertinent legal standard. 16 C.F.R. §3.31(c)(1)(iii). To the contrary, Complaint Counsel concedes that the discovery order it seeks would "have little import for this case." CCAB71.

Complaint Counsel nevertheless seeks an advisory opinion that would "clarify, for the benefit of the ALJs, the private litigants and Complaint Counsel in future actions," that discovery orders on backup tapes "should not be conditioned on the Commission's bearing some or all the costs of production." CCAB71. But this request for a new, broad-based discovery rule should be summarily denied because an

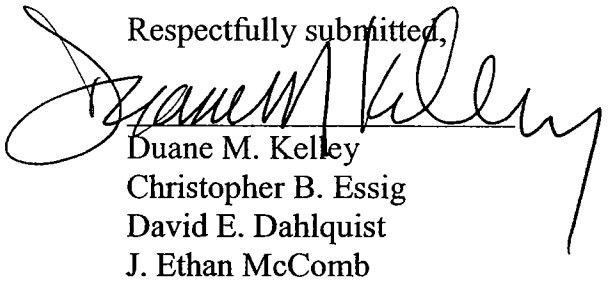
adjudicative proceeding cannot "include other proceedings such as. . .the promulgation of substantive rules and regulations." 16 C.F.R. §3.2.

Regardless, the ALJ's fact-specific discovery ruling left open the possibility that a future Respondent could be ordered to incur the cost of restoring backup data if, unlike here, the circumstances supported such an order. Order Den. Compl. Counsel's Mot. Compel at 3-4 (Sept. 22, 2004). Complaint Counsel thus has no basis to claim that this discovery order creates an "insurmountable burden on the Commission in future investigations and litigation matters." CCAB71.

CONCLUSION

For all these reasons, the Complaint should be dismissed.

Respectfully submitted,



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ATTACHMENT A

(REDACTED)

ATTACHMENT B

(REDACTED)

ATTACHMENT C

(REDACTED)

CERTIFICATE OF SERVICE

I hereby certify that on March 22, 2006 copies of the **Respondent's Brief In Reply and Opposition To Cross-Appeal (Public Version)** were served (unless otherwise indicated) by messenger on:

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