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

FEDERAL TRADE COMMISSION

and

STATE OF ILLINOIS

Plaintiffs,

v.

ADVOCATE HEALTH CARE NETWORK,

ADVOCATE HEALTH AND HOSPITALS CORPORATION,

and

NORTHSHORE UNIVERSITY HEALTHSYSTEM

Defendants.

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

[redacted]

PLAINTIFFS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

TABLE OF CONTENTS

PLAINTIFFS' PROPOSED FINDINGS OF FACT

TABLE OF CONTENTS

PLAINTIFFS' PROPOSED CONCLUSIONS OF LAW

TABLE OF AUTHORITIES

PLAINTIFFS' PROPOSED CONCLUSIONS OF LAW

Cases

Statutes

Other Authorities

Treatises

PLAINTIFFS' PROPOSED FINDINGS OF FACT

I. THE PARTIES TO THE ACQUISITION

A. Advocate Health Care Network

1. Defendants Advocate Health Care Network and Advocate Health and Hospitals Corporation (collectively, "Advocate") are Illinois not-for-profit corporations. Advocate, headquartered in Downers Grove, Illinois, is the largest health system in Illinois. It operates 11 general acute care ("GAC") hospitals in Illinois. For the fiscal year ending on December 31, 2014, Advocate generated $5.2 billion in revenue. PX06000 Tenn Report ¶ 20.

B. NorthShore University HealthSystem

2. Defendant NorthShore is a not-for-profit health system headquartered in Evanston, Illinois. It operates four GAC hospitals in Chicago's northern suburbs—three in northern Cook County and one in Lake County. PX06000 Tenn Report ¶ 14.

II. THE PROPOSED MERGER

3. On September 11, 2014, Advocate and NorthShore entered into an Affiliation Agreement to create Advocate NorthShore Health Partners ("ANHP") in a transaction valued at $2.2 billion (the "Proposed Merger"). The combined entity would operate 15 GAC hospitals in Illinois and would generate approximately $7.0 billion in revenue. Complaint (Under Seal) ¶¶ 17, 18, 20, 23; Dkt. #37 (NorthShore Answer) ¶¶ 17, 20, 23; Dkt. #38 (Advocate Answer) ¶¶ 17, 18, 20, 23.

III. FUNDAMENTALS OF HOSPITAL COMPETITION AND PRICING

A. Reimbursements for Hospital Services

4. Commercial payers negotiate with hospitals to determine the reimbursement rates and terms for services provided to health plan members. *See* Hamman (HCSC) PI Hrg. Tr. at 149:12-20; Norton (Cigna) PI Hrg. Tr. at 76:8-19; Dechene (Northwestern) PI Hrg. Tr. at

299:16-23; JX00009 Englehart (Advocate) IH Tr. at 142:2-5; *see also* [redacted]. By contrast, the government sets the reimbursement rates and terms for hospital services provided to patients covered by Medicare and Medicaid, and self-pay patients, including indigent patients, pay hospitals directly. *See* PX06000 Tenn Report ¶ 63.

5. Payers can compensate providers under either fee-for-service ("FFS") or risk-based contracts ("RBC") in which all terms are negotiated between the payers and providers. *See* [redacted]; Hamman (HCSC) PI Hrg. Tr. at 149:12-150:11; PX06000 Tenn Report ¶ 33; *see also* Norton (Cigna) PI Hrg. Tr. at 76:8-19; [redacted]. Like for-profit hospitals, non-profit hospitals have an incentive to negotiate the most favorable rates and terms. PX06000 Tenn Report ¶ 192.

B. Relationships Between Employees, Employers, Payers, and Hospitals

6. Under self-insured health plans, employers collect premiums from their employees and pay the full costs of employees' healthcare, bearing the risk that healthcare costs may exceed premiums. Provider reimbursement increases directly impact self-insured employers. PX03012 Hodge (Albertsons) Decl. ¶ 6; [redacted] PX03004 Maxwell (Humana) Decl. ¶ 4.

7. Under fully-insured health plans, a payer collects premiums from employers and pays the cost of the employees' healthcare, bearing the risk that healthcare costs may exceed premiums. PX03012 Hodge (Albertsons) Decl. ¶ 6; PX03004 Maxwell (Humana) Decl. ¶ 4. As provider reimbursement increases, employers with fully-insured health care benefits face higher costs in the form of higher premiums, copayments, deductibles, and/or out-of-pocket costs. PX03012 Hodge (Albertsons) Decl. ¶ 6; [redacted] PX03004 Maxwell (Humana) Decl. ¶ 4.

8. Employers pass along at least some of the costs of provider reimbursement increases to employees in the form of higher premiums and out-of-pocket expenses. PX03012 Hodge (Albertsons) Decl. ¶ 5; *see also* [redacted].

C. Negotiations Between Payers and Hospitals

9. There are two stages of competition that hospital systems face. PX06000 Tenn Report ¶ 35. In the first stage, hospital systems and payers negotiate over whether a hospital system will be included in a payer's provider network. PX06000 Tenn Report ¶ 35. Providers engage in price competition, or compete on other value terms, to be included in-network. Hamman (HCSC) PI Hrg. Tr. at 151:12-22; PX06000 Tenn Report ¶ 36.

10. In the second stage, in-network hospitals compete with each other to attract patients. PX06000 Tenn Report ¶ 37; *see* Norton (Cigna) PI Hrg. Tr. at 78:2-9. Insured patients face little or no variation in out-of-pocket costs among in-network providers, thus competition among in-network providers occurs on the basis of non-price factors such as service offerings, amenities, quality, and reputation. PX06000 Tenn Report ¶ 37.

1. Bargaining Dynamics

11. A hospital system's bargaining position is determined by the availability and attractiveness of alternative hospitals if the payer and hospital system fail to reach agreement. [redacted]. Healthcare providers for which payers have fewer substitutes possess more leverage and occupy a better negotiating position to extract better terms, including higher reimbursement rates. [redacted]; Hamman (HCSC) PI Hrg. Tr. at 150:22-151:11; PX06000 Tenn Report ¶ 39; JX00009 Englehart (Advocate) IH Tr. at 157:2-4. Conversely, payers have more leverage when they could turn to substitute providers and still offer a marketable product. [redacted]; Hamman (HCSC) PI Hrg. Tr. at 151:12-22; PX06000 Tenn Report

¶ 39; *see* [redacted]. Payers attempt to leverage competing hospitals against one another to get a lower price, even if not explicitly stated. Hamman (HCSC) PI Hrg. Tr. at 151:12-152:19.

2. Payers' Criteria for Creating Hospital Networks

12. Payers must assemble networks that are attractive to potential members. Norton (Cigna) PI Hrg. Tr. at 75:11-16; PX03014 Bhargava (Aetna) Decl. ¶ 3. In evaluating a particular hospital for inclusion in a network, payers consider the attractiveness of the hospital (its quality and reputation), its geographic coverage (to ensure access for patients in a given area), and the reimbursement terms it is willing to accept. Hamman (HCSC) PI Hrg. Tr. at 149:1-11; Norton (Cigna) PI Hrg. Tr. at 74:18-76:19; *see also* [redacted].

13. Payers offering narrower networks seek to price such networks below broader networks—consumers will only purchase a network with fewer providers if the cost is lower. *See* Nettesheim (Aetna) PI Hrg. Tr. at 1176:1-16, 1204:19-1205:1; [redacted]; Hamman (HCSC) PI Hrg. Tr. at 147:14-148:11, 218:18-20. Providers will agree to lower reimbursement rates for participation in narrow networks if they exclude geographically proximate competitors. *See* Hamman (HCSC) PI Hrg. Tr. at 151:12-152:10; *see also* [redacted] Payers attempt to price narrow networks roughly 10 percent lower than comparable broader networks. Hamman (HCSC) PI Hrg. Tr. at 215:20-216:3; [redacted]. Lower reimbursement rates allow payers to offer narrow network products at lower prices compared to broad networks. *See generally* Hamman (HCSC) PI Hrg. Tr. at 152:20-153:22.

14. Despite the growing popularity of narrow networks, the majority of health plan members still subscribe to broader insurance plans because they prefer provider choice. Hamman (HCSC) PI Hrg. Tr. at 250:4-13. This is specifically true of employers, who may have

geographically dispersed employees and therefore require broader access. Hamman (HCSC) PI Hrg. Tr. at 250:4-251:17; JX00019 Maxwell (Humana) Dep. Tr. at 30:5-8, 56:2-12. Employers who offer a narrow network product often offer a broader network plan as well. Hamman (HCSC) PI Hrg. Tr. at 251:18-252:2.

IV. THE RELEVANT MARKET IS GENERAL ACUTE CARE INPATIENT SERVICES SOLD AND PROVIDED TO COMMERCIAL PAYERS AND THEIR INSURED MEMBERS IN THE NORTH SHORE AREA

A. General Acute Care Inpatient Hospital Services Sold and Provided to Commercial Payers and Their Members Constitute a Relevant Product Market

15. The relevant product market in which to assess the competitive effects of the proposed merger of Advocate and NorthShore is inpatient GAC services sold and provided to commercial payers and their insured members ("GAC Services"). Tenn PI Hrg. Tr. at 441:22-442:7. Whether inpatient or outpatient care is appropriate is a clinically driven decision, *i.e.*, is determined based on medical considerations, not price. Beck (United) PI Hrg. Tr. at 1128:6-12; Tenn PI Hrg. Tr. at 446:20-447:5; Neaman (NorthShore) PI Hrg. Tr. at 636:8-12; PX06000 Tenn Report ¶ 61; PX06020 Tenn Rebuttal Report ¶ 59.

16. GAC Services are a cluster of medical and surgical diagnostic and treatment services that require a patient to be admitted to a hospital for treatment, typically for (at least) an overnight or 24-hour stay. PX06000 Tenn Report ¶ 58; *see* Norton (Cigna) PI Hrg. Tr. at 78:17-19; Hamman (HCSC) PI Hrg. Tr. at 154:9-11. A hypothetical monopolist of GAC Services could profitably raise price by a small but significant amount. Tenn PI Hrg. Tr. at 443:22-444:5; PX06000 Tenn Report ¶¶ 53, 58.

17. Distinct inpatient GAC services generally are not substitutes for each other. Consequently, one might separately delineate each individual inpatient GAC service as a distinct product market. Tenn PI Hrg. Tr. at 444:11-14. Separately analyzing hundreds of individual

inpatient services would be highly burdensome, redundant, and unnecessary where, as in the case of GAC Services, competitive conditions are similar across services, the individual services are offered by a similar set of competitors (hospitals), and conditions for entry by new and existing competitors are similar. Tenn PI Hrg. Tr. at 444:6-445:20; PX06000 Tenn Report ¶¶ 59-60; *see* Norton (Cigna) PI Hrg. Tr. at 78:25-79:10, 80:13-20.

18. Defendants' expert, Dr. McCarthy, assumes the appropriate relevant product market in this case is inpatient general acute care services. McCarthy PI Hrg. Tr. at 1270:3-6; *see also id.* at 1271:1-2. Dr. McCarthy explains that "for the sake of analytical convenience and tractability, I restrict my analysis to a product market defined as GAC inpatient hospital services." PX06020 Tenn Rebuttal Report ¶ 56 (citing DX5000 McCarthy Report ¶ 37). Dr. McCarthy agrees that customers of GAC Services receive those services at hospitals, and that it is appropriate to use a cluster market for GAC inpatient services. McCarthy PI Hrg. Tr. at 1270:3-6, 1313:11-16.

1. Outpatient services are not reasonably interchangeable with inpatient services

19. Outpatient services are not substitutable for inpatient services, and thus, are not in the relevant product market. Tenn PI Hrg. Tr. at 445:21-446:2; PX06000 Tenn Report ¶ 61; PX06020 Tenn Rebuttal Report ¶ 59; *see* Beck (United) PI Hrg. Tr. at 1129:10-15; *see also* JX00028 Tallarico (Advocate) Dep. Tr. at 147:8-20. Defendants' expert agrees that it is not appropriate to include outpatient services in the relevant product market. McCarthy PI Hrg. Tr. at 1271:3-1272:9.

20. Certain inpatient services can only be performed on an inpatient basis. Norton (Cigna) PI Hrg. Tr. at 80:22-81:8; Beck (United) PI Hrg. Tr. at 1128:24-1129:15. Payers could not market a network that included only outpatient service providers. Norton (Cigna) PI Hrg. Tr.

at 79:18-23, 80:22-81:8; Hamman (HCSC) PI Hrg. Tr. at 155:13-156:3. Hospital providers do not view outpatient facilities as competitors for inpatient hospital services. Dechene (Northwestern) PI Hrg. Tr. at 309:15-25, 312:7-9.

2. The competitive and entry conditions are quite different for inpatient and outpatient services

21. While only hospitals provide GAC Services, a wider range of facilities provide outpatient services. PX06000 Tenn Report ¶ 61; *see* Hamman (HCSC) PI Hrg. Tr. at 154:22-155:8; Dechene (Northwestern) PI Hrg. Tr. at 309:15-25, 312:7-9. It would cost significantly less to build an outpatient facility than a GAC hospital. JX00012 Gallagher (NorthShore) Dep. Tr. at 175:19-176:8, 178:3-11. The State of Illinois's standards for obtaining a Certificate of Need differ for outpatient and inpatient facilities. *See* JX00015 Havill (Advocate) IH Tr. at 50:19-51:3.

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

22. The delineated geographic market—the North Shore Area—includes 11 hospitals: Advocate's Lutheran General and Condell; NorthShore's Evanston, Glenbrook, Highland Park and Skokie; Swedish Covenant; Presence Resurrection; Northwest Community; Vista East; and Northwestern Lake Forest. The North Shore Area is approximately 270 square miles, with a population of approximately 847,000 people. PX06000 Tenn Report ¶ 101. The northern suburbs of Chicago, approximately northern Cook County and southern Lake County, is the primary area of competition between Advocate's Lutheran General and Condell hospitals and NorthShore's four hospitals. Tenn PI Hrg. Tr. at 450:2-13; PX04032-009, 041, 043, 050, 052, 059, 068 (Advocate); JX00019 Maxwell (Humana) Dep. Tr. at 31:14-32:1, 105:18-106:3; PX06000 Tenn Report ¶ 17; *see* [redacted]. This region is the most likely source of merger-related competitive effects. PX06000 Tenn Report ¶ 17.

23. Ordinary course documents indicate that Defendants view the northern suburbs of Chicago as a distinct geographic market. Advocate documents assess market shares and competitive conditions in a "North Market," which includes the geographic area north of downtown Chicago. *See, e.g.*, PX04074-003, 007, 014, 019 (Advocate). NorthShore focuses specifically on Lake and northern Cook counties in the ordinary course. PX05257-001 (NorthShore); PX05093-002-008 (NorthShore); PX05203-001 (NorthShore); *see* PX02012 Murtos (NorthShore) IH Tr. at 56:1518, 56:21-57:9, 58:14-23.

24. Northwestern Lake Forest is a 120-bed community hospital that competes primarily with NorthShore Highland Park and Advocate Condell. Dechene (Northwestern) PI Hrg. Tr. at 289:20-290:10, 308:5-21; *see* PX07076-005, 008 (Northwestern). Northwestern breaks up the geographic area north of Chicago, which it calls the "North Market," into four distinct sub-markets—Near North Lake, Far North Lake, Near North Inland, and Far North Inland—and views each of these as separate geographic areas. Dechene (Northwestern) PI Hrg. Tr. at 303:25-305:10; PX07017-008-009 (Northwestern); *see* PX07075-022-024 (Northwestern).

25. Hospitals outside of the North Shore Area compete only to a limited degree with hospitals in the North Shore Area. *See* Norton (Cigna) PI Hrg. Tr. at 83:15-84:8; Dechene (Northwestern) PI Hrg. Tr. at 289:20-290:10, 308:5-21; PX07076-005, 008 (Northwestern). Advocate's hospitals outside of the North Shore Area face different competitive conditions than Advocate's hospitals in the North Shore Area. JX00022 Powder (Advocate) Dep. Tr. at 26:2-16, 27:7-28:6. Advocate does not believe it competes with Presence St. Francis Hospital. Skogsbergh (Advocate) PI Hrg. Tr. at 412:14-18.

1. Patients prefer to receive GAC Services locally

26. Patients prefer to receive GAC Services close to home. Hamman (HCSC) PI Hrg. Tr. at 158:1-3; Dechene (Northwestern) PI Hrg. Tr. at 305:17-23; PX02022 Weiss (NorthShore)

(Day One) Dep. Tr. at 107:2-18, 108:10-24; PX04069-001 (Advocate) ("We cannot expect patients to travel for routine care."); PX02008 Hall (NorthShore) IH Tr. at 187:9-18; JX00027 Steele Dep. Tr. at 25:12-17; *see* Beck (United) PI Hrg. Tr. at 1130:4-11. Patients typically leave from home to go to a hospital for inpatient services and prefer to be close to home in part so family can conveniently visit. Dechene (Northwestern) PI Hrg. Tr. at 312:10-313:1.

27. Patients may travel farther for more complex services that are not available locally or if a provider, like an academic medical center, has a strong reputation for that particular high-acuity service. Norton (Cigna) PI Hrg. Tr. at 84:1-8; Dechene (Northwestern) PI Hrg. Tr. at 299:3-12, 316:5-15; JX00027 Steele Dep. Tr. at 25:25-26:19, 27:19-28:13.

28. Employers require access to in-network hospitals located close to the homes of employees. PX07087-007 (Albertsons); PX07086-001 (Albertsons); JX00016 Hodge (Albertsons) Dep. Tr. at 134:1-137:22; [redacted]; JX00001 Abrams (Medline) Dep. Tr. at 58:8-12, 69:8-70:3; *see* Norton (Cigna) PI Hrg. Tr. at 84:12-23; Hamman (HCSC) PI Hrg. Tr. at 158:1-7.

29. Advocate's CEO confirmed that Advocate's Good Shepherd Hospital, Sherman Hospital, Illinois Masonic Hospital, Christ Medical Center, Trinity Hospital, and Suburban Hospital are located too far away to address an alleged gap in their geographic coverage along the North Shore. Skogsbergh (Advocate) PI Hrg. Tr. at 377:12-378:8.

30. Advocate and NorthShore are close substitutes for patients desiring local treatment in the northern suburbs of Chicago. PX06020 Tenn Rebuttal Report ¶ 79; *see* [redacted]; Norton (Cigna) PI Hrg. Tr. at 92:13-25, 93:9-15. Advocate Lutheran General is a primary alternative for NorthShore's Evanston, Skokie, and Glenbrook hospitals, while Advocate Condell is a primary alternative for NorthShore's Highland

Park Hospital. Norton (Cigna) PI Hrg. Tr. at 81:22-83:1; [redacted]; JX00001 Abrams (Medline) Dep. Tr. at 54:7-55:1.

31. Analysis of patient travel patterns demonstrates that a large majority, 73%, of North Shore Area residents receive care locally. PX06000 Tenn Report ¶ 74. A quarter of patients living in NorthShore's service area travel 3 miles or less (less than 6 minutes) to the admitted hospital, half of patients travel less than 7 miles (less than 11 minutes), and 75% of patients travel less than 13 miles (18 minutes or less). PX06000 Tenn Report ¶ 106. That some patients who live in the North Shore Area travel outside of the area for inpatient care does not undermine the conclusion that the North Shore Area constitutes a properly defined geographic market. Tenn PI Hrg. Tr. at 1641:4-1642:4. Dr. McCarthy does not dispute the findings reached by Dr. Tenn with respect to how far patients drove when they sought care at North Shore Area hospitals. McCarthy PI Hrg. Tr. at 1343:23-1344:3.

32. Regulatory "network adequacy" standards are unrelated to whether a network with minimal coverage is commercially viable. Tenn PI Hrg. Tr. at 1670:1-5, 1670:22-1671:2.

2. A hypothetical monopolist of North Shore Area hospitals could profitably impose a SSNIP

33. When defining a relevant geographic market, one should use the hypothetical monopolist test, as required by the *U.S. Department of Justice & Federal Trade Commission Horizontal Merger Guidelines* (2010) [hereinafter *Merger Guidelines*]. Tenn PI Hrg. Tr. at 451:24-452:24; McCarthy PI Hrg. Tr. at 1316:2-10; PX06000 Tenn Report ¶ 75. When performing the hypothetical monopolist test to determine if a small but significant and non-transitory increase in price ("SSNIP") (*i.e.*, 5% or more) could be imposed, one should start narrowly with the hospitals of the merging parties. Tenn PI Hrg. Tr. at 453:1-7; McCarthy PI Hrg. Tr. at 1316:11-18. As Dr. Tenn explains, "[i]n general, one wants to focus on the narrowest

market that passes the hypothetical monopolist test," Tenn PI Hrg. Tr. at 459:13-14, and Dr. McCarthy agrees that "[t]he basic objective to defining a relevant geographic market is to identify the smallest region over which a hypothetical monopolist could impose and sustain a SSNIP," DX5000 McCarthy Report ¶ 38.

34. Dr. McCarthy agrees that the geographic market can be properly identified by starting with a narrow definition of the market and broadening it until the hypothetical monopolist test is satisfied. DX5000 McCarthy Report ¶ 38.

35. Once a hypothetical monopolist owns enough hospitals such that a SSNIP would be profitable, there is no need to add more hospitals—a relevant geographic market would be established under the *Merger Guidelines*. Tenn PI Hrg. Tr. at 461:15-23; McCarthy PI Hrg. Tr. at 1319:11-15; DX5000 McCarthy Report ¶ 38.

36. Dr. McCarthy agrees that, under the *Merger Guidelines*, Dr. Tenn could have appropriately defined a narrow relevant geographic market consisting of only the six party hospitals after establishing that those hospitals could impose a SSNIP under common ownership. McCarthy PI Hrg. Tr. at 1319:11-19. If a hypothetical monopolist of only the six Advocate and NorthShore hospitals could impose a SSNIP, that could conclude the market definition exercise. McCarthy PI Hrg. Tr. at 1320:8-12.

37. Dr. McCarthy does not contend that Dr. Tenn made any errors implementing his methodology for identifying the five additional hospitals Dr. Tenn included in his North Shore Area geographic market. McCarthy PI Hrg. Tr. at 1332:13-20. Dr. McCarthy also acknowledges that Dr. Tenn's robustness check analysis, which includes 15 hospitals (including all local hospitals that overlap with a relevant Advocate *or* NorthShore hospital to a significant degree), supports the existence of an alternative relevant geographic market that would pass the

hypothetical monopolist test and trigger the presumption for illegality under the *Merger Guidelines*. McCarthy PI Hrg. Tr. at 1334:4-9; PX06000 Tenn Report ¶ 100 n.196.

38. Diversion ratios—estimated by a widely-accepted hospital choice model—demonstrate that the level of substitution across the 11 hospitals in the North Shore Area is sufficiently high to pass the hypothetical monopolist test, *i.e.*, a hypothetical monopolist that owned all of them could profitably raise price by a SSNIP. PX06000 Tenn Report ¶¶ 96-100.

39. The North Shore Area hospitals could profitably impose a SSNIP for at least one of the party hospitals because their exclusion from a payer's provider network would make that network significantly less desirable. Tenn PI Hrg. Tr. at 1633:19-1634:1; PX06000 Tenn Report ¶ 100; *see also* [redacted]; [redacted]. A hypothetical monopolist who could threaten to exclude all of the North Shore Area hospitals from the payer's provider network would have significantly greater negotiating leverage. Hamman (HCSC) PI Hrg. Tr. at 150:22-151:11; [redacted]; Tenn PI Hrg. Tr. at 453:1-13, 461:12-23, 466:21-469:8, 470:15-471:10; PX06000 Tenn Report ¶¶ 71-72 and Fig. 2; PX06020 Tenn Rebuttal Report ¶¶ 79-80; *see also* [redacted].

3. Downtown hospitals, including Northwestern Memorial, could not prevent a hypothetical monopolist of North Shore Area hospitals from imposing a SSNIP

40. That the North Shore Area hospitals constitute a relevant geographic market neither implies nor requires that other hospitals in the area do not compete with North Shore Area hospitals; it only means that hospitals outside the market could not constrain a SSNIP by a monopolist of the North Shore Area hospitals. Tenn PI Hrg. Tr. at 471:11-23, 608:19-609:10. "As the [Merger] Guidelines make clear, it's appropriate to include in the market the smallest set of competitors where the elimination of the competitive constraints they impose on each other

leads to a small but significant price increase. Therefore, in a properly defined geographic market, it is almost always the case you exclude potential alternatives to the merging parties." Tenn PI Hrg. Tr. at 1637:20-1638:1; *see also Merger Guidelines* §§ 4, 4.2. Defendants' expert agrees that, when applying the hypothetical monopolist test pursuant to the *Merger Guidelines*, one often excludes significant competitors of the merging parties from the relevant geographic market. *See* McCarthy PI Hrg. Tr. at 1320:13-17, 1321:1-4.

41. Commercial payers must assemble networks that provide access to local hospitals; destination hospitals are not network substitutes for the local hospitals in the North Shore Area. Hamman (HCSC) PI Hrg. Tr. at 157:21-158:14; Norton (Cigna) PI Hrg. Tr. at 84:12-23, 93:9-21; Nettesheim (Aetna) PI Hrg. Tr. at 1170:1-4; Beck (United) PI Hrg. Tr. at 1130:4-1131:6; Tenn PI Hrg. Tr. at 609:19-610:8, 1637:10-16; PX06020 Tenn Rebuttal Report ¶¶ 79-80.

42. Northwestern Memorial, located in downtown Chicago, serves a different geographic area than Northwestern Lake Forest and other hospitals in the North Shore Area. Dechene (Northwestern) PI Hrg. Tr. at 294:13-295:4, 297:5-17; JX00015 Havill (Advocate) IH Tr. at 35:24-36:10.

43. Although Northwestern Memorial draws patients from the northern suburbs of Chicago for inpatient care, it does not view itself as a significant competitor to GAC hospitals in the northern suburbs of Chicago. Dechene (Northwestern) PI Hrg. Tr. at 314:1-10, 314:24-315:5; PX07075-022 (Northwestern). Less than 5% of patients residing in Northwestern's Near North Lake and Far North Lake sub-markets go to Northwestern Memorial for inpatient care. Dechene (Northwestern) PI Hrg. Tr. at 315:2-14; PX07075-022 (Northwestern); DX1420.0023 (Northwestern).

V. EXTRAORDINARILY HIGH MARKET SHARES AND MARKET CONCENTRATION LEVELS ESTABLISH A STRONG PRESUMPTION OF HARM TO COMPETITION IN THE RELEVANT MARKET

A. The Proposed Merger Is Presumptively Illegal in the Relevant Market

44. Within the North Shore Area, NorthShore and Advocate are the largest providers with shares of 31% and 29%, respectively. PX06000 Tenn Report ¶¶ 112-13 & Tbl. 6. The next largest providers are Northwest Community (14%) and Swedish Covenant (8%). PX06000 Tenn Report ¶¶ 112-13 & Tbl. 6. The remaining providers, CHS/Vista, Northwestern, and Presence, each have a 6% share. PX06000 Tenn Report ¶¶ 112-13 & Tbl. 6. These share calculations include GAC inpatient services provided to all commercial patients who received care at the 11 North Shore Area hospitals regardless of where those patients live. Tenn PI Hrg. Tr. at 474:7-14; McCarthy PI Hrg. Tr. at 1330:11-15.

45. These market shares lead to a pre-merger HHI of 2,161. Tenn PI Hrg. Tr. at 480:14-20; PX06000 Tenn Report ¶¶ 113-15. The Proposed Merger would cause an HHI increase of 1,782, resulting in a post-merger HHI of 3,943. Tenn PI Hrg. Tr. at 480:14-20; PX06000 Tenn Report ¶¶ 113-15. These figures are far beyond those identified by the *Merger Guidelines* as presumptively "likely to enhance market power." *Merger Guidelines* § 5.3.

46. Dr. Tenn measured market concentration in several ways to ensure his results were not sensitive to the precise boundaries of the geographic market or the method of calculating shares. Tenn PI Hrg. Tr. at 477:20-478:1. First, Dr. Tenn employed an approach that reports the average level of concentration across the entire area from which a given hospital attracts patients, incorporating the admission share of the "destination" hospitals. Tenn PI Hrg. Tr. at 478:6-21. Second, Dr. Tenn calculated admission shares for patients living in the 51 ZIP code area that NorthShore defines as its primary service area, again accounting for share of the "destination" hospitals. Tenn PI Hrg. Tr. at 479:9-18. Dr. Tenn found that these methods of

calculating market concentrations also showed the Proposed Merger would significantly increase market concentration. Tenn PI Hrg. Tr. at 480:6-20; PX06000 Tenn Report ¶¶ 117-22.

B. Ordinary Course Materials Are Consistent with the Relevant Market

47. Advocate analyzes competition in five broad and roughly defined geographies, one of which is called "Metro Chicago North." PX04044-004 (Advocate); PX04056-004 (Advocate). In Metro Chicago North, Advocate has a 29.9% market share and NorthShore, one of Advocate's "Top Competitors," has a market share of 19.9%. PX04044-004 (Advocate). No other competitor has a higher market share in Metro Chicago North. PX04044-004 (Advocate); *see also* PX04040-023 (Advocate) ("Advocate is the Lake County Market Leader"; NorthShore is second.); PX04182-002 (Advocate).

48. NorthShore also analyzes competition in a geographic area proximate to its hospitals. *See, e.g.*, PX05019-016 (NorthShore); PX05087-004-005, 008 (NorthShore). Dr. Joseph Golbus delivered a February 2013 Report to NorthShore Medical Group's Board of Directors informing them that, "Advocate is number one in almost all service lines" in most of NorthShore's core service area, that "NorthShore and Advocate are the number one or number two players in almost every service line" of inpatient specialty services, and that "Advocate is gaining share in our core markets." PX05101-006-010 (NorthShore); Golbus (NorthShore) PI Hrg. Tr. at 736:12-738:11. The report showed that Advocate had approximately 22.5% of inpatient discharges within NorthShore's core service area, while NorthShore had 21.4%. PX05101-024 (NorthShore); Golbus (NorthShore) PI Hrg. Tr. at 738:12-739:18.

49. Northwestern's North Market Assessment for fiscal year 2015 concluded that Advocate was the "market leader for health systems in the North Market" by inpatient market share, and NorthShore was second. PX07017-016 (Northwestern); Dechene (Northwestern) PI Hrg. Tr. at 316:16-317:6.

50. In Northwestern's Near North Lake sub-market, described as "eastern Cook County north of the City of Chicago, roughly up to the Lake County line," Northwestern's North Market Assessment concluded that "NorthShore is the market leader followed by Advocate and Presence; Northwestern Medicine ranks #4 in the Near North Lake submarket." PX07017-018 (Northwestern); Dechene (Northwestern) PI Hrg. Tr. at 305:24-306:3, 321:14-322:10. Market shares for this market were: NorthShore (30.2%); Advocate (23.7%); and Northwestern (5.0%). PX07017-016 (Northwestern); Dechene (Northwestern) PI Hrg. Tr. at 317:7-15, 321:22-24.

51. In Northwestern's Far North Lake sub-market, described as "the two-thirds eastern portion of Lake County, roughly," the top four systems by inpatient market share were: Advocate (30.8%); Vista (24.1%); NorthShore (17.6%); and Northwestern (15.8%). Dechene (Northwestern) PI Hrg. Tr. at 306:5-11, 317:7-15, 321:22-24; PX07017-016 (Northwestern).

52. Other market participants acknowledge the dominance of a combined Advocate/NorthShore in the North Shore Area. *See* [redacted].

VI. THE PROPOSED MERGER WOULD SUBSTANTIALLY LESSEN COMPETITION IN THE RELEVANT MARKET

A. Advocate and NorthShore Are Close Competitors in the Relevant Market

53. Dr. Tenn uses a widely accepted hospital choice model to consider the fraction of Advocate's patients for whom NorthShore is the next best alternative, and vice versa. Dr. Tenn's analysis shows that the merging parties have been close substitutes going back to at least 2008, which is the earliest time for which he had data to analyze. Tenn PI Hrg. Tr. at 1646:6-9. Across the six party hospitals at issue, the average diversion ratio to the other system is 21%,

which is sufficiently high to cause a significant post-merger price increase. Tenn PI Hrg. Tr. at 484:1-485:14; PX06000 Tenn Report ¶¶ 133-36.

54. Dr. McCarthy admits that diversion analyses are commonly used to identify which hospitals patients view as close substitutes. McCarthy PI Hrg. Tr. at 1306:9-13. Further, Dr. McCarthy admits that to employ a diversion analysis based on the hospital choice model, one need not reach a conclusion on the appropriate geographic market definition. McCarthy PI Hrg. Tr. at 1311:2-7; *see also* Tenn PI Hrg. Tr. at 1638:16-18.

55. Dr. McCarthy also agrees with Dr. Tenn's use of the hospital choice model to calculate diversions here; when calculating diversion ratios on a hospital merger case, his preferred method is to use the hospital choice model, not surveys. McCarthy PI Hrg. Tr. at 1341:2-13. Dr. McCarthy admits that he and Dr. Tenn use essentially the same hospital choice model to calculate their respective diversion ratios. McCarthy PI Hrg. Tr. at 1341:14-16.

56. Dr. McCarthy also concludes that Advocate and NorthShore are "good substitutes for each other" and "[c]onstrain [e]ach [o]ther." McCarthy PI Hrg. Tr. at 1307:17-1308:4; DX5000 McCarthy Report at § VI.B; PX06020 Tenn Rebuttal Report ¶ 109 (citing DX5000 McCarthy Report ¶ 95). The diversions that Dr. McCarthy calculates lead to the same conclusion as Dr. Tenn's diversions, indicating that 21% of patients admitted to one of the six party hospitals in the North Shore Area would switch to the other party if their first choice were unavailable. PX06020 Tenn Rebuttal Report ¶ 107 (citing DX5000 McCarthy Report ¶ 72). While there is diversion from the merging party hospitals to hospitals outside of the North Shore Area, "Dr. McCarthy and [Dr. Tenn] agree that the level of diversion from the merging parties to third-party competitors, such as Northwestern Memorial, is of limited relevance to evaluating the

competitive effect of the proposed transaction. What matters is the level of substitution between the merging parties' hospitals." Tenn PI Hrg. Tr. at 1646:2-7; DX5000 McCarthy Report ¶ 75.

57. Defendants' documents and testimony from Dr. McCarthy show that Advocate is NorthShore's most significant competitor in almost every major inpatient service line in NorthShore's service area—Northwestern is a significantly more distant competitor. PX05101-09 (NorthShore); McCarthy PI Hrg. Tr. at 1284:24-1288:3. Dr. Eisenstadt agrees that Advocate and NorthShore compete. Eisenstadt PI Hrg. Tr. at 1569:18-22.

58. Advocate's CEO presented to Advocate's Board a presentation titled "NorthShore University Health System: Strategic Planning and Growth" as they contemplated the Proposed Merger. Skogsbergh (Advocate) PI Hrg. Tr. at 382:6-23; PX04032-003 (Advocate). Numerous maps depicted the substantial overlap of the primary service areas ("PSAs") of NorthShore and Advocate. *See* PX04032-009, 039, 048, 057, 066 (Advocate); *see also* JX00022 Powder (Advocate) Dep. Tr. at 78:13-17. In the PSA of each of the NorthShore hospitals, the merging parties have a combined market share of at least: Evanston (42.8%); Glenbrook (60.2%); Highland Park (54.1%); and Skokie (44.6%). PX04032-042, 051, 060, 069 (Advocate).

59. Advocate's CEO testified that the merging parties compete in the areas in which their PSAs overlap. Skogsbergh (Advocate) PI Hrg. Tr. at 386:5-9, 387:20-22, 399:18-21, 400:17-21, 402:14-18, 405:4-7. Advocate's CEO agreed that the combined market shares of Advocate and NorthShore across the PSAs of the four NorthShore hospitals suggest that Advocate and NorthShore are each other's closest competitors in those PSAs. Skogsbergh (Advocate) PI Hrg. Tr. at 407:4-15.

60. NorthShore retained Bain & Co., a long-time advisor to NorthShore, in September 2012 to develop a strategy for NorthShore to successfully position itself for the future. Neaman (NorthShore) PI Hrg. Tr. at 641:2-10; [redacted]

61. After months of review by NorthShore executives and presentations to NorthShore executives, Bain's strategy review was presented to the full NorthShore Board of Directors in June 2013. Neaman (NorthShore) PI Hrg. Tr. at 641:16-642:8; *see also* [redacted]; [redacted] PX05028 (NorthShore); [redacted]; [redacted] PX02022 Weiss (NorthShore) (Day One) Dep. Tr. at 208:11-16. The strategy review concluded that Advocate was the "#1 provider in NorthShore's service area" and "NorthShore and Advocate are the #1 or #2 players in almost every service line," including seven of NorthShore's top eight service lines within NorthShore's "core service area." Neaman (NorthShore) PI Hrg. Tr. at 644:6-11, 644:21-647:21; [redacted]. The strategy review also concluded that "Advocate is the #1 competitor" around NorthShore's central region, [redacted] and "Advocate poses the greatest threat." Neaman (NorthShore) PI Hrg. Tr. at 649:11-16, 650:19-651:17; [redacted]; [redacted]; *see also* [redacted]; [redacted] Mr. Neaman followed the Board presentation by presenting "Management Comments" reacting to it. [redacted]; Neaman (NorthShore) PI Hrg. Tr. at 643:6-11. These conclusions were also presented to NorthShore's medical group. *See, e.g.*, PX05057-011-012; Golbus (NorthShore) PI Hrg. Tr. at 734:3-735:8, 735:16-736:10.

62. Other ordinary course documents from NorthShore reveal NorthShore's ongoing concern with losing patients to Advocate and identify Advocate as NorthShore's primary competitor. PX05207-004 (NorthShore); PX02022 Weiss (NorthShore) (Day One) Dep. Tr. at 104:17-19; PX05039-004 (NorthShore); PX05049-001-002 (NorthShore); PX05106-001 (NorthShore); PX05127-002 (NorthShore). Advocate's ordinary course documents also demonstrate that Advocate views NorthShore as a close competitor. PX04100-014-015 (Advocate); PX04291-004 (Advocate); PX04299-021 (Advocate).

63. Local employers view Advocate and NorthShore as close substitutes for employees living in the North Shore Area. JX00001 Abrams (Medline) Dep. Tr. at 66:9-16; *see also* [redacted].

64. Payers view Advocate Lutheran General and Advocate Condell as close substitutes for NorthShore's four hospitals in northern Cook County and southern Lake County. [redacted]; [redacted]. Members receiving services at NorthShore Highland Park view Advocate Condell as a main alternative, and members view Advocate Lutheran General as a primary substitute for the other three NorthShore hospitals. [redacted]; *see* Norton (Cigna) PI Hrg. Tr. at 81:22-82:12 (Evanston), 82:17-83:1 (Highland Park).

B. Head-to-Head Competition Between Advocate and NorthShore Results in Significant Benefits to Consumers

65. [redacted]

[redacted]

66. [redacted].

C. The Merger Would Enable Defendants to Raise Rates

1. The quantitative evidence predicts competitive harm

67. In order to examine the Proposed Merger's likely competitive effects, Dr. Tenn employed a widely-used measure known in the economics literature as "willingness to pay" ("WTP"). Tenn PI Hrg. Tr. at 486:18-487:18. This statistic measures the change in welfare between excluding a combined Advocate-NorthShore from a payer's network compared to individually excluding each system. PX06000 Tenn Report ¶¶ 144-145. This calculation shows the Proposed Merger's effect on the combined firm's negotiating leverage for payer contracts. Tenn PI Hrg. Tr. at 487:19-488:9.

68. Dr. Tenn found that the estimated change in welfare from simultaneously excluding both systems is 8% higher than the change in welfare from excluding each system individually. Tenn PI Hrg. Tr. at 488:10-25; PX06000 Tenn Report ¶ 147, Tbl. 13. Defendants' experts calculate a similar change in WTP from the merger. McCarthy PI Hrg. Tr. at 1347:3-10; Eisenstadt PI Hrg. Tr. at 1553:13-1554:1.

69. Dr. Tenn also conducted a merger simulation analysis to predict the likely competitive impact of the Proposed Merger. Tenn PI Hrg. Tr. at 489:7-10. Consistent with the economics literature and the *Merger Guidelines*, he uses price and margin data from the parties, together with the estimated diversion ratios, to predict the post-merger price change. Tenn PI Hrg. Tr. at 1647:2-8; PX06000 Tenn Report ¶ 176. The analysis shows that the merger is likely to cause an average predicted price increase of 8% across the six party hospitals in the North Shore Area. Tenn PI Hrg. Tr. at 489:22-490:1; PX06000 Tenn Report ¶ 184. The merger simulation indicates that, on an annual basis, the six party hospitals will be able to extract a $45 million increase in inpatient GAC reimbursement from area payers, and ultimately, area patients. Tenn PI Hrg. Tr. at 490:9-25; PX06000 Tenn Report ¶ 184.

70. Defendants' experts use merger simulation methods that generate implausible results that contradict basic economic reasoning. Defendants' experts' methodology would predict little or no harm to competition for mergers combining dozens of Chicago hospitals, which is simply not credible. Tenn PI Hrg. Tr. at 497:5-498:6, 1652:17-1653:25; PX06020 Tenn Rebuttal Report ¶¶ 13, 35, 38-39, 53.

71. Dr. McCarthy verified that Dr. Tenn's merger simulation model is equivalent mathematically to the bargaining model used by Haas-Wilson and Garmon, which assumes a splitting of bargaining power between payers and hospitals. McCarthy PI Hrg. Tr. at 1347:20-25. Unlike Dr. Eisenstadt, Dr. McCarthy does not believe that Dr. Tenn's merger simulation model assumes hospitals possess all of the bargaining leverage. McCarthy PI Hrg. Tr. at 1348:22-1349:4; Eisenstadt PI Hrg. Tr. at 1555:22-1556:5, 1557:14-25.

72. Dr. McCarthy agrees that if hospitals are close substitutes, a merging hospital (Hospital A) may have a strong incentive to raise price post-merger, given that its merger partner

(Hospital B) will likely recapture much of the lost patient volume in the event that a price increase leads to Hospital A being dropped from a payer's network. McCarthy PI Hrg. Tr. at 1309:16-1310:2. Dr. McCarthy also agrees that Hospital A's incentive to raise price will be stronger if the recaptured customers are profitable for Hospital B—as reflected by Hospital B's gross margin. McCarthy PI Hrg. Tr. at 1311:8-12. Dr. McCarthy acknowledges that there is no requirement that a merger needs to be between closest competitors to result in competitive harm. McCarthy PI Hrg. Tr. at 1330:16-19, 1331:3-5.

73. Diversion from the merging parties to third-party hospitals in Chicagoland, including Northwestern Memorial, does not obviate the competitive effects the merger will cause based on the high level of substitution between the merging parties. Tenn PI Hrg. Tr. at 485:15-486:17. Dr. McCarthy and Dr. Tenn agree that "the competitive effects prediction [for the Proposed Merger] relies largely on diversion between the Defendants, irrespective of diversion from the Defendants to a third, competing hospital (like Northwestern Memorial)." PX06020 Tenn Rebuttal Report ¶ 110 (citing DX5000 McCarthy Report ¶ 75).

2. Payers expect the merger to result in increased bargaining leverage and higher rates

74. BCBSIL expects that the merger will give the combined Advocate-NorthShore "much greater bargaining leverage," manifesting in higher prices to payers. Hamman (HCSC) PI Hrg. Tr. at 167:8-19, 183:4-11. BCBSIL's experience has been that typically, mergers of hospital systems do not result in lower prices to consumers. Hamman (HCSC) PI Hrg. Tr. at 167:23-168:7. Consolidation gives providers more leverage to negotiate higher rates. Hamman (HCSC) PI Hrg. Tr. at 253:14-254:1; *see* DX0035.0018 (HCSC).

3. A hospital network that excludes Advocate and NorthShore is far less attractive to employer groups with employees in the North Shore Area

75. A provider network that excluded both Advocate and NorthShore would not be an attractive product to employer groups with employees residing in the North Shore Area. [redacted]; JX00017 Levin (Aon) Dep. Tr. at 156:3-23; [redacted].

76. Employers recognize that a hospital network that excludes Advocate and NorthShore would create a gap in the northern suburbs of Chicago, rendering the hospital network inadequate to serve local employees. JX00001 Abrams (Medline) Dep. Tr. at 66:21-67:20; PX03012 Hodge (Albertsons) Decl. ¶ 10; *see also* [redacted]. Employers state that their employees require access to at least one of the merging parties. PX03012 Hodge (Albertsons) Decl. ¶ 11; [redacted].

77. BCBSIL offers a narrow network PPO product called Blue Choice, which excludes both Advocate and NorthShore from the hospital network. Hamman (HCSC) PI Hrg. Tr. at 168:18-168:23. Approximately 80 percent of Blue Choice subscribers are individuals. Hamman (HCSC) PI Hrg. Tr. at 169:5-169:11. Blue Choice has not been an attractive network to employer groups. Hamman (HCSC) PI Hrg. Tr. at 168:24-169:2. Moreover, Blue Choice does not sell well in the North Shore Area—only about 1.5% of subscribers live in northern Cook County. [redacted].

78. [redacted]

[redacted]

D. The Merger Would Eliminate Beneficial Non-Price Competition

79. In-network providers compete for patients through non-price competition such as quality, convenience, service offerings, amenities, and reputation. PX06000 Tenn Report ¶ 37; Neaman (NorthShore) PI Hrg. Tr. at 622:3-623:20; PX06000 Tenn Report. Patients benefit from competition on quality and convenience. Neaman (NorthShore) PI Hrg. Tr. at 622:7-9, 622:18-20. For example, in 2013 NorthShore concluded that "Obstetrics and neonatology cases are going to Condell." PX05093-001, 006 (NorthShore). NorthShore subsequently invested in opening modern, integrated delivery rooms to attract patients to Highland Park. JX00013 Hall (NorthShore) Dep. Tr. at 137:18-138:19, 139:5-140:1. Post-merger, the combined system would have less incentive to make such investments. PX06000 Tenn Report ¶ 129.

80. NorthShore competes for physician talent based on facilities, technology, culture, opportunity, and reputation, and this competition for physicians benefits patients. Neaman (NorthShore) PI Hrg. Tr. at 623:9-17.

81. Advocate and NorthShore compete against each other to recruit physicians in an effort to secure inpatient volume. *See* PX04059-003 (Advocate); PX04065-003 (Advocate); PX04077-014 (Advocate); PX05090-002 (NorthShore); PX04091-023 (Advocate); PX04045-001 (Advocate); *see also* JX00009 Englehart (Advocate) IH Tr. at 102:9-12. For example, the departure of a NorthShore orthopedic surgeon for Lutheran General was a contributing factor to

NorthShore's loss of orthopedic market share in 2013 and Advocate's 73% increase in orthopedic volume that same year. *See* PX02012 Murtos (NorthShore) IH Tr. at 96:1-98:1; PX05093-008 (NorthShore). NorthShore then opened the NorthShore Orthopaedic Institute to increase its orthopedic volume in Lake County. PX02012 Murtos (NorthShore) IH Tr. at 96:22-97:8.

VII. DEFENDANTS HAVE FAILED TO REBUT THE STRONG PRESUMPTION OF HARM TO COMPETITION IN THE RELEVANT MARKET

A. Defendants' Quantitative Analyses Do Not Undermine the Presumption

82. Dr. McCarthy never performed a hypothetical monopolist test for Defendants' purported markets consisting of 18 or 20 hospitals, nor did he test whether Plaintiffs' geographic market passed the hypothetical monopolist test. McCarthy PI Hrg. Tr. at 1334:13-18; Tenn PI Hrg. Tr. at 1635:8-24. Dr. McCarthy's methodology cannot answer the *Merger Guidelines* question of whether a hypothetical monopolist could raise price at a single hospital of the merging parties. McCarthy PI Hrg. Tr. at 1328:18-1329:1; *see Merger Guidelines* § 4.2.1. His regression analysis is not informative as to whether a hypothetical monopolist could impose a SSNIP if it owned the 18 or 20 hospitals in his purported markets. McCarthy PI Hrg. Tr. at 1339:20-23; Tenn PI Hrg. Tr. at 1634:2-12, 1635:8-24.

83. Dr. McCarthy believes the *Merger Guidelines* creates different requirements to pass the hypothetical monopolist test based solely on whether hospital systems negotiate rates on a collective, as opposed to individual hospital, basis, yet admitted that the *Merger Guidelines* does not include any language to support this proposition. McCarthy PI Hrg. Tr. at 1325:24-1326:10.

84. All eight of Dr. McCarthy's cross-sectional specifications show a negative relationship between his WTP measure and price, while three of his specifications show a

statistically significant negative relationship between WTP and price. McCarthy PI Hrg. Tr. at 1336:11-13. Similarly, 57 of Dr. Eisenstadt's 61 regression specifications show a negative correlation between WTP and price, and 38 of these show a statistically significant negative relationship between WTP and price. Eisenstadt PI Hrg. Tr. at 1558:23-25, 1559:9-16.

85. According to Dr. McCarthy, the results of his preferred specification could be interpreted to say that, all else equal, a ten percent increase in WTP leads to a four percent decrease in price. McCarthy PI Hrg. Tr. at 1358:12-16. Dr. McCarthy acknowledged that, "[o]f course, this is inconsistent with the hypothesis of the bargaining model, that an increase in WTP makes a hospital system more attractive and may lead to a higher price." DX5000 McCarthy Report ¶ 100; McCarthy PI Hrg. Tr. at 1358:17-23. Dr. Eisenstadt was unable to identify a single paper that suggests one should expect a negative relationship between WTP and price. Eisenstadt PI Hrg. Tr. at 1559:17-25. Dr. McCarthy agrees that economic theory indicates that, all else equal, more desirable hospital systems should be able to negotiate higher prices. McCarthy PI Hrg. Tr. at 1346:6-10.

86. Dr. McCarthy's cross-sectional regression analysis would predict that price would fall by 33 percent if one were to apply the results of his regression to a hypothetical merger of 48 hospitals in the Chicagoland area. McCarthy PI Hrg. Tr. at 1364:15-1365:8.

87. Dr. McCarthy concedes that his analysis suffers from endogeneity bias. *See* McCarthy PI Hrg. Tr. at 1361:1-2 ("There are other things that can intervene."); *see also* Tenn PI Hrg. Tr. at 1652:20-1654:13. He admitted that he did not use instrumental variables to account for endogeneity bias. McCarthy PI Hrg. Tr. at 1356:4-25.

B. Entry or Repositioning in the GAC Services Market Would Not Be Timely, Likely, or Sufficient

1. Significant barriers to entry exist

88. Entry, expansion, and repositioning are highly unlikely to offset the merger's anticompetitive harm because high entry barriers—particularly Certificate of Need ("CON") regulation and the high costs required for facility construction—exist in the hospital industry. Tenn PI Hrg. Tr. at 499:2-500:4.

89. Construction of a new hospital in Illinois requires a CON from the state. Skogsbergh (Advocate) PI Hrg. Tr. at 409:1-4. Illinois rarely grants a CON and the likelihood of getting a CON for a new hospital is "slim to none." Skogsbergh (Advocate) PI Hrg. Tr. at 409:5-10; JX00023 Primack (Advocate) Dep. Tr. at 177:3-7.

90. Building a new hospital would require a significant investment of as much as a billion dollars and two to five years of construction. Skogsbergh (Advocate) PI Hrg. Tr. at 407:25-408:21; JX00023 Primack (Advocate) Dep. Tr. at 187:9-14; JX00012 Gallagher (NorthShore) Dep. Tr. at 172:14-17.

91. Northwestern is building a replacement hospital for its current facility at Lake Forest. Dechene (Northwestern) PI Hrg. Tr. at 333:24-334:1. The replacement hospital will not add any new beds and will not offer any new inpatient services other than those the current Lake Forest Hospital offers. Dechene (Northwestern) PI Hrg. Tr. at 357:16-358:7.

2. Outpatient repositioning would not defeat a price increase

92. Activity from physicians and outpatient facilities in and around the North Shore Area will not mitigate the merger's harm, primarily because these providers do not serve as substitutes for GAC inpatient hospitals. Tenn PI Hrg. Tr. at 500:5-25; PX06020 Tenn Rebuttal Report ¶ 114. To the extent outpatient service availability in the North Shore Area impacts the

demand and competition for inpatient services, Dr. Tenn's competitive effects analysis already accounts for this. PX06020 Tenn Rebuttal Report ¶ 114.

93. Dr. McCarthy admits that the diversion analyses that he and Dr. Tenn performed took into account all of the historical "repositioning" actions taken by Northwestern through 2015. McCarthy PI Hrg. Tr. at 1343:4-7. Dr. McCarthy admits that decisions by patients to drive a certain time or distance to seek inpatient care at a North Shore Area hospital, as shown in Dr. Tenn's analysis, accounted for any "repositioning" by hospitals in the region that had occurred through June 2015. McCarthy PI Hrg. Tr. at 1345:5-8, 1345:17-22.

94. Although Dr. McCarthy testified that diversion ratios from NorthShore's hospitals to Northwestern Memorial increased significantly between 2013 and 2014, purportedly from Northwestern opening new outpatient facilities, he was not aware whether Northwestern Memorial changed how it categorized data used in this analysis. McCarthy PI Hrg. Tr. at 1231:20-1232:5, 1276:11-1277:21. Data underlying Exhibit 14 of Dr. McCarthy's report shows that in 2013, Northwestern Memorial had 4,806 in HMO and "self-administered" admissions and zero in 2014. In 2014, Northwestern had 5,372 more commercial admissions than in 2013. Dr. McCarthy was unaware of this problem and had not tested the impact it would have on his results, and admitted the change in data categorization could affect his conclusions regarding the degree to which diversion ratios for Northwestern Memorial changed between 2013 and 2014. McCarthy PI Hrg. Tr. at 1278:2-8.

C. Defendants Failed to Substantiate Any Cognizable Efficiencies from the HPN

95. Defendants claim that the purpose of the proposed merger is to create a new product for the insurance marketplace (the "ANHP-HPN"), which they assert will improve quality and lower costs to consumers. Sacks (Advocate) PI Hrg. Tr. at 1389:14-22. Defendants refer to such a product as a "high-performance network" or "HPN." Sacks (Advocate) PI Hrg.

Tr. at 1420:20-21. However, neither Advocate nor NorthShore currently sells health insurance products or even has a license to sell health insurance products. Sacks (Advocate) PI Hrg. Tr. at 1418:8-14; JX00012 Gallagher (NorthShore) Dep. Tr. 116:12-17. [redacted] Therefore, it is appropriate to analyze Defendants' claimed benefits arising from the HPN as related to a product or products offered by third-party payers, not by the merged system acting as an insurer.

1. A merger is not necessary for Defendants to participate independently or jointly in a low-priced, narrow network product

a. Advocate could participate in a single-provider HPN product absent the merger

96. According to Advocate, an HPN product that included Advocate but not NorthShore would not be attractive to large group employers because of a supposed geographic gap east of I-94. Sacks (Advocate) PI Hrg. Tr. at 1440:15-22, 1452:8-12. For the litigation, Defendants created a demonstrative map to highlight their alleged "geographic gap." *See* Sacks (Advocate) PI Hrg. Tr. at 1435:3-6. Yet, as shown by a map Advocate created to analyze the Proposed Merger, most zip codes within this supposed "geographic gap" east of I-94 are in fact part of Advocate's PSA (the area from which the majority of Advocate's hospital patients reside) and actually overlap with NorthShore's PSA. Sacks (Advocate) PI Hrg. Tr. at 1445:3-1449:7; *see also* PX04032-001, 003, 008-009 (Advocate); McCarthy PI Hrg. Tr. at 1294:2-1295:5, 1298:5-8, 1299:11-14. Network adequacy analyses show that Advocate has adequate coverage in Cook and Lake counties. PX04310-001 (Advocate); PX04298-001 (Advocate).

97. BlueCare Direct with Advocate is already an HPN product. Sacks (Advocate) PI Hrg. Tr. at 1449:10-12. Advocate is the only covered hospital provider in the product, and there are no out-of-network benefits. [redacted] BlueCare Direct

with Advocate is offered today to individuals on the public exchange and to small group employers. [redacted]; Sacks (Advocate) PI Hrg. Tr. at 1451:19-23. BCBSIL and Advocate had planned to offer BlueCare Direct with Advocate to large employers regardless of the merger. [redacted]; PX04306-001 (Advocate). However, the month after commencement of this litigation and notice of BCBSIL's opposition to the merger, Advocate informed BCBSIL that it would not give permission to go forward with the large group product. Sacks (Advocate) PI Hrg. Tr. at 1455:12-21; [redacted].

98. [redacted]

99. As Dr. Tenn explains, Dr. Eisenstadt's analysis of the consumer savings associated with the ANHP-HPN assumes that absent the merger, an Advocate-only HPN would not be sold to large employers. PX06020 Tenn Rebuttal Report ¶ 120; *see* [redacted]

[redacted]

100. Defendants' expert admits that any sales an Advocate-only HPN could achieve on its own should not be attributed as savings from the merger, yet he conducted no analysis of savings that might be achieved by an Advocate-only product for large groups. Eisenstadt PI Hrg. Tr. at 1551:21-24, 1552:1-8.

b. Defendants could jointly participate in an HPN product absent the merger, with each other or with other providers

101. No payer or broker has demanded that Defendants merge in order to participate in a joint insurance product. JX00017 Levin (Aon) Dep. Tr. at 50:1-7; [redacted]; PX03005 Montrie (Land of Lincoln) Decl. ¶ 20; *see* JX00012 Gallagher (NorthShore) Dep. Tr. 204:10-13; *see also* PX04095-013 (Advocate); PX04106-017 (Advocate).

102. Dr. Eisenstadt assumes that NorthShore will participate in an HPN with Advocate only if the merger occurs. PX06020 Tenn Rebuttal Report ¶ 120. Yet Advocate and NorthShore already jointly participate in low-priced narrow networks, such as Aetna Whole Health, a narrow network product sold to individuals on the public exchange and small employer groups. Nettesheim (Aetna) PI Hrg. Tr. at 1198:12-1199:19. Aetna reached an agreement with Advocate to offer an Advocate-only product on the individual exchange at a price reflecting that agreement. Nettesheim (Aetna) PI Hrg. Tr. at 1199:10-19; [redacted]. Aetna subsequently added NorthShore as a participating provider in those products without changing Aetna's price. Nettesheim (Aetna) PI Hrg. Tr. at 1198:12-1199:19; PX03014 Bhargava (Aetna) Decl. ¶ 11; [redacted]. NorthShore and Aetna are currently in discussions to add NorthShore as a participating provider for all three products for 2017.

Nettesheim (Aetna) PI Hrg. Tr. at 1200:2-1201:17; PX03014 Bhargava (Aetna) Decl. ¶ 11. Advocate and NorthShore do not need to merge for Aetna to offer Aetna Whole Health to all consumer segments. Nettesheim (Aetna) PI Hrg. Tr. at 1201:7-25, 1202:9-18; *see* [redacted].

103. Independent entities also already participate in risk-based, low-priced, narrow networks. [redacted]. Aetna currently has Accountable Care Organization agreements, featuring some elements of risk, with Advocate and Rush Health to participate in Aetna Whole Health sold to employers. *See* Nettesheim (Aetna) PI Hrg. Tr. at 1201:7-25, 1202:9-18; [redacted]. Cigna has value-based collaborative contracts with seven independent providers in the Chicago area that are in the same provider network. Norton (Cigna) PI Hrg. Tr. at 87:9-17.

104. Leakage generally refers to the concept of attributed patients visiting providers outside of a clinically-integrated network. *See* Hamman (HCSC) PI Hrg. Tr. at 164:11-19; [redacted]. Providers have ways to address leakage concerns independent of merging into a single-provider network. Jha PI Hrg. Tr. at 992:8-993:10; JX00015 Havill (Advocate) IH Tr. at 168:1-9, 184:4-185:8; [redacted]; *see also* Norton (Cigna) PI Hrg. Tr. at 87:20-88:7; PX05059-001 (NorthShore). Payers also have capabilities to help providers control leakage through plan design or other tools. Hamman (HCSC) PI Hrg. Tr. at 166:8-167:7; Jha PI Hrg. Tr. at 992:23-993:10; *see* [redacted]; PX07029-005 (Humana). BCBSIL's HMO product experiences

much less leakage than its PPO product, driven by the difference in plan design (*e.g.*, referral requirements and care coordination). Hamman (HCSC) PI Hrg. Tr. at 166:8-167:7.

2. Defendants have not demonstrated that any savings associated with the proposed HPN are likely to occur, let alone outweigh the harm from the merger

105. Dr. Eisenstadt's report did not include any estimate of the total magnitude of any savings or cost reductions associated with the ANHP-HPN product. Eisenstadt PI Hrg. Tr. at 1542:4-1543:3. Dr. Tenn concludes that Dr. Eisenstadt's calculations of potential "efficiencies" related to adding NorthShore to an ANHP-HPN product (specifically, BlueCare Direct with Advocate) are inappropriate and unreliable. PX06020 Tenn Rebuttal Report ¶ 118.

106. To reach his conclusion that that there may be "cognizable efficiencies" resulting from the launch of an ANHP-HPN, Defendants' expert relies on a "price pledge" by Advocate to offer the ANHP-HPN at a lower price than other insurance products. Eisenstadt PI Hrg. Tr. at 1537:6-9, 1537:19-1538:18. Although he is unaware whether there is a contractual commitment by Advocate to offer the ANHP-HPN product at a lower price, Dr. Eisenstadt testified that this "price pledge" is sufficient to make him "comfortable" that any savings resulting from the launch of an ANHP-HPN would be cognizable under the *Merger Guidelines*. Eisenstadt PI Hrg. Tr. at 1536:12-25, 1537:19-1538:18.

107. Dr. Eisenstadt admits that the cognizability of the per-member-per-year savings that he estimates may result from the launch of the ANHP-HPN products "depends on the [Defendants'] execution of the pledge" to keep prices low. Eisenstadt PI Hrg. Tr. at 1541:22-1542:1. Thus, Dr. Eisenstadt did not include in his report any analysis that would inform the magnitude of any cognizable efficiency that would result from the launch of an ANHP-HPN product. Eisenstadt PI Hrg. Tr. at 1540:7-14. He explained that this is "because it's up to the

parties to carry through on their pledge . . . . [I]t's up to them to demonstrate or follow through on the pledge." Eisenstadt PI Hrg. Tr. at 1540:14-18.

108. Dr. Eisenstadt agrees that there are instances where merging firms, despite their good faith efforts, fail to achieve efficiencies. Eisenstadt PI Hrg. Tr. at 1539:2-5. Yet Dr. Eisenstadt testified that in reaching his conclusions about the efficiencies likely to result from the ANHP-HPN product, he is "accepting their . . . offer and their testimony in court that this is the plan to offer this product at a price that will be ten percent below at least the price of Blue Precision . . . ." Eisenstadt PI Hrg. Tr. at 1541:11-21. He did not offer an opinion about how Defendants might actually implement their price pledge post-merger. Eisenstadt PI Hrg. Tr. at 1541:11-21.

a. Dr. Eisenstadt's savings calculations are unreliable

109. Defendants' expert admits that his calculation of the benefit to individual customers who would switch to the ANHP-HPN is not based on the nominal price difference between the consumer's previous insurance plan and the ANHP-HPN price, but rather the difference in *value* of the products, inclusive of both the comparative price and quality levels of the insurance products. Eisenstadt PI Hrg. Tr. at 1544:7-13. For consumers who switch to the ANHP-HPN from a broad network product like the BCBSIL PPO, the calculation must account for the decrease in value associated with losing the broad access the PPO provides. Eisenstadt PI Hrg. Tr. at 1544:14-17.

110. Although he did not testify at the hearing how he performed each analysis, Dr. Eisenstadt considered three estimates of per-member-per-year benefits for consumers who enroll in the ANHP-HPN post-merger. *See* DX6000 Eisenstadt Report ¶¶ 54-56. The first estimate—which leads to the highest purported savings—is for consumers who switch from an Aetna Whole Health product to the HPN. *See* Eisenstadt PI Hrg. Tr. at 1545:16-1546:3. This estimate

is the basis for Defendants' claim in opening arguments that individuals would pay "a thousand dollars less per year" for insurance. Robertson (Advocate) PI Hrg. Tr. at 38:12-18. This calculation is based on the assumption that consumers would switch between products with the exact same hospital networks (and thus would not lose the non-price value of leaving a broader network). Eisenstadt PI Hrg. Tr. at 1545:16-1546:3, 1547:16-20, 1548:16-1549:11. Yet, Aetna Whole Health's network for large group employers is unlikely to be limited to Advocate and NorthShore; it includes Rush, and Aetna intends to continue to include Rush in-network in the future. Nettesheim (Aetna) PI Hrg. Tr. at 1201:14-17; *see also* Eisenstadt PI Hrg. Tr. at 1547:8-14. Thus, Dr. Eisenstadt admits that his calculation of the benefits of switching from Aetna Whole Health "would not be a meaningful measurement of the value" to customers. Eisenstadt PI Hrg. Tr. at 1548:1-1549:11.

111. Dr. Eisenstadt's second estimate calculates savings assuming customers who switch to the HPN come from plans other than Aetna Whole Health. PX06020 Tenn Rebuttal Report ¶ 123. As Dr. Tenn explains, the possible benefits for such customers could range from zero to the difference in price between Aetna Whole Health on the exchange and the HPN. *See* PX06020 Tenn Rebuttal Report ¶ 123. Dr. Eisenstadt's analysis arbitrarily assumes without basis that the average benefit across these consumers is half of the price difference between Aetna Whole Health and the HPN. PX06020 Tenn Rebuttal Report ¶ 123.

112. Finally, in Dr. Eisenstadt's third estimate, he assumes that the consumer benefit is equal to the difference between the proposed HPN (referred to as "BlueCare Direct with Advocate-NorthShore," or "BCD/A-N") and Blue Precision. PX06020 Tenn Rebuttal Report ¶ 124; DX6000 Eisenstadt Report ¶ 56. Dr. Tenn demonstrates that this analysis is also flawed and, in fact, if it were performed properly would show that between 124,000 and 4.45 million

additional enrollees in the HPN would be required to outweigh the likely harm from the merger. PX06020 Tenn Rebuttal Report ¶¶ 124-125.

b. Defendants do not quantify total savings (calculate enrollees)

113. Defendants have not provided any reliable estimates of the expected enrollment in the proposed HPN. PX06020 Tenn Rebuttal Report ¶ 128. Nor have Defendants made any formal projections of enrollment for an HPN product that would include Advocate and NorthShore. Sacks (Advocate) PI Hrg. Tr. at 1457:7-12; JX00011 Fisk (NorthShore) Dep. Tr. at 137:8-138:25. The only known enrollment estimate of any HPN product offering both Advocate and NorthShore is the "back-of-the-envelope" estimate of Advocate's Dr. Lee Sacks. Sacks (Advocate) PI Hrg. Tr. at 1461:9-13.

114. Dr. Eisenstadt identifies an enrollment threshold for the ANHP-HPN product, above which he asserts that savings associated with the HPN "would more than offset alternative estimates of potential harm." Eisenstadt PI Hrg. Tr. at 1543:8-11. Yet he does not project a number of actual enrollees expected to purchase the ANHP-HPN product. Eisenstadt PI Hrg. Tr. at 1543:17-24.

115. The only evidence Dr. Eisenstadt cites for his conclusion that the proposed merger will lead to a significant increase in BCD/A-N enrollment is a highly flawed survey conducted by Defendants' expert, Dr. Van Liere, which Dr. Eisenstadt mischaracterizes by claiming the results indicate that more than 80 percent of employers are likely or very likely to offer BCD/A-N as an option to their employees. PX06020 Tenn Rebuttal Report ¶ 128 (citing PX06023 Ford Report ¶ 78); *see* DX6000 Eisenstadt Report ¶ 59.

116. BCBSIL calculated projections pertaining to Blue Care Direct; those projections cover the product with Advocate only and are limited to 2016. Sacks (Advocate) PI Hrg. Tr. at 1455:25-1456:5; [redacted]. BCBSIL did not

calculate projections for adding NorthShore via merger or contract. [redacted]; *see* Sacks (Advocate) PI Hrg. Tr. at 1456:16-19. [redacted]

117. Employers that submitted letters to Defendants in support of the merger confirm that they have made no assessment as to whether employees would find the proposed HPN attractive. *See* PX03028 Miller (North American) Decl. ¶ 7; PX03019 Gourlay (Walgreens) Decl. ¶ 4.

118. Aon, an insurance broker and consultant, submitted a letter at Advocate's request expressing interest in potentially offering an Advocate/NorthShore narrow network product on Aon's health insurance exchange. DX1704 (Advocate); JX00017 Levin (Aon) Dep. Tr. at 64:11-24. However, Aon's Mr. Levin testified that he has not: (a) looked at the service areas of either Advocate or NorthShore or studied the geographic overlap between them; (b) performed any analysis of the geographic reach of the combined entity; (c) spoken with any employers or payers about either the geographic reach of a combined Advocate/NorthShore or the employer's/payer's possible interest in an Advocate/NorthShore narrow network product; or (d) performed any modeling, spoken with Advocate, or spoken with any payers regarding the pricing of a potential Advocate/NorthShore narrow network product. JX00017 Levin (Aon) Dep. Tr. at 65:10-21, 68:16-19, 108:24-109:14, 111:24-112:9, 117:18-23.

D. Defendants Failed to Substantiate Any Efficiencies from Cost Savings or Quality Improvements

1. Defendants failed to present verifiable cost efficiencies

119. In their opening statement, Defendants claimed to have evidence of cost savings efficiencies related to the merger. Robertson (Advocate) PI Hrg. Tr. at 58:13-58:16.

120. Dr. Eisenstadt agrees that the *Merger Guidelines* requires the merging firms to substantiate efficiency claims to permit verification of the likelihood and magnitude of each efficiency, the costs of achieving it, how the efficiency would enhance the merged firm's ability and incentive to compete, and why each efficiency is merger-specific. Eisenstadt PI Hrg. Tr. at 1539:7-18; *Merger Guidelines* § 10. He agrees that the *Merger Guidelines* requires that the specific magnitude of any savings must be shown to treat them as cognizable efficiencies. Eisenstadt PI Hrg. Tr. at 1539:22-25. Dr. Eisenstadt offered no opinion on whether the merger will result in a cost reduction for Advocate, NorthShore, or both. Eisenstadt PI Hrg. Tr. at 1570:2-12. Not until after his report was submitted and after his deposition did Dr. Eisenstadt generate his analysis that a decrease in NorthShore's physician reimbursement rates should be credited to offset any projected harm. Eisenstadt PI Hrg. Tr. at 1563:10-25.

121. Defendants have not conducted a detailed assessment of potential cost savings from the merger, PX06022 Dagen Rebuttal Report ¶ 5, and moreover have only very high-level plans to implement potential cost savings from the Proposed Merger, as any such plans were placed "on pause" and are currently incomplete. Skogsbergh (Advocate) PI Hrg. Tr. 429:7-429:19; *see also* JX00012 Gallagher (NorthShore) Dep. Tr. 123:17-24; JX00005 Calcagno (Advocate) Dep. Tr. 56:25-59:20.

122. The only support cited by Defendants for the supposed cost savings is the Weiss Declaration, a document submitted two weeks after the close of fact discovery. PX06022 Dagen

Rebuttal Report ¶ 12. This declaration attempts to explain a spreadsheet created in June or July 2015, but not shared with anyone—including counsel—until after Mr. Weiss' first deposition in February 2016. PX02053 Weiss (NorthShore) (Day Two) Dep. Tr. 10:14-18, 15:24-16:2, 17:4-7, 18:2-13. The Weiss Declaration is completely unverifiable because it is based wholly on personal judgment, without input or review of anybody in either the NorthShore or Advocate organizations. PX06022 Dagen Rebuttal Report ¶¶ 15, 21; *see also* PX02022 Weiss (NorthShore) (Day One) Dep. Tr. at 62:12-17; PX02053 Weiss (NorthShore) (Day Two) Dep. Tr. at 9:5-15, 18:7-21:8, 32:17-18.

123. Mr. Weiss's document categorizes the overwhelming majority of claimed savings as "All other (tbd)," the specifics of which are "not identified at this point" but could come from "other opportunities" that will only be identified post-closing. PX02022 Weiss (NorthShore) (Day One) Dep. Tr. at 69:4-10, 72:2-8; PX06022 Dagen Rebuttal Report ¶ 16. Mr. Weiss admitted that no one has even looked at the "details necessary to come to better estimates of savings," and that it is "absolutely" possible that his claimed savings may not be obtainable once the merged firm actually looked into the details. PX02022 Weiss (NorthShore) (Day One) Dep. Tr. at 73:25-74:3, 81:1-6. When asked how to verify his claims, Mr. Weiss bluntly testified: "I'm at a loss as to what to advise." PX02053 Weiss (NorthShore) (Day Two) Dep. Tr. at 84:2. Defendants' claimed efficiencies are thus speculative and not verifiable. PX06022 Dagen Rebuttal Report ¶ 5.

2. The merger is not necessary for NorthShore to reduce costs in order to participate in a low-priced narrow network

124. At the conclusion of an independent analysis in 2012-13, [redacted] Since that time, NorthShore has succeeded in

reducing [redacted] of a targeted [redacted] in costs, and [redacted] PX06002 Dagen Report ¶ 23; [redacted] PX06001 Jha Report ¶ 60. NorthShore's CFO testified that NorthShore's continuing cost-cutting efforts are not dependent on or related to the merger with Advocate. PX02022 Weiss (NorthShore) (Day One) Dep. Tr. at 111:12-20, 112:22-113:15.

125. Advocate claims that the majority of cost savings from the merger will result from improved "clinical management," *i.e.*, changing the way that physicians care for patients. PX04161-001 (Advocate); *see also* Sacks (Advocate) PI Hrg. Tr. at 1468:23-1469:2 (describing "clinical transformation"). Advocate claims that substituting its "value-based incentives" for NorthShore's FFS incentives will reduce costs because Advocate believes that NorthShore's current FFS contracts create incentives for physicians to maximize revenues and engage in unnecessary care. Sacks (Advocate) PI Hrg. Tr. at 1466:8-21, 1470:5-1472:13; PX05197-014 (NorthShore/Advocate). NorthShore disagrees, and does not believe that its physician compensation structure incentivizes physicians to increase utilization or provide unnecessary care. Golbus (NorthShore) PI Hrg. Tr. at 749:7-18. NorthShore's CEO testified that the assertion that FFS incentivizes providers to perform unnecessary health care services is "misguided," and he "strongly" believes that NorthShore does not provide unnecessary services. Neaman (NorthShore) PI Hrg. Tr. at 639:18-640:22.

126. Employers that submitted letters to Defendants in support of the merger have not had any substantive discussions with Advocate or NorthShore about how the merger could improve the quality of care or reduce the total cost of care. *See* JX00001 Abrams (Medline) Dep. Tr. at 72:16-73:5; JX00017 Levin (Aon) Dep. Tr. at 84:19-85:5, 130:13-16; PX03028

Miller (North American) Decl. ¶ 8; PX03020 Inacker (Cardinal) ¶ 4; PX03041 Stein (Mark Vend) Decl. ¶ 6. Additionally, payers received no information and conducted no independent analysis of the alleged potential efficiencies. Hamman (HCSC) PI Hrg. Tr. at 169:23-170:12; Nettesheim (Aetna) PI Hrg. Tr. at 1195:19-1196:5; 1196:14-1197:10; Beck (United) PI Hrg. Tr. at 1123:15-1124:1, 1125:6-24; PX03005 Montrie (Land of Lincoln) Decl. ¶ 17; PX03004 Maxwell (Humana) Decl. ¶ 19; PX03014 Bhargava (Aetna) Decl. ¶ 14.

3. Defendants failed to establish that claimed quality efficiencies are verifiable or merger-specific

a. NorthShore already performs as well as Advocate on efficiency and utilization metrics

127. Defendants presented no reliable evidence that Advocate is a more efficient, cost-effective system than NorthShore. PX06001 Jha Report ¶ 109. Dr. Jha analyzed publicly available data and outcome measures from the Centers for Medicare & Medicaid Services ("CMS"), such as Medicare Spending per Beneficiary and rates of unnecessary imaging, which showed that NorthShore performs as well as, if not better than, Advocate on important efficiency and utilization measures. Jha PI Hrg. Tr. at 871:1-874:14, 875:4-10; PX06001 Jha Report ¶¶ 110-113, Tbls. 3-4.

b. Northshore already performs as well as, if not better than, Advocate in population health outcomes and quality

128. NorthShore does not need to merge with Advocate in order to achieve high quality or population health management ("PHM") because NorthShore already performs better than Advocate on these measures. Jha PI Hrg. Tr. at 878:2-10, 880:20-22, 882:16-20; PX06001 Jha Report ¶¶ 140, 143-148, 151, Tbls. 7a-7f. Dr. Jha compared Advocate's and NorthShore's performance on key metrics for assessing a provider's success with PHM. Jha PI Hrg. Tr. at

867:12-15, 877:3-23, 878:18-879:5, 879:18:25-881:3, 881:23-15; PX06001 Jha Report ¶¶ 143-148, Tbls. 7a-7e.

129. NorthShore and Advocate are comparable on rates of hospital-acquired infections. Jha PI Hrg. Tr. at 880:1-10; PX06001 Jha Report ¶ 147, Tbl. 7e. Other metrics show that NorthShore's outcomes are comparable to, and even slightly better than, Advocate's outcomes across the entire continuum of care, not just for inpatient hospitalization. Jha PI Hrg. Tr. at 867:2-17, 876:11-877:23, 878:18-879:5, 880:25-882:15. NorthShore performs slightly better than Advocate on all five rates of mortality publicly reported by CMS, which account for inpatient, outpatient, and post-acute care. Jha PI Hrg. Tr. at 876:13-24, 877:13-23; PX06001 Jha Report ¶¶ 143, 149, Tbls. 7a, 8. Readmission outcomes measure clinical integration and information flow across the continuum of healthcare providers. Jha PI Hrg. Tr. at 866:14-867:17. NorthShore performs better than Advocate on five of the six readmissions measures publicly reported by CMS, and on the last measure, Advocate and NorthShore perform the same. Jha PI Hrg. Tr. at 878:25-879:5; PX06001 Jha Report ¶¶ 145, 149, Tbls. 7c, 8. NorthShore performs better than Advocate on three out of four disease management measures, which are outpatient measures. Jha PI Hrg. Tr. at 880:23-882:15; PX06001 Jha Report ¶ 144, Tbl. 7b.

130. Dr. Jha used the most valid, widely used, and well-tested metrics to measure performance. Jha PI Hrg. Tr. at 869:10-16; 870:3-15, 957:13-22, 958:6-11, 958:23-959:5. Using data from CMS is the standard approach to measuring overall hospital, physician, and outpatient care quality. Jha PI Hrg. Tr. at 870:3-15; PX06001 Jha Report ¶ 17. Even Truven, which Dr. Sacks cited to as a PHM recognition, uses the same Medicare claims data from CMS. Jha PI Hrg. Tr. at 1714:9-19. The outcome metrics Defendants use also show that NorthShore performs as well as, if not better than Advocate, on PHM outcome measures. *See* Jha PI Hrg. Tr. at

1716:10-1717:9; DX7000 Dudley Report ¶ 69, Fig. 12. The metrics Defendants cite to as evidence of Advocate's leadership in PHM are primarily process measures (*e.g.*, administering a test), which are less important than outcome measures. Jha PI Hrg. Tr. at 1715:9-20, 1716:2-9; *see* Dudley PI Hrg. Tr. at 1580:22-1581:16; Sacks PI Hrg. Tr. at 1405:14-1406:10.

131. The relative socioeconomic status ("SES") of Advocate and NorthShore's patients does not account for NorthShore's relative performance. PX06021 Jha Rebuttal Report ¶¶ 59-71. Dr. Jha ran a series of analyses that confirmed there is no meaningful, consistent relationship between a hospital's SES makeup and its mortality rates or Medicare Spending per Beneficiary. Jha PI Hrg. Tr. at 954:2-4, 986:24-988:18; PX06021 Jha Rebuttal Report ¶¶ 60-66, Fig. 4, Tbls. 2-3. Dr. Dudley is incorrect that SES drives the difference between the hospitals' performance. Jha PI Hrg. Tr. at 986:15-18; PX06021 Jha Rebuttal Report ¶¶ 60-66, Fig. 4, Tbls. 2-3. Dr. Dudley did not seek to quantify whether and to what extent SES may impact Advocate and NorthShore's relative performance on key outcome metrics. Dudley PI Hrg. Tr. at 1611:17-1612:20.

132. Payers confirm that NorthShore and Advocate are both high-quality institutions that engage in PHM initiatives. PX03014 Bhargava (Aetna) Decl. ¶ 13; *see* JX00019 Maxwell (Humana) Dep. Tr. at 46:23-47:5, 107:18-24. NorthShore has received numerous recognitions: U.S. News & World Report named NorthShore Evanston Hospital one of the top ten hospitals in Illinois, and Leapfrog Group gave all four NorthShore hospitals a grade A in its hospital safety score initiative. Neaman (NorthShore) PI Hrg. Tr. at 618:16-18, 621:6-622:2; PX08008-001-002. NorthShore has earned the same PHM recognitions that Dr. Sacks pointed to as evidence of Advocate's success with PHM. Jha PI Hrg. Tr. at 1712:23-1714:8. For example, Hospitals &

Health Networks magazine named NorthShore one of the "Most Wired" health systems in the country for 11 straight years. Neaman (NorthShore) PI Hrg. Tr. at 618:19-24; PX08008-001.

c. Merger is not necessary for NorthShore to pursue RBC

133. NorthShore is already doing RBC and can continue to absent the merger. Jha PI Hrg. Tr. at 884:17-885:2, 893:20-894:4, 895:2-13, 897:2-5, 898:1-899:8; PX06001 Jha Report ¶¶ 65-73, 76, 78, 80, 90, 92; PX06021 Jha Rebuttal Report ¶¶ 82-93; *see* PX08004-005.

134. NorthShore would not be "starting from scratch" with respect to RBC absent the merger. Hamman (HCSC) PI Hrg. Tr. at 253:8-13. One internal estimate categorized at least 23% of NorthShore's patient population as being treated under some form of RBC. PX05196-006 (NorthShore). NorthShore's risk contracts are at the far end of the risk-continuums presented by Dr. Jha, Dr. Dudley, and Dr. Steele. Jha PI Hrg. Tr. at 886:18-887:4.

135. NorthShore has participated in BCBSIL's HMOI product for years; under the agreement, BCBSIL pays NorthShore a capitated payment for physician and ambulatory radiology services. [redacted]; Jha PI Hrg. Tr. at 885:15-24; PX06001 Jha Report ¶ 68. NorthShore has a shared savings ACO agreement with BCBSIL that went into effect in January 2015 and covers 58,000 patients. [redacted]; PX06001 Jha Report ¶ 66; PX05193-008 (NorthShore). NorthShore entered into the ACO agreement with BCBSIL as a "step in [the] path to risk," and in part to further develop its organizational skills in PHM. PX05193-009 (NorthShore). NorthShore has a number of bundled payment contracts. PX06001 Jha Report ¶ 67; PX05195-009-010 (NorthShore).

136. NorthShore is currently in negotiations for additional RBC. Jha PI Hrg. Tr. at 890:10-14; PX06001 Jha Report ¶ 69. NorthShore is in negotiations to participate in Aetna Whole Health in 2017 on a shared savings basis. PX06001 Jha Report ¶ 70. BCBSIL has also

approached NorthShore with the opportunity to participate in a number of risk products, and NorthShore has expressed an interest in learning more about participation in a global risk HMO agreement. PX06001 Jha Report ¶ 73; PX07013-001 (HCSC); PX07014-001-002 (HCSC); PX06001 Jha Report ¶ 69. [redacted].

137. NorthShore has expressed an interest and ability to pursue additional RBC absent the merger. Jha PI Hrg. Tr. at 889:17-890:14; PX06001 Jha Report ¶¶ 71-73; Neaman (NorthShore) PI Hrg. Tr. at 625:23-626:1; Golbus (NorthShore) PI Hrg. Tr. at 813:21-814:8, 814:16-19. In a publicly filed Medicaid application, NorthShore averred that it had "successfully positioned [itself] from both a network and functional administrative perspective to transition to the management of full-risk contracts such as the ACE program." PX08004-005.

138. NorthShore's size and geographic coverage are not an impediment to increasing RBC. Jha PI Hrg. Tr. at 890:15-892:15; PX06001 Jha Report ¶¶ 80-91, Fig. 5, Tbl. 1. While there is no clear minimum population threshold for engaging in RBC, the federal government, through CMS, has established that 5,000 patients is the minimum threshold for a provider to do RBC. Jha PI Hrg. Tr. at 892:7-11. Cigna's efforts toward value- or risk-based contracting include providers with as few as 2,500 to 5,000 attributed lives. Norton (Cigna) PI Hrg. Tr. at 85:19-86:19, 86:23-87:8. Humana testified that a provider's geographic footprint is irrelevant to successful participation in a risk-based contract, including global capitation. JX00019 Maxwell (Humana) Dep. Tr. at 43:8-44:12. NorthShore has approximately 445,000 unique patients per year. Jha PI Hrg. Tr. at 892:10-15; PX06001 Jha Report ¶ 127. Health systems smaller than or comparable to NorthShore are successfully pursuing RBC today. Jha PI Hrg. Tr. at 891:5-15, 892:13-15, PX06001 Jha Report ¶¶ 80, 82-88, 90, Fig. 5; JX00006 Cassidy (AMITA) Dep. Tr. at

227:6-227:9. Swedish Covenant, a single hospital system, successfully engages in full capitation arrangements for both Medicare and commercial populations. *See* Jha PI Hrg. Tr. at 891:4-12; PX06001 Jha Report ¶ 82; JX00021 Newton (Swedish Covenant) Dep. Tr. at 68:11-69:21, 74:2-24, 207:1-20; [redacted].

139. The concept of narrow networks and a provider's ability to participate in narrow networks is separate and distinct from RBC and a provider's ability to participate in RBC. Jha PI Hrg. Tr. at 861:14-24, 890:23-891:5; PX06001 Jha Report ¶ 52. Providers can participate in narrow networks under both FFS and RBC arrangements. Jha PI Hrg. Tr. at 861:19-24.

d. Merger is not necessary for NorthShore to pursue PHM

140. PHM, as defined by CMS, is about improving the outcomes of a population. Jha PI Hrg. Tr. at 857:14-22; PX06001 Jha Report ¶ 29. While providers can engage in PHM using a variety of tools and processes, what ultimately matters is how a provider performs on measures of population health, such as disease management, mortality, and readmissions. Jha PI Hrg. Tr. at 858:18-859:12, 894:11-15; PX06001 Jha Report ¶ 32.

141. Providers do not need to engage in RBC to be incentivized to do PHM. Jha PI Hrg. Tr. at 904:11-21, 1709:20-1710:14; PX06001 Jha Report ¶ 38; *see also* PX02022 Weiss (NorthShore) (Day One) Dep. Tr. at 50:10-16. Providers reimbursed under FFS arrangements have incentives to engage in PHM activities, such as preventive care or patient outreach, because these services are reimbursed under a FFS model. Jha PI Hrg. Tr. at 904:25-905:18.

142. Defendants' focus on Advocate's care for patients who do not encounter the health system is not the proper focus of PHM as only about 19-20% of patients do not encounter the health care system each year, and most of these patients are young and healthy. Jha PI Hrg. Tr. at 1704:8-1705:17.

143. Given that NorthShore already performs as well as, if not better than, Advocate on outcomes, the PHM processes the two systems use and the number of employees they have devoted to PHM are less relevant. Jha PI Hrg. Tr. at 936:16-23, 994:21-995:11, 1712:2-15. Yet Dr. Jha found that NorthShore engages in a number of important PHM activities. Jha PI Hrg. Tr. at 895:7-13, 897:2-899:8; PX06001 Jha Report ¶¶ 96-100, 103; PX06021 Jha Rebuttal Report ¶ 87; *see* PX08004-003-005.

144. In 2013, NorthShore formed the Care Transformation Team ("CTT"). PX06021 Jha Rebuttal Report ¶ 44; [redacted] NorthShore's CTT is a "Population Health & Value Based Capabilities Work Team" composed of an executive leadership group that meets on a regular basis to assess NorthShore's current PHM capabilities and future PHM needs. PX05013-001 (NorthShore); *see* Jha PI Hrg. Tr. at 895:14-25; JX00012 Gallagher (NorthShore) Dep. Tr. at 67:6-69:16; JX00020 Murtos (NorthShore) Dep. Tr. 44:3-8; PX06021 Jha Rebuttal Report ¶ 44.

145. Through its CTT, NorthShore has engaged in a number of PHM activities. Jha PI Hrg. Tr. at 897:2-898:14; PX05193-006 (NorthShore); JX00020 Murtos (NorthShore) Dep. Tr. at 51:6-21; *see also* PX05011-007 (NorthShore). NorthShore implemented a chronic disease management program. Jha PI Hrg. Tr. at 897:2-20; PX06001 Jha Report ¶ 97; JX00020 Murtos (NorthShore) Dep. Tr. at 51:9-20; PX05130-001, 006-014 (NorthShore). NorthShore has also furthered its clinical integration with extended providers to better manage patients' care across the continuum of providers. Jha PI Hrg. Tr. at 898:1-8; PX06001 Jha Report ¶ 98; PX08004-003-005. NorthShore has focused on developing ambulatory case management, where it identifies the most complex, highest-need patients. Jha PI Hrg. Tr. at 898:9-14; PX06001 Jha Report ¶ 99; JX00020 Murtos (NorthShore) 51:22-52:19; JX00029 Washa (NorthShore) Dep. Tr.

70:15-22, 97:4-11; PX08004-005. NorthShore has used its case management efforts to target patients with a high likelihood of hospital readmission, such as patients with congestive heart failure. JX00020 Murtos (NorthShore) Dep. Tr. at 52:15-53:22.

146. One of NorthShore's most important PHM assets is its health information technology ("HIT") infrastructure. Jha PI Hrg. Tr. at 898:15-899:8; PX06001 Jha Report ¶¶ 105-106; JX00012 Gallagher (NorthShore) Dep. Tr. 146:23-147:1, 147:25-148:23, 149:22-150:11; PX08004-005. NorthShore has won critical acclaim for its use of HIT in its clinical workflows, and NorthShore was the first hospital system in the entire country to achieve the HIMSS Analytics Stage 7 EHR designation for its physicians' offices and ambulatory clinics. Jha PI Hrg. Tr. at 898:15-899:8; PX06001 Jha Report ¶ 105. NorthShore's use of Epic, its EHR, "allows us to deliver seamless coordinated care to our patients across the whole organization." PX08004-005. Defendants actually intend to switch Advocate's physicians to NorthShore's EHR system because they recognized that NorthShore's use of EHR is "more advanced and effective than what [is] in place at Advocate." JX00012 Gallagher (NorthShore) Dep. Tr. at 152:2-5; JX00029 Washa (NorthShore) Dep. Tr. at 159:17-160:8, 160:12-161:4.

e. Defendants failed to establish that claimed quality and efficiency benefits are merger-specific

147. RBC and PHM are only relevant to the extent that they lead to better outcomes or lower costs. Jha PI Hrg. 883:24-884:10, 893:1-20, 894:10-15; PX06001 Jha Report ¶ 39.

148. Even if NorthShore could not independently engage in PHM and RBC, less anti-competitive alternatives exist other than merging with Advocate. Jha PI Hrg. Tr. at 902:19-904:7, 905:19-906:8. Third-party consulting firms, such as Dr. Steele's xG Health Solutions and United's Optum, can help providers succeed at PHM and RBC quickly. Jha PI Hrg. Tr. at 903:1-

904:7; Beck (United) PI Hrg. Tr. at 1127:14-1128:5; JX00027 Steele Dep. Tr. at 106:14-107:1, 109:22-113:4; 158:24-159:4.

149. Payers can also assist providers with PHM and RBC. Jha PI Hrg. Tr. at 905:19-906:8. Humana offers care management programs to help identify and fill gaps in a patient's care. JX00019 Maxwell (Humana) Dep. Tr. at 36:9-15. Cigna has begun to enter into collaborative care arrangements to better coordinate the care of the patients. Norton (Cigna) PI Hrg. Tr. at 86:7-19. United offers a two-year "boot camp" to help providers that are good candidates take on risk. Beck (United) PI Hrg. Tr. at 1126:13-1127:13. BCBSIL provides incentives for a provider to achieve certain cost and quality thresholds with a specific population. Hamman (HCSC) PI Hrg. Tr. at 160:15-161:21. Aetna formed its Accountable Care Solutions team to create "enablement services" to help provider systems transition to and engage in PHM. Nettesheim (Aetna) PI Hrg. Tr. at 1172:1-12.

150. Even small health systems or independent hospitals are currently engaging in broad PHM initiatives. [redacted]; JX00021 Newton (Swedish Covenant) Dep. Tr. at 202:10-205:10. Providers can and do use non-merger affiliations in order to fill clinical capability gaps to enhance services, improve the total cost of care, improve the quality of care, and help manage the health of a population. *See, e.g.*, [redacted]; JX00021 Newton (Swedish Covenant) Dep. Tr. at 208:12-212:24.

f. Defendants have failed to show the merger is likely to improve quality or decrease costs

151. Defendants failed to offer any concrete, detailed plans as to how the merger will actually lower costs or improve quality, instead focusing on broad notions of changing culture at NorthShore. Jha PI Hrg. Tr. at 910:2-5, 911:2-6; PX06021 Jha Rebuttal Report ¶¶ 14-15. Given

the significant costs and challenges of fully integrating two large health systems, Defendants needed to present a verifiable integration plan that clearly demonstrated what specific costs or quality improvements they planned to make at NorthShore. Jha PI Hrg. Tr. at 910:2-5, 912:1-13; PX06001 Jha Report ¶¶ 152, 155, 159-165.

152. Defendants failed to present any verifiable integration plan that would demonstrate how the proposed merger will actually lower costs or improve quality. PX06021 Jha Rebuttal Report ¶¶ 11, 15. This lack of planning resulted in Defendants' failure to recognize that NorthShore performs better than Advocate on key aspects of clinical care and efficiency, and thus, implementing the AdvocateCare model may have no impact, or may even reduce NorthShore's clinical care quality and efficiency. *See, e.g.*, Jha PI Hrg. Tr. at 908:10-910:5; PX06021 Jha Rebuttal Report ¶¶ 13, 15.

153. Defendants claim that this merger will result in efficiencies by changing the way NorthShore's physicians provide care, specifically by implementing the AdvocateCare incentive program for NorthShore's employed physicians post-merger. Sacks (Advocate) PI Hrg. Tr. at 1477:19-1478:8. However, Dr. Sacks testified that he does not know how NorthShore's physicians are currently compensated or whether their compensation is tied to performance on quality outcomes. Sacks (Advocate) PI Hrg. Tr. at 1478:9-11, 1478:14-16. Likewise, NorthShore does not know how Advocate's physicians are compensated or how Advocate's physician compensation structure compares to NorthShore's physician compensation structure. Golbus (NorthShore) PI Hrg. Tr. at 748:25-749:2; Neaman (NorthShore) PI Hrg. Tr. at 627:14-628:8. Additionally, Dr. Golbus testified that while he will be in charge of the combined NorthShore and Advocate medical groups post-merger, he has conducted "[n]o detailed planning" regarding the actual integration of the physician groups. Golbus (NorthShore) PI Hrg.

Tr. at 745:19-22. Dr. Golbus testified that while NorthShore physicians' "values and ethics" prevent them from providing unnecessary care, there is no concrete or detailed plan to meet the "challenge" of integrating the distinct physician cultures possessed by each organization. Golbus (NorthShore) PI Hrg. Tr. at 746:5-748:14. In fact, the NorthShore Medical Group physician compensation model already has incentive structures in place tied to quality metrics that lead to the provision of higher quality care. Golbus (NorthShore) PI Hrg. Tr. at 748:15-24, 749:3-6; PX08004-003-005.

154. Defendants needed to present detailed integration plans because merging two large health systems will be difficult, time consuming, and costly. Jha PI Hrg. Tr. at 912:1-13; PX06001 Jha Report ¶¶ 152, 155-157, 159-165; *see also* [redacted]. Integrating the systems' EHRs is essential to the overall integration of the merged system, yet this process could take two to three years and Defendants have already raised "red flags" on the HIT integration process. Jha PI Hrg. Tr. at 912:1-22; PX06001 Jha Report ¶ 159; PX05015-001 (NorthShore). According to Advocate, the integration of NorthShore's physicians can be accomplished in just 12 months. Sacks (Advocate) PI Hrg. Tr. at 1469:19-24. But clinical integration is challenging because it requires changing a system's culture and the way their doctors and nurses practice care. Jha PI Hrg. Tr. at 910:6-16; PX06001 Jha Report ¶¶ 162, 164. Clinical integration will be especially difficult because, as Defendants and their own experts admit, these two organizations have very different cultures. Jha PI Hrg. Tr. at 910:11-911:6; PX06001 Jha Report ¶ 163. Defendants believe that it could take two to three years before the two systems fully integrate, though Dr. Jha believes that this is at best a conservative timeline. Jha PI Hrg. Tr. at 912:14-22; PX06001 Jha Report ¶ 163.

155. Similar mergers have failed due to cultural conflicts. PX06001 Jha Report ¶ 165. For example, the merger between Geisinger and Hershey in 1997 failed and required the two systems to demerge in 2000 due to contrasting cultures and a poor governance structure. Jha PI Hrg. Tr. at 910:17-24; JX00027 Steele Dep. Tr. at 53:12-16. The 50/50 representation and having two CEOs proved impossible to manage. JX00027 Steele Dep. Tr. at 55:21-56:3, 56:8-13. The Proposed Merger also features a 50/50 governance structure with two CEOs, and NorthShore and Advocate have similarly contrasting cultures. Sacks (Advocate) PI Hrg. Tr. at 1467:25-1468:2; JX00027 Steele Dep. Tr. at 209:11-211:6.

156. Advocate's previous acquisitions of Condell and Sherman do not provide evidence that they will be able to reduce costs or improve quality at NorthShore. PX06001 Jha Report ¶¶ 167-169. The merger with NorthShore is materially different than the Condell and Sherman acquisitions, as both of those hospitals had some level of financial duress and had potentially been poorly managed. PX06001 Jha Report ¶ 167. Condell and Sherman were single hospitals, whereas NorthShore is a four-hospital network with nearly 2,000 employed and affiliated physicians. PX06001 Jha Report ¶ 168.

157. The significant variation in quality and population health outcomes across Advocate's hospitals, and the fact that several Advocate hospitals perform below the national average on these metrics, raises series doubts as to whether implementing the AdvocateCare model at NorthShore will actually lower costs or improve quality. Jha PI Hrg. Tr. at 911:14-25; PX06001 Jha Report ¶¶ 150, 168-169; *see also* PX04187-008, 011, 018, 020 (Advocate). Dr. Eisenstadt does not conclude that the implementation of AdvocateCare will reduce costs at NorthShore. Eisenstadt PI Hrg. Tr. at 1571:10-13, 1570:2-12.

PLAINTIFFS' PROPOSED CONCLUSIONS OF LAW

I. NATURE OF THE ACTION, JURISDICTION, VENUE

1. This is a civil action arising under Acts of Congress protecting trade and commerce against restraints and monopolies, and is brought by an agency of the United States authorized by an Act of Congress to bring this action. The Proposed Merger is alleged to violate Section 7 of the Clayton Act, 15 U.S.C. § 18, and Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45.

2. This Court has subject matter jurisdiction pursuant to Section 13(b) of the FTC Act, 15 U.S.C. § 53(b), and Section 16 of the Clayton Act, 15 U.S.C. § 26, and upon 28 U.S.C. §§ 1331, 1337, and 1345.

3. The FTC is an administrative agency of the United States established, organized, and existing pursuant to the FTC Act, 15 U.S.C. § 41 *et seq.* The FTC is vested with authority and responsibility for enforcing, *inter alia*, Section 7 of the Clayton Act, 15 U.S.C. § 18.

4. The State of Illinois is a sovereign state of the United States. This action is brought by and through its Attorney General, who is the chief law enforcement officer of the State, with the authority to bring this action on behalf of the State pursuant to Section 16 of the Clayton Act, 15 U.S.C. § 26.

5. At all relevant times, Defendants have been engaged in activities in or affecting "commerce" as defined in Section 4 of the FTC Act, 15 U.S.C. § 44, and Section 1 of the Clayton Act, 15 U.S.C. § 12.

6. Defendants transact business in the Northern District of Illinois and are subject to personal jurisdiction therein. Venue is proper. 28 U.S.C. § 1391(b)-(c); 15 U.S.C. § 53(b).

7. This Court has jurisdiction to issue a preliminary injunction pending the conclusion of an administrative proceeding that will determine whether the Proposed Merger

violates Section 7 of the Clayton Act. 15 U.S.C. § 53(b).

II. THE 13(B) STANDARD FOR A PRELIMINARY INJUNCTION

8. Plaintiffs "seek a preliminary injunction to prevent a merger pending the Commission's administrative adjudication of the merger's legality." *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 714 (D.C. Cir. 2001) (internal quotation marks omitted). Preliminary injunctions are "readily available" under 15 U.S.C. § 53(b) "to preserve the status quo while the FTC develops its ultimate case." *FTC v. Whole Foods Mkt., Inc.*, 548 F.3d 1028, 1036 (D.C. Cir. 2008).

9. Section 13(b) of the FTC Act authorizes this Court to grant a preliminary injunction if, upon "weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest . . . ." 15 U.S.C. § 53(b); *see also FTC v. Elders Grain, Inc.*, 868 F.2d 901, 903 (7th Cir. 1989); *FTC v. Rhinechem Corp.*, 459 F. Supp. 785, 787 (N.D. Ill. 1978).

10. "Therefore, in determining whether to grant a preliminary injunction under Section 13(b), a district court must (1) determine the likelihood that the FTC will ultimately succeed on the merits and (2) balance the equities." *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1073 (N.D. Ill. 2012) (quoting *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1217 (11th Cir. 1991)); *see also FTC v. ProMedica Health Sys., Inc.*, No. 3:11 CV 47, 2011 WL 1219281, at *53 (N.D. Ohio Mar. 29, 2011).

11. To evaluate the FTC's "likelihood of success" at the administrative trial, this Court need only "measure the probability that, after an administrative hearing on the merits, the Commission will succeed in proving that the effect of the [proposed] merger '*may be* substantially to lessen competition, or to tend to create a monopoly' in violation of section 7 of the Clayton Act." *Heinz*, 246 F.3d at 714 (quoting 15 U.S.C. § 18) (emphasis added); *see also FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 22 (D.D.C. 2015). The Commission "is not required to

establish that the proposed merger would in fact violate Section 7 of the Clayton Act." *Heinz*, 246 F.3d at 714. In fact, the district court "'is not authorized to determine whether the antitrust laws . . . are about to be violated.' That responsibility lies with the FTC." *Whole Foods*, 548 F.3d at 1035 (citation omitted); *see also ProMedica*, 2011 WL 1219281, at *53 ("The ultimate determination as to a section 7 violation of the Clayton Act is an adjudicatory function vested in the FTC.") (internal citations and quotations omitted).

12. The second prong of Section 13(b) requires the Court to "weigh the equities" to determine whether a preliminary injunction is in the public interest. *Heinz*, 246 F.3d at 726. "The principal public equity weighing in favor of issuance of preliminary injunctive relief is the public interest in effective enforcement of the antitrust laws." *Id.* The Commission's showing of a likelihood of success on the merits "weighs heavily in favor of a preliminary injunction blocking the acquisition." *FTC v. PPG Indus., Inc.*, 798 F.2d 1500, 1508 (D.C. Cir. 1986) (internal quotation marks omitted). Absent such relief, it would be extremely difficult, if not impossible, for competition to be restored to its previous state if the Commission ultimately finds the merger unlawful. *FTC v. Weyerhaeuser Co.*, 665 F.2d 1072, 1085-86 n.31 (D.C. Cir. 1981). In fact, "[n]o court has denied relief to the FTC in a [Section] 13(b) proceeding in which the FTC has demonstrated a likelihood of success on the merits." *ProMedica*, 2011 WL 1219281, at *60.

13. The "risk that the transaction will not occur at all" is "a private consideration that cannot alone defeat the preliminary injunction." *Whole Foods*, 548 F.3d at 1041 (internal quotation marks omitted); *see also Heinz*, 246 F.3d at 726-27; *Sysco*, 113 F. Supp. 3d at 87.

III. CLAYTON ACT SECTION 7 STANDARD AND CONCLUSIONS

14. Plaintiffs' underlying antitrust claims—which will be adjudicated in the administrative trial on the merits—are brought under Section 7 of the Clayton Act and Section 5

of the FTC Act. Section 7 of the Clayton Act prohibits mergers "the effect of [which] may be substantially to lessen competition" in "any line of commerce." 15 U.S.C. § 18.

15. Section 7 of the Clayton Act is intended to prevent anticompetitive mergers "in their incipiency," *before* they create anticompetitive harm. *See United States v. Phila. Nat'l Bank*, 374 U.S. 321, 362 (1963) (internal quotation marks omitted). "Congress used the words '*may* be substantially to lessen competition' . . . to indicate that its concern was with probabilities, not certainties"—even on the ultimate merits. *Heinz*, 246 F.3d at 713 (internal quotation marks omitted). "[C]ertainty, even a high probability, need not be shown," and "doubts are to be resolved *against* the transaction." *Elders Grain*, 868 F.2d at 906 (emphasis added).

16. Courts employ a burden-shifting approach to determine if the FTC has shown a likelihood of success on the merits of its Section 7 claim. *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1074 (citing *Heinz*, 246 F.3d at 715). "Initially, the FTC must make a prima facie showing that the proposed merger would result in 'a firm controlling an undue percentage share of the relevant market,'" consisting of a product market and a geographic market component, as well as "a significant increase in the concentration of firms in that market." *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1074 (quoting *Phila. Nat'l Bank*, 374 U.S. at 363).

17. An acquisition that causes undue market share and significantly increases concentration "is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects." *Phila. Nat'l Bank*, 374 U.S. at 363. "If the government makes this prima facie showing, a presumption of illegality arises." *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1074 (quoting *Univ. Health*, 938 F.2d at 1218); *see also FTC v. Staples, Inc.*, 970 F. Supp.

1066, 1083 (D.D.C. 1997) ("By showing that the proposed transaction . . . will lead to undue concentration [for a particular product in a particular geography], the Commission establishes a presumption that the transaction will substantially lessen competition."). This presumption establishes a *prima facie* case that the merger is unlawful. *See Heinz*, 246 F.3d at 715.

18. Defendants bear the burden of rebutting the *prima facie* case. *United States v. Marine Bancorp. Inc.*, 418 U.S. 602, 631-32 (1974). Indeed, a presumptively unlawful merger "must be enjoined," *Phila. Nat'l Bank*, 374 U.S. at 363, unless Defendants provide rebuttal evidence demonstrating "that the market-share statistics give an inaccurate account of the merger's probable effects on competition in the relevant market." *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1075 (quoting *Heinz*, 246 F.3d at 715). The "more compelling the prima facie case, the more evidence the defendant must present to rebut it successfully." *Heinz*, 246 F.3d at 725 (citation omitted); *accord United States v. H&R Block, Inc.*, 833 F. Supp. 2d 36, 72 (D.D.C. 2011). If, and only if, Defendants come forward with evidence sufficient to rebut the presumption, does the burden of producing additional evidence of anticompetitive effects shift back to the government. *H&R Block*, 833 F. Supp. 2d at 50; *Sysco*, 113 F. Supp. 3d at 23.

A. GAC Services Constitute a Relevant Product Market

19. A relevant product market "for antitrust purposes is the one relevant to the particular legal issue at hand." *H&R Block*, 833 F. Supp. 2d at 51 n.8 (emphasis omitted) (quoting 5C Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law ¶ 533, at 251 (3d ed. 2007)). In a merger case, a relevant product market is the line of commerce in which competition may be substantially lessened because of the merger. *See Phila. Nat'l Bank*, 374 U.S. at 355-56; *Brown Shoe Co. v. United States*, 370 U.S. 294, 324 (1962).

20. "An analytical method often used by courts to define a relevant market is to ask hypothetically whether it would be profitable to have a monopoly over a given set of

substitutable products." *H&R Block*, 833 F. Supp. 2d at 51. If such a hypothetical monopolist could profitably impose a small but significant non-transitory increase in price—typically five percent—over particular products or services, then those products or services constitute a relevant antitrust market. *Id.*; *Merger Guidelines* §§ 4.1.1-4.1.3.

21. This approach—the "hypothetical monopolist test"—is endorsed by the *Merger Guidelines* and has been widely used by courts. *See Heinz*, 246 F.3d at 719; *Sysco*, 113 F. Supp. 3d at 33; *H&R Block*, 833 F. Supp. 2d at 51-52; *Merger Guidelines* §§ 4.1.1-4.1.3.

22. Defining a relevant product market turns on inclusion of all reasonable substitute products. *See H&R Block*, 833 F. Supp. 2d at 50-51. In some instances, otherwise separate individual relevant product markets also can be grouped together into a cluster market for analytical convenience. *See ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 565-68 (6th Cir. 2014); *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1075-76. Such clustering is appropriate only when the individual products face similar competitive conditions. *See ProMedica*, 749 F.3d at 565-68; *In the Matter of ProMedica Health Sys., Inc.*, FTC Dkt. No. 9346, 2012 WL 2450574, at *33-36 (F.T.C. June 25, 2012). If the products face similar competitive conditions, then the product market analysis will be the same whether conducted for each product individually or for the cluster as a whole. *See Brown Shoe*, 370 U.S. at 327-28.

23. It also can be appropriate to define a relevant market based on distinct categories of customers. *See OSF Healthcare Sys.*, 852 F. Supp. 2d at 1075-76 (finding a relevant product market of GAC Services sold to commercial health plans).

24. The relevant product market in this case is GAC Services. This is a "cluster market" of services that courts consistently have found when analyzing hospital mergers. *See, e.g., United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990); *OSF*

Healthcare Sys., 852 F. Supp. 2d at 1075-76; *Univ. Health*, 938 F.2d at 1210-11; *ProMedica*, 2011 WL 1219281, at *9; *In the Matter of Evanston Nw. Healthcare Corp.*, FTC Dkt. No. 9315, 2007 WL 2286195, at *47 (F.T.C. Aug. 6, 2007).

25. The inpatient services included in the cluster market are not substitutes for one another (*i.e.*, appendectomies and coronary bypass surgery are not interchangeable). *Rockford Mem'l*, 898 F.2d at 1284; *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1260-61 (N.D. Ill. 1989). However, individual product markets may be clustered for analytical convenience if "the competitive conditions for two markets are similar enough to analyze them together." *ProMedica*, 749 F.3d at 567. "The competitive conditions for hospital services include the barriers to entry for a particular service—*e.g.*, how difficult it might be for a new competitor to buy the equipment and sign up the professionals necessary to offer the service—as well as the hospitals' respective market shares for the service and the geographic market for the service." *Id.* at 565. In this case, GAC Services included in the relevant product market are provided by the same competitors and under similar competitive conditions, including entry conditions; thus, it is appropriate to analyze these GAC Services together. *See, e.g.*, *id.* at 565-66; *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1075-76.

26. The relevant product market excludes outpatient services because they are not substitutes for inpatient services and because they are subject to different competitive conditions (including a different set of providers) than are inpatient services. *Rockford Mem'l*, 898 F.2d at 1284 (excluding outpatient services from GAC Services product market); *Evanston*, 2007 WL 2286195, at *46; *ProMedica*, 749 F.3d at 565-66; *ProMedica*, 2011 WL 1219281, at *9.

27. The relevant product market also excludes inpatient psychiatric and rehabilitation services because they are provided by a different set of firms and are subject to different

competitive conditions than the provision of GAC Services. *See OSF Healthcare Sys.*, 852 F. Supp. 2d at 1076.

B. The Relevant Geographic Market is the North Shore Area

28. Section 7 of the Clayton Act prohibits acquisitions that are likely to lessen competition in "any section of the country," otherwise known as a geographic market. *Phila. Nat'l Bank*, 374 U.S. at 355-56. The ultimate question for geographic market definition is "where, within the area of competitive overlap, the effect of the merger on competition will be direct and immediate." *Phila. Nat'l Bank*, 374 U.S. at 357; *In the Matter of Polypore Int'l, Inc.*, FTC Dkt. No. 9327, 2010 WL 9549988, at *16 (F.T.C. Nov. 5, 2010).

29. "Under the case law and Merger Guidelines, the relevant question to define the geographic market is whether a hypothetical monopolist controlling all . . . hospitals [in the geographic area] could profitably implement a small but significant non-transitory increase in price ('SSNIP')." *ProMedica*, 2011 WL 1219281, at *55 (citing *Merger Guidelines* § 4.2). "The hypothetical monopolist test requires that a hypothetical profit-maximizing firm that was the only present or future producer of the relevant product(s) located in the region would impose at least a SSNIP *from at least one location, including at least one location of one of the merging firms*." *Merger Guidelines* § 4.2.1 (emphasis added).

30. The relevant geographic market "is the area in which consumers can practically turn for alternative sources of the product and in which the antitrust defendants face competition." *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1076 (internal quotation omitted); *see also Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 784 (9th Cir. 2015) ("The relevant geographic market is the area of effective competition where buyers can turn for alternate sources of supply. . . . Put differently, a market is the group of sellers or producers who have the actual or potential ability to deprive each other of significant

levels of business.") (internal citations and quotations omitted). The relevant geographic market must "correspond to the commercial realities of the industry" as determined by a "pragmatic, factual approach" to assessing the industry. *Brown Shoe*, 370 U.S. at 336 (internal quotation omitted); *see also ProMedica*, 2011 WL 1219281, at *55; *see generally Phila. Nat'l Bank*, 374 U.S. at 358-62.

31. The relevant geographic market within which to analyze the competitive effects of the Proposed Merger is no broader than the North Shore Area.

32. No court has ever held that a market definition in one case is binding in subsequent cases because market definition determinations are "factual findings" based on "supporting record evidence." *United States v. Microsoft Corp.*, 253 F.3d 34, 52 (D.C. Cir. 2001); *see also Vesta Corp. v. Amdocs Mgmt. Ltd.*, 129 F. Supp. 3d 1012, 1025 (D. Or. 2015); *United States v. Bazaarvoice, Inc.*, 13-cv-00133-WHO, 2014 WL 203966, at *22 (N.D. Cal. Jan. 8, 2014). Prior market determinations cannot dictate future determinations because "the law of mergers looks not only at the parties but also at the market circumstances, and the market circumstances change with each subsequent merger." 9C Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law ¶ 927 (3d ed. 2007).

C. The Proposed Merger is Presumptively Unlawful Based on Market Shares and Market Concentration Thresholds

33. A merger that significantly increases market shares and concentration is presumed unlawful under Section 7 of the Clayton Act. *See Phila. Nat'l Bank*, 374 U.S. at 363. Such a merger "is so inherently likely to lessen competition substantially that it *must be enjoined*" unless Defendants can rebut the presumption. *Id.* (emphasis added); *see also Heinz*, 246 F.3d at 715.

34. Market concentration can be measured using the Herfindahl-Hirschman Index ("HHI"), as adopted by the federal antitrust enforcement agencies. *Merger Guidelines* § 5.3.

Courts have likewise adopted and relied on the HHI as a measure of market concentration. *See, e.g., Univ. Health*, 938 F.2d at 1211 n.12; *ProMedica*, 2011 WL 1219281, at *56; *PPG Indus.*, 798 F.2d at 1502-03; *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 53-54 (D.D.C. 1998); *Staples*, 970 F. Supp. at 1081-82 & n.12. The HHI is calculated by summing the squares of the individual market share of each market participant. *See Sysco*, 113 F. Supp. 3d at 52.

35. A merger is presumptively unlawful if it increases the HHI by more than 200 points and results in a post-merger HHI exceeding 2,500. *Merger Guidelines* § 5.3; *see also OSF Healthcare Sys.*, 852 F. Supp. 2d at 1079-80; *ProMedica*, 2011 WL 1219281, at *56.

36. "Sufficiently large HHI figures establish the FTC's prima facie case that a merger is anti-competitive." *Heinz*, 246 F.3d at 716; *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1079.

37. The Proposed Merger, which would result in a post-merger HHI over 3,900 points, an HHI increase of over 1,750 points, and a post-merger market share of 60%, is presumptively unlawful. *See Heinz*, 246 F.3d at 716-17. The market concentration shares and HHI levels here far exceed levels found to be unlawful by the Supreme Court and other courts. *See, e.g., Phila. Nat'l Bank*, 374 U.S. at 364-65 (concluding that a merger resulting in a single firm controlling at least 30% of the relevant market was sufficient to "raise an inference that the effect of the contemplated merger . . . may be substantially to lessen competition" and violated the Clayton Act); *Univ. Health*, 938 F.2d at 1211 n.12, 1219 (FTC "clearly established a prima facie case" where the merger would have resulted in a firm with 43% of the GAC Services market); *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1078-79 (explaining that the court "ha[d] no trouble finding" that the proposed merger was presumptively anticompetitive where the merged entity would control 59.4% of the GAC Services market); *ProMedica*, 2011 WL 1219281 at *12, (finding, "[b]y a wide margin," that the proposed acquisition was "presumptively

anticompetitive" where the merged entity would control 58.3% of the GAC Services market); *Cardinal Health*, 12 F. Supp. 2d at 52-54 (enjoining two mergers that would have resulted in 600 and 800 point increases in HHI).

D. Competitive Effects Evidence Bolsters the Strong Presumption of Harm and Illegality

38. Rather than defining markets and calculating market shares and HHIs to establish a presumption that the Proposed Merger is unlawful, the FTC may also demonstrate a likelihood of success on the merits by producing direct evidence that the Proposed Merger would likely result in a substantial lessening of competition. *See Whole Foods*, 548 F.3d at 1036 (establishing a presumption of illegality based on undue concentration "does not exhaust the possible ways to prove a § 7 violation on the merits").

39. Courts have repeatedly held that transactions that would eliminate significant head-to-head competition are likely to result in anticompetitive effects. *See, e.g.*, *Sysco*, 113 F. Supp. 3d at 61-65; *H&R Block*, 833 F. Supp. 2d at 88-89; *FTC v. Swedish Match*, 131 F. Supp. 2d 151, 169 (D.D.C. 2000); *Staples*, 970 F. Supp. at 1083. "The elimination of competition between two firms that results from their merger may alone constitute a substantial lessening of competition" leading to unilateral anticompetitive effects. *Merger Guidelines* § 6. "A merger is likely to have unilateral anticompetitive effect if the acquiring firm will have the incentive to raise prices or reduce quality after the acquisition, independent of competitive responses from other firms." *H&R Block*, 833 F. Supp. 2d at 81. "The extent of direct competition between . . . the merging parties is central to the evaluation of unilateral effects." *ProMedica*, 749 F.3d at 569 (quoting *Merger Guidelines* § 6.1).

40. However, the merging parties need not be each other's closest competitor for their merger to lead to unilateral anticompetitive effects. *See, e.g.*, *H&R Block*, 833 F. Supp. 2d at 83.

"A merger may produce significant unilateral effects . . . even though many more sales are diverted to . . . non-merging firms than to . . . the merger partner. *Merger Guidelines* § 6.1; *see also ProMedica*, 749 F.3d at 569.

41. "[A] merger between two competing sellers prevents buyers from playing those sellers off against each other in negotiations." *Merger Guidelines* § 6.2. The elimination of that competition "alone can significantly enhance the ability and incentive of the merged entity to obtain a result more favorable to it, and less favorable to the buyer, than the merging firms would have offered separately absent the merger." *Merger Guidelines* § 6.2. Thus, where a merger "eliminates a supplier whose presence contributed significantly to a buyer's negotiating leverage," the merger is likely to cause competitive harm. *Merger Guidelines* § 8.

42. Plaintiffs are not "required to show that *all* competition will be eliminated as the result of a merger in order to obtain an injunction." *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1083 (emphasis added). Plaintiffs must show only that the merger may substantially *lessen* competition. *See* 15 U.S.C. § 18 (emphasis added). Where, as here, a significant portion of Defendants' customers consider the merging systems as their first and second best alternatives, the merger is likely to substantially lessen competition even if the merged firm will still face competition from third parties. *See Heinz*, 246 F.3d at 713, 717-19; *Swedish Match*, 131 F. Supp. 2d at 169; *Staples*, 970 F. Supp. at 1083. The Proposed Merger will eliminate close competition between Advocate and NorthShore for GAC Services in the North Shore Area and thus leaves "little doubt" that the Merger "will tend to harm competition in that market." *Whole Foods*, 548 F.3d at 1043.

43. To prevail under Section 7, plaintiffs need only establish that the merged firm will have the ability to raise prices or reduce quality after the Merger. *See H&R Block*, 833 F. Supp.

2d at 81. "All that is necessary is that the merger create an appreciable danger of [anticompetitive] consequences in the future. A predictive judgment, necessarily probabilistic and judgmental rather than demonstrable is called for." *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1082 (quoting *Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1389 (7th Cir. 1986)). There is "no authority indicating that a merger simulation is required in order to obtain a preliminary injunction." *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1086. The fact that an expert has not "performed a merger simulation to determine the actual price effect of the proposed merger . . . does not overcome the FTC's compelling prima facie case." *Id.*

E. Defendants Cannot Rebut the Strong Presumption of Illegality or Plaintiffs' Showing of Likely Competitive Harm

44. With the presumption of illegality established, the burden shifts to Defendants to rebut the presumption by "produc[ing] evidence that 'show[s] that the market-share statistics [give] an inaccurate account of the [merger's] probable effects on competition' in the relevant market." *Heinz*, 246 F.3d at 715 (quoting *United States v. Citizens & S. Nat'l Bank*, 422 U.S. 86, 120 (1975)); *Univ. Health*, 938 F.2d at 1218; *ProMedica*, 2011 WL 1219281, at *56. Defendants must produce evidence that "clearly show[s]" that no anticompetitive effects are likely in order to overcome Plaintiffs' *prima facie* case. *Phila. Nat'l Bank*, 374 U.S. at 363. Defendants bear a heavy burden given the strength of Plaintiffs' *prima facie* case. *See Sysco*, 113 F. Supp. 3d at 23 (explaining that the stronger the *prima facie* case, the more evidence defendants must present to rebut the established presumption); *Heinz*, 246 F.3d at 725 ("[T]he more compelling the prima facie case, the more evidence the defendant must present to rebut it successfully.") (internal citation and quotation marks omitted); *see also OSF Healthcare Sys.*, 852 F. Supp. 2d at 1082.

1. Entry, Expansion, or Repositioning Will Not Be Timely, Likely, or Sufficient To Rescue this Anticompetitive Merger

45. Entry must be "timely, likely, and sufficient in its magnitude, character and scope to deter or counteract the competitive effects" of a proposed merger. *Merger Guidelines* § 9; *FTC v. Procter & Gamble, Co.*, 386 U.S. 568, 579 (1967); *FTC v. Bass Bros. Enters., Inc.*, No. C84-1304, 1984 WL 355, at *12-13 (N.D. Ohio June 6, 1984) (noting unlikelihood of entry due to regulatory and cost barriers); *see also Cardinal Health*, 12 F. Supp. 2d at 54-58 (adopting and applying "timely, likely, and sufficient" test). Defendants must show both that entry is likely—meaning technically possible and economically sensible—and that it will replace the competition that existed prior to the merger. *See Cardinal Health*, 12 F. Supp. 2d at 56-58; *In re Chicago Bridge & Iron Co.*, 138 F.T.C. 1024, 1071-72 (2005), *aff'd sub nom. Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410 (5th Cir. 2008).

46. To counteract the competition lost through the Merger, any "repositioning" by competitors must be the "equivalent to new entry." *See FTC v. CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 57 (D.D.C. 2009).

47. The Illinois Certificate of Need ("CON") statute is a well-recognized "regulatory barrier to entry" that makes it less likely that sufficient entry will occur in a timely manner. *See Rockford Mem'l*, 898 F.2d at 1285; *see also Hosp. Corp. of Am.*, 807 F.2d at 1387-89; *Univ. Health*, 938 F.2d at 1219.

48. The higher the barriers to entry, as in this case, the less likely it is that the "timely, likely, and sufficient" test can be met. *United States v. Visa U.S.A., Inc.*, 163 F. Supp. 2d 322, 342 (S.D.N.Y. 2001), *aff'd*, 344 F.3d 229, 240 (2d Cir. 2003).

49. Entry, expansion, or repositioning will not be timely, likely, or sufficient to counteract the competition lost through the Proposed Merger.

2. Defendants' Purported Efficiencies Are Not Cognizable and Do Not Outweigh Competitive Harm

50. Defendants bear a heavy burden to "verify by reasonable means the likelihood and magnitude of each asserted efficiency, how and when each would be achieved (and any costs of doing so), how each would enhance the merged firm's ability and incentive to compete, and why each would be merger-specific." *H&R Block*, 833 F. Supp. 2d at 89 (citing *Merger Guidelines* § 10); *Heinz*, 246 F.3d at 720-21; *see also Sysco*, 113 F. Supp. 3d at 82 ("[T]he court must determine whether the efficiencies are merger specific—meaning they represent a type of cost saving that could not be achieved without the merger—and verifiable—meaning the estimate of the predicted saving must be reasonably verifiable by an independent party.") (internal citation and quotation marks omitted); *Univ. Health*, 938 F.2d at 1223; *Staples*, 970 F. Supp. at 1089-90; *Cardinal Health*, 12 F. Supp. 2d at 62 ("In light of the anti-competitive concerns that mergers raise, efficiencies, no matter how great, should not be considered if they could also be accomplished without a merger."). Only efficiencies specific to the merger are cognizable. *Heinz*, 246 F.3d at 721 ("[T]he asserted efficiencies must be 'merger-specific' to be cognizable as a defense.").

51. Where the court finds "high market concentration levels, defendants must present proof of extraordinary efficiencies to rebut the government's *prima facie* case." *Sysco*, 113 F. Supp. 3d at 81 (internal citations and quotation omitted); *see also Heinz*, 246 F.3d at 720.

52. "[D]efendant[s] [cannot] overcome a presumption of illegality based solely on speculative, self-serving assertions." *Univ. Health*, 938 F.2d at 1223. "While reliance on the estimation and judgment of experienced executives about costs may be perfectly sensible as a business matter, the lack of a verifiable method of factual analysis resulting in the cost estimates renders them not cognizable by the Court." *H&R Block*, 833 F. Supp. 2d at 91.

53. Efficiency claims "generated outside of the usual business planning process" are "viewed with skepticism." *ProMedica*, 2011 WL 1219281, at *40; *Merger Guidelines* § 10.

54. The Court must undertake a "rigorous" analysis to ensure that Defendants' claimed efficiencies are not just "promises about post-merger behavior." *Heinz*, 246 F.3d at 721. "Delayed benefits . . . are less proximate and more difficult to predict," and thus are entitled to little weight. *CCC Holdings*, 605 F. Supp. 2d at 73; *Merger Guidelines* § 10 n.15.

55. Although the fact that a merged entity "might provide better service to patients after the merger" is "a laudable goal, . . . the Clayton Act does not excuse mergers that lessen competition or create monopolies simply because the merged entity can improve its operations." *Saint Alphonsus Med. Ctr.*, 778 F.3d at 792.

56. The sharing of best practices is not a merger-specific efficiency. *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1092-93 ("[T]his claimed efficiency is not cognizable because the sharing of best practices is not merger-specific."); *see also Rockford Mem'l*, 717 F. Supp. at 1291 ("[T]he standardization of clinical practices does not require a merger.").

57. An expert's survey-based opinions, such as those cited here by Defendants in support of their claim that the proposed merger will create a new product for the insurance marketplace, are "entitled to no weight" if the survey is found to be unreliable due to defects in the survey design and execution, such as "(1) the screening questionnaire failed to identify relevant respondents; (2) the questionnaire instructions were complex and confusing; (3) a pre-test was not conducted; (4) the response rate was low; (5) non-response bias was not addressed; (6) respondents were unwilling or unable to devote time to take the survey seriously; (7) the results could not be replicated; (8) a standard error measurement was not calculated; and (9) a

key parameter estimate was arbitrarily changed." *United States v. Dentsply Int'l, Inc.*, 277 F. Supp. 2d 387, 453-54 (D. Del. 2003), *rev'd on other grounds*, 399 F.3d 181 (3d Cir. 2005).

58. "No court in a [Section] 13(b) proceeding, or otherwise, has found efficiencies sufficient to rescue an otherwise illegal merger." *ProMedica*, 2011 WL 1219281, at *57; *see also Sysco*, 113 F. Supp. 3d at 82 (stating that in no case have "merging parties . . . successfully rebutted the government's *prima facie* case on the strength of the efficiencies") (citing *CCC Holdings*, 605 F. Supp. 2d at 72); *Procter & Gamble*, 386 U.S. at 580 ("[P]ossible economies cannot be used as a defense to illegality. Congress was aware that some mergers which lessen competition may also result in economies but it struck the balance in favor of protecting competition."). "[T]he Clayton Act is in full force, and it must be enforced. The Act does not give the Court discretion to set it aside to conduct a health care experiment." *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 2014 WL 407446, at *25 (D. Idaho Jan. 24, 2014).

59. Defendants' purported efficiencies are not cognizable and do not overcome the anticompetitive effects of the Proposed Merger.

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

60. Courts have repeatedly rejected "behavioral remedies" or conduct restrictions that merging parties claim will prevent substantial reduction in competition. *See In re ProMedica Health Sys.*, FTC Dkt. No. 9346, 2012 WL 1155392, at *48-49 (F.T.C. Mar. 28, 2012), *aff'd*, 749 F.3d at 572-73; *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1085 (rejecting stipulation to behavioral remedy related to payer contracting in hospital merger). The Supreme Court has long held that structural remedies, such as divestiture or enjoining a merger entirely, are the "natural remedy" for unlawful mergers and acquisitions because they are "simple, relatively easy to

administer, and sure." *United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 329-31 (1961). Compared to conduct restrictions, structural remedies are "desirable because, in general, a remedy is more likely to restore competition if the firms that engage in pre-merger competition are not under common ownership," and there are "usually greater long term costs associated with monitoring the efficacy of a conduct remedy than with imposing a structural solution." *ProMedica*, 2012 WL 2450574, at *66 (quoting *Evanston Nw.*, 2007 WL 2286195, at *77); *see also Commonwealth v. Partners Healthcare Sys.*, No. SUCV2014-0233-BLS2, 2015 WL 500995, at *1-2 (Sup. Ct. Mass. Jan. 30, 2015) ("[S]o-called 'conduct-based' remedies" are "temporary and limited in scope—like putting a band-aid on a gaping wound that will only continue to bleed (perhaps even more profusely) once the band-aid is taken off.").

IV. THE EQUITIES FAVOR A PRELIMINARY INJUNCTION

61. A preliminary injunction is in the public interest. *See Heinz*, 246 F.3d at 726. Because Plaintiffs have shown a likelihood of success on the merits, "there is a presumption in favor of injunctive relief." *Sysco*, 113 F. Supp. 3d at 86.

62. The strong interests weighing in favor of injunctive relief include "(i) the public interest in effectively enforcing antitrust laws and (ii) the public interest in ensuring that the FTC has the ability to order effective relief if it succeeds at the merits trial." *Sysco*, 113 F. Supp. 3d at 86; *see also Heinz*, 246 F.3d at 726; *Swedish Match*, 131 F. Supp. 2d at 173.

63. "[T]he equities will often weigh in favor of the FTC, since 'the public interest in effective enforcement of the antitrust laws' was Congress's specific 'public equity consideration' in enacting [Section 13(b)]." *Whole Foods*, 548 F.3d at 1035 (quoting *Heinz*, 246 F.3d at 726). When the FTC demonstrates that it is likely to succeed on the merits, a "great weight" is assigned to the "potential injury to the public" from lost competition. *Rhinechem*, 459 F. Supp. at 785. Indeed, "[n]o court has denied relief to the FTC in a [Section] 13(b) proceeding in which

the FTC has demonstrated a likelihood of success on the merits." *ProMedica*, 2011 WL 1219281, at *60; *see also PPG Indus.*, 798 F.2d at 1508 (likelihood of success "weighs heavily in favor of a preliminary injunction") (quoting *Weyerhaeuser*, 665 F.2d at 1085).

64. An equally important public equity is the preservation of the Commission's ability to obtain effective relief if the Proposed Merger is ultimately found to violate Section 7 of the Clayton Act. Without a preliminary injunction, Defendants can "scramble the eggs"—that is, combine their operations and make it extremely difficult, if not impossible, for competition to be restored to its previous state. *Heinz*, 246 F.3d at 726 (citing *FTC v. Dean Foods Co.*, 384 U.S. 597, 606 n.5 (1966) ("Administrative experience shows that the Commission's inability to unscramble merged assets frequently prevents entry of an effective order of divestiture.")); *Weyerhaeuser*, 665 F.2d at 1085-86 n.31; *Whole Foods*, 548 F.3d at 1034.

65. Defendants have offered no valid equities weighing against a preliminary injunction. Private equities "are not proper considerations for granting or withholding injunctive relief under Section 13(b)." *ProMedica*, 2011 WL 1219281, at *60 (citing *FTC v. Food Town Stores, Inc.*, 539 F.2d 1339, 1346 (4th Cir. 1976)); *see also Elders Grain*, 868 F.2d at 903. Moreover, "if the benefits of a merger are available after the trial on the merits, they do not constitute public equities weighing against a preliminary injunction." *ProMedica*, 2011 WL 1219281, at *60; *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1095; *Heinz*, 246 F.3d at 726 ("If the merger makes economic sense now, the appellees have offered no reason why it would not do so later.").

66. The equities decisively favor a preliminary injunction.

Dated: May 18, 2016

Respectfully Submitted,

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CERTIFICATE OF SERVICE

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

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