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.

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

[redacted]

PUBLIC VERSION

AMENDED/CORRECTED REPLY MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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Defendants' proposed merger would combine the first and second largest hospital systems in the northern suburbs of Chicago. In the highly concentrated general acute care inpatient services ("GAC Services") market, Defendants have a combined share of 60%, which is well above the threshold necessary to establish a presumption of illegality. While this evidence is alone sufficient to establish Plaintiffs' likelihood of success on the merits, numerous other sources of evidence confirm that the merger is likely to harm competition. Defendants' own internal strategy documents show that Advocate and NorthShore are close and important competitors. Defendants' own experts agree that the two systems are good substitutes for each other and that each Defendant is constrained by competition from the other. Defendants' most important customers confirm that the elimination of this close and unmatched competition will greatly enhance the merged system's bargaining power. The inevitable result, as Plaintiffs' expert economist shows, is that the merger will lead to price increases.

Against this evidence, Advocate and NorthShore attempt to justify their anticompetitive merger with the speculative and implausible argument that it is actually *good* for consumers because it will allow managed care organizations ("MCOs") to sell Advocate's "high performing network" to more subscribers. "High performing network" is just a marketing term for a narrow network HMO insurance product, and being able to sell a narrow network to more subscribers is not an efficiency recognized under the antitrust laws.

Defendants claim that the purpose of the merger is to provide lower cost and higher quality healthcare. While these are laudable goals, Defendants fail entirely to demonstrate how the merger will generate such benefits. Any conceivable benefit of the "HPN" – which in any event would affect only the minority of residents who might choose this particular insurance

product – can be attained through means other than a merger of the two largest healthcare systems in northern Cook and southern Lake counties.

While the alleged benefits of the proposed merger are speculative, the harms from the merger are not. The merger will eliminate the substantial head-to-head competition between Advocate and NorthShore that benefits all healthcare consumers in the North Shore Area. Once the merger is consummated, the eggs cannot be unscrambled and competition cannot be restored. A preliminary injunction is warranted.

ARGUMENT

The standard applicable to Plaintiffs' Motion is well settled and uncontroversial. The FTC Act provides that a district court may grant a preliminary injunction "[u]pon a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest." *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 902 (7th Cir. 1989). The Seventh Circuit, like other circuits, applies a "sliding scale" approach to preliminary injunction motions brought under the FTC Act. *See id.* at 903. Here, Plaintiffs easily meet the applicable standard because they are very likely to succeed on the merits of their Section 7 claim and the public interest in maintaining competition pending a full administrative hearing far outweighs any potential harm caused by a preliminary injunction.

I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS

The FTC is likely to succeed on the merits of its Section 7 claim. Defendants take pot shots at the definitions of the relevant product and geographic markets but their arguments lack factual and legal support, and certainly are insufficient to overcome the detailed evidence

adduced by Plaintiffs.[1] Defendants also fail to produce evidence sufficient to rebut the presumption of illegality or the substantial evidence establishing the likely anticompetitive effects of their merger.

A. The Relevant Product Market is the Market for Inpatient GAC Services

Defendants completely ignore established precedent, the Merger Guidelines, and their own expert to argue that the relevant product market must include outpatient services. Defendants admit that courts—including the Seventh Circuit—have consistently recognized a cluster market of *inpatient* GAC Services that excludes outpatient services because of the fundamental differences in the competitive conditions under which the two sets of services are provided. Defendants' Opposition to Plaintiffs' Motion for a Preliminary Injunction ("Defs' Opp.") at 16.[2] As that precedent establishes, the clustering of services that are not substitutes into a single market for administrative purposes is only appropriate if those services are offered under similar competitive conditions. *See, e.g.*, *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 566 (6th Cir. 2014). Here, Defendants do not dispute that outpatient services are provided in the Chicagoland area by a different set of competitors than inpatient GAC Services, including physician's offices and ambulatory care facilities.[3] In light of this undisputed evidence, even Defendants' own expert (Dr. McCarthy) agrees that it is inappropriate as a matter of economics to include outpatient services in a cluster market with GAC Services.[4]

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[1] *See United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1285 (7th Cir. 1990) (recognizing that although it is "always possible to take pot shots at a market definition," evidence of "immense shares in a reasonably defined market create a presumption of illegality").

[2] While Defendants claim there are "exceptions" they cite only a single case, *United States v. Carilion Health Sys.*, 707 F. Supp. 840 (W.D.Va. 1989). The Seventh Circuit has expressly found *Carilion* both unpersuasive and inconsistent with Seventh Circuit precedent. *Rockford Mem'l Corp.*, 898 F.2d at 1286.

[3] Defendants also do not deny that the competitive conditions are different for inpatient and outpatient services. Among other things, the entry barriers for inpatient services are extraordinarily high but, according to Defendants, "outpatient facilities can be built in less than a year." Defs' Opp. at 26.

[4] PX02058 McCarthy Depo. at 14:8-10; *see also id.* at 13:1-3.

Distinct markets for inpatient and outpatient services are further confirmed by the Merger Guidelines, which state "[m]arket definition focuses solely on demand substitution factors, i.e., on customers' ability and willingness to substitute away from one product to another in response to a price increase or a corresponding non-price change such as a reduction in product quality or service." U.S. Dep't of Justice & FTC Horizontal Merger Guidelines, § 4 (2010) ("Merger Guidelines"). There is no evidence that individual patients could use outpatient services as substitutes for inpatient services in response to a small but significant increase in the price of GAC Services, nor (relatedly) that MCOs would be able to do so. Indeed, given the fact that MCOs must offer access to provider networks that meet the needs of their customers, and given individual patients' inability to substitute outpatient services for inpatient services, it is implausible to suggest that an MCO could offer an attractive network that failed to provide access to inpatient services.

Defendants nonetheless depart from precedent and bedrock principles to argue, without any supporting evidence, that inpatient and outpatient services are a single market because MCOs "must purchase" inpatient and outpatient services "bundled together." Defs' Opp. at 17. First, even if this were true—which it is not—it would be irrelevant. While MCOs need to provide their customers with access to *both* inpatient and outpatient services, the products are not substitutes for each other. Defendants badly miss the mark when they argue that the prices of inpatient and outpatient services are "linked" when hospitals and MCOs negotiate both sets of prices at the same time. When hospitals and MCOs negotiate such combined contracts, the value each party derives from the contract depends on their relative bargaining positions. If a hospital controlled access to all inpatient GAC Services in a given market, and also provided outpatient services in competition with others, it might use its bargaining leverage to demand higher rates

for inpatient GAC Services, higher rates for outpatient services, or both. The monopolist of inpatient GAC Services would have market power and the ability to unilaterally raise prices even if it faced significant competition in the outpatient services market and regardless of whether the rates for outpatient and inpatient services appear in the same contract.[5] Defendants' error is that they confuse *how* market power could be expressed with the fundamental question of *whether* competition from providers of outpatient services would prevent a monopolist of GAC Services from raising prices.

While it is true that MCOs must offer their members (i.e., patients) a network that provides both inpatient and outpatient services, there is no requirement that MCOs *purchase* inpatient and outpatient services together. To the contrary, MCOs frequently enter into contracts with outpatient service providers that are not hospitals. Defendants offer no evidence that MCOs are willing to pay a premium to have both sets of services offered in a single package. Thus, "there are no market forces that bind" inpatient and outpatient "services together like a single plywood sheet." *ProMedica Health Sys.*, 749 F.3d at 568.

Finally, the fact that some healthcare procedures that have historically been performed only on an inpatient basis can today be performed on an outpatient basis does not make these services substitutes such that patients (or MCOs) can substitute outpatient services for inpatient services in response to a price increase. As the testimony cited by Defendants shows, the trend towards outpatient services is fueled primarily by advances in medical knowledge and technology.[6] The growing use of outpatient services is a function of medical judgment and expanding treatment options, it does not suggest that economic incentives can lead patients (or MCOs) to replace inpatient services with outpatient services. And, even if it were true that risk-

[5] *See* PX06020 Tenn Rebuttal ¶¶ 60-64.
[6] *See* Defs' Opp. at 18 n.42.

based contracts change the incentives of hospitals, hospitals' incentives are irrelevant to patients' (and MCOs') ability to substitute outpatient services for inpatient services.

B. The Relevant Geographic Market is the North Shore Area

Defendants argue that the North Shore Area is not a relevant geographic market because (1) it does not include every hospital Defendants compete with, (2) it does not meet "inflow" and "outflow" thresholds under a discredited method that their own expert rejects, and (3) the Commission defined a different market when it analyzed a different proposed merger. These arguments are wholly without merit.

1. Defendants Ignore the Hypothetical Monopolist Test

As Defendants' economist Dr. McCarthy explains, defining the relevant geographic market is an iterative process that begins by asking whether a hypothetical monopolist could profitably impose a small but significant nontransitory increase in price (a "SSNIP") in a narrow candidate market.[7] If the answer is no, an additional competitor is added to the market, and then another competitor, until the candidate market satisfies the hypothetical monopolist test. This is exactly what Dr. Tenn did. He started with a narrow market consisting of just the four NorthShore hospitals and the two closest Advocate hospitals, Lutheran General and Condell. As Dr. Tenn demonstrated, those six hospitals constitute a relevant geographic market because if one firm owned all of the hospitals that firm could profitably impose a SSNIP at one or more hospitals.[8] Dr. Tenn could have stopped there, but to be conservative he also considered a second iteration of the market, the "North Shore Area," that includes five additional hospitals that compete with both Advocate and NorthShore. That broader market also satisfies the SSNIP

[7] DX5000 McCarthy Rep. ¶ 38.
[8] PX06000 Tenn Rep. ¶¶ 76-78.

test and is a relevant geographic market.[9]

Defendants argue that the North Shore Area is not a relevant geographic market because it does not include destination hospitals or hospitals that compete with only one party but not the other. This argument misses the point of geographic market definition altogether. The purpose is not to identify a market capturing every competitor, but to identify a market within which a hypothetical monopolist could profitably impose a SSNIP. Thus, "properly defined antitrust markets often exclude some substitutes to which some customers might turn in the face of a price increase even if such substitutes provide alternatives for those customers." Merger Guidelines § 4; *see also FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 30-31 (D.D.C. 2015) ("the fact that Defendants sometimes compete against other channels of distribution in the larger marketplace does not mean that those alternative channels belong in the relevant product market for purposes of merger analysis"). Even Dr. McCarthy agrees that under the Merger Guidelines there is no reason to consider additional competitors once the hypothetical monopolist test is satisfied, and that significant competitors are often excluded from properly defined markets.[10]

Section 4 of the Merger Guidelines explains why it is appropriate to start with local competitors and then move outward in successive iterations if the market of local competitors fails the hypothetical monopolist test:

> Defining a market broadly to include relatively distant product or geographic substitutes can lead to misleading market shares. This is because the competitive significance of distant substitutes is unlikely to be commensurate with their shares in a broad market.

Merger Guidelines § 4. Here, including destination hospitals like Northwestern Memorial and Rush would lead to misleading market shares. Using Dr. Tenn's approach, which Dr. McCarthy

[9] *Id.* ¶¶ 79-111.
[10] PX02058 McCarthy Depo. at 252:4-16; 253:16-254:6 ("that's how I understand that part of the guidelines to work.")

agrees is widely accepted,[11] market shares are calculated based on a hospital's total admissions. Northwestern Memorial and other destination hospitals have a higher number of admissions than local hospitals, but their patients come from a much wider region and only 16% of the patients of the downtown destination hospitals come from NorthShore's service area.[12] Including all of the admissions at those hospitals would overstate their competitive significance to patients who currently obtain GAC Services from hospitals in the North Shore Area and who are most likely to be affected by the merger.[13]

2. Defendants Rely on a Discredited Patient Migration Approach that their Own Expert Rejects

Defendants repeatedly argue that the North Shore Area is not a relevant geographic market because the rate of patient "inflow" and "outflow" exceed thresholds established in other cases. Defendants' own expert disagrees with their approach, which he considers "neither reliable nor a bright line test."[14] According to Dr. McCarthy, the structural approach to market definition that Dr. Tenn applies is "widely considered to be superior to previous approaches that relied on various measures of patient flows in and out of the merging hospitals' service areas to determine the relevant geographic market" and represents "a clear improvement over previous patient flow based approaches in many ways."[15]

Ignoring the preferred approach of their own expert, Defendants instead repeatedly cite to cases in which courts applied a patient migration analysis known as the Elzinga-Hogarty (E-H) test. *See* Def.'s Opp. at 6-11. The E-H test is now widely recognized as being an inappropriate method for delineating a relevant geographic market in the context of a hospital merger. In fact,

[11] *See* DX5000 McCarthy Rep. ¶ 40.
[12] *See* PX06020 Tenn Rebuttal ¶¶ 81-82 and Appendix A.
[13] *Id.* ¶ 82.
[14] PX02058 McCarthy Depo. at 280:13-18.
[15] DX5000 ¶¶ 40, 43.

more than five years ago, Professor Elzinga (who co-developed the test) published an article explicitly acknowledging that in hospital cases the E-H method is inconsistent with the Merger Guidelines' hypothetical monopolist test.[16] Indeed, Professor Elzinga testified to that effect in the litigation concerning the Evanston/Highland Park merger.[17]

Among other deficiencies, the E-H or patient flow approach suffers from the "silent majority fallacy." As Dr. McCarthy explains in his report, the fact that a *minority* of patients are willing to travel for inpatient care is not necessarily predictive of the preferences of the *majority* of patients who do not travel.[18] For example, there may be patients who live in the northern suburbs of Chicago who receive GAC Services downtown because they work there. The fact that those patients receive GAC Services downtown, however, is not predictive of the preferences of patients who *do not* work downtown.[19] Indeed, Defendants' experts agree that patients overwhelmingly prefer to receive GAC Services locally.[20]

Patient flow analysis also fails to predict whether small but significant increases in the *price* of local GAC Services would cause MCOs to offer insurance plans without the hospitals in question or would lead to more patients travelling further distances. MCOs are not likely to

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[16] Kenneth G. Elzinga and Anthony W. Swisher, *Limits of the Elzinga-Hogarty Test in Hospital Mergers: The Evanston Case*, 18 ANTITRUST BULLETIN 45 INT'L J. ECON. BUS. 133 (2011).

[17] Opinion of the Commission, *In the Matter of Evanston Nw. Healthcare Corp.*, FTC Dkt. No. 9315, 2007 WL 2286195, at *65 (FTC Aug. 6, 2007) ("Elzinga concluded that because the ability of particular hospitals to raise prices is not disciplined or thwarted by the travel patterns of patients, using patient flow data is uninformative about whether it would be profitable for merging hospitals to raise prices, and that the application of the E-H test to patient flow data would identify overly broad geographic markets. We find Elzinga's testimony to be persuasive.") (internal quotations and citations omitted).

[18] DX5000 McCarthy Rep. ¶ 41.

[19] *See, e.g., Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 785 (9th Cir. 2015)(patients "who traveled generally went to [primary care physcians] near their Boise places of employment" and the district court "reasonably found this statistic not determinative of whether other Nampa residents would be willing to travel.").

[20] PX02057 Dudley Depo. at 238:17-18 ("do most people come from nearby areas, yeah."); *Id.* at 239:3-6 ("And that just reflects that people tend to go nearby…they tend to go to the hospitals that are near them"); *Id.* at 239:20-23 ("they talk about their neighborhood hospital, and they tend to use things that are nearby."); PX02061 Steele Depo. at 25:13-15 ("Q. In your experience, have you found that patients tend to go to nearby or local hospitals? A. Absolutely.").

exclude all eleven hospitals in the North Shore Area from their health plans even if a hypothetical monopolist of those hospitals demanded incrementally higher reimbursement rates. And, as Defendants themselves argue in support of their merger, patients are not motivated to travel significantly greater distances by small price differentials. According to Defendants, large employers with employees living near Lake Michigan in Cook and Lake counties would not find Advocate's existing narrow network product attractive because those employees would be unwilling to drive to Advocate hospitals a few miles across I-94 to save 10% on their insurance premiums. If so, those same patients obviously would not travel to a hospital all the way downtown in response to a SSNIP of 5% in the North Shore Area.

Leaving aside the fact that the E-H test is an inappropriate method for delineating relevant geographic markets in hospital mergers—and that even their own expert finds the method unreliable—Defendants grossly misapply it. The structural approach employed by Dr. Tenn defines the relevant geographic market by hospital (i.e. supplier) location.[21] When a market is defined by supplier location, the market includes customers located outside of the market boundary:

> Geographic markets based on the locations of suppliers encompass the region *from which sales are made*. Geographic markets of this type often apply when customers receive goods or services at suppliers' locations. Competitors in the market are firms with relevant production, sales, or service facilities in that region. Some customers who buy from these firms *may be located outside the boundaries of the geographic market*.

[21] PX06000 Tenn Rep. ¶ 75.

Merger Guidelines § 4.2.1 (emphasis added). Applying a patient migration analysis to a market defined by hospital location will always result in high inflows because the hospitals along the border of the market draw patients from the communities surrounding their locations.[22]

3. The Commission is Not Judicially Estopped from Defining a Geographic Market in Light of the Relevant Factual Circumstances

Defendants next argue that the Commission is estopped from defining a relevant geographic market in this case that is different from the geographic market definition the Commission adopted in a previous matter. The previous matter, *In the Matter of Evanston Northwestern Healthcare Corporation,* concerned the consummated acquisition of Highland Park Hospital by Evanston Northwestern Healthcare Corporation ("ENHC"), which already owned Evanston Hospital and Glenbrook Hospital.[23] The Commission found that substantial evidence established that ENHC imposed significant prices increases as a result of the merger. Because ENHC, as a monopolist of the three hospitals, was able to impose a price increase higher than 5%, the three-hospital market satisfied the hypothetical monopolist test. *In the Matter of Evanston Nw. Healthcare Corp.*, FTC Dkt. No. 9315, 2007 WL 2286195, at *53, *66 (FTC Aug. 6, 2007).

According to Defendants, by limiting the market in *Evanston* to the three ENHC (now NorthShore) hospitals, the Commission implicitly concluded that Condell and Lutheran General did not constrain those hospitals and the Commission cannot now contend that they do.

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[22] *Id.* ¶ 81, n. 167. While the North Shore Area geographic market is limited to the *hospitals* within the boundary line on Dr. Tenn's map, it encompasses all of the *patients* who use those hospitals regardless of which side of that line they live on. *Id.* Thus, Dr. Tenn calculates market shares using all admissions to the hospitals in the market and not just the admissions of patients residing within the bounds of the geographic market. *Id.*; *see also* PX02058 McCarthy Depo. at 237:22-24 ("Now, I'll quickly say, he does count the whole of the -- not -- of the commercial discharges. . ."). Dr. McCarthy's criticism is that Dr. Tenn should have visually represented the hospitals within the North Shore Area market by placing stars on the hospitals and not by drawing a line on the map. *Id.* at 237:24-238:2.

[23] ENHC subsequently purchased Skokie and became NorthShore. *See, e.g.*, PX06000 Tenn Rep. ¶¶ 22-23.

Remarkably, Defendants make this argument despite the conclusion of their *own expert* that "Advocate and NorthShore *do* constrain each other."[24] Under Defendants' theory of estoppel, because the Commission found that no competing hospitals constrained ENHC's ability to raise prices following the prior merger, NorthShore is now free to merge with any competing hospital.

No court has ever held that a market definition determination 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.*, No. 3:14-CV-1142-HZ, 2015 WL 5178073, at *10 (D. Or. Sept. 3, 2015); *United States v. Bazaarvoice, Inc.*, 13-cv-00133-WHO, 2014 WL 203966, at *22 (N.D. Cal. Jan. 8, 2014). The "boundaries of a relevant market will turn on the factual allegations presented in any given case." *Little Rock Cardiology Clinic PA v. Baptist Health*, 591 F.3d 591, 599 (8th Cir. 2009).[25] 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."[26] To hold otherwise would ignore the basic economic reality that overlapping geographic markets exist in which market power might be exercised – for example a hypothetical monopolist of all supermarkets in the state of Illinois could likely increase supermarket prices, even though a hypothetical monopolist of all supermarkets in Chicago could also do so.

[24] DX5000 McCarthy ¶ 20 (emphasis added).
[25] Defendants argue that the court in *Lab. Corp.* rejected the FTC's proposed market because it was inconsistent with a previous FTC market definition but that holding nowhere appears in the case. *See FTC v. Lab. Corp. of Am.*, SAVC-10-1873 AG (MLGx) 2011 WL 3100372, at * 6 (C.D. Cal., Feb. 22, 2011) (listing, among 111 findings of fact, a conflicting product market definition in another case but not relying on that conflict for any conclusion of law).
[26] Areeda and Hovenkamp, ANTITRUST LAW-AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION ¶ 927.

C. High Market Shares and Market Concentration Establish a Presumption of Illegality and Shift the Burden to Rebut the Presumption to Defendants

As Plaintiffs established in their opening brief, the merger would significantly increase concentration in an already highly concentrated market. The increase in concentration, and Defendants' combined market share of 60%, far exceed the thresholds for establishing a presumption of illegality. That presumption applies in cases based on unilateral effect theories of competitive harm.[27] *See Bazaarvoice*, 2014 WL 203966, at *64 (N.D. Cal. Jan. 8, 2014); *Sysco Corp.*, 113 F. Supp. 3d at 8; *United States v. H & R Block, Inc.*, 833 F. Supp. 2d 36, 81 (D.D.C. 2011). Because Plaintiffs have established that the proposed merger is presumptively unlawful, the burden shifts to Defendants to produce evidence rebutting that presumption.[28]

D. Numerous Sources of Evidence Confirm the Strong Presumption of Harm to Competition

Plaintiffs' opening brief laid out the overwhelming evidence showing that, by eliminating the competition between these two large hospital systems, the merger is likely to substantially harm competition and lead to higher prices and reduced quality of services.[29] In their opposition, Defendants do not dispute that they are direct competitors in the GAC Services market or that their competition benefits MCOs and consumers. As Dr. McCarthy agrees, "Advocate is a

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[27] As Defendants' counsel recently explained in the Antitrust Law Journal:

> allowing plaintiffs to invoke the structural presumption to make a *prima facie* case makes sense. Disregarding concentration in merger cases when concentration is used throughout the rest of competition law does not. It also seems unreasonable to eliminate the presumption when Section 7 itself (and Congress's intent) focuses on markets and concentration.

J. Robert Robertson, *Editor's Note: Philadelphia National Bank at 50*, 80 ANTITRUST L.J. 189, 200 (2015).

[28] Defendants argue that the burden remains with Plaintiffs but rely on phrases pulled out of context from cases that actually uphold the burden-shifting framework. *See, e.g., FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 129-30 (D.D.C. 2004) ("Defendants have, therefore, successfully rebutted the presumption that the merger will substantially lessen competition and the Court will proceed to examine the issue of the likely competitive effects of the proposed merger in the relevant market"); *United States v. Baker Hughes Inc.*, 908 F.2d 981, 982 (D.C. Cir. 1990) ("[b]y showing that a transaction will lead to undue concentration in the market for a particular product in a particular geographic area, the government establishes a presumption that the transaction will substantially lessen competition" and the "burden of producing evidence to rebut this presumption then shifts to the defendant").

[29] *See* Plaintiffs Opening Br. at 22-31(citing substantial evidence of direct competition).

competitor of NorthShore" and "Advocate and NorthShore do constrain each other."[30] Dr. McCarthy's "results confirm that the two systems are good substitutes."[31]

1. Defendants' Arguments Rely on Standards that Do Not Exist

Because they cannot deny that competition from the other constrains each of them, Defendants argue that their merger will not harm competition because the parties also compete with other hospitals. To prevail on their unilateral effects claim, however, Plaintiffs are not required to establish that the merging parties *only* compete with each other. Merger Guidelines § 6 (the "elimination of competition between two firms that results from their merger may alone constitute a substantial lessening of competition" and "such unilateral effects are by no means limited to" mergers to monopoly); *see also FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1083 (N.D. Ill. 2012) ("Although it is true that SwedishAmerican will remain as a competitor, the court is not aware of, and defendants have failed to cite, any authority which holds that the FTC is required to show that all competition will be eliminated as the result of a merger"). Where, as here, a significant portion of the Defendants' customers consider these 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 FTC v. H.J. Heinz Co.*, 246 F.3d 708, 713, 717-19 (D.C. Cir. 2001) (holding that elimination of competition between second- and third-largest jarred baby food manufacturers would weaken competition); *FTC v. Swedish Match*, 131 F. Supp. 2d 151, 169 (D.D.C. 2000).

Nor do Plaintiffs need to establish that Defendants are each other's *closest* competitor. Merger Guidelines § 6.1 (unilateral effects "normally requires that a significant fraction of the customers" view "the other merging firm as their next-best choice" however "that significant

[30] DX5000 McCarthy Rep. ¶ 20 and Appendix A.
[31] *Id.* ¶ 95.

fraction need not approach a majority."). Under the Merger Guidelines "[a] merger may produce significant unilateral effects … *even though many more sales are diverted to … non-merging firms* than to … the merger partner." *Id.* (emphasis added); *see also ProMedica Health Sys*, 749 F.3d at 569.

Defendants fault Plaintiffs for not uncovering documents or testimony in which Defendants admit to a specific plan to raise prices, but here again Defendants seek to impose a standard that no court has ever adopted. To prevail under Section 7, a plaintiff is not required to come forth with specific proof of what the merging parties will do or what their intentions are after the merger. *See, e.g.*, *Bazaarvoice*, 2014 WL 203966, at *11 (N.D. Cal. Jan. 8, 2014)("intent is not an element of a Section 7 claim"). Plaintiffs need only establish that the acquiring firm will have the *ability* to raise prices or reduce quality after the acquisition. *H&R Block*, 833 F. Supp. 2d at 81 (emphasis added). "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 America v. FTC*, 807 F.2d 1381, 1389 (7th Cir.1986) (citation omitted)).

2. The Merger Will Increase Defendants' Bargaining Leverage

Defendants argue that they will not have bargaining leverage after the merger because health plans can create viable networks without including any NorthShore or Advocate hospitals. Yet when explaining the rationale for the merger, they argue that, although an Advocate-only network has been successfully marketed to individuals on the public exchange, "[i]n order to sell the High Performing Network to *groups* (*i.e* employees), employers and health insurers have told Advocate that it needs" coverage near Lake Michigan in Cook and Lake Counties. Defs' Opp. at 1-2 (emphasis in the original). If it is true that an ultra-narrow network product will *only* be

marketable if it *includes both* NorthShore and Advocate then it is not true that health plans are commercially viable even if they *exclude both* NorthShore and Advocate. If employers cannot be persuaded that their North Shore employees would be willing to travel a few miles across I-94 for GAC Services, even for a 10% premium discount, then those same employers will not be satisfied with a health plan that excludes most of the hospitals in the North Shore Area.

Defendants provide two examples of plans that exclude both Advocate and NorthShore: BlueChoice [redacted][32] and [redacted] (a concept that never even got off the ground).[33] But Defendants show no evidence that any MCO has ever successfully marketed a large group plan in the northern Chicago suburbs that excluded both NorthShore and Advocate. As the evidence establishes, the truth lies between Defendants' contradictory positions: to be marketable to large groups, a plan must include *either* NorthShore or Advocate, but need not include both.[34] Competition between NorthShore and Advocate for inclusion in health-plan networks yields lower prices and better quality, as testimony from numerous of Defendants' customers' illustrates.[35]

Defendants attempt to downplay the significance of this customer testimony and argue that the Court should disregard what Defendants call the "self-serving declarations of health insurers" such as BCBS-IL that swear, under oath, that they could not successfully market health plans that exclude both NorthShore and Advocate hospitals. Defendants claim that BCBS-IL is

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[32] [redacted]

[33] [redacted]

[34] *See, e.g.,* [redacted] PX02047 Levin (Aon) Depo. at 156:18-23 ("So if you have neither NorthShore and you have neither Advocate, you have neither in the product, I think very few people would buy it, given many people on our exchange live in the geographies represented there").

[35] *See* Pls' Opening Br. at 26-29.

not credible because it fears competition from Advocate in the insurance market. However, Advocate cannot compete against BCBS-IL in the insurance market because it does not have an insurance license and [redacted].[36]

Defendants also point out that some MCOs wrote letters in support of the merger and stated that they believe that the merger will reduce costs and improve quality. Each of the MCOs identified by Defendants, however, has submitted a declaration stating that it drafted its letter at Defendants' request and had little to no basis for the beliefs expressed in the letter regarding the merger's impact on costs and quality.[37]

E. Economic Analysis Demonstrates that the Merger Will Lead to Increased Prices and Reduced Quality

Dr. Tenn's analysis shows that the combined firm would be able to raise reimbursement rates for GAC Services at one or more of its six hospitals in the North Shore Area.[38] The average price change predicted by Dr. Tenn across those hospitals is 8%.[39] Defendants' experts agree with most of Dr. Tenn's analysis.[40] According to Defendants' experts, however, Dr. Tenn's merger simulation analysis is flawed and therefore his price estimates are unreliable. Their argument is astounding considering that the merger simulation model Drs. Eisenstadt and McCarthy employ is so fundamentally flawed that it predicts that mergers result in *lower* prices. For example, the model "faithfully" employed by Defendants' experts predicts that if forty-eight

[36] [redacted].
[37] *See*,PX03014 Bhargava (Aetna) Decl. ¶¶ 13, 14; PX03004 Maxwell (Humana) Decl. ¶ 19; [redacted]; PX03001 Beck (United) Decl. ¶¶ 30-31.
See PX06000 Tenn Rep. ¶¶ 124-192; PX06020 Tenn Rebuttal ¶¶ 106-112.
[39] PX06000 Tenn Rep. ¶ 184.
[40] DX5000.0058 n.147 ("The differences between Dr. Tenn's estimates of diversions and WTP and mine, to the extent there are any, are minor.")

hospitals in the greater Chicago area merged (including all of the hospitals owned by parties, all of the downtown destination hospitals, and multiple additional hospital systems)), such a merger would produce anywhere from a 33% *decrease* to a very modest 6% increase in the price of GAC Services.[41] Such a result is implausible and contrary to basic economic theory and common sense. Dr. Tenn correctly concluded that the methods employed by Drs. Eisenstadt and McCarthy are unreliable.

F. Defendants' "Repositioning" Argument Lacks Merit

Defendants argue that their competitors could "reposition" and therefore defeat a post-merger increase in the price of GAC Services. Defendants do not argue that their competitors would open new hospitals or expand existing hospitals. As Dr. McCarthy admitted in his testimony, "my judgment right now is … that [it is] unlikely that the competition will be through expansion and it will be through the placement of outpatient services and physician services."[42] As previously established, outpatient services are not substitutes for GAC Services.

Despite the fact that the "repositioning" described by Dr. McCarthy has been going on for years in the North Shore Area, inpatient market shares have stayed remarkably constant and Defendants have remained close competitors.[43] Indeed, according to Advocate, relative market shares for inpatient services have remained constant since 1999.[44] There is simply no evidence that the kind of outpatient "repositioning" described by Defendants could or would impose any constraint on the merged entity's ability to increase prices for GAC Services.

Defendants are also contradicting themselves again. According to Defendants, Advocate cannot attract large employers to its "HPN" because it has a coverage gap east of I-94. At the

[41] PX06020 ¶ 53.
[42] PX02058 McCarthy Depo. at 111:2-6.
[43] *See, e.g,* PX04032 (showing steady market shares in the PSA of each NorthShore hospital).
[44] PX04156-007.

same time, Defendants argue that their competitors would quickly respond to any attempt by the merged entity to increase prices for GAC Services by opening outpatient facilities and physician offices near Defendants' hospitals in order to drive referrals to their own hospitals. This begs the question, if Advocate's competitors can reposition to compete in new geographic areas, why can't Advocate? The answer, in the words of Advocate's CEO (testifying on behalf of Advocate), is that it is "easier said than done."[45] According to Advocate, it never even considered opening outpatient facilities as a means of closing its purported coverage gap in NorthShore's service area.[46]

Defendants cannot have it both ways. Advocate is the largest hospital system in the State and claims to be far superior to other health systems on nearly every measure of cost and quality. If Advocate is unable to "reposition" east of I-94, despite its large and well-regarded hospitals just a few miles away, then it is extremely unlikely that other, more distant systems could effectively reposition in the North Shore Area post-merger. On the other hand, if other hospitals can easily open outpatient facilities and physician offices in the North Shore Area, then so can Advocate and this merger is not necessary to fill any gap in Advocate's coverage area.

G. Defendants' Claimed Efficiencies are Vague, Unsubstantiated and Not Merger-Specific

Defendants make three arguments about cost reductions but fail to present evidence establishing any verifiable, merger-specific efficiency. *See, e.g., Sysco*, 113 F. Supp. 3d at 82. Defendants' vague and unsubstantiated claims are precisely the type that courts and the Merger Guidelines have cautioned should not be credited in justifying an anticompetitive merger.

[45] PX02036 Sacks Depo. at 130:15-24. In fact, Advocate has argued in submissions to the Commission that it has had "little success" opening outpatient locations in NorthShore's service area. PX04156-019.

[46] PX04156-019 ("The area east of I-94 is and has been a core part of NorthShore's service area, but historically Advocate has not sought to expand there. *None* of Advocate's major capital investments to date, and for at least the next five years, have occurred or will occur in this area east of I-94.")

First, Defendants argue that the merger will reduce costs to payers because Advocate has lower rates than NorthShore. Defendants provide no evidence of the actual rates charged by the parties and do not conduct any analysis of the impact of the merger on those rates. By their own admission, while applying Advocate's rates to NorthShore's services could involve a rate reduction, it also could be "cost neutral." Defs' Opp. at 31-32.

Second, Defendants assert several times in their brief that the merger will result in cost savings of $200 million. *Id.* at 27, 32. Defendants rely solely upon the declaration of a NorthShore fact witness, Gary Weiss, who, in turn, based his declaration on a spreadsheet that he prepared on his own initiative eight or nine months ago and never shared with anyone (including his own counsel, despite the document being responsive to Plaintiffs' discovery requests) until *after* his deposition in this case.[47] The overwhelming majority of the savings identified in the spreadsheet are in the category labeled "All other (tbd)."[48] Defendants do not identify any cost savings that are independently verifiable or identify any evidence supporting Mr. Weiss's assumptions, and thus fail to identify any cognizable efficiencies.[49]

Third, Defendants assert Advocate has a lower total cost of care, so the merger will reduce NorthShore's total cost of care. This suggestion fails because Defendants have no credible evidence establishing that Advocate produces healthcare services at a cost lower than NorthShore.[50] Even if some of Advocate's eleven hospitals have lower costs, Defendants cannot explain how the merger would improve NorthShore's costs.[51] Defendants imply that deploying Advocate's population health management ("PHM") expertise at NorthShore's hospitals will

[47] PX02022 Weiss Depo. at 87:22-89:1; PX02053 Weiss Depo. (Day 2) at 10:14-18; *id.* at 17:4-13.
[48] *See* PX05270; PX06022 Dagen Rebuttal ¶ 16.
[49] PX06022 Dagen Rebuttal ¶¶ 15-21.
[50] *See* PX06021 Jha Rebuttal ¶¶ 72-18; PX06022 Dagen Rebuttal ¶¶ 8-10.
[51] Defendants' experts also provide no explanation. *See* PX02063 Eisenstadt Depo. at 139:14-17 ("I'm not offering an estimate as to the amount by which AdvocateCare is going to reduce costs at NorthShore or how that cost reduction is going to be achieved through what processes at NorthShore.")

bring down NorthShore's supposedly higher costs by allowing "careful management of utilization," Defs' Opp. at 32, but never even attempt to show what portion of NorthShore's costs derive from excessive utilization.[52] They also ignore that Advocate has had mixed success in controlling its own costs across hospitals.[53]

II. THE EQUITIES STRONGLY FAVOR PRELIMINARY RELIEF

Because Plaintiffs have shown a likelihood of success on the merits, "there is a presumption in favor of injunctive relief." *Sysco Corp.*, 113 F. Supp. 3d at 86. To overcome the public equities, "Defendants must now show that, despite the likely anticompetitive effects of their proposed merger, the merger would nonetheless benefit their customers." *FTC v. CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 75 (D.D.C. 2009). The vague and unsubstantiated efficiencies asserted by Defendants do not outweigh the public interest in effective enforcement of the antitrust laws. *See, e.g., OSF Healthcare Sys.*, 852 F. Supp. 2d at 1095.

Defendants arguments that their merger will benefit the public rely almost entirely on their post-merger participation in the so-called "HPN" – a product that MCOs will supposedly be able to offer post-merger. But this planned "High performing network" is just a marketing term adopted to avoid the negative connotations of "HMO" and "narrow network," it is not a public benefit.[54] Moreover, although Defendants argue that they are "merging to create a new insurance product," the product in fact already exists. The current "HPN" is an Advocate-only HMO marketed by BCBS-IL on the public exchange as "BlueCare Direct with Advocate" ("BCD-

[52] Even assuming that NorthShore has higher costs due to excessive utilization rates (and there is no evidence that it does) the merger is not necessary to reduce NorthShore's costs. *See, e.g.*, PX02061 Steele Depo. at 119:11-18 (Dr. Steele's company can help providers reduce unnecessary hospitalizations and reduce the total cost of care).
[53] *See* PX04314 (showing increasing costs of care at most Advocate hospitals).
[54] PX08096 ("'We call it a high-performing network,' said Dr. Sacks. 'It was a term we stole from a consultant a year ago to kind of get away from the negative connotations of narrow [HMO] network'"); *see also* PX02063 Eisenstadt Depo at 99:24-100:1; PX04200-013.

A").[55] And this product is far less innovative than Defendants claim – while they tout the risk-based payment structure of the "HPN" as revolutionary, Advocate is in fact paid on a capitated basis under other HMO plans offered by BCBS-IL in addition to BCD-A.[56]

Defendants' focus on the features of the "HPN" is misleading because only efficiencies specific to the *merger* are cognizable. *Heinz Co.*, 246 F.3d 708 at 721. Advocate clearly does not need to merge with the second largest health system in the North Shore Area to participate in BCD-A, because it already does so. Moreover, the evidence does not support Defendants' contention that Advocate has a coverage gap east of I-94 that requires a merger with NorthShore to make BCD-A or a similar product marketable to large groups. Advocate has never tried to market BCD-A to large groups, and, according to BCBS, the merger of these close competitors is not necessary to create a marketable narrow network.[57] According to Defendants' experts, what Advocate lacks east of I-94 is "access points" and the opening of outpatient facilities and physician offices could fill that gap and allow it to market an "HPN" without the merger.[58]

Indeed, while Defendants repeatedly claim that their merger is necessary to deal with the evolving healthcare landscape, other firms are meeting this challenge by offering narrow network and risk-based products while maintaining, rather than reducing, provider competition. For example, [redacted]

[55] *See, e.g.*, PX08011-037-038.
[56] *See, e.g.*, PX04200-012 (for HMOs BCBS has "paid us under global capitation which better aligns incentives and allows Advocate and the APP physicians to share in any savings, as opposed to having to share with BCBIL.") The benefit design of the HMO plans prevents leakage and allows Advocate to participate on a capitated basis without incurring financial risk for care provided by other participating providers. *Id.; see also* PX02039 Hamman (HCSC) Depo. at 201:23-202:9 (there is "not very much" leakage in the HMO products compared to ACO and Advocate's leakage in the HMO is only 8-10%); *id*. at 199:23-200:1 (testifying that benefit design is important to prevent leakage); [redacted] PX02052 Sacks (Advocate) Day 2 Depo. at 55:2-9 ("leakage depends on benefit plan design"). Despite Defendants arguments to the contrary, a merger is not necessary to prevent leakage. *See* Defs' Opp. at 36-37.
[57] PX03000 Hamman Decl. at ¶ 46 ("BCBS-IL does not need Advocate and NorthShore to merge in order to create a narrow network that includes both systems.")
[58] DX5000 McCarthy Rep. ¶ 28; P02058 McCarthy Depo. at 187:5-188:24.

[redacted] Thus, if Advocate participates in this plan – or any similar plan – it can do so on a capitated basis and price its system at 10 percent below the lowest priced HMO.[63]

According to Defendants, even if Advocate can participate in a marketable HPN, NorthShore cannot and NorthShore's inclusion in the HPN will benefit consumers. Defendants are focusing on the wrong issue. NorthShore's ability to participate in an insurance product is not in itself relevant. Instead, Defendants must demonstrate that the merger will result in price reductions or quality improvements that are otherwise unobtainable.

1. The Merger Will Not Increase the Quality of Care

Defendants assert that the merger will increase the quality of care at NorthShore (but not Advocate) because "NorthShore will incorporate Advocate's PHM practices and tools." Defs' Opp. at 31. In fact, NorthShore performs better than Advocate across a wide range of quality

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59 [redacted]

60 [redacted]

[redacted].

62 [redacted] *see also* PX02063 Eisenstadt Depo. at 87:10-88:3 (explaining that the [redacted] plan is designed to encourage price competition).

63 *See* [redacted] PX02063 Eisenstadt Depo. at 96:11-17.

measures.[64] Despite its much-touted use of PHM and risk-based contracting, Advocate's performance on quality measures actually *decreased* from 2013 to 2015.[65]

Defendants never identify what specific features of Advocate's purported PHM capabilities NorthShore is missing and could not obtain on its own. Defendants' expert on population health management, Dr. Dudley, characterizes what Advocate has and NorthShore lacks as a "culture," a "commitment," a certain "feeling," and a "special sauce."[66] As both Dr. Dudley and Dr. Steele admit, NorthShore can purchase all of the concrete components of effective PHM without the merger and can hire consultants that specialize in PHM to help integrate those components.[67] Defendants fail to explain how Advocate's "culture" or "special sauce" would be deployed at NorthShore's hospitals or what specific impact that expertise would have on NorthShore's quality of care. Indeed, Advocate has "troubling variation in several key measures of quality" across its existing hospitals, which "casts doubt on Advocate's assertion that they can effectively implement a PHM program across NorthShore's four hospitals."[68]

2. The Merger Will Not Benefit the Public

Defendants argue that the merger will generate specific cost savings for consumers because the HPN will be priced 10% below the next cheapest HMO product. Defendants are again conflating the purported benefits of BCD-A (an existing product) with merger-specific efficiencies. The rationale for the merger is that it is necessary to enable their participation in an insurance products MCOs will market to large groups. While BCBS-IL offers the existing BCD-A product on the exchange at a 10% discount to other plans, [redacted]

[64] PX06001 Jha Rep. ¶¶ 143-149.
[65] *See* PX06021 Jha Rebuttal ¶ 19.
[66] PX02057 Dudley Depo. at 104:2-3; 116:20-117:4; 148:2-13; 194:3-10; 251:18-252:13; 221:9-19.
[67] PX02057 Dudley Depo. at 193:20-21; PX02061 Steele Depo. at 119:19-120:24. As Dr. Steele testified, the differences in culture at NorthShore and Advocate cultures raises real concerns about whether the merger would fail. PX02061 Steele Depo. at 211:2-6.
[68] PX06001 Jha Rep. ¶ 150.

[redacted][69] Neither Defendants nor any MCO has any future obligation (and no plan) to offer the product (or any similar product) to large groups at a price 10% below competing products. Defendants' mere assertion that the product will be offered at a low price is not a cognizable efficiency. *See H.J. Heinz Co.*, 246 F.3d at 721. But, even if the price differential were set in stone, it is inappropriate to assume that simply because the price of the HPN is discounted that it provides any actual cost savings to consumers. The HPN is discounted because it severely reduces enrollees' choice of in-network providers and is less attractive. Consumers may pay less for the HPN but will also receive less in return.[70]

Defendants have made no projections about how many members would enroll in the HPN if it were offered on the large group market at the discounted price.[71] At best, only a small minority of area residents would enroll in such a plan. The majority of consumers – and the majority of Defendants' patients – will remain covered under the same plans they have now and will face the likelihood of higher prices as a result of the merger.

CONCLUSION

For the reasons stated above, this Court should grant Plaintiffs' request for an injunction.

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[69] [redacted]; *see also* PX04200-013 ("We would also design a similar product for the large group market at a higher price point for 2017").

[70] *See, e.g.*, DX9111.0005 (the low price target "reflects the narrowing of the overall network that potential members perceive as a reduction in benefits compared to a broad network option.")

[71] Defendants rely on a survey conducted by Dr. Van Liere. Defs' Opp. at 33. Dr. Van Liere admits that his survey does not convey any information about the likelihood of *actual purchases* of an Advocate-NorthShore HPN and he has no opinion as to likely consumer interest in a health plan like that described in his survey. PX02062 Van Liere Depo. at 31:24-32:5; 73:9-12; 240:9-16; 245:19-246:3. The survey is unreliable for multiple reasons, including that Dr. Van Liere did not ask respondents whether they would be interested in an Advocate-only or NorthShore-only product. *See* PX06023 Ford Rep. ¶¶ 12, 28-39.

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Respectfully Submitted,

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