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
Magistrate Judge Jeffrey Cole

FILED UNDER SEAL

DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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INTRODUCTION

NorthShore[1] and Advocate[2] are merging to create a new insurance product, a High Performing Network that will deliver lower cost and higher quality healthcare to consumers. This Network is based on a proven model that Advocate has developed over 20 years. Advocate's way of delivering care aligns the incentives of hospital, physicians, insurers, and patients, and results in decreased costs, increased quality, and better outcomes. If this merger is blocked, Chicagoland consumers will be harmed by losing the opportunity to save hundreds of dollars per individual in the Network every year.

Traditional health insurance products pay healthcare providers based on the volume of services they provide ("fee-for-service" model). The High Performing Network operates on a fixed per member per month fee ("capitation" or "full-risk" model). Under this model, the merged company bears the *entire* risk of providing health care services. Thus, its incentive is *not* to raise inpatient prices (as Plaintiffs allege), but instead to keep patients healthy so as to *avoid* unnecessary inpatient services altogether. To be commercially successful, the High Performing Network must – and will – be priced at least ***10 percent less*** than the lowest priced comparable product available today.

The High Performing Network will succeed because Advocate has been at the forefront of innovation in population health management (known as AdvocateCare®) and risk-based contracting with health insurers. This year, Advocate began offering to *individuals* on the public health care exchange a version of the product. However, in order to sell the High Performing Network to *groups* (*i.e.*, employees), employers and health insurers have told Advocate that it

[1] NorthShore University Health System is a non-profit health system with four hospitals.

[2] Advocate Health Care Network and Advocate Health and Hospitals Corporation constitute a non-profit health care system with eleven hospitals.

needs physicians and facilities in communities along Lake Michigan East of Interstate 94. Neither Advocate alone nor NorthShore alone can create this new product with the price and geographic coverage that employers demand. Without the merger, NorthShore will be unable to offer a High Performing Network in the foreseeable future on the health care exchange or anywhere. Further, Advocate and NorthShore cannot offer the High Performing Network together without financial alignment under unified governance.

Plaintiffs ask the Court to ignore the extraordinary consumer benefits from this merger and assume that prices will go up solely on the basis of the Plaintiffs' contrived geographic market definition, which is divorced from the realities of hospital competition in Chicago. Plaintiffs' geographic market is gerrymandered to exclude some of the closest competitors of Advocate and NorthShore and excludes downtown Chicago hospitals, even though many consumers that live in the "North Shore Area" routinely seek care at those hospitals. Finally, Plaintiffs' alleged inpatient services product market ignores competition from outpatient services that hospitals sell as a bundle with inpatient services, particularly with the High Performing Network.

Including the hospital competitors that the Plaintiffs ignore results in post-merger market concentration that is far lower than any level associated with a presumption of harm. Moreover, Plaintiffs have failed to offer any other reliable evidence that the merger will have anticompetitive effects. Plaintiffs' expert, Dr. Tenn, ignores the FTC's own methodology and actual price data in his effort to predict a price increase. When the FTC's model is correctly applied, it predicts *no price increase whatsoever*. Plaintiffs refuse to recognize the huge benefits to consumers – public equities – that require denying Plaintiffs' request to stop the merger.

This merger will die if the Court grants an injunction. This Court will decide whether consumers will benefit from this merger. The Court should hold Plaintiffs to their substantial burden and deny Plaintiffs' request for a preliminary injunction. The Court should permit the merger to proceed so that the parties can move forward with the purpose of the merger: to provide lower cost and higher quality health care for the people of Chicagoland.

LEGAL STANDARD

"[A] preliminary injunction is an extraordinary and drastic remedy, one that should not be granted unless the movant, *by a clear showing*, carries the burden of persuasion." *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (per curiam) (quotation omitted); *FTC v. Foster*, 2007 WL 1793441, at *51 (D.N.M. 2007) (FTC has "heavy burden," because it is "an extraordinary and drastic remedy") (citation omitted). "A preliminary injunction is an extraordinary remedy never awarded as of right." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008). Indeed, "*the granting of a preliminary injunction is an exercise of a very far-reaching power, never to be indulged in except in a case clearly demanding it.*" *Schwinn Bicycle Co. v. Ross Bicycles, Inc.*, 870 F.2d 1176, 1181 (7th Cir. 1989) (citation and alterations omitted).

Section 7 of the Clayton Act prohibits mergers and acquisitions where "the effect of such acquisition may be substantially to lessen competition, or tend to create a monopoly." 15 U.S.C. § 18. Under Section 13(b) of the FTC Act, a district court may preliminarily enjoin an alleged violation of Section 7 only "[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." 15 U.S.C. § 53(b)(2). Thus, a district court must "(1) determine the likelihood that the Commission 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). "[T]he 'likelihood of success'

analysis and the 'public equities' analysis are legally different points and the latter should be analyzed separately, no matter how strong the agency's case on the former." *FTC v. CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 75 (D.D.C. 2009); *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 903-4 (7th Cir. 1989) (same); *Foster*, 2007 WL 1793441, at *58 (same); *FTC v. Lab. Corp. of Am.*, No. SACV 10-1873 AG (MLGX), 2011 WL 3100372 (C.D. Cal., Feb. 22, 2011) (same).

"[T]he FTC has a substantial burden under Section 13(b)" because "[e]xperience seems to demonstrate that … the grant of a temporary injunction in a Government antitrust suit is likely to spell the doom of an agreed merger." *FTC v. Great Lakes Chem. Corp.*, 528 F. Supp. 84, 86 (N.D. Ill. 1981) (denying preliminary injunction) (quotation omitted). Granting a preliminary injunction is a "particularly" drastic remedy in the merger context because it "may prevent the transaction from ever being consummated." *FTC v. Exxon Corp.*, 636 F.2d 1336, 1343 (D.C. Cir. 1980).[3] "[A] court ought to exercise extreme caution because judicial intervention in a competitive situation can itself upset the balance of market forces, bringing about the very ills the antitrust laws were meant to prevent." *United States v. Syufy Enters.*, 903 F.2d 659, 663 (9th Cir. 1990).

ARGUMENT

I. PLAINTIFFS CANNOT MEET THEIR BURDEN OF PROVING LIKELIHOOD OF SUCCESS ON THE MERITS.

"To establish a likelihood of success on the merits, the FTC must show a violation of the law." *FTC v. Phoenix Avatar, LLC*, No. 04 C 2897, 2004 WL 1746698, at *9 (N.D. Ill. July 30, 2004). Thus, Plaintiffs must prove a "substantial lessening of competition" that is "probable and imminent." *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 115 (D.D.C. 2004). "The Government

[3] *See also United Indus. Corp. v. Clorox Co.*, 140 F.3d 1175, 1179 (8th Cir. 1998) ("[T]he burden on the movant is heavy, in particular where, as here, granting the preliminary injunction will give the movant substantially the relief it would obtain after a trial on the merits.") (quotation marks and alterations omitted).

must prove not that the merger in question may possibly have an anti-competitive effect, but rather that it will *probably* have such an effect." *Great Lakes,* 528 F. Supp. at 86 (emphasis added) (quotations omitted); *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 984 (D.C. Cir. 1990) (same). Given the stakes, "[a] showing of a fair or tenable chance of success on the merits will not suffice for injunctive relief."[4] *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1074 (N.D. Ill. 2012).

Section 7 prohibits only those acquisitions that would allow the combined company to raise price or restrict output. *FTC v. Occidental Petroleum Corp.*, No. 86-900, 1986 WL 952, at *13 (D.D.C. Apr. 29, 1986).[5] To satisfy its burden, Plaintiffs must prove: "(1) the relevant product market in which to assess the transaction, (2) the geographic market in which to assess the transaction, and (3) the transaction's probable effect on competition in the relevant product and geographic markets." *Arch Coal*, 329 F. Supp. 2d at 117 (citations omitted). The Plaintiffs' failure to prove the relevant market is fatal. *See, e.g., FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995); *Arch Coal*, 329 F. Supp. 2d at 116–17. Plaintiffs have the burden on every element of their Section 7 challenge, and a failure of proof in any respect will mean the transaction should not be enjoined." *Id.* at 116.

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[4] The FTC has previously argued that it may demonstrate a likelihood of success on the merits by simply raising a "serious question." *OSF*, 852 F. Supp. 2d at 1074. However, the Supreme Court has soundly rejected the notion that this language reflects a lower standard, finding that "[a] difficult question . . . is, of course, no reason to grant a preliminary injunction." *Munaf v. Geren*, 553 U.S. 674, 90 (2008). Indeed, the "serious questions" language is simply a gloss on the standard applicable to *all* preliminary injunctions. The court in *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 714–15 (2001) cited *FTC v. Beatrice Foods Co.*, 587 F.2d 1225, 1229 (D.C. Cir. 1978) for the standard, which, in turn, cited *FTC v. Lancaster Colony Corp.*, 434 F. Supp. 1088, 1090-91 (S.D.N.Y. 1977), which, in turn, cited *Hamilton Watch Co. v. Benrus Watch Co.*, 206 F.2d 738, 740 (2d Cir. 1953). The *Hamilton Watch* court cited an opinion from 1897 in which a *private plaintiff* (not the FTC) sought an injunction. *See City of Newton v. Levis*, 79 F. 715, 718 (8th Cir. 1897). Thus, the origin of the "serious question" language has nothing to do with any unique FTC "public interest" standard.

[5] *See also Elders Grain*, 868 F.2d at 904 (A merger should not be enjoined if "likely to lead to lower prices … or other efficiencies will benefit consumers."); *United States v. Archer–Daniels Midland Co.*, 866 F.2d 242, 246 (8th Cir. 1988) (A merger should not be enjoined unless firms can "raise prices above competitive levels for a significant period of time.").

Plaintiffs can establish a prima facie case by showing "a significant increase in the concentration of the market."[6] *Id*. Upon such a showing, the burden shifts to the Defendants to offer evidence that Plaintiffs' "market-share statistics produce an inaccurate account of the merger's probable effects on competition in the relevant market."[7] *Arch Coal*, 329 F. Supp. 2d at 116; *United States v. Citizens & S. Nat'l Bank*, 422 U.S. 86, 120 (1975). Once the defendant offers such evidence, "the burden of producing additional evidence of anti-competitive effect shifts to [Plaintiffs], and merges with the ultimate burden of persuasion[.]" *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 715 (D.C. Cir. 2001) (quotation omitted). The burden of proof "remains with the government at all times." *Id.*

Here, Plaintiffs have failed to (1) establish a presumption of illegality based on market concentration or (2) present evidence that the merger will likely increase prices. Plaintiffs' request for a preliminary injunction should therefore be denied.

A. Plaintiffs' Geographic Market Is Fundamentally Flawed.

Proving the relevant market is "a necessary predicate" to Plaintiffs' claim. *United States v. E.I. Du Pont De Nemours & Co.*, 353 U. S. 586, 593 (1957); *Freeman Hosp.*, 69 F.3d at 268 ("Without a well-defined relevant market, an examination of a transaction's competitive effects is without context or meaning."). Thus, Plaintiffs must prove "the area of effective competition … in which the seller operates, and to which the purchaser can practicably turn for supplies." *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 359 (1963) (quotation omitted). "[T]he

[6] The Merger Guidelines require a post-merger HHI of 2500 with an increase in HHI of at least 200 in order to establish a presumption. U.S. Dep't of Justice & FTC, Horizontal Merger Guidelines § 5.3 (2010) ("Merger Guidelines") *available at* https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf.

[7] The presumption is the same as any other presumption under Rule 301 of the Federal Rules of Evidence. *Cf. Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1340 (7th Cir. 1981) (reversing the FTC because rebutting the FTC's presumption is not an "affirmative defense"; instead "the government continues to bear the burden of persuasion even after it has made out a prima facie case through statistical evidence."); *Baker Hughes, Inc.*, 908 F.2d at 984 (same).

relevant geographic market must both correspond to the commercial realities of the industry and be economically significant." *Arch Coal*, 329 F. Supp. 2d at 123. (internal quotation marks and citation omitted). "A properly defined geographic market includes potential suppliers who can readily offer consumers a suitable alternative to the defendant's services." *FTC v. Tenet Health Care Corp.*, 186 F.3d at 1043 (8th Cir. 1999). The evidence "must address where consumers could practicably go, not where they actually go." *Id.* at 1053. A geographic market is properly defined "where the evidence shows that purchasers within the geographic area cannot realistically turn to outside sellers should prices rise within the defined area." *Republic Tobacco, L.P. v. N. Atl. Trading Co.*, 254 F. Supp. 2d 985, 1004 (N.D. Ill. 2002) (internal quotation marks omitted).

In the health care context, courts routinely examine where patients travel to obtain health care services when determining the relevant geographic market. Courts have soundly rejected proposed geographic markets in which *either* (a) more than 10 percent of patients *leave* that area to obtain health care services ("outflow") or (b) more than 10 percent of patients *enter* that area to obtain health care services ("inflow").[8] Indeed, in *Tenet*, the Eighth Circuit rejected the FTC's alleged geographic market because the FTC "improperly discounted the fact that over twenty-two percent of people in the most important zip codes already use hospitals outside the FTC's proposed market." *Id.* at 1054. Similarly, in *Rockford*, the Court rejected the DOJ's geographic market because the geographic market should be defined as an area "representing about 90% of the admissions of the defendants … Any area smaller would ignore competitors whowhile small,

[8] *Nilavar v. Mercy Health Sys.-W. Ohio*, 244 F. Appx. 690, 697 (6th Cir. 2007) ("[A] geographic market is properly defined when 10% or less of the customers leave the area to obtain the product and when 10% or less of consumers who obtain the product come in from outside the area."); *Kochert v. Greater Lafayette Health Servs., Inc.*, 372 F. Supp. 2d 509 (N.D. Ind. 2004), aff'd, 463 F.3d 710 (7th Cir. 2006) (rejecting 20 percent outflow); *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1074 (N.D. Cal. 2000), *aff'd*, 217 F.3d 846 (9th Cir. 2000) (rejecting 15 percent outflow); *Gordon v. Lewistown Hosp.*, 272 F. Supp. 2d 393, 428 (M.D. Pa. 2003) (rejecting 16 percent outflow).

do compete for a significant segment of the defendants' admission base." *Rockford*, 717 F. Supp. at 1278.

Courts also evaluate the "hypothetical monopolist" test found in the Merger Guidelines, which asks whether "a hypothetical profit-maximizing firm that was the only … producer of the relevant product(s) located in the region" could successfully implement a small, but significant, non-transitory increase in price ("SSNIP"). Merger Guidelines § 4.2.1. Courts evaluate whether the number of patients that would leave the geographic area in response to such a price increase would be sufficient to make the price increase unprofitable to the hypothetical monopolist. *Tenet*, 186 F.3d at 1050; *Sutter*, 84 F. Supp. 2d at 1077-81. Courts have found that losses of as little as *four percent* of patients are sufficient to deter a hypothetical hospital monopolist from imposing a price increase and therefore sufficient to disprove a purported geographic market. *Sutter*, 84 F. Supp. 2d at 1077-81. In this case, Plaintiffs' proffered geographic market fails all of the above tests for defining geographic markets and is flatly inconsistent with the FTC's prior alleged geographic market in the exact same geographic area in the *Evanston* case.[9]

1. Plaintiffs' Geographic Market Is Gerrymandered And Divorced From Competitive Realities In Chicagoland.

Plaintiffs allege a geographic market that artificially inflates defendants' market shares. Instead of applying the tests in the Merger Guidelines and the case law, Plaintiffs have drawn arbitrary geographic boundaries that exclude major competitors in an attempt to fabricate a presumption of anticompetitive effects.

The only basis Plaintiffs offer for their "North Shore Area" geographic market is that patients typically prefer to receive hospital services "locally." But what is "local" depends on actual patient behavior. Hospital data show where patients reside and where they travel for

[9] *In re Evanston Nw. Healthcare Corp.*, FTC Docket No. 9315, 2007 WL 2286195 (Aug. 6, 2007).

health care services. That data clearly shows that an extraordinary *27 percent* of patients leave the "North Shore Area" to receive inpatient hospital services. Pls.' Mem. 16. This is a *far* higher level of patient "outflow" than the 10 percent level that courts might tolerate when defining hospital geographic markets. *See, e.g.*, *Tenet*, 186 F.3d at 1054; *Rockford*, 717 F. Supp. at 1278. Moreover, Plaintiffs ignore the striking fact that *almost half* of the patients treated in "North Shore Area" hospitals travel from *outside* that area[10] - again a *far* higher level of patient "inflow" than courts accept. *Id.* Accordingly, the "North Shore Area" is not a market at all because it excludes hospitals that compete with Advocate and NorthShore for over a *quarter* of the patients that reside *inside* that area, as well as those hospitals that compete for *almost half* of the patients that reside *outside* that area that travel into the area for inpatient care.

Plaintiffs' expert, Dr. Tenn, uses a novel approach for geographic market definition that has no support in the academic literature or case law. First, Dr. Tenn arbitrarily excludes major competitors, such as Northwestern Memorial Hospital and Rush University Medical Center, dismissing them as so-called "destination" hospitals.[11] But as Dr. McCarthy explains, Northwestern Memorial is a *primary* competitor of NorthShore, and has many outpatient facilities that channel "North Shore Area" patients to its downtown hospital, just outside of the boundaries of Plaintiffs' gerrymandered geographic market.[12] Northwestern has the first or second highest market share in many parts of the alleged market,[13] and thousands of patients that reside in that alleged market visit both Northwestern and Rush for routine inpatient services.[14] Because patients choose these so-called "destination" hospitals for services that they could have obtained more locally, there is no basis to exclude these competing hospitals from the market.

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10 DX5000, McCarthy Report ¶ 70.
11 *Id.* ¶¶ 51-59.
12 *Id.* ¶¶ 54-56, 76.
13 *Id.* ¶ 51.
14 *Id.* ¶¶ 52, 59.

Dr. Tenn also excludes major hospitals that compete for patients in the "North Shore Area" simply because those hospitals (1) compete with either Advocate or NorthShore (but allegedly not both) or (2) have less than a two percent market share in the alleged market. These arbitrary criteria have no support in the law or economic literature.[15] Dr. Tenn uses these invented thresholds as a one-way ratchet against Defendants to exclude competitor hospitals, but not Defendants' hospitals, that meet the same test. For example, he asserts that NorthShore Skokie Hospital is in the relevant market, despite the fact that its market share is only 1.5 percent. But if this same threshold were applied to all hospitals, *nine more hospitals* would be included in the relevant geographic market.[16] The Court should reject Dr. Tenn's purported geographic market because it does not include all "potential suppliers who can readily offer consumers a suitable alternative to the defendant's services." *Tenet*, 186 F.3d at 1052.

Plaintiffs' alleged relevant geographic market suffers from other material flaws. Unlike any other hospital merger challenge, Plaintiffs here assert that the geographic market is "bounded" by a line that arbitrarily connects the dots between six hospitals, ignoring the competitive constraints faced by hospitals sitting on that boundary from hospitals just beyond the alleged market. Compl. ¶ 4. Moreover, Plaintiffs ignore the greater Chicagoland area – including *major* hospitals that are located on the way to downtown where many residents of the "North Shore Area" work and seek care.[17] *Cf. Tenet,* 186 F.3d at 1053-54 (rejecting FTC's "contrived market area that stops just short of including a regional hospital" as "absurd").

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15 *Id.* ¶¶ 60-64.

16 *Id.* ¶ 62.

17 Patients consider hospitals located near their work to be "local." [redacted]

Indeed, patients who reside in the alleged "North Shore Area" are particularly willing to travel to hospitals in Chicago,[18] including the University of Chicago Medical Center,[19] Northwestern Memorial Hospital,[20] and Rush University Hospital.[21] Hospitals and health insurers also consider the broader Chicagoland market[22] – and certain providers within a [redacted] radius[23] – in assessing competition. Consistent with these observations, courts have upheld hospital geographic markets that encompass entire metropolitan areas.[24] However, courts have rejected hospital geographic markets that slice metropolitan areas into arbitrary pieces that ignore

[18] *See, e.g.,* [redacted]; DX9016, Primack (Advocate) Dep. at 77:24-78:10 ("We look at the five academic hospitals within the city who have routinely pulled volume out of Lake County."); *see also id.* at 81:11-82:1; *id.* at 90:4-91:21.

[19] DX9133.003 (reporting that in FY 2010-2012, "[d]owntown hospitals, specifically Children's Memorial and University of Chicago, have seen an increase in patients from Lake County.").

[20] *See* [redacted] DX9034, Sacks (Advocate) Dep. at 129:12-21 ("[T]he striking example is that women travel hour and a half, two hours, to come downtown to Northwestern Memorial for obstetrics care."); [redacted]

[21] *See* [redacted] DX9015, Hall (NorthShore) Dep. at 169:7-11 ("Rush has very significant orthopedics and neurosurgery, neurosciences services that are very well-known. We have people leaving Lake County, heading into the city, yes.").

[22] [redacted]

[24] *See, e.g., FTC v. ProMedica Health Sys., Inc.*, No. 3:11 CV 47, 2011 WL 1219281, at *10 (N.D. Ohio Mar. 29, 2011) (Lucas County, OH (Toledo) geographic market); *OSF*, 852 F. Supp. 2d at 1076-77 (area within thirty-minute drive of downtown Rockford, IL geographic market); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1291-94 (W.D. Mich. 1996), *aff'd sub nom*, 121 F.3d 708 (6th Cir. 1997) (thirty-mile radius of Grand Rapids, MI geographic market); *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1210-11 (11th Cir. 1991) (three-county area around Augusta, GA geographic market).

commercial realities.[25] This case is no different, and the Court should reject Plaintiffs' alleged "North Shore Area" geographic market.

Plaintiffs also rely on a "hypothetical monopolist" test performed by Dr. Tenn in support of their gerrymandered geographic market. But Dr. Tenn's market definition test is nothing more than the same model he used to try to predict a price increase, which is flawed for the numerous reasons discussed below.[26] Moreover, he finds what Plaintiffs call a "high level of intra-market diversion" of consumers within the "North Shore Area." Pls.' Mem. 19. In fact, the evidence shows the opposite. A staggering *52 percent* of patients that chose hospitals in the "North Shore Area" would travel to a competing hospital *outside* of that area if their first hospital choice were unavailable to them.[27] In other words, Plaintiffs' geographic market hinges on the implausible assumption that a "hypothetical monopolist" comprised of the hospitals within the alleged market would risk *over half of its patient volume* in order to impose a small inpatient price increase.

2. Plaintiffs' Geographic Market Is Inconsistent With The FTC's Prior Litigation Position.

The FTC's market in the *Evanston* case provides stark evidence that Plaintiffs have s gerrymandered the market in this case. In *Evanston*, the FTC examined NorthShore's consummated acquisition of Highland Park Hospital, finding a market limited to the "geographic triangle" formed by three of the same NorthShore hospitals at issue in this case – Evanston, Glenbrook, and Highland Park. *Evanston*, 2007 WL 2286195, at *48. In an 88-page opinion, the five FTC Commissioners "rejected" a broader geographic market that included *both*

[25] *See California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1132 (N.D. Cal. 2001) (rejecting geographic market that severed East Bay from the rest of the San Francisco Bay Area); *United States v. Long Island Jewish Med.l Ctr.*, 983 F. Supp. 121, 141-42 (E.D.N.Y. 1997) (rejecting geographic market that severed two counties on Long Island from Suffolk County and Manhattan).

[26] DX5000, McCarthy Report ¶¶ 49, 65.

[27] PX0600,Tenn Report ¶ 99.

Advocate and NorthShore, finding that Advocate Lutheran General and Condell Medical Center could not constrain an inpatient price increase by the NorthShore hospitals. *Id*. at *48-49.

Fast forward eight years, and the FTC now argues that Advocate has somehow gone from a hospital system that does not constrain NorthShore's inpatient pricing to being NorthShore's purported "closest" competitor. Pls.' Mem. 1. The FTC does not argue – nor could it – that these fundamentally inconsistent "markets" reflect actual changes in hospital competition in Chicagoland. Instead, the FTC will apparently extend its geographic market just far enough to include merging hospitals, but no further, in an effort to inflate the parties' purported market shares. The FTC should be judicially *estopped* from taking diametrically opposed litigation positions in the *same* geographic area as to the *same* party.[28] Indeed, at least one court has rejected the FTC's proposed market where it was inconsistent with the FTC's prior position.[29] The FTC should not be given carte blanche to redraw geographic markets whenever it happens to suit their litigation interests.

B. Market Concentration In A Properly-Defined Geographic Market Is Insufficient To Establish A Presumption Of Anticompetitive Effects.

Plaintiffs' alleged market shares are meaningless because they are based on a gerrymandered "North Shore Area" geographic market. *United States v. Engelhard Corp.*, 970 F. Supp. 1463, 1485 (M.D. Ga. 1997) ("If the market is incorrectly defined, the market shares

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[28] *See New Hampshire v. Maine*, 532 U.S. 742, 749 (2001) ("Where a party assumes a certain position in a legal proceeding … he may not thereafter, simply because his interests have changed, assume a contrary position") (alterations and citation omitted); *Remcor Prods. Co.. v. Scotsman Grp., Inc.*, 860 F. Supp. 575, 578-59 (N.D. Ill. 1994) (judicial estoppel applies to FTC administrative proceedings). The FTC itself has recently argued that "[w]here a party assumes a certain position in a legal proceeding, and succeeds in maintaining the position, he may not thereafter, simply because his interests have changed, assume a contrary position." Opp'n of the FTC and the State of Idaho to Mot. for Stay Pending Review at 14, *St. Alphonsus Medical Center – Nampa, Inc. v. St. Luke's Health System, Ltd.*, No. 14-35173 (9th Cir. July 7, 2014).

[29] *Lab. Corp. of Am.*, 2011 WL 3100372, at *6 (rejecting product market that excluded fee-for-service clinical laboratory services as inconsistent with prior FTC position).

would have no meaning.") (quotation omitted). In contrast, Defendants' expert, Dr. McCarthy, determined that the market must include at least nine other hospitals[30] (in addition to the eleven identified by the FTC) in order to include all hospitals that actually compete with Advocate and NorthShore.[31] Within this properly defined market, the market concentration statistics are nowhere close to the level required to establish a presumption of anticompetitive effects. Dr. McCarthy found that Advocate and NorthShore have a combined market share of between 28 and 30 percent, and that the merger would result in an HHI level of only about 1,700.[32] This is ***far lower*** than what is necessary to establish a presumption of anticompetitive effects. Merger Guidelines § 5.3. Instead, mergers in such markets may only "potentially" raise antitrust concerns – concerns that Plaintiffs must *prove* and cannot *presume*. *Id*.

The change in market concentration resulting from the merger also is far below that of all of the other enjoined hospital mergers that Plaintiffs rely upon in their brief.[33] Indeed, as shown in the chart below,[34] practically all of the hospital mergers challenged by the FTC in recent years

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30 DX5000, McCarthy Report ¶ 85 n. 135.

31 The geographic market likely is even larger, given the broad travel and commuting patterns of patients that reside in the Chicagoland area. But the geographic market must be at least as broad as this set of hospitals. *See id.* ¶ 85.

32 *Id*.

33 The FTC also relies on *Philadelphia National Bank*, 374 U.S. 321 , which does not reflect the current standards of the FTC or the courts that instead now focus on changes in market concentration – not market share. Moreover, the Court evaluated the parties combined market share in the *entire* four-county Philadelphia metropolitan area, *id*. at 357-59, unlike here where the FTC has gerrymandered a geographic market to exclude most of Chicago to inflate Defendants' market shares.

34 *In re Promedica Health Sys., Inc.*, FTC Docket No. 9346, 2012 WL 1155392, at *24 (March 28, 2012); *Saint Alphonsus Med. Ctr. - Nampa, Inc. v. St. Luke's Health Sys., Ltd.*, No. 1:12-CV-00560-BLW, 2014 WL 407446, at *1, *8 (D. Idaho Jan. 24, 2014); *In re Phoebe Putney Health System, Inc.*, FTC Docket No. 9348, 2011 WL 1595863, at *11 (April 19, 2011); *In re Reading Health Sys.*, FTC Docket No. 9353, 2012 WL 5879804, at *10 (Nov. 16, 2012); *OSF*, 852 F. Supp. 2d at 1078–79; *In re Inova Health Sys. Found.*, FTC Docket No. 9326, 2008 WL 2061411, at *5-6 (May 8, 2008); *FTC v. Tenet Healthcare Corp.*, 17 F. Supp. 2d 937, 946 (E.D. Mo. 1998), *rev'd*, 186 F.3d 1045 (8th Cir. 1999); *Butterworth Health Corp.*, 946 F. Supp. at 1294; *In re Columbia/HCA Healthcare Corp.*, 120 F.T.C. 949, 952 (Nov. 24, 1995); *In re Adventist Health Sys./West*, 117 F.T.C. 224, 263 (April 1, 1994); *Univ. Health, Inc.*, 938 F.2d 1206, 1211 n.12, 1219 (11th Cir. 1991); *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1280 (N.D. Ill. 1989) *aff'd*, 898 F.2d 1278 (7th Cir. 1990).

resulted in a *far more* "highly concentrated" market, for which a presumption of anticompetitive effects could be warranted, unlike here. This merger is a clear outlier among hospital merger challenges over the past decade or more.

CASE	COMBINED SHARE	HHI Increase	POST-MERGER HHI	Result
Advocate	**28.1%**	**394**	**1,747**	
ProMedica	58%	1,078	**4,391**	FTC won
St. Luke's	80%	1,607	**6,219**	FTC won
Phoebe Putney	86%	1,675	**7,453**	FTC won
Reading	66.5%	2,050	**4,585**	Abandoned
OSF	60%	1,767	**5,179**	FTC won
Inova	73%	808	**5,562**	Abandoned
Tenet	84%	3,200	**7,000**	FTC lost
Butterworth	65%	2,889	**4,521**	FTC lost
Columbia	70%	2,400	**6,400**	FTC won
Adventist	94%	2,500	**5,600**	FTC lost
University Health	43%	630	**3,200**	FTC won
Rockford	72%	2,621	**5,647**	FTC won

Finally, Plaintiffs are not entitled to a presumption because their case is based on "unilateral effects" for which there is no presumption based on market concentration.[35] Compl. ¶¶ 40-46. Merger Guidelines § 6.1; U.S. Dep't of Justice & FTC, Commentary on the Horizontal Merger Guidelines at 16 (market concentration "unimportant" and has "little impact" on unilateral effects theory) *available at* https://www.ftc.gov/sites/default/files/attachments/merger-review/commentaryonthehorizontalmergerguidelinesmarch2006.pdf. Plaintiffs are not entitled to a presumption from market concentration statistics because its legal theory precludes it. Because Plaintiffs are not entitled to a presumption based on market concentration statistics, the Court

[35] *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1123 (N.D. Cal. 2004) ("A presumption of anticompetitive effects from a combined share of 35% in a differentiated products market is unwarranted. Indeed, the opposite is likely true. To prevail on a differentiated products unilateral effects claim, a plaintiff must prove a relevant market in which the merging parties would have essentially a *monopoly or dominant position*.") (emphasis added).

must evaluate whether Plaintiffs have presented sufficient evidence of actual competitive effects. As discussed below in Section I.D, the Plaintiffs have not done so.

C. The Relevant Product Market Is Broader Than GAC Services.

Plaintiffs' contrived market share statistics are also based on a flawed product market. Although there are exceptions,[36] courts have acknowledged product markets consisting of "clusters" of inpatient services. Pls.' Mem. 9. Those courts also have acknowledged Plaintiffs' rationale that the "competitive conditions" for inpatient services are the *same* (because they are sold by hospitals) whereas the "competitive conditions" for outpatient services may be *different* (*e.g.*, because they are sold by ambulatory surgery centers). *Id*. at 11-12. This overly-simplistic argument does not apply here.

Plaintiffs ignore the fact that cluster markets are not confined to situations where the same competitors sell all the same products. Indeed, the Supreme Court rejected this proposition in one of the earliest cluster market cases, finding that the district court "erred" by parsing commercial banking into "different groupings" of particular products or services where competition may be more or less "absen[t]" or "widespread." *United States v. Phillipsburg Nat'l Bank & Tr. Co.*, 399 U.S. 350, 359-60 (1970). Instead, the Court said it must evaluate the "broader line of commerce that has economic significance." *Id*. at 360. Indeed, products should be included in the same market where their prices are *linked*, as Judge Posner noted in both *Rockford Memorial* and *Marshfield Clinic*.[37] The FTC's own Merger Guidelines state that *all*

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[36] *United States v. Carilion Health Sys.*, 707 F. Supp. 840, 847 (W.D. Va.), *aff'd*, 892 F.2d 1042 (4th Cir. 1989) (per curiam) ("Based on the finding above that providers of outpatient services compete with providers of inpatient services for the same patients in a significant number of cases, the court concludes that the relevant service market for this case includes not only other inpatient hospitals but also various outpatient clinics . . . .").

[37] *Rockford Mem'l*, 898 F.2d at 1284 (Inpatient and outpatient services should be in the same market only if their prices are "linked" as either "substitutes or complements"); *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1410-11 (7th Cir. 1995) ("Even if two products are

products that "significantly affect their pricing incentives for products in the candidate market" should be included in the relevant product market. Merger Guidelines at 9, n.4; *see also Lab. Corp. of Am.*, 2011 WL 3100372, at *17 (rejecting the FTC's exclusion of complementary products).

In this case, the prices of inpatient and outpatient services are inextricably linked. Inpatient and outpatient services are complementary products that health insurers must purchase bundled together in order to serve large patient populations that require a full continuum of care.[38] Health insurers negotiate prices simultaneously for *all* of the services sold by a hospital.[39] The prices across this bundle are linked because both the hospital and the health insurers are concerned only about the bottom line across their entire patient population.[40] Because the prices of inpatient and outpatient services are linked, they all should be included in the relevant product market. *Rockford Mem'l*, 898 F.2d at 1284; *Marshfield Clinic*, 65 F.3d at 1410-11.

Inpatient and outpatient prices are also linked as substitutes. The HPN product reflects a continuing and significant shift in health care delivery from pay-for-volume to pay-for-value.[41] Under this new model, inpatient services are no longer a driver of additional revenue, but are instead an additional cost that the providers seek to minimize by, among other things, shifting

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completely different from the consumer's standpoint, if they are made by the same producers an increase in the price of one that is not cost-justified will induce producers to shift production from the other product to this one in order to increase their profits by selling at a supracompetitive price.").

[38] DX5000, McCarthy Report ¶¶ 31-37.

[39] [redacted]

[40] *Kentmaster Mfg. Co. v. Jarvis Prods. Corp.*, 146 F.3d 691, 694 (9th Cir. 1998) ("[O]nly an idiot would think of the cost of A without taking into account the cost of B…. There is a single product, sold over time; the rationally-calculated price is the price of [the two products] together."); [redacted]

[41] [redacted]

procedures to less expensive outpatient settings.[42] This substitution requires expanding the cluster market beyond inpatient services to include outpatient services.[43] Plaintiffs' exclusion of outpatient services from its statistics "produce[s] an inaccurate account of the merger's probable effects on competition in the relevant market," precluding reliance upon any presumption of anticompetitive effects. *Arch Coal*, 329 F. Supp. 2d at 116.

D. Plaintiffs Have No Evidence Of Actual Anticompetitive Effects.

Because there can be no presumption of anticompetitive effects, Plaintiffs' request for a preliminary injunction rises or falls based on actual "evidence of anti-competitive effect." *Heinz*, 246 F.3d at 715 (citation omitted). Plaintiffs cannot meet that burden. Indeed, Plaintiffs' lack of evidence of anticompetitive effects dooms their case *regardless* of market concentration levels because "a broad analysis of the market to determine any effects on competition is required." *Arch Coal*, 329 F. Supp. 2d at 130; *Baker Hughes*, 908 F.2d at 984 (same). Indeed, "only a further examination of the particular market—its structure, history and probable future—can provide the appropriate setting for judging the probable anticompetitive effect of the merger." *Brown Shoe Co. v. United States*, 370 U.S. 294, 322 n.38 (1962); *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 498 (1974) (statistics are "not conclusive indicators of anticompetitive effects"); *Kaiser*, 652 F.2d at 1336 (same). "To allow the government virtually

42 [redacted]

See, e.g., Santa Cruz Med. Clinic v. Dominican Santa Cruz Hosp., No. C93 20613 RMW, 1995 WL 853037, at *7 (N.D. Cal. Sept. 7, 1995) (finding "a genuine issue of material fact as to whether [outpatient] services … place a check on the prices of the core of inpatient services"); *see also United States v. Columbia Steel Co.*, 334 U.S. 495, 510-11 (1948) (supply substitution of rolled steel and steel plates and shapes) (citations omitted).

to rest its case" on market shares statistics, "leaving the defendant to prove the core of the dispute, would grossly inflate the role of statistics" in merger cases; "[t]he Herfindahl–Hirschman Index cannot guarantee litigation victories." *Baker Hughes*, 908 F.2d at 992.

Plaintiffs' evidentiary burden is higher because they have alleged only "unilateral effects" based on the theory that the combined company will somehow have the ability to unilaterally raise prices post-merger. Merger Guidelines § 6.1. In order to state a claim based on a unilateral effects theory, Plaintiffs must prove all of the following: (1) "the products controlled by the merging firms must be differentiated;" (2) "the products controlled by the merging firms must be close substitutes;" (3) "other products must be sufficiently different from the products controlled by the merging firms that a merger would make a small … price increase profitable for the merging firms;" and (4) "repositioning by the non-merging firms must be unlikely." *Oracle*, 331 F. Supp. 2d at 1117-18; *see also CCC*, 605 F. Supp. 2d at 68 (same). If any of these elements are missing, Plaintiffs' theory fails.

Plaintiffs have failed to carry their burden of establishing: (a) that Advocate and NorthShore are such close substitutes that it would be profitable for the merged enterprise to unilaterally increase prices; and (b) that repositioning by the numerous other health care providers in Chicagoland would not defeat any such attempt to increase prices.

1. Plaintiffs Have No Evidence That The Merged Company Could Unilaterally Increase Price.

Plaintiffs claim that the merger will lead to higher prices for inpatient services. However, despite more than a year-long investigation and the production of 2.6 million pages of documents, there are *no* documents and there is *no* testimony – zero – showing or suggesting that Advocate and/or NorthShore will raise prices as a result of the merger. Instead, Plaintiffs rely on two categories of "evidence": (1) competition between Advocate and NorthShore and (2)

Advocate and NorthShore contracting with insurers. However, neither category of "evidence" satisfies Plaintiffs' burden.

First, the fact that documents and testimony show that Advocate and NorthShore compete does not mean that they compete *only* against each other.[44] What Plaintiffs have not – and cannot – prove is that competition with the other hospitals in Chicagoland is not "equally vigorous," and that customers would not simply switch to those hospitals in response to a post-merger price increase.[45] *Oracle*, 331 F. Supp. 2d at 1171.

The evidence shows that Advocate and NorthShore compete vigorously with other hospitals. For example, documents show that Advocate Lutheran General closely monitors Northwestern Memorial, Alexian Brothers, Resurrection Medical Center, Northwest Community Hospital, Presence, and NorthShore.[46] Indeed, Advocate Condell counts Northwestern Lake Forest and Vista Health System among its "closest competitors."[47] NorthShore has identified Northwestern Memorial as "competition" and an "environmental threat[]"[48] and notes "increased competition" from Northwestern as an "aggressive" competitor.[49] NorthShore documents show that it competes with other hospitals as well, including Cadence, University of Chicago, Loyola

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44 *Oracle,* 331 F. Supp. 2d at 1169 ("Simply because [two firms] often meet on the battlefield and fight aggressively does not lead to the conclusion that they do so in the absence of [other competition].") (rejecting unilateral effects claim).

45 DX5000, McCarthy Report ¶¶ 81-82, Appendix A.

46 DX9123; DX9114.0022, 0029 ; DX9122.003-0004.

47 DX9127.0019; *see also* DX9124.0017; DX9125.0006.

48 DX9151.0011.

49 DX9135.0002; *see also* DX9136.0001 ((stating that "Northwestern has purchased/committed to a presence on the NorthShore"); DX9134.0003 ("What we know: Competitors are becoming aggressive[.] Northwestern is steadily moving into our PSA."); DX9138.0001 (noting that "the competition is heating up!" in reference to Northwestern); [redacted]

Medical Center, Northwest Community Hospital, and Swedish Covenant.[50] [redacted]

Second, Plaintiffs argue that health insurers somehow will lose bargaining leverage if Advocate and NorthShore merge. As a threshold matter, the Court should disregard the self-serving declarations of health insurers such as [redacted] The Court should be skeptical of BCBS-IL's position because "customers may oppose, or favor, a merger for reasons unrelated to the antitrust issues raised by that merger." Merger Guidelines §§ 2.2.2-3; *Oracle*, 331 F. Supp. 2d at 1131, 1167 ("[U]nsubstantiated customer apprehensions do not substitute for hard evidence."); *Arch Coal*, 329 F. Supp. 2d at 145-46 (same). Indeed, the unreliability of Plaintiffs' evidence is demonstrated by the fact that multiple insurers, including [redacted], have expressed their *support* for the merger, recognizing that the merger will reduce costs and improve quality.[53]

Moreover, Plaintiffs' own examples show not only that health insurers view Advocate and NorthShore as interchangeable with other hospitals, but also that neither is necessary for a health insurance product to be commercially viable. Indeed, BCBS-IL recently sought to create

[50] DX9136.0001; DX9134.0003; DX9137.0001; DX9141.0001-0002; DX9144.0001; DX9143.0001; DX9142.0001; DX9136.0001.

[51] [redacted]

a new narrow network product that did *not* include either Advocate or NorthShore called "Project Remedy."[54] [redacted]

Other insurers are no different. [redacted] While Dr. Tenn alludes to several other examples in his expert report, he fails to explain how they show that prices would increase post-merger. [redacted]

54 [redacted].

55 [redacted]

57 [redacted] *see also* DX9034, Sacks (Advocate) Dep. at 152:16-19 (noting that "the fastest growing product in the marketplace was a product called Blue Choice, that [Advocate] didn't participate in").

58 [redacted]

59 [redacted]

60 [redacted]

61 [redacted]

[redacted] A primary reason why health insurers will not be negatively impacted by the merger is that they can "steer" patients to particular providers using various benefit designs,[66] giving the insurer leverage to negotiate lower reimbursement rates and to deter any attempted price increase.[67]

2. Plaintiffs' "Economic Analysis" Does Not Show That The Merged Company Could Unilaterally Increase Price.

Plaintiffs' expert, Dr. Tenn, claims his model show that the merger would result in a price increase. Pls.' Mem. 28; Tenn Report ¶ 145 *et seq.* There are several critical flaws with Dr. Tenn's analysis. As discussed below, his model is "static" and does not account for cost savings, efficiencies, or the repositioning of health care providers in the North Shore Area in response to any price increase.[68] Moreover, the model is stacked in Plaintiffs' favor because, as an FTC Commissioner has acknowledged, it *always* predicts a price increase.[69] Indeed, the FTC and DOJ economists who laid the foundation for the model have stated unequivocally that it should

62 [redacted]

63 [redacted]

64 [redacted]

65 [redacted]

66 [redacted]

Advocate has accepted lower rates from United to ensure that patients are not steered to other hospitals. [redacted]

68 DX5000, McCarthy Report ¶ 102-6.

69 *In re Promedica Health Sys., Inc.*, 2012 WL 1134234, at *3-4 (March 28, 2012) (noting that "the 'willingness to pay' model is not an appropriate basis on which to find that the transaction will result in unilateral effects" and that "such studies always predict a price increase if there is any degree of substitution between the merging parties' products").

not be used to "predict post-merger prices."[70] *Cf. City of New York v. Grp. Health Inc.*, No. 06CIV.13122RJS, 2010 WL 2132246, at *6 n.6 (S.D.N.Y. May 11, 2010) *aff'd*, 649 F.3d 151 (2d Cir. 2011) (rejecting "upwards pricing pressure" test); *FTC v. CCC-Mitchell*, 605 F. Supp. 2d 26, 67 (D.D.C. 2009) (rejecting FTC's unilateral effects model where the FTC had no "data" to support its "diversion ratios" besides "market shares.").

Dr. Tenn's model also does not measure *actual* substitution between Advocate and NorthShore and simply *assumes* that, for example, certain patients prefer Advocate and NorthShore hospitals when those patients might *actually* prefer Northwestern Memorial Hospital if their true preferences were known.[71] Indeed, economists have specifically studied whether the model purportedly employed by Dr. Tenn accurately predicts hospital price increases in the North Shore Area, and found that the model's predictions were vastly different than actual observed changes in prices.[72] Each of these problems renders Dr. Tenn's analysis unreliable.

More importantly, Dr. Tenn's application of the model is fundamentally flawed and yields inherently unreliable results. Dr. Tenn failed to apply the *FTC's own methodology* in conducting his analysis, ignoring the necessary second half of the analysis that is based on actual price data.[73] Both Dr. McCarthy[74] and Dr. Eisenstadt[75] faithfully applied the FTC's methodology in a variety of merger simulations, analyzed actual price data from Chicagoland insurers, and

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[70] DX9107, Joseph Farrell & Carl Shapiro, *Upward Pricing Pressure in Horizontal Merger Analysis: Reply to Epstein and Rubinfeld*, 10 B.E. J. Theoretical Econ., Art. 41 (2010).

[71] The fact that Dr. Tenn presents no actual evidence of substitution between NorthShore and Advocate dooms the FTC's unilateral effects case. *See, e.g., United States v. Oracle Corp*., 331 F. Supp. 2d 1098, 1172 (N.D. Cal. 2004) (declining to enjoin merger where plaintiffs "failed to prove that there are a significant number of customers…who regard Oracle and PeopleSoft as their first and second choices").

[72] Charles River Associates, *Predicting the price effects of hospital mergers: An Evaluation of the willingness-to-pay technique* (March 2014), *available at* http://www.crai.com/sites/default/files/publications/Predicting-the-price-effects-of-hospital-mergers.pdf.

[73] *See* DX6000, Eisenstadt Report ¶¶ 72-74.

[74] *See* DX5000, McCarthy Report ¶¶ 89-92, 98-101, 105.

[75] *See* DX6000, Eisenstadt Report¶¶ 72-74.

found that the merger would have ***no statistically significant effect on price***. At bottom, Plaintiffs have presented no evidence that the merger will result in higher prices, and thus Plaintiffs cannot establish the likelihood of success. Plaintiffs' motion should be denied.

3. Repositioning Of Providers Prevents Any Competitive Effects.

"Repositioning" or competitive responses by existing providers also would defeat any effort by the merged company to increase price.[76] Dr. Tenn's model fails to take repositioning into account, and incorrectly assumes that other providers would not react to a price increase by changing their own products or opening new outpatient and other facilities. The FTC's own economists have acknowledged the flaw in Dr. Tenn's model, noting that "current hospital merger simulation methods cannot explicitly evaluate the likelihood of post-merger entry or competitor repositioning."[77]

Dr. Tenn's failure to take repositioning into account is particularly glaring because providers in the Chicagoland area are actively repositioning *now*. Dr. McCarthy describes many examples of repositioning, including upgrading and/or replacing hospitals, opening new physician offices and outpatient facilities to drive hospital referrals, and hiring new doctors to

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[76] *FTC v. Whole Foods Mkt., Inc.*, 502 F. Supp. 2d 1, 42 (D.D.C. 2007) *rev'd on other grounds*, 548 F.3d 1028 (D.C. Cir. 2008) (Merger is lawful "if it is easy for other market participants to enter the market or reposition themselves better to compete."); *Arch Coal*, 329 F. Supp. 2d at 159 (finding that the likely "expansion [of existing firms] is more than enough to cover any demand shortfall and defeat any price increase").

[77] DX9104, Keith Brand & Christopher Garmon, *Hospital Merger Simulation*, American Health Lawyers Association, January 2014, *available at* https://www.healthlawyers.org/Events/Programs/Materials/Documents/AT14/h_brand.pdf; DX9150, David A. Argue & Richard T. Shin, *An Innovative Approach to an Old Problem: Hospital Merger Simulation*, ANTITRUST, Fall 2009, at 49; DX9105, Michael Mazeo, Katja Seim, & Mauricio Varela, *The Welfare Consequences of Mergers with Product Repositioning*, December 2013, *available at* http://www.cepr.org/sites/default/files/Mazzeo-merger_paper_v10.pdf; *see also* DX5000, McCarthy Report at 10 (explaining that the model treats products and services as if they "cannot adjust after the merger" and therefore fails to properly analyze the post-merger market by assuming that "the set of differential products offered by market participants to be identical pre- and post-merger.")

strengthen practice areas.[78] [redacted] Hospitals often use outpatient facilities and physician offices as beachheads in areas from which they are seeking to increase their patient volume. [redacted] This repositioning can be achieved quickly; outpatient facilities can be built in less than a year. Dr. Tenn's model fails to acknowledge the possibility – indeed, the probability – that such repositioning would defeat the ability of the merged firm to increase price.

E. Substantial Efficiencies Outweigh Any Potential Harm From The Merger.

"[A] defendant may rebut the government's *prima facie* case with evidence showing that the intended merger would create significant efficiencies in the relevant market."[84] *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 146-47 (E.D.N.Y. 1997) (quotation omitted); *see also Arch Coal, Inc.*, 329 F. Supp. 2d at 150). The merger will generate efficiencies that increase competition for health care services in the Chicagoland area by (a) delivering higher quality health care to Chicagoland consumers; (b) lowering the cost of care through cost

78 *See, e.g.*, DX5000, McCarthy Report at 80-82.

79 [redacted]

80 [redacted]

81 [redacted]

82 [redacted]

83 DX5000, McCarthy Report at 32; *id.* Ex. 14.

84 Merger Guidelines, § 10 ("[A] primary benefit of mergers to the economy is their potential to generate significant efficiencies and this enhance the merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service or new products.").

synergies and Advocate's proven experience managing health care of a population; and (c) delivering to the Chicagoland marketplace an attractive new health insurance product sold at a price that is at least 10 percent lower than current products on the market. These efficiencies will *enhance* competition and the transform health care in the Chicagoland market in two critical ways: first, by spurring rivals to develop competitive alternatives to the HPN product;[85] and second, by providing a unique product through which smaller health plans can better compete with BCBS-IL, the dominant payor in Chicagoland.[86] As discussed in more detail below, the parties anticipate more than $200 million in net cost savings.[87] More importantly, the merger will deliver to Chicagoland consumers a higher-quality and lower cost health care option in the form of a High Performing Network, which translates into hundreds of dollars, if not $1,000, in savings per individual subscriber per year.[88] As discussed below, these efficiencies are merger-specific because, without the merger, Advocate and NorthShore will not offer the HPN to employer groups in Chicagoland.

II. THE BALANCE OF THE EQUITIES FAVORS THE MERGER.

85 [redacted]

[redacted].

87 [redacted]

DX6000, Eisenstadt Report¶ 8.

Contrary to Plaintiffs' argument, "the 'likelihood of success' analysis and the 'public equities' analysis are legally different points and the latter should be analyzed separately, no matter how strong the agency's case on the former." *CCC*, 605 F. Supp. 2d at 75; *Elders Grain*, 868 F.2d. at 903-04 (Plaintiffs improperly "collapse[s] the issue of equity or relative harm into the merits"). Plaintiffs have an independent burden to "show that the equities favor issuing the relief sought." *FTC v. Ill. Cereal Mills, Inc.*, 691 F. Supp. 1131, 1140 (N.D. Ill. 1988); *Arch Coal*, 329 F. Supp. 2d at 160; *Lab. Corp. of Am.*, 2011 WL 3100372, at *21.

Balancing the equities is not a mere "mechanical" task for the court because Plaintiffs cannot rely on the public interest in "antitrust enforcement" alone. *Weyerhaeuser Co.*, 665 F.2d at 1081 ("We do not believe [Section 13(b)'s] deliberate addition of a reference to 'the equities' should be brushed aside as essentially repetitive or meaningless."). Instead, Plaintiffs must prove that "the harm to the parties and to the public that would flow from a preliminary injunction is outweighed by the harm to competition, if any, that would occur in the period between denial of a preliminary injunction and the final adjudication of the merits of the Section 7 claim." *Great Lakes*, 528 F. Supp. at 86.

"[P]ublic equities" include "the potential benefits, both public and private, that may be lost by enjoining a merger." *FTC v. Swedish Match*, 131 F. Supp. 2d 151, 172 (D.D.C. 2000). "For instance, if potential merger partners can present credible evidence that the merged company will lower consumer prices," the merger should not be enjoined. *CCC*, 605 F. Supp. 2d at 75-76. "Public equities include improved quality, lower prices, increased efficiency, realization of economies of scale, consolidation of operations, and elimination of duplication." *Lab. Corp. of Am.*, 2011 WL 3100372, at *22 (citation omitted). Indeed, "[t]he public interest in enforcing the antitrust laws" is in fact consumers' collective interest in lower priced, higher

quality goods and services. *See Elders Grain*, 868 F.2d at 904. "[P]articularly strong equities [that] favor the merging parties" bars injunctive relief." *Whole Foods*, 548 F.3d at 1035. Conversely, "[a]bsent a likelihood of success on the merits, equities alone will not justify an injunction." *Arch Coal*, 329 F. Supp. 2d at 159.

This merger will result in lower priced, higher quality health care, and therefore the balance of equities favor denial of a preliminary injunction.

A. The Merger Will Result In Substantial Public Equities.

The merger will enable the combined company to offer a novel HPN product that is sought by employers,[89] and that several health plans are ready to offer now.[90] That HPN product will benefit consumers in at least two ways. First, the product will enhance the quality of health care provided to consumers throughout Chicagoland. Second, the product will lower costs, resulting in prices that are 10 percent lower than the lowest-priced comparable alternative ,[91] which amounts to savings of hundreds of dollars each year for individuals in the Network.[92] These benefits are real and will be destroyed if this merger is enjoined.

1. The Merger Will Result In Higher Quality Health Care For Chicagoland Consumers.

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89 DX8100, Van Liere Report, ¶ 25.

90 [redacted]

DX6000, Eisenstadt Report ¶¶ 32, 48; *see also* DX9034, Sacks (Advocate) Dep. 119:21-120:1 ("As I know you're aware, on the public exchange, our product, Blue Care Direct, is the lowest priced BlueCross product, at least 10 percent below the next lowest product. And outside of Cook County, it's the absolute lowest product on the exchange."). Notably, Health plans in the Chicago market have stated that the premium price of a narrow network product must be 8-15% below the premium of the next-best alternative product in order to be attractive to employer groups. *See* DX9111.0003; *see also* DX9112.0003.

92 Eisenstadt Report ¶ 8; *see also id.* at Table 6; DX9034, Sacks (Advocate) Dep. 286:18-288:05 (estimating that the High Performing Network would save Chicago consumers $500 to $800 million annually).

The United States health care system is undergoing dramatic change, shifting away from fee-for-service reimbursement that encourages overutilization and toward alternative payment approaches that reward providers for the value they provide, rather than the volume of services they perform.[93] These new payment approaches aim to align the incentives of providers, payers, and patients. Full risk-based contracts shift all risk to providers for addressing the health care needs of a defined population, thereby incentivizing providers to proactively manage the health care of a population. This is often referred to as "population health management" ("PHM").[94]

Providers engaged in PHM strive to keep patients healthy and out of the hospital through physician and ambulatory services, including preventative care.[95] The providers' goal is not to raise hospital prices, but rather to avoid hospitalizations altogether. Instead of a revenue item, each hospitalization is a cost. This approach reflects a 180 degree shift for hospitals that have been under fee-for-service contracts. Very few hospitals have made this shift. At best, certain hospitals are gradually assuming some limited risk under payment approaches that fundamentally remain fee-for-service and reward them for increased volume.[96]

Advocate is an exception. It has embraced full-risk contracts and is a national leader in PHM.[97] Over the past twenty-plus years, Advocate has invested substantial resources to develop the culture, infrastructure, and capabilities to engage in PHM.[98] Advocate has demonstrated success at managing care under full risk-based contracts.[99] The results of these efforts do not lie.

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93 DX7000, Dudley Report ¶¶ 9, 18-19; *see also*, DX8000, Steele Report ¶ 14.
94 DX7000, Dudley Report ¶ 9.
95 DX9023, Dan (Advocate) Dep. at 62:09-63:24.
96 DX8000, Steele Report ¶ 16.
97 DX7000, Dudley Report ¶¶ 64-81, 101; [redacted]
DX7000, Dudley Report ¶¶ 64-81, 101.
99 DX6000, Eisenstadt Rep. ¶ 15.

Advocate uses various measures to evaluate its performance and consistently ranks high among its leading national peers.[100]

NorthShore is a high-quality hospital, but it is still focused on the old fee-for-service model and has invested little in PHM.[101] [redacted] By virtue of the merger, NorthShore will incorporate Advocate's PHM practices and tools so that it can better serve its population.[103] Notably, the quality benefits from this merger will extend to the entire population served by Advocate and NorthShore regardless of an individuals' health plan coverage.

2. The Merger Will Lower Costs For Chicagoland Consumers.

The merger will result in lower costs of care in at least three ways. First, [redacted]

[100] DX9037, Esposito Dep. at 36:20-24 (agreeing that "Advocate has one of the most rigorous processes with respect to identifying measures and using them as a vehicle for improvement"); DX7000, Dudley Report ¶¶ 64-75.

[101] DX7000, Dudley Report ¶ 34 ("Advocate had far more sophisticated PHM capabilities that NorthShore could not easily buy or develop"); DX8000, Steele Report ¶ 27 ("The resources committed by NorthShore to preparing its systems to transform from volume-based payment to value-based payment are vastly less than at Advocate, even taking into account the differences in the size of the two systems. In my opinion, NorthShore is not engaged in population health management in any meaningful way.").

[102] [redacted]

[103] [redacted]

[104] DX6000, Eisenstadt Rep. ¶ 71 ("there is substantial evidence that Advocate has significantly lower costs than Northshore and it intends to transfer its operational cost advantages to NorthShore after the merger.").

[redacted] Second, [redacted] Third, Advocate and NorthShore will achieve net cost savings estimated at over $200 million as a result of the merger.[107] These savings include, among other things, supply chain savings opportunities, employee health costs, and fees for redundant maintenance agreements.[108] These savings will be passed on to consumers.

3. The Merger Will Create A New Low-Price, High-Quality Product For Chicagoland Employers.

Higher quality and lower costs are not hypothetical goals; they are the central objective of the merger reflected in the development of the HPN product. The HPN will be priced 10 percent below the least costly major HMO plan in the area,[109] will result in substantial savings per member in comparison to presently-marketed comparable health plans,[110] and could be filed with regulators to approve enrollment as early as 2018.[111] The combination of an aggressive price point, substantial savings per member, and the exceptional reputations for quality that Advocate and NorthShore each already command will drive demand for the HPN.[112] In fact, in a recent

105 [redacted]

106 [redacted]

107 [redacted]

108 [redacted]

109 DX5000, McCarthy Report, ¶ 26 ("The Defendants intend for [the] HPN to be developed and sold over the six-county Chicago metro area, with a price point that is set at 10 percent below the lowest-cost major HMO in Chicago."); *see also*, Eisenstadt Report¶ 29 ("Price reductions will occur because of the introduction of the ANHP HPN.").

110 DX6000, Eisenstadt Rep., Tables 1A through 1F.

111 DX9034, Sacks (Advocate) Dep. at 146:12-20 (explaining that "if the merger gets approved later this year we'd be interested in talking about this for 2018").

112 DX8000, Steele Report, ¶ 17 ("Both Advocate and NorthShore health systems have credible brands and deservedly excellent reputations in and outside of the Chicagoland market."); *see also* McCarthy Report, ¶ 26.

survey of Chicagoland employers, almost 90% of respondents stated that they would be very interested or somewhat interested in offering the HPN to their employees.[113] [redacted] all have expressed an interest in offering such a product that will cover the entire Chicago area.[114]

Importantly, the benefits of the HPN will not be limited to its members. It will have a profound impact in increasing competition in Chicagoland with respect to both health care services and health insurance. The HPN will be "disruptive" and will force other health systems to accelerate their own transition toward risk-based payment models.[115] The new HPN product means that Plaintiffs' arguments – based solely on market concentration statistics – "give an inaccurate account" of the Proposed Transaction's "probable effects on competition." *H.J. Heinz Co.*, 246 F.3d at 715. The HPN will attract substantial numbers of patients, and result in significant price and cost reductions.[116] It will thereby "create significant efficiencies" that will "benefit competition and, hence, consumers." *Univ. Health, Inc.*, 938 F.2d at 1222, 1223. The Court should not stand in the way of these benefits.

B. The Consumer Benefits Are Merger-Specific.

The merger is necessary to achieve the above benefits. Advocate and NorthShore must be financially aligned under unified governance in order to offer the HPN.

First, the benefits of the merger cannot be achieved without Advocate extending its capabilities to NorthShore. Advocate is national leader and years ahead of NorthShore in its

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113 DX8100, Van Liere Report, ¶ 25.

114 [redacted]

DX7000, Dudley Report ¶ 102; *see also* DX5000, McCarthy Report ¶ 108.

116 DX6000, Eisenstadt Report ¶¶ 58-59.

ability to manage the health of a defined population.[117] Advocate has been developing its capabilities and tools for decades.[118] Through the merger, Advocate will extend its PHM capabilities to NorthShore.[119] Absent the merger, NorthShore would not be able to buy, hire, or develop these capabilities without substantial capital investment over many years.[120] Even then, NorthShore would face the significant hurdle of shifting the incentives that drive the current organization under a fee-for-service paradigm to those that are inherent in an organization that has a substantial share of its revenue under risk-based contracts.[121]

Second, the merger is necessary to achieve the geographic coverage required to sell the product. Absent the merger, neither Advocate nor NorthShore has the geographic coverage to serve Chicagoland employer groups through a narrow network product consisting of only a single provider system. Starting October 1, 2015, Advocate through BCBS-IL began offering a "BlueCare Direct" product for individuals on the Public Exchange.[122] Advocate discussed

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117 DX7000, Dudley Report ¶¶ 13, 33.

118 *See* DX9034, Sacks (Advocate) Dep. at 36:22-24 (noting that Advocate's clinical performance initiatives were among the first in the country); *id.* at 57:23-25 (Advocate has been pursuing a payment-for-value model for five years); *id.* at 40:20-21 ("Advocate has been using registries for over a decade."); *id.* at 32:12-16, 50:15-17; Esposito Dep. 33:25-34:04 ("It's taken us a long time to get to the point where we're at with respect to developing . . . meaningful metrics to support improvement for our health outcomes for quality and safety.").

119 Advocate has similarly integrated the targets of prior acquisitions. *See* DX9023 Dan (Advocate) Dep. at 74:08-22, 76:22-77:23, 97:05-16 (describing successful clinical integration of BroMenn and Sherman hospitals).

120 [redacted]

121 *See* DX7000, Dudley Report ¶ 57; [redacted]

122 The existing Advocate-only BlueCare Direct product does not contradict this assertion because that product is only sold to individuals and small groups which require far less geographic coverage. Employers and payers have expressed the need for access to providers in the area "east of Rt. 94" in the northern suburbs of Chicago. *See* DX6000, Eisenstadt Rep. ¶ 34 n. 42.

offering a similar Advocate-only product for employer groups beginning in 2013.[123] Advocate was consistently told by payers, employers and brokers that it lacked the necessary geographic footprint in the Chicagoland area to be attractive to employer groups.[124] Specifically, it was told that it lacked coverage in the area east of I-94 in northern Cook and Lake Counties;[125] that employers would not offer a network that lacked coverage in the geography where many key corporate decision makers reside;[126] and that it would need to add either NorthShore or Northwestern Health to any such network in order to fill the North Shore geographic coverage gap.[127] Advocate's experience with BlueCare Direct corroborates the views of employers, brokers, and health insurers. Although the product has attracted nearly 60,000 enrollees, the vast

[123] *See, e.g.*, DX9119 (Advocate meeting with); DX9126 (Advocate and NorthShore meeting with); DX9121 (Advocate meeting with).

[124] DX9034, Sacks (Advocate) Dep. at 122:6-14 ("We have been told repeatedly by health plans and employers that to be effective in those markets we need broader geographic coverage."); *see also* DX9117.0001 ("Payers said [to Advocate] that either Northwestern or NorthShore University Health System would address the north shore geographic gap."); *see also* DX9113.0001 (Map of Chicago Hospital Locations) ; DX9111.0008; DX9112.0007; DX9120.0004-0005; DX9129.0002 .

[125] *see also* DX9113.002 Map. Employers and payors also identified Will County a second geographic hole in Advocate's footprint. Advocate sought to address this gap as well and did so with an affiliation in 2014 with Silver Cross Hospital of New Lenox, IL. *See* DX9128.

[126] *See* DX9116.0001-0002; *see also* DX9120.0011.

majority of purchasers are individuals and only about 2,000 (or 3 percent) of the enrollees were members of groups.[128]

Third, the HPN cannot be created through contractual or other arrangements short of a merger for at least two reasons. [redacted] Second, previous attempts by Chicagoland payers to construct networks of providers by contract that will share financial risk and coordinate patient care have failed.

With respect to the latter, a full-risk capitated payment involves providers receiving a fixed fee for each member assigned to a particular provider, and providers assuming full responsibility for all of the care required by that member. In a purely contractual relationship, Advocate, for example, would incur the financial risk for services provided by other network providers (e.g., NorthShore) that are outside of its control. Advocate has documented this problem and calls it "leakage."[130] [redacted]

[128] DX6000, Eisenstadt Report ¶¶ 32, 49; [redacted]

[129] [redacted]

DX9019, Skogsberg (Advocate) Dep. at 67:04-68:04.

[redacted]

C. The Merger Will Change The Landscape Of Chicagoland Health Care.

The HPN is not simply a new product; rather it will have a transformative impact in the markets for health care delivery and insurance throughout Chicagoland. Health policy makers often describe how hospitals have "one foot . . . on the boat and one on the dock" because they are facing diametrically inconsistent incentives.[132] Hospitals are reluctant to move to risk-based payment contracts that penalize them for hospitalizations while they are still being largely reimbursed under the old fee-for-service approaches that reward volume and make them accountable for services provided by other hospitals.

Advocate has taken the leap into the boat of risk-based payment, but it needs to complete this merger with NorthShore to offer a truly "disruptive" alternative in the Chicagoland area. That alternative, priced at least 10 percent lower than other products and attractive to employers and consumers throughout the Chicago area, will force other health systems to move much more quickly toward full-risk and PHM. In addition, it will enable other insurers to offer novel products that are alternatives to BCBS-IL – first with Advocate/NorthShore, and then with other health systems – that will generate greater competition in the health insurance market, with

131 [redacted]

See Larry Beresford, *A Conversation With Stephen M. Shortell, PhD, MPH, MBA: Will We Ever Achieve The 'Holographic Organization'?*, Managed Care (September 2014), http://www.managedcaremag.com/archives/2014/9/conversation-stephen-m-shortell-phd-mph-mba-will-we-ever-achieve-holographic.

resulting lower costs and increased quality. In short, unlike other hospital mergers that the FTC has challenged, this merger is about far more than just obtaining efficiencies that can come from greater scale. The merger is aimed at the type of innovation that the government and health policymakers are seeking as the most promising way to address higher health care costs.

These public benefits will be lost if the preliminary injunction is granted, competitive responses shelved, and the status quo maintained.[133]

CONCLUSION

For the reasons set forth above, Defendants respectfully request that the Court deny Plaintiffs' Motion for a Preliminary Injunction.

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Respectfully Submitted,

/s/ J. Robert Robertson
J. Robert Robertson, Esq.
Robert F. Leibenluft, Esq. *(pro hac pending)*
Leigh L. Oliver, Esq.
Hogan Lovells US LLP
Columbia Square
555 Thirteenth Street, N.W.
Washington, DC 20004
Phone: (202) 637-5600
Fax: (202) 637-5910
robby.robertson@hoganlovells.com
robert.leibenluft@hoganlovells.com
leigh.oliver@hoganlovells.com

Robert W. McCann, Esq.
Kenneth M. Vorrasi, Esq.
Drinker Biddle & Reath LLP
1500 K Street, N.W.
Washington, DC 20005
Phone: (202) 842-8800

[133] *See* DX6000, Eisenstadt Report ¶¶ 25-29, 36.

Fax: (202) 842-8465
robert.mccann@dbr.com
kenneth.vorrasi@dbr.com

Counsel for Defendants Advocate Health Care Network and Advocate Health and Hospitals Corporation

David E. Dahlquist
Michael S. Pullos
Winston & Strawn LLP
35 W. Wacker Drive
Chicago, IL 60601
Phone: (312) 558-5660
Fax: (312) 558-5700
ddahlquist@winston.com
mpullos@winston.com

Counsel for Defendant NorthShore University HealthSystem

CERTIFICATE OF SERVICE

The undersigned, an attorney, certifies that Defendants' Opposition to Plaintiffs' Motion for a Preliminary Injunction was served this 18th day of March, 2016, upon the following counsel via email:

J. Thomas Greene, Esq.
Kevin Hahm, Esq.
Sean P. Pugh, Esq.
Jennifer Milici, Esq.
Federal Trade Commission
Bureau of Competition
600 Pennsylvania Avenue, N.W.
Washington, DC 20580
Phone: (202) 326-5196
Fax: (202) 326-2286
tgreene2@ftc.gov
khahm@ftc.gov
spugh@ftc.gov
jmilici@ftc.gov

Counsel for Plaintiff Federal Trade Commission

Robert W. Pratt, Esq.
Blake Harrop, Esq.
Office of the Attorney General
State of Illinois
100 West Randolph Street
Chicago, IL 60601
Phone: (312) 814-3000
Fax: (312) 814-4209
rpratt@atg.state.il.us
bharrop@atg.state.il.us

Counsel for Plaintiff State of Illinois

/s/ J. Robert Robertson
J. Robert Robertson, Esq.