IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS, WESTERN DIVISION

FEDERAL TRADE COMMISSION Plaintiff, v. OSF HEALTHCARE SYSTEM and ROCKFORD HEALTH SYSTEM Defendants.	Case No. 3:11cv50344 Hon. Frederick J. Kapala Hon. P. Michael Mahoney, Magistrate Judge **PUBLIC (REDACTED)**

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INTRODUCTION

The FTC bases its attack on the proposed affiliation of OSF Healthcare System ("OSF") and Rockford Health System ("RHS") mostly by citation to a 23-year-old ruling that is disconnected from the current regulatory, competitive and economic environment, with no concrete factual support for its claim of likely competitive harm. Indeed, the government later declined to challenge a more analogous proposed merger of two Rockford hospitals in 1997.

The FTC's case is premised on little more than a "presumption" derived from market share calculations. The evidence will show, however, that the consolidation of OSF and RHS will generate substantial cost savings – more than $114 million in capital cost avoidance and potentially $40-53 million in annual recurring operating costs – and efficiencies and improved health care delivery services that are only achievable through affiliation. When the Court balances the FTC's weak "evidence" against the transaction's procompetitive benefits, the FTC cannot meet its preliminary injunction burden.

Moreover, the FTC proffers two inconsistent, alternative theories of competitive harm to support its claim – arguing that the merged entity will both collude with, and exclude, the remaining hospital system. These irreconcilable arguments are devoid of credible factual support for the FTC's claims of likely competitive harm. In contrast, the weight of the evidence will show that the proposed affiliation answers the call of a healthcare system in crisis for transformative, economical, efficient delivery of high quality healthcare services that will benefit the citizens of Rockford, while preserving a highly competitive hospital and physician market. Accordingly, the Court should deny the FTC's request for injunctive relief.[1]

[1] After participating in the FTC's eight-month investigation, the Illinois Attorney General chose not to challenge this affiliation.

FACTUAL BACKGROUND

I. MARKET STRUCTURE

The structure of the healthcare market in Rockford is not in dispute. The three hospital systems – OSF's St. Anthony Medical Center ("SAMC"), RHS and SwedishAmerican Health System ("SAH") – all offer the same general acute care inpatient hospital, outpatient, and ancillary services, and employ primary care and specialty physicians.[2]

There are a limited and decreasing number of commercial insurers, or managed care organizations ("MCOs"), that contract with one or some combination of the Rockford hospital systems to provide the full range of healthcare services to their commercially-insured members. Often, but not always, the MCOs contract with two of the three hospital systems in Rockford to be part of the provider network, which the MCOs offer to employers through a variety of fully- or self-insured health insurance products.[3] Blue Cross Blue Shield of Illinois ("BCBS IL") is the largest MCO, serving approximately [redacted] of the commercially-insured covered lives in the Rockford area.[4] Other prominent MCOs in the region include Aetna, Cigna, Humana, UnitedHealthcare ("United"), the Employers Coalition on Health ("ECOH"), and The Alliance.[5]

The Rockford healthcare systems offer MCOs an integrated, coordinated system of care for their insureds (or patients), and the contract negotiations between hospitals and MCOs cover the entire array of services that the healthcare systems provide.[6] These negotiations focus on the

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[2] Complaint ¶¶ 20, 21, 51; DX0008 (Kaatz Decl.) ¶¶ 5, 8, 10.
[3] DX0183 (Dillon IHT) at 203:18-204:5.
[4] DX0712 (Pocklington Dep.) at 55:19-25, 179:6-10; DX0707 (Lobe Dep.) at 48:16-18; DX0718 (Golias Dep.) at 198:25-199:10.
[5] DX0007 (Dillon Decl.) ¶¶ 39-49.
[6] DX0183 (Dillon IHT) at 30:24-31:20; DX0197 (Breeden IHT) at 20:22-22:24, 152:18-154:6; DX0006 (Seybold Decl.) ¶ 11; DX0007 (Dillon Decl.) ¶ 7; DX0003 (Schertz Decl.) ¶ 25; DX0001 (Schoeplein Decl.) ¶ 11; DX0719 (Peterson Dep.) at 73:9-74:6, 163:5-164:2. [redacted] DX0183 (Dillon IHT) at 129:20-130:22.

"total healthcare cost" of treating an MCO's insured population, not just one type of service, because patients often require treatment from more than one provider within a hospital system.[7] Non-price terms, such as prompt payment, claim submission and review procedures, and provider manual obligations are an important part of the contract negotiations because they impact the system's actual reimbursement from the MCO (and the insured patient).[8] MCOs negotiate to achieve the lowest total cost of the healthcare services provided to their insureds.[9] On the other hand, healthcare providers seek to negotiate rates that will generate net revenues greater than their total cost of treating the MCOs' patients, thereby allowing them to recover the losses they incur in treating Medicare, Medicaid, charity care and self-pay patients.[10]

II. THE AFFILIATION OF OSF AND RHS

Following the recession that began in 2008, the deterioration of economic conditions in Rockford and the spiraling costs of providing healthcare services led RHS to seek an affiliation with another hospital system.[11] RHS tentatively agreed to affiliate with Advocate Health Care, but both ultimately concluded that a transaction was not in either system's best interest.[12]

OSF and RHS then began discussing a potential partnership.[13] Seizing the opportunity to dramatically reduce costs, improve healthcare services through clinical innovation and

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[7] DX0006 (Seybold Decl.) ¶ 12; DX0007 (Dillon Decl.) ¶¶ 32, 36; DX0008 (Breeden Decl.) ¶¶ 14-18; DX0712 (Pocklington Dep.) at 105:21-25; DX0703 (Hall Dep.) at 74:13-20; DX0699 (Arango Dep.) at 55:21-56:20, 123:14-20.

[8] DX0006 (Seybold Decl.) ¶ 14; DX0007 (Dillon Decl.) ¶¶ 29-31; DX0008 (Breeden Decl.) ¶¶ 14, 16-18.

[9] Most of the MCOs in Rockford are large, for profit corporations. DX0703 (Hall Dep.) at 70:3-5; DX0707 (Lobe Dep.) at 156:11-157:6; DX0719 (Peterson Dep.) at 54:2-55:11; 165:21-166:6; DX0699 (Arango Dep.) at 144:3-5.

[10] Medicare and Medicaid typically reimburse hospitals less than their total cost of treating Medicare and Medicaid patients. DX0717 (Walsh Dep.) at 52:23-53:3. RMH recovers [redacted] of its costs from Medicare and Medicaid, respectively; for SAMC, Medicare covers [redacted] but Medicaid only [redacted] of SAMC's cost of delivering the care. DX0005 (Noether Rpt.) ¶ 31.

[11] DX0004 (Kaatz Decl.) ¶ 15.

[12] DX0004 (Kaatz Decl.) ¶ 16-18.

[13] DX0004 (Kaatz Decl.) ¶ 20; DX0003 (Schertz Decl.) ¶ 33; DX0001 (Schoeplein Decl.) ¶ 19.

integration, and create synergies not obtainable independently, OSF and RHS executed an Affiliation Agreement on January 31, 2011.[14] If consummated, OSF will become the sole corporate member of RHS, which will manage the affiliated entity, OSF Northern Region.[15]

STANDARD OF REVIEW

FTC Act Section 13(b) provides that a preliminary injunction may be granted "[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) (emphasis added). To show a likelihood of ultimate success, the FTC must "raise questions going to the merits so serious, substantial, difficult and doubtful as to make them fair ground for thorough investigation, study, deliberation and determination by the FTC in the first instance and ultimately by the Court of Appeals." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1051 (8th Cir. 1999); *FTC v. Whole Foods Mkt., Inc.*, 548 F.3d 1028, 1035 (D.C. Cir. 2008); *FTC v. Lab. Corp. of America*, No. SACV 10-1873 AG (MLGX), 2011 WL 3100372 at *16 (C.D. Cal. Mar. 11, 2011). This burden is "not insubstantial," *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 116 (D.D.C. 2004), and the district court may not "rubber stamp an injunction whenever the FTC provides some threshold evidence." *Whole Foods*, 548 F.3d at 1035. As one court said:

> If Congress did not want federal courts to play some meaningful role in the injunction process, it could have given injunction power directly to the FTC. Congress did not structure the process that way. Despite Congress' lessening of what the FTC must show to secure a preliminary injunction, the FTC's burden remains heavy, because the granting of any injunction by a federal court is an "extraordinary and drastic remedy."

FTC v. Foster, 2007 U.S. Dist. LEXIS 47606, at *129-30 (D.N.M. 2007 May 29, 2007) (citation omitted).

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[14] DX0004 (Kaatz Decl.) ¶ 21-23; DX0003 (Schertz Decl.) ¶ 33; DX0001 (Schoeplein Decl.) ¶¶ 19-20; DX0002 (Sister Diane Marie McGrew Decl.) ¶¶ 23-25; DX0617 (Affiliation Agreement).
[15] DX0004 (Kaatz Decl.) ¶ 26; DX0617 (Affiliation Agreement) § 2.5.

When weighing the equities, the Court may consider both public and private equities. *FTC v. Elders Grain*, 868 F.2d 901, 903 (7th Cir. 1989). Public equities include "improved quality, lower prices, increased efficiency, realization of economies of scale, consolidation of operations, and elimination of duplication," all of which enhance competition and may result from a merger. *Lab. Corp.*, WL 3100372 at *20, 22 *citing FTC v. Owens-Illinois, Inc.*, 681 F. Supp. 27, 52 (D.D.C. 1998). Indeed, the 2010 Merger Guidelines state that "a primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products." U.S. Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines*, § 10 (2010). As a result, courts have denied preliminary injunctive relief where the defendant can establish that the merger will result in efficiencies that benefit consumers. *Lab. Corp.*, WL 3100372 at * 20-21. Giving primacy to the cost savings, efficiencies and improved delivery of services is particularly important in the unique world of healthcare, where less will have to provide more. The FTC's attack on the affiliation of RHS with OSF is at cross purposes with healthcare reform and the parties' efforts to enhance the public interest by their combination.

ARGUMENT

I. THE FTC CANNOT SHOW A LIKELIHOOD OF SUCCESS ON THE MERITS

The FTC cannot meet its burden of showing a likelihood of success on the merits because the community benefits that will result from this affiliation outweigh any "evidence" the FTC has to support its *prima facie* case. The FTC relies overwhelmingly on conjecture for its claims that, following the affiliation, OSF Northern Region will coordinate its behavior with SAH, exclude SAH from MCOs' networks as a pre-condition to contracting with MCOs, or extract

supra-competitive prices from MCOs in the two alleged product markets (general acute care inpatient services and primary care physician services).

A. The FTC Cannot Rely Solely on Market Concentration to Meet Its Burden

Throughout its Complaint and pre-hearing submissions, the FTC repeatedly argues that the market for general acute care inpatient services is highly concentrated and, therefore, the transaction is "presumptively unlawful." Contrary to the FTC's belief, it is not entitled to, and this Court should not issue, an injunction simply because the market is concentrated and a merger may increase that concentration. *See United States v. Baker Hughes, Inc.*, 908 F.2d 981, 984 (D.C. Cir. 1990) ("[e]vidence of market concentration simply provides a convenient starting point for a broader inquiry into future competitiveness . . . .").[16] Market share analysis is just the beginning, not the end, of the Court's "broad inquiry." *FTC v. Foster*, 2007 U.S. Dist. LEXIS, at *138 (D.N.M. May 29, 2007); *see also FTC v. CCC Holdings Inc.*, 605 F. Supp. 2d 26, 46 (D.D.C. 2009); *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1222 (W.D. Mo. 1995). Were it otherwise, the Court would be stripped of its responsibility to determine whether the likelihood of success outweighs the equities that will result from the transaction. Examination of the evidence relating to the "structure, history and probable future," *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 498 (1974), of health care in the Rockford area demonstrates that the affiliation is in the public interest and will not enable OSF Northern Region to substantially increase prices in the market for either general acute care inpatient services or primary care

[16] In *Baker Hughes* the pre-merger HHI was 2878, indicating a "highly concentrated" market, and the challenged transaction brought about what the court characterized as a "dramatic" increase in the HHI to 4303. Nevertheless, the court denied the government's request for injunctive relief noting, "The Herfindahl-Hirschman Index cannot guarantee litigation victories." 908 F.2d at 992.

physician services.[17]

B. The Remaining Evidence Shows that OSF Northern Region Will Not Be Able to Charge Supra-Competitive Prices for General Acute Care Inpatient Services

The issue for the Court is whether the FTC has shown that rates MCOs pay to hospitals will increase more than they otherwise would absent the affiliation, and to supra-competitive levels. Besides the market share presumption, however, the FTC can only speculate that the proposed affiliation will result in anticompetitive effects.

The gist of the FTC's claim (and all of its proof) is that, following the affiliation of RHS with OSF, only two competitors will remain in Rockford instead of three and, *ipso facto*, that will result in higher rates to MCOs for general acute care inpatient and primary care physician services. But the FTC's economist, representatives of the MCOs, and employers (who rely on the MCOs to negotiate reimbursement rates with providers) offer no factual evidence for their conjecture that the affiliation will cause prices to increase (let alone increase to supra-competitive levels). Instead, the evidence shows that MCOs wield significant leverage over the Rockford hospitals, and can reject any attempt by OSF Northern Region to increase prices above competitive levels. Moreover, SAH – Rockford's largest and fastest growing hospital – is a viable, marketable alternative to OSF Northern Region that will constrain any attempt by OSF Northern Region to raise its rates above competitive levels.

1. MCOs Have Significant Leverage And Can Reject Any Provider's Attempt To Increase Prices Above Competitive Levels

When MCOs negotiate contracts with the Rockford healthcare systems, they typically negotiate for [redacted] as part of the same negotiation.[18] The

[17] Defendants have found no case where the FTC has obtained, or even sought, a preliminary injunction where the post-merger HHIs are less than 1930, as they are here for the primary care physician market.

MCOs approach this process with a wealth of information, much of which the hospital providers do not have, including knowledge of the rates they pay to the negotiating provider's competitors, and their insureds' historical utilization with the provider's competitors.[19] This knowledge gives the MCOs significant bargaining leverage over the hospitals in Rockford. For example, although SAH [redacted] faster than any other hospital in Rockford, it has [redacted].[20] Moreover, the Rockford hospitals rely on the revenue they get from the MCOs to make up for losses they incur treating Medicare, Medicaid, self-pay and charity care cases;[21] the hospitals need to contract with the MCOs (to gain access to commercially-insured patients) more than the MCOs need to include every hospital in their provider networks.

That means that if OSF Northern Region tried to raise rates for general acute care inpatient services to supra-competitive levels, MCOs could offer a narrower provider network, for all or some of their health insurance products, at lower cost to their insureds. For example, prior to 2010, ECOH's River Valley product, which included only RHS, covered about [redacted] of ECOH's commercially-insured lives.[22] BCBS IL also offers an HMO product with SAH as the sole in-network hospital.[23] And United Healthcare recently introduced its "Core" product in the

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[18] DX0197 (Breeden IHT) at 20:22-22:6; DX0183 (Dillon IHT) at 85:4-86:2; DX0719 (Petersen Dep.) at 73:9-74:6, 163:5-164:2.
[19] DX0007 (Dillon Decl.) ¶ 37; DX0008 (Breeden Decl.) ¶ 20.
[20] DX0717 (Walsh Dep.) at 46:4-47:25.
[21] DX0006 (Seybold Decl.) ¶ 11; DX0007 (Dillon Decl.) ¶ 7; DX0003 (Schertz Decl.) ¶ 25; DX0001 (Schoeplein Decl.) ¶ 11.
[22] DX0712 (Pocklington Dep.) at 49:3-50:16.
[23] DX0197 (Breeden IHT) at 105:7-107:14. RHS' ECOH River Valley contract [redacted]. DX0318 at RHS007_0100876.

Rockford area, which has SAH as its only in-network hospital.[24] This marketing by MCOs of products with narrow provider networks is not unique to Rockford; it is a [redacted].[25]

Moreover, in response to continually escalating healthcare costs, many Rockford-area employers are trying to reduce costs by offering health plans with fewer provider choices to their employees, or contracting directly with the hospitals in Rockford for healthcare services. For example, Rockford Acromatic now contracts directly and only with SAMC to provide healthcare services to its employees to reduce its healthcare costs.[26] Claims by the MCOs and the FTC that narrow networks are neither marketable nor viable is unsubstantiated and wrong. No MCO declarant or deponent in this case [redacted] in the Rockford area.[27] To the contrary, ECOH's Director of Provider Services [redacted].[28]

The FTC claims that OSF Northern Region will have the power to require MCOs to exclude SAH from their networks or force MCOs to contract with all OSF hospitals as a condition to contracting with the new system.[29] Those allegations are both devoid of supporting evidence and contrary to how things work in two-hospital markets in Illinois communities

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[24] DX0707 (Lobe Dep.) at 27:20-28:21. Introduced in 2010, the number of enrollees in this product [redacted].

[25] DX0364 (Noether Supplemental Rpt.) at ¶¶ 9-11.

[26] DX0010 (Olson Decl.), ¶¶ 4, 6; DX0711 (Olson Dep.) at 62:11-64:11. Similarly, [redacted] DX0717 (Walsh Dep.) at 168:15-169:18; DX0711 (Olson Dep.) at 161:13-164:7, 178:13-20.

[27] *See, e.g.,* DX-712 (Pocklington Dep.) at 89:6-10, 115:21-116:5 [redacted]; DX0703 (Hall Dep.) at 50:13-16, 50:19-51:13, 53:9-22, 145:2-6 [redacted]; DX0707 (Lobe Dep.) at 151:19-152:18; DX0719 (Petersen Dep.) at 109:24-113:22, 114:8-117-6, 120:8-15, 122:21-123:12.

[28] DX0712 (Pocklington Dep.) at 163:10-19.

[29] *See, e.g.,* Complaint, ¶ 58; [redacted]

similar in size to Rockford,[30] where most MCOs contract with both hospitals at substantially-discounted rates.[31] Nonetheless, OSF and RHS will stipulate that: (1) they will not demand the exclusion of SAH as a condition to contracting with OSF Northern Region; and (2) neither OSF nor OSF Northern Region will require an MCO to contract with OSF or any other OSF hospital as a condition for a contract with OSF Northern Region. These commitments will enable and encourage MCOs to negotiate alternative rates from OSF Northern Region and SAH – one rate as the network's only Rockford provider, and another if both systems are in-network. Employers, therefore, will have three options at potentially different price points – a single-provider network with either OSF Northern Region or SAH as the provider, or a network with both Rockford systems. A copy of the proposed stipulation is attached as Attachment A.

By so stipulating and subjecting themselves to the Court's contempt power, OSF and RHS have publicly committed that they will not engage in conduct, which the FTC claims, but OSF and RHS do not concede, is anticompetitive; the Court has the direct ability to enforce that promise. Courts have relied on this kind of assurance in refusing to enjoin hospital mergers. *See FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1304-07 (W.D. Mich. 1996). Moreover, [redacted] that with such a stipulation, the transaction will foster, and not deter, competition between the Rockford hospitals, because [redacted][32] In other words, the transaction will have procompetitive, not anticompetitive effects.

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[30] In most of these communities, the markets have consolidated recently from three hospitals to two. DX0009 (Ingrum Decl.) ¶¶ 7-10.

[31] DX0009 (Ingrum Decl.) ¶¶ 7, 12-13; DX0705 (Ingrum Dep.) at 29:9-30, 71:20-74:15, 112:11-113:8, 136:16-140:3, 160:24-161:20, 172:4-19, 184:5-187:21, 191:21-194:25, 201:10-203:9.

[32] PX289 (Gorski Decl.) ¶ 43.

2. SwedishAmerican Will Constrain OSF Northern Region's Ability to Charge Supra-Competitive Prices

SAH also will constrain any attempt by OSF Northern Region to increase prices to supra-competitive levels. SAH's CEO [redacted][33] It has sufficient [redacted] to handle additional patients if MCOs choose to offer a product with SAH as the only in-network hospital in Rockford or otherwise steer patients away from OSF Northern Region.[34] SAH's size and growth,[35] coupled with its new heart hospital and its affiliation with UW Health,[36] have made it the most desired hospital provider for MCOs. SAH will prevent OSF Northern Region from raising its rates above competitive levels.[37]

C. No Evidence Supports the FTC's Allegations Regarding Primary Care Physicians

The Rockford healthcare systems negotiate rates with most MCOs for primary care physician services as part of the total health care package. There is no factual support for the FTC's claim that the affiliation will lead to supra-competitive prices for primary care physicians.

MCOs have even greater leverage over the hospitals in Rockford with respect to physician services than they do for general acute care inpatient services. At least one MCO [redacted] literally dictates prices for physician services in Rockford – it tolerates no

[33] PX289 (Gorski Decl.) ¶ 43.
[34] DX0005 (Noether Rpt.) ¶ 59.
[35] DX0005 (Noether Rpt.) ¶¶ 47-49.
[36] DX0004 (Kaatz Decl.) ¶ 11; DX0003 (Schertz Decl.) ¶ 9.
[37] PX289 (Gorski Decl.) ¶ 43 [redacted]

negotiation. [redacted] take-it-or-leave-it contracting strategy for physician reimbursement rates leaves hospitals with a simple choice – accept [redacted] proposed fee schedule, or not contract with [redacted].[38] The affiliation will have no effect on [redacted] power.

The FTC has proffered no facts to support its speculation that the affiliation will cause primary care physician rates to rise to supra-competitive levels. Indeed, no barriers to entry exist to enable primary care physicians to exercise market power. Many independent primary care physicians practice in Rockford who presently mostly treat government-insured patients; they could easily increase their treatment of commercially-insured patients without having to relocate their practices.[39] Moreover the evidence will show that at least [redacted] primary care physicians have entered the Rockford market in the preceding 24 months.[40] And Rockford's largest primary care physician group – employed by SAH – is readily expandable through recruitment of residents who complete the family practice residency program there and from the Crusader Clinic.[41]

In addition, most physicians admit to [redacted].[42] Accordingly, the transaction will not change physician referral patterns. The consolidation of the OSF and RHS physician practices will not change the competitive landscape for the services offered by the hospitals.

D. The Affiliation Will Not Result in the Unlawful Coordination of Competitive Activities

It is impossible to reconcile the FTC's alternative theories that OSF Northern Region will unilaterally require MCOs to exclude SAH from their networks *and* that OSF Northern Region

[38] DX0008 (Breeden Decl.) ¶ 19.
[39] DX0005 (Noether Rpt.) fn 113.
[40] DX0242 at p. 16.
[41] DX0717 (Walsh Dep.) at 84:11-85:8; 86:5-87:5.
[42] DX0005 (Noether Rpt.) ¶ 45.

and SAH will coordinate their competitive conduct after the affiliation. It makes no sense that OSF Northern Region would force the exclusion of SAH from the MCOs' networks on the one hand, and collude with SAH to eliminate competition between them on the other. These mutually inconsistent propositions are not additive; they cancel one another and highlight the absence of any fact-based evidence that would permit the FTC to sustain its burden of proof.

Moreover, the FTC lacks evidence showing that the systems have coordinated or will coordinate their competitive activities. That the hospital systems monitor each other's service line offerings, recruitment, and capital expenditures is consistent with competition, not coordination.[43] Each hospital system makes its own decisions regarding investments, services and amenities independently to fulfill its mission to provide quality healthcare to the community, based on its perception of the best interest of the Rockford community.[44] The FTC will present no evidence that hospital executives in Rockford have exchanged competitively sensitive information regarding their strategic initiatives or negotiations with MCOs.[45] Further, [redacted], and the executives from RHS and OSF will testify, that the hospital systems in Rockford have not agreed and will not agree to defer competitive initiatives or coordinate on any aspect of their negotiations with MCOs.[46]

Further, competition between healthcare systems involves not only price, but also quality and service dimensions.[47] It would be exceedingly difficult for OSF Northern Region and SAH

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[43] DX0717 (Walsh Dep.) at 74:22-77:2, 81:1-10.
[44] DX0717 (Walsh Dep.) at 74:22-77:2, 81:1-10; *see also* 25:13-20 [redacted]
[45] DX0717 (Walsh Dep.) at 159:11-23; DX0703 (Hall Dep.) at 149:12-150:10.
[46] DX0717 (Walsh Dep.) at 159:6-10.
[47] DX0005 (Noether Rpt.) ¶ 81. [redacted]

(continued...)

to monitor or enforce any attempt to coordinate their competitive behavior in connection with MCO contracts (the terms of which are not public) or the quality or services they offer.[48]

This case is not 1989 re-visited. The suggestion in the 1989 record that the hospital systems may have colluded with one another has no analog and no support in the record pertinent to the present transaction. *See United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1286 (7th Cir. 1990); *United States v. Rockford Memorial Corp.*, 717 F. Supp. 1251, 1286 (N.D. Ill. 1989). The proposed merger of OSF and SAH in 1997, which the Antitrust Division investigated and approved, is far more analogous. That merger, like this one, involved the two smaller hospitals, whose objectives mirrored those of OSF and RHS today – to generate cost savings, efficiencies and quality improvements in a declining economic environment that they could not achieve on their own, for the benefit of the community.

II. THE EQUITIES WEIGH IN FAVOR OF THE AFFILIATION

Rockford area residents will realize a number of significant benefits because of the affiliation of RHS and OSF. These benefits outweigh the likelihood of anticompetitive harm that the FTC must show here (even assuming the FTC could do so, which OSF and RHS deny).

OSF Northern Region will be a more sustainable and higher quality health care delivery system than RHS or SAMC could be independently. The affiliation will promote greater patient access to integrated primary, secondary and tertiary health care services. This will result in fewer patients in need of specialized treatment having to leave the community to receive it. The affiliation will allow the consolidation of certain services (such as trauma, women's and children's, and cardiovascular surgery), which in turn will lead to excellence in clinical

[redacted]

[48] DX0005 (Noether Rpt.) ¶ 82.

innovations, services, quality, and outcomes.[49] And, the transaction will enhance OSF Northern Region's ability to recruit talented specialist and sub-specialty physicians to Rockford, who will train more physicians and clinical staff to innovate and improve quality and outcomes.

OSF Northern Region will achieve greater efficiency and more substantial cost-savings in its delivery of healthcare services than either hospital system can achieve on its own.[50] These savings include at least $114 million in capital cost avoidance and $40-53 million in annual recurring operating cost reductions, representing [redacted] of the parties' current net operating expenses.[51] The operating cost savings will result from the consolidation of [redacted].[52] By combining underutilized or complementary assets, the affiliation will allow the parties to more productively deploy capital resources in the community.[53] These cost savings and efficiencies are substantial and transaction-specific; significant portions are cognizable under the antitrust laws.[54] They are the best way to stop the upward spiral of healthcare costs and provide the resources, support programs and services that neither system can afford on its own.

CONCLUSION

The FTC's "support" for its request for a preliminary injunction consists of little more than speculation and the unsubstantiated claim that reducing the number of hospitals in Rockford

[49] DX0012 (Manning Decl.) ¶¶ 31-86, 118-21; DX0013 (Bradley Decl.) ¶¶ 5-6, 11-12; DX0011 (Brown Rpt.) ¶¶ 13-16, 20, 24, 27-30, 35-39, 40, 51, 54, 63, 67-68, 70; DX0011 (Brown Rpt.) Tables 3, 7, 10, 13, 18, 28.

[50] OSF and RHS respectfully invite the Court to make a site visit to the two Rockford hospital facilities at the Court's convenience in aid of its analysis.

[51] DX0011 (Brown Rpt.) ¶¶ 9, 20-21, 24, 32, 40-41, 63, 66-68, 78-79, 85, 88, 98, 104-110, 113-120; DX0011 (Brown Rpt.) Tables 1, 7, 10, 13-14, 18-19, 28, 36, 52.

[52] DX0006 (Seybold Decl.) ¶ 23; DX00012 (Manning Decl.) ¶ 144, Table 1.

[53] DX0012 (Manning Decl.) ¶¶ 35-47, 108-32; DX0013 (Bradley Decl.) ¶¶ 5-6, 11-12; DX0011 (Brown Rpt.) ¶¶ 19, 21, 23-24, 41, 54-56, 61-62, 68, 70-77, 79, 84-88, 91, 93, 98-99, 100, 103, 105-110, 113-123; DX0011 (Brown Rpt.) Tables 23, 31-32, 34, 37, 40, 48, 53-57, 61-62.

[54] DX0012 (Manning Decl.) ¶¶ 7, 85, 99-128, 133-40; DX0011 (Brown Rpt.) Tables 1, 2, 12-13; DX0011 (Brown Rpt.) Appendix A, Appendix A Tables 1, 2, 4, 10, 13-14, 21-22.

from three to two must be anticompetitive. There are many two-hospital towns, so that cannot be correct. But the FTC has nothing more; it has no evidence that the affiliation will cause prices paid by commercial MCOs to increase to supra-competitive levels. On the other hand, OSF and RHS can show that their affiliation will generate substantial community benefits. For these reasons, the Court should deny the FTC's motion for preliminary injunction.

Dated: April 19, 2012

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 19th day of April, 2012, a copy of foregoing Public (Redacted) version of Defendants' Pre-Hearing Memorandum was filed electronically under seal through the Court's CM/ECF System. Notice of this filing was served on the following counsel by electronic mail:

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