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 CORP., and NORTHSHORE UNIVERSITY HEALTHSYSTEM, *Defendants*.	Case No.: 1:15-cv-11473 Judge Jorge L. Alonso Mag. Judge Jeffrey Cole **FILED UNDER SEAL**

DEFENDANTS' POST-HEARING MEMORANDUM IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Robert W. McCann, Esq.
Kenneth M. Vorrasi, Esq.
John L. Roach, IV, Esq.
Jonathan Todt, Esq.
Drinker Biddle & Reath LLP
1500 K Street, N.W.
Washington, D.C. 20005

John R. Robertson, Esq.
Leigh Oliver, Esq.
Robert Leibenluft, Esq.
Hogan Lovells US LLP
555 13th Street, N.W.
Washington, D.C. 20004

Counsel for Defendants Advocate Health Care Network and Advocate Health and Hospitals Corp.

Daniel K. Webb, Esq.
David E. Dahlquist, Esq.
Michael S. Pullos, Esq.
Winston & Strawn LLP
35 W. Wacker Drive
Chicago, Illinois 60601

Counsel for Defendant NorthShore University HealthSystem

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

CASES

TABLE OF AUTHORITIES
(cont'd)

Page(s)

TABLE OF AUTHORITIES
(cont'd)

Page(s)

STATUTES

Advocate Health Care Network, Advocate Health and Hospitals Corp. ("Advocate") and NorthShore University HealthSystem ("NorthShore") (collectively, "Defendants"), submit this Post-Hearing Memorandum in Opposition to Plaintiffs' Motion for Preliminary Injunction.

INTRODUCTION AND SUMMARY

The Advocate-NorthShore merger will create tangible and significant value for consumers. It will bring a new insurance option to 4.8 million Chicagoans who obtain health care coverage through their employers and new and needed competition to the health insurance marketplace. Plaintiffs' opposition to this merger is grounded in flawed economics and a rear-facing perspective that prefers the costly status quo of the health care system to innovation that will benefit consumers. At a more basic level, Plaintiffs' opposition to the merger is unfounded because it ignores the settled principle that a merger is unlawful only if "there is a *reasonable probability* that the merger will *substantially* lessen competition." *Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962) (emphasis added).

But Plaintiffs' predictions of competitive harm are not grounded in reality. Dr. Tenn's "North Shore Area" market – that selectively excludes obvious and significant competitors – is a work of fiction, not fact. The law requires that we look at the world "as it is, and not as the FTC wishes it to be." *FTC v. Penn State Hershey Med. Ctr. et al.*, No. 1:15-cv-2362, 2016 WL 2622372, at *9 (M.D. Pa. May 9, 2016). And the reality is that the Chicagoland health care market is competitive and fragmented. Advocate and NorthShore face competition in the northern suburbs and across the metropolitan area from a wide range of hospitals and health systems, notably including some of the finest academic medical centers in the United States.

The testimony and documents of market participants – both competitors and insurance payers – demonstrate the breadth and depth of this competition. Advocate's and NorthShore's competitors are engaged in ongoing repositioning in response to changes in the competitive land-

scape. Indeed, the mere prospect of an Advocate-NorthShore merger already has provoked such responses, notably, including "Project Remedy" from Blue Cross Blue Shield of Illinois (BCBSIL) – an effort to launch an insurance product to [redacted]

Notably absent from the record is any shred of evidence that Defendants intend to raise prices post-merger. Plaintiffs' prediction of post-merger price increases is based on a methodologically unsound analysis that the FTC itself has deemed inappropriate for this purpose. Plaintiffs' expert, Dr. Steven Tenn, failed to demonstrate that his merger simulation model is reliable, and admitted that it has never been used in any federal court nor any hospital merger case.

Plaintiffs' case against the merger rests on the testimony of three biased fact witnesses. BCBSIL believes the merger threatens its dominance over health insurance in Chicago and embarked on an "anti-Advocate" strategy to oppose the merger and "box out" its competition. Despite its initial support for the merger, Cigna turned against the merger only after Advocate partnered with BCBSIL to offer a limited version of the HPN to individuals on the Illinois Health Insurance Exchange (the "Public Exchange"). Northwestern Memorial HealthCare ("Northwestern") is a direct competitor to both parties that would rather merge with NorthShore itself than compete with a merged Advocate and NorthShore.

In contrast, four other insurers, including BCBSIL's two biggest rivals in Chicago – Aetna and United Healthcare – stand behind the merger as a strategy to increase competition and reduce the total cost of care. These payers acknowledge that the merger is necessary to achieve the geographic coverage and the operational integration necessary to make the HPN successful.

Specifically, the merger is necessary for Advocate and NorthShore to successfully sell the HPN to employer groups. In the creation and sale of this product, Advocate and NorthShore are complements, not competitors. The aggregate savings to employers and consumers who buy

the HPN will far exceed the amount of any alleged inpatient price increases attributed to the merger.

Plaintiffs have attempted to obscure the equities of the merger by misconstruing the important consumer benefits that will result. Plaintiffs argue that the merger is not necessary in order for the parties to engage in population health management, to achieve quality objectives, or to manage insurance risk. That argument is wholly irrelevant to this case. Although Defendants intend all of these outcomes to result from the merger, none of them is necessary to create or sell the HPN to employer groups, and Defendants have made clear their intent to launch the HPN into the market at the earliest opportunity following the merger.

The fate of the merger lies in the outcome of this proceeding. Having spent two years cooperating with the FTC's investigation and, subsequently, defending the transaction, Defendants cannot afford to continue standing still for the duration of a protracted FTC administrative process. If the proposed merger is enjoined, the benefits to Chicagoland consumers – estimated in the hundreds of millions of dollars – will be lost. The Advocate-NorthShore merger is good for consumers, good for competition, and good for Chicago. Plaintiffs' motion should be denied.

LEGAL STANDARD

When the FTC seeks to enjoin a merger, "the issuance of a preliminary injunction prior to a full trial on the merits is an extraordinary and drastic remedy," because "it may prevent the transaction from ever being consummated." *FTC v. Exxon Corp.*, 636 F.2d 1336, 1343 (D.C. Cir. 1980) (citations omitted). Because "the grant of a temporary injunction in a Government antitrust suit is likely to spell the doom of an agreed merger," the FTC faces a "substantial burden." *FTC v. Great Lakes Chem. Corp.*, 528 F. Supp. 84, 86 (N.D. Ill. 1981) (denying preliminary injunction) (citation omitted); *see also, Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (per curiam); *FTC v. Foster*, No. CIV 07-352, 2007 WL 1793441, at *51 (D.N.M. 2007). In-

deed, whenever the granting of a preliminary injunction would provide substantially all the relief obtainable at trial, "the plaintiff's burden is a heavy one." *Robbins ex rel. Robbins v. Ind. High Sch. Athletic Ass'n, Inc.*, 941 F. Supp. 786, 791 (S.D. Ind. 1996). Thus, "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).

Section 13(b) of the FTC Act authorizes a court to resort to this "extraordinary remedy" only when the FTC has made "a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest" because the transaction would violate Section 7 of the Clayton Act. 15 U.S.C. § 53(b)(2); *see also* 15 U.S.C. § 18 (prohibiting mergers the effect of which "may be substantially to lessen competition, or to tend to create a monopoly."). The FTC must show that "there is a *reasonable probability* that the merger will *substantially* lessen competition." *Brown Shoe*, 370 U.S. at 325; *FTC v. Staples Inc.*, 970 F. Supp. 1066, 1072 (D.D.C. 1997) (same). The court's judgment is independent of the FTC's view of the facts. *Foster*, 2007 WL 1793441, at *51 ("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.").

The FTC's burden to demonstrate its likelihood of success on its underlying Section 7 claim is a necessary condition: "absent a likelihood of success on the merits, equities alone will not justify an injunction."[1] *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 116 (D.D.C. 2004) (ci-

[1] The FTC has previously argued that it may demonstrate a likelihood of success on the merits by simply raising a "serious question." *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1074 (N.D. Ill. 2012). 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, 690 (2008). Indeed, the "serious questions" language is simply a gloss on the standard applicable to *all* preliminary injunctions. The court of appeals in *FTC v. H.J. Heinz Co.*, 246

tation omitted); *see also, Hershey Med. Ctr.*, 2016 WL 2622372, *5; *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1217 (11th Cir. 1991); *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1073 (N.D. Ill. 2012). The "likelihood of success" analysis and the "public equities" analysis are legally different points and are to be analyzed separately. *FTC v. CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 75-76 (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, *21 (C.D. Cal., Mar. 11, 2011) (same).[2]

ARGUMENT

I. PLAINTIFFS FAILED TO PROVE THAT THE MERGER IS LIKELY TO REDUCE COMPETITION IN A RELEVANT MARKET.

Plaintiffs failed to meet their burden of demonstrating a likelihood of success on the merits, because they failed to prove that the merger is likely to substantially reduce competition in any relevant market. More specifically, Plaintiffs failed to define a relevant geographic market, and further failed to offer convincing evidence that the merger will produce any particular anti-competitive harm, such as an increase in prices, within a relevant market. Accordingly, the Court should deny Plaintiffs' motion for a preliminary injunction.

Section 7 prohibits only those mergers that would allow the combined company to raise price or restrict output. *FTC v. Occidental Petroleum Corp.*, Civil Action No. 86-900, 1986 WL 952, at *13 (D.D.C., Apr. 29, 1986). Plaintiffs' burden is to prove a "substantial lessening of

---

F.3d 708, 714-15 (D.C. Cir. 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.

[2] However, courts weigh the two factors (likelihood of success and equities) on a "sliding-scale." Where the FTC submits weaker proof that the balance of the equities disfavors the merger, it must then elicit stronger proof of likely success on the merits, and vice versa. *Elders Grain, Inc.*, 868 F.2d at 903; *see also, Lab. Corp. of Am.*, 2011 WL 3100372, at *15.

competition" that is "probable and imminent." *Arch Coal, Inc.*, 329 F. Supp. 2d at 115 (citations omitted); *see also Elders Grain, Inc.*, 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 the combined firm can "raise prices above competitive levels for a significant period of time").

Mere proof that the two merging parties compete with one another is not enough to establish a violation. The merger must reduce competition in a properly-defined market as a whole.[3] Further, Plaintiffs 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 Chem. Corp.*, 528 F. Supp. at 86 (emphasis added) (citations omitted); *United States v. Baker Hughes, Inc.*, 908 F. 2d 981, 984 (D.C. Cir. 1990) (same). "A showing of a fair or tenable chance of success on the merits will not suffice for injunctive relief." *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1074 (citations omitted).

To satisfy their burden here, Plaintiffs were required to 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). Plaintiffs have the burden on each element. *Id.* at 116. In particular, a failure to prove the relevant market is fatal. *Brown Shoe*, 370 U.S. at 324 (determination of the relevant market is a "necessary predicate"); *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995); *Arch Coal*, 329 F. Supp. 2d at 116–17.

[3] Congress' 1950 amendments to Section 7 codified the requirement to assess a merger's likely competitive effects in a broader "line of commerce," expressly rejecting prior interpretations that focused on the elimination of competition between the merging parties. *See* J. Keyte and K. Schwartz, "Tally-Ho!": UPP and the 2010 Horizontal Merger Guidelines, 77 Antitrust L.J. 587 (2011) (citing 1950 U.S.C.C.A.N. 4293, 4296-98, S. Rep. No. 1775, 81st Cong. 2d Sess. (1950)).

Only if the FTC proves a relevant product and geographic market and demonstrates undue concentration therein is it entitled to a structural presumption that the merger is illegal. *See H.J. Heinz Co.*, 246 F.3d at 715. Upon such a showing, the burden shifts to 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." *Arch Coal*, 329 F. Supp. 2d at 116 (citations omitted). Once a 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[.]" *H.J. Heinz*, 246 F.3d at 715 (citation omitted). The burden of proof "remains with the government at all times." *Id*. Where the FTC cannot establish a presumption of undue concentration, it bears the burden of proof and persuasion to show the merger will substantially lessen competition. *See Baker Hughes Inc.*, 908 F.2d at 938.

A. The "Tenn North Shore Area" Is Not a Relevant Geographic Market.

To establish a relevant geographic market, Plaintiffs must define the area in which consumers *can practicably turn* for substitute services should the merger be consummated and prices become anticompetitive. *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 359 (1963); *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1052 (8th Cir. 1999); *see also Arch Coal*, 329 F. Supp. 2d at 116 (same) (quoting *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 49 (D.D.C. 1998)). The geographic market must be defined in relation to "commercial realities." *E.I du Pont de Nemours & Co. v. Kolon Indus. Inc.*, 637 F.3d 435, 442-43 (4th Cir. 2011); *see also*, *Hershey Med. Ctr.*, 2016 WL 2622372, at *3 (same).

Plaintiffs' alleged geographic market – which Dr. Tenn describes as his "North Shore Area" (hereinafter the "Tenn North Shore Area")[4] – is unrealistically narrow, divorced from com-

[4] Dr. Tenn testified that the relevant geographic market was either just six hospitals owned by the merging parties in the northern and northwest suburbs of Chicago (Advocate Condell, Advocate Lutheran General,

mercial realities, and departs from the Merger Guidelines and relevant law.[5] DPFOF ¶¶ 72-76. It excludes many hospitals to which Defendants' consumers "can practicably turn" for service. It does not include a large number of hospitals to which consumers in the Tenn North Shore Area already go to for care today. DPFOF ¶¶ 77-82. Nor does it include "potential suppliers who can readily offer consumers a suitable alternative to [the defendants'] services." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1053 (8th Cir. 1999). Simply put, the Tenn North Shore Area does not qualify as a relevant geographic market for antitrust purposes.

Because "[t]he failure to properly define a relevant market may lead to the dismissal of a Section 7 claim[,]" the Court should deny Plaintiffs' motion on this ground alone. *Lab. Corp. of Am.*, 2011 WL 3100372, at *17; *see also Hershey Med. Ctr.*, 2016 WL 2622372, at *3 (denying injunction for failure to define relevant geographic market); *Foster*, 2007 WL 1793441 at *56 (failure to properly define the market constitutes grounds for dismissal of a Section 7 claim).

1. Tenn's Model Is Fatally Flawed and Cannot Be Used to Satisfy Plaintiffs' Burden of Proving the Relevant Geographic Market.

The Tenn North Shore Area is no closer to a legally sustainable "relevant" geographic market than was the recently rejected ***4-county*** "Harrisburg Area" market in *Hershey*, which also excluded significant competitors, and which was "dispositive to the outcome" in that case. *Hershey Med. Ctr.*, 2016 WL 2622372, at *3-5. Over 40 percent of Hershey's patients traveled from *outside* the FTC's alleged market, and several thousand Pinnacle patients resided outside the area as well. *Id.* at *4. Here, patient "flow" data similarly exposes the Tenn North Shore Area as

---

NorthShore Evanston, NorthShore Glenbrook, NorthShore Highland Park and NorthShore Skokie) or those six hospitals plus five non-party hospitals (Northwest Community, Northwestern Lake Forest, Presence Resurrection, Swedish Covenant and Vista East) located in what Dr. Tenn calls the North Shore Area. Defendants' Proposed Findings of Fact (hereinafter "DPFOF") ¶ 69.

[5] FTC & U.S. Dep't of Justice, *Horizontal Merger Guidelines*, §5.1 ("All firms that currently earn revenues in the relevant market are considered market participants.").

"unrealistically narrow" and flawed. Nearly 50 percent of patients that receive inpatient services in the Tenn North Shore Area travel from *outside* the area to do so, and more than 25 percent of patients that live within the area seek inpatient services from hospitals *outside* it, many in downtown Chicago merely a few miles away. DPFOF ¶¶ 79-80.[6] Plaintiffs have not explained why insurers could not easily turn to the numerous hospitals outside of the Tenn North Shore Area when 50 percent of patients already travel into the alleged market (and logically could use local hospitals outside of the alleged market) and over 25 percent of patients already travel outside of the alleged market (indicating the ease of travel to hospitals outside of the alleged market). As in *Hershey*, "[t]hese salient facts" show that the Tenn North Shore Area "is too narrow because it does not appropriately account for where the Hospitals . . . draw their business" and is not a properly defined market in which "few patients leave . . . and few patients enter." *Id*. 9-10.

Plaintiffs create this unrealistic geographic market using a "hypothetical monopolist" test performed by Dr. Tenn. This test is based on the very *same* model that Dr. Tenn used to calculate a post-merger price increase, and its flaws are discussed in greater detail, *infra*, in Part II. DPFOF ¶ 237. In short, Dr. Tenn's model is predisposed to predict a price increase and does not account for hospitals' lack of bargaining power in the Chicago market. Dr. Tenn himself admits that he is not aware of *any* federal court that has accepted this model.[7] DPFOF ¶ 241.

Dr. Tenn's results using this test make no sense. The hypothetical monopolist test looks at whether a firm could profitably raise prices by a small but significant amount. DPFOF ¶ 237. Dr. Tenn's own results show that 52 percent of patients who choose hospitals in the Tenn North

[6] To be clear, Defendants here do not assert that in-migration and out-migration statistics define the relevant market. However, the statistics cast a large shadow of common sense doubt on Dr. Tenn's assumptions and methodology.

[7] In fact, at least one federal court has noted that "its research has not revealed a single decision of a federal court adopting this test." *City of New York v. Grp. Health Inc.*, No. 06 Civ. 13122(RJS), 2010 WL 2132246, at *6 n.6 (S.D.N.Y. May 11, 2010), *aff'd*, 649 F.3d 151, 158 (2d Cir. 2011).

Shore Area would divert to a competing hospital *outside* of that area in the absence of their first choice. In other words, Plaintiffs' geographic market hinges on the implausible assumption that a hypothetical monopolist would risk over half of its customers to impose a small price increase.

2. The "Tenn North Shore Area" Is Based on Exclusion Criteria that Are Unsupported by Either Economic Theory or Commercial Realities.

That Plaintiffs' alleged market is unreasonably narrow is further confirmed in that Dr. Tenn arbitrarily excluded *all* hospitals that: (1) qualify, under Dr. Tenn's personal definition, as "destination" hospitals; (2) possess service areas that overlap with the service areas of *only* Advocate or *only* NorthShore hospitals, but not both; or (3) have less than a two percent share in service area overlap with *both* merging systems. DPFOF ¶ 88. These restrictions have no basis in case law, economic theory or market reality yielding odd – and self-serving – results. Dr. Tenn used the criteria to assume away key competitors to which consumers can, and do, practicably turn for services in Chicagoland. *Tenet Health*, 186 F.3d at 1053; DPFOF ¶ 88.

Dr. Tenn created the fictional category of "destination hospital" to summarily exclude from the geographic market prestigious teaching hospitals such as Northwestern Memorial Hospital, Rush University Medical Center (RUMC), Lurie Children's Hospital, and the University of Chicago Medical Center, all of which draw significant patient volume from the Tenn North Shore Area. DPFOF ¶¶ 89-132. Dr. Tenn asserted that "destination hospitals" are not competitors because they do not provide sufficiently "local" care and draw patients mainly for advanced services. DPFOF ¶ 90. The facts belie his assertion: the vast majority of Tenn North Shore Area patients who obtain services from "destination hospitals" do so for routine services, virtually all of which are also available in the Tenn North Shore Area. DPFOF ¶ 92. Northwestern Memorial, in particular, drew about 3,500 commercial discharges from the Tenn North Shore Area during July 2014-June 2015, virtually all of which were for services that could be obtained from

hospitals located within the Tenn North Shore Area, including 1,281 births. DPFOF ¶ 104. That patients in the Tenn North Shore Area visit downtown facilities for the same care provided closer to home is not surprising. Chicago is a "commuter market" in which patients travel significant distances every day, and prefer care near their home *or* their work. DPFOF ¶ 77.

Dr. Tenn's exclusion of hospitals that compete with one, but not both Advocate and NorthShore hospitals, similarly defies market realities in Chicago. Post-merger, hospitals that compete with *either* hospital system have the ability to discipline the merged system. DPFOF ¶ 134. For this reason, the Merger Guidelines recommend including "[a]ll firms that currently earn revenues in the relevant market" in calculating market concentration.[8] DPFOF ¶ 86.

The fundamental problem with Dr. Tenn's criteria, however, is that they yield a market that assumes away obvious competitors. DPFOF ¶¶ 153, 156. For example, the Tenn North Shore Area excludes Presence St. Francis even though that hospital sits less than three miles from and directly competes with NorthShore's flagship medical center, Evanston Hospital. DPFOF ¶¶ 135, 138-139. Nor does it include Northwestern Memorial, NorthShore's number one competitor based on qualitative evidence and diversion data. DPFOF ¶¶ 94-113, 166-175.

Diversion ratios indicate even more clearly that Advocate and NorthShore compete with hospitals that Dr. Tenn excluded. "Diversion" is a concept that indicates where customers will go when a market participant raises prices or is excluded from the market.[9] DPFOF ¶ 81. The diversion ratios in Dr. Tenn's own report demonstrate that both Advocate and NorthShore have higher diversion to other nearby hospitals, including the excluded academic medical centers, than they do to one another. Northwestern Memorial is the *closest* substitute for two NorthShore hos-

[8] Merger Guidelines, § 5.1.

[9] Merger Guidelines § 6.1 ("The diversion ratio is the fraction of unit sales lost by the first product due to an increase in its price that would be diverted to the second product.")

pitals (Evanston and Highland Park), and the second-closest substitute for the other two NorthShore hospitals (Glenbrook and Skokie). DPFOF ¶ 109. Under the Merger Guidelines, competitive hospitals of this sort, including Northwestern, should be in the market.[10]

Moreover, the evidence establishes that the hospitals Dr. Tenn excluded from his market, including Northwestern Memorial [redacted] have opened outpatient facilities and physician offices throughout the lakefront suburbs as "front doors" to draw patients to their hospitals for inpatient services. DPFOF ¶¶ 99-100, 117. And these strategies are in fact working. These hospitals acquire significant inpatient volume from the Tenn North Shore Area. DPFOF ¶ 104-105, 120. Northwestern Memorial's outreach efforts in that area have been particularly effective, as that hospital has high market shares in the zip codes that coincide precisely with Advocate's geographic gap in the lakefront suburbs east of Interstate 94. DPFOF ¶ 100.

As the foregoing facts indicate, Plaintiffs exclude multiple alternative hospitals to which patients "could practicably turn" in the event of a price increase by the merging parties. *Tenet Health*, 186 F.3d at 1052. In fact, many patients residing in the Tenn North Shore Area *already* use providers excluded from Plaintiffs' proposed geographic markets in large numbers, including Northwestern Memorial, RUMC, Presence St. Francis, and many others. Plaintiffs have thus failed to meet their burden of establishing a relevant geographic market.

B. Plaintiffs' Alleged Relevant Product Market Is Flawed.

Plaintiffs' narrow view of the relevant product market as only inpatient services fails to account for the impact of outpatient services on competition and how inpatient services are priced within a bundle that includes outpatient and other ancillary services. DPFOF ¶¶ 61-68.

[10] Merger Guidelines § 4.1.1, Example 6.

C. In a Properly Defined Market, the Market Concentration Is Insufficient to Establish a Presumption of Anticompetitive Effects.

Dr. McCarthy concluded that Dr. Tenn excluded at least seven (and as many as nine) hospitals from his proposed market that compete with Advocate and NorthShore to at least the same degree as the hospitals that Dr. Tenn included in his market. DPFOF ¶¶ 164-165. Those hospitals include Northwestern Memorial, Presence St. Francis, and RUMC. Dr. McCarthy's conclusions were based on sound methods that reflect actual market dynamics, including patient flow, diversion, and documentary evidence. DPFOF ¶¶ 88-165.

Under the Merger Guidelines, an assessment of market shares and market concentration must consider all market participants.[11] DPFOF ¶ 86, 162. The proper inclusion of the additional competitors identified by Dr. McCarthy pushes the HHI well below 2,500, which is the Merger Guidelines' threshold for a structural presumption against the merger.[12] Thus, the transaction may not be presumed to enhance the merged firms' market power.[13] DPFOF ¶¶ 163-165. In fact, far fewer than all of Dr. McCarthy's additional hospitals are needed to defeat a presumption. The HHI falls below the threshold with the addition of *only* RUMC, Northwestern Memorial, and Presence St. Francis to the Tenn North Shore Area. DPFOF ¶ 164.

II. PLAINTIFFS FAILED TO PROVE ANTICOMPETITIVE EFFECTS.

Plaintiffs' failure to prove a relevant market in this case is fatal. *Brown Shoe*, 370 U.S. at 324. But even if the Court were to agree with one of Plaintiffs' proposed markets and find that market shares and concentrations within that market establish a presumption of anticompetitive

[11] Merger Guidelines, §5.1.

[12] For Dr. McCarthy's 20 hospital market, Defendants' post-merger market share is 29.9%, Herfindahl–Hirschman Index is 1,762, and change in Herfindahl–Hirschman Index is 443. For Dr. McCarthy's 18 hospital market, the Defendants' post-merger market share is 28.1%, the Herfindahl–Hirschman Index is 1,747, and the change in Herfindahl–Hirschman Index is 394. DPFOF ¶ 165.

[13] Merger Guidelines, §5.1.

effects, this would not end the inquiry. *See United States v. Gen. Dynamics Corp*., 415 U.S. 486, 498 (1974); *see also Arch Coal*, 329 F. Supp. 2d at 130. Here, other evidence amply demonstrates that the proposed merger is unlikely to result in a substantial unilateral price increase.

A. Dr. Tenn's Pricing Effects Model Cannot Reliably Predict a Price Increase.

The principal anticompetitive effect Plaintiffs assert in their Complaint is that the merged hospitals will "unilaterally" raise their inpatient prices after the merger occurs. The economic modeling Dr. Tenn used to predict a price increase, however, is flawed and unreliable.

Dr. Tenn only accounted for three inputs in his overly simplified model: diversion, margins, and price ratios. He estimated the pre-merger diversion ratio from one party hospital to the other system in the event of a price increase. DPFOF ¶ 237. He then attempted to estimate the value of that diversion by multiplying it by estimated price-cost margins at the party hospital receiving increased volume, then dividing by two and summing the result across all hospitals from the other system in his geographic market. According to Dr. Tenn, the result indicates that the merger will incentivize the parties to raise prices at six hospitals by an average of 8%. The key assumption underlying this analysis was that higher diversion and higher margins would create incentives for Advocate and NorthShore to increase prices. DPFOF ¶¶ 237, 240.

This model is predisposed to *always* predict a price increase. DPFOF ¶ 239. It also fails to account for competitive dynamics specific to the hospital industry in Chicago, such as repositioning, efficiencies, and, in particular, a hospital's actual bargaining power. DPFOF ¶ 246. Accordingly, both economists and the FTC have described Dr. Tenn's approach as only a "starting point" that cannot reliably predict a price increase in any specific setting.[14] DPFOF ¶¶ 242-243,

[14] *See* Statement of the Federal Trade Commission, In the Matter of Dollar Tree, Inc., FTC File No. 141-0207, at *2 (July 13, 2015); C. Shapiro, Unilateral Effects Calculations, at *1 (Oct. 2010), *available at* http://faculty.haas.berkely.edu/shapiro/unilateral.pdf; S. Salop et al., Charles Rivers Associates, Scoring

247. The academic article on which Dr. Tenn based his model specifically recommends *against* using it to estimate price increases because "these models are very simple and cannot alone form the basis of any conclusions regarding competitive effects in any specific proposed merger."[15] One of the economists who developed this model has also stated – in an article Dr. Tenn cited in his own expert report – that "[i]t is simply not possible, and one should not expect, to fully predict price changes on the basis" of the limited inputs Dr. Tenn used.[16] And Dr. Tenn himself conceded that no court has ever accepted his model to predict a price increase. DPFOF ¶ 241.

B. Dr. Tenn Failed to Account for Bargaining Leverage as it Operates in the Hospital Industry.

Dr. Tenn's model is particularly ill-suited to the *hospital* industry, because it fails to adequately account for the actual bargaining leverage of hospitals and payers. DPFOF ¶¶ 240, 244-245. Dr. Tenn admitted that his contribution margin variable is the only parameter in his model that approximates actual bargaining power. DPFOF ¶ 240. However, high contribution margins for hospitals are driven by high fixed costs (*i.e.*, costs associated with the hospital building itself, medical equipment, salaried doctors and nurses, and bond financing), and thus are not necessarily indicative of actual bargaining power. Given the high fixed costs in the hospital industry, contribution margins are particularly misleading as a way of estimating bargaining leverage here.[17]

Unilateral Effects with the GUPPI: The Approach of the New Horizontal Merger Guidelines, at *3 (Aug. 31, 2010), *available at* http://www.crai.com/uploadedFiles/Publications/Commentary-on-the-GUPPI.pdf.

[15] C. Shapiro, Unilateral Effects Calculations, at *1 (Oct. 2010), *available at* http://faculty.haas.berkely.edu/shapiro/unilateral.pdf.

[16] C. Shapiro, Mergers with Differentiated Products, 10 Antitrust 23, 27 (1996).

[17] Contribution margin is revenues minus variable expenses. All else equal, a firm with higher fixed costs will have lower variable costs and a higher contribution margin. *See* K Elzinga & D. Mills, The Lerner Index of Monopoly Power: Origins and Uses," 101:3 American Economic Review: Papers and Proceedings 558, 559 (2011) (explaining that the contribution margin "'does not recognize that some of the deviation of *P* from *MC* comes from either efficient use of scale or the need to cover fixed costs.' When using the Index to assess departures from the social optimum of firms with increasing returns to scale, it is misleading to attribute the entire departure to the exercise of monopoly power.").

Moreover, by his own admission, Dr. Tenn did not have contribution margin data for any of the eleven hospitals in his proposed market besides Advocate and therefore had to extrapolate from the limited Advocate data he had. DPFOF ¶ 240.

In failing to actually calculate bargaining leverage, Dr. Tenn deliberately disregarded a model repeatedly espoused by the FTC and supported in academic literature and case law.[18] DPFOF ¶¶ 224, 235. FTC economists have developed the Hospital Merger Simulation ("HMS") model to estimate a potential price increase following a hospital merger. DPFOF ¶ 224. "Stage 2" of HMS measures the relationship between actual prices and payers' willingness-to-pay (WTP) to keep the system network, which is a measure of that system's bargaining position. DPFOF ¶ 225. The statistical relationship between "WTP" and actual hospital prices reflects the bargaining power "split" between the hospital systems and commercial payers. DPFOF ¶ 226. This HMS model "is the 'standard practice' for predicting the price effects of hospital mergers," as stated by the FTC and FTC economists themselves.[19] DPFOF ¶ 224. Stage 2 analysis is a crucial aspect of HMS because the effect of the merger is calculated as the increase in "WTP" (*i.e.*, bargaining position) resulting from the merger multiplied by the *empirically estimated* effect of "WTP" on hospital system prices (*i.e.*, the true bargaining power of hospital systems).

[18] This approach was most recently on display in a 2010 hospital-merger case. In *ProMedica*, the Commission relied on a regression analysis using WTP by the FTC's own expert to conclude that the merger was likely to result in a price increase. *See* Opinion of the Commission, *In re ProMedica Health Sys., Inc.*, Docket No. 9346, 2012 WL 2450574 at *50-51 (June 25, 2012). The FTC's endorsement confirms that this regression-based analysis – which Dr. McCarthy performed in this case – is the appropriate and reliable way to estimate a price increase in hospital-merger cases.

[19] Keith Brand & Christopher Garmon, "Hospital Merger Simulation." American Health Lawyers Association (2014), pgs. 12-13; Farrell, Joseph, David J. Balan, Keith Brand, and Brett W. Wendling. "Economics at the FTC: Hospital mergers, authorized generic drugs, and consumer credit markets." Review of Industrial Organization 39.4 (2011): 271-296; Carlson, Julie A. et al. "Economics at the FTC: Physician acquisitions, standard essential patents, and accuracy of credit reporting." Review of Industrial Organization 43.4 (2013): 303-326, at 311.

Dr. Tenn conducted no Stage 2 analysis. In other words, Dr. Tenn did not estimate the empirical relationship between merger-induced increases in WTP and hospital pricing *in this market*.[20] DPFOF ¶ 236. Dr. Tenn justified this maneuver by arguing that the hospitals' bargaining leverage is reflected in his estimated contribution margins. DPFOF ¶¶ 237, 240. As discussed, however, contribution margins do not accurately reflect bargaining power or the split of such power between hospitals and insurance companies.

The ability to predict price effects in a particular market with any degree of confidence depends on knowing the actual bargaining split, because that value can vary widely from one market to another. DPFOF ¶¶ 245-247. Just last week, in another ongoing case, the FTC argued that "fail[ing] to analyze the geographic market from the perspective of the rate-negotiation process between insurance company customers and hospitals" resulted in "fundamental[] err[or]."[21] Because Dr. Tenn's estimate of bargaining power through estimated margins is inaccurate, his estimated price effect is inherently unreliable. DPFOF ¶¶ 244-247. It is also contrary to common sense. Insurers – and especially BCBSIL – have far greater bargaining power than hospitals in Chicago, because many provider alternatives are available for network formation, and there is excess capacity (*i.e.*, empty beds) at Chicago area hospitals. DPFOF ¶¶ 64, 223.

The importance of this methodological omission became clear during Dr. McCarthy's testimony, which showed that Dr. Tenn's model will predict a price increase as long as there is *any* diversion between the merging parties. DPFOF ¶ 239. Empirical evidence from other hospital mergers, however, demonstrates that an increase in WTP does not always translate into a price increase post-merger. DPFOF ¶ 233. In fact, even despite an increase in WTP, frequently

[20] Dr. Tenn could have used payer claims data subpoenaed by the FTC, but he admitted that he did not even look at those data.

[21] Emergency Mot. of the FTC & the Commonw. of Penn. for an Injunction Pending Appeal and to Expedite Appeal at 2, *FTC v. Penn State Hershey Med. Ctr.*, No. 16-2365 (3d Cir. May 12, 2016).

prices *decrease* following a hospital merger. DPFOF ¶ 233. Thus, using a model that effectively assumes that a price increase will *always* take place does not comport with the empirical evidence here or in other markets. DPFOF ¶¶ 234, 236, 239, 246.

In light of this, the Court should follow the uniform guidance of economists and the FTC itself that Dr. Tenn's model cannot reliably predict a price increase in any particular setting.

C. Properly Constructed Pricing Analyses Confirm that Defendants Could Not Successfully Implement a Price Increase in the Tenn North Shore Area.

Unlike Dr. Tenn, Dr. McCarthy used an accepted model that has survived peer review. This model relies on pricing data from insurers and actually seeks to determine and apply the respective bargaining leverage of hospitals and insurers during the negotiations that set prices.[22] DPFOF ¶ 229. Dr. McCarthy analyzed the price impact of the merger by estimating the relationship between hospital system bargaining position (WTP) and inpatient hospital prices. Dr. McCarthy used a patient choice model and constructed hospital system prices using claims data from insurers. DPFOF ¶ 230. Indeed, Dr. McCarthy relied explicitly on the pricing data from Chicago area insurers that Dr. Tenn did not even examine. DPFOF ¶¶ 229, 236.

Based on his analysis, Dr. McCarthy concluded that the merger is not likely to lead to a material price increase for inpatient hospital services. DPFOF ¶ 231. Dr. McCarthy analyzed numerous different iterations of the accepted model, and found that, overall, these models show

[22] Dr. Tenn admitted that he did not conduct any empirical testing to substantiate his claims of endogeneity bias or measurement error, and his criticisms of Dr. McCarthy's regression analysis are unwarranted. He did not run his own regressions correcting for any perceived flaws. He did not even take the basic step of adjusting Dr. McCarthy's regressions to control for the additional variables that he claims were improperly omitted. Without any empirical proof of bias or statistical error, Plaintiffs have not shown that Dr. McCarty's methods are unreliable. The widespread use of regressions based on WTP by the FTC and other economists confirms that they are not. As courts have observed in employment discrimination cases, which often rely on statistical regression and involve a similar burden shifting scheme, "[t]he burden is on the opposing party to clearly rebut statistical evidence; hypotheses or conjecture will not suffice." *Franklin v. Local 2 of the Sheet Metal Workers Int'l Assoc.*, 565 F.3d 508, 517 (8th Cir. 2009) (quotations omitted).

no systematic evidence of a positive relationship between the increase in WTP created by the merger and post-merger prices. DPFOF ¶ 231.

D. Defendants Have Offered Not to Raise Prices in Any Event.

Defendants have offered a binding commitment not to raise prices charged to payers under non-risk contracts for inpatient hospital services above the general rate of inflation for seven years.[23] DPFOF ¶ 222. Plaintiffs have not accepted that offer.

It is common practice in antitrust cases—indeed, it is encouraged—for the merging parties to propose a "fix" that addresses the competitive concerns of the enforcement agency.[24] Here, Defendants' expressed commitment not to raise prices is highly probative of whether the proposed transaction will have anticompetitive effects. This is particularly so given Plaintiffs' assertion that a price increase to payers is the precise harm that is likely to result from the merger. DPFOF ¶ 14. Other courts have found similar commitments "extremely compelling" when denying a preliminary injunction to block a merger. *Hershey Med. Ctr.*, 2016 WL 2622372, at *4; *see also FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1298 (W.D. Mich. 1996).

E. The FTC Otherwise Failed to Prove a Likelihood of Adverse Competitive Effects.

1. Plaintiffs' Third Party Witnesses Did Not Testify Credibly; Plaintiffs Admitted They Cannot Show Advocate and NorthShore Are Closest Substitutes.

Plaintiffs called three fact witnesses: Steve Hamman of BCBSIL, Tyler Norton of Cigna, and James Dechene of Northwestern. Each of these witnesses had ulterior motives for opposing the merger and the Court should not credit their testimony regarding merger's competitive effects.

[23] This offer extends to all 16 hospitals of the merged firm, not just the six party hospitals in Plaintiffs' alleged market.

[24] See ECF No. 423-5 (Darren S. Tucker, "The Elephant in the Room: Litigating the Fix After Arch Coal and Dairy Farmers," The Antitrust Source (Jan. 2006) at 1.

[redacted] BCBSIL partnered with Advocate to sell a version of the HPN called "BlueCare Direct with Advocate" ("BCD") on the Public Exchange as an intentional strategy to "box out" Cigna, Aetna, and United from partnering with Advocate-NorthShore to sell their own version of the HPN. DPFOF ¶ 213.

Cigna's opposition was a direct response to Advocate's decision to pursue the HPN with BCBSIL instead of Cigna. Cigna abruptly changed its position on the merger once it perceived that it had lost out to BCBSIL on the initial opportunity to partner with Advocate to market the HPN on the Public Exchange. In January 2015, Cigna supported the merger, as evidenced by the letter of support authored by the President of its Midwest region. DPFOF ¶ 207. Once Cigna learned in October 2015 that Advocate had contracted with BCBSIL to market BCD, Cigna changed its position. DPFOF ¶ 210.

Northwestern is a direct competitor of both Advocate and NorthShore, and it naturally fears the price competition that will result from the merger. DPFOF ¶¶ 101, 105, 107, 166. For that reason, Mr. Dechene's testimony that the merger would eliminate competition in the northern suburbs is particularly self-serving. In fact, Northwestern labeled the merger as a "competitive threat" within a week of its announcement, [redacted] DPFOF ¶¶ 111, 251-252. But Northwestern's opposition to the merger has another side as well. Northwestern has stated its interest in merging with NorthShore, which would eliminate the intense competition between them. Both the CEO of Northwestern Medicine and the President of

Northwestern University told Mr. Neaman that they hoped NorthShore lost the Advocate FTC case so that NorthShore and Northwestern could then merge. DPFOF ¶¶ 112-113.

Meanwhile, in their 30(b)(6) deposition, Plaintiffs conceded that they did not attempt to identify the closest competitors of the party hospitals. DPFOF ¶ 84. Neither did they seek to identify the closest competitors of the various non-party hospitals they excluded from the Tenn North Shore Area. DPFOF ¶ 84. Those admissions discredit Plaintiffs' ability to claim that Advocate and NorthShore are necessary substitutes for one another. *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1117-18 (N.D. Cal. 2004).

2. Payers Testified Credibly that the Merger Will Benefit Chicago Healthcare Consumers.

Both Aetna and United testified in support the merger, and two additional payers, Humana and Land of Lincoln, also support the merger and believe it will benefit their members. DPFOF ¶¶ 199, 203, 205-206. According to these payers, the merger will lower the overall cost of care and enhance coordination and clinical efficiencies. DPFOF ¶¶ 199, 203, 205-206. Brigitte Nettesheim of Aetna testified that a combined Advocate-NorthShore will more easily achieve clinical efficiencies that drive a lower total cost of care due to a single governance structure. DPFOF ¶ 204. Her testimony was based on Aetna's experience in other large markets where merged, integrated systems led to the creation of narrow networks marketable to employers, while also successfully reducing utilization and enhancing efficiencies. DPFOF ¶ 204.

Joanne Beck testified that United supports the merger because it will improve the quality of care while reducing total costs as NorthShore incorporates and applies the PHM expertise and clinical integration quality measures that Advocate has developed – [redacted] DPFOF ¶ 199. [redacted]

[redacted]

3. Providers in Chicago Compete Vigorously and Are Repositioning in Light of the Proposed Transaction.

Defendants demonstrated that Chicago hospital systems are already repositioning to compete more robustly against the Defendants following the merger and those actions will defeat any attempted post-merger price increase. DPFOF ¶¶ 248-262. *Oracle Corp.*, 331 F. Supp. 2d at 1117-18; *see, also*, *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 … 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"). These efforts are similar to the repositioning dynamic found to be underway in central Pennsylvania. *Hershey Med. Ctr.*, 2016 WL 2622372, at *8.

[redacted]. DPFOF ¶¶ 261-262.

As another example of repositioning, Northwestern announced in April 2016 its intention to acquire Centegra Health System, which has hospitals in McHenry County that compete directly with some Advocate hospitals. DPFOF ¶ 253. Record evidence also shows that Northwestern, [redacted], and other hospital systems that compete with Advocate and NorthShore are pursu-

ing physician and outpatient strategies to capture inpatient admissions, building "front doors" to their hospitals throughout the northern suburbs. DPFOF ¶¶ 252, 254, 258.

F. The Merger Will Create Immediate Price Reductions for Physician Services.

Defendants demonstrated compelling efficiencies that will result from the merger, especially as a result of the HPN, as discussed, *infra*, in Part III. In addition to those efficiencies, Defendants also demonstrated that the merger will immediately lead to price savings for consumers – even those who do *not* participate in the HPN. Dr. Sacks testified that Advocate will move NorthShore's physicians to Advocate's lower physician reimbursement rates upon merging, in accordance with rights retained by payers under their contracts with Defendants. DPFOF ¶ 318. BCBSIL agreed this would benefit its members. DPFOF ¶ 319. Dr. Eisenstadt testified this migration will result in an overall price savings of $30.2 million annually. DPFOF ¶ 320.[25] These savings – unrebutted by Plaintiffs – constitute an immediate merger-related benefit to consumers.

III. THE MERGER WILL CREATE TANGIBLE CONSUMER BENEFITS THROUGH THE INTRODUCTION OF A LOW-PRICED "HPN" INSURANCE PRODUCT.

Even if Plaintiffs had been able to establish a likelihood of success in proving a Section 7 violation, they are not entitled to a preliminary injunction because of the weaknesses of their alleged market definition and their countervailing failure to demonstrate that the balance of equities favors injunctive relief. Public equities that militate against a preliminary injunction include "the potential benefits, both public and private, that may be lost by enjoining" the proposed merger at issue. *FTC v. Swedish Match,* 131 F. Supp. 2d 151, 172 (D.D.C. 2000). "Public equities include improved quality, lower prices, increased efficiency, realization of economies of scale,

[25] Lessening Dr. Tenn's $45 million estimate of potential harm by $30.2 million, the maximum potential harm is $14.8 million. Using the same HPN savings estimates discussed *infra* in Part III.2, this $14.8 million amount would require HPN enrollment of only 11,000 to 53,000 (or 0.2% to 1.2% of the 4.8 million people in the employer group market) to offset the remaining potential harm Plaintiffs estimate. DPFOF ¶ 321.

consolidation of operations, and elimination of duplication." *Lab. Corp. of Am.*, 2011 WL 3100372, at ∗22 (citations omitted). "[P]articularly strong equities [that] favor the merging parties" bar injunctive relief. *Whole Foods Mkt. Inc.*, 548 F.3d at 1035.[26] Conversely, Plaintiffs cannot rely on equities alone to justify an injunction. *Arch Coal*, 329 F. Supp. 2d at 159.

A merger between Advocate and NorthShore, or more specifically, a transaction that fully aligns both systems' incentives, including cost reductions and pricing, is necessary for the creation of a two-system HPN that can be sold successfully to Chicagoland employers. Without a merger, Advocate will lack the necessary geographic coverage and NorthShore will not participate in HPN-type products on the price terms necessary for the products' commercial success. It is for this reason that the transaction's HPN efficiencies are merger-specific.[27] The balance of equities favors the merger and disfavors – indeed precludes – a preliminary injunction.[28]

1. The Creation of an HPN Product for the Group Insurance Market Is a Principal Objective of the Proposed Merger of Advocate and NorthShore.

Since 2010, Advocate has pursued the restructuring and re-alignment of its resources in pursuit of population health management (PHM) and payment-for-value arrangements. DPFOF ¶¶ 29-30, 44, 59. A PHM approach to the delivery of health care is in the long-term best interests of patients and will reduce the total cost of care. DPFOF ¶¶ 32, 36-37.

---

[26] *See also Hershey Med. Ctr.*, 2016 WL 2622372 at *5-9 (efficiencies in addressing capacity constraints, competitors' repositioning, and advantages in connection with risk-based contracting that the merger will provide credited as equities favoring the merger).

[27] Merger Guidelines, § 10 (2010) ("The Agencies credit only those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects. These are termed merger-specific efficiencies.").

[28] Plaintiffs have gone to great lengths to create a debate over whether the merger is necessary to enhance NorthShore's quality or ability to undertake population health management. Although Defendants believe that quality and PHM improvements are likely to be salutary by-products of the merger for the merged firm, the HPN is the merger-specific efficiency being created, and Defendants do not assert (nor have Plaintiffs shown) that the HPN is dependent on achievement of quality and PHM improvements.

Existing health plans in the Chicago market do not reward providers for effective management of population health or for reducing the total cost of care by directing additional patients to them. DPFOF ¶¶ 39-41. Consequently, Advocate determined that the most effective strategy to gain share and maintain adequate profitability is through the design of a "high performing network" – lower-cost, lower-priced products sold either through health plans or directly to employers/consumers, based on a benefit design that incentivizes patients to obtain their health care services from Advocate providers.[29] DPFOF ¶ 44. Benefit plan design that incentivizes patients to receive care within a high performing network will result in more care coordination, reducing unnecessary testing, complications, and readmissions. All of this enables a high performing network to provide a better product at a lower overall cost.

2. The HPN Creates Substantial Consumer Gains that Far Outweigh any Putative Competitive Harm.

Defendants' expert, Dr. Eisenstadt estimated the consumer benefits from the HPN by comparing the premium for existing Public Exchange products that include both Advocate and NorthShore to the premiums for the same benefit level of BCD. DPFOF ¶ 274. This comparison is a reasonable estimate of enrollees' annual savings from switching to the HPN because it is the difference in price between the HPN (BCD) and alternative products that drives the calculation, not the absolute prices. DPFOF ¶ 274. Dr. Eisenstadt found that the premium savings across several representative demographics (age, sex, family status) are substantial, ranging from $284 to $1,426 per person per year. DPFOF ¶ 275. Plaintiffs did not rebut these findings. Based on his estimates, Dr. Eisenstadt concluded that the HPN needs to gain only a small enrollment, ranging from a low of 32,000 (representing 0.7% of the potential market) to 159,000 (representing

[29] Advocate also determined that its HPN strategy must include the ability to earn some of the profit that otherwise would be earned by the insurer, *i.e.*, by assuming full capitation risk.

3.6% of the potential market), in order to offset Plaintiffs' asserted price increase.[30] DPFOF ¶ 276.

The benefits of the HPN are readily achievable. Aetna, United, [redacted], Land of Lincoln, and the largest insurance broker in Illinois, Aon, each contend the HPN will be commercially successful with Chicago employers and are prepared to distribute it. DPFOF ¶¶ 282-288.

Corroborating this, Dr. Van Liere testified that his survey of Chicago-area employers found significant interest in the HPN product. DPFOF ¶¶ 291-294. Dr. Van Liere's survey found that 82% of surveyed employers are very likely or somewhat likely to offer the HPN, and that 25% of surveyed employers are very likely to offer the HPN as their *only* health benefit plan. DPFOF ¶ 292. If only a small fraction of interested employers actually purchase the product, the survey results indicate the required enrollment calculated by Dr. Eisenstadt is readily attainable.

Further, Dr. Sacks testified that if the HPN attains the same share of the group market that BCD has attained in the Public Exchange market (approximately 21%), the HPN would cover more than 210,000 lives. DPFOF ¶ 277. Dr. Sacks estimated that the aggregate premium savings to Chicagoland consumers would exceed $210 million annually, DPFOF ¶ 277, or more than four times Plaintiffs' predicted price increase. Dr. Sacks further testified this is a "low" estimate and, based on several alternative estimations, annual consumer savings of $500 million is realistic and "I would put a stake in the ground that we could achieve that." DPFOF ¶ 277.

[30] Like Dr. McCarthy, Dr. Eisenstadt also concluded that Dr. Tenn's predicted price increase was methodologically unsound and erroneous. DPFOF ¶ 278. Correcting for Dr. Tenn's errors, the maximum potential economic harm from this merger is $11 million, which requires HPN enrollment in the employer group market of only 8,000 to 39,000 people to offset any potential harm. This equates to the HPN achieving only 0.2% to 0.9% share of the 4.8 million people in the employer market. DPFOF ¶ 278.

3. The Merger Is Necessary to Successfully Sell the HPN to Employer Groups.

Advocate created an Advocate-only version of the HPN with BCBSIL (*i.e.*, BCD). However, the market for BCD is limited. BCD was created primarily for sale to individuals and eligible small group insurance (SHOP) buyers on the Public Exchange. DPFOF ¶ 264. As described in the testimony of Drs. Sacks and Eisenstadt, nearly 90% of the commercial insurance market (4.8 million people) consists of employees and their dependents who obtain health insurance through their employers (both in large and small employer groups) that purchase health insurance outside of the Public Exchange. DPFOF ¶ 10.

Thus, to maximize the potential of the HPN as a business strategy, Advocate also must sell the HPN in the employer group market. Employers, brokers, and potential insurance partners consistently informed Advocate that to sell a "narrow" network insurance product such as the HPN to employer groups, it must be competitively attractive in comparison to traditional, broader-network products. Specifically, the HPN (1) must offer sufficient geographic coverage for employers whose employees reside throughout Chicagoland and (2) must be sold at a highly competitive price. DPFOF ¶ 296. Further, Advocate determined that the HPN should have a PPO-type design that permits patients to freely select among in-network providers without requiring patients to select a "gatekeeper" physician for specialist referrals. DPFOF ¶ 265, 267. The merger with NorthShore is necessary for the simultaneous achievement of these conditions.

4. Advocate Alone Lacks the Geographic Access Required by Employers.

Beginning in 2013, Advocate explored the viability of an Advocate-only insurance product to be sold to employers through direct discussions with employers and brokers, and subsequently with insurers. DPFOF ¶ 44. Advocate was consistently advised that it lacks the necessary geographic footprint in the six-county Chicago market to effectively sell such a product to employer groups alone. DPFOF ¶¶ 45-46. In particular, Advocate was informed that its lack of

access points along lakefront suburbs of Chicago means that any such product would not be sufficiently attractive to those mid-size and larger employers that have employees residing throughout the Chicagoland area. DPFOF ¶ 46.

For example, Aetna approached Advocate about selling an Aetna-branded narrow network product ("Accountable Care Solutions" or "ACS") both to employers and on the Public Exchange. DPFOF ¶ 47. Aetna has a track record of successfully selling single-provider, narrow network products in other metropolitan areas. DPFOF ¶¶ 47, 204. Aetna made clear that any Advocate-centered network must include another provider that has geographic scope along the lakefront suburbs, specifically either NorthShore or Northwestern.[31] DPFOF ¶ 47.

5. On Its Own, NorthShore Cannot Price to the Required Benchmark.

In order to be attractive to potential enrollees, a health insurance product that offers a narrower set of providers must be sold at a reduced premium compared to products offering a broader panel of providers. Health plans in the Chicago market have stated that the premium price of such a product must be 8-15% below the premium price of the next-best alternative product. DPFOF ¶ 270. Consistent with that market advice, [redacted]. DPFOF ¶ 269. In Chicago, for a product sold to employers, the reference product is Blue Advantage, a BCBSIL HMO in which both Advocate and some NorthShore providers participate. DPFOF ¶ 271.

To make a competitive premium economically feasible, providers in turn must be willing to accept lower rates of payment in exchange for the expected increase in volume created by the

[31] Advocate's experience with BCD is consistent with the views of the employers, brokers, and health plans. BCD is offered to both individuals and eligible small group insurance buyers on and off the Public Exchange. Public Exchange enrollment for 2016 closed in January. Although the product attracted nearly 60,000 enrollees, virtually all purchasers were individuals and fewer than 1,000 of the enrollees were members of insured groups. DPFOF ¶¶ 272, 281.

product's more limited provider network. Although Advocate has determined that this trade-off is rational for itself, NorthShore has determined that, acting by itself, it will not be able capture enough incremental volume through an HPN to offset the revenue reduction created by the lower reimbursement it would receive for services. DPFOF ¶¶ 301, 304.

Aetna's ACS product never came to the market for this reason. Aetna initially pursued development of the product through separate contracts with Advocate and with NorthShore, but NorthShore rejected Aetna's suggested pricing for the ACS product because its reimbursement would have been less than its costs. DPFOF ¶¶ 307-309.

NorthShore subsequently agreed to participate in a different iteration of an Aetna narrow-network product in which Advocate also participates (called "Aetna Whole Health Chicago" or "AWH")). DPFOF ¶ 310. However, the rates that NorthShore receives from Aetna for AWH are much higher than the rates Aetna sought from NorthShore for ACS in 2014, and NorthShore does not participate in the offering to large employers. DPFOF ¶ 310. Consequently, AWH is sold at a premium that is much higher than BCD. DPFOF ¶¶ 310-311.

6. A Merger Is Necessary to Create an Advocate-NorthShore HPN; It Cannot be Created by Contract.

A contractual form of HPN (*i.e.*, in which Advocate and NorthShore would each contract separately with a payer and would otherwise have no economic relationship) will not support the full-risk (capitation) arrangements that underpin Advocate's HPN strategy. DPFOF ¶ 314. Capitation involves the payment of a fixed fee to a provider for each insured plan member assigned to that provider, and the assumption by that provider of the full responsibility for all of the care required by that member. DPFOF ¶ 31. In a purely contractual relationship, Advocate, for example, would incur the financial risk for assigned members who obtain services provided by other contracted providers (*e.g.*, NorthShore) that are outside of its control. DPFOF ¶ 314.

The option for Advocate and NorthShore to contract with each other (*i.e.*, to form a joint venture) to offer the HPN is economically infeasible. BCBSIL, which controls 72% of the commercial health insurance market, will not enter into value-based contracts with a provider joint venture. DPFOF ¶ 299. Indeed, BCBSIL has refused to recognize Advocate's contractual relationship with Silver Cross Hospital for purposes of marketing BCD, even though it would be in BCBSIL's interest to do so. DPFOF ¶ 299.

Joint pricing by a merged firm comprising two formerly independent sellers of complementary products will result in a lower price for the combined product compared to the prices each would offer independently.[32] DPFOF ¶ 305. This is because, individually, each firm "bids" on the basis of its own, independent financial requirements, and not on the basis of maximizing the combined economic result (because there is no sharing of that result). DPFOF ¶¶ 305-306. If Advocate accepts a lower price, *i.e.*, in order to increase overall demand for the HPN, that increased demand by definition will benefit NorthShore more than Advocate. In that situation, each firm believes it is "leaving money on the table" by lowering its prices. This basic proposition (elimination of a pricing externality, also referred to as "double marginalization") is well accepted in merger enforcement policy.[33] DPFOF ¶¶ 305-306.

CONCLUSION

For the reasons explained above, Defendants Advocate Health Care Network, Advocate Health and Hospitals Corp. and NorthShore University HealthSystem respectfully request that

[32] Compare this to *Hershey Med. Ctr.*, 2016 WL 2622372 at *9. While the court there agreed with the FTC that "Hershey and Pinnacle independently are capable of continuing to operate under the risk-based model," the court found persuasive the testimony on how the merger in that case would provide advantages for risk-based contracting including size and scale, and these advantages counted as among the equities supporting denial of the requested preliminary injunction.

[33] *See also* Joseph Farrell & Michael Katz, *Innovation, Rent Extraction, and Integration in Systems Markets*, 2000 JOURNAL OF INDUSTRIAL ECONOMICS 48 (4), 413-32, *available at* http://oz.stern.nyu.edu/phd04/farrell.pdf.

the Court deny Plaintiffs' Motion for Preliminary Injunction, and for such other and further relief as the Court deems to be just and proper.

Dated: May 18, 2016

Respectfully submitted,

/s/ David E. Dahlquist .
Dan K. Webb, Esq.
David E. Dahlquist, Esq.
Michael S. Pullos, Esq.
Winston & Strawn LLP
35 W. Wacker Drive
Chicago, IL 60601
Phone: (312) 558-5660
Fax: (312) 558-5700
Email: DDahlquist@winston.com

Counsel for Defendant NorthShore University HealthSystem

/s/ Robert W. McCann
Robert W. McCann, Esq.
Kenneth M. Vorrasi, Esq.
John L. Roach, IV, Esq.
Jonathan Todt, Esq.
Drinker Biddle & Reath LLP
1500 K Street, N.W., Suite 1100
Washington, D.C. 20005
Phone: (202) 230-5149
Fax: (202) 842-8465
Email: Robert.McCann@dbr.com

John R. Robertson, Esq.
Leigh Oliver, Esq.
Robert F. Leibenluft, Esq.
Hogan Lovells US LLP
555 13th Street, NW
Washington, D.C. 20004
Telephone: (202) 637-5774
Email: robby.robertson@hoganlovells.com

Counsel for Defendants Advocate Health Care Network and Advocate Health and Hospitals Corp.

CERTIFICATE OF SERVICE

I hereby certify that on May 18, 2016 I caused a copy of the foregoing Defendants' Post-Hearing Memorandum in Opposition to Plaintiffs' Motion for Preliminary Injunction to be filed and served on all counsel of record for Plaintiffs via electronic mail.

/s/ Robert W. McCann
Robert W. McCann