No. 16-2492

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

FEDERAL TRADE COMMISSION *et al.*,

Plaintiffs-Appellants,

v.

ADVOCATE HEALTH CARE NETWORK *et al.*,

Defendants-Appellees.

On Appeal from the United States District Court
for the Northern District of Illinois
No. 1:15-cv-11473
Hon. Jorge L. Alonso

BRIEF AND REQUIRED SHORT APPENDIX OF APPELLANTS FEDERAL TRADE COMMISSION AND STATE OF ILLINOIS

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JURISDICTIONAL STATEMENT

The Federal Trade Commission brought this action under 15 U.S.C. § 53(b) to preliminarily enjoin the proposed merger of Advocate Health Care Network and Advocate Health and Hospitals Corporation (collectively, "Advocate") with NorthShore University HealthSystem ("NorthShore") pending a decision by the Commission as to whether the transaction violates Section 7 of the Clayton Act, 15 U.S.C. § 18. The State of Illinois sought the same relief under 15 U.S.C. § 26. *See* ECF No. 18 (sealed complaint). The district court had jurisdiction under 28 U.S.C. §§ 1331, 1337 and 1345. The district court issued an Order denying the motion for a preliminary injunction (ECF No. 472) on June 14, 2016, explaining its reasoning in a separate Memorandum Opinion and Order (ECF No. 473) that was filed under seal. The FTC and Illinois (collectively, the "Government") timely filed a notice of appeal on June 15, 2016. ECF No. 474. The district court subsequently issued a sealed Amended Memorandum Opinion and Order correcting two citation errors noted by the parties, but making no substantive change, as well as a redacted public version of that decision. ECF Nos. 484, 485. This Court has appellate jurisdiction because the district court's Order of June 14 was a final decision that disposed of all claims in the case, 28 U.S.C. § 1291, and because the district court denied injunctive relief, *id.* § 1292(a)(1).

STATEMENT OF THE ISSUES

The Government contends that the proposed merger of Advocate and NorthShore will enable them to raise prices for inpatient general acute care ("GAC") hospital services as a result of the combined entity's increased market power. In assessing whether a merger will unlawfully increase the combined firm's market power, a key question is the relevant geographic market—the area in which the competitive effects of the merger should be analyzed. This case concerns the definition of the relevant geographic market.

The Government used a standard analytical method known as the "hypothetical monopolist test" to show that a group of 11 local hospitals in Chicago's northern suburbs constitutes a relevant geographic market. This test is set forth in the *Horizontal Merger Guidelines* issued by the FTC and the Department of Justice and has been endorsed by many courts—including the First, Second, Sixth, Eighth, Ninth, Eleventh and District of Columbia Circuits—as a legally sufficient method of defining relevant markets consistent with the Supreme Court's holdings on market definition in *Brown Shoe Co. v. United States*, 370 U.S. 294 (1962) and *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321 (1963). There is no dispute that if the Government's geographic market is correct, the proposed merger is presumptively unlawful.

The district court ruled that the Government had not met its burden of establishing a relevant geographic market. But it reached that conclusion without ever assessing whether the Government's proposed market satisfied the

hypothetical monopolist test. Instead, the district court criticized the criteria the Government used to identify a proposed market. In particular, it questioned the Government's decision to limit the market to local hospitals in the northern suburbs and suggested that the market should also include hospitals outside that area, including "destination" hospitals—academic medical centers in downtown Chicago that provide highly sophisticated and specialized services and draw patients from across the Chicago area and beyond. In reaching these conclusions, the court rejected evidence that patients require local access for inpatient hospital services and that insurers must therefore include local hospitals in their provider networks.

The questions presented are:

1. Did the district court fail as a matter of law to apply a legally sufficient test for determining the relevant geographic market?

2. Did the district court clearly err in rejecting evidence that patients require local access to inpatient hospital services and that insurers cannot successfully market health plans in Chicago's northern suburbs that do not include local hospitals in their provider networks?

STATEMENT OF THE CASE

A. The Parties And The Merger

This case concerns the proposed merger of two large health systems that operate hospitals in northern Cook and southern Lake Counties. Advocate is the largest health system in Illinois, with 11 general acute care ("GAC") hospitals, approximately 70 or more outpatient facilities, over 5,000 employed and affiliated physicians, and $5 billion in 2014 revenue. PX06000 ¶¶ 8, 13.[1] It operates two hospitals in the northern suburbs that are relevant to this case: Advocate Lutheran General Hospital and Advocate Condell Medical Center. PX06000 ¶¶ 91-92. NorthShore operates four hospitals, all located in the northern suburbs: Evanston Hospital, Skokie Hospital, Glenbrook Hospital in northern Cook County and Highland Park Hospital in southern Lake County. PX06000 ¶ 15.

The NorthShore hospitals are fierce competitors with Advocate's Condell and Lutheran General. A NorthShore strategic review concluded that "NorthShore and Advocate are the #1 or #2 players in almost every service line," and that Advocate was NorthShore's "#1 competitor" and "poses the greatest threat" in NorthShore's service area. Tr. 644-47, 649-50 (A119-22, 123-24); PX07010 at 013-14; PX07033 at 007, 037. Advocate's CEO testified that Advocate and NorthShore were each other's

[1] Citations to "Tr__" refer to the hearing transcript. Parenthetical references in the form (A__) refer to the Appellants' separate Circuit Rule 30(b) Appendix, which includes the cited pages of the transcript. Citations in the form "PX___," "DX___ and "JX___" refer, respectively, to plaintiffs', defendants' and joint hearing exhibits, which are in the record at ECF Nos. 447 to 455. Citations to "Op." refer to the district court's Amended Memorandum Opinion and Order (ECF No. 484),which appears in the appendix bound with this brief.

closest competitors on a system basis in NorthShore's service area, Tr. 407 (A36), and Advocate's internal analyses likewise show that it views NorthShore as a major competitor. *See* PX04032, PX04100 at 014-15, 018-20; PX04291 at 004-06, 008-09, 011-12. Insurers also view the Advocate and NorthShore hospitals as the best substitutes for each other in the North Shore suburbs. *See, e.g.*, Tr. 82 (A5).

Advocate and NorthShore compete on the basis of price, offering discounted rates to health insurers so that they can be included in those insurers' provider networks. For example, NorthShore [redacted] Tr. 104-05 (A8-9). During negotiations with another insurer, NorthShore concluded that [redacted] Tr. 756-58 (A125-127); PX05067 at 001. They also compete to attract patients based on service offerings. For example, when NorthShore found that obstetrics and neonatology patients were choosing Condell, it added modern, integrated delivery rooms to attract patients to Highland Park. PX05093 at 001, 006; JX00013 at 137-45. As these examples illustrate, competition between the two systems generally helps to control prices and maintain or improve service quality, to the benefit of payers and patients.

Rather than continuing to compete, however, Advocate and NorthShore decided in September 2014 to combine into a single system. As one insurer representative explained, "[t]he combined entity of Advocate-NorthShore would

have a much greater bargaining leverage in negotiations" with health insurers, and that leverage "would manifest itself in higher prices, higher unit prices that [insurers] pay for services." Tr. 167 (A19). In light of these serious antitrust concerns, the Commission voted unanimously to institute an administrative proceeding to determine whether the transaction violates Section 7 of the Clayton Act. Such cases are decided in the first instance by an administrative law judge after a full evidentiary hearing, and are then subject to review by the full Commission. The Government filed this action to preliminarily enjoin the transaction pending a final decision by the Commission.

The district court held an eight-day evidentiary hearing, during which 15 witnesses testified live. It also received evidence in the form of deposition testimony, expert reports, and documentary exhibits.

B. Economics Of Commercial Hospital Markets

A threshold issue in Clayton Act merger cases is the identification of the relevant market, including both the relevant product market and the relevant geographic market. *Brown Shoe*, 370 U.S. at 324. In this case, the parties' experts agreed that the relevant product market was inpatient GAC hospital services ("inpatient services") sold to commercial payers (*i.e.*, insurers) and their members, and the district court agreed. Op. 5; Tr. 441-42, 1270 (A41-42, 136). The dispute between the parties—and the source of the district court's error—concerns the relevant geographic market.

Understanding how the Government analyzed the relevant geographic market requires consideration of the competitive dynamics of the healthcare marketplace. Unlike the typical two-party market, the market for inpatient hospital services has four participants—hospitals, insurers, employers, and patients—that engage in a multifaceted relationship. A majority of patients are covered by commercial insurance plans—often offered by an employer—which pays the bulk of their hospital costs. Insurers (also referred to as payers, health plans, or managed care organizations) assemble networks of hospitals that agree to treat covered patients at specific prices negotiated between hospitals and insurers. Thus insurers are the direct buyers of hospital services. *See St. Alphonsus Med. Ctr.–Nampa, Inc. v. St. Luke's Health Sys.*, 778 F.3d 775, 784 & n.10 (9th Cir. 2015); *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 562 (6th Cir. 2014). Patients typically pay the same amount for any in-network hospital. Thus, as to in-network hospitals, they are largely insensitive to price and typically select hospitals based on nonprice considerations, such as geographic convenience and reputation for quality of care. *See St. Alphonsus*, 778 F.3d at 784 n.10.

Competition within this market takes place at multiple levels. At one level, hospitals compete for inclusion in insurers' plans, largely on the basis of price, because being in-network means they can attract patients covered by those plans. *St. Alphonsus*, 778 F.3d at 784 n.10; *see also ProMedica*, 749 F.3d at 562 (noting that "[h]ospitals need patients like stores need customers"). At another level, insurers compete to sell health insurance plans to employers and individuals and

must be able to offer a network that is attractive to those customers. *See Ball Mem. Hosp., Inc. v. Mut. Hosp. Ins., Inc.*, 784 F.2d 1325, 1330 (7th Cir. 1986) (noting that "employers may shop among different plans"). Both levels of competition are relevant to market definition in this case.

1. Prices for inpatient services are determined in negotiations between hospitals and insurers based on each side's bargaining leverage.

Insurers negotiate prices for medical services with hospitals. As in any business transaction, each side has a certain amount of bargaining power, or leverage, and the agreement reached depends on the relative strengths of each party's leverage. Tr. 105-07, 151, 183, 1155 (A9-11, 16, 22, 129); *see also ProMedica*, 749 F.3d at 562. Leverage ultimately is a function of one party's ability to walk away from a negotiation and refuse to deal with the other party. *Id.* A hospital has an incentive not to demand prices that are too high because if it does and the insurer has adequate alternatives, it may abandon the negotiation and the hospital will lose access to patients in the insurer's plan. Conversely, the insurer has an incentive not to ask for unreasonably low prices for fear that the hospital will walk away and the insurer will be unable to include that hospital in its plan, potentially making the plan less attractive to subscribers.

The relative leverage between an insurer and a hospital thus depends on how important that hospital is to the insurer's network and the availability of desirable alternative substitute hospitals. As an insurer representative explained, [redacted]

[redacted] Tr. 106-07 (A10-11). Where a hospital has few close substitutes, it has greater leverage to obtain higher prices because "if they were not part of these networks, then [the insurer's] product to the market becomes less attractive . . . ." Tr. 151 (A16). Conversely, where there is competition between hospitals, insurers can "leverage one versus the other to get a lower price." *Id.*

Competition between hospitals (or the lack thereof) is critically important in determining the price of hospital services. Generally, greater competition leads to lower prices and reduced competition leads to higher prices. "If a provider becomes so dominant in a particular market that no [insurer] can walk away from it and remain competitive . . . then that provider can demand—and more to the point receive—monopoly rates." *ProMedica*, 749 F.3d at 562. Although the increased prices for hospital services are borne by insurers in the first instance, some portion of those increases likely will be passed on to employers and employees in the form of higher premiums, copayments and deductibles. Tr. 490-91 (A90-91).

2. Insurers need to include local hospitals in their networks to successfully market health plans to employers.

To successfully market health insurance plans to employers, insurers must offer provider networks that will be attractive to employees. Tr. 73-75, 148-49 (A1-3, 14-15). Although the attractiveness of a network depends on several different factors (including price and quality of service), a key consideration is geographic coverage. As one insurer representative testified, "[g]eographic coverage is very important, certainly to provide that access that those patients, those

members, are looking for." Tr. 149 (A15); *see also id.* at 74 (A2) ("First, we look at access and we look at geographic area."). In other words, insurers must offer networks that include hospitals in locations where patients want to receive services.

This means that insurers' provider networks must include hospitals located near the areas where patients live. As this Court has recognized, "for the most part hospital services are local. People want to be hospitalized near their families and homes, in hospitals in which their own—local—doctors have hospital privileges." *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1285 (7th Cir. 1990); *see also Philadelphia Nat'l Bank*, 374 U.S. at 358 ("[I]n most service industries, convenience of location is essential to effective competition."). Accordingly, an insurance plan that does not include local hospitals in its provider network is unattractive and difficult (if not impossible) to market.

The district court heard abundant evidence confirming that patients living in Chicago's northern suburbs typically require access to local hospitals for inpatient services. For example, one insurer representative testified that "[t]ypically people get most routine care close to where they live. So the requirement of them to travel downtown would not be an attractive option for them." Tr. 158 (A18). Another testified that "a lot of our customers . . . do prefer to receive care within the communities with which they live." Tr. 93 (A7); *see also id* at 84 (A6) ("Typically [patients] seek care in their own communities."). Similarly, an executive at Northwestern Memorial HealthCare ("Northwestern") testified that "in our experience, patients tend to like to stay close to home when they need to have

community healthcare services." Tr. 305 (A31).[2] He elaborated, "[i]f you're in the hospital, you're staying overnight, you'd like to make it convenient for your family to come visit you. . . . You're trying to basically make it as convenient as you can to get the inpatient hospital services, which is near home." Tr. 312-13 (A33-34). Testimony from Advocate and NorthShore executives and internal company documents likewise indicate that patients generally prefer to receive hospital care close to home.[3] And numerous other hospital executives, employers and insurers said the same thing.[4]

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[2] Northwestern operates seven hospitals in the Chicago area, two of which are in Lake and Cook Counties. Northwestern Lake Forest is located in Chicago's northern suburbs (and is one of the 11 hospitals in the Government's proposed market). Northwestern Memorial, a leading academic medical center, is located in downtown Chicago, and is not in the Government's proposed market. This brief uses "Northwestern" to refer to the system as a whole, and "Northwestern Memorial" to refer specifically to the downtown medical center.

[3] *See* PX02008 at 187 (NorthShore executive testimony "if a patient can receive care closer to home, it is easier on their family"); PX02022 at 106-07 (NorthShore executive testimony that research shows "consumers will travel, only travel certain distances to obtain their healthcare" and that healthcare is a local business); PX04069 at 001 (Advocate document stating that "[w]e cannot expect patients to travel for routine care"); PX07010 at 034 (NorthShore presentation concluding that healthcare "is Still Largely a 'Local' Business"); [redacted]; JX00028 at 271 (Advocate executive testimony that "when something is considered routine, [patients] expect to be able to stay within their local health community").

[4] See JX00001 at 58 (testimony of employer that "people tend to go to their local hospital, and then if they need to move on from there, they do. But people that live near Advocate hospitals are going to go to Advocate hospitals because it's close"); *id.* at 69-70 ("[F]or the routine things that occur in a hospital every single day, people want to go to the closest hospital"); [redacted] (testimony of [redacted] executive that most patients prefer to receive routine inpatient care close to home); JX00014 at 319 (testimony from Northwest Community Hospital executive that most patients prefer to receive routine medical care close to home when possible); [redacted] (testimony of employer that it wanted to ensure employees did not have to travel long distances to receive care); [redacted] (testimony of insurer that people typically receive care "around

(continued)

Undisputed expert analysis further confirmed that patients prefer to receive hospital care locally. The Government's economic expert, Dr. Steven Tenn, found that 73% of patients living in his proposed North Shore Area market receive inpatient services there. PX06000 ¶ 107. Over 50% of patients admitted to one of the North Shore Area hospitals traveled seven miles or less, or less than 12 minutes, to obtain inpatient services. Tr. 454-55 (A54); PX06000 ¶ 104. Advocate and NorthShore's expert, Dr. Thomas McCarthy, reviewed these findings and testified that he had "no reason to believe [they are] wrong." Tr. 1343-44 (A143-144).

Several insurers testified that a plan that excluded both Advocate and NorthShore would be unattractive to members in the northern suburbs. For example, a Blue Cross Blue Shield ("Blue Cross") executive testified that a plan including only downtown hospitals would be unattractive and that [redacted] Tr. 157-58, 186-87 (A17-18, 23-24). He pointed to a plan called Blue Choice, which excludes both Advocate and NorthShore, noting that it "has not been that attractive to employer groups" and that only about 1.5% of that plan's participants reside in northern Cook County. Tr. 168-69 (A20-21). Similarly, a Cigna executive testified that [redacted]

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their home"); *See* [redacted] (testimony of [redacted] executive that "[p]atients . . . like to go to a hospital around where they live so their families can visit"); PX03005 ¶ 12 (declaration from insurer that its members "generally prefer to—and generally do—receive routine inpatient general acute care hospital services close to home").

[redacted] Tr. 109 (A13). And a UnitedHealth Group executive, who was called as a witness for the defendants, testified that her company [redacted] Tr. 1156 (A130); *see also* JX00017 at 156 (testimony of insurance broker that "if you have neither NorthShore and you have neither Advocate, you have neither in the product, I think very few people would buy it"). This indicates that a merger of Advocate and NorthShore would significantly increase the combined entity's bargaining leverage in negotiations with insurers. *See* Tr. 167 (A19).

C. The Government's Analysis Of The Relevant Market

The Government defined the relevant market using the "hypothetical monopolist test" as set forth in the *Horizontal Merger Guidelines* issued by the Department of Justice and the FTC. *See* U.S. Dep't of Justice & Federal Trade Comm'n, *Horizontal Merger Guidelines* § 4 (2010) (hereinafter "*Merger Guidelines*"). This test asks whether a hypothetical profit-maximizing firm controlling all sellers in a candidate market could profitably impose a "small but significant non-transitory increase in price" ("SSNIP")—typically a 5% price increase—on buyers from at least one seller location (including one location of the merging parties). *Id.* § 4.2.1. If the hypothetical monopolist could profitably impose a SSNIP, that means that sellers outside the candidate geographic market are not meaningful substitutes

for the buyers. In that case, the candidate market is a relevant antitrust market and no further analysis is needed. But if buyers could turn to sellers outside the candidate market and thereby make a SSNIP unprofitable, that means the outside sellers are meaningful substitutes and the candidate market is not a relevant antitrust market. In that event, the candidate market must be expanded and the test repeated. Defendants' economic expert, Dr. McCarthy, agreed conceptually that the hypothetical monopolist test is an appropriate way of identifying the relevant geographic market. Tr. 1317-18 (A137-38); DX5000 ¶ 38.

1. Dr. Tenn's application of the hypothetical monopolist test

Consistent with the *Merger Guidelines*, the Government's expert, Dr. Tenn, explained that the proper way to conduct the hypothetical monopolist test is to begin with a narrow candidate market, and then to expand the market if the test is not satisfied. Tr. 459-61 (A59-61). Defendants' expert, Dr. McCarthy, agreed with this approach. Tr. 1317-18 (A137-38); DX5000 ¶ 38.

In defining the candidate market, Dr. Tenn focused on the market dynamics of the hospital industry, including the fact that prices are set through negotiations with insurers and that patients require access to local hospital care. He initially applied the test to a candidate market consisting of just the four NorthShore hospitals plus Advocate's Condell and Lutheran General. He concluded that a single owner of these six hospitals could profitably impose a SSNIP on insurers. Tr. 453 (A53); PX06000 ¶ 76. Dr. Tenn's analysis could have stopped there, but in an effort to be conservative in the defendants' favor, he went on to consider a broader

candidate market. Tr. 453 (A53); PX06000 ¶ 79. He sought to include in that market "all of the local competitors that significantly overlap with the relevant Advocate and NorthShore hospitals." Tr. 453 (A53).

Dr. Tenn used three criteria to identify this broader candidate market. First, he included only local hospitals, not hospitals in downtown Chicago, which include academic medical centers such as Northwestern Memorial, Rush University Medical Center ("Rush), and the University of Chicago Medical Center ("UCMC"). These hospitals, which Dr. Tenn referred to as "destination" hospitals, offer a broader range of services than local hospitals and attract patients from across the Chicago metropolitan area. Tr. 453-58 (A53-58); *see also* Tr. 290-91, 295-98, 313 (A25-26, 27-30, 34) (testimony of Northwestern executive about academic medical centers). Dr. Tenn explained that he drew this distinction between local hospitals and destination hospitals because the evidence (such as insurer testimony and his own analysis of travel patterns) showed that patients typically prefer to receive local care when possible and that downtown hospitals were therefore not an adequate substitute for local hospitals from an insurer's standpoint. Tr. 453-58 (A53-58).[5]

Second, Dr. Tenn included local competitors with at least a 2% market share (using a weighted average of zip code-level market share) in the areas from which

[5] Dr. Tenn testified that he would have treated a destination hospital as a local hospital if it was in the same local area as the Advocate and NorthShore hospitals, but there were no such hospitals. Tr. 460-61 (A60-61).

the Advocate and NorthShore hospitals draw patients, because these were likely to be significant competitors. Tr. 463-64 (A63-64).

Finally, Dr. Tenn included hospitals that met the 2% cutoff with at least one Advocate and at least one NorthShore hospital, but not those that met that cutoff with respect to a hospital from only one of the parties, again because these were most likely to be significant competitors. Tr. 464-65 (A63-64).

Application of these three criteria yielded a candidate market of 11 local hospitals (including the four NorthShore hospitals, Condell and Lutheran General).[6] Dr. Tenn referred to the area around these 11 hospitals as the "North Shore Area." Tr. 449 (A49); PX06000 ¶ 92. This area is roughly consistent with North Shore's service area, and it is also similar to the "North Market" defined by Advocate in the ordinary course of its business. Tr. 450 (A50), PX04074 at 003-04. A map showing the locations of the 11 hospitals in the North Shore Area and surrounding areas is found in the Addendum. Dr. Tenn's analysis took account of "all patients, regardless of where they live" that use one of these 11 hospitals, not just those patients within the area defined by the blue line on the map. Tr. 451 (A51).

As required by the *Merger Guidelines*, Dr. Tenn assessed whether a hypothetical monopolist of these 11 hospitals could profitably impose a SSNIP on insurers. To do so, Dr. Tenn assessed whether the hypothetical monopolist would

[6] The other five hospitals in the candidate market were Northwest Community Hospital, Northwestern Lake Forest Hospital, Presence Resurrection Medical Center, Swedish Covenant Hospital and Vista Medical Center East.

have increased leverage to obtain higher prices from insurers. This involves analyzing the insurer's ability to form an attractive network that excluded the hypothetical monopolist's hospitals but included hospitals outside the North Shore Area. In applying this test, Dr. Tenn used a quantitative measure of substitutability: diversion ratios. *Id.* at 467-68 (A67-68). A diversion ratio is the percentage of patients that would switch from one hospital (Hospital A) to another (Hospital B) if the first were not available. In other words, Dr. Tenn considered the extent to which patients who use hospitals in the candidate market would switch to *any* hospital, including downtown medical centers or other local hospitals, if their first choice were not available.

Dr. Tenn found a high level of intramarket diversion: 48% of patients admitted to one of the 11 North Shore Area hospitals would substitute to another hospital in that market if their first-choice hospital were not available. PX06000 ¶ 99. At these intramarket diversion levels, he concluded that a hypothetical monopolist would have substantial leverage in negotiations with insurers, and that an insurer would accept a SSNIP rather than try to market a plan that did not include any of the candidate market hospitals. *Id.* ¶¶ 94, 100. He therefore concluded that the 11 hospitals constitute a relevant geographic market for antitrust purposes. Tr. 470-71 (A70-71).

2. Market shares and concentration in the relevant market

Dr. Tenn next assessed whether the Advocate/NorthShore merger is presumptively unlawful based on market share and market concentration figures in

the 11-hospital market. Tr. 474-80 (A74-80). As the Supreme Court has explained, "a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market, is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects." *Phila. Nat'l Bank*, 374 U.S. at 363; *see also Rockford Mem'l*, 898 F.2d at 1285 ("The defendants' immense shares in a reasonably defined market create a presumption of illegality.").

In *Philadelphia National Bank*, the Court held that a combined market share of 30% was sufficient to trigger the presumption. *Phila. Nat'l Bank*, 374 U.S. at 363. In this case, Dr. Tenn calculated that Advocate's and NorthShore's combined market share in the 11-hospital market would be twice that level—60%. PX06000 ¶ 113; *cf. Rockford Mem'l*, 898 F.2d at 1283 (merger presumptively anticompetitive where it would result in combined market share between 64% and 72%). Additionally, Dr. Tenn assessed market concentration using another standard econometric tool, the Herfindahl-Hirschman Index ("HHI"), which is calculated by summing the squares of the market shares of all firms in the relevant market. A market is highly concentrated if the HHI exceeds 2,500, and a merger that increases the HHI by more than 200 points in a highly concentrated market is deemed presumptively anticompetitive. *Merger Guidelines* § 5.3; *ProMedica*, 749 F.3d at 568; *St. Alphonsus*, 778 F.3d at 786. Here, the pre-merger HHI for the 11-hospital market is 2,161, and the merger would increase the HHI by 1,782—almost

nine times the amount deemed presumptively anticompetitive—resulting in post-merger concentration of 3,943. In light of these findings, Dr. Tenn concluded that "[t]he proposed merger will increase significantly concentration in an already concentrated market, . . . triggering the presumption of harm under the Merger Guidelines." Tr. 480 (A80).

3. Robustness checks to candidate market

Dr. Tenn conducted robustness checks to determine whether using different criteria to define the candidate market would affect his results. Tr. 464-66 (A64-66). Using a lower 1% market share cutoff added three additional local hospitals to the candidate market. PX06000 ¶ 93 n.183.[7] Using the 2% cutoff but including hospitals that overlapped with either Advocate or NorthShore individually (rather than both) added these three hospitals plus one additional local hospital.[8] *Id.* ¶ 101 n.196. This broader 15-hospital candidate market also passed the hypothetical monopolist test and resulted in combined market shares and market concentration levels that are presumptively anticompetitive. Tr. 464-66 (A64-66); PX06000 ¶ 101 n.196, ¶ 116. Thus modifying these criteria did not affect Dr. Tenn's ultimate conclusion that the merger is presumptively unlawful.

4. Effects of the merger on hospital prices

Finally, as part of a competitive effects analysis, Dr. Tenn also attempted to calculate the monetary harm that would result from the merger. He concluded that

[7] The three hospitals are Centegra McHenry, Alexian Brothers, and St. Alexius.

[8] The additional hospital is Presence St. Francis.

the merger would result in an 8% price increase across the six Advocate and NorthShore hospitals included in the market, amounting to approximately $45 million per year in higher costs. Tr. 489-90 (A89-90); PX06000 ¶ 184.

D. Defendants' Analysis

Defendants' expert, Dr. McCarthy, disagreed both with the way in which Dr. Tenn applied the hypothetical monopolist test and his conclusion that the 11 North Shore Area hospitals constitute a relevant market. Tr. 1210, 1216, 1225 (A132, 134, 135). In Dr. McCarthy's view, the relevant market should include at least 18 or 20 hospitals, including several downtown academic medical centers (Northwestern Memorial, Rush, and UCMC) and a downtown pediatric hospital (Lurie Children's Medical Center). Tr. 1211, 1225 (A133, 135). Although Dr. McCarthy agreed that the hypothetical monopolist test was a conceptually appropriate method for identifying markets, he never actually conducted *any* test on *any* market. Tr. 1334-35, 1635 (A141-42, 150).

E. The District Court Opinion

The district court held that the Government had not met its burden of proving a relevant market, but did so without addressing the substance of Dr. Tenn's analysis. The court acknowledged that Dr. Tenn relied on the hypothetical monopolist test, Op. 8, and never asserted that this test was inappropriate. Nor did it identify any problem with the way in which Dr. Tenn applied the test (*i.e.*, the model he used to determine whether a hypothetical monopolist of the 11 hospitals could profitably impose a SSNIP on insurers). It likewise did not question Dr. Tenn's conclusion that a single firm controlling the 11 hospitals in his proposed

market could profitably impose a SSNIP on insurers. Rather, the district court held only that the *criteria* Dr. Tenn used to identify the candidate market were "flawed." Op. 9. Thus the district court focused entirely on the way in which Dr. Tenn identified the candidate market—not whether that market passed the hypothetical monopolist test.

With respect to the candidate market, the district court first held that it was improper to "exclud[e]" destination hospitals on the theory that this "assumes the answer to the very question the geographic market exercise is designed to elicit; that is, are the destination hospitals substitutes for the merging parties?" *Id.* The court also stated that the "assumption that the destination hospitals are not substitutes is based on the notion that patients prefer to receive GAC services near their homes." Op. 10. But it found the evidence on this point "equivocal," citing a handful of excerpts from the hearing and deposition testimony. *Id.* And it discounted insurers' testimony that they could not successfully market a plan that did not include Advocate or NorthShore to employers with employees who live in the North Shore suburbs, holding that this testimony was "undermined" by Dr. Tenn's diversion ratios. *Id.* at 9 n.4.

The court also held that the failure to include destination hospitals in the market ignored the "commercial realities" of the industry. Op. 11 (quoting *Brown Shoe*, 370 U.S. at 336). It focused, however, on conditions in the market for *outpatient* services, stating that "(1) payers negotiate a single contract with a hospital system for both inpatient and outpatient services; (2) outpatient services

are on the rise and inpatient services on the decline; and (3) outpatient services are a key driver of hospital admissions." *Id.* (citations omitted).

Finally, the court criticized Dr. Tenn's decision to include in the candidate market only hospitals that overlap with both Advocate and NorthShore, rather than just one of them, as "problematic." Op. 12-13. It did not address Dr. Tenn's testimony that relaxing this criterion—*i.e.*, including all hospitals that overlap with either Advocate or NorthShore—made no difference in the ultimate conclusion that the transaction is presumptively anticompetitive. *See* discussion *supra* at 19.

Based on this analysis, the district court held that the Government had not "shouldered [its] burden of proving a relevant geographic market," and therefore failed to show a likelihood of success. Op. 13. In light of this holding, the district court denied the preliminary injunction motion without addressing the equities or defendants' arguments about the supposed benefits the merger would bring to consumers.

F. Injunction Pending Appeal

The Government promptly appealed the district court's order denying injunctive relief and moved for an injunction pending appeal to preserve the *status quo*. ECF Nos. 474, 478. The district court granted that motion, and later modified its order to state that the injunction would expire four days after a ruling by a panel of this Court. *See* ECF Nos. 482, 520. Accordingly, the parties have not yet consummated the merger.

SUMMARY OF ARGUMENT

1. *Errors of Law*. The district court erred by failing to apply appropriate legal standards to determine the relevant geographic market. Supreme Court precedent makes clear that the geographic market must be determined by a "pragmatic, factual approach" that is "economically significant" and "correspond[s] to the commercial realities of the industry." *Brown Shoe*, 370 U.S. at 336-37 (internal quotation marks and footnote omitted). The question is "where, within the area of competitive overlap, the effect of the merger will be direct and immediate." *Phila. Nat'l Bank*, 374 U.S. at 357. The standard test that courts, agencies, and economists use to define markets under these principles is the hypothetical monopolist test, which has been endorsed by six circuits and is consistent with the principles of market definition this Court applies.

Where an antitrust plaintiff relies on the hypothetical monopolist test to establish the relevant market, and no alternative test is suggested, the district court is obliged to consider whether the test is satisfied. The district court here failed to do so. It never considered whether a hypothetical monopolist of the Government's proposed 11-hospital market could profitably impose a SSNIP on insurers. Instead it merely criticized the criteria that Dr. Tenn used to initially identify that market. But those criteria were used merely to propose what market to test. It is the application of the test that determines whether a candidate market is in fact a relevant market. And here, the court never considered whether the test was satisfied. That was error.

The district court also erred in holding that downtown "destination" hospitals and local hospitals that overlap with either Advocate or NorthShore (rather than with both) must be included in the market. Both this Court's decision in *Rockford Memorial* and the *Merger Guidelines* make clear that a relevant market need not include every potential competitor. Here, application of the hypothetical monopolist test shows that downtown destination hospitals and other local hospitals are not economically meaningful substitutes for antitrust purposes. And defining the market broadly to include all of these hospitals (i.e., accepting Dr. McCarthy's proposed 20-hospital market) is unreasonable on its face.

The district court further erred by holding that conditions in the market for outpatient services require that downtown destination hospitals be included in the market. Outpatient services are separate and distinct from inpatient services and thus inpatient services are a distinct product market, as defendants' expert conceded and the district court properly found. The factors cited by the district court relating to outpatient services have no bearing on the proper determination of the geographic market for inpatient services.

2. *Clearly Erroneous Factual Findings*. The district court clearly erred in holding that the evidence that patients prefer to receive inpatient services near home was "equivocal." The evidence overwhelmingly showed that most patients in the North Shore Area require access to local hospitals for inpatient services. The passages cited by the district court do not state otherwise; to the contrary they confirm the patient preference for local hospital care. Testimony from other fact

witnesses and expert analysis, which the district court did not cite, further confirms this point.

The district court also clearly erred in holding that Dr. Tenn's diversion ratios undermined insurers' testimony that they could not successfully market a plan in the North Shore suburbs that excluded both Advocate and NorthShore. The district court misunderstood the significance of diversion ratios, which merely show what patients' second-choice hospitals would be if their first-choice hospital system were not available—not third or subsequent choices. In this case, the diversion ratios showed roughly half the patients using hospitals in the 11-hospital North Shore Area market would use another hospital in that market if their first choice were not available. Such high levels of intramarket diversion—which show patients' preference for local care—would give a hypothetical monopolist immense leverage over insurers in price negotiations. By focusing on the number of patients who would be willing to travel outside the market to obtain inpatient services, the district court fell prey to an analytical error known as the silent majority fallacy. The relevant question is whether insurers would be willing to pay a SSNIP to avoid losing access to all hospitals in the proposed market, not whether some patients would use hospitals outside the proposed market. Dr. Tenn's diversion ratios support, rather than undermine, the clear insurer testimony that a plan excluding both Advocate and NorthShore would be unattractive to patients residing in Chicago's northern suburbs.

STANDARD OF REVIEW

This Court reviews the district court's decision on a motion for a preliminary injunction under three standards: findings of fact for clear error, conclusions of law de novo, and the ultimate decision to grant or deny the preliminary injunction for abuse of discretion. *See, e.g.*, *Lawson Prods., Inc. v. Avnet, Inc.*, 782 F.2d 1429, 1437 (7th Cir. 1986). Although the district court's definition of an antitrust geographic market is typically a factual finding reviewed for clear error, *see Rockford Mem'l*, 898 F.2d at 1285, the Court "is not bound by that standard . . . 'if the trial court bases its findings on a mistaken impression of applicable legal principles.'" *Cox v. City of Chicago*, 868 F.2d 217, 220 (7th Cir. 1989) (quoting *Inwood Labs, Inc. v. Ives Labs., Inc.*, 456 U.S. 844, 855 n.15 (1982)); *see also Bose Corp. v. Consumers Union,* 466 U.S. 485, 501 (1984) ("Rule 52(a) does not inhibit an appellate court's power to correct errors of law, including . . . a finding of fact that is predicated on a misunderstanding of the governing rule of law."); *Pullman-Standard v. Swint*, 456 U.S. 273, 287 (1982) ("[I]f a district court's findings rest on an erroneous view of the law, they may be set aside on that basis.").

To put it another way, "when the district court employs the wrong legal standard in assessing the facts, its findings are clearly erroneous." *Moriarty v. Glueckert Funeral Home, Ltd.*, 155 F.3d 859, 864 (7th Cir. 1998). Of course, a finding is also clearly erroneous when "although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction

that a mistake has been committed." *Anderson v. Bessemer City*, 470 U.S. 564, 573 (1985) (citation and internal quotes omitted).

ARGUMENT

Section 7 of the Clayton Act prohibits mergers that "may" substantially lessen competition or tend to create a monopoly "in any line of commerce" and "in any section of the country." 15 U.S.C. § 18. Congress used the word "may" deliberately "to indicate that its concern was with probabilities, not certainties." *Brown Shoe,* 370 U.S. at 323. "[T]he statute requires a prediction, and doubts are to be resolved against the transaction." *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 906 (7th Cir. 1989). Congress vested principal responsibility for enforcement of Section 7 with the FTC, and authorized the agency to sue in a district court to preserve the *status quo* pending an administrative hearing on the merits. 15 U.S.C. § 53(b); *Elders Grain,* 868 F.2d at 902. States also have authority to seek injunctive relief. *See* 15 U.S.C. § 26. In seeking a preliminary injunction, the Government "is not required to *establish* that the proposed merger would in fact violate section 7 of the Clayton Act." *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 714 (D.C. Cir. 2001). It merely must show some likelihood that the transaction will be found unlawful in the administrative proceeding. *Id.*; *Elders Grain*, 868 F.2d at 903. The likelihood of success must then be weighed against the harm the Government will suffer if the injunction is denied in relation to the harm the defendant will suffer if the injunction is granted, using a "sliding scale" approach. *Id.*

The district court held that the government failed to meet its burden of proof as to the relevant geographic market and thus had shown no likelihood of success. But that conclusion is based both on mistaken application of the relevant legal principles and on factual findings that cannot be squared with the record. Accordingly, the district court's decision cannot stand. *See United States v. Household Finance Corp.*, 602 F.2d 1255, 1256-57 (7th Cir. 1979) (reversing finding as to line of commerce where "the district court in reaching [its] conclusion both incorrectly applied legal standards and made clearly erroneous findings of fact").

I. THE DISTRICT COURT FAILED TO PROPERLY FORMULATE AND APPLY ANY TEST FOR DETERMINING A RELEVANT GEOGRAPHIC MARKET.

The district court's conclusion that the Government failed to prove a relevant geographic market rests on a series of legal errors. The first and most fundamental error was in failing to consider whether Dr. Tenn's proposed 11-hospital market passed the hypothetical monopolist test—*i.e.*, whether a single entity controlling those hospitals could profitably impose a SSNIP on insurers. Courts have consistently recognized that the hypothetical monopolist test is an appropriate and legally sufficient way to define a market consistent with the standards set forth by the Supreme Court in *Brown Shoe* and *Philadelphia National Bank*. The district court did not dispute that the hypothetical monopolist test was appropriate. Where the Government relied on that test to prove the relevant geographic market (and defendants' expert agreed it was a conceptually proper test), the district court's failure to apply the test was error.

The district court compounded that error by suggesting that downtown academic medical centers and other hospitals used by some patients living in Chicago's northern suburbs must be included in the relevant market. And it further erred by using evidence of competition in the market for outpatient services—a separate product market—to define the relevant geographic market for inpatient services. These errors individually and collectively mandate reversal.

A. The District Court Erred In Failing To Consider Whether The Government's Proposed Market Passed The Hypothetical Monopolist Test.

A market, for antitrust purposes, is "the set of sellers to which a group of buyers can turn for supplies at existing or slightly higher prices." *Elders Grain, Inc.*, 868 F.2d at 907. The Supreme Court has held that the relevant geographic market is to be determined by a "pragmatic, factual approach" and must "correspond to the commercial realities of the industry and be economically significant." *Brown Shoe*, 370 U.S. at 336-37 (internal quotation marks and footnote omitted). The question "is not where the parties to the merger do business or even where they compete, but where, within the area of competitive overlap, the effect of the merger on competition will be direct and immediate." *Phila. Nat'l Bank,* 374 U.S. at 357. The market must be "drawn narrowly to encompass [that] area," but it "need not . . . be defined with scientific precision." *United States v. Conn. Nat'l Bank*, 418 U.S. 656, 668 (1974).

Although "Congress neither adopted nor rejected specifically any particular tests for measuring the relevant markets," *Brown Shoe*, 370 U.S. at 320, courts,

agencies and economists have developed tests that apply the principles set forth by the Supreme Court. The hypothetical monopolist test is the standard test that is routinely used for both geographic and product market definition. *See St. Alphonsus*, 778 F.3d at 784 (hypothetical monopolist test is "a common method to determine the relevant geographic market); *Food Lion, LLC v. Dean Foods Co. (In re Se. Milk Antitrust Litig.)*, 739 F.3d 262, 282 (6th Cir. 2014) (test is "a useful framework for organizing the factors courts have applied in geographic market definition") (citation and internal quotation marks omitted). The test was articulated by leading academic treatises in the late 1970s.[9] It was first adopted by the Department of Justice in the 1982 version of the *Merger Guidelines* and reaffirmed in the 1992 revision issued jointly by the Department of Justice and the FTC.[10] The current 2010 version of the *Merger Guidelines* continues to endorse the test, as does the most recent edition of Professor Areeda's antitrust law treatise.[11]

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[9] *See* Gregory J. Werden, *The 1982 Merger Guidelines and the Ascent of the Hypothetical Monopolist Paradigm,* 71 ANTITRUST L.J. 253, 255 (2003) (test "began to crystallize" with publication of treatises by Professor Sullivan in 1977 and Professors Areeda and Turner in 1978).

[10] *See* U.S. Dep't of Justice, *Merger Guidelines* § 2 (1982); U.S. Dep't of Justice and Federal Trade Comm'n, *Horizontal Merger Guidelines* § 1 (1992).

[11] *See* IIB PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 530, at 236-37 (4th ed. 2014); *see also* Christine A. Varney, The *2010 Horizontal Merger Guidelines: Evolution, Not Revolution*, 77 ANTITRUST L.J. 651, 653 (2011) (test is "now well-established" and courts have "embraced the analytical rigor it gives the relatively general pronouncements of the Supreme Court"); Malcolm B. Coate & Jeffrey H. Fischer, *A Practical Guide to the Hypothetical Monopolist Test for Market Definition,* 4 J. COMPETITION L. & ECON. 1031 (2008) (test is "well established as the test for market definition at the United States enforcement agencies, the federal courts, and many international antitrust regimes"); RICHARD A. POSNER, ANTITRUST LAW 156 (2d ed. 2001)

(continued)

At least seven federal courts of appeals have recognized the hypothetical monopolist test as an appropriate and legally sufficient way to identify a relevant market. *See Coastal Fuels Inc. v. Caribbean Petroleum Corp.*, 79 F.3d 182, 198 (1st Cir. 1996); *AD/SAT v. Associated Press*, 181 F.3d 216, 228 (2d Cir. 1999); *Food Lion,* 739 F.3d at 282; *H.J., Inc. v. Int'l Tel. & Tel. Corp.*, 867 F.2d 1531, 1537 (8th Cir. 1989); *United States v. Engelhard Corp.*, 126 F.3d 1302, 1306 (11th Cir. 1997); *St. Alphonsus*, 778 F.3d at 784; *FTC v. Whole Foods Market, Inc.*, 548 F.3d 1028, 1038 (D.C. Cir. 2008) (opinion of Brown, J.); *id.* at 1052 (Kavanagh, J., dissenting but endorsing hypothetical monopolist test).

While this Court has not explicitly adopted the hypothetical monopolist framework or had recent occasion to consider whether to do so, it has recognized the basic principles underlying the test. For example, the Court has held that "a market is defined to aid in identifying any ability to raise price by curtailing output." *Israel Travel Advisory Serv. v. Israel Identity Tours*, 61 F.3d 1250, 1252 (7th Cir. 1995). The hypothetical monopolist test is designed to determine whether a group of sellers has that ability. And in *Hospital Corp. of America v. FTC*, 807 F.2d 1381, 1387 (7th Cir. 1986), the Court noted that if purchasers could turn to hospitals outside the Chattanooga market in the event of a price increase, that would mean the market should include those other hospitals. That is precisely the way the hypothetical monopolist test works; if the test shows that buyers could turn

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(noting that adoption of SSNIP test in 1982 *Merger Guidelines* solved problems of earlier market definition approaches).

to sellers outside of a candidate market to avoid a SSNIP, then the market must be expanded to include those other sellers. The test also comports with this Court's insistence on econometric analysis to support market definition. *See Reifert v. S. Cent. Wisc. MLS Corp.*, 450 F.3d 312, 320 (7th Cir. 2006); *Menasha Corp. v. News Am. Mktg. In-Store Servs., Inc.*, 354 F.3d 661 (7th Cir. 2004).

In short, the hypothetical monopolist test is a legally sufficient test for establishing a relevant market. Where a plaintiff relies on that test to prove the relevant market, and no alternative test is suggested, the district court has an obligation to consider whether the test is in fact satisfied. This is especially true where, as here, defendants' expert agrees that the test is a conceptually appropriate way to define the market. In this case, Dr. Tenn's analysis showed that a hypothetical monopolist of 11 local hospitals in the North Shore Area could profitably impose a SSNIP on insurers (the relevant buyers). That evidence established that these 11 hospitals constitute a relevant geographic market. The district court, however, did not address the substance of Dr. Tenn's hypothetical monopolist analysis at all, much less conclude that the test was not satisfied. Instead, it merely criticized the criteria Dr. Tenn used to identify a candidate market and faulted him for "excluding" certain hospitals, even though the application of the test showed those hospitals were outside the market. Op. 9. That was error.

Moreover, the district court's criticisms fundamentally misapprehend the way the hypothetical monopolist test works. First, the candidate market is only a

proposed market—a postulation as to what might be a relevant market based on an expert's evaluation of evidence. It is the *application* of the test that determines whether that proposed market in fact qualifies as a relevant geographic market. If the candidate market passes the test, then outside competitors cannot constrain a hypothetical monopolist from imposing a SSNIP, which means that they are not economically significant substitutes. This necessarily means that the candidate market is a relevant market for antitrust purposes.

Here, Dr. Tenn identified a candidate market based upon reasonable assumptions about what might qualify as a relevant market for antitrust purposes. His analysis was informed by insurer testimony and data indicating that many patients require access to local hospitals for inpatient care and that insurers cannot successfully market plans in the North Shore suburbs without local alternatives. Moreover, the North Shore Area he identified approximates the way that NorthShore and Advocate define their service areas in the ordinary course of business. Tr. 450-51 (A50-51); PX04074 at 003-04. But Dr. Tenn did not rely on those facts alone. Instead, he conducted the hypothetical monopolist test and found that the 11 hospitals could profitably impose a SSNIP on insurers. This group of hospitals therefore constitutes a relevant antitrust market.

Furthermore, it is incorrect to view Dr. Tenn as "excluding" hospitals from the candidate market. The Supreme Court has made clear that the relevant geographic market must be "drawn narrowly." *Conn. Nat'l Bank*, 418 U.S. at 668. As the *Merger Guidelines* explain, "[d]efining a market broadly to include relatively

distant . . . geographic substitutes can lead to misleading market shares" because "the competitive significance of distant substitutes is unlikely to be commensurate with their shares in a broad market." *Merger Guidelines* § 4. Thus the test initially "requires selection of the *smallest* area in which a SSNIP could be successfully imposed." *Food Lion*, 739 F.3d at 282 (emphasis added). If that narrow market satisfies the test, there is no need to continue the analysis.

Indeed, defendants' expert, Dr. McCarthy, agreed that when applying the hypothetical monopolist test it is proper to begin with a narrow market definition, and then expand the market to include additional sellers if the test is not satisfied. Tr. 1317-18 (A137-38); DX5000 ¶ 38. In this case, Dr. Tenn's analysis showed that an 11-hospital candidate market satisfied the test. That established that the 11 hospitals constitute a relevant market, and there was no need to expand the candidate market to include additional hospitals.

In sum, the Government presented legally sufficient evidence that Dr. Tenn's 11-hospital market is a relevant antitrust market under a widely accepted analytical framework that is fully consistent with Supreme Court precedent. The district court's failure to consider that evidence was error.

B. The District Court Erred In Holding That Destination Hospitals And Other Hospitals Used By Some North Shore Area Residents Must Be Included In The Relevant Market.

The district court likewise erred in holding that Dr. Tenn's analysis "assumes the answer to the very question the geographic market exercise is designed to elicit: that is, are the destination hospitals substitutes for the merging parties." Op. 9.

Dr. Tenn did not assume the answer to that question; rather, he concluded that destination hospitals were not economically meaningful substitutes based on the results of the hypothetical monopolist test.

To be sure, downtown academic medical centers may be alternatives to North Shore Area hospitals for some patients. Some Advocate or NorthShore patients might be willing to travel downtown to one of these hospitals, even for routine inpatient care, if their first-choice hospital were not available. But that does not mean that these hospitals must be included in the relevant market. "[P]roperly defined antitrust markets often exclude some substitutes to which some customers might turn in the face of a price increase even if such substitutes provide alternatives for those customers." *Merger Guidelines* § 4. The Court recognized this principle in *Rockford Memorial*, where it affirmed the district court's geographic market definition even though that market might not "exhaust the alternatives open to the residents of that area." 898 F.2d at 1284. Indeed, even defendants' expert, Dr. McCarthy, acknowledged that "the presence of significant competitors outside the 'North Shore Area' does not necessarily imply that it is not an appropriately defined geographic market." DX5000 ¶ 65; *see also* Tr. 1320-21 (A139-40).

The district court's conclusion that Dr. Tenn should have included all local hospitals that overlap with either Advocate or NorthShore (rather than both) in the candidate market suffers from the same logical error. This conclusion erroneously implies that a hypothetical monopolist could not profitably impose a SSNIP if an

out-of-market hospital constrains just one of the merging party's hospitals. But the court's conclusion is directly contradicted by the *Merger Guidelines*, which provide that the hypothetical monopolist test is satisfied if the hypothetical monopolist can profitably impose a SSNIP from "at least one location." *Merger Guidelines* § 4.2.1. Moreover, Dr. Tenn did consider an alternative candidate market that included hospitals that overlapped with either Advocate or NorthShore (raising the total number of hospitals in the candidate geographic market to 15), and found that it also passed the hypothetical monopolist test and resulted in market share and market concentration levels that are presumptively unlawful; the district court simply ignored these findings. *See* discussion *supra* at 19. But in any case, the fact that the narrower 11-hospital market passes the hypothetical monopolist test demonstrates that these other local competitors are not economically meaningful substitutes and do not need to be included in the market.

In effect, the district court held that the relevant market must be at least as broad as the 20-hospital market described by Dr. McCarthy. But the district court did not consider the implications of that line of reasoning. If the narrowest possible relevant market were a 20-hospital market containing four downtown academic medical centers, that would imply that a hypothetical monopolist controlling 19 of these hospitals—but not, for example, the University of Chicago Medical Center—could not impose a SSNIP on insurers attempting to sell health plans in the North Shore suburbs. Tr. 1636 (A151). Or, to put it another way, it would imply that payers could successfully market a plan to employers and patients in the North

Shore Area that excluded these 19 hospitals (including all of the local hospitals) so long as it included the University of Chicago Medical Center among the hospitals in its provider network. This would require patients in the North Shore suburbs to undertake long and time-consuming travel to reach the nearest in-network hospital. Requiring the relevant market to be this broad is not only contrary to the evidence in this case, which clearly shows that insurers cannot successfully market plans in the North Shore Area that exclude local hospitals—it defies common sense.

As the Court noted in *Rockford Memorial*, "[i]t is always possible to take pot shots at a market definition." 898 F.2d at 1285. But the hypothetical monopolist test provides an economically rigorous framework for determining which hospitals are sufficiently close competitors to the merging parties that they must be included in the relevant market. Thus, the proper question is not whether downtown medical centers or other hospitals outside of Dr. Tenn's 11-hospital candidate market compete to some degree with Advocate and NorthShore, but whether they could constrain the ability of a hypothetical monopolist to impose a SSNIP. Dr. Tenn did not assume the answer to that question; instead, he analyzed it and found that the competition between the 11 hospitals in his candidate market and all of the hospitals outside that market is not sufficiently great to prevent a hypothetical monopolist of the candidate market from imposing a SSNIP. If the diversions to other hospitals were sufficient to enable payers to constrain a single owner of these 11 hospitals from imposing a SSNIP on payers, the market would not have passed the hypothetical monopolist test. But it did.

C. The District Court Erred By Relying On Evidence Of Competition In The Outpatient Services Market To Determine The Geographic Market For Inpatient Services.

The district court further erred by holding that the failure to include destination hospitals in the candidate market ignores "commercial realities" of the hospital industry. Op. 11. The court's analysis on this point focuses on the market for *outpatient* services, which is a separate and distinct market from inpatient services. Specifically, the district court made three points: "(1) payers negotiate a single contract with a hospital system for both inpatient and outpatient services; (2) outpatient services are on the rise and inpatient services on the decline; and (3) outpatient services are a key driver of hospital admissions." Op. 11 (citations omitted). None of these assertions is in any way relevant to the determination of the relevant geographic market for *inpatient* services.

The district court's analysis confuses two distinct product markets. As the district court itself properly found, the relevant product market in this case is inpatient GAC hospital services—the cluster of medical services that require a patient to be admitted to a hospital at least overnight—sold to commercial payers. Op. 5-6. Although each inpatient service could theoretically be classified as a separate product market, it is appropriate to group the cluster of inpatient services together for purposes of antitrust analysis because they are sold under similar competitive conditions. *See ProMedica*, 749 F.3d at 565-67. But outpatient services are not a substitute for inpatient services, and cannot be clustered with inpatient services because they are sold under different competitive conditions. Outpatient

services are available in a variety of settings, including doctor's offices, clinics, and outpatient surgical centers, while inpatient services are available only in hospitals. Tr. 79, 309 (A4, 32); *see also Rockford Mem'l,* 898 F.2d at 1284 ("For many services provided by acute-care hospitals, there is no competition from other sorts of providers."). Thus courts have repeatedly viewed inpatient and outpatient services as separate for purposes of market definition. *See ProMedica*, 749 F.3d at 565-67; *Rockford Mem'l*, 898 F.2d at 1284.

Once the district court found that the relevant product market was inpatient services sold to commercial payers, it should have focused exclusively on ascertaining the relevant geographic market for that line of commerce. That is because the relevant geographic market is the "area of effective competition in the *known line of commerce*." *Phila. Nat'l Bank*, 374 U.S. at 359 (quoting *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1961) (emphasis added); *see also United States v. Marine Bancorp.*, 418 U.S. 602, 620-21 (1974) (defining relevant geographic market as "the area in which *the goods or services at issue* are marketed to a significant degree by the acquired firm") (emphasis added); *Merger Guidelines* § 4.2.1 (hypothetical monopolist test focuses on producers of "the *relevant product(s)* located in the region . . . ") (emphasis added). Instead the court muddled the issue by turning back to an assessment of competitive conditions for outpatient services.

With respect to the district court's first point, it is true that insurers and hospitals typically negotiate a single contract that covers both inpatient and outpatient services. But that does not mean that those services belong in the same

market. *See, e.g.*, *In re Evanston N.W. Healthcare Corp.,* 144 F.T.C. 1, 498 (2007) ("[T]he fact that a customer purchases two sets of services from a supplier does not automatically lead to the conclusion that the two products are substitutes, or that one acts as a competitive constraint on the other.") (citing *Rockford Mem'l*, 898 F.2d at 1284); *see also FTC v. Staples, Inc.*, 2016 WL 2899222, at*13-14 (D.D.C. May 17, 2016) (even though ink and toner were part of bundle of office supplies sold by defendants, often under a single contract, they were not properly included in the same market because competitive conditions were different). Here, inpatient and outpatient services do not belong in the same market for the reasons stated above. And the geographic market for inpatient services depends on the group of hospitals that provide those services, not the much broader group of outpatient service providers.

As to the district court's second point—that outpatient services are growing while inpatient services are declining—it made the same error that the defendants made in *Rockford Memorial*. In that case, the product market was defined as inpatient services, but defendants "point[ed] out correctly that a growing number of services provided by acute-care hospitals are also available from nonhospital providers." 898 F.2d at 1284. The Court held that this trend was irrelevant, explaining that "[i]f a firm has a monopoly of product X, the fact that it produces another product, Y, for which the firm faces competition is irrelevant to its monopoly unless the prices of X and Y are linked," and that the prices for inpatient and outpatient services were not linked. *Id.* It focused solely on the relevant

geographic market for inpatient services. *Id.* at 1284-85. The same reasoning applies here. As in *Rockford Memorial,* the prices of inpatient and outpatient services are not linked—*i.e.*, the price for a particular inpatient procedure does not depend on the price of any outpatient procedure, and an increase in the price of inpatient services would not allow payers to substitute outpatient providers in their networks. Thus the fact that hospitals face significant (and perhaps increasing) competition for outpatient services has no bearing on the proper geographic market for inpatient services.

The district court's third point is that some patients' choice of a hospital for inpatient services might be influenced by where they receive outpatient services. For example, in some cases a patient who receives outpatient services at a Northwestern outpatient facility might choose to go downtown to Northwestern Memorial for inpatient hospital treatment, even if that is not the closest available hospital.[12] But to the extent that outpatient services affect inpatient admissions, the hypothetical monopolist test fully accounts for that factor because it considers both where patients actually receive inpatient care and diversion ratios showing where they would go for treatment if their chosen hospital were not available. In other words, any reasons a patient may have for choosing one hospital or another are already factored into Dr. Tenn's hypothetical monopolist analysis. Again, that

[12] The district court's assertion that outpatient services are a "key driver" of hospital admissions overstates the case. For example, although Northwestern has expanded its outpatient facilities in the North Shore suburbs in recent years, ordinary course documents show that its share of inpatient admissions has remained relatively constant. *See* PX04032 at 034, 042, 051, 060, 069; DX1420 at 23.

analysis showed that the percentage of patients who receive inpatient care at one of the 11 North Shore Area hospitals and who would prefer to remain in that market if their chosen hospital were not available is high enough that insurers would accept a SSNIP rather than attempting to market a plan that excluded all 11 hospitals from its coverage network.

For all these reasons, the district court's conclusion that Dr. Tenn's analysis ignores the commercial realities of the Chicago hospital industry is erroneous.

II. THE COURT CLEARLY ERRED IN REJECTING OVERWHELMING EVIDENCE THAT PATIENTS REQUIRE ACCESS TO LOCAL HOSPITALS AND THAT INSURERS CANNOT MARKET A PLAN THAT DOES NOT INCLUDE LOCAL HOSPITAL OPTIONS.

The Government presented overwhelming evidence that (a) many patients require access to local hospitals for inpatient care and (b) insurers cannot successfully market plans to employers with employees in the North Shore Area without including local hospitals in their provider networks. In rejecting the Government's proposed market, the district court downplayed or ignored most of this evidence and misconstrued the evidence that it did consider. The district court held that the evidence that patients prefer to receive inpatient services near their homes was "equivocal" and that insurer testimony about the difficulty of marketing plans that do not include local options was "undermined" by the diversion ratios Dr. Tenn calculated. Op. 9-11 & n.4. Both these findings are clearly erroneous.

A. The Evidence That Patients Require Access To Local Hospitals Is Overwhelming And Undisputed.

Contrary to the district court's assertion, the evidence that many patients prefer to receive inpatient hospital care close to home is not equivocal. In fact, *all* of the evidence that the district court cited confirms that patients typically receive hospital care close to home, particularly for routine services. This evidence justifies Dr. Tenn's decision to define and test a candidate market consisting solely of local hospitals in the North Shore suburbs, rather than one that also included downtown destination hospitals.

The district court cited ample evidence that patients typically prefer to receive inpatient hospital care close to home, at least for routine services. *See* Tr. 158 (A18) (testimony of Blue Cross executive that "[t]ypically people get most routine care close to where they live. So the ability for them or requirement of them to travel downtown would not be an attractive option for them"); *id.* at 330 (testimony of Northwestern executive that "people prefer to receive inpatient hospital care near to where they live"); [redacted] JX00028 at 271 (testimony of Advocate executive that "when something is considered routine, [patients] expect to be able to stay within their local health community"); PX02008 at 187 (testimony of

North Shore executive that "[f]or more ordinary in-patient procedures, . . . patients prefer to receive care closer to home.").[13]

None of the other statements the district court cited contradicts this testimony in any way. At most, these statements indicate that *some* patients may opt to receive inpatient hospital care near where they work or be influenced by other factors. For example, the district court cited a Cigna representative's testimony that patients in the North Shore suburbs "typically . . . seek care in their own communities, but some do travel to where they work or for a higher level of care potentially at an Academic Medical Center if there's a specialty they're looking for." Tr. 84 (A6). It also cited an Aetna representative's testimony that some Chicago area residents "live[] in one place and work[] in another and often receive[] [medical] services at both locations," and that there was "up to a 40-mile difference between where people lived and worked" and that they "utilized services at both ends." Tr. 1169 (A131); *see also id* at 330 (A35) (testimony of Northwestern executive agreeing that it "seeks to provide care where patients live and work").

Notwithstanding the fact that some patients may commute long distances, many others may live and work in the same community. For these patients, there may be no significant difference between receiving care near work or near home. But in any event, none of this testimony undermines the conclusion that many patients require local access to hospitals for inpatient services. At most, it shows

[13] The language quoted by the district court is actually from a question posed to the NorthShore executive. His response was: "My experience would say that, yes, if a patient can receive care closer to home, it is easier on their family." JX02008 at 187.

that some subset of patients who work far from home may prefer to receive care near their place of work. And even for those who may receive care near their place of work, the evidence does not show that they would be willing to accept an insurance plan that would require them (and family members who may not travel to work) to use hospitals far from home.

Similarly, the district court cited the testimony of a UnitedHealth Group executive that where a patient receives care is "really a personal decision of each member." Tr. 1130 (A128). The fact that an individual member's choice of hospital is a personal decision in no way undermines the conclusion that many patients make that decision based on geographic considerations and choose to receive inpatient care near home. In fact, the UnitedHealth Group witness agreed that "some patients prefer to receive care near their homes." *Id.* Likewise, the district court cited testimony from an employer that employee preferences for healthcare (though not specifically inpatient hospital care) turn on factors such [redacted]. Again, this testimony is consistent with a conclusion that many patients prefer to receive care near where they live. Contrary to the district court's characterization, this witness made clear that "where people live tends to have an influence on where they may want to get their healthcare services because of the convenience of those providers." *Id.* And she also indicated that her company's employees "select providers that are relatively close to home for routine medical care" and that "employees who live and work in the North Shore-area most

often choose to obtain medical care locally rather than traveling to downtown Chicago or a more distan[t] suburb." *Id.* at 72-73, 89.

In short, none of the evidence the district court cited in any way undercuts the conclusion that many patients living in the North Shore Area require access to local hospitals for inpatient care. Moreover, the district court ignored considerable additional testimonial evidence that reinforces this conclusion. *See* testimony cited *supra* at 10-11 & nn. 3-4. It also disregarded undisputed expert evidence on this point. Dr. Tenn found that 73% of patients living in his proposed North Shore Area market receive inpatient treatment there, and that 50% of patients admitted to North Shore Area hospitals traveled less than 12 minutes and 75% traveled less than 20 minutes to get there. Tr. 455 (A55); PX06000 ¶¶ 104, 107. Dr. McCarthy did not dispute these findings. Tr. 1343-44 (A43-44).

Taken as a whole, the evidence in this case overwhelmingly confirms this Court's conclusion in *Rockford Memorial* that "for the most part hospital services are local" because "[p]eople want to be hospitalized near their families and homes, in hospitals in which their own—local—doctors have hospital privileges." 898 F.2d at 1285. The district court's misinterpretation of evidence regarding patients' demand for local care and its refusal to acknowledge additional facts demonstrating this preference were clear error.

B. Diversion Ratios Do Not Undermine The Overwhelming Evidence That Insurers Cannot Market A Plan In The North Shore Area That Excludes Local Hospitals.

Overwhelming evidence showed that insurers cannot successfully market plans that exclude local hospitals—and more specifically plans that exclude both Advocate and NorthShore—to employers with employees in the North Shore Area. A Blue Cross executive testified that [redacted] Tr. 186-87 (A23-24). A Cigna executive testified that [redacted] Tr. 109 (A13). And a UnitedHealth Group executive called as a defense witness testified that her company [redacted] Tr. 1156 (A130); *see also* [redacted]

This testimony supports the Government's geographic market definition because it bolsters Dr. Tenn's findings under the hypothetical monopolist test. If insurers cannot successfully market a health plan that excludes both Advocate and NorthShore, they would logically be willing to pay more to keep those hospitals in-network. Consequently, insurers would be even more likely to pay higher prices to maintain access to all 11 of the hospitals in the Government's proposed geographic

market. As such, a hypothetical monopolist of these 11 hospitals could profitably impose a SSNIP because insurers would be unwilling to market a network without these hospitals.

But the district court discounted this testimony, stating that it was undermined by the diversion ratios that Dr. Tenn calculated. It is unclear which specific diversion ratios the district court meant. It referenced Dr. Tenn's calculation that 48% of patients admitted to one of the 11 North Shore Area hospitals would substitute to another hospital in that area if their chosen hospital was no longer available, and it also referenced the hospital-level diversion ratios set forth in Table 9 of Dr. Tenn's report. Op. 8, 9. What is clear, however, is that the district court fundamentally misunderstood the significance of diversion ratios and the role they play in the geographic market analysis. Properly understood, the diversion analyses here are consistent with the insurer testimony and support the Government's proposed geographic market.

First, the district court's characterization of the data in Table 9 of Dr. Tenn's report is incorrect. This table shows diversion ratios between numerous Chicago-area hospitals and the Advocate and NorthShore hospitals—*i.e.*, for a given hospital *X*, the percentage of patients admitted to an Advocate or NorthShore hospital who would switch to hospital *X* if none of the Advocate or none of the NorthShore hospitals, respectively, were available. It shows that for five of the six relevant Advocate and NorthShore hospitals, Northwestern Memorial has the highest or second highest diversion ratio of the hospitals listed. From this data, the district

court incorrectly concluded that "Northwestern Memorial Hospital is the second or third choice for patients who use five of the six relevant party hospitals in the North Shore Area." Op. 9. But diversion ratios are not informative about patients' third choices.[14] More importantly, the diversion data do not indicate that if the Advocate or NorthShore hospitals were unavailable, a sufficient volume of patients would divert to Northwestern Memorial such that a payer could exclude or credibly threaten to exclude these hospitals during negotiations to constrain a price increase by a hypothetical monopolist of the North Shore Area hospitals. While Northwestern Memorial is a viable alternative for some patients, the data show that many more patients would require that insurers retain North Shore Area hospitals in their network. Thus diversions to Northwestern Memorial do not contradict clear evidence in the record that patients require access to North Shore Area hospitals.

For example, Table 9 shows that the diversion ratio from Advocate's Lutheran General to Northwestern Memorial is 11.2%. PX06000 Tbl. 9. But the sum of the diversion ratios from Lutheran General to the four NorthShore hospitals is 22% and the sum of the diversion ratios from Lutheran General to all of the other non-Advocate North Shore Area hospitals collectively is 51.3%. *Id.* Thus more than

[14] Diversion ratios show what fraction of patients would go to Hospital Y if Hospital X was unavailable and for those patients, Hospital Y would be their second choice. Similarly, diversion ratios show the fraction of patients that would go to Hospital Z if Hospital X is unavailable and for those patients, Hospital Z would be their second choice. But the court was mistaken in assuming that if Hospital Z (in this case Northwestern Memorial) has the second-highest level of diversion from Hospital X, it is the third choice for patients of Hospital X.

half of Lutheran General's patients would divert to another hospital in the North Shore Area if none of the Advocate hospitals were available, while only 11.2% would choose Northwestern Memorial.

Similarly, Table 9 shows that the diversion ratio from the four NorthShore hospitals to Northwestern Memorial is 21.3%. *Id.* But the sum of the diversion ratios from the NorthShore hospitals to the other seven hospitals in the North Shore Area is 40.8%. *Id.* Thus, roughly twice as many NorthShore patients would use another North Shore Area hospital if their first choice were not available than would use Northwestern Memorial. The hypothetical monopolist test turns on whether insurers can avoid paying a SSNIP by creating, or threatening to create, attractive networks that do not include the hypothetical monopolist. The level of substitution between in-market hospitals is the key inquiry and the focus on diversion to Northwestern Memorial is misplaced.

In other words, the ultimate question here is not what fraction of patients would be willing to travel downtown to Northwestern Memorial (or another hospital outside the North Shore Area market) if a hospital within that market was not available. Rather, it is whether *insurers* would be willing to pay a SSNIP to avoid losing access to all hospitals in that 11-hospital market. *See St. Alphonsus*, 778 F.3d at 784-85 & n.10. The district court's analysis implies that insurers could avoid a SSNIP by marketing a provider network that excludes all 11 of these local hospitals, despite testimony from actual market participants that such a product would not be attractive. By focusing solely on the number of patients who would

travel outside the market, the district court fell victim to an error known as the "silent majority fallacy"—the "false assumption that patients who travel to a distant hospital to obtain care significantly constrain the prices that the closer hospital charges to patients who will not travel to other hospitals." *Evanston*, 144 F.T.C. at 498. The fact that some (or even many) Advocate or NorthShore patients would go to Northwestern Memorial if their first choice were not available does not imply that insurers could successfully market a health plan that did not include any local North Shore Area hospitals.

Moreover, as Dr. Tenn explained, he used diversion ratios for all Chicago area hospitals in determining whether a hypothetical monopolist could impose a SSNIP. Tr. 467-69 (A67-69). Thus the analysis accounts for competition from all hospitals—not just those included in the candidate market. His analysis showed that 48% of patients admitted to one of the 11 hospitals in the candidate market would choose another hospital in that market if their first choice were not available and that this level of diversion would allow a hypothetical monopolist to impose a SSNIP at each of defendants' hospitals in the North Shore Area. PX06000 ¶¶ 99-100. Logically, an insurer would prefer to accept a small price increase rather than attempt to market a plan without any of those 11 hospitals, given that such a plan would be unattractive to roughly half the patients in the North Shore Area. Thus the diversion ratios found by Dr. Tenn are fully consistent with and support the undisputed testimony of insurers that they could not successfully market a plan

excluding both Advocate and NorthShore to employers with employees in the North Shore Area. The district court's finding to the contrary was clear error.

CONCLUSION

For the foregoing reasons, the order of the district court denying preliminary injunctive relief should be reversed and the case remanded for further proceedings.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7) because it contains 13,608 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii). It complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and 7th Cir. R 32(b) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using 12-point Century Schoolbook type in the body of the brief and 11-point Century Schoolbook type in footnotes, using Microsoft Word 2010.

s/ Matthew M. Hoffman
Matthew M. Hoffman

CERTIFICATE OF SERVICE

I certify that on July 15, 2016, I electronically filed the foregoing with the Clerk of the Court of the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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CIRCUIT RULE 30(d) STATEMENT

All of the materials required by 7th Cir. Rule 30(a) are included in the Required Short Appendix bound with this brief. All materials required by 7th Cir. Rule 30(b) are included in a separately bound Appendix.

s/ Matthew M. Hoffman
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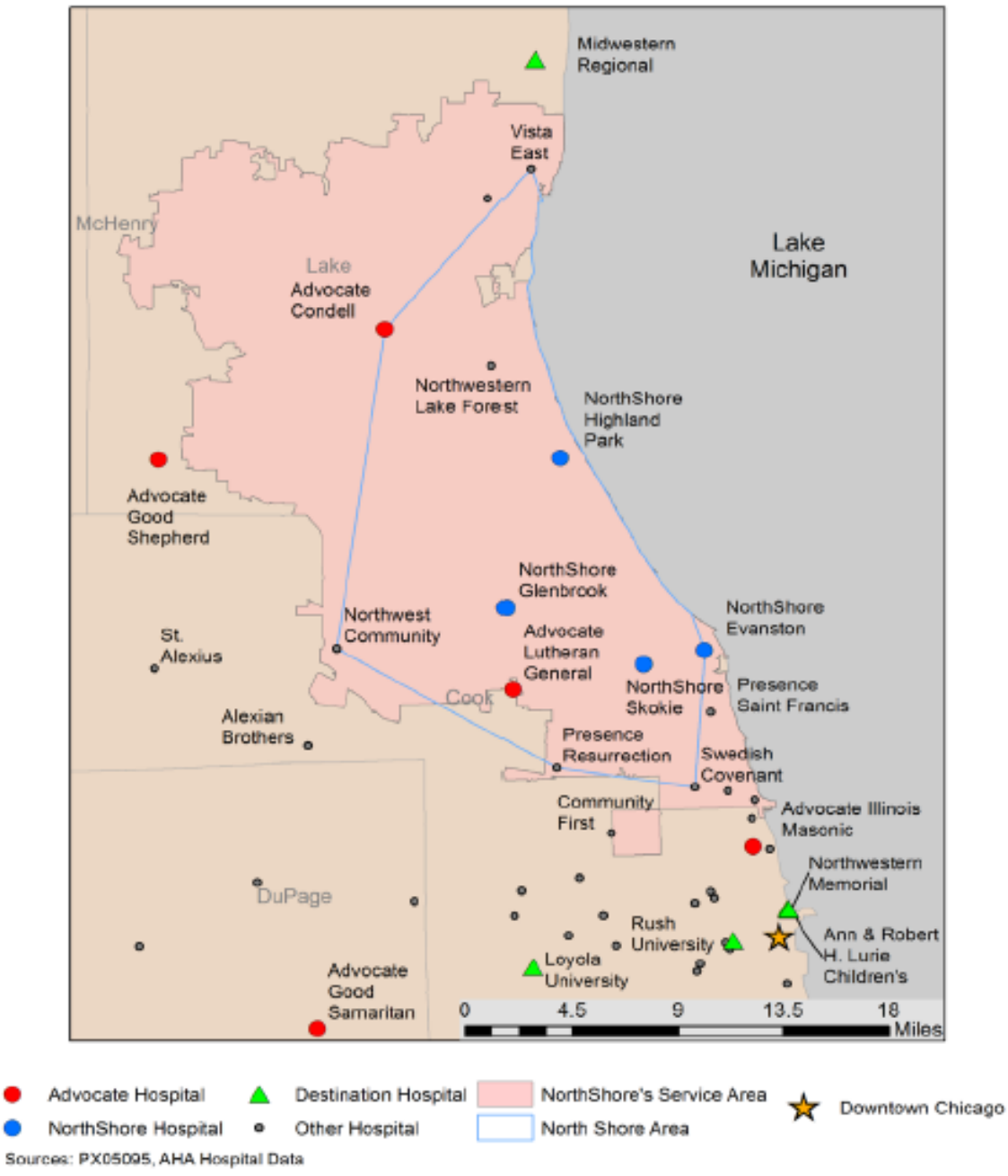
ADDENDUM

MAP OF NORTH SHORE AREA AND SURROUNDING HOSPITALS



Sources: PX05095, AHA Hospital Data

REQUIRED SHORT APPENDIX
PURSUANT TO 7TH CIRCUIT RULE 30(a)

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

FEDERAL TRADE COMMISSION and STATE OF ILLINOIS,	)	
Plaintiffs,	)	**No. 15 C 11473**
v.	)	**Judge Jorge L. Alonso**
ADVOCATE HEALTH CARE, ADVOCATE HEALTH AND HOSPITALS CORPORATION, and NORTHSHORE UNIVERSITY HEALTHSYSTEM,	)	
Defendants.	)	

ORDER

Plaintiffs have sued defendants to enjoin them from consummating their proposed merger pending completion of the FTC's administrative trial on the merits of plaintiffs' antitrust claims. After a six-day hearing and consideration of the parties' evidentiary submissions and arguments, the Court finds that plaintiffs have not met their burden of showing that there is a likelihood that they will succeed on the merits of their antitrust claims. Therefore, the Court denies plaintiffs' motion for a preliminary injunction [152].

Because the Court's Memorandum Opinion and Order contains competitively sensitive information, the Court will issue it under seal, so the parties may meet and confer with one another and third parties about proposed redactions. The parties are to submit their proposed redactions to the Court no later than 12:00 p.m. on Friday, June 17, 2016. After considering the proposed redactions, the Court will issue a public version of the Memorandum Opinion and Order.

SO ORDERED. **ENTERED: June 14, 2016**

HON. JORGE L. ALONSO
United States District Judge

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

FEDERAL TRADE COMMISSION and STATE OF ILLINOIS,	)	
Plaintiffs,	)	**No. 15 C 11473**
v.	)	**Judge Jorge L. Alonso**
ADVOCATE HEALTH CARE, ADVOCATE HEALTH AND HOSPITALS CORPORATION, and NORTHSHORE UNIVERSITY HEALTHSYSTEM,	)	
Defendants.	)	

AMENDED[1] MEMORANDUM OPINION AND ORDER

Plaintiffs have sued defendants to enjoin them from consummating their proposed merger pending completion of the FTC's administrative trial on the merits of plaintiffs' antitrust claims. For the reasons set forth below, the Court denies the motion.

Background

Parties

Advocate Health Care Network, which is the parent of Advocate Health and Hospitals Corp., is a health care system that includes eleven hospitals: (1) BroMenn Medical Center; (2) Christ Medical Center; (3) Condell Medical Center; (4) Eureka Hospital; (5) Good Samaritan Hospital; (6) Good Shepherd Hospital; (7) Illinois Masonic Medical Center; (8) Lutheran General Hospital; (9) Sherman Hospital; (10) South Suburban Hospital; and (11) Trinity

[1]When the parties submitted their proposed redactions to the Court's sealed Memorandum Opinion and Order, they pointed out two citation errors, both on page 11, which the Court has corrected.

Hospital. *See* http://www.advocatehealth.com/hospital-locations (last visited May 31, 2016). NorthShore University HealthSystem is a health care system that includes four hospitals: (1) NorthShore Evanston Hospital; (2) NorthShore Glenbrook Hospital; (3) NorthShore Highland Park Hospital; and (4) NorthShore Skokie Hospital. *See* http://www.northshore.org/locations (last visited May 31, 2016). In September 2014, Advocate and NorthShore signed an affiliation agreement to merge and create Advocate NorthShore Health Partners. (*See* DX3118, Affiliation Agreement.) "The combined entity would operate 15 GAC [general acute care] hospitals in Illinois and would generate approximately $7.0 billion in revenue." (Pls.' Findings of Fact & Conclusions of Law ("PFFCL") ¶ 3.)

Health Care Contracting

Commercial health insurers (also called payers) try to create networks of health care providers that are attractive to potential members. (*Id.* ¶ 12; Defs.' Findings of Fact & Conclusions of Law ("DFFCL") ¶ 21; Preliminary Injunction Hr'g Tr. ("Tr.") 75:11-16 [Norton-CIGNA]; *id.* at 148:12-18 [Hamman-Blue Cross Blue Shield of Illinois ("BCBSIL")].) Among the factors insurers consider when determining whether to include a hospital in a network are "the attractiveness of that hospital, the quality, the reputation of that hospital, . . . its willingness to . . . meet certain price points," and its geographic coverage. (Tr. at 149:3-11 [Hamman-BCBSIL]; *see id.* at 74:18-75:7 [Norton-CIGNA].)

Hospitals compete to be included in insurers' networks and negotiate reimbursement rates and services with the insurers. (PFFCL ¶ 9; Tr. 76:8-19 [Norton-CIGNA]; *id.* at 149:12-20 [Hamman-BCBSIL]; JX 9, Englehart Investigative Hearing ("IH") Tr. at 142:2-9).) A hospital has more bargaining leverage if there are fewer substitutes for it that can be included in the

insurer's network; the insurer has more leverage if there are more substitutes for the hospital. [redacted]; *id.* at 150:22-151:22 [Hamman-BCBSIL]; [redacted].)

The Chicago market is dominated by one commercial payer, BCBSIL, which has about 4 million members in the Chicago area. (Tr. at 145:9-11 [Hamman-BCBSIL]; *id.* at 1121:3-8 [Beck-United]; *id.* at 1175:13-22 [Nettesheim-Aetna]; *id.* at 1412:18-25 [Sacks-Advocate].) The other payers include United Health Group, Aetna, CIGNA, and Humana, which have about 1.5 million, 389,000, 350,000, and 172,000 members, respectively, in the area. (Tr. 72:2-4 [Norton-CIGNA]; *id.* at 1115:4-6 [Beck-United]; DX1515.0002, Carrier Market Share Calculation; DX1862.0005, Advocate/Aetna Collaboration Discussion Guide.)

Insurers pay health care providers under fee-for-service ("FFS") or risk-based contracts. Under FFS contracts, the payer pays a set fee for every service the provider gives to a patient. (Tr. 85:16-18 [Norton-CIGNA].) Risk-based contracts "[are] a set of payment arrangements in which providers hold some degree of financial risk." (PX 6001, Jha Report ¶ 10.) These arrangements include, from the lowest to the highest level of risk: shared savings, bundled payments, partial capitation, and full capitation/global risk. (*Id.* ¶ 24.) "Under shared savings agreements, [a]payer[] and [a] provider[] agree to a target or benchmark level of spending that they believe a certain population is likely to incur," and if the provider spends less than the target amount, it will split with the payer the difference between the target and the actual amount spent. (*Id.*) "Under bundled payment contracts, providers are given a lump sum of money to finance all of the care needed for a patient's single episode [of care]." (*Id.*) Under a partial capitation arrangement, the provider is paid a set amount per patient for a negotiated set of health care services. (*Id.*) The services that are not subject to capitation are paid on an FFS basis. (*Id.*)

Under a full capitation arrangement, a provider is paid a set amount per patient per month for all of that patient's health care services. (*Id.*) Ninety percent of NorthShore's commercial revenues come from FFS contracts; less than a third of Advocate's commercial revenues come from FFS contracts. (DFFCL ¶ 50; Tr. at 785:10-13 [Golbus-NorthShore]; *id.* at 1410:18-20 [Sacks-Advocate].)

Rationale for the Merger

Advocate's alleged rationale for the merger is "to create a new, low-cost, high performing network ("HPN") insurance product that can be sold . . . throughout Chicagoland," which it claims it cannot do "unless and until the merger with NorthShore is consummated due to [Advocate's] geographic gap east of Interstate 94." (DFFCL ¶¶ 38, 49.) Northshore's alleged rationale for the merger is "[to] engage in large-scale full risk contracting," which it says it cannot do "absent a merger, because it lacks: (1) sufficient geographic coverage; and (2) utilization management tools, care management tools, physician workflows and experience, . . . which Advocate can provide." (*Id.* ¶ 52.)

Discussion

Section 7 of the Clayton Act prohibits a merger "in any line of commerce or in any activity affecting commerce in any section of the country, the effect of [which] may be substantially to lessen competition, or tend to create a monopoly." 15 U.S.C. § 18. The Court may preliminarily enjoin a violation of § 7 "[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). "Therefore, 'in determining whether to grant a preliminary

injunction . . . , a district court must (1) determine the likelihood that the FTC will ultimately succeed on the merits and (2) balance the equities.'" *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1073 (N.D. Ill. 2012) (quoting *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1217 (11th Cir. 1991)). "[T]o demonstrate such 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) (quotations omitted). "A showing of a fair or tenable chance of success on the merits will not suffice . . . ; Section 7 deals in probabilities not ephemeral possibilities." *Id.* However, "the statute requires a prediction, and doubts are to be resolved against the transaction." *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 906 (7th Cir. 1989).

"Determination of the relevant product and geographic markets is 'a necessary predicate' to deciding whether a merger contravenes the Clayton Act." *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 618 (1974) (quoting *United States v. E. I. Du Pont De Nemours & Co.*, 353 U.S. 586, 593 (1957)); *see Tenet Health Care*, 186 F.3d at 1051 ("It is . . . essential that the FTC identify a credible relevant market before a preliminary injunction may properly issue."); *OSF Healthcare*, 852 F. Supp. 2d at 1075 (quoting *Tenet Health Care*, 186 F.3d at 1052) ("'[A] monopolization claim often succeeds or fails strictly on the definition of the product or geographic market.'").

The parties agree that the relevant product market in this case is inpatient general acute care services sold to commercial payers and their insured members ("GAC services"). (PFFCL ¶ 15; Tr. at 1270:3-6 (defense expert McCarthy conceding that the relevant product market is GAC services).) GAC services are a cluster of medical services that require a patient to be admitted to

a hospital at least overnight. (PFFCL ¶ 16; Tr. at 78:18-19 [Norton-CIGNA]); *see OSF Healthcare*, 852 F. Supp. 2d at 1075 ("This is a 'cluster market' of services that courts have consistently found in hospital merger cases, even though the different types of inpatient services are not strict substitutes for one another. *See FTC v. ProMedica Health Sys., Inc.*, No. 3:11 CV 47, 2011 WL 1219281, at *54 (N.D. Ohio Mar. 29, 2011) (collecting cases); *see also United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990) (upholding a similar GAC product market).").

The parties do not agree, however, on the relevant geographic market, *i.e.*, "[the] area in which the seller operates, and to which the purchaser can practicably turn for supplies." *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 359 (1963) (quotation omitted). There is no formula for determining the geographic market; rather, it should be identified in "a pragmatic [and] factual" way and should "correspond to the commercial realities of the industry." *Brown Shoe Co. v. United States*, 370 U.S. 294, 336-37, (1962) (quotation omitted). The geographic market "need not . . . be defined with scientific precision," *United States v. Connecticut National Bank*, 418 U.S. 656, 669 (1974), but "must be sufficiently defined so that the Court understands in which part of the country competition is threatened," *Federal Trade Commission v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 49 (D.D.C. 1998). "The FTC's failure to sufficiently define the relevant geographic market can be grounds to deny the requested injunction." *Id.*

Plaintiffs contend that the relevant geographic market, which their expert Steven Tenn refers to as the "North Shore Area," includes six of the merging hospitals – Advocate Lutheran General Hospital, Advocate Condell Medical Center, NorthShore Evanston Hospital, NorthShore Skokie Hospital, Glenbrook Hospital, and Highland Park Hospital – as well as Vista East Hospital, Northwest Community Hospital, Presence Resurrection Hospital, Northwestern Lake

Forest Hospital, and Swedish Covenant Hospital, all of which are located in northern Cook or southern Lake Counties. (PX 6000, Tenn Report ¶¶ 9-11, 14-15, 18, 72.)[2] Tenn constructed this market based on the location of the hospitals and by including: (1) local hospitals and excluding what he called destination hospitals, *i.e.*, Northwestern Memorial Hospital, Rush University Hospital, University of Chicago Hospital, Loyola University Hospital, Cancer Treatment Centers of America, and Lurie Children's Hospital; (2) hospitals "with at least a two percent share in the area from which the relevant Advocate and NorthShore hospitals attract patients"; and (3) hospitals "that overlap with [, *i.e.*, draw patients from the same area as] both Advocate and NorthShore" rather than those that overlap with just one. (*Id.* at n.175; Tr. at 453:22-23, 463:2-465:12.)

Tenn's rationale for the first criterion was that:

> [T]he purpose of the geographic market definition is to illuminate the competitive impact of the proposed transaction.
>
> Here the competitive concern is that Advocate and NorthShore are substitutes for commercial payers when they're putting together provider networks in the northern Chicago suburbs. The destination hospitals do not -- are not located in the northern Chicago suburbs and, therefore, do not fulfill this role for commercial payers.
>
> And, therefore, I include local hospitals which do fulfill this role.

(*Id.* at 454:1-11.) His rationale for the second criterion was that "competing hospitals that attract a greater number of admissions from the same areas as the relevant Advocate and NorthShore hospitals are likely to be more significant competitors to Advocate and NorthShore," and two

[2]Tenn also opined that the four NorthShore hospitals as well as Advocate's Lutheran General and Condell Hospitals constitute a relevant geographic market. (*See* PX 6000, Tenn Report ¶ 76.) However, he "focus[ed] [his] analysis on . . . the North Shore Area." (*Id.* ¶ 79.)

percent was a reasonable and conservative threshold. (*Id.* at 463:10-464:14.) His rationale for the third criterion was:

> [T]he concern is that a significant fraction of patients view Advocate and NorthShore as their first and second choices. And, therefore, it's natural to look at, for that set of patients, what alternative hospitals would be the next best alternative. And those competing hospitals are likely to be in the areas which overlap with both Advocate and NorthShore.

(*Id.* at 465:6-12.)

After identifying the market, Tenn tested whether it passed the hypothetical monopolist test; that is, whether a hypothetical monopolist that owned all of the hospitals in the market could raise prices by a small but significant amount ("SSNIP") at one or more of the merging hospitals. FTC Horizontal Merger Guidelines § 4.1.1. A market passes the test if the hospitals in it "are sufficiently close substitutes that the internalization of substitution by a hypothetical monopolist would make it profitable to [impose a SSNIP]." (PX 6000, Tenn Report ¶ 57.) Tenn measured the level of substitution by calculating diversion ratios, that is, the fraction of patients who use one hospital for GAC services that would switch to another hospital, if their first-choice hospital were no longer available. (*Id.* ¶¶ 95-98.) He determined that 48% of the patients admitted to one of the eleven hospitals in the North Shore Area would substitute to one of the other hospitals in the North Shore Area, if their chosen hospital were no longer available. (*Id.* ¶ 99.) This "level of intra-market diversion," Tenn opined, "is sufficiently high . . . to pass the hypothetical monopolist test." (*Id.* ¶ 100.)

Defendants contend that plaintiffs' proposed market is too narrow because it arbitrarily excludes so-called destination hospitals and other "firms 'with relevant production, sales, or service facilities in that region.'" (DFFCL ¶ 86 (quoting Merger Guidelines § 4.2.1); *see* Merger Guidelines § 4.2.1 ("Geographic markets based on the locations of suppliers encompass the

region from which sales are made. . . . Competitors in the market are firms with relevant production, sales, or service facilities in that region."). In defendants' view, the market should include hospitals that are outside of Tenn's North Shore Area but are associated with outpatient facilities or doctor's offices within the Area that drive significant inpatient volume to, *i.e.*, sell GAC services of, those outside hospitals. (DFFCL ¶ 87.) As support, defendants point to Tenn's diversion ratios, which show that Northwestern Memorial Hospital is the second or third choice for patients who use five of the six party hospitals in the North Shore Area – Advocate Lutheran General, NorthShore Evanston, NorthShore Skokie, NorthShore Highland Park, and NorthShore Glenbrook.[3] (*See* PX 6000, Tenn Report, Table 9.)

The Court agrees with defendants that the criteria Tenn used to identify the geographic market are flawed. Tenn offers no economic basis for the "destination hospital" designation in his first criterion. (*See id.* at n.175 (defining "destination hospitals" as those "that attract patients from throughout the Chicago metropolitan area, at long distances"); Tr. at 515:24-517:20.) Even if he had, his rationale for excluding such hospitals – that they are not substitutes for Advocate and NorthShore – assumes the answer to the very question the geographic market exercise is designed to elicit; that is, are the destination hospitals substitutes for the merging parties?[4] *See Phila. Nat'l Bank*, 374 U.S. at 359 (the geographic market is "[the] area in which

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[3]Moreover, despite the considerable distance between the two, Northwestern Memorial is the fifth choice for Condell patients, while NorthShore Evanston, Northwest Community, and Northshore Glenbrook are the sixth, seven, and ninth choices, respectively, for those patients. (*See* PX 6000, Table 9.)

[4]Tenn says that is an appropriate assumption, given payers' testimony that they could not successfully market a health plan that did not include Advocate or Northshore to employers with employees who live in the northern suburbs [redacted] However, that testimony – from parties opposed to the merger – is undermined by the diversion ratios that Tenn

the seller operates, and to which the purchaser can practicably turn for supplies"). Moreover, his assumption that the destination hospitals are not substitutes is based on the notion that patients prefer to receive GAC services near their homes (*see* Tr. at 454:15-457:4), a point on which the evidence is equivocal. (*Compare id.* at 330:9-11 (Dechene of Northwestern testifying that "people prefer to receive inpatient hospital care near to where they live"); JX 27 Steele Dep. at 25:15-17 (defense expert testifying that "patients tend to go to nearby or local hospitals"), PX 2008, Hall [NorthShore] IH Tr. at 187:9-18 (testifying that "[f]or more ordinary in-patient procedures, . . . patients prefer to receive care closer to home"), *with* Tr. at 158:1-2, 246:12-23 (Hamman of BCBSIL testifying that "people get most routine care," which is largely outpatient, "close to where they live"); *id.* at 330:14-16 (Dechene testifying that Northwestern "seeks to provide care where patients live and work"), *id.* at 1130:8-11 (Beck of United Healthcare testifying that "some patients prefer to receive care near their homes," but where a patient receives care is "really a personal decision of each member"); *id.* at 83:15-84:8 (Norton of CIGNA testifying that CIGNA's members in northern Cook and Southern Lake Counties "[t]ypically . . . seek care in their own communities, but some . . . travel to where they work or for a higher level of care"); *id.* at 1169:15-22 (Nettesheim of Aetna testifying that in Chicago, people "live[] in one place and work[] in another and often receive[] [medical] services at both locations," and that "there was up to a 40-mile difference between where people lived and worked, . . . utiliz[ing] services at both ends"); [redacted]; JX 28,

calculated.

Tallarico [Advocate] Dep. 272:20-23 ("[W]hen . . . something is considered routine, [patients] expect to be able to stay within their local health community").) Finally, Tenn's exclusion of destination hospitals ignores "the commercial realities of th[is] industry," *Brown Shoe*, 370 U.S. at 336 (quotation and footnote omitted), specifically that: (1) payers negotiate a single contract with a hospital system for both inpatient and outpatient services (*see* Tr. at 241:15-20 [Hamman-BCBSIL]; *id.* at 76:20-77:1, 78:13-16, 79:24-80:5 [Norton-CIGNA]; *id.* at 1117:10-15 [Beck-United]); JX 19, Maxwell Dep. [Humana] at 98:16-99:1; DX 1878 Montrie Dep. [Land of Lincoln] at 98:11-20); (2) outpatient services are on the rise and inpatient services on the decline (*see* Tr. at 767:4-11 (Golbus of NorthShore testifying that "[t]here's been tremendous growth [in outpatient services] over the last five years as technology and advances in medical care have made it much more easy to do these procedures outside the inpatient environment," inpatient services are "[c]ontinually" declining, and "for most patients today, an inpatient admission is a very rare or never event"); *id.* at 659:16-18 (Neaman of NorthShore testifying that two-thirds of NorthShore's revenues come from outpatient services); JX 19, Maxwell Dep. at 95:1-97:16 (testifying on behalf of Humana that inpatient volume is "trending down" and expected to continue to decline) [redacted]; and (3) outpatient services are a key driver of hospital admissions (*see* Tr. at 345:19-346:10 (Dechene testifying that outpatient facilities and doctor's offices are "front doors" to the hospital); *id.* at 1116:14-18 (Beck testifying that "a member's physician relationship influence[s] where they seek hospital care"); JX 24, Reilly Dep. at 45:7-12 (testifying on behalf of Presence

that "physicians . . . have a very significant effect on patient's [sic] choice of hospitals for inpatient services"); JX 3, Bagnall Dep. at 37:2-8 (testifying on behalf of University of Chicago Medical Center that "patients don't shop for inpatient providers, they shop for physicians" and "it's the physician who makes the decision of what inpatient facility that patient goes to"); [redacted]; JX 19, Maxwell Dep. at 94:1-24 (testifying on behalf of Humana that hospitals "extend their geographic breadth" by opening outpatient centers and doctor's offices further from the hospital, and the doctor "plays a significant role [in determining] where [a] patient goes to seek care"); JX 23, Primack [Advocate] Dep. at 76:6-14 ("[O]rganizations' satellite facilities . . . are funnels to an organizational partnership of patient referrals"); DX 1878, Montrie Dep. at 81:1-4 (testifying on behalf of Land of Lincoln that "a patient's physician plays a significant role in where the patient goes to seek care"); DX 1880 Pugh [FTC] Dep. at 370:15-19 (testifying that "referring physicians play a role in their patients' choices for inpatient services")).

The third criterion Tenn used to construct the market, including hospitals that overlap with both Advocate and NorthShore rather than just one of them, is also problematic. Tenn states that this criterion is designed to determine which hospitals "would be the next best alternative" for the patients whose first and second hospital choices are the merging parties. (Tr. at 465:6-12.) However, instead of analyzing data to make this determination, Tenn simply assumes the answer – that "those . . . hospitals are likely to be in the areas which overlap with both Advocate and NorthShore." (*Id.* at 465:10-12.) But, as defense expert McCarthy pointed

out, "you can constrain the postmerger system by constraining any [one] of its hospitals" (*id.* at 1224:7-8), so requiring a hospital to constrain both parties to be included in the geographic market makes little sense. In short, plaintiffs have not shouldered their burden of proving a relevant geographic market. Absent that showing, they have not demonstrated that they have a likelihood of succeeding on their Clayton Act claim. Therefore, the Court denies plaintiffs' motion for a preliminary injunction [152].

SO ORDERED. **ENTERED: June 20, 2016**

HON. JORGE L. ALONSO
United States District Judge