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.

Appeal from the United States District Court for the
Northern District of Illinois, Eastern Division
Case No. 1:15-cv-11473
Hon. Jorge L. Alonso, presiding

BRIEF OF APPELLEES

(*Public Version*)

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

APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 16-2492

Short Caption: Federal Trade Commission, et al. vs. Advocate Health Care Network, et al.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party or amicus curiae, or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

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(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P 26.1 by completing item #3):

NorthShore University Health System

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Winston & Strawn, LLP

(3) If the party or amicus is a corporation:

i) Identify all its parent corporations, if any; and

None

ii) list any publicly held company that owns 10% or more of the party's or amicus' stock:

None

Attorney's Signature: s/ Linda T. Coberly Date: August 1, 2016

Attorney's Printed Name: Linda T. Coberly

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** X **No** ____

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None

Attorney's Signature: s/ David E. Dahlquist Date: August 1, 2016

Attorney's Printed Name: David E. Dahlquist

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ____ **No** X

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Appellee Advocate Health Care Network is the parent of Appellee Advocate Health and Hospitals Corp.

ii) list any publicly held company that owns 10% or more of the party's or amicus' stock:

None

Attorney's Signature: s/ Daniel J. Delaney Date: August 1, 2016

Attorney's Printed Name: Daniel J. Delaney

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ____ **No** X

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None

Attorney's Signature: s/ Robert W. McCann Date: August 1, 2016

Attorney's Printed Name: Robert W. McCann

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ____ **No** X

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E-Mail Address: robert.mccann@dbr.com

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None

Attorney's Signature: s/ Andrew C. Nichols Date: August 1, 2016

Attorney's Printed Name: Andrew C. Nichols

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ____ **No** X

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None

Attorney's Signature: s/ Leigh L. Oliver Date: August 1, 2016

Attorney's Printed Name: Leigh L. Oliver

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** _____ **No** X

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None

Attorney's Signature: s/ Michael S. Pullos Date: August 1, 2016

Attorney's Printed Name: Michael S. Pullos

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ____ **No** X

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None

Attorney's Signature: s/ Conor A. Reidy Date: August 1, 2016

Attorney's Printed Name: Conor A. Reidy

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ____ **No** X

Address: Winston & Strawn, LLP, 35 W. Wacker Drive, Chicago, Illinois, 60601

Phone Number: (312) 558-7542 Fax Number: (312) 559-5700

E-Mail Address: CReidy@winston.com

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None

Attorney's Signature: s/ John L. Roach Date: August 1, 2016

Attorney's Printed Name: John L. Roach, IV

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ____ **No** X

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Phone Number: (202) 230-5129 Fax Number: (202) 842-8465

E-Mail Address: lee.roach@dbr.com

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None

Attorney's Signature: s/ J. Robert Robertson Date: August 1, 2016

Attorney's Printed Name: J. Robert Robertson

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** X **No** ____

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None

Attorney's Signature: s/ Catherine E. Stetson Date: August 1, 2016

Attorney's Printed Name: Catherine E. Stetson

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** _____ **No** X

Address: 555 13th Street NW, Washington, DC 20004

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Attorney's Signature: s/ Jonathan H. Todt Date: August 1, 2016

Attorney's Printed Name: Jonathan H. Todt

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Address: Drinker Biddle & Reath LLP,
1500 K Street, N.W., Suite 1100, Washington, DC 20005

Phone Number: (202) 230-5823 Fax Number: (202) 842-8465

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The Court prefers that the disclosure statement be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

[ ] PLEASE CHECK HERE IF ANY INFORMATION ON THIS FORM IS NEW OR REVISED AND INDICATE WHICH INFORMATION IS NEW OR REVISED.

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P 26.1 by completing item #3):

Advocate Health Care Network

Advocate Health and Hospitals Corp.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Drinker Biddle & Reath LLP

Hogan Lovells US LLP

(3) If the party or amicus is a corporation:

i) Identify all its parent corporations, if any; and

Appellee Advocate Health Care Network is the parent of Appellee Advocate Health and Hospitals Corp.

ii) list any publicly held company that owns 10% or more of the party's or amicus' stock:

None

Attorney's Signature: s/ Kenneth M. Vorrasi Date: August 1, 2016

Attorney's Printed Name: Kenneth M. Vorrasi

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ____ **No** X

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APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 16-2492

Short Caption: Federal Trade Commission, et al. vs. Advocate Health Care Network, et al.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party or amicus curiae, or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

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(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P 26.1 by completing item #3):

NorthShore University Health System

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Winston & Strawn, LLP

(3) If the party or amicus is a corporation:

i) Identify all its parent corporations, if any; and

None

ii) list any publicly held company that owns 10% or more of the party's or amicus' stock:

None

Attorney's Signature: s/ Dan K. Webb Date: August 1, 2016

Attorney's Printed Name: Dan K. Webb

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ____ **No** X

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INTRODUCTION

This appeal concerns a district court's fact-driven determination that Appellants failed to prove a geographic market—a necessary predicate for their Clayton Act claim. Advocate and NorthShore have agreed to merge their health care systems into one, thereby lowering heath care costs and improving the quality of care for patients across Chicagoland. The FTC and the State of Illinois (collectively "FTC" or "Appellants") sought to enjoin that merger. After an eight-day evidentiary hearing, the court denied a preliminary injunction, finding the FTC's showing deficient in two respects. *First*, the proposed market arbitrarily excludes what the FTC labels "destination hospitals"—hospitals that draw from all across Chicagoland. The court found "no economic basis" for this exclusion, which "assumes the answer to the very question the geographic market exercise is designed to elicit" and rests on an unproven factual premise. Am. Mem. Op. & Order 9, 10, ECF No. 484 ("Op."). *Second*, the FTC's carve-out of nearby hospitals that are significant competitors of Advocate *or* NorthShore, but not both, "makes little sense." *Id.* 12-13.

Appellants have failed to show any error—much less clear error—in these findings. Further, their brief does exactly what the Supreme Court and the FTC's own *Merger Guidelines* forbid: it tries to use a hypothetical calculation to justify a market that excludes close competitors and "ignore[s] 'the commercial realities of th[e] industry.'" *Id.* 11 (quoting *Brown Shoe Co. v. United States*, 370 U.S. 294, 336 (1962)). This Court should reject that tactic and affirm the decision in all respects.

JURISDICTIONAL STATEMENT

The statement of jurisdiction in Appellants' brief is complete and correct.

STATEMENT OF THE ISSUE

Did the district court commit clear error in rejecting the FTC's proposed geographic market, finding that the FTC had not proven that its market included all hospitals to which consumers "can practicably turn" as a substitute in the event of a price increase at the merging hospitals? *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 359 (1963).

STATEMENT OF THE CASE

A. Hospital competition across Chicagoland

This case is about health care delivery in Chicagoland, where more than 70 hospitals compete to provide "general acute care inpatient services" (the product market in this case) to Chicago-area residents who require these services. These hospitals compete intensely with one another—by improving quality, expanding services, establishing outpatient and physician offices to refer patients to these hospitals, and lowering prices. The map below shows some of the 70-plus hospitals and hospital systems providing the relevant services in the Chicago metropolitan area:

DX5000, Ex. 3.

Though Chicagoland has many hospitals, it has few insurers. By far the largest is Blue Cross Blue Shield of Illinois ("Blue Cross"), which "dominate[s]" over

70% of the market and thus has immense bargaining power. Op. 3; Hr'g 205:2-6; *infra* 52-53. Other area insurers include United Health Group, Aetna, Cigna, Humana, and Land of Lincoln. Op. 3. Insurers (or "payers") negotiate to create networks of health care providers that they believe will be attractive to their own customers—predominantly employers and their employees. *Id.* 2. They consider a variety of factors in deciding whether to include a hospital in a network, including "'the attractiveness of that hospital, the quality, the reputation of that hospital, … its willingness to … meet certain price points,' and its geographic coverage." *Id.* (citation omitted). Because the insurer's own business plans depend on attracting employers and their employees as customers, patient preferences matter a great deal.[1]

Neither insurers nor customers regard the Chicagoland area as having any strict geographical subdivisions. Insurers uniformly view their market as consisting of members who reside throughout the entire Chicagoland area, and they assemble networks accordingly.[2]

Although the FTC asserts that patients prefer "local" hospitals—described as those "close to home" (FTC Br. 43)—the district court found the evidence on this point to be "equivocal." Op. 10. Indeed, the record evidence shows that Chicagoland

[1] PX6000, ¶ 43.

[2] *See, e.g.,* Hr'g 1168:5-1169:12; Hr'g 1170:23-1171:10 (Aetna examines a seven-county market, not a northern Cook County/southern Lake County market); *see also* Hr'g 241:2-14 (testifying that Blue Cross at times analyzes the Chicago metropolitan area beyond six counties); [redacted].

patients have a very different understanding of "local" than the FTC does.[3] Even for non-specialized services, like surgeries or childbirth, patients in Chicagoland often drive by closer hospitals to reach their preferred option. *See infra* 36. Further, in an area like Chicagoland with long work-commute times, patients seek care not only near where they live but frequently near where they work.[4] One analysis performed by Aetna, for example, found that there may be "up to a 40-mile difference between where people lived and worked," and Chicago area patients "utilized services at both ends."[5]

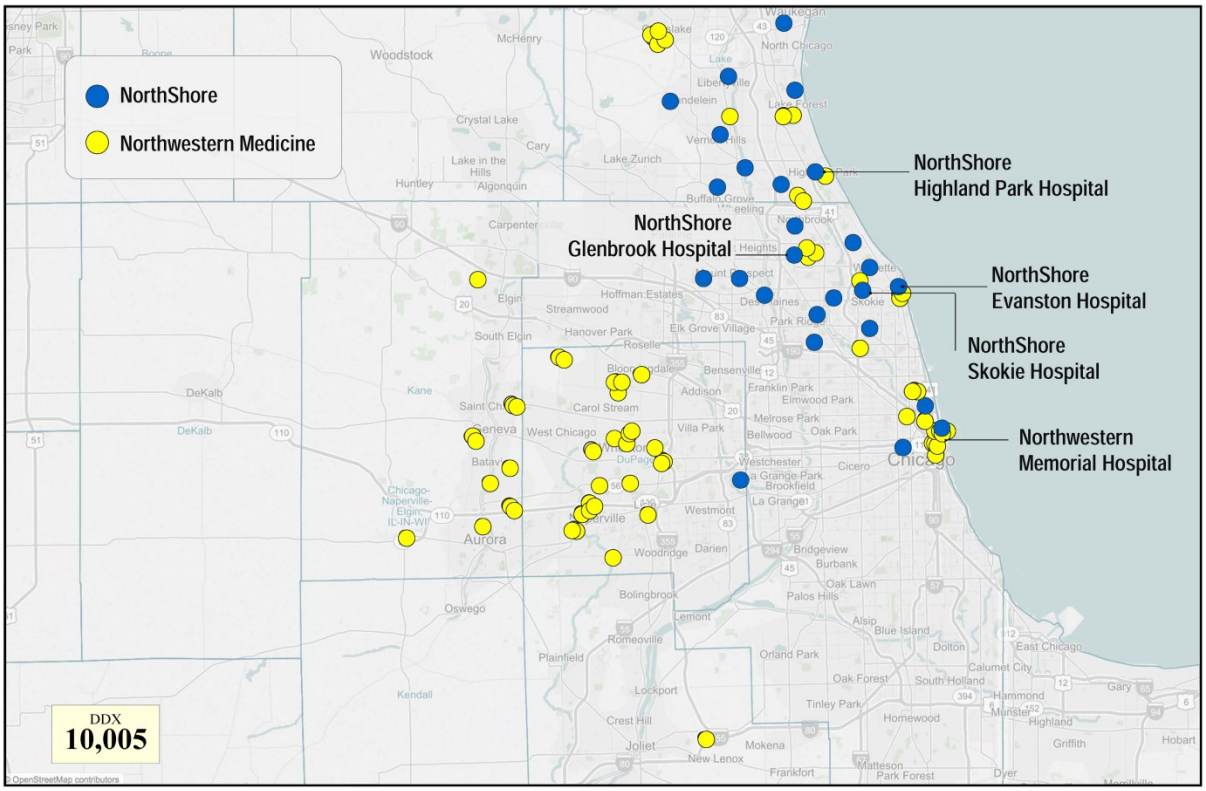
Where patients choose to obtain inpatient services in Chicagoland is also influenced by the advice of their physicians. Hospitals in Chicagoland are well aware of this important factor, and they use it as part of their inpatient growth strategies. Op. 11-12. Northwestern Memorial, for example, has opened outpatient facilities and physician offices throughout the lakefront suburbs as a means to draw patients to its downtown hospital for inpatient services.[6] These facilities and offices are shown as yellow dots in the map below, geographically interspersed with the hospitals in the NorthShore system:

[3] *See, e.g.*, [redacted]; JX00004, Butler Dep. 144:5-18.

[4] Hr'g 83:25-84:8; Hr'g 1116:6-13; Hr'g 330:14-25 (A35).

[5] Hr'g 1169:13-1170:4.

[6] Hr'g 346:3-10, 362:1-13.



Such outpatient centers operate as "front doors" for patients to enter those particular hospital systems, and doctors in those centers admit the majority of their patients to the hospitals with which they are affiliated even if the hospitals are somewhat farther away from the patients' homes.[7]

B. Advocate's and NorthShore's complementary strengths

Advocate is a faith-based health care system with ten hospitals in Chicagoland (and two more in central Illinois).[8] Although Advocate operates many facilities

[7] *Id.* (testifying that Northwestern's outpatient centers are "front doors" for patients to enter its system and physicians admit the majority of their patients to Northwestern hospitals); *see also* JX00019, 93:13-94:24 (testifying that hospital systems extend their geographic breadth by establishing outpatient and physician locations further from their hospitals).

[8] *About Advocate*, http://www.advocatehealth.com/overview-of-advocate (last accessed Aug. 1, 2016).

in Chicagoland,[9] it has no presence in the northern Chicago suburbs along Lake Michigan.[10] NorthShore was one of the options insurers identified to Advocate to fill that geographic gap because NorthShore has four hospitals plus many outpatient clinics and doctors' offices in the lakefront suburbs where Advocate is absent.[11] Accordingly, from Advocate's perspective, NorthShore is an excellent complement to its own facilities in terms of geographic coverage.

Advocate complements NorthShore's existing services by providing special expertise in proactive delivery of health care services (known in the industry as "Population Health Management") and in the related area of taking and managing full financial risk for insured populations.[12]

C. The proposed merger and its benefits for consumers

In September 2014, Advocate and NorthShore ("Defendants," or the "Hospitals") agreed to merge to maximize their complementary strengths. The new entity, Advocate NorthShore Health Partners, will be able to offer more Chicagoland patients and employers better health outcomes with a new low-cost network.[13] The combined system will be *low-cost* because it will practice proactive medicine—

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[9] *See Outpatient Locations*, http://www.advocatehealth.com/outpatient-locations (last accessed Aug. 1, 2016); *Advocate Medical Group*, http://www.advocatehealth.com/amg-location (last accessed Aug. 1, 2016).

[10] Hr'g 1434:10-1435:14; DX7004B.0005.

[11] Hr'g 1440:15-23, 1452:8-12, 1434:10-1435:2, 1454:19-1455:11, 1483:1-17; Hr'g 1178:25-1179:6; Hr'g 659:2-4, 674:9-20.

[12] Hr'g 162:7-13, 219:15-220:3; Hr'g 792:10-22; Hr'g 1418:21-1419:22, 1431:19-14:32-10, 1478:4-8; DX0064.0082; DX7000, ¶¶ 9, 19.

[13] Hr'g 1389:14-22.

keeping patients healthy and thus out of the hospital—and its patients will enjoy the economic benefits of this approach through Advocate's market-leading experience managing patient populations under full-risk contracts.[14]

These benefits are not theoretical. The merger will allow Chicagoland insurers to offer this low-cost, integrated system in a package attractive to small and large employers, which comprise almost 90% of the Chicagoland commercial insurance market.[15] Indeed, the evidence at the hearing showed that 86% percent of Chicago-area employers surveyed indicated that they were interested in offering such a network, and 25% said they would be very likely to offer it as the sole option.[16] Insurers are also very interested. Even Blue Cross, which opposes the merger, testified that it wants to offer the Advocate-NorthShore low-cost network to employers.[17] Three other insurers (United, Aetna and [redacted]), as well as the largest insurance broker in Illinois (Aon), testified that they are ready to offer it, too.[18]

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[14] Hr'g 1389:23-1390:9; PX04018-005; Hr'g 796:19-24.

[15] Hr'g 1423:23-1424:9 (over 4.8 million Chicagoland residents purchase their health care through their employer); Hr'g 1492:10-14, 1500:3-8; [redacted].

[16] DX8100, ¶¶ 9, 25, 28, 31, 33; Hr'g 1042:19-1043:9, 1048:1-9, 1051:17-1052:14, 1055:3-19.

[17] Hr'g 217:18-218:4.

[18] Hr'g 1193:5-14 (SA15); [redacted]; Hr'g 1416:8-23, 1417:16-22; Hr'g 1452:25-1453:6; DX6000, ¶¶ 19, 34-36, 49, 34 n.39-42; JX00017, Levin Dep. 153:22-154:4; [redacted]; DX2009.0002 (SA20).

The consumer savings will be substantial—from $284 to $1,426 per person per year in insurance premium costs.[19] Indeed, as the Hospitals' economic expert testified, the participation of only 1% to 4% of the Chicago-area employer group market in the Advocate-NorthShore network would create annual premium cost savings for consumers of at least $45 million.[20] Even a modest increase in the enrollment of large-group employers would result in more than $200 million in additional consumer savings, with reasonable estimates approaching $500 million.[21]

The merger will also benefit consumers by making NorthShore's doctors more affordable. Today, pre-merger, Chicago-area health insurers pay NorthShore physicians more than Advocate physicians.[22] But post-merger, insurers are contractually entitled to select which contract with the pre-merger firms they wish to honor, and they will undoubtedly choose the lower-priced option.[23] [redacted].[24] That will save insurers $30.2 million every year.[25]

Despite these savings and its own demonstrated market power, Blue Cross opposes the Advocate-NorthShore merger, as does Cigna. Op. 9 n.4. All the re-

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[19] Hr'g 1503:10-19; DX6000, tbls. 1A-1F; *id.* ¶¶ 32 n.28, 39, 58, tbl.4; DDX11002.0021.

[20] Hr'g 1505:1-1507:15; DX6000, ¶¶ 8; 58 tbl. 4; DDX11002.0023, 0036.

[21] Hr'g 1427:5-1428:10; 1429:23-1430:14; 1431:13-18.

[22] DX6000, ¶ 71.

[23] Hr'g 1424:10-1425:3.

[24] [redacted]

[25] Hr'g 1519:15-1520:13; DDX11002.044.

maining insurers—Aetna,[26] United Health Group,[27] Humana,[28] and Land of Lincoln[29]—favor it. Blue Cross opposes the merger because it [redacted],[30] based on the fear that Advocate would partner with Blue Cross's rivals, allowing those insurers to gain market share at Blue Cross's expense by selling the new, low-cost Advocate-NorthShore network to employers.[31] Indeed, even Cigna initially favored the merger and submitted a letter to Advocate supporting it[32] before changing its position when it learned that Advocate had contracted with Blue Cross—which sought to "box out" its competitors—for Advocate's pre-merger "Advocate-only" network available only to individuals and certain small employers.[33]

D. This lawsuit and the evidentiary hearing

Even though four Chicagoland insurers support the Advocate-NorthShore merger, the FTC and State of Illinois filed this action to enjoin it. Over the ensuing two months, the parties completed extensive discovery from competitor hospitals,

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[26] Hr'g 1189:6-11 (SA11), 1190:10-1191:15 (SA12-13), 1192:14-1193:4 (SA14-15), 1196:9-17.

[27] Hr'g 1114:7-24 (SA3), [redacted]; DX0003.0001.

[28] [redacted]; DX1517.0001.

[29] DX1878 12:23-13:20 (SA18-19); DX1582.0001.

[30] [redacted]

[31] Hr'g 220:21-221:14, 221:22-222:6.

[32] DX1276.0001.

[33] Hr'g 132:6-133:6, 135:6-10; [redacted]; DX1106.0001 ("true value to us will be to box out our competitors and retain competitive advantage …").

insurers and employers in Chicagoland—obtaining more than 2.8 million pages of documents and taking 36 depositions. ECF No. 187 at 1-2.

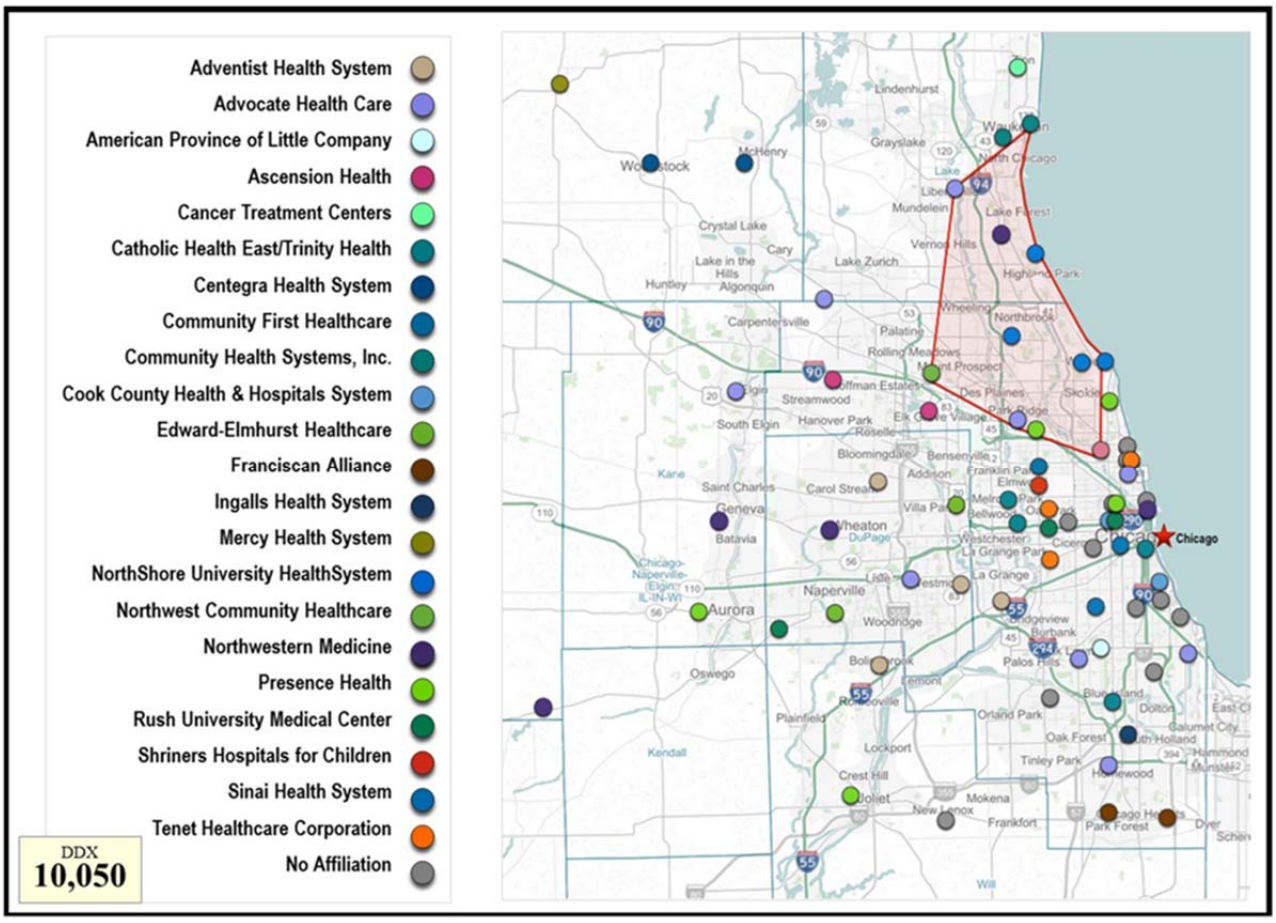
The district court conducted an eight-day evidentiary hearing, receiving 368 exhibits and hearing live testimony from fifteen witnesses. The FTC presented the testimony of the General Counsel of a competitor hospital (Northwestern Memorial), two insurers with business reasons to oppose the merger (Blue Cross and Cigna), and two expert witnesses. The Hospitals presented testimony by two insurers supportive of the merger (Aetna and United), four expert witnesses, and four Advocate and NorthShore executives. The main dispute at the hearing concerned the requirement that the FTC prove a relevant geographic market—the area in which "the seller operates and to which [customers] can practicably turn for supplies." *Phila. Nat'l Bank*, 374 U.S. at 359; *see also infra* 24-25.

1. The FTC's proposed "North Shore Area" market

According to the FTC, the relevant geographic market consists of eleven selectively chosen hospitals located in Cook and Lake Counties, all providing general acute care. These eleven hospitals include six owned by either Advocate or NorthShore (Advocate Lutheran General Hospital, Advocate Condell Medical Center, NorthShore Evanston Hospital, NorthShore Skokie Hospital, NorthShore Glenbrook Hospital, and NorthShore Highland Park Hospital) and five owned by competitors (Vista Medical Center East, Northwest Community Hospital, Presence Resurrection Medical Center, Swedish Covenant Hospital, and Northwestern Lake Forest Hospital). The FTC refers to the area containing these hospitals—an oddly drawn irregular polygon—as the "North Shore Area." *See* FTC Br., Addendum

(map showing the "North Shore Area"). There is no evidence, however, that any insurer, patient or health care provider has ever treated this novel geographic subdivision as a distinct market for inpatient services.

Notably, the FTC's "North Shore Area" omits many competing hospitals. In particular, the FTC carved out a panhandle along Lake Michigan to exclude Presence St. Francis, which sits just three miles down the street from NorthShore's Evanston Hospital and is both farther north and closer to the lake than Swedish Covenant and Presence Resurrection (both of which the FTC included in its proposed market). The "North Shore Area" also omits a cluster of major hospitals just a few miles away in Chicago itself, including Northwestern Memorial, which is NorthShore's top competitor. The following map shows the large number of Chicagoland hospitals that lie outside the FTC's proposed market:



The FTC constructed its "North Shore Area" by: (1) excluding "what [FTC expert witness Dr.] Tenn 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"; and (2) including only those hospitals "that overlap with [*i.e.*, draw patients from the same area as] both Advocate and NorthShore" rather than with just one or the other. Op. 7. Oddly, although Dr. Tenn excluded all "destination hospitals" on the ground that they "are not located in the northern Chicago suburbs" (*id.* (quoting Dr. Tenn)), he included two hospitals in the FTC's proposed market that are located

in Chicago itself. Dr. Tenn also admitted that several of the excluded hospitals (like Northwestern Memorial, Rush, University of Chicago, and Presence St. Francis) are, in fact, substitutes for the party hospitals—and in many cases are among the top alternatives.[34]

By excluding such hospitals, Dr. Tenn could not say that he included all hospitals to which "purchasers can practicably turn," as the law requires. *Phila. Nat'l Bank*, 374 U.S. at 359. Instead, in an attempt to rationalize his curiously-shaped geographic market, Dr. Tenn invoked his own version of the "hypothetical monopolist test," employing an economic model that has never been used in or accepted by any court. Applying his own version of this test, Dr. Tenn claimed that a hypothetical monopolist of the eleven hospitals in his already-defined "North Shore Area" could impose a small but significant and non-transitory increase in price (referred to in the FTC's *Horizontal Merger Guidelines* as a "SSNIP").[35] This, the FTC claims, is enough to justify Dr. Tenn's market no matter how it was constructed—and no matter whether it included all practicable substitutes to which customers can turn. *See*, *e.g.*, FTC Br. 23, 32-34.

2. Hospitals near or adjacent to the FTC's proposed market

The Hospitals, for their part, showed that patients and insurers who use Advocate and NorthShore, and other patients residing in the "North Shore Area," not

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[34] *See* Op. 9; Hr'g 453:19-23 (A53), 527:6-17, 536:18-537:06.

[35] FTC & DOJ, *Horizontal Merger Guidelines* §§ 4.1.1, 4.2.2 (2010), https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf (SA22-28).

only *can* but *do* "practicably turn" to other Chicagoland hospitals like Northwestern Memorial, Rush, University of Chicago, Lurie, and Presence St. Francis, among others. Indeed, the district court heard substantial testimony that Chicago-area hospitals outside the FTC's "North Shore Area" can and do strongly compete with hospitals within that same area.[36]

Dr. Tenn could not identify any literature defining (much less endorsing) the term "destination hospital," and insurers testified that *no* Chicagoland hospital fit any definition of "destination hospital" they could fathom, such as when patients travel "outside of the United States, and they can recover on a beach."[37]

Testimony by both NorthShore and insurer witnesses showed that Northwestern Memorial near downtown Chicago—excluded from the FTC's market—is, in fact, NorthShore's top competitor and closest substitute.[38] An Aetna executive testified that Northwestern Memorial and NorthShore are "pretty much interchangeable."[39] Northwestern Memorial has opened outpatient facilities and physician offices in the northern suburbs near the Lake and uses them as a "front door" to feed inpatient admissions to its hospital near downtown Chicago, adding "a dozen, 15"

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[36] *See supra* 5-6; *see also*, *e.g.*, Hr'g 1116:6-13; Hr'g 83:25-84:8; Hr'g 330:14-16 (A35); *see also* Hr'g 1169:13-1170:4.

[37] Hr'g 515:24-516:8; Hr'g 1118:6-13 (SA4); Hr'g 1170:15-22 (SA10) ("Q. In your 15 years in the Chicagoland health care market, have you ever heard a Chicago hospital referred to as a destination hospital? A. I have not heard of a specific Chicago hospital referred to as a destination hospital.").

[38] Hr'g 690:18-25; Hr'g 1118:20-1119:3.

[39] Hr'g 1183:16-25.

such offices "in the last few years."[40] Dr. Tenn admitted that his data showed Northwestern Memorial to be the top alternative for *both* NorthShore and Advocate.[41]

As the district court explained, the FTC "measured the level of substitution" from one hospital to another by calculating "diversion ratios"—that is, "the fraction of patients who use one hospital for [general acute care] services that would switch to another hospital, if their first-choice hospital were no longer available." Op. 8. In colloquial terms, a hospital's "diversion ratio" identifies its patients' next best alternatives.[42]

Those ratios showed that Northwestern Memorial is the first alternative choice of patients of two of the four NorthShore hospitals, and it is the first choice for *all four NorthShore hospitals* combined.[43] Still further, it is the preferred alternative choice for *all four Advocate hospitals* located in or near the "North Shore Area."[44] Other excluded "destination hospitals" located in or near Chicago itself—such as Rush, University of Chicago, and Lurie—also are significant alternatives for NorthShore and Advocate hospitals located in that area based on the FTC's diversion ratio analysis.[45]

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[40] Hr'g 335:16-22, 342:6-25, 346:3-10; Hr'g 675:8-11, 688:23-689:8.

[41] Hr'g 540:8-14, 615:7-19.

[42] Hr'g 559:23-560:1.

[43] PX6000, tbl. 9 (SA2); DX5001, ¶ 45.

[44] PX6000, tbl. 9 (SA2); Hr'g 540:8-14.

[45] PX6000, tbl. 9 (SA2); DX5001, ¶¶ 45, 74; Hr'g 1241:14-25.

E. The district court's ruling

After the eight-day evidentiary hearing, and after carefully reviewing the extensive evidentiary record and the parties' post-hearing submissions, the district court denied the FTC's motion for a preliminary injunction. Op. 13. The court found that the FTC failed to show a likelihood of success on the merits of its challenge because it failed to shoulder its burden of proving a relevant geographic market—"'a necessary predicate' to deciding whether a merger contravenes the Clayton Act." *Id.* 5, 12-13 (quoting *United States v. Marine Bancorp., Inc.*, 418 U.S. 602, 618 (1974)).

The court found that the FTC and its expert, Dr. Tenn, had provided "no economic basis" for distinguishing "destination" hospitals from "local" hospitals and that his analysis was "flawed." Op. 9. In fact, the court explained, the FTC's purported "rationale for excluding [destination] 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?" *Id.* (citing *Phila. Nat'l Bank*, 374 U.S. at 359).

The court carefully examined the testimony of the FTC's two insurer witnesses that it would be difficult or impossible to market a health plan in the northern suburbs that excluded both Advocate and NorthShore. *Id.* 8, 9 n.4. But the court did not find this testimony credible, explaining that it was presented by "parties opposed to the merger" and that it was "undermined by the diversion ratios that Tenn calculated." *Id.* 9 n.4. Those diversion ratios showed that Northwestern Memorial would be the first or second most common alternatives for patients of five of the six

party hospitals in the FTC's "North Shore Area," if the patients' first choice were unavailable. *Id.* 8, 9.

The court further found that the FTC's "exclusion of destination hospitals ignores 'the commercial realities of th[is] industry'" in other respects as well. *Id.* 10-11 (quoting *Brown Shoe*, 370 U.S. at 336). The court based this finding in part on evidence showing the role that *outpatient* services play in driving a patient's choice of a hospital for *inpatient* services. As the court observed: "outpatient services are a key driver of hospital admissions[.]" *Id.* 10-12 (citations omitted). This evidence undermines the exclusion of the so-called "destination" hospitals, particularly given Northwestern Memorial's efforts to open "front door" outpatient facilities within the FTC's "North Shore Area." *See supra* 5-6.

Finally, the court rejected the FTC's reasoning for excluding "local" hospitals that purportedly compete with either Advocate or NorthShore but not both. As the court explained, Dr. 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. 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.' But, as defense expert [Dr. Thomas] McCarthy pointed out, 'you can constrain the postmerger system by constraining any [one] of its hospitals,' so requiring a hospital to constrain both parties … makes little sense." *Id.* 12.

Given the lack of both factual and economic support for the FTC's proposed market, the district court found that Appellants "had not shouldered their burden of proving a relevant geographic market" and, therefore, "have not demonstrated that they have a likelihood of succe[ss]" on their merger challenge. *Id.* 12-13. Having reached this conclusion, the court found it unnecessary to address whether the merger's consumer benefits outweighed any potential anticompetitive effects.

The day after the district court denied the motion for a preliminary injunction, Appellants filed this appeal. ECF No. 474. The district court granted an injunction pending resolution of the appeal before this Court. ECF Nos. 481, 520.

SUMMARY OF ARGUMENT

I. The FTC is required to define the relevant geographic market as a "'necessary predicate'" to its Clayton Act claim. *Marine Bancorp.*, 418 U.S. at 618 (citations omitted). The relevant geographic market is the area in which consumers "can practicably turn" if prices at their first-choice hospital increase. *Phila. Nat'l Bank*, 374 U.S. at 359.

The factual record amply supports the district court's decision to reject the FTC's proposed "North Shore Area" market. The court correctly recognized that excluding so-called destination hospitals "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. Further, this exclusion "'ignore[s] the commercial realities of th[is] industry.'" *Id.* 10-11. The evidentiary record confirms that no one—insurers, patients, or providers—has ever regarded the FTC's gerrymandered, eleven-hospital market to be a distinct market for inpatient ser-

vices. The evidence shows that patients at hospitals in the FTC's "North Shore Area" can and do turn to the so-called "destination hospitals" in and near downtown Chicago as alternatives. For two of the party hospitals, in fact, Northwestern Memorial is the *closest* substitute.

Appellants argue that the "destination hospitals" are no substitute from the perspective of *insurers*, claiming that a few of them testified that they would not be able to sell a hospital network to certain employers if it excluded the eleven supposedly "local" hospitals in the proposed market. This misstates the testimony, which actually concerned the importance of Advocate and NorthShore hospitals throughout Chicagoland, not the eleven hospitals in the "North Shore Area." In any event, the court found this testimony not credible, in light of both witness bias (from insurers opposed to the merger) and the FTC's own "diversion ratios." There is no basis for upsetting that finding on appeal.

The district court correctly rejected the FTC's effort to further gerrymander its market by carving out nearby hospitals—including one just a few minutes down the street in the same suburb—that are close competitors with *either* Advocate *or* NorthShore but not both. *Id.* 12-13. This too "assumes the answer" and "makes little sense." *Id.* As the Hospitals' expert explained, a hospital that currently competes with one system or the other can still discipline prices in the merged system by draining away patients. It was no error at all for the court to credit that expert's analysis.

II. The FTC cannot avoid the clear deficiencies in its proposed market by performing a mathematical test on that unsupported candidate market. Appellants' brief insists that "[t]he standard test that courts, agencies, and economists use to define markets under these principles is the hypothetical monopolist test." But no court has ever held that this "test" can justify a market that overtly excludes close competitors to which consumers "can practicably turn." Indeed, it has been horn-book law for 50 years that "[t]here is no formula for determining the geographic market," *id.* 6 (citing *Brown Shoe*, 370 U.S. at 336-37), which is no doubt why this Court has evaluated mergers for years without applying any such formula. As the FTC told the Third Circuit recently, "[i]n antitrust analysis, economic realities rather than a formalistic approach must govern." The district court did not err here—clearly or otherwise—in declining to allow a formalistic test to justify a market that plainly ignores economic realities.

The FTC's own *Merger Guidelines* underscore this conclusion. Under the *Guidelines*, a proposed geographic market must be rejected if it excludes close competitors, *even if, under a "SSNIP" analysis, a price increase could be profitably imposed without them*. *See* SA22-23, § 4.1.1 & ex. 6. The FTC's proposed market excludes hospitals—*e.g.*, Presence St. Francis, Northwestern Memorial, and Rush—that are closer substitutes for the party hospitals than are many of the hospitals included in the FTC's proposed market. Thus, the FTC misapplies its own *Guidelines*.

Lastly, even if the FTC's hypothetical monopolist test in theory could save its ill-defined market, the FTC failed to prove an essential element of that test—that

is, that any imposed price increase would be profitable. As another Circuit has explained, "it is possible for only a few customers who switch to alternatives to make the price increase unprofitable, thereby protecting a larger number of customers who would have acquiesced in higher ... prices." *United States v. Engelhard Corp.*, 126 F.3d 1302, 1306 (11th Cir. 1997). Yet, at trial, the FTC failed to elicit any testimony that it would be *profitable* for a hypothetical monopolist to implement a price increase. Indeed, given the highly concentrated insurance market in Chicagoland, even a small price increase puts the hypothetical monopolist at risk of losing as much as 72% of its commercial patient business if just one insurer decided to walk away from the negotiating table. The FTC's assumptions about bargaining in this market are divorced from the factual record and confirm that the district court reached the correct conclusion.

STANDARD OF REVIEW

This Court reviews a district court's findings of fact for clear error. *United Air Lines, Inc. v. Air Line Pilots Ass'n, Int'l*, 563 F.3d 257, 269 (7th Cir. 2009). The definition of an antitrust geographic market "within which to measure the effects on competition of the proposed [merger] is a question of fact." *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1329 (7th Cir. 1981). The FTC's challenges to the district court's findings are therefore reviewed under a clear error standard. *Winforge, Inc. v. Coachmen Indus., Inc.*, 691 F.3d 856, 868 (7th Cir. 2012).

A finding of fact is clearly erroneous only when there exists a "definite and firm conviction that a mistake has been committed." *Anderson v. Bessemer City*, 470 U.S. 564, 573 (1985). And only a factual interpretation that is "'implausible,

illogical, internally inconsistent or contradicted by documentary or other extrinsic evidence'" rises to this level. *Furry v. United States*, 712 F.3d 988, 992 (7th Cir. 2013) (citation omitted). "Where there are two permissible views of the evidence, the factfinder's choice between them cannot be clearly erroneous," and this Court "may not reverse" even if it would have weighed the evidence differently. *Anderson*, 470 U.S. at 574. The burden rests squarely on the FTC's shoulders to demonstrate that "particular factual findings were clearly erroneous." *Carnes Co. v. Stone Creek Mech., Inc.*, 412 F.3d 845, 847 (7th Cir. 2005).

ARGUMENT

I. The district court did not clearly err in finding that the FTC's geographic market ignores commercial realities.

The "[d]etermination of the relevant product and geographic market is a 'necessary predicate' to deciding whether a merger contravenes the Clayton Act." *Marine Bancorp.*, 418 U.S. at 618 (citation omitted)).[46] The district court denied the FTC's motion for a preliminary injunction because its proposed geographic market failed to satisfy the controlling legal standards. Op. 13; *see, e.g., FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1051 (8th Cir. 1999) ("It is thus essential that the FTC identify a credible relevant market before a preliminary injunction may properly issue."). There was no error in that ruling.

[46] Congress deliberately placed the requirement of a geographic market into Section 7 of the Clayton Act in 1950, and deleted references to the "effect on competition between the acquiring and acquired firms." S. Rep. No. 81-1775 (1950), *as reprinted in* 1950 U.S.C.C.A.N. 4293, 4296; *see also Brown Shoe*, 370 U.S. at 317 n.30 (noting the change).

A. The geographic market must include all hospitals to which the relevant consumers can—and already do—"practicably turn" for inpatient services.

The relevant geographic market is the area in which consumers "can practicably turn" for substitute services if prices rise at their first-choice provider. *Phila. Nat'l Bank*, 374 U.S. at 359 (citation omitted); *see also, e.g., Republic Tobacco Co. v. N. Atl. Trading Co., Inc.,* 381 F.3d 717, 738 (7th Cir. 2004) (same). The FTC agrees that this is the controlling legal standard, citing this Court's decision in *Hospital Corp. of America. v. FTC*, 807 F.2d 1381, 1387 (7th Cir. 1986), for the proposition that "if purchasers could turn to hospitals outside the [proposed] market in the event of a price increase, that would mean the market should include those other hospitals." FTC Br. 31-32.[47]

Thus, "evidence of consumers' actual habits is not enough to establish [the] relevant geographic market," as courts must consider where such consumers also "could practicably go for the products and services." *Bathke v. Casey's Gen. Stores, Inc.*, 64 F.3d 340, 345-46 (8th Cir. 1995).[48] Products and services offered in more distant locations may be "practical alternatives" for consumers. *See, e.g.*, *Tenet Health*, 186 F.3d at 1052-55 (reversing district court's conclusion that FTC had

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[47] The FTC's *amici*, however, make no mention of the *Philadelphia National Bank* standard or this Court's application of that standard.

[48] *See also Doctors Hosp. of Jefferson, Inc. v. Se. Med. Alliance, Inc.*, 123 F.3d 301, 311 (5th Cir. 1997) ("Critically, evidence must be offered demonstrating not just where consumers currently purchase the product, but where consumers could turn for alternative products or sources of the product if a competitor raises prices."); *Morgenstern v. Wilson*, 29 F.3d 1291, 1296-97 (8th Cir. 1994) (rejecting proposed market because it "focused upon where Lincoln and Omaha residents actually went, as opposed to where they could practicably go," including "more distant heart programs").

proven a geographic market where "evidence shows that hospitals in [two additional] towns, as well as rural hospitals throughout the area, are practical alternatives for many ... consumers").

The geographic market also must "correspond to the commercial realities of the industry." *Brown Shoe*, 370 U.S. at 336-37. When evaluating a proposed market, courts "look to whether [it] is largely segregated from, independent of, or not affected by competition elsewhere." *Wampler v. Sw. Bell Tel. Co.*, 597 F.3d 741, 745 (5th Cir. 2010); *see also 42nd Parallel N. v. E Street Denim Co.*, 286 F.3d 401, 406 (7th Cir. 2002) (affirming dismissal of Sherman Act claim based in part on "absurdly small" proposed geographic market covering just part of a Chicago suburb, when "'Chicagoland' is home to many shopping venues" for retail products at issue).

The first step in appropriately defining the relevant geographic market for the merging parties' inpatient services is to identify the potential competitive substitutes—*i.e.*, where patients can "practicably turn" for such services.[49] Particularly in the context of hospital mergers, this exercise "is highly fact sensitive." *Tenet Health*, 186 F.3d at 1052 (citation omitted). This is all the more true in sprawling urban areas like Chicagoland. *See Cal. v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1120-28, 1131-32 (N.D. Cal. 2001) (rejecting government's proposed geographic

[49] 2B Phillip E. Areeda & Herbert Hovenkamp, ANTITRUST LAW ¶ 530a (4th ed. 2014) (initial step in defining relevant geographic market is to "[i]dentify the closest substitutes"); *see, e.g., Phila. Nat'l Bank*, 374 U.S. at 359; *Tenet Health*, 186 F.3d at 1052-55 (reversing entry of preliminary injunction where FTC's proposed geographic market failed to include hospitals that were "practical alternatives" for consumers); *Gordon v. Lewistown Hosp.*, 423 F.3d 184, 212 (3d Cir. 2005) (rejecting plaintiff's proposed two-county market that excluded competitors in other counties to which Lewistown area patients were referred").

market limited to parts of just two counties in the San Francisco Bay area when evidence demonstrated that patients residing there did and could seek inpatient care at other hospitals in the metropolitan area); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 141 (E.D.N.Y. 1997) (government failed to define geographic market correctly in New York City area, where evidence showed that some patients preferred local care for more routine care while others would travel farther for other inpatient services).

These long-settled legal principles demonstrate that the FTC's first "Question Presented" rests on a false premise. The FTC accuses the district court of failing "to apply a legally sufficient test for determining the relevant geographic market." FTC Br. 3. Yet the test the court applied is, in fact, the very test prescribed by the Supreme Court, this Court, and other federal appellate courts in numerous cases—a test requiring factual identification of providers to which consumers "can practicably turn" for the same services. *Phila. Nat'l Bank*, 374 U.S. at 359; *see also Hosp. Corp. of Am.*, 807 F.2d at 1387; *see* Op. 9-13. That test *is* "legally sufficient," and no court has ever held otherwise.

B. The district court correctly found that the exclusion of "destination hospitals" lacked any economic basis or support in the record.

The FTC's evidence did not support its proposed market—a limited set of eleven hospitals in selected portions of Cook and Lake Counties. The court correctly found that the FTC's proposed market excluded critical, real-world competitors and substitutes for those hospitals without any adequate justification. The FTC has demonstrated no error—much less clear error—in this conclusion.

The FTC arbitrarily excluded from its proposed geographic market *all* hospitals subjectively defined as "destination hospitals." PX6000, ¶¶ 85, 87, 89; *see also* FTC Br. 15. According to the FTC's expert witness Dr. Tenn, a "destination hospital" is one that attracts patients from "throughout the Chicago metropolitan area." PX6000, ¶ 85, n.175. The insurers who testified at trial either had never heard that term or viewed it as meaning something entirely different than Dr. Tenn's personal definition. *See supra* 15 & n.37.

In any event, excluding such hospitals from the geographic market "'ignores the commercial realities of th[is] industry.'" Op. 11 (quoting *Brown Shoe*, 370 U.S. at 336). The fact that a hospital is highly attractive to patients throughout Chicagoland—including in the very neighborhoods where the six party hospitals in the "North Shore Area" sit—is a compelling reason to *include* it in the geographic market, not to *exclude* it. Indeed, precisely because they are acknowledged to be desirable destinations for the services at issue here, the FTC's "destination hospitals" should be the *first* competitors considered for inclusion in any relevant geographic market involving the party hospitals.

Northwestern Memorial, for example, attracts more patients residing in the FTC's "North Shore Area" than four of the six party hospitals located there and more than any other hospital located anywhere. PX6000, tbl. 8 (SA1); *see supra* 5-6, 15-16, nn.40-41.[50] Ordinary course hospital documents confirm that Northwestern

[50] Table 8 in Dr. Tenn's report provides inpatient admission figures at numerous Chicago-area hospitals from just those patients residing in the 51 zip codes comprising the "primary service area" of NorthShore as a system. Dr. Tenn identified the "North Shore

Memorial is a primary competitor for the NorthShore and Advocate hospitals in the "North Shore Area."[51]

The parties' experts also relied on "diversion ratios" to identify hospitals to which "North Shore Area" patients could turn if prices at their preferred hospital became uncompetitive. As noted above, a "diversion ratio" is a measure of substitution, seeking here to determine which hospital is the next-best alternative for a consumer if the first choice hospital is no longer available or too expensive. *See supra* 16. Dr. Tenn's own diversion ratios show that Northwestern Memorial is the *closest* substitute for two of the four NorthShore hospitals and the second closest substitute for the other two NorthShore hospitals. PX6000, tbl. 9 (SA2); DX5001, ¶ 45. The same data also show that Northwestern Memorial is the closest substitute for "all four NorthShore hospitals" and "all four Advocate hospitals" located in or near the "North Shore Area." Hr'g 540:8-541:4; PX6000, tbl. 9 (SA2). Other highly regarded Chicagoland medical centers that the FTC labeled as "destination hospitals"—such as Rush, University of Chicago, and Lurie—also attract significant numbers of pa-

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Area" as "largely coincid[ing]" with those 51 zip codes. PX6000, ¶ 73 & n.51, 92, 105; Hr'g 450:14-451:3 (A50-51), 508:9-22. Dr. Tenn recognized, however, that the "service area" of a hospital or hospital system does *not* constitute a relevant geographic market for antitrust purposes. Hr'g 491:12-22 (A91), 592:17-593:4; *see also Gordon*, 423 F.3d at 212 (absent more, a hospital's service area is not a relevant geographic market).

[51] *See, e.g.,* DX1740 (noting Northwestern expansion into NorthShore market and comparing patient experiences between the two systems); DX1742.0003 (NorthShore service area map comparing NorthShore and "enemy" Northwestern outpatient locations); DX9151.0011 (viewing Northwestern Memorial's expansion into northern suburbs as an "environmental threat"); DX9123.0010 (Advocate viewing Northwestern's growing presence in the Northern suburbs as a competitive threat); DX9114.0047 (noting that "Northwestern brand recognition is very high in the [Advocate Lutheran General] market").

tients residing in the proposed market, and those hospitals have relatively high diversion ratios from the NorthShore and Advocate hospitals located in that area.[52]

On appeal, the FTC seeks to downplay the significance of its own expert's diversion analysis, arguing that the district court "misunderstood" the significance of such diversion ratios because they "merely show what patients' second-choice hospitals would be if their first-choice hospital system were not available—not third or subsequent choices." FTC Br. 25. But this ignores how both sides' experts used diversion ratios at trial. Diversion ratios are calculated on a population-wide basis; they start with the demographics of a target population (here, patients of the party hospitals) and then examine the different hospitals selected by people with those same demographics. DX5001, ¶ 94. This produces an entire array of possible choices, ranked by the closeness of the substitution. PX6000, ¶ 96 (Dr. Tenn explaining that higher diversion ratios show that the hospitals "are increasingly close substitutes"). It was certainly within the district court's sound discretion to credit the experts' analysis and use these ratios to determine which hospitals were the second and third best alternatives. Op. 9.

The district court correctly held that the exclusion of all "destination hospitals" has "no economic basis" and "assumes the answer to the very question the geographic market exercise is designed to elicit; that is, are the destination hospitals

[52] *See, e.g.*, Hr'g 667:22-25 (identifying Northwestern, Presence, Rush, and Advocate as integrated systems that NorthShore competes against); Hr'g 770:16-23 (identifying Lurie and Rush as competitors); Hr'g 1434:1-1434:9 (discussing competition with Rush and the University of Chicago); PX6000, tbls. 8, 9 (SA1-2).

substitutes for the merging parties?" *Id.* Ignoring real-world facts, the FTC and its expert witness used the "destination hospital" moniker to assume away important competitors. *See Tenet Health*, 186 F.3d at 1053 (holding it was error to exclude hospitals in nearby towns and rural areas); *Sutter Health Sys.*, 130 F. Supp. 2d at 1124, 1131-32 (rejecting proposed geographic market that excluded hospitals in other parts of the San Francisco Bay area where patients did and could practicably turn for inpatient services).

Far from clear error, the district court's decision on this point was exactly right. An expert provides no support for a proposed market if he "start[s] his analysis with [an] assumption" about that market and then "look[s] for corroborating evidence without meaningfully testing this assumption." *In re Live Concert Antitrust Litig.*, 863 F. Supp. 2d 966, 988 (C.D. Cal. 2012); *see also, e.g.*, *Winters v. Fru-Con, Inc.*, 498 F.3d 734, 743 (7th Cir. 2007) (no weight given to testimony of expert whose analysis assumes an answer to the question he was called upon to resolve). That is exactly what happened here.

Indeed, for some party hospitals in the FTC's proposed market, an excluded "destination hospital" is the *closest* competitor. Yet the FTC admitted that once it concluded that NorthShore and Advocate were close competitors of one another, it stopped looking for their *closest* competitors. As the FTC's Rule 30(b)(6) witness conceded: "Yeah, we have not analyzed whether Northwestern is the closest competitor of NorthShore." DX1880, Pugh Dep. 294:10-11.

It is no answer to say that the FTC somehow ultimately "accounts" for diversions to out-of-market hospitals by calculating whether a "hypothetical monopolist" in the FTC's proposed market could impose a "small but significant non-transitory increase in price" (a "SSNIP")—*i.e.*, on the theory that the calculation itself, based on diversion ratios, trumps whether the candidate market was properly chosen. FTC Br. 51. The *Merger Guidelines* expressly say otherwise, requiring that closer competitors—like Northwestern Memorial and Rush—must be included in a market *even if a SSNIP could be imposed without them*. *See infra* 48-49.

The FTC's argument simply puts the cart before the horse. The initial question for the geographic market is which hospitals are close substitutes to which consumers "could practicably turn." As the FTC concedes, "if purchasers could turn to hospitals outside the [proposed] market in the event of a price increase, that would mean the market should include those other hospitals." *Id.* at 31-32 (citing *Hosp. Corp. of Am.*, 807 F.2d at 1387). Here, more than half the patients currently using one of the eleven "North Shore Area" hospitals would turn instead to one of the other 55-plus hospitals in the Chicago area if "North Shore Area" hospitals became unavailable or too expensive. *See infra* 53. Indeed, such patients could and would turn to many of the so-called "destination hospitals" as substitutes for the party hospitals.

Nor is it any answer to say that the district court inappropriately focused "on the conditions in the market for *outpatient* services," rather than those for inpatient services—as if the district court simply forgot what market was at issue. FTC Br.

21 (emphasis in original). What the district court actually found was that the FTC's focus on hospitals closest to home "ignore[d] the commercial realit[y]" that "outpatient services are a key driver of hospital admissions." Op. 11; *see also, e.g.*, DX5001, ¶¶ 35-37. And so-called "destination hospitals" are steadily expanding their outpatient services in the "North Shore Area," precisely so that they can draw such patients to their hospitals.[53] The record evidence amply backed this conclusion (*see supra* 5-6; Op. 11-12), and the FTC fell short of its required showing by ignoring this fundamental "commercial realit[y]." Op. 11; *Brown Shoe*, 370 U.S. at 336.

Finally, contrary to the assertions of the FTC's *amici*, neither the Hospitals nor the district court take the view that in-migration and out-migration statistics—that is, the historical percentage of patients who enter and leave the proposed market for care—are sufficient by themselves to define the relevant market, *i.e.*, under the Elzinga-Hogarty method employed by some courts. Econ. Am. 4-10; States' Am. 11-14. Still, however, those data do reveal where patients in Chicagoland already receive care, and they undermine the FTC's decision to ignore well-regarded hospitals just a few miles from the "North Shore Area." *See, e.g.*, *In re Evanston Nw. Healthcare Corp.*, No. 9315, 2007 WL 2286195, at *66 (F.T.C. Aug. 6, 2007) (clarifying that "the percentage of patients in a given area who use a hospital can, in certain circumstances, provide some rough indication of [insurer] preferences when

[53] *See, e.g.,* Hr'g 346:3-10, 362:1-13 (testifying that Northwestern's outpatient centers are "front doors" for patients to enter its system and physicians admit the majority of their patients to Northwestern hospitals).

they form a network."). The substantial movement of patients into and out of the FTC's proposed market is at least some evidence that such a market is too narrow.

In addition, *amici*'s argument conflates migration data—showing where patients *have* gone—with diversion ratios, which show where patients *would* go and measures whether a particular competitor is a close substitute. The district court and the parties looked at both types of data. Op. 9, 10-11, 12-13. Because diversion ratios predict where patients would go based on patients with similar characteristics who currently select an alternative hospital, *see* PX06000, ¶ 97, they are not susceptible to the so-called "silent-majority fallacy." FTC Br. 25, 51; *see* DX5001, ¶¶ 42-43. The district court properly relied on diversion data. And, as discussed, those data amply demonstrate that the FTC arbitrarily excluded key competitors. In any event, it is simply not the case, as the FTC's *amici* contend, that migration data is entirely irrelevant to the determination of whether other hospitals could provide "practical alternatives" to patients currently choosing a hospital in the FTC's proposed market.

C. The district court correctly rejected the FTC's contention that so-called "destination hospitals" cannot be a substitute for the supposedly "local" hospitals.

The FTC urges the Court to ignore its exclusion of key competitors and ask simply "whether insurers would be willing to pay a [price increase] to avoid losing access to all hospitals in the proposed market." FTC Br. 25. According to the FTC, the answer to this question, appearing later in its brief, is no because, it says, the "[o]verwhelming" record evidence indicated 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." *Id*. at 47. This argument is wrong twice over.

As an initial matter, the FTC points to the wrong evidence to answer its question. In answering whether an insurer can market a health plan without the eleven "North Shore Area" hospitals, *id.* at 25, the FTC cites testimony of insurers about whether they can market a network that excludes the entirety of the Advocate and NorthShore health systems, including their combined *16* hospitals, located both inside and outside that proposed market. *Id.* at 47.

Further, the FTC ignores the evidence regarding network formation. As the FTC's expert conceded, the preferences of insurers depend on and reflect the preferences of patients. PX6000, ¶ 43 ("patients' hospital preferences are a key determinant of the price negotiated between a hospital and an [insurer]"); *see also ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 572 (6th Cir. 2014) (insurers "assemble networks based primarily upon patients' preferences, not their own" and thus whether insurers regard hospitals as close substitutes "depends upon the extent to which the [insurer's] members do."), *cert. denied*, 135 S. Ct. 2049 (2015). Accordingly, if *patients* do or can turn to hospitals outside the "North Shore Area" in the event of a price increase, then the market should include those hospitals.

The district court specifically rejected the testimony on which the FTC relies. It concluded the FTC *had not proven* that insurers "could not successfully market a health plan that did not include Advocate or Northshore to employers with employees who live in the northern suburbs." Op. 9-10, n.4. Here, the court determined

that the subjective testimony of the third parties opposed to the merger was not believable because it flew in the face of the FTC's own data showing where patients could seek inpatient care in the event of a price increase at Advocate and NorthShore hospitals. *Id.*, *see infra* 39-40.

Ignoring the district court's weighing of insurer testimony, the FTC asserts that (1) "patients typically receive hospital care close to home, particularly for routine services" (FTC Br. 43); (2) insurers therefore cannot successfully market plans that exclude the Advocate and NorthShore hospitals in the "North Shore Area" (*id.* at 47); and (3) the FTC's own data undermining these conclusions not only can be but *must* be ignored (*id.* at 51). However, the entirety of the evidence amply supports the district court's finding, which must be affirmed even if the FTC can cite some evidence to support its position. *Anderson*, 470 U.S. at 574 ("Where there are two *permissible* views of the evidence, the factfinder's choice between them cannot be clearly erroneous" and an appellate court "may not reverse" even if it would have weighed the evidence differently.) (emphasis added).

First, the FTC's vague contention that patients prefer a "local" hospital for "routine" care fails to find support in the record. The FTC's argument elides the crucial point that inpatient services always entail hospitalization, typically including an overnight hospital stay, and therefore hardly qualify as "routine."[54] The same services that residents in the FTC's proposed market seek at "destination

[54] PX6000, ¶ 58; Hr'g 767:8-14 (inpatient services are declining and an "inpatient admission is a very rare or never event.").

hospitals" are commonly performed at any number of the hospitals that residents drive past on their way to Northwestern and other hospitals near downtown. DX5001, ¶ 17.[55] And the evidence shows that Northwestern Memorial is apparently convenient enough: between July 2014 and June 2015, it provided about 3,500 hospital stays for patients residing in the "North Shore Area"—virtually all of which were for services that could be obtained from other hospitals within the "North Shore Area," including 1,281 births. DX5001, ¶ 17.

Further, Northwestern Memorial and other "destination hospitals" are located near downtown, where many area residents work. Rush, another excluded "destination hospital" near downtown, has the third-largest share of any provider in the metropolitan area; and its service area draws patients from across Chicagoland, including the north side of Chicago and its northern suburbs.[56]

Moreover, "local" is in the eye of the beholder. The FTC can cite no evidence linking "local" with the particular boundaries of its proposed market. Indeed, focusing on hospitals "close to home"—as the FTC does in its brief (FTC Br. 15-17)—is not a meaningful way to define a market in a metropolitan area where patients' res-

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[55] *See also* Hr'g 243:20-244:3 (admitting there are many crossover services between Northwestern Memorial, Loyola, University of Chicago, Rush, and Advocate and Northshore); Hr'g 766:5-9 ("The services we provide are substantially the same as those provided by the Academic Medical Centers."); Hr'g 1226:1-25 (noting that most patients could be seen locally); DX1878 80:11-16 (acknowledging that academic medical centers provide the same types of routine care); DX5001, ¶¶ 17, 52, 59 (same); DX5000, ex. 4 (tables showing discharges).

[56] *See* JX00004 15:19-16:21, 52:6-53:8 (testifying that Rush draws patients from an eight-county area); [redacted] *see also supra* 28-29 & n.52 (discussing Rush's patient base within the proposed "North Shore Area").

idences are distributed throughout. *See supra* 4-5. For people who live at the southern end of the FTC's proposed market, in fact, Northwestern Memorial is far closer to home than the hospitals that are included in the proposed market at the northern end. *See* FTC Br., Addendum. And much of the testimony cited by the FTC for this supposed preference for "local" hospitals was certainly not unequivocal and did not attempt to explain the meaning of "local" in a major metropolitan area like Chicago with long work-commute times. *Compare* FTC Br. 44-45 *with* Hr'g 84:1-8 (A6) (testifying that some "seek care in their own communities but, some do travel to where they work"); Hr'g 157:18-158:7 (A17-18) (acknowledging that consumption patterns show that members travel to downtown Chicago and that "[t]hey're looking for broader access than just one particular small geography of hospitals"); Hr'g 1130:4-11 (A128) (stating that receiving care is "really a personal decision" and that some patients want to receive care near work while others want to receive care near home). Indeed, to support this argument, the FTC even cites testimony the district court *excluded from the record* as lacking foundation. *Compare* FTC Br. 11-12 (citing PX03005, ¶ 12), *with* Hr'g. 1799:6-10.

The FTC cites this Court's decision in *Rockford Memorial* as saying that "for the most part hospital services are local." FTC Br. 45. However, the FTC fails to note that in *Rockford Memorial*, the Court had in mind a "local" market that encompassed *six counties*—a much larger geography than what the FTC deems "local" in this case. *See, e.g.*, *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1277 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278, 1285 (7th Cir. 1990).

Indeed, the FTC itself alleged in its Complaint that patients seek hospital care close to "where they live *or work*." ECF No. 14, ¶ 34 (emphasis added). Moreover, ample testimony contradicts the FTC's position on appeal that patients prefer to receive care only near their homes. *See, e.g.*, Op. 10-12 (citing voluminous testimony that patients also seek care close to where they work and not just where they live).[57] The FTC further ignores the significant role that physician referrals to hospitals play in how far patients travel for inpatient services.[58] And the placement of physician offices and other outpatient facilities within the FTC's proposed market further drives patients to hospitals elsewhere. *See supra* 5-6; Op. 11-12.

Second, contrary to the FTC's selective account, many insurers expressly rejected the notion that a network excluding both Advocate and NorthShore could not be marketed to employers in Chicago—and in fact testified that they are currently and successfully marketing such networks. *See, e.g.*, Hr'g 168:15-23 (A120); 244:14-245:12 (testifying that Blue Cross's "Blue Choice" insurance product, its fastest-

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[57] *See also* DX1880 371:19-23 ("Q. Is employment location a factor in determining where North Shore residents prefer to obtain their patient care? A. Yes, it's my understanding that that is a factor for some patients."); Hr'g 83:25-84:8 (stating that some members seek care near work); Hr'g 1116:6-13 (agreeing that people can receive care near both home and work); *id.* 1119:4-9 (stating that some members travel to Northwestern Memorial for care); Hr'g 1169:13-1170:4 (describing Chicagoland as a commuter market where people seek care near both work and home); JX00013, Hall Dep. 153:12-15 (discussing patients who receive care at Northwestern and Presence), 169:2-11 (stating that some patients travel to Northwestern and Rush for care).

[58] Hr'g 1436:12-17 ("Patients want access within 15 or 20 minutes of work or home for primary care services, a physician office. Once they have a relationship with a physician, they'll travel a long way when they need inpatient hospital services"); Hr'g 1116:14-18 ("a member's physician relationship influence[s] where they seek hospital care");

growing insurance product in Illinois, excludes both Advocate and NorthShore); Hr'g 232:16-235:1 (testifying that Blue Cross was pursuing a "Project Remedy" network, which would exclude both Advocate and NorthShore); [redacted]

Third, the diversion ratios that the district court referenced from Dr. Tenn's report tell a much different—and more compelling—story than the insurer testimony selectively referenced by the FTC. As noted in Section I-B, *supra*, Dr. Tenn's own data suggest that a hypothetical monopolist owning *all* eleven hospitals comprising the "North Shore Area" would risk over half of its customers by implementing an above-market price increase. Hr'g 559:17-22; PX6000, tbl. 5. The FTC acknowledges that patients of just the four NorthShore hospitals would flee in even greater numbers—nearly 60%. FTC Br. 50.

As the district court correctly concluded, these data—all of which come from the FTC's own expert—undermine the notion that insurers cannot construct a viable network without Advocate and NorthShore. Op. 9, n.4. To the contrary, these diversion ratios show that in the event of an above-market price increase at the party hospitals, most patients would be willing to divert to hospitals that the FTC *excluded* from its proposed market, and that insurers therefore could market a network excluding those hospitals to large numbers of such patients.

The case law and other authoritative antitrust guidance support the district court's finding that these objective data (such as "[p]ast shifts by customers or other

producers") are more reliable than "subjective testimony by customers that they would or would not defect in response to a given price increase." 2B Areeda & Hovenkamp, § 538; *see also Tenet Health*, 186 F.3d at 1054 (finding suspect the testimony of local managed care providers that they would simply pay a higher price rather than send their clientele to more distant hospitals); *FTC v. Freeman Hosp.*, 69 F.3d 260, 266 (8th Cir. 1995) (disregarding the "statements of market participants as 'informal, off-the-cuff remarks' which could not substitute for economic analysis").

Ultimately, the FTC is arguing that the district court should have weighed the evidence differently. This does not amount to clear error—and certainly not when the argument depends on selective, vague, and limited testimony from a small number of third parties that was contradicted by objective evidence. Because the FTC has failed to show that the district court's evidentiary findings were "implausible, illogical, internally inconsistent or contradicted by documentary or other extrinsic evidence," *Furry*, 712 F.3d at 992, there is no basis to set them aside.

D. The district court correctly rejected the FTC's attempt to exclude hospitals that significantly compete with Advocate or NorthShore but not both.

The district court also found the FTC's proposed geographic market flawed because it excluded hospitals that are close competitors of Advocate hospitals or NorthShore hospitals but are not sufficiently close competitors for *both*. Op. 12-13. Post-merger, however, hospitals that compete with *either* hospital system have the ability to discipline the merged system. Hr'g 1224:04-08, 1236:23-1237:23; DX5001, ¶ 61. As the Hospitals' expert economist, Dr. McCarthy, explained: "By imposing

this condition that the rival hospital must reach his standard that it constrains *both* systems, Dr. Tenn effectively restricts the set of patients in the relevant market to mostly those patients that view the Defendants as their top two hospital choices…." DX5001, ¶ 61; *see also* Hr'g 1224:4-8.

In other words, this condition, like the "destination hospital" condition, effectively assumes the conclusion the FTC sought to reach. The district court was well within its discretion to credit Dr. McCarthy's analysis and discredit Dr. Tenn. Op. 12-13; *see, e.g.*, *Goodpaster v. City of Indianapolis*, 736 F.3d 1060, 1068 (7th Cir. 2013) ("It is up to the trier of fact, however, to evaluate the 'soundness of the factual underpinnings of the expert's analysis and the correctness of the expert's conclusions based on that analysis …. We give a district court's credibility determinations of expert witnesses 'great weight.'") (citations omitted); *Freeman Hosp.*, 69 F.3d at 269 n.13 (finding it "axiomatic" that a district court has the discretion to evaluate the credibility of expert witnesses).

The FTC used this exclusion criterion to remove, for example, Presence St. Francis, despite the fact that St. Francis sits three miles away on the same street in the same suburb as NorthShore Evanston Hospital. *See supra* 12-13. The FTC's diversion ratios demonstrate that St. Francis closely competes with the party hospitals. PX6000, tbl. 9 (showing St. Francis to be a closer substitute to the four NorthShore hospitals than three hospitals the FTC includes in its "North Shore Area"—Presence Resurrection, Swedish Covenant, and Advocate Condell). Ordinary

course documents support that conclusion.[59] As a close competitor with party hospitals, St. Francis should have been included in the FTC's geographic market.

Attempting to escape that conclusion, the FTC again retreats to its preferred mathematical calculation for defining a relevant geographic market—whether a hypothetical monopolist in the proposed market could impose a SSNIP. FTC Br. 36, 37. But that calculation does not correct the deficiencies in its initial selection of hospitals for a candidate market on which to run its calculation, and the district court expressly found that selection to be fatally flawed. Op. 12-13. The FTC's "robustness" checks of market concentration, conveniently excluding the "destination hospitals," (FTC Br. 19, 36), did not cure these flaws either. The FTC's flawed factual assumptions rendered its mathematical test invalid. The FTC offers no other evidence that St. Francis and other hospitals that compete primarily with NorthShore or Advocate do not and would not constrain a price increase by the party hospitals post-merger.

II. The FTC cannot use a hypothetical calculation to avoid the commercial realities of the Chicagoland hospital market.

In an effort to paper over the demonstrated flaws in its geographic market, the FTC purportedly relies on a version of the *Merger Guidelines'* "hypothetical monopolist" test—which asks whether the owner of all hospitals in a proposed (or "candidate") market could profitably impose a small but significant non-transitory increase in price. The FTC argues that so long as it can find any candidate market

[59] *See, e.g.*, [redacted]

of hospitals for which its mathematical formula predicts that a hypothetical monopolist owning those hospitals could impose a SSNIP, then that candidate market must be the relevant market. *Id*. 32-34. In essence, the FTC asks this Court to treat the FTC's own mathematical analysis as the sole, conclusive means of defining the geographic market, without regard to the marketplace's commercial realities and binding Supreme Court precedent.

As the district court correctly observed, "[t]here is no formula for determining the geographic market." Op. 6. Rather, as the Supreme Court observed over 50 years ago, "Congress neither adopted nor rejected specifically any particular tests for measuring the relevant markets." *Brown Shoe*, 370 U.S. at 320. Instead, a mathematical or economic tool used in defining a market must be appropriate for the case and applied consistently with the Supreme Court's standard. As the FTC told the Third Circuit recently, "[i]n antitrust analysis, economic realities rather than a formalistic approach must govern." *See* FTC Emergency Mot. for Inj. Pending Appeal at 11-12, *FTC v. Penn State Hershey Med. Ctr*, No. 16-2365 (3d Cir. May 12, 2016). The FTC's hypothetical monopolist test was neither required to determine the geographic market nor properly applied by the FTC in this case.

A. No mathematical test can be used to construct a geographic market that fails to include all competitors to which customers can "practicably turn" as alternatives.

According to the FTC, Dr. Tenn's version of the hypothetical monopolist test—all by itself—is a "legally sufficient test for establishing a relevant market" that the district court was "obligat[ed]" to apply. FTC Br. 32. Indeed, the FTC chastises the district court for supposedly failing to consider its mathematical test

to define a relevant market, asserting that its failure to do so amounted to legal error. *Id.* 28. But the FTC mischaracterizes what the district court did and did not do, the controlling legal precedent on market definition, and its own *Merger Guidelines*.

The only "test" the district court was required to apply here is the one repeatedly articulated by the Supreme Court, this Court, and every other federal court to decide a merger case in the last 50 years: namely, whether the proposed geographic market is the area in which consumers "can practicably turn" for substitute services, in a manner consistent with the "commercial realities of the industry." *See, e.g.*, *Phila. Nat'l Bank*, 374 U.S. at 359; *Brown Shoe*, 370 U.S. at 336-37; *Republic Tobacco,* 381 F.3d at 738. The district court followed this standard in evaluating whether the FTC's proposed "North Shore Area" properly reflected the commercial realities of hospital competition in Chicago. Op. 8-13.

While the FTC asserts that the hypothetical monopolist test in its *Merger Guidelines* is "the standard test" used for the purpose of defining a market (FTC Br. 30), courts (including this Court) are not "obligated" to use any one method. *See Brown Shoe*, 370 U.S. at 320. Such a test is merely one of many tools for analyzing the geographic-market definition in a case. *See, e.g.*, *St. Alphonsus Med. Ctr. Nampa, Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 784 (9th Cir. 2015) (describing it as "a common method") (cited at FTC Br. 30); *Food Lion, LLC v. Dean Foods Co.*, 739 F.3d 262, 278 (6th Cir. 2014) (describing the *Merger Guidelines* as being "written to describe the analytical process that the [federal antitrust agencies] will em-

ploy in determining whether to challenge a horizontal merger" (internal citations omitted)) (cited at FTC Br. 30).

The FTC fails to cite a single case holding that the hypothetical monopolist test is *required*—much less that it is sufficient to overcome defects in a market definition. Indeed, the FTC's *Merger Guidelines* are just that—guidelines. They are "statements of enforcement policy," not law,[60] and as the FTC ultimately concedes, courts are not required to use the hypothetical monopolist test in every case to define a market. FTC Br. 31; *see also Evanston*, 2007 WL 2286195, at *46 ("Courts are not required to follow the Merger Guidelines' [hypothetical monopolist test] approach.").

It is no surprise, therefore, that this Court has consistently defined markets in antitrust cases for decades without utilizing a hypothetical monopolist test; instead, it has relied on other methods, following the Supreme Court's direction on how to define them. *See, e.g.*, *Republic Tobacco*, 381 F.3d at 738; *Elliot v. United Ctr.*, 126 F.3d 1003, 1005 (7th Cir. 1997); *Rockford Mem'l*, 898 F.2d at 1283; *FTC v. Elders Grain Inc.*, 868 F.2d 901, 907 (7th Cir. 1989).

The FTC's approach in this case plainly illustrates why courts are skeptical of pure mathematical formula tests to define a market—because those tests can easily be manipulated. *Brown Shoe*, 370 U.S. at 321 n.36. Its economic expert em-

[60] *Native Am. Arts, Inc. v. Waldron Corp.*, 399 F.3d 871, 874 (7th Cir. 2005) (stating that *Guidelines* are "statements of enforcement policy" that "describe the circumstances in which the Department [or FTC] will challenge a merger as a violation of federal antitrust law"); *see also IGT v. Alliance Gaming Corp.*, 702 F.3d 1338, 1345, n.3 (Fed. Cir. 2012) ("the Guidelines are not binding on the courts.").

ployed a mathematical model that no court has ever accepted to construct a market or that was ever shown to predict an actual price increase following a real-world merger.[61] Dr. Tenn used his same, untested mathematical model at each stage of his analysis—to construct his geographic market, to calculate whether the merger will result in a price increase, and to determine its amount.[62] And unlike the Hospitals' expert, who used actual claims data reflecting actual prices paid by Chicago-area insurers *as a result of hospital-insurer bargaining*, Dr. Tenn used an untested, hypothetical model that ignored all such actual data.[63] Dr. Tenn simply failed to show the district court any evidentiary or economic proof that his model worked or why it contradicted all the actual evidence in the case.

As this Court has held, "[e]conomic analysis is virtually meaningless if it is entirely unmoored from at least a rough definition of a product and geographic market." *Republic Tobacco*, 381 F.3d at 737. The FTC argues that its expert only "postulated" his proposed "candidate market" for purposes of running the SSNIP test; and once he made "reasonable assumptions about what might qualify as a rel-

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[61] Hr'g 494:1-14 (A94), 544:4-10,574:4-575:8, 575:25-576:14; *see also* Hr'g 1253:13-1254:12 (explaining that the original proponents of the mathematical model employed by Dr. Tenn "warn explicitly against" using it to predict a price increase); DX5001, ¶ 103 n.155 (discussing proponent literature explaining same); *see also, e.g.*, *City of New York v. Grp. Health Inc.*, No. 06 CIV. 13122, 2010 WL 2132246, at *6 n.6 (S.D.N.Y. May 11, 2010) ("The Court notes that its research has not revealed a single decision of a federal court adopting this test."), *aff'd*, 649 F.3d 151 (2d Cir. 2011); Statement of the FTC, *In re Dollar Tree, Inc.*, No. 141-0207, at *2 (F.T.C. July 13, 2015) (agreeing that this type of model is "inappropriate at this stage of economic learning").

[62] Hr'g 567:13-21 (admitting to using the same model to conduct a SSNIP test and to determine an alleged price increase).

[63] Hr'g 560:8-24, 567:13-21.

evant market," the district court was only permitted to do one thing: evaluate his conclusions about the results of that test. FTC Br. 32-34. In essence, the FTC contends that no matter how its expert chose the hospitals for its "candidate market"—whether they were chosen to maximize the concentration of the market or just randomly without purpose—the district court cannot exercise its discretion to consider whether the assumptions used to arrive at the candidate market are "reasonable," and instead can only examine the output of a mathematical formula. That is plainly wrong.

It is the responsibility of the trier of fact "to evaluate the soundness of the factual underpinnings of the expert's analysis," and the reviewing court gives that evaluation "great weight." *Goodpaster*, 736 F.3d at 1068 (citations omitted). The district court properly evaluated Dr. Tenn's assumptions about which hospitals to include and exclude in his candidate market—and unequivocally found those assumptions unsound because they were inconsistent with the record evidence. Op. 7-13. Having considered and rejected Dr. Tenn's assumptions about which hospitals should be in the candidate market, the district court properly rejected Dr. Tenn's conclusions. *See, e.g.*, *Petit v. City of Chicago*, 239 F. Supp. 2d 761, 784 (N.D. Ill. 2002) ("Where assumptions underlying an expert's analysis are undermined, it is well within the factfinder's power to reject the analysis."), *aff'd*, 352 F.3d 1111 (7th Cir. 2003); *United States v. Cooper*, 277 F.2d 857, 860 (5th Cir. 1960) (holding that if an expert's assumptions are "not otherwise taken to be true, the opinion is worthless").

Contrary to the FTC's assertion, the district court quite properly applied the controlling legal precedents and determined that the FTC's underlying factual assumptions were contrary to the evidence and the "commercial realities" here. Op. 10-11. The district court did not err—let alone clearly err—in weighing that evidence.

B. The FTC's position ignores what its own *Merger Guidelines* say about how to define a geographic market.

The FTC's mathematical approach purports to be based on the *Merger Guidelines*, but its execution in this case in fact contradicts them.

First, the *Merger Guidelines* require that close competitors be included in the geographic market, *even if a hypothetical monopolist test excluding them would pass a SSNIP test*. *See, e.g.*, SA22-23, 27-28, *Merger Guidelines* §§ 4.2.1, 4.1.1, Ex. 6 (stating that closer competitors to a merging party than other competitors placed in the candidate market—as measured by diversions—will "normally be included in the relevant market" even if a small but significant price increase could be imposed when excluding the closer competitors from the candidate market).[64] The FTC's brief and its *amici* wholly ignore these sections of the *Guidelines*, which show that the hypothetical monopolist test is not satisfied here. As the then-Assistant Attorney General for Antitrust noted, this newly-added section of the *Guidelines* "help[s] assure that close substitutes are not omitted from a market and avoid unduly nar-

[64] The FTC's economic expert admitted that Section 4.1.1 of the *Merger Guidelines*—and by extension Example 6 therein—"applies to geographic market delineation." PX6000, ¶ 93 n.185.

row markets." Christine A. Varney, *The 2010 Horizontal Merger Guidelines: Evolution, Not Revolution*, 77 ANTITRUST L.J. 651, 656 & n.36 (2011); *see also* SA22-24, *Merger Guidelines*, § 4.1.1 (stating the same).

Not surprisingly, courts have rejected markets that ignore obvious competitors; even if those markets were purportedly defined using the hypothetical monopolist test. *See, e.g.*, *Ky. Speedway, LLC v. Nat'l Ass'n of Stock Car Auto Racing, Inc.*, 588 F.3d 908, 917-18 (6th Cir. 2009) (agreeing with lower court that appellant's expert "inadequately examined possible substitutes").

Second, consistent with the prevailing legal standard, the hypothetical monopolist test requires enforcement agencies to "consider any reasonably available and reliable evidence" to determine where consumers will turn in the event of a price increase. SA27-28, *Merger Guidelines* § 4.2.1 (listing sources of relevant evidence). Indeed, while the FTC now disputes the relevance of diversion data (FTC Br. 25), that is the first kind of evidence the *Guidelines* advise the FTC to examine. The *Guidelines* state that in evaluating customers' likely reactions to price increases in a "candidate geographic market," one should consider "how customers have shifted purchases in the past between different geographic locations in response to relative changes in price or other terms and conditions." *Id.* SA27-28, § 4.2.1. As discussed in Section I.B., *supra*, both of the parties' economic experts relied on diversion analysis of this very sort as a useful metric for determining substitutability. And the district court relied on that analysis for its findings. Op. 9.

C. The FTC failed to prove a relevant geographic market even under its own test.

Even if the FTC were correct that the district court was required only to determine whether their proposed market satisfied the FTC's preferred mathematical formula, the Court should still affirm because the FTC failed to show that the hypothetical monopolist's price increase would be *profitable*.

The FTC and its economist both concede, as they must, that in order to pass that test, "a hypothetical monopolist would need to find it *profitable* to increase price[s] …." PX6000, ¶ 75 (emphasis added); FTC Br. 14 ("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"); *see also id.* 48; SA25-28, *Merger Guidelines* §§ 4.1.3, 4.2.1 & Ex. 12 (theoretical price increase must be "profitable"). Federal antitrust cases that have assessed such a test also uniformly hold that the plaintiff must show that the theoretical price increase would be profitable. *See, e.g., AD/SAT v. Associated Press*, 181 F.3d 216, 228-29 (2d Cir. 1999) (rejecting plaintiff's proposed market definition because "price increase would not prove profitable" due to potential substitution to other sellers) (cited at FTC Br. 31).

This required the FTC to show that the lost revenues attributable to patients who would substitute to hospitals outside the FTC's proposed market in order to avoid a price increase—or because their insurer cut the hospitals out of its network—would be offset by the added revenues from patients who would not switch and pay more money. "If buyers in a defined area would respond to a small, lasting

increase in price—a SSNIP—by purchasing from another supplier, rendering the SSNIP unprofitable, the market has been too narrowly defined." *Food Lion*, 739 F.3d at 277-78 (cited at FTC Br. 30).[65] Absent that showing, the FTC has not met its burden under its own hypothetical monopolist test.

At trial, the FTC failed to elicit any testimony to establish that it would be *profitable* for a hypothetical monopolist to increase prices substantially at one or more party hospitals. Although the FTC asserts that a price increase would be profitable, it cites hearing testimony that says nothing about profitability at all. *See* Hr'g. 453 (A53) (cited at FTC Br. 14). To be sure, Dr. Tenn at least asserts profitability in his report—and the FTC later cites that assertion too (*see* FTC Br. 17 (citing PX6000, ¶¶ 94, 100))—but Dr. Tenn fails to provide the necessary evidentiary basis for his asserted conclusion.

Dr. Tenn admits that the specific inputs necessary to show that a SSNIP would be profitable include: (i) the intra-market diversion rates; (ii) each "in-market" hospital's profit margin (or its variable cost margin); and (iii) the relevant demand elasticity (*i.e.*, how much do revenues decline when price is raised). PX6000, ¶ 100 n.194; s*ee also FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 123 (D.D.C. 2004) ("the relevant geographic market depends on interchangeability and

[65] *See also, e.g.*, *Engelhard*, 126 F.3d at 1306 (sufficient number of customers switching to alternatives renders price increase unprofitable) (cited at FTC Br. 31); *United States v. Visa U.S.A., Inc.*, 163 F. Supp. 2d 322, 335-38 (S.D.N.Y. 2001) ("[A] market is properly defined when a hypothetical profit-maximizing firm selling all of the product in that market could charge significantly more than a competitive price, *i.e.,* without losing too many sales to other products to make its price unprofitable."), *aff'd,* 344 F.3d 229 (2d Cir. 2003).

cross-elasticity of demand"). The necessary data for two of these three inputs, however, is lacking. Dr. Tenn expressly admits that he lacked the necessary margin data for nine of the eleven hospitals and simply "assumed" it was 50% for each. PX6000, ¶ 100 n.195. And Dr. Tenn provides no figure, no calculation, nor even an assumption for the demand elasticity that he admits is a necessary element for any SSNIP profitability analysis and that the case law requires the FTC to prove.

Dr. Tenn's bare conclusion on profitability leaves the FTC unable to prove that it passed its own hypothetical monopolist test. "An expert who supplies nothing but a bottom line supplies nothing of value to the judicial process." *Huey v. United Parcel Serv., Inc.*, 165 F.3d 1084, 1087 (7th Cir. 1999) (citation omitted); *see also FTC v. Swedish Match*, 131 F. Supp. 2d 151, 161 (D.D.C. 2000) (rejecting expert's conclusions about elasticity of demand because expert relied on "undisclosed estimates" and the bases for his conclusions were "unknown, and therefore untested"); *In re Adventist Health Sys./West*, No. 9234, 117 F.T.C. 224, 291 (1994) (rejecting proposed geographic market, in part because the record did not "permit a determination of the degree of price sensitivity that would undermine an anticompetitive price increase by the hospitals in the proposed market").

Moreover, the evidence flatly contradicts a bare assumption that either the merging parties or a hypothetical monopolist would have sufficient bargaining leverage with insurers to implement such a price increase[66]—a point that was likewise

[66] *See* Hr'g 413:2-12, 419:13-21; Hr'g 709:15-710:20, 722:12-25, 723:9-14; [redacted]; Hr'g 1414:13-1415:5 (all attesting to a lack of bargaining power on the part of hospitals *vis-à-vis* insurers in the Chicago area); [redacted]

not addressed in Dr. Tenn's model.[67] Dr. Tenn's own data on patient behavior and preferences show that insurers actually have—and will retain—significant leverage in negotiations with Advocate and NorthShore.

In the highly concentrated insurance market in the Chicago area, a party hospital could lose as much as 72% of its commercial patient business in one stroke if just one insurer decided not to sign a contract with it and shifted those patients to any of the dozens of other hospitals in Chicagoland, including to hospitals as close as three miles away. *See* Hr'g 206:8-15 (Blue Cross does not believe that Advocate can afford to "walk away" from it); Hr'g 1412:21-23; PX6000, ¶¶ 35, 48 (insurer's customers from newly out-of-network hospitals will all go to hospitals of other systems instead); *see also* [redacted]. Moreover, Dr. Tenn's own analysis of patient inflows and outflows suggests that a hypothetical monopolist owning all eleven hospitals would risk over half of its customers if it were to implement an above-market price increase. PX6000, tbl. 5; *see also* Hospitals' Post-Hr'g Br. at 9-10, ECF No. 458.

For this reason as well, the FTC fails its own test. It offers only a naked assertion that a hypothetical monopolist of eleven hospitals could *profitably* raise

[redacted]

[67] *See* Hr'g 583:17-22; Hr'g 1216:1-10, 1249:10-23, 1252:3-1254:7; Hr'g 1512:3-20; DX6000, ¶ 87 (all explaining that Dr. Tenn used a price-setting model instead of a bargaining model and that his model did not even estimate the relevant bargaining "split" between hospitals and the insurers).

prices substantially above competitive levels, a failure to correctly apply its own test. In light of this problem—and the FTC's other failures to comply with its own *Guidelines* and the law—there is no basis to second-guess the district court and find that patients in the FTC's proposed geographic market lacked alternative hospitals to which they could practicably turn for inpatient services if faced with a substantial price increase.

CONCLUSION

For the reasons discussed above, the order of the district court denying the Appellants' request for a preliminary injunction should be affirmed.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH FED. R. APP. P. 32

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B)(i), as it contains 13,745 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6), as qualified by Circuit Rule 32(b), as it has been prepared in proportionally spaced typeface, Century Schoolbook, in a 12-point type in the body of the brief and 11-point type in the footnotes, by using Microsoft Word 2010.

Dated: August 1, 2016

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CERTIFICATE OF SERVICE

I hereby certify that on the 1st day of August, 2016, I electronically filed the foregoing with the Clerk of the court for 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.

Dated: August 1, 2016

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