No. 16-2492

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

FEDERAL TRADE COMMISSION *et al.*,

Plaintiffs-Appellants,

v.

ADVOCATE HEALTH CARE NETWORK *et al.*,

Defendants-Appellees.

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

REPLY BRIEF OF APPELLANTS FEDERAL TRADE COMMISSION AND STATE OF ILLINOIS

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INTRODUCTION AND SUMMARY

A geographic market must correspond to the "commercial realities" of the industry at issue and must reflect the area "where the effect of the merger will be direct and immediate." *Brown Shoe Co. v. United States*, 370 U.S. 294, 336 (1962); *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 359 (1963). As a matter of economics, the central question in assessing whether a proposed geographic market is an antitrust market is whether a supplier outside of the proposed market can sufficiently constrain the prices of suppliers inside of it.

Overwhelming and uncontroverted evidence in this case showed that the northern suburbs of Chicago—the "North Shore Area" market defined by the Government—is a valid antitrust market. Hospital patients in that area demand access to local hospital care. Three-quarters of them use hospitals in the area; half the people who use those hospitals would seek another local hospital if they could not go to their first-choice local hospital. As a result, the commercial reality of the North Shore Area market is that an insurance network must offer access to local hospitals or it will not be marketable. Every insurer that testified on the matter agreed. No insurer has successfully sold health plans in the North Shore Area that exclude all local hospitals. Any rational insurer therefore would pay higher prices to North Shore Area hospitals rather than offer a plan that did not include those hospitals in its health care network. Hospitals outside of the North Shore Area thus will not constrain the prices charged by hospitals inside that market, and that is true even if *some* patients in the market prefer to use those outside hospitals.

That evidence of the competitive dynamics of the North Shore Area market is ratified by economic analysis conducted by the Government's expert witness. He applied the "hypothetical monopolist test," a standard method to determine whether a given area is a geographic market, as both sides agreed. Every court of appeals that has considered the issue has accepted the test as a valid method for market definition; no court has ever rejected it. The hypothetical monopolist test is an economically rigorous encapsulation of the *Brown Shoe* standard: as pertinent here, it uses real-world industry data to measure whether a company that hypothetically owns every hospital in a given area could successfully demand a small, but significant price increase. If so, then the area is a valid antitrust market because hospitals outside the market do not constrain prices inside of it. That test showed that the North Shore Area is a valid geographic market.

The district court ignored all this evidence. It did not analyze the Government's proposed market under the hypothetical monopolist framework or any other approach that incorporates the economic standards set forth by the Supreme Court. Instead, the court rejected the proposed market on the ground that it should have contained more hospitals. Yet the question of which hospitals should be in or out of the market is the very one answered by the hypothetical monopolist test. Putting the cart before the horse in that manner and skipping the basic economic inquiry was a fundamental error of law. Antitrust markets must be assessed under economically sound principles, and the district court failed to do so.

Nothing in defendants' brief salvages the court's error. They concede that the court never analyzed the proposed market under the hypothetical monopolist test or its equivalent. They nevertheless defend the court's decision on the ground that patients practicably can turn to hospitals outside the market and thus will use such hospitals in the event of a price increase. That is no defense because *patients* are not the relevant buyers of hospital services. *Insurers* are. They, not patients, negotiate hospital prices. Patients themselves are largely insensitive to price by the very fact that they have insurance. The pertinent question in this case therefore is how *insurers* would react to a price increase by a hospital monopolist in the North Shore Area. The only economic analysis of that question showed that they would accede to the increase. In other words, the North Shore Area is a valid antitrust market.

Defendants also attempt to deride the hypothetical monopolist test as a mathematical formula that does not reflect commercial reality. The claim collides with the holdings of the seven courts of appeals that have accepted the test as a valid method for determining antitrust markets. The test relies on data about the behavior of hospitals, patients, and insurers and predicts the reaction of buyers to demanded price increases. Moreover, the test aligns fully with the overwhelming evidence below of actual insurer behavior in the real world.

At bottom, the Government reasonably constructed a proposed geographic market supported by overwhelming evidence and tested with economic rigor. Indeed, a prior merger of just three of the hospitals involved here resulted in

substantial price increases, and there is good reason to believe that the same thing will happen again if this merger is allowed to proceed. The Clayton Act requires "a prediction" about the consequences of a merger, and "doubts are to be resolved against the transaction." *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 906 (7th Cir. 1989). The district court ignored that admonition, and its decision should be overturned.

ARGUMENT

Section 7 of the Clayton Act declares a merger unlawful if it substantially lessens competition in "*any section* of the country." 15 U.S.C. § 18 (emphasis added). The statutory language indicates that there is no fixed single geographic "market" for determining if a merger violates the Act. Rather, in assessing whether a *proposed* geographic market is a *proper* antitrust market, a district court's central task is to determine whether in that market the merging parties will have "any ability to raise price." *Israel Travel Advisory Serv. v. Israel Identity Tours, Inc.*, 61 F.3d 1250, 1252 (7th Cir. 1995). "The purpose of defining a geographic market is to reveal whether, or to what extent, market power exists" and that would give merging companies the "ability to charge a supracompetitive price." *In re Se. Milk Antitrust Litig.*, 739 F.3d 262, 277 (6th Cir. 2014); IIB Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law ¶929.d (4th ed. 2014). If competition outside of a proposed geographic market will not sufficiently constrain prices within it, then the proposed market is a proper one for antitrust purposes.

I. THE DISTRICT COURT COMMITTED LEGAL ERROR BY FAILING TO PROPERLY ASSESS THE GEOGRAPHIC MARKET

The Government and the defendants agreed that the hypothetical monopolist test is an appropriate method to assess a proposed geographic market. But the court did not apply that test or any other economically sound method for assessing the proper boundaries of the market. Instead, the court examined only the criteria used by the Government's expert economist to construct the *proposed* market. The court did not properly analyze whether that market in fact constituted a relevant geographic market for antitrust purposes.

That was legal error, subject to de novo review. *See United States v. Household Finance Corp.*, 602 F. 2d 1255, 1260 n.7 (7th Cir. 1979); *United States v. Conn. Nat'l Bank*, 418 U.S. 656, 663 (1974). Indeed, the "formulation of … market tests may be freely reviewed on appeal as a matter of law." *White & White, Inc. v. Amer. Hosp. Supply Corp.*, 723 F.2d 495, 500 (6th Cir. 1983). Defendants' brief supplies no basis to sustain the judgment below.

A. The District Court Did Not Properly Analyze The Market

Defendants claim that the district court applied "the very test prescribed by the Supreme Court" to assess geographic markets. Br. 26. As articulated by this Court, a market is "the set of sellers to which a set of buyers can turn for supplies at existing or slightly higher prices." *Elders Grain*, 868 F.2d at 907; *see Hospital Corp. of America v. FTC*, 807 F.2d 1381, 1387-88 (7th Cir. 1986). Defendants argue that the court analyzed the market correctly when it looked at "competitive substitutes" outside the FTC's proposed market—hospitals where "patients can 'practicably turn'

for [general acute care] services." Br. 25 (quoting *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1052 (8th Cir. 1999)). Because patients in the Government's proposed market can seek care at other area hospitals outside that market, defendants posit, those hospitals necessarily will constrain prices in the proposed market, which therefore was not a proper antitrust market. Br. 27. The claim is meritless.

1. Insurers, not patients, are the relevant customers.

Defendants' exclusive reliance on patient preferences is wrong because *patients* are not the direct buyers in the market for hospital services; *insurance companies* are. Insurance companies negotiate prices with hospitals; in many cases, they pay the bills directly. Tr.76 (RSA1), 149 (A14), 299 (RSA10); PX03004 ¶4; PX03014 ¶3; *see Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 785 (9th Cir. 2015); *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 562 (6th Cir. 2014). Indeed, as both sides agreed, the product market in this case is inpatient general acute care services *sold to commercial payors—i.e.*, insurance companies—and provided to their members. Tr.441-42, 1270 (A41-42, 136). By virtue of their insurance, patients themselves face little or no variation in out-of-pocket costs between hospitals in their insurance network. PX06000 ¶37; Tr.1462 (RSA18). A price increase at any given hospital will affect how much the insurer pays for services, but it will not directly influence the patient's choice of hospital.

The proper inquiry for determining the geographic market thus is where *insurance companies* can turn for alternative hospital services, not where individual patients can turn if prices increase. Yet defendants' entire argument turns (and the district court's analysis implicitly turned) on "patients who would substitute to hospitals outside the FTC's proposed market in order to avoid a price increase." Br. 50. Defendants ignore entirely what insurers would do if the hospitals in the North Shore Area raise their prices in contract negotiations. Their effort to defend the district court's analysis improperly overlooks critical "commercial realities" of the healthcare industry. *See Brown Shoe*, 370 U.S. at 336.

For that reason, the district court's (and defendants') reliance on standalone "diversion ratios" untethered from application of the hypothetical monopolist test is misplaced. A diversion ratio from one hospital to another measures the percentage of patients admitted to the first hospital who would choose to go to the second hospital if the first were unavailable. *See* Gov't Br. 48-49. The ratios are useful in determining how important a given hospital is to an insurer's provider network (and thus how an insurer may react to a price increase), but they do not, without more, indicate whether any given hospital should be included in a geographic market. That can be determined only by assessing all the inputs to the hypothetical monopolist analysis or its equivalent.

Diversion ratios (along with gross profit margins and prices) were key inputs into the full hypothetical monopolist analysis. The test assesses whether a hypothetical monopolist would face sufficient competition from outside the proposed

geographic market to constrain its prices. Here, nearly half of all patients who use a hospital in the Government's proposed market would choose another hospital in that same market as their second choice. PX06000 ¶99. That uncontested fact indicates that local hospitals are extremely important to insurers that wish to sell policies to those customers. No rational insurer faced with a small but significant price demand from a hypothetical monopolist would reject the price demand and attempt to market a plan that is unattractive to roughly half the patients in the market. Used as an input to a hypothetical monopolist analysis, the diversion figures show that hospitals in the Government's proposed market do not face sufficient price constraints from hospitals outside of it.

2. The district court improperly failed to apply the hypothetical monopolist test.

The most widely used tool for analyzing a geographic market is the hypothetical monopolist test. As pertinent here, that test evaluates whether insurers would accept a small but significant non-transitory increase in price (a "SSNIP") from a hypothetical monopolist owning all hospitals in the proposed market. If enough insurers would accept the price increase, then the proposed market is a proper market because hospitals outside the market will not constrain the price increase. If the insurers would reject the higher price, then the market must be expanded. That test incorporates the Supreme Court's articulation of the proper scope of the market. As the Sixth Circuit has explained, the hypothetical monopolist test and the market definition standards set forth by the Supreme Court "are practically equivalent." *In re Se. Milk Antitrust Litig.*, 739 F.3d at 277-78

(quoting Earl W. Kintner et al., Federal Antitrust Law § 10.15 (2013)); *see* Areeda ¶910.1d (test is "absolutely consistent with *Brown Shoe*'s requirement that a market definition is essential for identifying the appropriate … section of the country in which competition is threatened").

Every court of appeals to consider the issue—seven in all—has endorsed the hypothetical monopolist test as a legally sufficient test for market definition.[1] Defendants have identified no court that has rejected or questioned it as a valid means of defining antitrust markets, and we are aware of none.

To be sure, this Court has not had occasion to assess or apply the hypothetical monopolist test, but the Court likewise looks to whether an outside competitor could sufficiently constrain prices as the touchstone for market definition. *See Ball Mem'l Hosp., Inc. v. Mut. Hosp. Ins., Inc.*, 784 F.2d 1325, 1336 (7th Cir. 1986); *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1283 (7th Cir. 1990). And the Court has explained that *Brown Shoe* "recognize[s] the importance of economic analysis" in defining a relevant market. *Reifert v. S. Cent. Wisconsin MLS Corp.*, 450 F.3d 312, 320 (7th Cir. 2006).

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[1] *See Saint Alphonsus*, 778 F.3d at 784-785 (test is a "common method to determine the relevant geographic market"); *In re Se. Milk Antitrust Litig.*, 739 F.3d at 277-78; *Coastal Fuels of Puerto Rico, Inc. v. Caribbean Petroleum Corp.*, 79 F.3d 182, 198 (1st Cir. 1996); *AD/SAT v. Associated Press*, 181 F.3d 216, 228 (2d Cir. 1999); *H.J., Inc. v. Int'l Tel. & Tel. Corp.*, 867 F.2d 1531, 1537 (8th Cir. 1989); *United States v. Engelhard Corp.*, 126 F.3d 1302, 1306 (11th Cir. 1997); *FTC v. Whole Foods Market, Inc.*, 548 F.3d 1028, 1038 (D.C. Cir. 2008) (Brown, J.); *id.* at 1052 (Kavanagh, J., dissenting but endorsing test); *see also* Gov't Br. at 30 & n.11.

The widespread judicial and academic acceptance of the hypothetical monopolist test as a valid means to assess markets fatally undermines defendants' attempt to deride it as a mere "mathematical" formula with little probative value. Br. 45. Defendants nevertheless rely on the Supreme Court's statement in *Brown Shoe* that "Congress neither adopted nor rejected specifically any particular tests for measuring the relevant markets." Br. 43 (quoting 370 U.S. at 320). The test may not be the *only* possible way to define a market. But courts have unanimously deemed it a legally sufficient way, so if a proposed market satisfies the hypothetical monopolist test then it necessarily passes muster under *Brown Shoe* and *Philadelphia National Bank*. Moreover, where both sides' experts agreed that the hypothetical monopolist test was the appropriate model to use, the district court should have assessed whether the test, or at least the principles underlying it, was satisfied. Yet the court rejected the FTC's proposed market without *any* such analysis.

Defendants concede that the district court did not apply the hypothetical monopolist test to the Government's proposed market. Had it done so (or used some other test to assess the same thing), the court would have found that the Government had shown that competitors outside of the proposed market could not prevent a hypothetical monopolist in the market from profitably raising prices to insurers. *See* Areeda ¶910.1d ("a showing that a merger may 'substantially lessen competition' drives the market analysis, and not the other way around"). The

court's failure to conduct that inquiry was legal error, salvaged by nothing in defendants' brief.

B. A Proper Antitrust Market May Exclude "Competing" Hospitals

Defendants contend that the law requires a properly defined market to include *every* location where patients could go to receive the same product or service provided by the merging parties and that the geographic market therefore must include downtown academic hospitals. Br. 44 (citing *Phila. Nat'l Bank*, 374 U.S. at 359; *Brown Shoe*, 370 U.S. at 336-37; and *Republic Tobacco Co. v. N. Atl. Trading Co.*, 381 F.3d 717, 738 (7th Cir. 2004)). This is incorrect.

Properly defined geographic markets frequently exclude suppliers outside the market that are alternatives for some purchasers and thus "compete" in the vernacular sense. *See United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1286 (7th Cir. 1990) (geographic market "may not exhaust the alternatives" open to residents of the area); *FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 30-31 (D.D.C. 2015). "The proper question to be asked … is not where the parties to the merger do business *or even where they compete*, but where, within the area of competitive overlap, the effect of the merger on competition will be direct and immediate." *Phila. Nat'l Bank*, 374 U.S. at 357 (emphasis added). Defendants' expert agreed, stating that "the presence of significant competitors outside the 'North Shore Area' does not necessarily imply that it is not an appropriately defined geographic market." DX5000 ¶65; *see also* Tr.1318 (A138). He similarly recognized that "the basic objective to defining a relevant geographic market is to identify the smallest

region over which a hypothetical monopolist could impose and sustain a SSNIP." Tr. 1317 (A137).

The district court erred when it overlooked the critical question of whether hospitals outside of the Government's proposed market could sufficiently constrain prices inside the market. That, of course, is the very question the hypothetical monopolist test addresses.

The cases cited by defendants themselves prove this point. Each decision assessed whether the geographic market included competitors that would constrain market power; none held, as the district court did below, that a market must include competitors that cannot sufficiently constrain prices. *See Republic Tobacco*, 381 F.3d at 738 (market is nationwide where all distributors publish price lists and sell across the country); *Rockford Mem'l*, 898 F.2d at 1285 (market must exclude competitors that customers would not seek out in response to a price increase); *Elders Grain*, 868 F.2d at 907 (commodity market was nationwide because industry participants "ship industrial dry corn all over the United States" and any competitor could constrain prices).[2]

The district court did not consider whether hospitals outside the North Shore Area would sufficiently constrain a hypothetical monopolist within that market. The court's lone mention of price constraints demonstrates its misunderstanding of the relevant law and economic principles. The court quoted testimony from

[2] *Elliot v. United Ctr.*, 126 F.3d 1003, 1005 (7th Cir. 1997), which concerned whether a privately owned sports venue is a relevant geographic market for the sale of peanuts, is simply irrelevant here.

defendants' expert, Dr. McCarthy, that "you can constrain the post-merger system by constraining any [one] of its hospitals." Op. 13 (quoting Tr.1224 (RSA16)). The court relied on that testimony to hold that the relevant geographic market must include hospitals that overlap with either NorthShore or Advocate but not necessarily both. *Id.* That conclusion is wrong as a matter of both economic theory and fact.

As a matter of economics, Dr. McCarthy's logic cannot be correct because it would lead to the absurd result that a monopolist of all hospitals in Illinois would lack market power so long as one hospital along the Missouri border was constrained by a competing hospital in St. Louis. That is why under Section 4.2.1 of the *Merger Guidelines* the hypothetical monopolist test is satisfied if the monopolist could impose a SSNIP "from at least one location, including at least one location of one of the merging firms."

As a factual matter, the district court's conclusion is wrong because Dr. McCarthy did not perform a hypothetical monopolist test (or any other similar test) nor did he testify that any hospital outside the Government's proposed market could sufficiently constrain the prices charged by a monopolist in that market. Dr. Tenn's analysis, by contrast, showed that no hospital outside the North Shore Area could prevent a North Shore Area monopolist from profitably imposing a SSNIP at one or more hospitals.

If a market satisfies the hypothetical monopolist test, it is immaterial that the market excludes a nearby supplier (such as, here, Presence St. Francis).

Geographic markets need not be alleged or proven with "scientific precision," *Conn. Nat'l Bank*, 418 U.S. at 669, and no market definition is perfect, *see Rockford Mem'l*, 898 F.2d at 1285. Antitrust defendants routinely argue that plaintiffs have wrongly excluded some competitor or another. Unless that competitor could sufficiently constrain the hypothetical monopolist's prices, however, the law does not require it to be included in the market.

C. The Government Used Reasonable Criteria To Identify The Hospitals In The Proposed Market

Defendants accuse the Government of "gerrymandering" the market to reach a predetermined result, Br. 19, 20, and claim that under the Government's theory of the case it could pick a market "randomly without purpose," Br. 47. Those charges are baseless.

Both sides' experts explained that market definition under the *Merger Guidelines* (*i.e.*, the hypothetical monopolist test) begins with a narrow market consisting only of the defendants' hospitals. *See* Tr.453 (A53), 1316 (RSA17); DX5000 ¶38. If a hypothetical monopolist owning those hospitals could profitably impose a SSNIP, then an area containing just those hospitals constitutes a relevant geographic market. If the monopolist could *not* impose a SSNIP, then additional hospitals must be added to the market until the test is satisfied. *See* DX5000 ¶38.

Once the candidate market satisfies the hypothetical monopolist test, it is a relevant market for antitrust purposes and there is no need to continue adding hospitals to the market. PX06000 ¶86; DX5000 ¶38. Applying the test in this way does not mean that the market is "gerrymandered" or that the Government has

"assume[d] the answer" to the question of which hospitals should be in the market. Br. 19. It is simply how economically sound market analysis is done.

Dr. Tenn concluded that a hypothetical monopolist owning just the six hospitals owned by Advocate and NorthShore in Chicago's northern suburbs could successfully impose a price increase of more than 5 percent. An area containing those six hospitals only is therefore a relevant geographic market for antitrust purposes. That market would have been sufficient in itself to analyze the merger.

But Dr. Tenn went further. To be conservative in defendants' favor, he applied neutral criteria, using evidence-based assumptions about what hospitals might be in a relevant market, to add five nearby non-party hospitals to the proposed market. *See* Gov't Br. 15-16. That broader market also passed the hypothetical monopolist test. Even within the expanded market, which Dr. Tenn called the North Shore Area, the merger would lead to market shares and concentration figures far beyond those presumed unlawful. PX06000 ¶115. The district court ignored the analysis entirely.

D. Defendants Conceded That Even If The Market Included Northwestern Memorial And Presence St. Francis, The Merger Would Still Be Presumptively Unlawful

The district court rejected the Government's proposed market largely on the ground that it improperly excluded downtown academic medical centers, which Dr. Tenn deemed "destination" hospitals. Op. 9-11. Defendants focus primarily on Northwestern Memorial, the second-choice option for 21.3 percent of NorthShore patients; no other downtown hospital comes close to that level of diversion.

Defendants also focus on Presence St. Francis, a local hospital three miles away from NorthShore Evanston. Br. 12, 14-15. But defendants have conceded that even if these two hospitals were added to the Government's proposed market, the merger would remain presumptively unlawful.

As explained at pages 18-19 of the Government's opening brief, a merger is presumptively unlawful if it results in market concentration figures—HHIs—exceeding certain thresholds. Dr. Tenn calculated pre- and post-merger HHIs for multiple different proposed markets, including a six-hospital market, the eleven North Shore Area hospitals, and a 15-hospital market. PX06000 ¶116. All yielded presumptively unlawful results. Dr. Tenn opined that the six-hospital market was a relevant market, but that at a minimum the relevant market should be no broader than the 11-hospital market.[3]

Defendants expressly conceded in their closing argument before the district court that even if Presence St. Francis and Northwestern Memorial are added to the 11-hospital market, market concentration exceeds the threshold and the merger is *still* presumptively unlawful. Tr.1890-91 (RSA21-22).

[3] Dr. Tenn also performed a competitive effects analysis and concluded that the merger would result in an 8 percent price increase at defendants' hospitals no matter how the geographic market is defined. The analysis accounts for all hospitals in the greater Chicago area, including Northwestern Memorial and Presence St. Francis, wherever located. Tr. 489-490 (A89-90); PX06000 ¶184; *see also* DX5000 ¶39 (defendants' expert stating that the patient choice model is "designed to estimate merger-induced price increases and assess merger effects without need for a geographic market definition"); Tr.1638 (A153).

II. THE GOVERNMENT'S EXPERT PROPERLY APPLIED THE HYPOTHETICAL MONOPOLIST TEST TO THE PROPOSED MARKET

Defendants assert that the Government improperly applied the hypothetical monopolist test. The alleged errors, they claim, render the district court's decision legally sound. Br. 21.

The argument fails at the outset because the district court did not assess whether the Government's expert properly applied the test and it did not reject the Government's proposed market on the ground that it failed to satisfy the hypothetical monopolist test. Rather, it rejected the market without even considering that test. Even if defendants were right that the Government incorrectly applied the test (they are wrong as described immediately below), that would not redeem the district court's basic analytical error. The Government's analysis was correct in any event.

A. The Merger Guidelines Do Not Require Outlying Hospitals To Be Included In The Market

Defendants argue that Example 6 of the *Merger Guidelines* "requires" that the relevant geographic market include certain competitors even if the hypothetical monopolist test shows those competitors cannot sufficiently constrain a price increase. Br. 48. The *Guidelines* state that "[w]hen applying the hypothetical monopolist test to define a market around a product offered by one of the merging firms, if the market includes a second product, the Agencies will *normally* also include a third product if that third product is a *closer substitute* for the first product than is the second product." *Merger Guidelines* § 4.1.1 (emphasis added).

Defendants appear to be arguing, based on diversion ratios, that Northwestern Memorial is a closer substitute for the NorthShore hospitals than the Advocate hospitals, and that Northwestern Memorial therefore should be included in the market.

To begin with, defendants' argument is a red herring. As described above, even if Northwestern Memorial were added to the 11-hospital market, defendants' proposed merger would remain presumptively unlawful.

Defendants also misconstrue Example 6. It does not *require* the inclusion of any competitor; rather, it *allows* inclusion under certain circumstances absent here. In the context of geographic market definition, Example 6 might be invoked to avoid implausible geographic markets that, for example, exclude competitors located in the center of the market (resulting in a donut-shaped geographic market), or exclude one link in the middle of an otherwise unbroken chain.

No such consideration exists here. The Government's proposed market does not resemble the donut-shaped or broken-chain market. It also conforms to the overwhelming evidence that when insurers assemble health care networks, they do not view Northwestern Memorial (or other downtown academic medical centers) as viable substitutes for local North Shore Area hospitals.

Moreover, defendants ignore other provisions in the *Guidelines* that support the decision to exclude Northwestern Memorial from the market. Immediately preceding Example 6, for instance, the *Guidelines* explain that a relevant market may properly be identified around a group of products (or suppliers) "even if

customers would substitute significantly to products [or suppliers] outside that group in response to a price increase." *Id.* § 4.1.1 & Ex. 5. Likewise, immediately following Example 6, the *Guidelines* explain that "[b]ecause the relative competitive significance of more distant substitutes is apt to be overstated by their share of sales, when the Agencies rely on market shares and concentration, they *usually do so in the smallest relevant market satisfying the hypothetical monopolist test.*" *Id.* & Ex. 7 (emphasis added). Here, where the conservatively estimated proposed market satisfies the hypothetical monopolist test, there is no good reason to broaden the market.

Read as a whole, the *Merger Guidelines* allow in some circumstances the inclusion of additional competitors beyond what would be necessary to satisfy the hypothetical monopolist test. But they do not require inclusion and indeed caution against creating an inaccurate picture of the merger's competitive effects. Under these circumstances, the Government's exclusion of Northwestern Memorial (and the other downtown academic hospitals) from the relevant geographic market is appropriate.

It is also supported by the great weight of the record evidence. Uncontroverted evidence reflecting the market's commercial realities demonstrates that insurers do not consider Northwestern Memorial, or any other downtown hospital, to be a sufficiently close substitute for North Shore Area hospitals that they should be included under Example 6. As described in greater detail in Argument III below, the evidence showed that insurers would sooner accept a price increase than

attempt to sell a plan that offered insured patients no access to North Shore Area hospitals, notwithstanding the existence of Northwestern and Presence St. Francis.

B. The Government Showed That A SSNIP Would Be Profitable.

Defendants also argue that Dr. Tenn failed to show that a SSNIP would be profitable. In fact, his analysis shows unambiguously that a SSNIP would be profitable. *See* PX06000 ¶¶98-100 (explaining why the hypothetical monopolist would be able to profitably raise price). By its very construction, Dr. Tenn's hypothetical monopolist test identifies the profit-maximizing price that a hypothetical monopolist would charge. Tr.491 (A91). In particular, Dr. Tenn's analysis relies on (i) the diversion ratios described above; (ii) Advocate, NorthShore and other hospitals' gross profit margins; and (iii) the parties' relative pre-merger prices. PX06000 ¶¶178-180.[4] By design, these factors account for all of the considerations that determine whether a price increase would be profitable. They show that a hypothetical monopolist of the hospitals in the North Shore Area could profitably raise prices by at least 5 percent.

[4] Defendants' assertion that Dr. Tenn had insufficient data for his calculations (Br. 51-52) is meritless. They contend that he lacked margin data, but he used Advocate's own margin data and made conservative assumptions about the margins of other North Shore Area hospitals, none of which defendants undermined at trial. PX06000 ¶100 n.195 & ¶179. Defendants claim that Dr. Tenn did not account for "demand elasticity," but by its design, Dr. Tenn's model did account for that measure. The hospitals' gross profit margins indicate both their pre-merger bargaining positions and the elasticity of demand.

Dr. Tenn did not offer this as a "bare conclusion," as defendants wrongly allege. Br. 52. Dr. Tenn explained his analysis in great detail, provided the underlying data, and was extensively deposed and cross-examined on the issue.

C. A Hypothetical Monopolist Could Successfully Impose Price Increases Even On Large Insurers

Defendants argue that because insurers, in particular Blue Cross, are large companies, that somehow neutralizes a hypothetical monopolist's ability to profitably raise prices. Br. 52-53. Not so.

To begin with, Blue Cross is not the only insurer in the market; other, smaller insurers have weaker bargaining positions. A hospital system with sufficient bargaining leverage could force even large insurers to accept price increases. *See ProMedica*, 749 F.3d at 562.

More fundamentally, a merger changes relative market power. Before the merger, both the hospitals and the insurers come to the negotiating table with a certain amount of bargaining power; the agreed-upon prices reflect their relative positions. After the merger, the insurers' bargaining power stays the same, while the now-combined hospitals' power has grown, enabling the hospitals to obtain increased prices. The antitrust laws guard against such merger-driven increases in market power.

Insurer testimony in this case confirms that hospitals can and do refuse to enter agreements with even the largest insurers, and that hospitals use their bargaining leverage to demand higher prices. *See, e.g.*, Tr.206 (RSA6) (Blue Cross could not just walk away from Advocate); Tr.249 (RSA7) (Advocate would not accept

the discount BlueCross requested to participate in BlueChoice); [redacted]; PX03014 ¶4 (a hospital with fewer competitors has greater leverage to negotiate higher rates).

III. THE DISTRICT COURT ERRONEOUSLY REJECTED OVERWHELMING EVIDENCE SHOWING THAT THE COMMERCIAL REALITY OF THE INSURANCE MARKET SUPPORTS THE GOVERNMENT'S PROPOSED MARKET

Defendants mischaracterize the Government's case as asking the 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." Br. 43. In fact, the evidence overwhelmingly demonstrates that hospitals themselves recognize the northern suburbs as a distinct market separate from downtown Chicago,[5] that Advocate and NorthShore compete closely in that market,[6] and that Northwestern Memorial and other downtown hospitals are inadequate substitutes from the perspective of insurers.[7] The district court improperly rejected that evidence, and defendants now ask this Court to ignore the commercial reality reflected in that record and rely instead on diversion statistics unconnected to a complete hypothetical monopolist analysis.

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[5] *See, e.g.*, PX04074-003, 007, 014, 019; PX07017-008-009.

[6] *See* Gov't Br. 45.

[7] *See, e.g.*, Tr.314-15; PX07076-008; PX04032; PX05101; Tr.83-84 (RSA3-4), 93 (A7), 157-58 (A17-18), 1156 (A130); PX03004 ¶20.

A. Commercial Reality Demands That Insurers Offer Plans In The North Shore Area That Provide Access To Local Hospitals

Uncontroverted evidence demonstrated that insurers cannot offer commercially viable health plans that do not offer access to local care. Indeed, defendants do not attempt to defend the district court's erroneous conclusion that the evidence on the question was "equivocal." *See* Gov't Br. 43-46.

The court erred further when it rejected in a two-sentence footnote (Op. at 9-10 n.4) Dr. Tenn's explanation for excluding downtown academic hospitals from his candidate market. The court determined that the evidence on which Dr. Tenn relied was unreliable because it came from "parties opposed to the merger" and because it was "undermined by the diversion ratios that Tenn calculated." Both of those conclusions are wrong.

As the Government explained in its opening brief, patient diversion ratios do not undermine the insurer testimony. The record shows that roughly three-quarters of patients in the North Shore Area receive inpatient services there, PX06000 ¶¶74, 107, and diversion ratios show that about half of North Shore Area patients would choose another local North Shore Area hospital as their second choice. *Id*. ¶99 Table 5. The district court assumed, in the absence of any evidence, that an insurer would offer a health plan that excludes the first and second choice hospitals of up to half of consumers before it would pay a small price increase. This was clear error.

Defendants conceded below that an insurer's hospital network will be marketable to employers—who make up the vast majority of the market—only if it can attract a "critical mass of employees." Def's FoF ¶45. If the network is not attractive to a significant fraction of employees, employers are unlikely to purchase it. The insurer testimony established that a network that offered access to neither Advocate nor NorthShore hospitals would be unmarketable to employers in the northern suburbs. *See, e.g.*, [redacted] *A fortiori*, a network that excluded all 11 hospitals in the North Shore Area would be even less marketable—and insurers would rather pay a SSNIP than attempt to sell that network.

Dismissing the insurer testimony as biased cannot be squared with the record. United and Humana may favor the merger, Br. 10, but their testimony firmly supports the Government's case.[8] A United executive testified unequivocally that her company [redacted] An executive from Humana similarly stated under oath that while his company [redacted]

[8] The district court mistakenly identified United as being opposed to the merger.

[redacted]

Id.

Defendants contend that similar insurer testimony "actually concerned the importance of Advocate and NorthShore hospitals throughout Chicagoland" and not just in the Government's proposed market. Br. 20; *see also id.* at 34. The record proves otherwise. [redacted] all testified that they would have difficulty offering a commercially viable product to consumers *in northern Cook and southern Lake counties* without Advocate or NorthShore.

[redacted]

B. No Insurer Successfully Sells Health Plans In The North Shore Area That Exclude All Local Hospitals

Defendants assert that 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." Br. 38 (emphasis added). This case concerns not "Chicago" but the specific North Shore Area. With respect to the Government's proposed market, the claim is dead wrong.

Witnesses from Blue Cross and Cigna testified about their "narrow network" insurance plans that offer a limited number of hospitals in exchange for a lower premium. Neither insurer remotely suggested that a network without both Advocate and NorthShore (much less one without all North Shore Area hospitals) would be commercially viable in the North Shore Area. To the contrary, [redacted]

[redacted]

Blue Cross's "Project Remedy," a proposed narrow network, disproves defendants' argument even more strongly. That network never advanced beyond a concept and was never marketed to any employer. Blue Cross testified that [redacted] Tr.186-187 (A23-24), 280-281 (RSA8-9). Blue Cross currently offers the BlueChoice network, which excludes Advocate and NorthShore but includes numerous downtown hospitals. That product has failed to attract employers despite marketing efforts. Tr.168-69 (A20-21). It is sold primarily to individuals directly on the public exchange, and even there residents of the northern suburbs are barely interested—about 1.5 percent of subscribers live in northern Cook County. Tr.169 (A21), 186-87 (A23-24), 280 (RSA8).

The testimony consistently showed that networks without local hospitals would be unattractive to a critical mass of employees in the North Shore Area and thus would not be marketable to employers.[9] That evidence indicated that a hypothetical monopolist owning all 11 hospitals in the North Shore Area could successfully demand at least a 5 percent price increase. Some patients may wish to obtain care near their workplace or may travel downtown due to physician referrals

[9] Aetna is the only insurer that did not offer testimony precisely on point. It testified that NorthShore and Northwestern are interchangeable "for network adequacy purposes," Tr.1183 (RSA15), a term that refers to regulatory requirements, not marketability. Tr.1670-71 (RSA19-20); *see also* Tr.1115 (A129), 1130-1131 (A128) (RSA14).

from outpatient facilities, but those factors do not undermine this conclusion. *See* Gov't Br. 25 (explaining "silent majority" fallacy); *Saint Alphonsus*, 778 F.3d at 785 (Nampa, Idaho was a relevant geographic market even though 30 percent of residents sought care near workplaces in Boise).

The district court utterly failed to take into account consistent testimony about the commercial reality of the insurance marketplace. As a result, its decision implicitly endorsed the defendants' view that the relevant market consists of at least 20 hospitals spanning from Waukegan to the South Side of Chicago. If that were the case, then no hospital merger in a major metropolitan region could ever be effectively challenged. But FTC precedent shows that three of *the very hospitals involved in this merger*—Evanston, Glenbrook, and Highland Park—were able to raise prices after they merged in 2000. In the *Evanston* proceeding, the FTC determined that those three hospitals alone (which later became NorthShore and joined with a fourth hospital) were able to profitably demand a substantial rate increase from insurers. The hospitals were successful in demanding the increase notwithstanding the presence of the very same academic medical centers on which defendants now rely. *In re Evanston Nw. Healthcare Corp.*, 2007 WL 2286195 at *2, 53, 66 (F.T.C. Aug. 6, 2007). The FTC found that just those three hospitals constituted a "well-defined antitrust geographic market under Section 7." *Id.* at *66. The present market is even larger.

The *Evanston* proceeding provides an additional lesson pertinent here: although the FTC ultimately held that the merger violated the Clayton Act, by the

time the proceeding had run its course, it was too difficult to unwind the merger. That is why Congress has authorized courts to preliminary enjoin mergers pending administrative proceedings.

CONCLUSION

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

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7) because it contains 6945 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii). It complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and 7th Cir. R. 32(b) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using 12-point Century Schoolbook type in the body of the brief and 11-point Century Schoolbook type in footnotes, using Microsoft Word 2010.

/s/ Imad D. Abyad
Imad D. Abyad

CERTIFICATE OF SERVICE

I certify that on August 12, 2016, I electronically filed the foregoing Reply Brief with the Clerk of the Court of the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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REPLY SUPPLEMENTAL APPENDIX

(PUBLIC VERSION)

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CERTIFICATE OF SERVICE

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up in Chicago, so I know the area fairly well, and we look to design a network that would be attractive to all the employer groups that we serve here within the marketplace as well as outside the marketplace that have employees that live here.

03:12:18 Q. Okay. And previously you mentioned access -- geographic access, service levels. What about price?

A. Oh, price is absolutely important. Price is key.

Q. Now, when you're negotiating with hospitals or other providers, what are the most significant issues in terms of

03:12:40 being -- terms being negotiated during those discussions?

A. So every negotiation is different. Price is something that we certainly look at, and it goes to the things I just talked about.

We look at price. We look at the services that are

03:12:55 provided. Our relationships, the different types of services that can be provided to the customers in the community, the geographic area, all those things combined, every negotiation is different, but those are certainly some of the main components we look at.

03:13:12 Q. Okay. And what determines ultimately the rates and terms that you agree upon with a hospital provider?

A. Ultimately, a very long negotiation, but certainly there's a discussion. We have to determine the services that each party is looking to include in the contract, and typically if

03:13:37 we're negotiating with a hospital, we're looking at inpatient

and outpatient services in totality.

We look at the geographic area.

We look at what our competitors, what we believe our competitors are paying for those same services, as well as the 03:13:53 competitors of those provider entities, so those health systems, we look at what their competitors are charging.

Q. So earlier you discussed in -- or participating versus nonparticipating providers in a network.

Does the ability to keep a hospital that's 03:14:09 nonparticipating affect the -- your final negotiating stance?

A. So in our Open Access product, we have all the providers and health systems in the Chicago market participating.

In a narrower network, there is ability to drive more volume when there are hospitals that are nonparticipating in 03:14:35 that network.

Q. By being able to drive more volume, what does that mean to the hospital?

A. More customers would seek care at a particular facility if others were nonparticipating because of the cost sharing.

03:14:45 Q. And what does that mean to Cigna in terms of the rates that you negotiate?

A. Typically, in those cases, we can negotiate a lower rate with that participating hospital.

Q. Now, do hospitals compete to be included in Cigna's 03:15:03 products?

A. They provide a similar type of service level and quality.
Q. And what about Northwestern Lake Forest?
A. Northwestern Lake Forest does not have some of the same services and levels of care that both Evanston -- NorthShore
03:21:51 Evanston and Advocate Condell provide.
Q. What's your basis for that statement?
A. Information that's publicly available. Both -- both Advocate Condell and NorthShore Evanston are Level 1, designated Level 1 trauma centers.
03:22:14 Q. And is having a Level 1 trauma center important to be included in a network?
A. Absolutely, and from a perception basis, there is a quality component that goes with that and a perception in the community.
03:22:30 Q. Okay. Now, Ms. Norton, do some of your members in the northern Cook County or southern Lake County travel to downtown Chicago for hospital care?
A. Potentially, yes.
Q. Okay. And tell us about that.
03:22:42 MR. WEBB: Well, object to the form -- I don't mind -- object to the narrative form of the question.
THE COURT: Sustained.
Another question, Mr. Hahm.
BY MR. HAHM:
03:22:52 Q. Do members travel to downtown Chicago?

A. So, potentially, there are members that live in the NorthShore catchment area, so in the Evanston-Skokie-Glenbrook- Highland-Park area, that travel into the city for care. Typically those people seek care in
03:23:13 their own communities, but some do travel to where they work or for a higher level of care potentially at an Academic Medical Center if there's a specialty that they're looking for.

Q. And an Academic Medical Center might be Northwestern
03:23:31 Memorial?

A. Correct.

Q. Now, could Cigna offer a network that only included Academic Medical Centers but did not include Advocate and NorthShore?

03:23:41 MR. WEBB: Objection, speculation.

THE COURT: Overruled.

BY THE WITNESS:

A. So when we constructed the Local Plus network, Northwestern Memorial is in our network and that is an
03:23:54 Academic Medical Center; but what we heard from consultants and brokers and from people in the community was that we needed some community-based health systems in that network for it to be viable.

BY MR. HAHM:

03:24:08 Q. Okay. And I just want to be clear, we're going to stay

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A. That's correct.
Q. In fact, to your knowledge, nobody at Blue Cross Blue Shield of Illinois has done so, correct?
A. That's correct.
12:01:30 Q. And have you threatened to cut NorthShore out of the Blue Cross Blue Shield system?
A. Not to my knowledge.
Q. And would it surprise you to know that Advocate actually, with all that business, 70 percent of the commercial business,
12:01:44 that they actually need you guys?
A. I think it's pretty solid that we need each other.
Q. In fact, you know -- you know when you go into negotiate that Advocate can't just walk away from Blue Cross Blue Shield; can they, sir?
12:02:02 A. Neither could we just walk away from them.
Q. And when Condell had a hard time with Blue Cross Blue Shield, they didn't actually run into fast, great times after they got out of the network; did they, sir?
A. They did not.
12:02:19 Q. They went downhill fast, right?
A. They did.
Q. In all your negotiations with Advocate, you never -- you never once mentioned to Dr. Sacks -- he's one of the fellows you negotiated with, right?
12:02:36 A. That's correct.

Q. Okay.

And Condell Hospital subsequently was acquired by Advocate; is that right?

A. That's correct.

01:59:44 Q. Now, counsel asked you if Advocate can do without Blue Cross. Now, doesn't Advocate -- isn't Advocate a non-participating provider in BlueChoice?

A. They are.

Q. Okay.

02:00:00 And why are they not participating in BlueChoice?

A. Despite our discussions and negotiations around their participation in BlueChoice, they chose not to take the requisite discount to participate in BlueChoice.

Q. Couldn't come to terms?

02:00:18 A. Couldn't come to terms, correct.

Q. Earlier there was a discussion about the growing interest in narrow networks. Is there -- is it beneficial to have as many providers as possible to compete to participate in those narrow networks?

02:00:39 A. The attraction of this, certainly of a product, is directly correlated with the breadth of the network and the value of cost it provides. So, very much it becomes more attractive the more hospitals and physicians you can add to it.

02:00:56 Q. And is it beneficial for Blue Cross to have as many

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SEALED MATERIAL OMITTED FROM PUBLIC APPENDIX

more intense services that it does, which also is part of being an Academic Medical Center, I think.

Q. Do patients generally travel farther for tertiary and quaternary care services?

03:05:41 A. Yes, they do.

Q. And do you have an understanding as to why that would be the case?

A. Well, basically, because if you need those kind of services, you're going to an Academic Medical Center; and,

03:05:54 usually you have to go farther to get to -- or you may have to go farther to an Academic Medical Center to get to those services.

Q. You previously mentioned you have some responsibilities with Northwestern's managed care contracting, correct?

03:06:06 A. Yes.

Q. What are Northwestern's goals when it enters into negotiations with managed care contracting companies or insurance companies?

A. Well, basically, its goals are to get as much

03:06:19 reimbursement as we can because, you know, it is expensive to run a health system and an Academic Medical Center, and we're trying to cover those costs and to be able to continue on our mission.

Q. Are you familiar with the term "in-network provider"?

03:06:34 A. I am.

Q. Do patients from the northern suburbs travel down to Memorial for inpatient services?
A. Some do, yes.
Q. What types of inpatient services do patients from the
03:43:23 northern suburbs travel to Memorial for?
A. Well, it actually is a mix. I mean, we do get some more primary care services, if you will. So obstetrics we do get from the north, but otherwise typically it would be a, you know, a surgery or an intense medical episode, where people
03:43:43 want to have access to the Academic Medical Center.
Q. And in your opinion, why do patients come down from the northern suburbs to receive hospital care at Northwestern Memorial?
MR. DAHLQUIST: Objection, your Honor. Calls for
03:43:55 speculation.
THE COURT: Overruled.
BY THE WITNESS:
A. Because they think that basically they're going to be able to get good care. They're trying to get the good care from an
03:44:01 Academic Medical Center, and if they're coming to us fortunately for us, they have chosen us as the source of that care.
BY MR. CAPUTO:
Q. Given that Memorial draws some patients from the northern
03:44:11 suburbs, would you consider Memorial to be a competitor with

the GAC hospitals in the northern suburbs of Chicago?
A. Not really. I mean, the key thing here is that the percentage of the near north and far north that is actually coming down, of the total admissions that are coming down to
03:44:29 Memorial Hospital is less than 5 percent.
Q. Does -- and what do you mean by less than 5 percent? Less than 5 percent of what?
A. Of hospital admissions.
Q. At Memorial?
03:44:42 A. No, no, at -- if I looked at the far north Lake and people that originate in that far north Lake market that need inpatient services, okay, less -- actually, in the case of far north Lake, it's less than 3 percent of those patients are coming down to Memorial.
03:44:59 Q. Okay. And what do you base your understanding on?
A. Well, we have and we have a lot of documents that we've produced that show that, that show what is the number of admissions and percentages of admissions at different hospitals, including Memorial, from the different market
03:45:14 areas.
Q. Does Memorial attract patients for inpatient care from the western suburbs of Chicago?
A. Yes.
Q. Does Memorial attract patients for inpatient care from the
03:45:24 southern suburbs of Chicago?

09:22:04 successful in blocking the merger between Advocate and
09:22:07 NorthShore, will United's members be harmed?
09:22:10 A. I believe so.
09:22:11 Q. Ms. Beck, tell the Court how large United is in Illinois.
09:22:18 A. As of February 2016, we're 1.5 million members; and that's
09:22:23 all segments, all funding.
09:22:25 Q. And what percent of United's business in Illinois is
09:22:30 commercial membership?
09:22:31 A. About 70 to 75 percent.
09:22:35 Q. I want to move on and briefly discuss how United puts
09:22:44 together its provider networks, on somewhat of a high level.
09:22:48 Are you familiar with the term "network adequacy"?
09:22:51 A. Yes.
09:22:51 Q. And what does that mean?
09:22:52 A. That means that we have time and motion requirements that
09:22:55 the State defines for an adequate network to be met for
09:23:02 different types of providers.
09:23:04 Q. For a primary care physician, what are those State
09:23:07 requirements?
09:23:08 A. They have an urban requirement and a rural requirement.
09:23:15 And that can vary from 30 minutes/30 miles or 60 minutes/
09:23:21 60 miles.
09:23:21 Q. Is Cook County and Lake County, are those urban or rural?
09:23:26 A. I would say urban.
09:23:27 Q. And so what would be the mileage standard in those

09:43:36 Q. Could United offer a network that was just made up of
09:43:41 downtown academic medical centers to its members in the
09:43:45 northern suburbs?
09:43:47 A. We would need physicians, ancillaries, and if the service
09:43:52 area was just Cook County, we would need additional hospitals
09:43:58 to meet the access requirements.
09:44:04 MS. MILICI: Okay. I think that that's all I have,
09:44:06 and the rest is for the closed session.
09:44:08 THE COURT: Thank you, Ms. Milici.
09:44:13 All right, ladies and gentlemen, at this time the
09:44:16 questioning is going to involve some confidential --
09:44:20 previously designated confidential documents and questions.
09:44:23 So I'm going to ask all the individuals that are not
09:44:25 designated as being able to remain to leave the courtroom.
09:44:29 And we will open the doors as soon as that line of direct and
09:44:34 cross is over.

(Whereupon proceedings were heard in closed courtroom)

11:06:07 Chicagoland, so I can't tell you how any other system scored
11:06:12 with that. But from our perspective, Advocate has the most
11:06:18 depth and breadth population health management capabilities in
11:06:24 the Chicagoland area.
11:06:25 Q. Is an Advocate -- I'm sorry. Strike that.
11:06:27 Is an Advocate-only Accountable Care Solutions
11:06:29 product marketable beyond the individual consumer segment?
11:06:33 A. Could you ask that again specifically?
11:06:35 Q. Sure.
11:06:35 Is an Advocate-only Accountable Care Solutions
11:06:37 product marketable beyond the individual segment?
11:06:41 A. We do not believe it's marketable beyond the individual
11:06:45 segment. The geographic breadth is not sufficient for us to
11:06:51 put the product in additional -- in additional segments at
11:06:56 this point in time.
11:06:56 Q. In order to fill that geographic gap to make the product
11:07:02 marketable for the -- up to the large-group employers as you
11:07:05 testified, what other providers did Aetna consider?
11:07:08 A. We considered both Northwestern, Northwestern Memorial,
11:07:12 and NorthShore.
11:07:13 Q. And based on Aetna's analysis, were Northwestern Memorial
11:07:18 and NorthShore interchangeable providers to complete the
11:07:22 network?
11:07:23 A. For network adequacy purposes, they were pretty much
11:07:27 interchangeable.

01:03:44 that uses this phrase "destination hospital" as a means to
01:03:48 exclude them from a geographic market?
01:03:50 A. I have not.
01:03:51 Q. Have you ever seen the same for this issue of having a
01:03:54 hospital that has to compete against both sides of the merging
01:03:59 parties before you can even look at them?
01:04:01 A. No. The idea would be that you can constrain the post
01:04:05 merger system by constraining any of its hospitals.
01:04:08 Q. And what about this two percent cutoff? Ever seen that
01:04:11 before, sir?
01:04:12 A. I'm sorry?
01:04:13 Q. This two percent cutoff that Dr. Tenn used, have you ever
01:04:17 seen that?
01:04:17 A. No, not -- no, not the cutoff.
01:04:19 Q. Does that make any economic sense to you?
01:04:22 A. There's a lot of things that are sort of arbitrary where
01:04:26 you got to pick a point, but there's no sacredness to that
01:04:30 point, two percent being that particular point.
01:04:32 Q. And just real quickly, those three things we just went
01:04:36 over, the destination hospitals, you have to compete against
01:04:41 both and the two percent cutoff, ever seen that in a hospital
01:04:44 case in court ever, sir?
01:04:46 A. No.
01:04:47 Q. Now, let's talk first about the destination hospital
01:04:51 issue. And I'll put up slide DDX 12048-17, which is slide 16,

03:18:04 significant competitive effect.
03:18:05 Q. In determining a relevant geographic market based on
03:18:08 supplier location -- and I'd appreciate it if we just limit
03:18:11 the discussion to that -- one uses the hypothetical monopolist
03:18:14 test; is that true?
03:18:15 A. That -- that's -- that's part of the process -- to use the
03:18:23 hypothetical monopolist test.
03:18:23 Q. It's what the Guidelines instructs is the process to use
03:18:26 when defining geographic market by supplier location, true?
03:18:29 A. Yes.
03:18:29 Q. And you start with the hospitals of the merging parties,
03:18:33 correct?
03:18:33 A. You -- you -- yes.
03:18:37 Q. You take the merging parties' hospitals and you ask, could
03:18:40 a hypothetical monopolist owning just the merging parties'
03:18:43 hospitals allow a hypothetical monopolist to raise price by
03:18:47 five percent or more, right?
03:18:48 A. That's the thought experiment, yes.
03:18:51 Q. And the question is whether the hypothetical monopolist
03:18:55 owning the two parties' hospitals could raise price by five
03:18:59 percent or more over prevailing prices, correct?
03:19:01 A. Generally, that's how it's defined.
03:19:03 Q. Now, if we could put up DX 5000-26, which is from your
03:19:09 expert report, I want to look at how you describe this process
03:19:14 in Paragraph 38.

12:12:58 the open access products that don't have benefit design like
12:13:01 the HMO.
12:13:02 Q. And leakage increases your costs under a risk contract,
12:13:06 correct?
12:13:07 A. In some cases it does.
12:13:10 Q. And the more leakage you experience, the less you stand to
12:13:14 earn under a risk contract, correct?
12:13:15 A. Possibly. There's leakage to lower-cost hospitals as
12:13:22 well. But in general, it leaks to higher costs.
12:13:25 But, you know, the other piece with leakage is we are
12:13:29 inadvertently subsidizing higher-cost hospitals because if you
12:13:36 buy a premium -- let's pick on Blue Cross PPO -- the premium
12:13:40 is the same for everybody, if they use Advocate or if they use
12:13:42 Northwestern or if they use Rush or if they split between.
12:13:45 The consumers have not gotten the benefit of our reduction in
12:13:50 the total cost of care. It's been diluted by some of our
12:13:54 competitors who pushed up prices to the health plans, as well
12:13:58 as starting with higher prices.
12:13:59 Q. So a problem with leakage then is that patients attributed
12:14:02 to Advocate could go elsewhere for care and Advocate would be
12:14:05 on the hook for that cost of care, correct?
12:14:08 A. Correct. And recall that in the shared-savings program,
12:14:14 attributed has nothing to do with patients making a choice.
12:14:19 It's a calculation done based on claims information. Whereas,
12:14:24 in the HPN, BlueCare Direct, or in the HMO products, patients

Do you know that -- you heard testimony in this case that the standard for the State of Illinois is 30 miles?
A. My understanding is that the minimum regulatory requirements, which is unrelated to whether or not -- that's
10:08:49 something that patients or employers would want.
Q. Okay. So, for example, we'll put up DDX 12062.
You're familiar with the State of Illinois mileage requirements for adequacy? Are you familiar with that?
A. I have some familiarity. I don't claim to be an expert on
10:09:17 this regulatory process.
Q. You do know it's 30 minutes or 30 miles for primary care, OB/GYN, and general hospital care, right, sir?
A. That sounds right to me. I couldn't say that with certainty. It does not sound incorrect.
10:09:26 Q. And you know for the Affordable Care Act, it's a lot further, right?
A. I don't know the specific numbers.
Q. Did you bother to check to see what the actual state and federal requirements are for drive times to hospitals?
10:09:39 A. I have reviewed a wide range of material. I believe I have reviewed these type of documents before.
The key question, of course, is to what extent are health plans unattractive if they don't have local providers. These regulatory requirements do not speak to the issue of do
10:09:56 patients and employers want to have local providers in the

northern suburbs. It's a minimum requirement in a regulatory process.

Q. I just asked if you checked for the state and federal standards. And the answer is you did not?

10:10:09 A. I believe what I just said is I reviewed a wide range of material including --

Q. Then just say you looked at it. Okay.

Now, you did hear testimony from Ms. Beck from United Healthcare about the 30-mile, 30-minute rule, right?

10:10:22 A. I recall people discussing it. I can't recall sitting here today whether it was Ms. Beck.

Q. And from Aetna; you remember seeing that, right?

A. As I just testified, I recall someone testifying to that. Whether it was Aetna or United, I could not say right now.

10:10:42 Q. And do you remember -- let me put up Nettesheim hearing transcript from this hearing, 1183, page 16 to 25.

Were you here during Aetna's testimony?

A. I was here for part of it.

Q. Did you know that she said that for network adequacy

10:11:03 purposes, that Northwestern Memorial and NorthShore were pretty much interchangeable, right?

A. I can read that here. I don't specifically recall whether I was here for that part of it. I may or may not have.

Q. And you agree with that, right?

10:11:15 A. I don't know what she means by network adequacy, whether

are in that far right-hand column, which are Presence Resurrection, Swedish Covenant, and Advocate Condell. They're in the relevant market and Presence St. Francis is excluded, which is a stronger competitor against NorthShore.

12:28:30 So, Your Honor, I told you at the beginning of the case I thought this case was not that complicated. We as lawyers always make things complicated. But if you just take the three hospitals I just talked about, if you take Northwestern, you take Rush, and you take St. Francis and you

12:28:58 just include those, just include those three and nothing else, then under this HHI guidelines that they're talking about, that you would then find under the Merger Guidelines that if you put those three in there, that there's -- that it's not concentrated enough to pass the HHI test; and there would be

12:29:10 no presumption of anticompetitive effects, and your judgment in this case would be to deny the plaintiffs' motion for a preliminary injunction, just based on those three hospitals. And when you compare those three hospitals to the other hospitals that Dr. Tenn included in the relevant geographic

12:29:27 market, there's just no justification for excluding those three hospitals. And it's that simple, in which case, the case would be in our favor.

Let me just --

THE COURT: Mr. Webb, I don't want to put you on the

12:29:42 spot, but what does that mean if I don't include all three?

What if I only include Northwestern and Swedish?

MR. WEBB: Well, we still would win the case because I think under the test, Your Honor, they're real competitors. But I was just referring to their HHI test.

12:29:56 THE COURT: Right. What does it do to those concentration levels, if you know?

MR. WEBB: If you only include two, they would be slightly above the mark that -- the HHI levels.

THE COURT: And I meant St. Francis and not Swedish.

12:30:10 MR. WEBB: Yes, I understand, Your Honor.

THE COURT: Yes, St. Francis. Okay.

MR. WEBB: But I wanted to point out to Your Honor that just those three, just those three if they're included, the verdict would be -- or the judgment would be in our favor.

12:30:20 I put here on the last chart, chart 21, Your Honor -- Mr. Robertson has walked through all these -- but there's five reasons why we believe you should deny the motion for preliminary injunction. The geographic market --

(Brief interruption.)

12:30:43 THE COURT: Mr. Webb, I'll apologize for whoever is actually responsible for that and the interruption.

MR. WEBB: I'm going to try to stay within our time limit. I'm going to conclude right now.

THE COURT: Take your time.

12:30:53 MR. WEBB: I put these five reasons on the chart that

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Q. No, no.
A. Sorry.
Q. What would be -- would that be effective -- how long -- what would be the earliest you could offer it on your private exchange?
A. So if the merger closed at the middle of this year?
Q. Yeah. The first of this year.
A. If the merger closed the first of this year, honestly I still think we'd be in the same place as before. I believe it would -- it would require extensive work over the next 12 months with multiple pricing exercises. They would have to figure out if they were going to go direct or through a payer. I don't see how that would all get done in a year. I still believe we'd be looking at 2018 to 2019 enrollment is my -- based on bringing 30 payers onto the system, I think this would take two years.
Q. Should the merger close, Mr. Levin, in 2016, would Aon still be interested in discussing with Advocate offering the combined Advocate/NorthShore high-performing network on

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the private exchange?
A. If the merger closes here, would we be interested in talking with them about it? Sure.
Q. Okay. But -- Let me see if I have one thing.
(Brief pause.)
BY MR. VORRASI:
Q. Earlier when you were talking with Mr. Dickinson, Mr. Levin, you said if a narrow network product is priced dramatically lower than the competitive set, in that case, it would be, additive was the word you used. What did you mean by additive?
A. So if you have -- narrow or broad, if you have a price point that has sufficient geographic spread, if enough hospitals are in the system, call it broad or narrow, and it's priced below the competitive set, it is additive. Meaning, employees who are choosing a plan would find it attractive because they can get health care at a cheaper price pint. And as the operator of the exchange, it's advantageous because it forces others who are already quoting to rethink their bids and

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potentially bring price down.
Q. And so if the Advocate/NorthShore high-performing network were priced as you just described, do you believe, given its geographic region, it would be additive to your employer clients?
A. I can't say definitively.
Q. But what's your assessment, looking at your letter?
A. Yeah. It's, again, hypothetical. So if -- if enough people thought it covered enough geographies and it was priced below the competitor set, then it stands to reason people would at least give it a look and be attractive.
MR. VORRASI: I have nothing further. Thanks for your time.
THE WITNESS: Okay.
MR. DICKINSON: I just have a couple of questions.
REDIRECT EXAMINATION
BY MR. DICKINSON:
Q. Sir, you testified a moment ago that if a network didn't have hospitals where people live, it's unlikely that those people

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would choose the network. Is that correct?
A. That is correct.
Q. In your opinion, would a network that excluded both Advocate and NorthShore be attractive to employers in the NorthShore area?
A. If there was a product that had neither system, it's hard for me to understand why anybody would buy it. In other words, I don't imagine people are going to drive outside the Chicago metro area to get care if that's where they live.
Q. And specifically in the NorthShore area, though, would you think -- in your opinion, would a product that excluded these two -- Advocate and NorthShore -- be attractive to those employers in the NorthShore area?
A. So I want to make sure I understand the question. So if you have neither NorthShore and you have neither Advocate, you have neither in the product, I think very few people would buy it, given many people on our exchange live in the geographies represented there.
Q. One other question. You were talking about the brand awareness point you

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