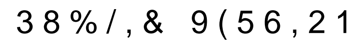
IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

FEDERAL TRADE COMMISSION And STATE OF ILLINOIS Plaintiffs, v. ADVOCATE HEALTH CARE NETWORK, ADVOCATE HEALTH AND HOSPITALS CORPORATION, And NORTHSHORE UNIVERSITY HEALTHSYSTEM Defendants.	No. 15-cv-11473 Judge Jorge L. Alonso Magistrate Judge Jeffrey Cole  3 8 % / , & 9 (5 6 , 2 1

AMENDED/CORRECTED REPLY MEMORANDUM
IN SUPPORT OF PLAINTIFFS' MOTION
FOR A PRELIMINARY INJUNCTION

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Vesta Corp. v. Amdocs Mgmt. Ltd., No. 3:14-CV-1142-HZ, 2015 WL 5178073
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Other Authorities

Defendants' proposed merger would combine the first and second largest hospital systems in the northern suburbs of Chicago. In the highly concentrated general acute care inpatient services ("GAC Services") market, Defendants have a combined share of 60%, which is well above the threshold necessary to establish a presumption of illegality. While this evidence is alone sufficient to establish Plaintiffs' likelihood of success on the merits, numerous other sources of evidence confirm that the merger is likely to harm competition. Defendants' own internal strategy documents show that Advocate and NorthShore are close and important competitors. Defendants' own experts agree that the two systems are good substitutes for each other and that each Defendant is constrained by competition from the other. Defendants' most important customers confirm that the elimination of this close and unmatched competition will greatly enhance the merged system's bargaining power. The inevitable result, as Plaintiffs' expert economist shows, is that the merger will lead to price increases.

Against this evidence, Advocate and NorthShore attempt to justify their anticompetitive merger with the speculative and implausible argument that it is actually good for consumers because it will allow managed care organizations ("MCOs") to sell Advocate's "high performing network" to more subscribers. "High performing network" is just a marketing term for a narrow network HMO insurance product, and being able to sell a narrow network to more subscribers is not an efficiency recognized under the antitrust laws.

Defendants claim that the purpose of the merger is to provide lower cost and higher quality healthcare. While these are laudable goals, Defendants fail entirely to demonstrate how the merger will generate such benefits. Any conceivable benefit of the "HPN" – which in any event would affect only the minority of residents who might choose this particular insurance

product – can be attained through means other than a merger of the two largest healthcare systems in northern Cook and southern Lake counties.

While the alleged benefits of the proposed merger are speculative, the harms from the merger are not. The merger will eliminate the substantial head-to-head competition between Advocate and NorthShore that benefits all healthcare consumers in the North Shore Area. Once the merger is consummated, the eggs cannot be unscrambled and competition cannot be restored. A preliminary injunction is warranted.

ARGUMENT

The standard applicable to Plaintiffs' Motion is well settled and uncontroversial. The FTC Act provides that a district court may grant a preliminary injunction "[u]pon a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest." FTC v. Elders Grain, Inc., 868 F.2d 901, 902 (7th Cir. 1989). The Seventh Circuit, like other circuits, applies a "sliding scale" approach to preliminary injunction mot9e

adduced by Plaintiffs.[1] Defendants also fail to produce evidence sufficient to rebut the

Distinct markets for inpatient and outpatient services are further confirmed by the Merger Guidelines, which state "[m]arket definition focuses solely on demand substitution factors, i.e.,

for inpatient GAC Services, higher rates for outpatient services, or both. The monopolist of inpatient GAC Services would have market power and the ability to unilaterally raise prices even if it faced significant competition in the outpatient services market and regardless of whether the rates for outpatient and inpatient services appear in the same contract.[5] Defendants' error is that they confuse *how* market power could be expressed with the fundamental question *whether* competition from providers of outpatient services could prevent a monopolist of GAC Services from raising prices.

test and is a relevant geographic market.[9]

Defendants argue that the North Shore Area is not a relevant geographic market because it does not include destination hospitals or hospitals that compete with only one party but not the other. This argument misses the point of geographic market definition altogether. The purpose

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agrees is widely accepted,[11] market shares are calculated based on a hospital's total admissions. Northwestern Memorial and other destination hospitals have a higher number of admissions than local hospitals, but their patients come from a much wider region and only 16% of the patients of the downtown destination hospitals come from NorthShore's service area.[12] Including all of the admissions at those hospitals would overstate their competitive significance to patients who currently obtain GAC Services from hospitals in the North Shore Area and who are most likely to be affected by the merger.[13]

more than five years ago, Professor Elzinga (who co-developed the test) published an article explicitly acknowledging that in hospital cases the E-H method is inconsistent with the Merger Guidelines' hypothetical monopolist test.[16] Indeed, Professor Elzinga testified to that effect in the litigation concerning the Evanston/Highland Park merger.[17]

Among other deficiencies, the E-H or patient flow approach suffers from the "silent majority fallacy." As Dr. McCarthy explains in his report, the fact that a minority of patients are willing to travel for inpatient care is not necessarily predictive of the preferences of the majority of patients who do not travel.[18] For example, there may be patients who live in the northern suburbs of Chicago who receive GAC Services downtown because they work there. The fact that those patients receive GAC Services downtown, however, is not predictive of the preferences of patients who do not work downtown.[19] Indeed, Defendants' experts agree that patients overwhelmingly prefer to receive GAC Services locally.[20]

Patient flow analysis also fails to predict whether small but significant increases in the price of local GAC Services would cause MCOs to offer insurance plans without the hospitals in question or would lead to more patients traveling further distances. MCOs are not likely to

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exclude all eleven hospitals in the North Shore Area from their health plans even if a hypothetical monopolist of those hospitals demanded incrementally higher reimbursement rates. And, as Defendants themselves argue in support of their merger, patients are not motivated to travel significantly greater distances by small price differentials. According to Defendants, large employers with employees living near Lake Michigan in Cook and Lake counties would not find Advocate's existing narrow network product attractive because those employees would be unwilling to drive to Advocate hospitals a few miles across I-94 to save 10% on their insurance premiums. If so, those same patients obviously would not travel to a hospital all the way downtown in response to a SSNIP of 5% in the North Shore Area.

Leaving aside the fact that the E-H test is an inappropriate method for delineating relevant geographic markets in hospital mergers—and that even their own expert finds the method unreliable—Defendants grossly misapply it. The structural approach employed by Dr. Tenn defines the relevant geographic market by hospital (i.e., supplier) location.[21] When a market is defined by supplier location, the market includes customers located outside of the market boundary:

> Geographic markets based on the locations of suppliers encompass the region from which sales are made. Geographic markets of this type often apply when customers receive goods or services at suppliers' locations. Competitors in the market are firms with relevant production, sales, or service facilities in that region. Some customers who buy from these firms may be located outside the boundaries of the geographic market.

[21] PX06000 Tenn Rep. ¶ 75.

Merger Guidelines § 4.2.1 (emphasis added). Applying a patient migration analysis to a market defined by hospital location will always result in high inflows because the hospitals along the border of the market draw patients from the communities surrounding their locations.[22]

3. The Commission is Not Judicially Estopped from Defining a Geographic Market in Light of the Relevant Factual Circumstances

Defendants next argue that the Commission is estopped from defining a relevant geographic market in this case that is different from the geographic market definition the Commission adopted in a previous matter. The previous matter, In the Matter of Evanston Northwestern Healthcare Corporation, concerned the consummated acquisition of Highland Park Hospital by Evanston Northwestern Healthcare Corporation ("ENHC"), which already owned Evanston Hospital and Glenbrook Hospital.[23] The Commission found that substantial evidence established that ENHC imposed significant price increases as a result of the merger. Because ENHC, as a monopolist of the three hospitals, was able to impose a price increase higher than 5%, the three-hospital market satisfied the hypothetical monopolist test. In the Matter of Evanston Nw. Healthcare Corp., FTC Dkt. No. 9315, 2007 WL 2286195, at *53, *66 (FTC Aug. 6, 2007).

According to Defendants, by limiting the market in Evanston to the three ENHC (now NorthShore) hospitals, the Commission implicitly concluded that Condell and Lutheran General did not constrain those hospitals and the Commission cannot now contend that they do.

[22] Id. ¶ 81, n. 167. While the North Shore Area geographic market is limited to the hospitals within the boundary line on Dr. Tenn's map, it encompasses all of the patients who use those hospitals regardless of which side of that line they live on. Id. Thus, Dr. Tenn calculates market shares using all admissions to the hospitals in the market and not just the admissions of patients residing within the bounds of the geographic market. Id.; see also PX02058 McCarthy Depo. at 237:22-24 ("Now, I'll quickly say, he does count the whole of the -- not -- of the commercial discharges. . ."). Dr. McCarthy's criticism is that Dr. Tenn should have visually represented the hospitals within the North Shore Area market by placing stars on the hospitals and not by drawing a line on the map. Id. at 237:24-238:2.

[23] ENHC subsequently purchased

C. High Market Shares and Market Concentration Establish a Presumption of Illegality and Shift the Burden to Rebut the Presumption to Defendants

As Plaintiffs established in their opening brief, the merger would significantly increase concentration in an already highly concentrated market. The increase in concentration, and Defendants' combined market share of 60%, exceed the thresholds for establishing a presumption of illegality. That presumption applies in cases based on unilateral effect theories of competitive harm.[27] See Bazaarvoice, 2014 WL 203966, at *64 (N.D. Cal. Jan. 8, 2014); Sysco Corp., 113 F. Supp. 3d at 8; United States v. H & R Block, Inc.,

competitor of NorthShore" and "Advocate and NorthShore do constrain each other."[30] Dr. McCarthy's "results confirm that the two systems are good substitutes."[31]

1. Defendants' Arguments Rely on Standards that Do Not Exist

Because they cannot deny that competition from the other constrains each of them, Defendants argue that their merger will not harm competition because the parties also compete with other hospitals. To prevail on their unilateral effects claim,

fraction need not approach a majority.”). Under the Merger Guidelines, “[a] merger may produce significant unilateral effects . . . even though many more sales are diverted to … non-merging firms than to … the merger partner.” Id. (emphasis added); see also ProMedica Health Sys., 749 F.3d at 569.

Defendants fault Plaintiffs for not uncovering documents or testimony in which Defendants admit to a specific plan to raise prices, but here again Defendants seek to impose a standard that no court has ever adopted. To prevail under Section 7, a plaintiff is not required to come forth with specific proof of what the merging parties will do or what their intentions are after the merger. See, e.g., Bazaarvoice, 2014 WL 203966, at *11 (N.D. Cal. Jan. 8, 2014) (“intent is not an element of a Section 7 claim”). Plaintiffs need only establish that the acquiring firm will have the ability to raise prices or reduce quality after the acquisition. H&R Block, 833 F. Supp. 2d at 81 (emphasis added). “All that is necessary is that the merger create an appreciable danger of [anticompetitive] consequences in the future. A predictive judgment, necessarily probabilistic and judgmental rather than demonstrable is called for.” OSF Healthcare Sys., 852 F. Supp. 2d at 1082 (quoting Hosp. Corp. of America v. FTC, 807 F.2d 1381, 1389 (7th Cir. 1986) (citation omitted)).

2. The Merger Will Increase Defendants’ Bargaining Leverage

Defendants argue that they will not have bargaining leverage after the merger because health plans can create viable networks without including any NorthShore or Advocate hospitals. Yet when explaining the rationale for the merger, they argue that, although an Advocate-only network has been successfully marketed to individuals on the public exchange, “[i]n order to sell the High Performing Network to groups (i.e. employees), employers and health insurers have told Advocate that it needs” coverage near Lake Michigan in Cook and Lake Counties. Defs’ Opp. at 1-2 (emphasis in the original). If it is true that an ultra-narrow network product will only be

not credible because it fears competition from Advocate in the insurance market. However, Advocate cannot compete against BCBS-IL in the insurance market because it does not have an insurance license and

.[36]

Defendants also point out that some MCOs wrote letters in support of the merger and stated that they believe that the merger will reduce costs and improve quality. Each of the MCOs identified by Defendants, however, has submitted a declaration stating that it drafted its letter at Defendants' request and had little to no basis for the beliefs expressed in the letter regarding the merger's impact on costs and quality.[37]

E. Economic Analysis Demonstrates that the Merger Will Lead to Increased Prices and Reduced Quality

Dr. Tenn's analysis shows that the combined firm would be able to raise reimbursement rates for GAC Services at one or more of its six hospitals in the North Shore Area.[38] The average price change predicted by Dr. Tenn across those hospitals is 8%.[39] Defendants' experts agree with most of Dr. Tenn's analysis.[40] According to Defendants' experts, however, Dr. Tenn's merger simulation analysis is flawed and therefore his price estimates are unreliable. Their argument is astounding cohserTd [etp7(reTcEbur thadtice estim)8.4(a-0yis)hRedu a0ing92.3 T

same time, Defendants argue that their competitors would quickly respond to any attempt by the merged entity to increase prices for GAC Services by opening outpatient facilities and physician offices near Defendants' hospitals in order to drive referrals to their own hospitals. This begs the question, if Advocate's competitors can reposition to compete in new geographic areas, why can't Advocate? The answer, in the words of Advocate's CEO (testifying on behalf of Advocate), is that it is "easier said than done."[45] According to Advocate, it never even considered opening outpatient facilities as a means of closing its purported coverage gap in NorthShore's service area.[46]

Defendants cannot have it both ways. Advocate is the largest hospital system in the State and claims to be far superior to other health systems on nearly every measure of cost and quality. If Advocate is unable to "reposition" east of I-94, despite its large and well-regarded hospitals just a few miles away, then it is extremely unlikely that other, more distant systems could effectively reposition in the North Shore Area post-merger. On the other hand, if other hospitals can easily open outpatient facilities and physician offices in the North Shore Area, then so can Advocate and this merger is not necessary to fill any gap in Advocate's coverage area.

G. Defendants' Claimed Efficiencies are Vague, Unsubstantiated and Not Merger-Specific

Defendants make three arguments about cost reductions but fail to present evidence establishing any verifiable, merger-specific efficiency. *See, e.g.*, *Sysco*, 113 F. Supp. 3d at 82. Defendants' vague and unsubstantiated claims are precisely the type that courts and the Merger Guidelines have cautioned should not be credited in justifying an anticompetitive merger.

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[45] PX02036 Sacks Depo. at 130:15-24. In fact, Advocate has argued in submissions to the Commission that it has had "little success" opening outpatient locations in NorthShore's service area. PX04156-019.

[46] PX04156-019 ("The area east of I-94 is and has been a core part of NorthShore's service area, but historically Advocate has not sought to expand there. None of Advocate's major capital investments to date, and for at least the next five years, have occurred or will occur in this area east of I-94.")

First, Defendants argue that the merger will reduce costs to payers because Advocate has lower rates than NorthShore. Defendants provide no evidence of the actual rates charged by the parties and do not conduct any analysis of the impact of the merger on those rates. By their own admission, while applying Advocate's rates to NorthShore's services could involve a rate reduction, it also could be "cost neutral." Defs' Opp. at 31-32.

Second, Defendants assert several times in their brief that the merger will result in cost savings of $200 million. *Id.* at 27, 32. Defendants rely solely upon the declaration of a NorthShore fact witness, Gary Weiss, who, in turn, based his declaration on a spreadsheet that he prepared on his own initiative eight or nine months ago and never shared with anyone (including his own counsel, despite the document being responsive to Plaintiffs' discovery requests) until after his deposition in this case.[47] The overwhelming majority of the savings identified in the spreadsheet are in the category labeled "All other (tbd)."[48] Defendants do not identify any cost savings that are independently verifiable, identify any evidence supporting Mr. Weiss's assumptions, and thus fail to identify any cognizable efficiencies.[49]

Third, Defendants assert Advocate has a lower total cost of care, so the merger will reduce NorthShore's total cost of care. This suggestion fails because Defendants have no credible evidence establishing that Advocate produces healthcare services at a cost lower than NorthShore.[50] Even if some of Advocate's eleven hospitals have lower costs, Defendants cannot explain how the merger would improve NorthShore's costs.[51] Defendants imply that deploying Advocate's population health management ("PHM") expertise at NorthShore's hospitals will

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[47] PX02022 Weiss Depo. at 87:22-89:1; PX02053 Weiss Depo. (Day 2) at 10:14-18; *id.* at 17:4-13.
[48] *See* PX05270; PX06022 Dagen Rebuttal ¶ 16.
[49] PX06022 Dagen Rebuttal ¶¶ 15-21.
[50] *See* PX06021 Jha Rebuttal ¶¶ 72-18; PX06022 Dagen Rebuttal ¶¶ 8-10.
[51] Defendants' experts also provide no explanation. *See* PX02063 Eisenstadt Depo. at 139:14-17 ("I'm not offering an estimate as to the amount by which AdvocateCare is going to reduce costs at NorthShore or how that cost reduction is going to be achieved through what processes at NorthShore.")

A”).[55] And this product is far less innovative than Defendants claim—while they tout the risk-based payment structure of the “HPN” as revolutionary, Advocate is in fact paid on a capitated basis under other HMO plans offered by BCBS-IL in addition to BCD-A.[56]

Defendants’ focus on the features of the “HPN” is misleading because only efficiencies specific to the merger are cognizable. *Heinz Co.*, 246 F.3d 708 at 721. Advocate clearly does not need to merge with the second-largest health system in the North Shore Area to participate in BCD-A, because it already does so. Moreover, the evidence does not support Defendants’ contention that Advocate has a coverage gap east of I-94 that requires a merger with NorthShore to make BCD-A or a similar product marketable to large groups. Advocate has never tried to market BCD-A to large groups, and, according to BCBS, the merger of these close competitors is not necessary to create a marketable narrow network.[57] According to Defendants’ experts, what Advocate lacks east of I-94 is “access points” and the opening of outpatient facilities and physician offices could fill that gap and allow it to market an “HPN” without the merger.[58]

Indeed, while Defendants repeatedly claim that their merger is necessary to deal with the evolving healthcare landscape, other firms are meeting this challenge by offering narrow network and risk-based products while maintaining, rather than reducing, provider competition. For example,

[55] See, e.g., PX08011-037-038.

[56] See, e.g., PX04200-012 (for HMOs BCBS has “paid us under capitation which better aligns incentives and allows Advocate and the APP physicians to share in any savings, as opposed to having to share with BCBIL.”) The benefit design of the HMO plans prevents leakage and allows Advocate to participate on a capitated basis without incurring financial risk for care provided by other participating providers. *Id.*; see also PX02039 Hamman (HCSC) Depo. at 201:23-202:9 (there is “not very much” leakage in the HMO products compared to ACO and Advocate’s leakage in the HMO is only 8-10%); *id.* at 199:23-200:1 (testifying that benefit design is important to prevent leakage); PX02052 Sacks (Advocate) Day 2 Depo. at 55:2-9 (“leakage depends on benefit plan design”). Despite Defendants arguments to the contrary, a merger is not necessary to prevent leakage. *See* Defs’ Opp. at 36-37.

[57] PX03000 Hamman Decl. at ¶ 46 (“BCBS-IL does not need Advocate and NorthShore to merge in order to create a narrow network that includes both systdt .6201 T(sigd Deeate a)-6(c)4(Tw 23n)4.voce.557 -161a(Tw 23n)48rwl1 Tc 5(e)

do so on a capitated basis and price its participates in this plan – or any similar plan – it can

According to Defendants, even if Advocate can participate in a marketable HPN,

are focusing on the wrong issue. NorthShore's ability to participate in an insurance product is not in itself relevant. Instead, Defendants must demonstrate that the merger will result in price

Defendants assert that the merger will increase the quality of care at NorthShore

Opp. at 31. In fact, NorthShore

see also PX02063 Eisenstadt Depo. at 87:10-88:3 (explaining that the plan is

[63] See PX02063 Eisenstadt Depo. at 96:11-17.

measures.[64] Despite its much-touted use of PHM and risk-based contracting, Advocate's performance on quality measures actually decreased from 2013 to 2015.[65]

Defendants never identify what specific features of Advocate's purported PHM capabilities NorthShore is missing and could not obtain on its own. Defendants' expert on population health management, Dr. Dudley, characterizes what Advocate has and NorthShore lacks as a "culture," a "commitment," a certain "feeling," and a "special sauce."[66] As both Dr. Dudley and Dr. Steele admit, NorthShore can purchase all of the concrete components of effective PHM without the merger and can hire consultants that specialize in PHM to help integrate those components.[67] Defendants fail to explain how

[69] Neither Defendants nor any MCO has any future obligation (and no plan) to offer the product (or any similar product) to large groups at a price 10% below competing products. Defendants' mere assertion that the product will be offered at a low price is not a cognizable efficiency. See H.J. Heinz Co., 246 F.3d at 721. But, even if the price differential were set in stone, it is inappropriate to assume that simply because the price of the HPN is discounted that it produces any actual cost savings to consumers. The HPN is discounted because it severely reduces enro

Dated: April 7, 2016

Respectfully Submitted,

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