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

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

For the reasons set forth below, the Court denies the motion.

Background

Parties

Advocate Health Care Network, which, ee

Corp., is a health care system that includes eleven hospitals: (1) BroMenn Medical Center; (2) Christ Medical Center; (3) Condell Medical Center; (4) Eureka Hospital; (5) Good Samaritan

Hospital. *See* http://www.advocatehealth.com/hospital-locations (last visited May 31, 2016). NorthShore University HealthSystem is a health care system that includes four hospitals: (1) NorthShore Evanston Hospital; (2) NorthShore Glenbrook Hospital; (3) NorthShore HighHi

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

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

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

Under a full capitation arrangement, a provider is paid a set amount per patient per month for all of that patient's health care services. (*Id.*) Ninety percent of NorthShore's commercial revenues come from FFS contracts; less than a third of Advocate's commercial revenues come from FFS contracts. (DFFCL ¶ 50; Tr. at 7

injunction . . . , a district court must (1) determine the likelihood that the FTC will ultimately succeed on the merits and (2) balance the equities.'" *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1073 (N.D. Ill. 2012) (quoting *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1217 (11th Cir. 1991)). "[T]o demonstrate such a likelihood of ultimate success, the FTC must raise questions going to the merits so serious, substantial, difficult and doubtful as to make them fair ground for thorough investigation, study, deliberation and determination by the FTC in the first instance and ultimately by the Court of Appeals." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1051 (8th Cir. 1999) (quotations omitted). "A showing of a fair or tenable chance of success on the merits will not suffice . . . ; Section 7 deals in probabilities not ephemeral possibilities." *Id.* However, "the statute requires a prediction, and doubts are to be resolved against the transaction." *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 906 (7th Cir. 1989).

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

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

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

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

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

Tenn's rationale for the first criterion was that:

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

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

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

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

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

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

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

region from which sales are made. . . . Competitors in the market are firms with relevant production, sales, or service facilities in that region.") In defendants' view, the market should [redacted]

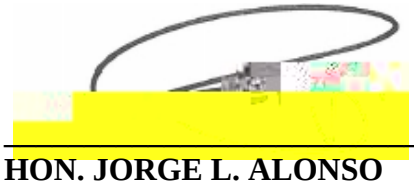
the seller operates, and to which the purchaser can practicably turn for supplies"). Moreover, his assumption that the destination hospitals are not substitutes is based on the notion that patients prefer to receive GAC services near their homes (*see* Tr. at 454:15-457:4), a point on which the evidence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

calculated.

Tallarico [Advocate] Dep. 272:20-23 ("[W]hen . . . something is considered routine, [patients] expect to be able to stay within their local health community").) Finally, Tenn's exclusion of destination hospitals ignores "the commercial realities of th[is] industry," *Brown Shoe*, 370 U.S. at 336 (quotation and footnote omitted), specifically that: (1) payers negotiate a single contract with a hospital system for both inpatient and outpatient services (*see* Tr. at 241:15-20 [Hamman-

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

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



HON. JORGE L. ALONSO
United States District Judge