IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT

to Federal Rules of Civil Procedure 52(a)(2).[1] For the reasons set forth below, the Court grants the motion.

BACKGROUND

Parties

Defendant Advocate Health Care Network, which is the parent of Advocate Health and Hospitals Corp. (collectively, "Advocate"), is a health care system that includes eleven hospitals: foes

Commercial health insurers (also called payers) try to create networks of health care providers that are attractive to potential members. (*Id.* ¶ 12; Defs.' Proposed Findings of Fact ("DFF") ¶ 21, ECF No. 459; Preliminary Injunction Hr'g Tr. ("Tr.") 75:11-16 [Norton-CIGNA]; *id.* at 148:12-18 [Hamman-Blue Cross Blue Shield of Illinois ("BCBSIL")].) Among the factors insurers consider when determining whether to include a hospital in a network are "the attractiveness of that hospital, the quality, the reputation of that hospital, . . . its willingness to . . . meet certain price points," and its geographic coverage. (Tr. at 149:3-11 [Hamman-BCBSIL]; *see id.* at 74:18-75:7 [Norton-CIGNA].)

Hospitals compete to be included in insurers' networks and negotiate reimbursement rates and services with the insurers. (PFF ¶ 9; Tr. at 76:8-19 [Norton-CIGNA];

Insurers pay health care

substantially to lessen competition, or tend to create a monopoly." 15 U.S.C. § 18. The Court may preliminarily enjoin a violation of § 7 "[u]pon a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest." 15 U.S.C. § 53(b). "Therefore, 'in determining whether to grant a preliminary injunction . . . , a district court must (1) determine the likelihood that the FTC will ultimately succeed on the merits and (2) balance the equities.'" *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1073 (N.D. Ill. 2012) (quoting *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1217 (11th Cir. 1991)). "[T]o demonstrate such a likelihood of ultimate success, the FTC must raise questions going to the merits so serious, substantial, difficult and doubtful as to make them fair ground for thorough investigation, study, deliberation and determination by the FTC in the first instance and ultimately by the Court of Appeals." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1051 (8th Cir. 1999) (quotations omitted). "Although the district court may not 'simply rubber-stamp an injunction whenever the FTC provi[illegible]

essential that the FTC identify a credible relevant market before a preliminary injunction may properly issue."); *OSF Healthcare*, 852 F. Supp. 2d at 1075 ("In fact, '[a] monopolization claim often succeeds or fails strictly on the definition of the product or geographic market.'") (quoting *Tenet Health Care*, 186 F.3d at 1052).

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"). (PFF ¶ 15; Tr. at 1270:3-6 (defense expert Dr. Thomas 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. (PFF ¶ 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 ser2011 WLer. kth(M)-1(ed)6(i)-6(ca)]c 0 Tw 3.09 0 Td ( )T

be sufficiently defined so that the Court understands in which part of the country competition is threatened," *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 49 (D.D.C. 1998).

1. Geographic market analysis of plaintiffs' expert Dr. Tenn

University Hospital, Cancer Treatment Centers of America, and Lurie Children's Hospital, because these hospitals draw patients from not just the North Shore Area but from all over the Chicago metropolitan area. (Tenn Report ¶ 85 at n.175.) As Dr. Tenn recognized, and as the evidence showed, patients generally prefer to receive GAC services close to home. (PFF ¶¶ 26-27, 41.) *See FTC v. Advocate Health Care Network*, 841 F.3d 460, 474 (7th Cir. 2016) ("*FTC*"). Based on this preference, employers require—and insurers must offer—health plans that provide patients with access to in-network hospitals near where they live. (PFF ¶¶ 26-32.) *See FTC*, 841 F.3d at 473-75. Thus, although many patients travel from the North Shore Area to these destination hospitals, Dr. Tenn nevertheless excluded them from his analysis because these hospitals cannot fulfill the function of providing local care within the North Shore Area. (Tr. at 454:4-9 ("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 . . . are not located in the northern Chicago suburbs and, therefore, do not fulfill this role for commercial payers.").)

After identifying the market, Dr. 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 profitably impose a small but significant non-transitory increase in price ("SSNIP") (*i.e.*, 5% or more) at one or more of the merging hospitals due to the hypothetical monopolist's "internalization of substitution" in the region. (PFF ¶ 33; Tenn Report ¶¶ 57, 71.) *See* DOJ/FTC Horizontal Merger Guidelines §§ 4, 4.1.1, 4.2, 4.2.1, available at https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf (last visited Jan. 31, 2017).

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. (Tenn Report ¶¶ 95-98.) He

effect, and the record as a whole supports that testimony because “the overwhelming weight of the evidence” shows “(1) the large proportion of patients who prefer hospitals close to their homes and (2) (the resulting-50(t)-2(he)]TJ 0 Tc 0 Taw 1.49 0 Td ( )Tj 0.002 Tc -0.00Tw 2.9 0 Td [(a)-ng he

reliance on diversion

In any case, even if the Court

ratios between merging hospitals are higher, then a price increase at a given merging hospital, assuming steady prices at nearby hospitals, would theoretically drive fewer patients away from the merged entity's

Under the Department of Justice and FTC's Horizontal Merger Guidelines, a useful measure of market concentration is the Herfindahl-Hirschman Index ("HHI"), which is calculated by summing the squares of the individual ftr(he)48 Tc 010Tc [illegible]

defendants' criticisms of Dr. Tenn's opinion of the merger's likely anticompetitive effects. Nevertheless, as the following discussion will demonstrate, even if plaintiffs were forced to rely on the anticompetitive effects portion of Dr. Tenn's opinion, Dr. Tenn's analysis is sound, and defendants' criticisms fail.

a. Inputs to Dr. Tenn's analysis

Dr. Tenn's model relied on three principal inputs: diversion ratios, contribution margins, and pricing data. The Court has already rejected defendants' argument that Dr. Tenn's use of diversion ratios impaired his analysis, but defendants take issue with the other two inputs as well.

Defendants argue that Dr. Tenn should not have used *contribution margins*, or as Dr. Tenn

NorthShore

basis. According to defendants, Dr. Tenn was unable to cite a case in which his model had accurately predicted a price increase following an actual, real-world merger, and in fact, defendants argue, there have been documented cases in which a hospital merger resulted in lower prices. (*See* Defs.' Post-Remand Br., at 9-10, ECF No. 557.)

Defendants may be correct that many hospital mergers actually result in lower prices, but it is defendants' burden to demonstrate that *this* particular merger will be one of those that has no anticompetitive effects. Defendants' experts focused more heavily on explaining their own bargaining-based models (which the Court will discuss in more detail below) than on demonstrating why Dr. Tenn's

and Dr. Eisenstadt used the Hospital Merger Simulation Model, developed by FTC economists, which measures the relationship between actual prices negotiated by hospital systems and "willingness to pay" ("WTP"), a quantitative measure of a hospital system's desirability, or the "willingness to pay" for access to a system. (*See* DX6000, Eisenstadt Report ¶ 73, ECF

decrease, which is patently absurd, to a modest 6% increase, which is too small to be plausible for such a large area. (Tenn Rebuttal Report ¶¶ 51-54.)

Dr. Tenn's critique is convincing. The Seventh Circuit cited a laundry list of economic literature demonstrating that hospital mergers in concentrated markets tend to lead to significant price increases. *FTC*, 841 F.3d at 472-73. Defendants now ask this Court, faced with choosing between an expert economic analysis that is consistent with this literature and another that is inconsistent with it, to choose the one that is inconsistent with the literature the Seventh Circuit has cited, without adequately explaining

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345:19-46:10 (Dechene of Northwestern testifying that outpatient facilities and doctor's offices are "front doors" to the hospital); *id.* at 1116:14-18 (Beck of United testifying that "a member's physician relationship influence[s] where they seek hospital care"); JX 3, Bagnall Dep. at 37:2-8, ECF No. 453-3 (testifying on behalf of University of Chicago Medical Center t1c 4(at)]TJ 0 Tc 0 Tw 4.0

While hospitals outside or on the fringes of the North Shore Area may be able to draw increasing numbers of patients from within the Area via their repositioning efforts, the merging hospitals will nevertheless "have market power over the insurers who need them to offer commercially viable products to customers who are reluctant to travel farther for [GAC services]." *Id.* at 476. Viewing the evidence in light of this guidance from the Seventh Circuit, the Court cannot accept that the repositioning of competitors will offset or prevent the anticompetitive effects that Dr. Tenn has identified without stronger evidence than the generalized testimony defendants have offered.

4. Efficiencies

Although the defense has never been sanctioned by the Supreme Court, the Horizontal Merger Guidelines and some lower courts recognize that defendants in a horizontal merger case may rebut the government's *prima facie* case by presenting evidence of efficiencies offsetting the anticompetitive effects. *See FTC v. H.J. Heinz Co.*, 246 F.3d 708, 720 (D.C. Cir. 2001). Where the merger would result in high market concentration levels, as in this case, the defendants must provide proof of "extraordinary efficiencies" based on a "rigorous analysis" that ensures that the proffered efficiencies represent more than "mere speculation and promises about post-merger behavior." *See id.* at 720-21. Further, the efficiencies must be "merger-specific," *i.e.*, "they must be efficiencies that cannot be achieved by either company alone." *Id.* at 721-22. Defendants contend that the merger will result in significant efficiencies providing substantial benefits to consumers and offsetting the anticompetitive effects. Plaintiffs respond that defendants have not sufficiently proven the claimed efficiencies.

that it cannot offer an HPN or similar ultra-narrow network without a

credibility. Defendants themselves have argued that BCBSIL, for example, views single-provider narrow networks as a threat to its own business because, if a healthcare provider can satisfy all of its patients' healthcare needs by itself, then the patients (or their employer) may as well pay the provider directly rather than the insurer middleman. (*See* DFF ¶¶ 211-17.) There is nothing in the way of expert testimony or economic analysis to support the position that Advocate cannot offer its Advocate-only narrow network product to employers without expanding east of I-94, and in fact one employer has quite successfully done so: Advocate itself. (Tr. at 1420:3-22 [Sacks-Advocate].)

ii. Defendants have not proven that the savings of consumers who s-0.004 Tc n 0 3.74mp

to attract in order for the consumer savings to offset the approximately $50 million in increased payments to the merging firms from commercial health plans that Dr. Tenn identified, concluding that the ANHP HPN need only attract about 1% of the Chicagoland employer-sponsored insurance market. (*Id.* ¶ 54, Table 4.)

The trouble with this approach is the assumption that all ANHP HPN enrollees would otherwise have purchased a large-employer version of AWH offered at the same price, which is essentially speculative. Aetna does not currently offer AWH as a large employer plan, and there is no reliable evidence showing how many enrollees the plan would have or where they might live if it did. There is also no reliable evidence as to how many enrollees an ANHP HPN would attract, nor is there even evidence of how many enrollees an Advocate-only HPN such as BCD would attract if it were offered to large employers, which Advocate insists, without explanation, it cannot do without explaining why. In short, there is no firm evidentiary ground for assuming that Dr. Eisenstadt's hypothetical Aetna plan, similar to AWH but offered to large employers, will ever exist and, if it did exist, that it would be the second choice of all ANHP HPN enrollees. (Tenn Rebuttal Report ¶ 122.)

For his second estimate, Dr. Eisenstadt assumes that all customers who enroll in the

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switching to the narrower HPN. (PFF ¶ 111.) Dr. Eisenstadt assumes that "consumers are uniformly distributed between these two bounds, so that the average consumer benefit is one half the price difference" between AWH and the HPN. (Tenn Rebuttal Report ¶ 123.) By that measure, the ANHP HPN need only attract between 1.7% and 2.7% of the Chicagoland employer-sponsored insurance market to offset any anticompetitive effects. (Eisenstadt Report, Table 4.) But there is no basis for the assumption that the consumer benefit that accrues to customers who switch to the HPN will be uniformly distributed thTJ 0 Tc 0 Tw 1.44 0 Td [( )-330(2oece0 .57

Eisenstadt's calculations of a lower bound of $298 and an upper bound of $1,426. (*See* Eisenstadt Report, Table 4.)

Dr. Tenn's critiques of Dr. Eisenstadt's opinion are persuasive. The upshot is that Dr. Eisenstadt's analysis sheds little light on what the true level of savings generated by the HPN might turn out to be, and Dr. Eisenstadt's calculations are essentially "uninformative regarding whether consumer benefits are likely to exceed consumer harm." (Tenn Rebuttal Report, ¶ 127, ECF No. 450-4.)

iii. Estimates of HPN enrollment are speculative and unsubstantiated. 0.014 Tw 6.92 0 Td

Dr. Eisenstadt's analysis might be helpful at least as a rough estimate of the range

Defendants take issue

of demonstrating that consumer benefits due to enrollment in the HPN will offset anticompetitive effects of the merger.

The Court agrees with plaintiffs that, for the reasons discussed above,[4] defendants have not carried their burden of proving that efficiencies will offset the anticompetitive effects. Plaintiffs have demonstrated a likelihood of success on the merits.

II. BALANCING THE EQUITIES

Because plaintiffs have demonstrated that they are likely to succeed in demonstrating that defendants' merger would cause harm to competition and damage consumer [illegible]