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**A DOSE OF BAD MEDICINE:  
THE FEDERAL TRADE COMMISSION'S ATTEMPT TO  
BREAK UP EVANSTON NORTHWESTERN HEALTHCARE**

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Antitrust Practice Group of Gardner Carton & Douglas LLP**

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**I.**

**Introduction**

The last five fully litigated challenges of general acute care hospital mergers by the federal antitrust enforcement agencies<sup>1</sup> have been met with abject failure.<sup>2</sup> All but one of these enforcement actions challenged the merger of nonprofit and community governed acute care hospitals. The appellate

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\* The **Antitrust Practice Group of Gardner Carton & Douglas LLP** (GCD) represents defendants in criminal and defendants and plaintiffs in civil antitrust treble damage and injunction cases in federal and state courts across the country and in federal and state courts of appeal. We have represented a party or intervenor in the following fully litigated antitrust hospital mergers cases: *FTC v. Freeman Hospital* (1995); *FTC v. Columbia Hospital Corp.* (1994); *In the Matter of Adventist Health System/West and Ukiah Adventist Hospital* (1993); and *United States v. Rockford Memorial Corporation and SwedishAmerican Corporation* (1989). Our attorneys have also successfully represented two major nonprofit hospital systems in their antitrust suits over the ownership of two Florida hospitals against the largest for-profit hospital system in the United States; *Orlando Regional Healthcare System, Inc., et al. v. Columbia/HCA Healthcare Corp., et al.* (1996); and *Adventist Health System/Sunbelt Healthcare Corp., et al. v. Columbia Hospital Corp., and Galen Healthcare, Inc., et al.* (1993).

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courts reviewing these cases all ruled against the government, finding that the government's alleged relevant geographic markets were too small. A sixth case was brought by the State of California under the federal antitrust laws when the Antitrust Division of the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC) declined to challenge the hospital merger. In that case, the U.S. District Court, in a very detailed opinion, also found that California's alleged geographic market was too small.<sup>3</sup>

Like Captain Ahab's persistent, senseless and dangerous pursuit of the white whale Moby Dick, the DOJ and FTC (the enforcement agencies) have soldiered on, no doubt with the best of intentions. After the FTC and DOJ undertook a "retrospective" to investigate, among other things, the effect of certain hospital mergers on competition, the FTC brought suit to challenge Evanston Hospital's acquisition of Highland Park Hospital. After the conclusion of hearings on the matter in Washington, D.C., on Thursday, October 20, 2005, Stephen J. McGuire, Chief Administrative Law Judge (ALJ) of the FTC, issued his *Initial Decision In the Matter of Evanston Northwestern Healthcare Corporation*, FTC Docket Number 9315, (the Initial Decision) holding that the January 2000 merger of Evanston Hospital (which also owns Glenbrook Hospital) with Highland Park Hospital to form Evanston Northwestern Healthcare Corporation (ENH) violated antitrust law, and ordered the divestiture of Highland Park Hospital. The decision is now on appeal to the full FTC.

This challenge will achieve disastrous consequences if not reversed. While challenging hospital mergers, these agencies have ignored billion-dollar anticompetitive mergers of for-profit managed care organization insurance firms (MCOs), which represent the chief revenue source for most hospitals. Such mergers have been cleared by the antitrust enforcement agencies, resulting in managed care markets that are now more concentrated than most acute care hospital markets even though MCOs have much greater financial resources than hospitals. Even without federal enforcement actions against hospital mergers, there is a substantial disparity in hospital bargaining power between most hospitals and MCOs, which is made even more disparate as a result of the enforcement regime.

## II.

### Executive Summary

For the reasons articulated below, ALJ McGuire's Initial Decision should be reversed by the FTC (and if not by the FTC, by the United States Court of Appeals for the Seventh Circuit):

1. **ALJ McGuire's finding of the relevant antitrust product market as "general acute care in-patient services sold to managed care organizations, which includes primary, secondary and tertiary patient services"<sup>4</sup> is contrary to all authority deciding this issue in litigated antitrust hospital merger cases.** The ALJ's limit on the product market to general acute in-patient hospital services sold to MCOs has never before been adopted by any court.

The ALJ's expansion of the relevant product market beyond any definition previously established by precedent puts other hospitals systems at risk of facing enforcement actions. Prior to the execution of a merger transaction, the parties analyze and assess precedent established by other similar merger transactions and rely on the product market definitions set forth in such transactions. In other words, hospitals have come to rely on the definition of a relevant product market as "general acute care in-patient services," including primary, secondary and tertiary patient services. Accordingly, transactions have been consummated based on the presumption that the merger would not violate antitrust laws given this product market. However, the ALJ's contraction of the relevant product market to general acute care in-patient services *sold to managed care organizations*, which is not supported by precedent, means that merging hospitals can no longer rely on well-established precedent in evaluating the antitrust risks involved with a proposed merger.

2. **ALJ McGuire's determination of the relevant geographic antitrust market is much smaller than any geographic market ever found, or even alleged, in any litigated hospital merger case, and is contrary to competitive realities.** The ALJ rejected the relevant geographic market alleged in the complaint by the FTC. However, the ALJ then, in effect, joined the FTC trial staff and found that the merger violated the antitrust laws based on a relevant geographic market that the ALJ defined as "the area encompassing the following seven hospitals: Evanston, Glenbrook, Highland Park, Lake Forest,

Advocate Lutheran General, Rush North Shore and St. Francis.”<sup>5</sup> In the areas served by these hospitals, there are numerous other hospitals which have served, do serve and will continue to serve patients also admitted to these seven hospitals.

Other hospitals in the Chicago area are now at risk of future antitrust enforcement action, given the ALJ’s miniscule definition of the relevant geographic market in the ENH case. As discussed in detail in this article, there are numerous Chicago area hospitals providing the same or similar services that were excluded from the geographic market without any reasonable explanation. These hospitals were, are and will be in the future, in competition with the three ENH hospitals and the additional four hospitals added by the ALJ.

The FTC’s Initial Decision condemning ENH for creating one nonprofit entity is nothing less than the issuance of a hunting license for other antitrust enforcement actions against hospital systems throughout the nation. Given that the ALJ in this case found that the merger of only three hospitals—out of 70 hospitals in only three of the 14 counties in the Chicago-Naperville-Joliet Consolidated Metropolitan Statistical Area<sup>6</sup>—resulted in an anticompetitive effect, and that the ALJ required divestiture of Highland Park Hospital, mergers of hospitals in areas of the country with only a handful of hospitals are at an even greater risk of an antitrust challenge.

**3. ALJ McGuire’s ruling that the anticompetitive effect of the merger was demonstrated by ENH’s post-merger price increases ignored the substantial benefits to consumers of substantially increased patient health care facilities and services at Highland Park Hospital as a direct result of the merger.** If the Initial Decision is allowed to stand, all hospitals that increase or have increased prices following a merger face potential enforcement action. The decision, if not reversed by the full Federal Trade Commission or by the Seventh Circuit Court of Appeals, puts in jeopardy all hospital mergers, no matter how far in the past, if the hospital raises prices post-merger. Because hospital prices have inexorably risen along with the inflation rate and hospitals have made capital improvements to maintain their facilities and keep pace with advances in medical treatment, all hospitals are vulnerable. Moreover, because many hospitals operate as nonprofit community organizations with missions focused

on providing quality patient care and not maximizing profits, standard antitrust principles should not apply to hospital mergers. Furthermore, patients typically choose medical care based on the quality of care that will be provided, rather than the price charged for the care.

4. **The FTC failed to call a single consumer or patient of any of the Evanston Northwestern Healthcare hospitals to demonstrate the alleged injury to competition.** It is clear that injury to competition is injury to consumers; but, the ALJ chose to rely solely on the self-serving testimony of MCOs as “customers” of ENH. ALJ McGuire’s acceptance of the MCOs executives’ testimony, despite an obvious bias and nonconformance to market realities, places all acute care hospitals at the mercy of the giant for-profit MCOs. Relying on the self-interested MCOs’ testimony is akin to asking a fox how to guard the henhouse. MCOs and patients have an inherent conflict. The MCOs goal is to maximize profits and shareholder value by maximizing premium revenues and minimizing payouts for claims. The main concern of patients is quality of care, but good quality care is expensive. Thus, the testimony of MCOs cannot be indicative of the actual effect on patients. Injury to competition is injury to consumers. In the hospital and health care field, the consumer is the patient. For the FTC and the ALJ to ignore patients’ concerns and rely only on MCOs is to stand the antitrust laws on their heads.

### **III.**

#### **Antitrust Cases Against Hospital Mergers**

Section 7 of the Clayton Act,<sup>7</sup> originally passed in 1914 and amended in 1950, provides the basis for antimerger enforcement actions by the FTC and DOJ by stating that:

No person engaged in commerce or any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effects of such acquisition may be substantially to lessen competition, or tend to create a monopoly (emphasis supplied).

The battleground in all hospital merger cases is the issue of what properly constitutes “any section of the country.” When the government loses a hospital merger case, it is usually because the

geographic market asserted by the government is found to be too small. Most important, in no litigated merger case has the government or any state alleged a geographic market smaller than a single metropolitan area. In fact, an enforcement agency successfully alleged a geographic market on the basis of a single urban area in only one case, *Hospital Corporation of America v. Federal Trade Commission*.<sup>8</sup> There, the enforcement agency successfully alleged that the geographic market was the area served by hospital providers in the Chattanooga, Tennessee, urban area.<sup>9</sup> In that case, the Seventh Circuit held that the FTC's "market definition, which is limited to hospital providers in Chattanooga,"<sup>10</sup> was appropriate based on the fact that "[g]oing to another city is out of the question in medical emergencies; even though an operation or some other hospital service can be deferred, the patient's doctor will not (at least not for reasons of price) send patients to another city, where the doctor isn't likely to have hospital privileges."<sup>11</sup> Because the defendant, Hospital Corporation of America, controlled five of the 11 hospitals in Chattanooga (45% of the hospitals), the Seventh Circuit held that the merger violated the Clayton Act.<sup>12</sup>

In the only other antitrust hospital merger opinion decided by the Seventh Circuit, *United States v. Rockford Memorial Corporation and SwedishAmerican Corporation*,<sup>13</sup> the court affirmed a district court ruling that the merger violated Section 7 of the Clayton Act, but characterized the federal government's proposed geographic market of the "Rockford area," which contained only three hospitals, as "the government's tiny proposed market."<sup>14</sup> If the Seventh Circuit thinks the Rockford area is "tiny," what would it call what ALJ McGuire has held as the geographic market in the ENH case?

One would think that in the light of repeated decisions by the courts expanding geographic markets and the aforementioned Seventh Circuit opinions, the enforcement agencies could not responsibly challenge any merger by asserting a geographic market that is smaller than a given metropolitan area. This, however, is not the case. Instead of learning from past mistakes, the enforcement agencies have sought ways to substantiate their largely unsuccessful charges against hospital mergers and, on August 28, 2002, the enforcement agencies announced their creation of a Merger Litigation Task Force to retroactively review specific hospital mergers, including the merger of Evanston Hospital and Highland Park Hospital that formed ENH in January 2000.

Subsequently, on February 10, 2004, the FTC issued its three-count Complaint *In the Matter of Evanston Northwestern Healthcare Corporation*,<sup>15</sup> in which the FTC alleged, in Count I, that the merger violated Section 7 of the Clayton Act and “tended to substantially lessen competition” in a “line of commerce” in a “section of the country.”<sup>16</sup> The FTC asserted that the relevant geographic market consisted of the “area directly proximate to the three ENH hospitals [Evanston Hospital, Glenbrook Hospital and Highland Park Hospital] and contiguous areas in the northeast Cook County and Lake County, Illinois.” The FTC’s complaint also sought, amazingly and without legal support, in Count II, to condemn the merger based solely on alleged anticompetitive price increases following the merger, and not on the relevant antitrust product (a “line of commerce”) or geographic market (a “section of the country”), as required by Section 7 of the Clayton Act.

On July 23, 2004, the federal antitrust enforcement agencies issued their joint report, *Improving Health Care: A Dose of Competition* (the “Joint Report”), containing the following observations and recommendations:

- The belief that antitrust enforcement is a better solution to the acquisition of monopsony (buyer) power by insurers than the exercise of countervailing power by providers;
- The continued viability of the 1992 Horizontal Merger Guidelines in hospital mergers;
- The rejection of the Elzinga-Hogarty text as an appropriate tool to define the relevant geographic market in hospital mergers;
- The use of strategic planning documents and customers’ testimony to define the relevant geographic market; and
- The use of empirical evidence, such as the willingness of patients to travel to another hospital in response to a local price increase, to determine the relevant geographic market.

The case was tried to Chief Administrative Law Judge Stephen J. McGuire in early 2005. ALJ McGuire issued his 225-page Initial Decision on October 20, 2005, in which he ruled that the merger of Evanston and Highland Park violated Section 7 of the Clayton Act by eliminating competition between the merged hospitals and enabling ENH to raise prices above competitive levels.

#### IV.

##### **The Combination of Evanston and Highland Park Was Investigated and Cleared by the Enforcement Agencies in 1990**

What makes the ALJ's decision and determination of the relevant geographic market so inappropriate is that the combination of Evanston Hospital and Highland Park Hospital was previously investigated—and approved—by the enforcement agencies in 1990. In connection with the execution of a network affiliation agreement (the nonprofit legal equivalent to a merger of four corporations) between Evanston Hospital Corporation (which then also owned Glenbrook Hospital), Lakeland Health Services, Inc. (the parent of Highland Park Hospital), Children's Memorial Hospital and Northwestern Memorial Hospital, the parties filed Premerger Notification Report Forms with the enforcement agencies on February 22, 1990. As a result, the DOJ opened an investigation, which resulted in the transmittal of an extensive "second request" for additional information on March 28, 1990. In this "second request," the DOJ defined the "relevant area" as "Lake County, Illinois and the portion of Cook County, Illinois north of Devon Avenue."<sup>17</sup>

A meeting between the DOJ and counsel for the merging hospitals, including an author of this article, was held on June 5, 1990. To assess the network merger, the enforcement agencies reviewed a map prepared by another author of this article, which showed all the general acute care hospitals in Lake County, Illinois and in the northern section of Cook County, Illinois and DuPage County, Illinois. The map demonstrated that numerous hospitals were serving the North Shore in addition to the hospitals involved in the network merger. On July 11, 1990, the DOJ terminated its investigations and the network formation was approved by both the DOJ and the FTC.

Not only did the enforcement agencies approve the merger of Evanston Hospital and Glenbrook Hospital with Highland Park Hospital, but they also approved the merger of *four* hospitals.

Prior to the 2000 merger of Evanston Hospital and Highland Park Hospital, the FTC's Premerger Notification Office advised Evanston Hospital and Highland Park that because the formation of ENH involved the merger of two nonprofit corporations that had Northwestern Healthcare Network as its sole

corporate member as a result of the 1990 network merger, the transaction was exempt from the reporting requirements under the Hart-Scott-Rodino Antitrust Improvements Act of 1976. In other words, the 2000 merger of Evanston Hospital and Highland Park Hospital was the nonprofit equivalent of the merger of two wholly owned subsidiaries of a corporate parent. Based on this advice, the ENH merger was closed on January 1, 2000. Ironically, in 2000 at the time of the ENH merger, ENH had only 38% of the total number of beds as the hospitals involved in the network merger.<sup>18</sup>

## V.

### **The Initial Decision's Definition of the Relevant Antitrust Product Market**

In the Initial Decision, ALJ McGuire defined the relevant antitrust product market as “general acute care inpatient services sold to managed care organizations, which includes primary, secondary, and tertiary inpatient services.”<sup>19</sup> In choosing not to include specialty hospitals within the relevant product market, the ALJ concluded that specialty hospitals “do not provide the full range of hospital services” and “may be specialized either in a particular service or for a particular category of patients.”<sup>20</sup> Also excluded from the relevant product market were outpatient services, which the ALJ found to be not functionally interchangeable with inpatient services.<sup>21</sup>

Typically, the relevant product market in hospital mergers consists of general acute care inpatient hospital services.<sup>22</sup> As stated by Judge McKeague in *Federal Trade Commission v. Butterworth Health Corporation*,<sup>23</sup> “general acute care inpatient hospital services is a product market that has been commonly used to evaluate the competitive effects of hospital mergers.”<sup>24</sup> In *U.S. v. Long Island Jewish Medical Center*, Judge Spatt rejected the DOJ's relevant product market consisting of “the bundle of acute inpatient services provided by anchor hospitals to managed care plans.” In doing so, Judge Spatt found, as did Judge McKeague, that the relevant product in hospital mergers was general acute care inpatient hospital services.<sup>25</sup>

However, the ALJ's limit on the product market of general acute inpatient hospital services *to managed care organizations* has never before been adopted by any court. Such a definition is impossibly narrow and ignores the fact that the product market of general acute inpatient hospital services would

have revealed that the patients served by ENH (including the Evanston, Glenbrook and Highland Park hospitals) have alternatives to MCOs with which they finance their health care transactions. The evidence provided did not include testimony from any patients or employers (who typically pay a substantial part of the medical insurance premiums charged by MCOs) to support such a narrow product market. Instead, the only evidence provided to support the designated product market was in the form of self-serving testimony of the MCOs, which pass on any price increases to their customers (*i.e.*, patients and their employers) despite their financial ability to absorb price increases.<sup>26</sup>

It seems that the primary purpose for defining the product market as narrowly as ALJ McGuire did was to defer to the MCOs' opinions regarding the hospitals patients go to, instead of relying on hard evidence demonstrating those hospitals to which patients actually do go.

## VI.

### **The Initial Decision's Definition of the Relevant Geographic Market**

ALJ McGuire defined the relevant geographic market as “the area encompassing the following seven hospitals: Evanston, Glenbrook, Highland Park, Lake Forest, Advocate Lutheran General, Rush North Shore, and St. Francis.”<sup>27</sup> Much like the definition of the relevant product market, ALJ McGuire defined the relevant geographic market based on MCOs' self-serving testimony, which was credited over actual data showing where patients actually do and could go for hospital services. By designating the MCOs as “customers,” the ALJ later adopted, as recommended by the enforcement agencies, such testimony from the MCOs on hospital alternatives to ENH. Contrary to settled authority, the ALJ's determination of the relevant geographic market rejected the use of actual data demonstrating where patients had gone for hospital services in the past—an indication of the hospitals that patients prefer regardless of price increases—and, instead, relied on certain MCOs' biased and incredible opinions about the appropriate geographic market.

ENH's Corrected Appeal Brief, filed on January 12, 2006, states that evidence was provided to demonstrate that “more than a dozen hospitals belong in the geographic market,” which is consistent with the testimony of its economic expert that “before the merger several hospitals, including Northwestern

Memorial, Holy Family, Swedish Covenant and others, acted as significant competitive restraints on ENH.”<sup>28</sup> In a footnote, ENH explains that its economic expert “did not include these other hospitals in her ‘minimum’ geographic market solely for a technical reason: she could not conclude that certain other hospitals located *closer* to ENH constrain ENH’s pricing, and therefore, under *Guidelines*’ technical approach, the more distant hospitals could not be included in the relevant geographic market . . . She made clear, however, that these hospitals have a substantial restraining effect on prices.”<sup>29</sup> It is unfortunate that ENH’s economic expert may have seemed somewhat equivocal as to which hospitals served the ALJ’s narrow geographic market; however, concrete evidence exists that demonstrates the competition of many other hospitals not included in the ALJ’s chosen geographic market.

In what seems a result preordained by the recommendations in the enforcement agencies’ Joint Report, the ALJ also rejected the use of the Elzinga-Hogarty test, which is generally relied upon in most litigated hospital merger cases (typically at the request of the enforcement agencies). The Elzinga-Hogarty test defines a relevant geographic market “based on the area from which the hospital attracts its patients (its service area) and where the patients within that service area go to receive healthcare.”

The ALJ ignored the Elzinga-Hogarty test and found that patients’ willingness to travel demonstrates little regarding price sensitivity because patients do not have control over prices charged for hospital services. In making this determination, the ALJ made two errors. First, there can be no dispute that patients pay (or their employers pay as part of their compensation) the MCOs’ premiums. Second, the ALJ mistakenly found that the Elzinga-Hogarty test “incorrectly assumes that if some patients are willing to travel to distant hospitals, then others will travel as well in response to a change in hospital prices, thereby incorrectly suggesting a broader geographic market.”<sup>30</sup> By ignoring where patients actually do and can go for medical treatment, ALJ McGuire, at the promptings of the FTC trial staff, ignored years of antitrust precedent regarding the proper definition of the relevant geographic market in hospital mergers.

In support of the contrived geographic market, the ALJ concluded that the area around ENH is “populated by ‘senior executives and decision-makers’ who are ‘educated’ and ‘outspoken,’” making it

difficult for any MCO or employer to exclude ENH from their provider network.<sup>31</sup> ALJ McGuire further relied on economic observations that “affluent consumers may be less willing to travel” because they value their time more than less affluent consumers.<sup>32</sup> However, ALJ McGuire lost sight of the fact that at least 50% of the executives residing in the North Shore area surrounding the Evanston and Highland Park hospitals spend a considerable amount of time commuting to their offices in downtown Chicago each day, where there are many high-quality alternate hospitals available. Moreover, ALJ McGuire’s reasoning failed to acknowledge that for many affluent individuals, distance is often not a factor in their buying preferences, specifically with respect to health care decisions. For instance, affluent patients often travel to the Mayo Clinic in Rochester, Minnesota, to receive top-notch health care.

### ***The Reality of the Chicago Hospital Market***

The relevant geographic market offered by the FTC absurdly encompassed “the area adjacent or contiguous to the three ENH hospitals.”<sup>33</sup> Although ALJ McGuire found the FTC’s definition of the relevant geographic market to be too constricted and wrongly expanded it to include Lake Forest Hospital, Advocate Lutheran General, Rush North Shore and St. Francis Hospital, he did not include a single Chicago hospital in the relevant geographic market, despite the fact that Evanston is located directly adjacent to Chicago.<sup>34</sup> Interestingly, the geographic market defined by the ALJ included Lake Forest Hospital, but not the 13 major hospitals in Chicago that are closer to Evanston Hospital and Glenbrook Hospital than Lake Forest Hospital and that treat medical conditions of the same level of severity.

ALJ McGuire should have come to Chicago to adequately assess the geographic market, instead of trying the case hundreds of miles away in Washington, D.C. If he had, he would have discovered that Evanston Hospital and St. Francis Hospital are the only two hospitals in Evanston and are merely a five- or six-minute drive and less than two miles apart, whereas Highland Park Hospital is 13.7 miles (a nearly 30-minute drive) from Evanston Hospital. The ALJ chose wrongly to accept testimony of the MCOs’ representatives that Evanston Hospital and Highland Park Hospital were primary competitors of each other rather than the testimony of Evanston Hospital’s CEO that Highland Park Hospital was not a

“substantial” competitor.<sup>35</sup> Furthermore, Evanston Hospital has 645 total staffed beds and St. Francis Hospital has 236 staffed beds<sup>36</sup> and both provide primary, secondary and tertiary care services, while prior to the merger, Highland Park Hospital did not provide any tertiary care and was, in fact, in a deteriorating condition. Accordingly, there is little to no evidence to support the ALJ’s agreement with the MCOs’ biased and self-serving testimony that Highland Park Hospital was the primary competitor of Evanston Hospital.

Among the hospitals located within 13.7 miles of Evanston Hospital (the distance between Evanston Hospital and Highland Park Hospital) are St. Francis Hospital, Rush North Shore Medical Center and Advocate Lutheran General Hospital, which ALJ McGuire included in the geographic market, as well as several highly respected teaching hospitals that were not included in the geographic market by the ALJ. These excluded hospitals include Northwestern Memorial Hospital (13 miles, 26 minutes from Evanston Hospital); Swedish Covenant Hospital (7.9 miles, 16 minutes from Evanston Hospital); Louis A. Weiss Memorial Hospital (8 miles, 20 minutes from Evanston Hospital); Advocate Illinois Masonic Medical Center (11 miles, 24 minutes from Evanston Hospital); Holy Family Medical Center of Des Plaines (11.3 miles, 27 minutes from Evanston Hospital); Resurrection Medical Center (12.1 miles, 25 minutes from Evanston Hospital); Our Lady of Resurrection Medical Center (12 miles, 25 minutes from Evanston Hospital); St. Joseph Hospital (12 miles, 24 minutes from Evanston Hospital); and Norwegian-American Hospital (13.1 miles, 28 minutes from Evanston Hospital).

In excluding the aforementioned hospitals from the geographic market, ALJ McGuire ignored testimony from ENH antitrust economist expert Monica Noether “that Northwestern Memorial places ‘substantial competitor constraint’ on ENH and other hospitals in the proposed geographic market even though it is located in downtown Chicago.”<sup>37</sup> ENH’s economic expert witness argued that “the relevant geographic market should, at a minimum, include three ENH hospitals plus Lake Forest, Advocate Lutheran General, Rush North Shore, St. Francis, Condell, and Resurrection.”<sup>38</sup> Strangely, ALJ McGuire concluded that ENH’s economist did not intend to include Northwestern Memorial, Swedish Covenant,

Holy Family and the Vista hospitals within the geographic market, even though she testified that such hospitals placed “competitive restraint on ENH.”<sup>39</sup>

By the ALJ’s own statements, Northwestern Memorial is closer to Evanston Hospital than Highland Park Hospital and offers top-notch medical services, which would seem to necessitate the inclusion of Northwestern Memorial Hospital in his geographic market. In fact, ALJ McGuire stated:

Northwestern Memorial is located in downtown Chicago, roughly 13 miles or 26 minutes (driving time) south of Evanston . . . Northwestern Memorial is a tertiary hospital with more than 700 beds . . . Northwestern Memorial is affiliated with the Northwestern Medical School and had .56 residents per bed in 1999 . . . Northwestern Memorial is the number one provider of obstetrical services in Illinois . . . It has the premier obstetrics brand in Chicago because of its Prentice Women’s Hospital and possesses the largest volume of delivering mothers in the Chicago area . . . Great West was the only managed care organization which mentioned Northwestern Memorial as an alternative to ENH . . .<sup>40</sup>

Moreover, Northwestern Memorial Hospital’s superior reputation has been heralded in various publications. The *Chicago Tribune Magazine* recently ran an advertisement headlined “Leading the Nation in Providing Women’s Healthcare” that stated:

Northwestern Memorial Hospital’s Prentice Women’s Hospital has long been recognized for excellence in obstetrics, the care of high-risk newborns and gynecology. Building on these considerable strengths with expanded new health programs and services that will support women throughout all stages of their life, Prentice Women’s Hospital will set the standard for what comprehensive women’s healthcare can be. Today, Prentice is the largest birthing center in the Midwest region and a major referral center for specialized obstetrical care. But Northwestern Memorial Services for women at Prentice throughout the medical campus include so much more.<sup>41</sup>

In discussing Highland Park Hospital, ALJ McGuire found that:

At the time of the merger the Obstetrics and Gynecological (OB/GYN) department was the largest patient care area at Highland Park. Chassin, Tr. 5196.<sup>42</sup>

For ALJ McGuire to have excluded Northwestern Memorial from his strained and constricted geographic market will come as a great shock to the many women in that area who use or have used and will use Northwestern Memorial Hospital for obstetric and gynecological care in the future. Had ALJ McGuire considered where patients went for hospital services, he would have realized that Northwestern

Memorial is a substantial competitor to Highland Park Hospital and would have had to place it in his geographic market.

Moreover, ALJ McGuire failed to appreciate evidence, which had been accepted by the DOJ and the FTC in 1990, that the populace served by ENH is also served by several other hospitals, including Saint Francis, Northwestern Memorial, Advocate Illinois Masonic, two Resurrection hospitals, Condell Memorial, Advocate Lutheran General, Louis Weiss and St. Joseph's. In connection with the DOJ's investigation of the formation of the Northwestern Healthcare Network in 1990, Highland Park Hospital commissioned a study showing the competitive realities then facing Highland Park Hospital and its competitors. One such exhibit reflects the 1987 rankings, hospital discharges and market shares of the top 15 hospitals (of 39 total hospitals) from the 90% Patient-Origin-Destination Service Area of Evanston/Glenbrook and Highland Park Hospitals as follows:<sup>43</sup>

<u>Rank</u>	<u>Hospital</u>	<u>Hospital Discharges</u>	<u>Market Share</u>
1	Evanston/Glenbrook	3,666	7.8
2	Lutheran General	3,490	7.4
3	Resurrection (Chicago)	2,615	5.5
4	Northwest Community	2,257	4.8
5	Saint Francis of Evanston	2,115	4.5
6	Northwestern Memorial	2,073	4.4
7	Saint Teresa	1,608	3.4
8	Illinois Masonic	1,459	3.1
9	Ravenswood	1,409	3.0
10	Columbus	1,388	2.9
11	Victory Memorial	1,366	2.9
12	Highland Park	1,363	2.9
13	Weiss Memorial	1,188	2.5
14	Rush-Presbyterian St. Luke's	1,169	2.5
15	Lake Forest	1,150	2.8
	TOTAL		60.4%

The above data clearly demonstrate that in 1987, many quality hospitals served patients living in the service areas of Evanston/Glenbrook Hospital and Highland Park Hospital. Today, 13 of the 15 aforementioned hospitals continue to serve this area, as do several additional hospitals, for which similar and more recent data could be obtained. Despite the availability of such concrete evidence, the FTC and the ALJ mistakenly ignored the competitive hospital market realities and defined a geographic market that was Lilliputian.

***The Legal Test for the Appropriate Geographic Markets in Antitrust Merger Cases***

In the first case decided by the Supreme Court following the 1950 amendments to Section 7 of the Clayton Act, *Brown Shoe Co. v. United States*,<sup>44</sup> the Supreme Court articulated that the “criteria to be used in determining the appropriate geographic market are essentially similar to those used to determine the relevant product market.” Further, the Supreme Court concluded,

The geographic market selected must . . . both “correspond to commercial realities” of the industry and be economically significant. Thus, although the geographic market in some instances may encompass the entire Nation, under other circumstances it may be as small as a single metropolitan area.<sup>45</sup>

More recently, in *FTC v. Freeman Hospital*,<sup>46</sup> the Eighth Circuit rejected the FTC’s contention that the relevant geographic market for appraising acute care inpatient hospital services in Joplin, Missouri, should be limited to areas within 27 miles of Joplin. The Eighth Circuit concluded that the FTC had painted “a static, rather than a dynamic, picture of the acute care market” that did not “address the decisive question of where consumers could practically go for alternative sources of acute care . . . services.”<sup>47</sup> The Supreme Court has repeatedly described the relevant geographic market as “the ‘area of effective competition in which a seller operates, and to which the purchaser can practicably turn for supplies.’”<sup>48</sup>

Other courts have also recognized a close interrelationship between the product market and geographic market when considering practical alternatives available to consumers. For example, in *United States v. Long Island Jewish Medical Center*,<sup>49</sup> the court found two separate relevant geographic

markets: a smaller market for primary and secondary care, which included hospitals in only Queens and Nassau Counties, and a market for tertiary care comprised of hospitals in Manhattan, Queens, Nassau and western Suffolk Counties.<sup>50</sup>

In the most recent decision by a United States Court of Appeals in a hospital merger case, *Federal Trade Commission v. Tenet Healthcare Corporation*,<sup>51</sup> the Eighth Circuit reversed the findings of the district court,<sup>52</sup> due to a lack of evidence to support the FTC's geographic market consisting of the 50-mile radius of downtown Poplar Bluff, Missouri.<sup>53</sup> In its decision, the Eighth Circuit noted:

Lucy Lee and Doctors' Regional [the two merging hospitals] obtain ninety percent of their patients from zip codes within a fifty-mile radius of Poplar Bluff. In eleven of the top twelve zip codes, however, significant patient admissions--ranging from 22% to 70%--were to hospitals other than those in Poplar Bluff. There is no dispute that Poplar Bluff residents travel to St. Louis, Memphis and Jonesboro for tertiary care. The evidence also shows, however, that a significant numbers of patients in Poplar Bluff service area travel to other towns for primary and secondary treatment that is also available in Poplar Bluff.<sup>54</sup>

The Eighth Circuit further held that to meet its burden to prove the relevant geographic market, the FTC "must present evidence on the critical issue of where consumers of hospital services could practicably turn for alternative services should the merger be consummated and prices become anticompetitive."<sup>55</sup> The Eighth Circuit further stated that a "geographic market is the market 'to which consumers can practically turn for alternative sources of the product and in which the antitrust defendants face competition.'"<sup>56</sup> The Eighth Circuit's opinion further held that:

The evidence in this case falls short of establishing the relevant geographic market that excludes the Sikeston or Cape Girardeau areas. The evidence shows that hospitals in either or both of these towns, as well as rural hospitals throughout the area, are practical alternatives for many Poplar Bluff consumers.

In adopting the FTC's position, the district court improperly discounted the fact that over twenty-two percent of people in the most important zip codes already use hospitals outside the FTC's proposed market for treatment that is offered at Poplar Bluff hospitals.

\* \* \*

If patients use hospitals outside the service area, those hospitals can act as a check on the exercise of market power for the hospitals within the service area.<sup>57</sup>

In light of the FTC's stinging defeat in the *Tenet* case, one would hope that the FTC would be more prudent in urging an appropriate geographic market, especially given that the ENH merger involves Chicago-area hospitals, which, unlike rural Missouri, is the third-largest population concentration in the United States and is served by numerous outstanding hospitals.

Of particular importance to the ENH case is the fact that the Eighth Circuit took a very dim view of the testimony of MCOs in *FTC v. Tenet*. The Eighth Circuit stated:

We question the district court's reliance on the testimony of managed care payers, in the face of contrary evidence, that these for-profit entities would unhesitatingly accept a price increase rather than steer their subscribers to hospitals in Sikeston or Cape Girardeau. Without necessarily being disingenuous or self-serving or both, the testimony is at least contrary to the payers' economic interests and thus is suspect. In spite of their testimony to the contrary, the evidence shows that large, sophisticated third-party buyers can resist price increases, especially where consolidation results in cost savings to the merging entities. The testimony of the market participants spoke to current competitor perceptions and consumer habits and failed to show where consumers could practicably go for inpatient hospital services.<sup>58</sup>

The Eighth Circuit in *Tenet* went on to criticize the district court as follows:

The district court rejected the Cape Girardeau hospitals as practicable alternatives because they were more costly. In so doing, it underestimated the impact of nonprice competitive factors, such as quality. The evidence shows that one reason for significant amount of migration from the Poplar Bluff hospitals to either Sikeston, Cape Girardeau, or St. Louis is the actual or perceived difference in quality of care. The apparent willingness of Poplar Bluff residents to travel for better quality care must be considered. As the district court noted, healthcare decisions are based on factors other than price. It is for that reason that, although they are less expensive, HMOs are not always an employer's or individual's choice in healthcare services. *See Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406, 1412, 1410 (7th Cir. 1995) (Posner, J.) (noting "[g]enerally you must pay more for higher quality" and "the HMO's incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible.") Thus, the fact the Cape Girardeau hospitals are higher priced than Poplar Bluff hospitals does not necessarily mean they are not competitors. *See, e.g., United States v. Archer-Daniels-Midland Co.*, 866 F.2d 242, 246-47 (8th Cir. 1988). The district court

placed an inordinate emphasis on price competition without considering the impact of a corresponding reduction in quality.<sup>59</sup>

In addition to the aforementioned cases, in the following cases courts have opined on the proper relevant geographic market in a challenged hospital merger:

<i>FTC v. University Health, Inc.</i> <sup>60</sup>	Geographic market consisting of Richmond and Columbia Counties in Georgia and Aiken County in South Carolina.
<i>California v. Sutter Health System</i> <sup>61</sup>	Geographic market consisting of the “East Bay” area rejected in favor of at least a three-county market.
<i>FTC v. Butterworth Health Corp.</i> <sup>62</sup>	Geographic market consisting of <i>greater</i> Kent County, Michigan.
<i>United States v. Mercy Health Services</i> <sup>63</sup>	Geographic market consisting of the area of DuPage County, Iowa and adjacent portions of Illinois and Wisconsin rejected as insufficient.
<i>In the Matter of Adventist Health Systems/West</i> <sup>64</sup>	Geographic market included hospitals 68 miles away from the merging hospitals in Ukiah, California, and was based on the “extensive admission to Santa Rosa hospitals of Ukiah area residents for routine inpatient care.”
<i>FTC v. Columbia Hospital Corp.</i> <sup>65</sup>	Injunction granted to protect the interests of the public, “particularly with respect to those in and around Charlotte County, Florida.” In this case, the <i>FTC</i> argued that the proper geographic market was Charlotte County, Florida and six zip codes in adjacent Sarasota County, Florida.
<i>U.S. v. Carilion Health Service</i> <sup>66</sup>	Proper geographic market was “the Roanoke Valley, defined as the cities of Roanoke and Salem, Roanoke County including the Town of Vinton, and adjacent parts of Montgomery, Craig, Floyd, Franklin, Bedford and Botecourt Counties that surround Roanoke County, Virginia.”

It remains well known that the Chicago area is a vibrant, medically blessed area with many outstanding hospitals that serve the entire Chicago area and surrounding areas. For the ALJ to construct a relevant geographic market consisting of only a small part of the northeast portion of Cook County and the southeast portion of Lake County served by only seven hospitals is simply ridiculous and flies in the face of precedent established by other courts. Moreover, in this case, the FTC failed to carry its burden of

proving its alleged three-hospital relevant geographic market, but the ALJ bizarrely created his own relevant geographic market.

### *Chicago's Outstanding Hospitals*

The Consolidated Metropolitan Statistical Area of Chicago as designated by the U.S. Census Bureau includes nine counties in Illinois, one county in Wisconsin and four counties in Indiana. Cook County, Illinois, has a population of 5.35 million; DuPage County, Illinois, has a population of 925,000 and Lake County, Illinois, has a population of 685,000. Thus, these three contiguous counties have a combined population of 6.96 million people.

Although this tri-county area is home to several million people, it is compact in size. For example, Evanston, an adjacent suburb north of Chicago, is a mere 10 miles from the center of downtown Chicago; Oak Park, one of Chicago's adjacent western suburbs, is only eight miles from the center of downtown Chicago; and the northern border of Cook County is only 24 miles from Wisconsin. Moreover, because the area of Cook, Lake and DuPage Counties is a contiguous metropolitan area connected by expressways, highways, streets and commuter railroads, patients in this tri-county area have access to an abundance of outstanding hospitals from which to choose.

Each year, the American Hospital Association publishes a guide to the healthcare industry, which is a compilation of data based on answers to questionnaires received from hospitals throughout the nation. Data in the *AHA Guide® 2006* shows that in this tri-county area alone, there are 70 separate acute care hospitals—43 of which are part of 17 different multi-hospital systems—with a total of 19,493 staffed beds. As the attached Appendix A (“General Medical and Surgical Acute Care Hospitals Located in Chicago, Cook County, DuPage County and Lake County, Illinois”) shows, Advocate Health Care is the largest acute care hospital system in the tri-county area of Cook, DuPage and Lake Counties, Illinois, with eight hospitals and 2,523 staffed beds; however, because there are many other hospitals in this area, it accounts for only 12.9% of the staffed beds in the tri-county area.

The “commercial reality” is that in the Chicago metropolitan area patients have numerous excellent hospitals from which to choose. For example, Chicago has superior medical schools, all with

affiliated hospitals in competition with each other, including Rush University, Loyola University, University of Chicago, University of Illinois and Northwestern University. University of Chicago Hospitals has been named to the honor roll of best U.S. hospitals.<sup>67</sup> Northwestern Memorial Hospital received the National Committee for Quality Health Care award in 2005.<sup>68</sup> In addition, *Modern Healthcare* recently ranked University of Chicago Hospitals, Evanston Northwestern Healthcare and Advocate Lutheran General Hospital among the top 100 hospitals in the nation,<sup>69</sup> and according to *Chicago* magazine’s January 2006 list of Chicago’s top doctors, the following hospitals top the list:<sup>70</sup>

Northwestern Memorial	72 doctors
University of Chicago Hospitals	63 doctors
Rush University Medical Center	47 doctors
Loyola University College of Medicine	39 doctors
Children’s Memorial Hospital	23 doctors
Evanston Northwestern Healthcare	20 doctors
Lutheran General	17 doctors
University of Illinois, Chicago	11 doctors

Recently, in the Winter 2006 edition of *Chicago Life*, an advertising supplement to *The New York Times* of February 5, 2006, the following hospitals, representing the geographic breadth of the Chicago area hospital market, ran advertisements for their services: Northwestern Memorial Hospital (downtown Chicago); Edward Heart Hospital (Naperville, DuPage County); Swedish Covenant Hospital (North Side of Chicago); the University of Chicago Hospitals (South Side of Chicago); University of Illinois Medical Center (West Side of Chicago); and the Alexian Brothers Hospital Network (Elk Grove Village and Hoffman Estates, Cook County). It is easy to see that Chicago-area residents—and those traveling to Chicago for medical care—have numerous outstanding choices of hospitals and the doctors who in most cases dictate the hospitals to which a patient will be admitted for health care services. Therefore, it is hard to see how the ALJ’s artificial geographic market will be sustained.

Some of the MCOs in the ENH case conceded that several hospitals, such as Condell, Resurrection and the Vista hospitals, are viable alternatives to ENH hospitals in addition to the seven chosen by ALJ McGuire to serve as the geographic market. ALJ McGuire, however, rejected such testimony. Stating that “geographic realities matter to competition,” the ALJ found persuasive a 2001

Lake Forest Hospital customer survey report indicating that patients are willing to travel “up to 16 minutes for emergency hospital care and 35 minutes for an overnight hospital stay.”<sup>71</sup> Using driving time estimates computed by ENH’s expert, ALJ McGuire therefore excluded all but one hospital located more than 16 minutes from either Highland Park Hospital or Evanston Hospital from the geographic market. This determination is absurd because Evanston and Highland Park Hospitals, which were found, wrongly, to be the primary competitors of each other by ALJ McGuire, are 27 minutes from each other. The ALJ also excluded from his market Swedish Covenant Hospital, which is 16 minutes south of Evanston, despite the fact that Swedish Covenant lies on the edge of the ALJ’s proposed geographic market and is a closer alternative for patients located eight minutes south of Evanston.

ALJ McGuire’s construction of the geographic market ignores precedent that requires evidence of “where consumers could practicably go, not on where they actually go,”<sup>72</sup> or, as other courts have articulated, where “customers will travel in order to avoid doing business at [the entity that has raised prices]” rather than the distance customers would travel absent a price increase.<sup>73</sup> ALJ McGuire expressly, deliberately and without legal support made his determination without this crucial evidence.

## VII.

### **ALJ McGuire’s Finding That Evanston Northwestern Healthcare Violated the Merger Act Is Wrong**

After incorrectly determining the relevant product and geographic markets, the ALJ focused on the potential anticompetitive effects of the merger. Relying on the *1992 Horizontal Merger Guidelines* (Merger Guidelines), ALJ McGuire found that the FTC established a prima facie case that the ENH merger resulted in a lessening of competition in the relevant market. The Merger Guidelines create a presumption of anticompetitive effects at or above certain concentration levels. The ALJ found that “in the relevant geographic market, in 1999, Evanston and Highland Park had a combined market share of approximately 35%. ENH’s post-merger market share increased to approximately 40% by 2002, with the other four hospitals in the geographic market all losing market shares from 1999 to 2002.”<sup>74</sup> Using the Herfindahl-Hirschman Index (HHI) of market concentration, the ALJ found that ENH had a post-merger

HHI of 2739, which “is substantially above” the threshold for a highly concentrated market, and that the post-merger increase in HHI “far exceed[ed]” the change in HHI presumed “likely to create or enhance market power or facilitate its exercise” in a highly concentrated market.<sup>75</sup> Accordingly, the ALJ determined that the FTC had demonstrated “sufficient market concentration to predict probable anticompetitive effects.”<sup>76</sup>

Since the ALJ chose to adopt a miniscule geographic market, ENH had the burden of presenting evidence demonstrating the factors that “make it unlikely that the merger will create or enhance market power or facilitate its exercise, in light of market concentration and market shares.”<sup>77</sup> Because no court has expressly rejected the Merger Guidelines (though courts have frequently ignored them) as a tool for measuring the anticompetitive effects of a merger, it was vitally important for the FTC to establish a narrow geographic market that fit within the Merger Guidelines’ benchmarks for a highly concentrated market. Interestingly, a review of merger challenges over the past five years indicates that the FTC has not challenged any merger outside of the oil and gas industry with a post-merger HHI below 3000, leading many to question the relevance of the Merger Guidelines’ concentration measures.

## VIII.

### **ENH’s Price Increases Led to Condemnation of the Merger**

Following the merger, the ALJ found that with the exception of prices charged to Blue Cross and Blue Shield (the largest MCO in Illinois), ENH used its increased market power to raise its prices above competitive levels. Although the ALJ concluded that “the record indicates, *but does not conclusively establish*, that [ENH’s] prices were supracompetitive” [emphasis added], he ultimately held, based on statements by ENH executives, that “ENH sought and achieved substantial price increases as a result of the merger.”<sup>78</sup>

The ALJ determined that in the five-year period between 1998 and 2002, ENH increased its inpatient service prices to commercial and self-pay patients by 46% on a per-day basis and 27% on a per-case basis.<sup>79</sup> During this period, the Consumer Price Index for medical care procedures increased by 20.3%.<sup>80</sup> The post-merger increase in the price per day to commercial and self-pay patients during this

period was found to be 26% to 29% greater than in other Chicago-area hospitals. On a per-case basis, the increases were 11.1% to 17% greater than in other hospitals in Chicago. The ALJ also found that prices to all patients and to other payer groups showed a similar increase, and ENH's expert agreed that ENH's post-merger prices increased by 9% to 10% more than a control group of hospitals.<sup>81</sup>

The ALJ concluded that an exercise of market power was the only possible reason for ENH's price increases and dismissed other possible explanations, such as changes in demand, changes in quality and changes in customer mix, all of which deserve more scrutiny than they were afforded by ALJ McGuire.<sup>82</sup> The ALJ's findings that changes in demand and quality could not explain the price increases cannot be reconciled with the fact that ENH raised its prices concurrently with an increase in market share of revenues from 35% to 40%, while the market shares for competing hospitals fell. Without access to the record evidence on revenues, which was redacted from the public Initial Decision, it is impossible to determine whether ENH's increase in revenue market share was caused by price increases or by increased patient volume. If the market share increase was caused by an increase in patient volume, an increase in demand (perhaps due to higher quality, or a perception of higher quality care at Highland Park Hospital) is clearly responsible.

The question is why, if the evidence of a price increase is true, consumers accept a price increase and do not shift demand to other hospitals. In *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*,<sup>83</sup> the Seventh Circuit noted that “[g]enerally you must pay more for higher quality” and, as the ALJ acknowledged, “large price increases alone do not mean that the merger gave ENH market power.”<sup>84</sup> The ALJ found that after the merger, the three hospitals within ENH operated “as though they were a single hospital entity” with a single medical staff and added improvements worth \$120 million to 16 distinct areas of hospital operations at Highland Park Hospital, including the opening of the Kellogg Cancer Center at Highland Park Hospital.<sup>85</sup> ALJ McGuire acknowledged that in opening the Kellogg Cancer Center at Highland Park Hospital, “ENH implemented a multidisciplinary approach that brought together an oncology team consisting of the physician oncologist, nurse, pharmacist, psychologist, social workers, and nutritionists who are available to patients in one location”<sup>86</sup> and

employed a specialty oncologist at Highland Park Hospital “so that patients would not have to travel for their consultations.”<sup>87</sup> Nevertheless, the ALJ incorrectly concluded that there was no improvement in the quality of care at Highland Park to justify ENH’s price increases. The addition of a top-notch oncology team alone increased the quality of patient care at Highland Park, not to mention the resources that it had available as a result of its merger with a hospital system as established and well regarded as ENH.

ALJ McGuire went on to minimize the advancements and improvements made by the Kellogg Cancer Center at Highland Park Hospital and decided that “Highland Park could have expanded its oncology services and research activities through an affiliation agreement with hospitals other than ENH and, in fact, it was exploring these options before the merger, including the possibility of a joint venture with ENH or another hospital for oncology services.”<sup>88</sup>

Ignoring this tremendous facility at Highland Park is indicative of the little weight the ALJ has given to testimony of ENH executives and physicians, which cast doubt on the FTC’s theory of its case. In fact, ALJ McGuire dismisses the entire \$120 million that ENH poured into Highland Park Hospital as totally irrelevant.

ALJ McGuire’s Initial Decision details the following improvements made by ENH to Highland Park Hospital: obstetrics and gynecological services; quality assurance programs; quality improvement program; nursing staff; physical plant; oncology services; radiology; radiation medicine and nuclear medicine; emergency care; laboratory medicine; pharmacy; cardiac surgery; interventional cardiology; psychiatry; and intensivist program.<sup>89</sup> Yet, even in light of such extensive and much-needed improvements made to Highland Park Hospital, ALJ McGuire wrongly found that 14 of the 16 improvements could have been achieved absent the merger, and ordered divestiture.<sup>90</sup> The improvements justification for price increases exist, however, regardless of whether the improvements occurred because of the merger.

In addition, the ALJ incorrectly rejected ENH’s status as a teaching hospital as a justification for the price increase based on determination that ENH has a lower “teaching intensity” than other teaching hospitals. However, the ALJ failed to recognize that Highland Park was not a teaching hospital prior to

the merger. As a result of the merger, Highland Park Hospital became affiliated with Northwestern University Medical School and 60 Highland Park physicians were able to obtain appointments at Northwestern University Medical School. Nevertheless, the ALJ dismissed the notion that the relationship between Highland Park Hospital and Northwestern Medical School, which “may have encouraged some top physicians to join its medical staff,”<sup>91</sup> justified finding an increase in quality at Highland Park.

A change in patient mix is another possible explanation for the price increases, which deserved additional scrutiny. The ALJ recognized that a hospital with an increased number of Medicare and Medicaid patients would be motivated to raise its prices to MCOs, especially when the payments from Medicare and Medicaid were reduced.<sup>92</sup> Evidence demonstrated that the percentage of revenues from Medicare and Medicaid rose from 43% at Highland Park Hospital and 39% at Evanston Hospital in 1999 to 50% for the combined entity in 2005. However, despite a concession by the FTC’s economic expert that he could not eliminate changes in the customer mix as a possible explanation for ENH’s price increases,<sup>93</sup> the ALJ rejected the possible explanation outright.

Further, while the MCOs testified that they obtained lower prices by pitting Evanston Hospital and Highland Park Hospital against each other, it is unclear from the record whether ENH’s post-merger prices are appreciably higher than any premerger price the MCOs obtained from Evanston Hospital and Highland Park Hospital when both hospitals were included in an MCO’s hospital network. Moreover, since the ALJ determined that affluent consumers in the area preferred nearby hospitals, it is logical that they would prefer and be willing to pay increased prices for a health plan that offered access to both Evanston Hospital and the improved Highland Park Hospital. Patients want to, and do go, to high-quality hospitals, not cheap hospitals.

## **IX.**

### **Self-Interested Testimony of the Managed Care Organizations**

As stated, ALJ McGuire relied on the testimony of some managed care payers that were obviously upset that the merger of Evanston-Glenbrook Hospital and Highland Park Hospital resulted in

an entity with increased bargaining power. Because of the MCOs' interest in the outcome of the case, their statements should have been disregarded as irrelevant opinion testimony.

According to the American Medical Association's publication *Competition in Health Insurance: A Comprehensive Study of US Markets (Second Edition 2002)*, the number one HMO/PPO health insurer in the Chicago-Gary-Kenosha metropolitan area in 2000 was Blue Cross Blue Shield of Illinois (HCSC), with 45% of the market share. Humana was the second largest HMO/PPO health insurer in the area, with 16% of the market share. According to the *2004 Update* of the same study, HCSC was the dominant insurer in the Chicago-Gary-Kenosha market, with 51% of the market in 2002, and UnitedHealthcare was the second largest insurer, with 16% of the market share. This study shows that by 2002, for managed care insurance for the combined HMO/PPO market in the Chicago metro area, Blue Cross Blue Shield of Illinois had a 51% market share, UnitedHealthcare had a 16% market share, Humana had a 15% market share and WellPoint had a 9% market share. Therefore, the managed care insurance market in the Chicago area is highly concentrated, with only four insurers making up 91% of the market, although the hospital market is not highly concentrated in the Chicago area.

While engaged in efforts to dismantle various hospital mergers over the past several years, the enforcement agencies have turned a blind eye to the mergers of mammoth health insurance firms, such as the \$16.5 billion merger of Anthem, Inc. and WellPoint Health Networks, Inc. in 2004,<sup>94</sup> the \$5.0 billion acquisition of Oxford Health Plans, Inc. by UnitedHealth Group and UnitedHealth Group's 2004 \$2.7 billion acquisition of Mid Atlantic Medical Services, Inc. in 2004.<sup>95</sup> Recently, WellPoint and WellChoice announced their intention to consummate another multibillion-dollar merger,<sup>96</sup> and UnitedHealth Group acquired PacifiCare for approximately \$8.2 billion.<sup>97</sup>

Moreover, while condemning hospital mergers for price increases, the enforcement agencies ignored the enormous compensation packages paid to the CEOs of the large insurers. For example, UnitedHealth Group's CEO received \$94.2 million in total compensation in 2003, Anthem's CEO received \$46 million in cash compensation and WellPoint's CEO received \$37 million in total compensation.<sup>98</sup>

UnitedHealthcare, a subsidiary of UnitedHealth Group, was a vocal opponent to the ENH merger.<sup>99</sup> According to a recent news article,

... giant managed-care providers have more bargaining muscle when they negotiate payment rates with doctors and hospitals. And a bigger organization is better able to make the so costly information-technology investments that boost efficiency in an increasingly complex regulatory environment.

That simple bigger-is-better logic has spawned a decade of mergers and acquisitions in the managed-care sector; and Minnetonka, Minn.-based UnitedHealth has been one of the most aggressive players. As the nation's second-largest provider, it serves about 55 million people.<sup>100</sup>

UnitedHealth's market capitalization of \$80.13 billion makes UnitedHealth one of America's largest corporations. By comparison, HCA, Inc., the largest for-profit hospital chain in the United States, has a market capital of \$22 billion to \$24 billion. Ironically, if all the hospitals in Chicago merged, they would not be near the size of UnitedHealth, yet the enforcement agencies and ALJ McGuire relied on testimony from UnitedHealth that ENH gained unfair bargaining power as a result of the merger.

Other hospitals have also felt the wrath of the large MCOs. For instance, UnitedHealthcare of Illinois, Inc. (UHI), a subsidiary of UnitedHealth Group, filed a Demand For Arbitration on November 26, 2003 against Advocate Health and Hospital Corporation (represented by able Chicago antitrust lawyer John P. Marren), which operates eight hospitals in Cook, Lake and DuPage counties. With 2,523 staffed beds, Advocate is the largest hospital system in Cook, DuPage and Lake counties, but only has 12.9% of the total staffed beds in this geographic market. As is shown by the attached Appendix A, this narrow geographic market is highly unconcentrated, because the five largest hospital entities have only 39.8% of total staffed beds. UHI filed shotgun charges alleging unlawful price-fixing, market allocation, refusals to deal and group boycott, tortious interference with contract, interference with prospective economic advantage, consumer fraud, defamation and deceptive business practices. On November 18, 2005, UHI's claims were wholly dismissed by the panel of well-known, highly respected antitrust lawyers, Anthony M. DiLeo, Jerald P. Esrick and Ronald Case Sharp. The arbitrators' detailed opinion shows that all the charges filed by UHI were without merit. On review of the ENH merger, the FTC should consider this

ruling, in light of the fact that gigantic and bloated for-profit UnitedHealth is using unsubstantiated allegations to harm acute care hospitals.

While some hospitals possess resources with which to confront the economic giant for-profit MCOs such as UnitedHealth, others are at their mercy, often with fatal consequences, as is amply illustrated in the case *Dardinger v. Anthem Blue Cross & Blue Shield*.<sup>101</sup> In *Dardinger*, the Ohio Supreme Court handed down a \$30 million verdict against Anthem, a for-profit Blue Cross & Blue Shield licensee, for denying payment for an additional chemotherapy treatment, which ultimately caused the patient's death. This case is one of hundreds in which MCOs are being sued for denial of medical coverage. MCOs refusal to pay for medical treatment is endemic and essentially amounts to denial of care.

Prior to December 20, 2005, the only health insurance merger ever challenged by a federal antitrust enforcement agency was Aetna's 1997 acquisition of Prudential. The challenge was directed at the effects of the merger in the two geographic areas in and around Houston and Dallas, Texas, and was, ultimately, resolved by Consent Decree.<sup>102</sup> The merging parties, thus, were allowed to consummate the transaction with a mere slap on the wrist. The DOJ also investigated, but it cleared the March 2001 acquisition by Health Alliance Plan and PPO Michigan of SelectCare, even though published reports suggested that the combined entity would have 44% of the HMO business in the Detroit area following consummation of the transaction.<sup>103</sup>

On December 20, 2005, the DOJ and UnitedHealth Group and PacifiCare Health Systems announced the DOJ's approval of the \$9.2 billion acquisition by UnitedHealth of PacifiCare in 2004. The combined entity now serves 50 states, has 20.5 million persons in medical membership, adjusted income of \$5.35 billion and market capitalization of \$80.4 billion.<sup>104</sup> Clearance of the transaction was allowed after the parties agreed to divest portions of PacifiCare's commercial health insurance business in Tucson, Arizona, and Boulder, Colorado, which did not even amount to a slap on the wrist.

The FTC's failure to recognize the necessary elements of the proper delivery of hospital and health care services has resulted in a bizarre antitrust enforcement action against mergers of hospitals (generally nonprofit hospitals), while approving mergers of gigantic for-profit health insurers. To

maximize profits, the for-profit health insurers write as many premiums as possible and pay the minimum amount of insurance claims. On the other hand, the hospital industry in the United States is comprised mainly of religiously sponsored institutions, community nonprofit charitable institutions, and academically affiliated hospitals, which are dedicated to the health and hospital care of their patients. Accordingly, superior patient care will result in higher prices, and good hospitals and hospital systems, such as ENH, are willing to spend millions of dollars to increase hospital facilities and health care services. The FTC, in the ENH trial, did not call a single patient who objected to ENH's prices or services. But, tragically, the FTC, in its litigation against ENH, has become, in effect, a surrogate for the interests of for-profit and gigantic MCOs, such as UnitedHealth. This is not only wrong economically, but also results in an inaccurate and unjust application of the antitrust laws, which, when properly applied, are crucial to a free market economy.

## X.

### Conclusion

By misapprehending that patients are driven by price rather than quality care and equating hospital pricing to that of for-profit merchandisers, the ALJ rendered a clearly erroneous Initial Decision in *FTC v. Evanston Northwestern Healthcare Corp.*, which should be reversed by the full FTC or by the Seventh Circuit. To preserve competition within all hospital health care markets, the following conclusions of ALJ McGuire should be reversed:

1. The relevant product market;
2. The relevant geographic market;
3. The impact of the competitive imbalance between MCOs and acute care hospitals; and
4. The anticompetitive effect.

If the decision is not reversed, hospital mergers of all kinds risk challenges by the enforcement agencies—especially if prices were raised following the merger. Because nonprofit hospitals are now

faced with serious cutbacks in Medicare and Medicaid reimbursements and serious inroads from for-profit specialty hospitals, the ENH Initial Decision could not have come at a worse time.

To avoid potential enforcement action, hospitals should convincingly link price increases to explicit goals to provide greater value to the community through advanced health and hospital care. In addition, merging hospitals should consider constructing an attainable and implementable post-merger plan that provides concrete improvements to the hospitals' facilities, systems, quality of care and access to care.

Appendix A

**GENERAL MEDICAL AND SURGICAL ACUTE CARE HOSPITALS LOCATED  
IN CHICAGO, COOK COUNTY, DUPAGE COUNTY AND LAKE COUNTY, ILLINOIS<sup>1</sup>**

	<b>Name of Local Hospital or System</b>	<b>Local Hospital or Address</b>	<b># of Staffed Beds</b>	<b>Market Share</b>
<b>1.</b>	<b>Advocate Health Care</b>  <b>8 hospitals : 2,523 beds</b>	<b>Advocate Bethany Hospital</b> <b>3435 West Van Buren Street</b> <b>Chicago, Illinois</b>	<b>136</b>	
		<b>Advocate Christ Medical Center</b> <b>4440 West 95th Street</b> <b>Chicago, Illinois</b>	<b>649</b>	
		<b>Advocate Good Samaritan Hospital</b> <b>3815 Highland Avenue</b> <b>Downers Grove, Illinois</b>	<b>278</b>	
		<b>Advocate Good Shepherd Hospital</b> <b>450 West Highway 22</b> <b>Barrington, Illinois</b>	<b>142</b>	
		<b>Advocate Illinois Masonic Medical Center</b> <b>836 West Wellington Avenue</b> <b>Chicago, Illinois</b>	<b>346</b>	
		<b>Advocate Lutheran General Hospital</b> <b>1775 Dempster Street</b> <b>Park Ridge, Illinois</b>	<b>569</b>	
		<b>Advocate South Suburban Hospital</b> <b>17800 South Kedzie Avenue</b> <b>Hazel Crest, Illinois</b>	<b>245</b>	
		<b>Advocate Trinity Hospital</b> <b>2320 E. 93<sup>rd</sup> Street</b> <b>Chicago, Illinois</b>	<b>158</b>	
<b>Total</b>			<b>2,523</b>	<b>12.9%</b>
<b>2.</b>	<b>Resurrection Health Care Corporation</b>  <b>9 hospitals : 2,392 beds</b>	<b>Holy Family Medical Center</b> <b>100 North River Road</b> <b>Des Plaines, Illinois</b>	<b>165</b>	
		<b>Our Lady of the Resurrection Medical Center</b> <b>5645 West Addison Street</b> <b>Chicago, Illinois</b>	<b>265</b>	
		<b>Resurrection Medical Center</b> <b>7435 West Talcott Avenue</b> <b>Chicago, Illinois</b>	<b>398</b>	

<sup>1</sup>The systems and individual hospitals' General Medicine and Surgical Acute Care Hospitals in this area are ranked by total number of staffed beds. The information summarized in this chart is from the *AHA Guide, 2006* published by the American Hospital Association.

<b>Name of Local Hospital or System</b>		<b>Local Hospital or Address</b>	<b># of Staffed Beds</b>	<b>Market Share</b>
		<b>St. Francis Hospital 355 Ridge Ave. Evanston, Illinois</b>	<b>236</b>	
		<b>St. Joseph Hospital 2900 North Lake Shore Dr. Chicago, Illinois</b>	<b>345</b>	
		<b>Sts. Mary and Elizabeth Medical Center 1431 North Claremont Street Chicago, Illinois</b>	<b>252</b>	
		<b>Sts. Mary and Elizabeth Medical Center 2233 West Division Street Chicago, Illinois</b>	<b>305</b>	
		<b>West Suburban Medical Center 3 Erie Court Oak Park, Illinois</b>	<b>246</b>	
		<b>Westlake Hospital 1225 Lake Street Melrose Park, Illinois</b>	<b>180</b>	
<b>Total</b>			<b>2,392</b>	<b>12.3%</b>
<b>3.</b>	<b>Rush University Medical Center  3 hospitals : 1,066 beds</b>	<b>Rush North Shore Medical Center 9600 Gross Point Road Skokie, Illinois</b>	<b>239</b>	
		<b>Rush University Medical Center 1653 West Congress Pkwy. Chicago, Illinois</b>	<b>679</b>	
		<b>Rush-Copley Medical Center 2000 Ogden Avenue Aurora, Illinois</b>	<b>148</b>	
<b>Total</b>			<b>1,066</b>	<b>5.5%</b>
<b>4.</b>	<b>Cook County Bureau of Health Services  3 hospitals : 1,029 beds</b>	<b>John H. Stroger, Jr. Hospital of Cook County 1835 West Harrison Street Chicago, Illinois</b>	<b>460</b>	
		<b>Oak Forest Hospital of Cook County 15900 Cicero Avenue Oak Forest, Illinois</b>	<b>450</b>	
		<b>Provident Hospital of Cook County 500 E. 51<sup>st</sup> Street Chicago, Illinois</b>	<b>119</b>	
<b>Total</b>			<b>1,029</b>	<b>5.3%</b>
<b>5.</b>	<b>Northwestern Memorial Hospital</b>	<b>251 East Huron Street Chicago, Illinois</b>	<b>744</b>	<b>3.8%</b>
<b>6.</b>	<b>Adventist Health System Sunbelt Health Care Corporation</b>	<b>Adventist GlenOaks Hospital 701 Winthrop Avenue Glendale Heights, Illinois</b>	<b>149</b>	

	<b>Name of Local Hospital or System</b>	<b>Local Hospital or Address</b>	<b># of Staffed Beds</b>	<b>Market Share</b>
	<b>30 hospitals : 5,887 beds systemwide</b>	<b>Adventist LaGrange Memorial Hospital 5101 South Willow Spring Road LaGrange, Illinois</b>	<b>178</b>	
		<b>Hinsdale Hospital 120 North Oak Street Hinsdale, Illinois</b>	<b>333</b>	
<b>Total</b>			<b>660</b>	<b>3.4%</b>
<b>7.</b>	<b>Evanston Northwestern Healthcare<sup>2</sup>  3 hospitals</b>	<b>1301 Central Street Evanston, Illinois</b>	<b>645</b>	<b>3.3%</b>
<b>8.</b>	<b>University of Chicago Hospitals</b>	<b>5841 South Maryland Avenue Chicago, Illinois</b>	<b>585</b>	<b>3.0%</b>
<b>9.</b>	<b>Alexian Brothers Health System  2 hospitals : 559 beds</b>	<b>Alexian Brothers Medical Center 800 Biesterfield Road Elk Grove Village, Illinois</b>	<b>348</b>	
		<b>St. Alexius Medical Center 1555 Barrington Road Hoffman Estates, Illinois</b>	<b>211</b>	
<b>Total</b>			<b>559</b>	<b>2.9%</b>
<b>10.</b>	<b>Vanguard Health System  16 hospitals : 3,238 beds systemwide</b>	<b>Louis A. Weiss Memorial Hospital 4646 North Marine Dr. Chicago, Illinois</b>	<b>192</b>	
		<b>MacNeal Hospital 3249 South Oak Park Avenue Berwyn, Illinois</b>	<b>320</b>	
<b>Total</b>			<b>512</b>	<b>2.6%</b>
<b>11.</b>	<b>Loyola University Medical Center</b>	<b>2160 South First Avenue Maywood, Illinois</b>	<b>505</b>	<b>2.6%</b>
<b>12.</b>	<b>Sisters of St. Francis Health Services, Inc.  8 hospitals : 2,562 beds systemwide</b>	<b>St. James Hospitals and Health Centers 20201 South Crawford Avenue Olympia Fields, Illinois</b>	<b>494</b>	<b>2.5%</b>
<b>13.</b>	<b>University of Illinois Medical Center at Chicago</b>	<b>1740 West Taylor Street Chicago, Illinois</b>	<b>443</b>	<b>2.3%</b>
<b>14.</b>	<b>Northwest Community Healthcare</b>	<b>800 West Central Road Arlington Heights, Illinois</b>	<b>412</b>	<b>2.1%</b>
<b>15.</b>	<b>Ingalls Memorial Hospital</b>	<b>One Ingalls Drive Harvey, Illinois</b>	<b>407</b>	<b>2.1%</b>
<b>16.</b>	<b>Palos Community Hospital</b>	<b>12251 South 80th Avenue Palos Heights, Illinois</b>	<b>357</b>	<b>1.8%</b>

<sup>2</sup>Includes Evanston Hospital, Glenbrook Hospital and Highland Park Hospital.

	<b>Name of Local Hospital or System</b>	<b>Local Hospital or Address</b>	<b># of Staffed Beds</b>	<b>Market Share</b>
17.	Elmhurst Memorial Hospital	200 Berteau Avenue Elmhurst, Illinois	348	1.8%
18.	Central DuPage Hospital	25 North Winfield Road Winfield, Illinois	327	1.7%
19.	Swedish Covenant Hospital	5145 North California Avenue Chicago, Illinois	324	1.7%
20.	Michael Reese Hospital and Medical Center	2929 South Ellis Avenue Chicago, Illinois	316	1.6%
21.	Sinai Health System	Mount Sinai Medical Center of Chicago California Avenue and 15th Street Chicago, Illinois	312	1.6%
22.	Mercy Hospital and Medical Center	2525 South Michigan Avenue Chicago, Illinois	304	1.6%
23.	America Province of Little Company of Mary  2 hospitals : 418 beds systemwide	Little Company of Mary Hospital and Health Centers 2800 West 95th Street Evergreen Park, Illinois	294	1.5%
24.	SSM Health Care  16 hospitals : 3,372 beds systemwide	St. Francis Hospital & Health Center 12935 South Gregory Street Blue Island, Illinois	260	1.3%
25.	Provena Health System  6 hospitals : 1,332 beds systemwide	Provena Mercy Center 1325 Highland Avenue Aurora, Illinois (DuPage-Kane Counties)	254	1.3%
26.	Gottlieb Memorial Hospital	701 West North Avenue Melrose Park, Illinois	251	1.3%
27.	Holy Cross Hospital	2701 West 68th Street Chicago, Illinois	244	1.3%
28.	Vista Health  2 hospitals : 237 beds systemwide	Victory Memorial Hospital 1224 N. Sheridan Rd. Waukegan, Illinois Provena Saint Therese Medical Center 2615 Washington Street Waukegan, Illinois	146 91	
<b>Total</b>			<b>237</b>	<b>1.2%</b>
29.	Edward Hospital	801 South Washington Avenue Naperville, Illinois	236	1.2%
30.	Norwegian-American Hospital	144 North Francisco Avenue Chicago, Illinois	230	1.2%
31.	Condell Medical Center	801 South Milwaukee Avenue Libertyville, Illinois	215	1.1%
32.	Jackson Park Hospital and Medical Center	7531 Stony Island Avenue Chicago, Illinois	212	1.1%
33.	Lake Forest Hospital	660 North Westmoreland Road Lake Forest, Illinois	205	1.1%

	<b>Name of Local Hospital or System</b>	<b>Local Hospital or Address</b>	<b># of Staffed Beds</b>	<b>Market Share</b>
34.	<b>St. Bernard Hospital and Health Care Center</b>	<b>326 West 64th Street Chicago, Illinois</b>	<b>194</b>	<b>1.0%</b>
35.	<b>Methodist Hospital of Chicago</b>	<b>5025 North Paulina Street Chicago, Illinois</b>	<b>189</b>	<b>1.0%</b>
36.	<b>Wheaton Franciscan Services, Inc.</b>  13 hospitals : 2,205 beds systemwide	<b>Rush Oak Park Hospital 520 South Maple Avenue Oak Park, Illinois</b>	<b>176</b>	<b>0.9%</b>
37.	<b>Loretto Hospital</b>	<b>645 South Central Avenue Chicago, Illinois</b>	<b>172</b>	<b>0.9%</b>
38.	<b>Merit Health System</b>  2 hospitals : 336 beds systemwide	<b>Lincoln Park Hospital 550 Webster Street Chicago, Illinois</b>	<b>155</b>	<b>0.8%</b>
39.	<b>Ascension Health</b>  69 hospitals : 14,442 beds systemwide	<b>St. Anthony Hospital 2875 West 19th Street Chicago, Illinois</b>	<b>151</b>	<b>0.8%</b>
40.	<b>Thorek Hospital and Medical Center</b>	<b>850 West Irving Park Road Chicago, Illinois</b>	<b>137</b>	<b>0.7%</b>
41.	<b>South Shore Hospital</b>	<b>8012 Crandon Avenue Chicago, Illinois</b>	<b>125</b>	<b>0.6%</b>
42.	<b>Roseland Community Hospital</b>	<b>45 West 111th Street Chicago, Illinois</b>	<b>110</b>	<b>0.6%</b>
43.	<b>Sacred Heart Hospital</b>	<b>3240 West Franklin Boulevard Chicago, Illinois</b>	<b>96</b>	<b>0.5%</b>
44.	<b>Kindred Healthcare</b>  47 specialty, long-term care, and general medical and surgical hospitals : 3,404 beds systemwide	<b>Kindred Hospital – Chicago Northlake 365 East North Avenue Northlake, Illinois</b>	<b>86</b>	<b>0.4%</b>
<b>GRAND TOTAL</b>			<b>19,493</b>	<b>100%</b>

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<sup>1</sup> Federal antitrust enforcement actions against mergers and acquisitions are civil actions brought under Sections 7 and 16 of the Clayton Act (15 U.S.C. §§ 18 and 26) and occasionally Sections 1 and 2 of the Sherman Act (15 U.S.C. §§ 1 and 2). The factual inquiry under Section 1 of the Sherman Act (an unreasonable restraint of trade) is identical to the factual inquiry under Section 7 of the Clayton Act (may be substantially to lessen competition). *U.S. v. Rockford Memorial Hosp.*, 898 F.2d 1298 at 1282-1283 (7th Cir. 1996). These laws are enforced by both the DOJ and by the FTC.

<sup>2</sup> See, *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 (8th Cir. 1999); *FTC v. Butterworth Health Corp.*, 121 F.3d 708 (6th Cir. 1997); *U.S. v. Mercy Health Services*, 902 F. Supp. 968, 64 U.S.L.W. 2306 (N.D. Iowa 1995), *vacated as moot* by 107 F.3d 632 (8th Cir. 1997); *FTC v. Freeman Hosp.*, 69 F.3d 260 (8th Cir. 1995); *U.S. v. Long Island Jewish Medical Center*, 983 F. Supp. 121 (E.D.N.Y. 1997).

<sup>3</sup> *California v. Sutter Health System*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001). The District Court's detailed decision of California's alleged geographic market is at pp. 1122-1132. The U.S. Court of Appeals for the Ninth Circuit affirmed the District Court's refusal to grant the State of California a preliminary injunction at 217 F.3d 846 (9th Cir. 2000).

<sup>4</sup> Initial Decision at 208 (emphasis added).

<sup>5</sup> *Id.*

<sup>6</sup> U.S. Census Bureau, *Statistical Abstract of the United States: 2006*, at 926.

<sup>7</sup> 15 U.S.C. § 18.

<sup>8</sup> *Hospital Corporation of America ("HCA") v. FTC*, 807 F.2d 1381 (7th Cir. 1986).

<sup>9</sup> *Id.* at 1388.

<sup>10</sup> 807 F.2d at 1388. The FTC full-Commission opinion in the matter had found that the relevant geographic market was the Chattanooga urban area. 106 F.T.C. 361, 1985 WL 668927 at \*32.

<sup>11</sup> *Id.* at 1388.

<sup>12</sup> *Id.* at 1389.

<sup>13</sup> 898 F.2d 1278 (7th Cir. 1990).

<sup>14</sup> *Id.* at 1285.

<sup>15</sup> FTC Docket No. 9315.

<sup>16</sup> Count III, which alleged price-fixing against the ENH Medical Group, Inc., was settled by a consent decree with the FTC on May 17, 2005.

<sup>17</sup> Devon Avenue is 6400 north and begins at Lake Michigan at the south boundary of the North Shore campus of Loyola University and runs west to O'Hare International Airport. Lake County is adjacent to Cook County (where Chicago is located) on the north. The border of Cook and Lake Counties is eight miles north of Howard Street, which is the border of Chicago and Evanston.

<sup>18</sup> *AHA Guide® to the Health Care Field 1992*.

<sup>19</sup> Initial Decision at 208.

<sup>20</sup> Initial Decision at 28, 134.

<sup>21</sup> Initial Decision at 29, 133-35.

<sup>22</sup> However, in *United States v. Carillion Health System*, 707 F. Supp. 840, 844-45, 847 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042 (4th Cir. 1989), the district court found that because some inpatient services can be obtained in an outpatient clinic or doctor's office, providers of such outpatient services should be deemed to compete with hospitals; in this respect, such outpatient services should be included in the relevant product market.

<sup>23</sup> 946 F. Supp. 1285 (W.D. Mich. 1996).

<sup>24</sup> See *Freeman Hosp.*, 69 F.3d at 268; *University Health*, 938 F.2d at 1211; *Mercy Health Services*, 902 F. Supp. at 976 (1290).

<sup>25</sup> 983 F. Supp. at 137-40.

<sup>26</sup> See Initial Opinion ¶¶ 187-88 at 27.

<sup>27</sup> Initial Decision at 208.

<sup>28</sup> Respondent's Corrected Appeal Brief at 34-35.

<sup>29</sup> *Id.* at footnote 7.

<sup>30</sup> Initial Decision at 30.

<sup>31</sup> Initial Decision at 31.

<sup>32</sup> Initial Decision at 31.

<sup>33</sup> Initial Decision at 137.

<sup>34</sup> Initial Decision at 208.

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<sup>35</sup> Initial Decision at 141-42.  
<sup>36</sup> *2006 AHA Guide*® at A194.  
<sup>37</sup> Noether, Tr. 5931 at 40.  
<sup>38</sup> Initial Decision at 137.  
<sup>39</sup> *Id.*  
<sup>40</sup> Initial Decision at 40.  
<sup>41</sup> *Chicago Tribune Magazine*, November 20, 2005, at 10.  
<sup>42</sup> Initial Decision at 109.  
<sup>43</sup> Summary of 90% Patient Origin: Discharges from Service Area Hospitals and Selective Others in the First 67 Zip Codes Comprising Evanston/Glenbrook, Highland Park 90% Patient Origin.  
<sup>44</sup> 370 U.S. 294 (1962).  
<sup>45</sup> *Id.* at 336-337.  
<sup>46</sup> 69 F.3d 260 (8th Cir. 1995).  
<sup>47</sup> *Id.* at 269.  
<sup>48</sup> *U.S. v. Philadelphia Nat'l Bank*, 374 U.S. 321, 359 (1963) (quoting *Tampa Electric Co. v. Nashville Coal Co.*, 369 U.S. 320, 327 (1961) (emphasis omitted)).  
<sup>49</sup> 983 F. Supp. 121 (E.D.N.Y. 1997).  
<sup>50</sup> *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 140-142.  
<sup>51</sup> 186 F.3d 1045 (8th Cir. 1999).  
<sup>52</sup> 17 F. Supp. 2d 937 (E.D. Mo. 1998).  
<sup>53</sup> *Id.* at 943.  
<sup>54</sup> 186 F.3d. at 1049-1050.  
<sup>55</sup> *Id.* at 1052; *Freeman Hosp.*, 69 F. 3d at 269.  
<sup>56</sup> *Id.*  
<sup>57</sup> *Id.* at 1053.  
<sup>58</sup> *Id.* at 1054.  
<sup>59</sup> *Id.* at 1054.  
<sup>60</sup> 938 F.2d 1206, 1210-11 (11th Cir. 1991).  
<sup>61</sup> 84 F. Supp. 2d 1057 (N.D. Cal. 2000).  
<sup>62</sup> 946 F. Supp. 1285, 1292 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1996).  
<sup>63</sup> 902 F. Supp. 968, 976-78 (N.D. Iowa 1995).  
<sup>64</sup> 117 F.T.C. 224, 263 (1994).  
<sup>65</sup> 1993-1 Trade Cases (CCH) ¶ 70,210, at 69,981.  
<sup>66</sup> 707 F. Supp. 840, 848 (W.D. Va. 1989) *aff'd*, 892 F.2d 1042 (4th Cir. 1989).  
<sup>67</sup> University of Chicago Hospitals Web site, November 22, 2005.  
<sup>68</sup> *Modern Healthcare*, November 21, 2005.  
<sup>69</sup> *Modern Healthcare*, February 27, 2006, at 25.  
<sup>70</sup> *Chicago*, "Chicago's Top Doctors," January 2006.  
<sup>71</sup> Initial Decision at 35, 142-43.  
<sup>72</sup> *Tenet Health Care Corp.*, 186 F.3d at 1052.  
<sup>73</sup> *Bathke v. Casey's General Stores, Inc.*, 64 F.3d 340, 346 (8th Cir.1995).  
<sup>74</sup> Initial Decision at 209.  
<sup>75</sup> Initial Decision at 151.  
<sup>76</sup> Initial Decision at 152.  
<sup>77</sup> Merger Guidelines § 1.51.  
<sup>78</sup> Initial Decision at 155.  
<sup>79</sup> Initial Decision at 77-78.  
<sup>80</sup> Initial Decision at 75.  
<sup>81</sup> Initial Decision at 86-88, 168, 173-75.  
<sup>82</sup> Initial Decision at 169.  
<sup>83</sup> 65 F.3d 1406, 1411-12 (7th Cir. 1995).  
<sup>84</sup> Initial Decision at 166.  
<sup>85</sup> Initial Decision at 14-15, 109-19, 182.  
<sup>86</sup> Initial Decision at 113.  
<sup>87</sup> Initial Decision at 113.

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- <sup>88</sup> Initial Decision at 114.
- <sup>89</sup> Initial Decision at 109-18.
- <sup>90</sup> Initial Decision at 182-83.
- <sup>91</sup> Initial Decision at 191.
- <sup>92</sup> Initial Decision at 95.
- <sup>93</sup> Initial Decision at 95.
- <sup>94</sup> WellPoint November 30, 2004 Press Release, [http://phx.corporate-ir.net/phoenix.zhtml?c=130104&p=irol-newsArticle\\_general&t=Regular&id=648665&](http://phx.corporate-ir.net/phoenix.zhtml?c=130104&p=irol-newsArticle_general&t=Regular&id=648665&).
- <sup>95</sup> UnitedHealth Group 2004 Form 10-K at 16.
- <sup>96</sup> WellPoint September 27, 2005 Press Release, [http://phx.corporate-ir.net/phoenix.zhtml?c=130104&p=irol-newsArticle\\_general&t=Regular&id=761487&](http://phx.corporate-ir.net/phoenix.zhtml?c=130104&p=irol-newsArticle_general&t=Regular&id=761487&).
- <sup>97</sup> UnitedHealth Group Third Quarter 2005 Form 10-Q at 7.
- <sup>98</sup> *Modern Healthcare*, August 2, 2004, at 6-7.
- <sup>99</sup> UnitedHealthcare of Illinois, Inc., a subsidiary of UnitedHealth Group, also recently asserted allegations of unlawful price-fixing and violations of the Sherman Act, among several other charges, against Advocate Health and Hospital Corporation, which has eight hospitals operating in Cook, Lake and DuPage counties and 12.8% of the total staffed beds in the geographic market. Such allegations claims were wholly dismissed by a well-known and highly respected panel of arbitrators on November 18, 2005.
- <sup>100</sup> “Deere Departs Health Business,” *Chicago Tribune*, Dec. 7, 2005, Business section, at 1-2.
- <sup>101</sup> 98 Ohio St. 3d 77, 781 N.E.2d 121 (2002).
- <sup>102</sup> Complaint, *U.S. v. Aetna Inc.*, NO.3-99CV 1398-H, (N.D. Tex. June 21, 1999); and Final Consent Order, *U.S. v. Aetna Inc.*, No.3-99CV 1398-H (N.D. Tex. Dec. 7, 1999).
- <sup>103</sup> *Modern Healthcare*, “Market Clout: HAP, PPOM Gain Edge in Michigan with Acquisition of SelectCare, Health Plan,” March 19, 2001.
- <sup>104</sup> *Modern Healthcare*, January 2, 2006, at 15.