UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

In the Matter of **OSF Healthcare System** **a corporation, and** **Rockford Health System** **a corporation**	**PUBLIC** **Docket No. 9349**

COMPLAINT COUNSEL'S PRE-TRIAL BRIEF

Richard A. Feinstein
Director

Norman A. Armstrong, Jr.
Deputy Director

Matthew J. Reilly
Assistant Director

Jeffrey H. Perry
Sara Y. Razi
Deputy Assistant Directors

Daniel K. Zach
Kenneth W. Field
Douglas E. Litvack
Katherine A. Ambrogi
Jeremy P. Morrison
Paul J. Nolan
Richard H. Cunningham
Jeanne H. Liu
Peter C. Herrick
Kajetan S. Rozga
Sarah K. Swain
Kevin K. Hahm
Stephanie L. Reynolds
Matthew A. Tabas
Andrea E. Zach
Attorneys

Federal Trade Commission
Bureau of Competition
Mergers IV
600 Pennsylvania Ave., N.W.
Washington, DC 20580
Telephone: (202) 326-2350
Facsimile: (202) 326-2286
Email: mreilly@ftc.gov

Counsel Supporting the Complaint

Dated: April 4, 2012

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INTRODUCTION

For decades, OSF Healthcare System ("OSF") and Rockford Health System ("RHS") have competed head-to-head, and against SwedishAmerican Hospital ("Swedish"), the only other hospital in Rockford, to provide general acute-care inpatient hospital ("GAC") and primary care physician ("PCP") services. As RHS's CEO testified during the preliminary injunction hearing in this matter, "[f]or general inpatient care for all patients in and around Rockford, [OSF's] Saint Anthony's and SwedishAmerican are RHS's only meaningful competitors." PX2511 at 774:17-20. A wealth of evidence shows that competition among these three hospitals has secured lower prices and new and higher-quality services for local employers and residents. OSF's proposed acquisition of RHS (the "Acquisition") would eliminate the substantial benefits RHS creates as an independent competitor and result in higher healthcare prices, lower quality, and less innovation for Rockford-area residents.

This is not the first time Rockford hospitals have attempted a merger to duopoly. In 1989, RHS and Swedish sought to combine. However, after a full trial on the merits, they were permanently enjoined from doing so by a federal district court, whose decision was affirmed by Judge Posner writing for the Seventh Circuit. In finding liability under Section 7 of the Clayton Act, the district court ruled that it could "safely be stated that the merger . . . would produce a firm controlling an undue percentage share of the relevant market, thus increasing the likelihood of market dominance by the merged entity or collusion." *United States v. Rockford Mem'l Corp.*, 717 F.Supp. 1251, 1281 (N.D. Ill. 1989), *aff'd* 898 F.2d 1278, 1285 (7th Cir. 1990).

All of the important facts that the *Rockford* district court and Seventh Circuit relied upon to conclude that the prior attempted merger to duopoly violated Section 7 remain unchanged

today. Although there have been many medical advancements and changes in the healthcare industry over the years, the same three Rockford hospitals, and only those hospitals, continue to compete with each other to provide GAC services to local residents. This competition remains the primary driver of pricing for these services, and also has provided the impetus for these hospitals to offer new, and better, services and amenities to local residents. Patients' strong preference to receive care near where they live and work also remains the same (or has strengthened), leaving the contours of the geographic market the same or narrower than they were in 1989. Potential entrants continue to face the same insurmountable barriers to entry. Thus, just like the prior merger, the current proposed merger to duopoly violates Section 7. 15 U.S.C. § 18.

In fact, well-settled case law and the tremendous body of evidence presented here and during the upcoming hearing, clearly show that this Acquisition is presumptively illegal. The Acquisition is presumed unlawful by a wide margin because it would substantially increase concentration in an already highly-concentrated GAC services market, resulting in OSF controlling more than 58 percent of that market, as well as between 34 and 46 percent of the PCP services market. This presumption is confirmed by a substantial amount of direct evidence showing that the Acquisition would not only lead to greater market power in the hands of OSF, but also a substantially heightened risk of coordination between OSF and Swedish.

The Acquisition would substantially increase the combined entity's bargaining leverage, allowing it to extract higher prices from health plans than OSF and RHS obtain independently. Post-Acquisition, rather than having three hospital competitors bidding with low rates to be in health plans' networks, there would be only two. By eliminating close competition from RHS and reducing the number of bidders for inclusion in each network, OSF would face significantly

less pressure to compete on price, quality, and service than it does today. Moreover, local employers and residents strongly prefer health plan networks that provide access to at least two hospitals in Rockford. For this reason, all of the major health plans today offer two of the three hospitals in Rockford as in-network options, recognizing that one-hospital networks are extremely unattractive to local residents. Indeed, Respondents' own executives have testified that "to be marketable [health plans] have to have two hospitals in Rockford." PX0213 at 95:4-18. Health plans agree, stating that "you need two of the three hospitals to achieve any real measure of success in Rockford." PX4764-001. If OSF acquires RHS, the only way health plans could offer a two-hospital network would be to reach an agreement with the combined entity. Thus, it would become a virtual "must have" system. As one health plan has testified, "[i]f we do not have the OSF hospitals in our system after the merger, then we are not going to be competitive." PX4002 at 112:2-15. Post-Acquisition, the only alternative to contracting with the combined entity would be to offer a highly-unattractive Swedish-only network, which would substantially increase OSF's bargaining leverage. Because Respondents' acknowledged negotiating strategy is to **{ }** the combined entity would undoubtedly use its heightened leverage to increase reimbursement rates to health plans. PX0458-001. These rate increases would ultimately be paid by local employers and employees, many of whom already are struggling with rising healthcare costs.

The Acquisition would also substantially heighten the risk of anticompetitive coordination. There has been a long history of hospital coordination in Rockford, including a group boycott of a major health plan described in the original *Rockford* case. 717 F.Supp. at 1286, 1304-06. More recently, evidence confirms that the three Rockford hospitals continue to exchange competitively-sensitive information about health plan negotiations and strategic plans,

with no legitimate business justification. By increasing market concentration and eliminating RHS as an independent competitor, the Acquisition would significantly increase the ability and incentives of OSF and Swedish to coordinate in the future to increase prices and limit the number and quality of services they offer.

Respondents fall woefully short of rescuing the Acquisition from Section 7 condemnation. Their efficiency claims are wholly speculative, non-merger-specific, and concocted specifically for this litigation. In fact, Respondents admit that "FTI [the firm that initially evaluated the Acquisition's purported efficiencies] was hired by Hinshaw & Culbertson and McDermott, Will & Emery jointly, and [its] work was done in anticipation of litigation[,]" not for any business purpose. PX0228 at 23:5-11. Their other purported defenses amount to nothing more than deeply-flawed, and, in some instances, completely irrelevant "justifications" that no court has ever accepted. The entirety of Respondents' defense comes nowhere close to overcoming the strong presumption that the Acquisition is illegal, much less outweighing the wealth of additional, direct evidence of competitive effects presented by Complaint Counsel.

Thus, Complaint Counsel respectfully submits that an order prohibiting the Acquisition and providing related ancillary relief is warranted.

I. FACTUAL BACKGROUND

A. The Merging Parties

1. OSF Healthcare System

OSF is a self-proclaimed "dominant" not-for-profit healthcare system in central Illinois. PX2510 (Schertz (OSF), PI Hr'g Tr.) at 625:6-16; *see also* PX0061-006 (**{**

}). OSF is headquartered in Peoria and operates six general acute-care hospitals in Illinois and another in Michigan. OSF

Answer at ¶ 14. In Rockford, OSF operates Saint Anthony Medical Center ("SAMC"), which is licensed to operate 254 beds. *Id*. By all accounts, SAMC is a high-quality hospital that offers a broad range of general acute-care inpatient services, is a designated Level I trauma center, and provides some higher-level services, including neurological and oncology services. PX2515 (Capps, Expert Report) at ¶ 18; PX2513 (Romano, Expert Report) at ¶¶ 11, 22-23. SAMC accounted for approximately 30 percent of the area's commercial general acute-care inpatient admissions in 2010, as well as roughly 34 percent of the days such patients spent in the hospital. PX2515 (Capps, Expert Report) at ¶¶ 174-175, 179. OSF also owns OSF Medical Group and employs approximately 80 physicians practicing at SAMC and throughout the Rockford area, including approximately 42 PCPs.[1] OSF Answer at ¶ 14; PX2515 (Capps, Expert Report) at ¶ 18; PX2520 (Capps, Rebuttal Report) at ¶ 136.

OSF as a system, and SAMC as a hospital, are financially sound. PX2516 (Dagen, Expert Report) at ¶¶ 172-176; PX2515 (Capps, Expert Report) at ¶¶ 19-21; PX4021 (Seybold (RHS), Dep.) at 59:12-23; PX0226 (Seybold (RHS), IHT) at 54:12-15. In fiscal year 2010, OSF generated approximately $1.7 billion in operating revenue; of that amount, SAMC generated approximately $325 million. OSF Answer at ¶ 14. OSF also **{**

} PX2516 (Dagen, Expert Report) at ¶ 174. Although SAMC experienced an operating loss in fiscal year 2011, its most recent forecast to the OSF board of directors in August 2011 projected it would **{**

} PX0371-029-031; PX2516 (Dagen, Expert Report) at ¶¶ 174-175.

[1] The PCPs OSF employs include geriatric PCPs and those that practice primarily at hospitals and urgent care centers.

2. Rockford Health System

RHS is a not-for-profit healthcare system headquartered in Rockford. RHS Answer at ¶ 15. RHS owns and operates one general acute-care hospital, RMH, with 396 licensed beds. *Id.* Like SAMC, RMH is a high-quality hospital that provides an extensive range of general acute-care inpatient services, as well as many higher-level services including the area's only pediatric intensive care and Level III neonatal intensive care units, as well as cardiovascular, neurological, and Level I trauma services. PX2515 (Capps, Expert Report) at ¶ 23; PX2513 (Romano, Expert Report) at ¶¶ 11, 22-23. In 2010, RMH handled approximately 30 percent of the commercially insured general acute-care inpatient admissions in the Rockford area and accounted for approximately 30 percent of the total number of days commercial patients in the area spent in the hospital. PX2515 (Capps, Expert Report) at ¶¶ 174-175, 179. RHS also owns and operates Rockford Health Physicians ("RHP"), which is the largest primary care and specialty physician network in the area and, along with RMH, employs approximately 160 physicians in the Rockford region. RHS Answer ¶ 15; PX2515 (Capps, Expert Report) at ¶ 23. RHP employs approximately 39 PCPs in the Rockford area, including hospitalists, urgent care physicians, and geriatric PCPs. PX2520 (Capps, Rebuttal Report) at ¶ 136.

RHS has been, and will continue to be, a financially healthy system. RHS's chief financial officer **{**

} PX0226 (Seybold (RHS), IHT) at 63:23-64:15. In 2010, RHS had total revenues of approximately $441 million. PX2516 (Dagen, Expert Report) at ¶ 178. RHS had net income of approximately $**{** **}** and an operating margin of **{** **}** in 2010; it had net income of $**{** **}** and an operating margin of **{** **}** in 2009. PX0210-025; PX2515 (Capps, Expert Report) at ¶ 24. Based on this performance, RHS's CEO,

Gary Kaatz, stated in his 2010 CEO Annual Report that, "[f]inancially, it ha[d] been a stellar year for Rockford Health System." PX3590-002. Although RHS had negative operating income in 2011, it **{** **}** and projects **{**

} PX2516 (Dagen, Expert Report) at ¶ 179; PX3682-004-005.

B. The Only Other Hospital in Rockford: SwedishAmerican Hospital

There is only one other general acute-care hospital in Rockford: Swedish. Swedish is located in downtown Rockford between SAMC and RMH and owned by SwedishAmerican Health System ("SAHS"), a non-profit organization. PX1258. Swedish is licensed to operate 333 beds and offers a wide array of primary and secondary general acute-care inpatient hospital services, as well as some tertiary inpatient services, including cardiovascular and oncology services. PX2515 (Capps, Expert Report) at ¶ 28; PX1258. Although it does not have a Level I trauma center, it provides services above the minimum requirements for a Level II trauma center. PX2515 (Capps, Expert Report) at ¶ 28. Swedish is currently the largest hospital in Rockford, accounting for approximately 41 percent of commercial admissions and 36 percent of commercial patient days. *Id*. at ¶¶ 175, 179. Like Respondents, Swedish is financially sound. It has operated profitably in recent years, including earning more than $14 million in profits between June of 2010 and May of 2011. PX1266-002. SAHS employs 110 physicians as members of its affiliated medical group, including approximately 33 PCPs. PX2515 (Capps, Expert Report) at ¶ 29; PX2520 (Capps, Rebuttal Report) at ¶ 136.

C. The 1989 District Court and Seventh Circuit *Rockford* Decisions

In 1989, RMH and Swedish sought to merge, but were permanently enjoined from doing so by the federal court in the Northern District of Illinois, whose opinion was affirmed by the

Seventh Circuit. *Rockford Mem'l*, 717 F.Supp. 1251, *aff'd* 898 F.2d 1278.[2] The district court ruled that the merger of two Rockford hospitals would "produce a firm controlling an undue percentage share of the relevant market, thus increasing the likelihood of market dominance by the merged entity or collusion." *Rockford Mem'l*, 717 F.Supp. at 1281. "Accordingly," it held, "the concentration of the post-merger market will inherently lessen competition substantially in the relevant market." *Id*.

In reaching this holding, the district court found that "the relevant product market consists of that cluster of services offered only by acute care hospitals," and "reject[ed] the defendants[']argument to include tertiary referral centers as part of the geographic market." *Id*. at 1261, 1277. The district court also excluded outpatient services from the relevant product market, concluding that, "[i]f defendants could assert a small but significant and non-transitory price increase in inpatient care, the exercise of market power could not be ameliorated by outpatient care." *Id*. at 1261. The district court defined the relevant geographic market as the "Winnebago-Ogle-Boone" – or "WOB" – area, which consisted of "all of Winnebago County, essentially all of Boone County, the northeast portion of Ogle County, and small fractions of McHenry (zip code 61052), DeKalb (zip code 60146), and Stephenson (zip code 61019) counties." *Id*. at 1277. This geographic market is identical to the one Complaint Counsel alleges in this proceeding. Complaint at ¶ 27. Thus, the district court defined the relevant market exactly the same as Complaint Counsel has done in the present case. *Id*. at ¶¶ 23-25, 27.

[2] Additionally, in 1997, OSF proposed a merger of SAMC with Swedish, but that merger never occurred either. OSF and Swedish argued to the Department of Justice, just as Respondents do today, that, if their proposed merger were "blocked, it is likely that SwedishAmerican or Saint Anthony will be forced to exit the market." PX1254-004; *see also* PX2510 (Schertz (OSF), PI Hr'g Tr.) at 612:17-22 (SAMC's CEO testified that he does not know why the Department of Justice closed its investigation.). After Swedish abandoned the merger in 1997 due to cultural differences between the two organizations, OSF warned that "[t]he decision not to merge will have serious impact on the future of healthcare in Rockford. This community does not need, nor can it support three hospitals." PX3076-002; PX4051 (Gorski (Swedish), Dep.) at 108:21-113:11. However, in the decade and a half since the proposed transaction was abandoned, none of these dire predictions has transpired. Neither SAMC nor Swedish failed; in fact, the two hospitals continue to be financially healthy and effective competitors.

The district court found liability under Section 7 of the Clayton Act because the merged entity would "control approximately two thirds of the present market, and after the merger, the two largest firms [i.e., the only two remaining Rockford hospitals] [would] control 90% of the market." *Rockford Mem'l*, 717 F.Supp. at 1280. Thus, the court held that the 1989 acquisition was illegal based on concentration levels almost identical to those that would result from the current Acquisition. *See* PX2515 (Capps, Expert Report) at ¶¶ 174-175, 179. Defendants found no greater reception to the merger on appeal before the Seventh Circuit, which held that "[t]he defendants' immense shares in a reasonably defined market create a presumption of illegality." *Rockford Mem'l*, 898 F.2d at 1285 (Posner, J.), *cert. denied*, 498 U.S. 920 (1990).

D. The Acquisition

Respondents have been planning the proposed Acquisition and crafting their antitrust defense strategy for nearly three years. OSF and RHS began discussions about the possibility of merging in the spring of 2009, and OSF presented RHS with a merger proposal in August of 2009. PX2510 (Schertz (OSF), PI Hr'g Tr.) at 592:9-593:14; PX0005-009. By August 2010, well in advance of executing their affiliation agreement, Respondents' outside antitrust counsel had retained two consulting firms, FTI Consulting Inc. ("FTI"), and its subsidiary Compass Lexecon, to begin fashioning antitrust defenses, including a report attempting to identify potential efficiencies that could result from the Acquisition.[3] PX2511 (Manning (Respondents' Expert), PI Hr'g Tr.) at 810:2-16; PX2510 (Schertz (OSF), PI Hr'g Tr.) at 609:1-6; PX0034; *see also* PX4023 (McGrew (OSF), Dep.) at 90:4-91:2 (testifying that Respondents were aware of the

[3] { } PX0681-001. Indeed, throughout the FTC's investigation and this litigation, Respondents have claimed attorney work product protection over FTI's efficiencies work ({ }), conceding that it was performed solely in anticipation of potential litigation and served no business purpose. PX0228 (Tosino (FTI), IHT) at 23:5-11; PX0681-001.

antitrust concerns raised by the Acquisition from the outset of their discussions). Respondents ultimately executed a formal Affiliation Agreement on January 31, 2011 (the "Agreement"). *See generally* PX0037. Although it has been styled as an "affiliation," the transaction is an acquisition. Under the terms of the Agreement, OSF plans to acquire all of RHS's operating assets and to become the sole corporate member of RHS. *Id*. at 011. OSF will hold reserve powers with respect to the governance and operations of RHS, granting it ultimate control over all significant business decisions of RHS, including strategic planning, operating and capital budgets, large capital expenditures, and significant borrowing and contracting. *Id*. at 016. {

} PX0301-003. Post-Acquisition, Respondents plan to operate SAMC and RMH jointly as "OSF Northern Region." *See* PX0037-016 (identifying Gary Kaatz, RHS's CEO, as the future CEO of OSF Northern Region); PX0005-009.

In addition to ceding control of RHS to OSF, the Agreement states that OSF must contribute at least $35 million to OSF Northern Region each year for eight years following the Acquisition. PX0037-017. **{**

} PX0226 (Seybold (RHS), IHT) at 101:24-102:7. In other words, nothing about the Agreement contemplates the merged entity increasing spending to bring new or better services to the local community. OSF must also continue to operate RMH as a general acute-care hospital for ten years after closing the Acquisition; although, after five years, OSF can close or convert RMH if three-fourths of OSF Northern Region's board agrees. PX0037-018; PX0225 (Sehring (OSF), IHT) at 159:10-160:8. Thus, the Agreement contemplates no meaningful change, if any, in the hospitals' capital expenditures or capacity relative to what would exist

absent the Acquisition.

II. PROCEDURAL HISTORY

Pursuant to the Hart-Scott-Rodino Act, OSF and RHS submitted premerger notification reports on February 11, 2011. 15 U.S.C. § 18(a). Prior to the expiration of the initial statutory waiting period, the FTC issued Requests for Additional Information ("Second Requests") to OSF and RHS on March 14, 2011. FTC staff conducted an extensive investigation of the Acquisition which unearthed a substantial body of evidence showing the proposed transaction would likely result in significant consumer harm, including testimony from 22 investigational hearings of Respondents' executives and consultants. On October 13, Respondents certified that they had substantially complied with their Second Requests, triggering a statutory waiting period after which they could have consummated the Acquisition absent an injunction or binding agreement.

On November 17, 2011, by a unanimous vote, the Commission found reason to believe that the Acquisition would violate Section 7 by substantially reducing competition for GAC services and PCP services sold to commercial health plans in the Rockford area. At that time, the Commission issued the complaint initiating this administrative proceeding, and authorized FTC staff to seek temporary and preliminary injunctive relief in the U.S. District Court for the Northern District of Illinois to maintain competition, preserve the *status quo*, and prohibit integration of OSF and RHS until the conclusion of this administrative proceeding and any subsequent appeals.

On November 18, 2011, FTC staff brought suit in the Northern District of Illinois seeking a temporary restraining order and preliminary injunction of the Acquisition. OSF and RHS voluntarily agreed not to consummate their transaction pending the district court's consideration of the FTC's preliminary injunction motion. After an extensive discovery process, which

included 16 fact depositions, seven expert depositions, and the production of a substantial volume of documentary and other evidence, Judge Frederick J. Kapala held a three-day evidentiary hearing that began on February 1, 2012. During that hearing the court heard approximately 20 hours of live testimony from eight witnesses, including:

- SAMC's CEO, David Schertz;
- RHS's CEO, Gary Kaatz;
- representatives from two Rockford area health plan providers;
- a Rockford area employer;
- Complaint Counsel's economic expert, Dr. Cory Capps;
- Complaint Counsel's healthcare quality expert, Dr. Patrick Romano; and
- Respondents' economic expert, Dr. Susan Manning.

See generally PX2509; PX2510; PX2511. Both sides submitted their final briefs to the district court on February 21, 2012. As of the filing of this brief, Judge Kapala has not yet ruled on Complaint Counsel's motion for preliminary injunction.

III. RELEVANT SERVICE MARKETS ARE GENERAL ACUTE-CARE INPATIENT HOSPITAL SERVICES AND PRIMARY CARE PHYSICIAN SERVICES

The relevant product or service market "identifies the products and services with which the [Respondents'] products compete." *FTC v. CCC Holdings Inc.*, 605 F. Supp. 2d 26, 37 (D.D.C. 2009).[4] Courts generally determine the boundaries of the relevant product market by considering the reasonable interchangeability of use and the cross-elasticity of demand between the product itself and substitutes for the product. *Brown Shoe Co., Inc. v. United States*, 370 U.S. 294, 325 (1962). Federal courts and the Commission define a relevant product market by assessing whether a hypothetical monopolist could profitably impose a small but significant and non-transitory increase in price ("SSNIP") for the product at issue using the methodology provided by the Horizontal Merger Guidelines ("Merger Guidelines"). *See, e.g., In re*

[4] For purposes of discussing the relevant market in this brief, Complaint Counsel uses the terms "relevant product market" and "relevant service market" interchangeably.

ProMedica Health Sys., Inc., No. 9346 (Opinion of the Commission), at 15 (F.T.C. Mar. 22, 2012); *FTC v. ProMedica Health Sys., Inc.*, No. 9346, 2011 U.S. Dist. LEXIS 33434, at **144-45 (N.D. Ohio Mar. 29, 2011); *FTC v. Whole Foods Mkt. Inc.*, 548 F.3d 1028, 1038 (D.C. Cir. 2008); *Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410, 431 n.11 (5th Cir. 2008); *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 716 n.9 (D.C. Cir. 2001); *FTC v. Univ. Health Inc.*, 938 F.2d 1206, 1211 n.12 (11th Cir. 1991); *In re Polypore Int'l, Inc.*, No. 9327, 2010 FTC LEXIS 97, at *32 (F.T.C. Dec. 13, 2010).

There are two relevant product markets in which to assess the competitive effects of this Acquisition: (1) general acute-care inpatient hospital services; and (2) primary care physician services.

A. General Acute-Care Inpatient Hospital Services Sold to Commercial Health Plans

The first relevant product market is general acute-care inpatient hospital services sold to commercial health plans – or GAC services. The GAC market includes a broad cluster of basic medical and surgical diagnostic and treatment services that include an overnight hospital stay, including, but not limited to, many emergency services, internal medicine services, and surgical procedures. Respondents do not dispute that the GAC market is an appropriate relevant service market in this case. PX1603 (Sched. Conf. Tr.) at 47:6-13; PX2263 (Noether, PI Expert Report) at ¶¶ 22-23 (**{**

}). "A cluster market for GAC inpatient hospital services has consistently been found to be the relevant market in prior hospital merger cases." *ProMedica*, No. 9346 (Opinion of the Commission), at 16 (citing *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995); *Univ. Health*, 938 F.2d at 1210-12; *Rockford Mem'l*,

898 F.2d at 1284; *In re Evanston Nw. Healthcare Corp*., No. 9315, 2007 WL 2286195, at **40-41 (F.T.C. Aug. 6, 2007).

Because the purpose of defining and analyzing product markets is to determine whether a merger may substantially lessen competition in *any* line of commerce, relevant markets are typically defined and analyzed on a product-by-product or service-by-service basis. 15 U.S.C. § 18; PX0205 § 4 ("First, market definition helps specify the line of commerce . . . in which the competitive concern arises."). Assessing a hospital merger, however, is different from assessing the more common merger of two suppliers who sell only a handful of products because each hospital usually offers hundreds of individual services. A court reviewing a hospital merger using the service-by-service analysis would likely have to define hundreds of potential relevant service markets; analyze each service market individually to identify overlaps between the merging parties; determine the scope of each relevant service market; and then assess the relevant geographic market, competitors, market shares, competitive effects, and entry conditions for each service market. Such an approach would be incredibly burdensome, if not impossible, for a trial court. *See ProMedica*, No. 9346 (Opinion of the Commission), at 18-19 (finding that a cluster market "enables us to analyze efficiently the Joinder's effect in hundreds of relevant product markets"). Therefore, courts generally use a cluster market approach to analyze hospital mergers more efficiently. *See, e.g.*, *Rockford Mem'l*, 717 F.Supp. at 1260-61; *Univ. Health*, 938 F.2d at 1210-11; *ProMedica*, 2011 U.S. Dist. LEXIS 33434, at *23-24; *Evanston*, 2007 WL 2286195, at *151.

The hundreds of individual inpatient medical and surgical services included in the GAC market are clustered together for analytical convenience, even though each is likely a distinct product market. There typically is no reasonable interchangeability of use or cross-elasticity of

demand among such services. *See ProMedica*, No. 9346 (Opinion of the Commission), at 18; PX2515 (Capps, Expert Report) at ¶ 146. For example, patients cannot substitute knee surgery for heart surgery in response to a price increase.[5] Nevertheless, it is wholly appropriate and efficient to group each GAC service into a single cluster market when "market shares and entry conditions are similar for each." *Emigra Group v. Fragomen*, 612 F. Supp. 2d 330, 353 (S.D.N.Y. 2009); *see also ProMedica*, No. 9346 (Opinion of the Commission), at 18 ("[C]luster markets based on analytical convenience are useful and appropriate for evaluating competitive effects . . . ."); *ProMedica*, 2011 U.S. Dist. LEXIS 33434, at *23, 146; PX2515 (Capps, Expert Report) at ¶¶ 146-148. As the Commission recently held in *ProMedica*, "[c]ollecting the service lines into a cluster based on whether they have similar market conditions enables an accurate assessment of the competitive effects, which is our ultimate goal." No. 9346 (Opinion of the Commission), at 19 (concluding that appropriate cluster market methodology "considers demand-side substitution because each individual service line . . . is found to be a relevant product market based on demand-side substitution" and grouped together only "for analytical convenience"). Here, the competitive effects of the Acquisition on the hundreds of distinct GAC services offered by OSF and RHS can be analyzed together in a single relevant service market without creating inconsistent or distorted results, because they are characterized by similar market conditions and are offered by the same market participants within the same geographic market. PX2515 (Capps, Expert Report) at ¶ 146. In addition, the cluster of GAC services actually corresponds to what most consumers consider when they evaluate the adequacy and

[5] Under the Merger Guidelines, market definition "focuses solely on demand substitution factors, i.e., on customers' ability and willingness to substitute away from one product to another in response to a price increase or a corresponding non-price change such as a reduction in product quality or service." PX0205 § 4.

quality of a health plan's network, because they usually do not know what their specific medical needs will be in advance. *Id*. at ¶ 147.

The GAC services market excludes outpatient services. As the district court in the 1989 *Rockford* case held, "[i]f the defendants could assert a small but significant and non-transitory price increase in inpatient care, the exercise of market power could not be ameliorated by outpatient care." 717 F.Supp. at 1261, *aff'd* 898 F.2d at 1284 (holding that GAC services are the appropriate relevant product market and the existence of outpatient services "places no check on the prices" of GAC services). "[C]ourts and adjudicators regularly exclude outpatient services from [GAC] cluster markets because the competitors for those services differ from the competitors in inpatient services." *ProMedica*, No. 9346 (Opinion of the Commission), at 20 (citing *Evanston*, 2007 WL 2286195, at **46-47; *Rockford Mem'l*, 898 F.2d at 1284; *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290-91 (W.D. Mich. 1996)). Moreover, this Court recently held in *ProMedica* that "[t]he GAC market excludes outpatient services . . . because health plans and patients could not substitute outpatient services for inpatient care in response to a price increase." No. 9346, 2011 LEXIS 294, at **71-72 (F.T.C. Dec. 12, 2011) (concluding that substitution between outpatient and inpatient services is "based on clinical considerations").

The specific facts of this case confirm that outpatient services are properly excluded from the GAC services market. Indeed, the competitive structure(s) of the markets for outpatient services in the Rockford area are not generally similar to the structure of the inpatient services market. PX2515 (Capps, Expert Report) at ¶ 150; PX2520 (Capps, Rebuttal Report) at ¶ 63. For example, while only hospitals provide inpatient services, several other types of facilities, including ambulatory surgery, imaging, and endoscopy centers, provide at least some outpatient

services. *See, e.g.*, PX1481 (Rockford Ambulatory Surgery Center); PX1482 (Rockford Gastroenterology Associates); PX1487 (Forest City Diagnostic Imaging); PX1508 (Summit Radiology); PX1490 (High Field OPEN MRI); *see also* PX2515 (Capps, Expert Report) at ¶ 150 (explaining that the barriers to opening or expanding an outpatient facility including cost, regulatory requirements, and minimum efficient scale are also generally much lower than those related to opening an inpatient acute-care hospital). In addition, outpatient services are not reasonably interchangeable with inpatient services from the perspective of patients or health plans. PX2515 (Capps, Expert Report) at ¶¶ 149, 151; PX2520 (Capps, Rebuttal Report) at ¶¶ 63, 65; PX2509 (Petersen (Coventry), PI Hr'g Tr.) at 221:4-16 (The decision to perform a procedure on an inpatient or outpatient basis is "based on medical need.").

The GAC services market also excludes complex tertiary and quaternary services because many of these services are not offered by any of the Rockford hospitals, and the competitive dynamic is generally different for those they do offer. PX2515 (Capps, Expert Report) at ¶¶ 3, 167. Sophisticated tertiary and quaternary services are not offered by the same market participants, within the same geographic market, or otherwise under similar market conditions as primary, secondary, and lower-level tertiary services. *Id*. Not surprisingly, patients are willing to travel much farther for highly complex services, such as cardiac surgery and organ transplants, than they are for routine hospital inpatient services. *See* PX2509 (Petersen (Coventry), PI Hr'g Tr.) at 222:2-20; PX2515 (Capps, Expert Report) at ¶ 167. Thus, the market for such complex tertiary and quaternary services is typically geographically broader and includes more market participants. *See ProMedica*, No. 9346 (Opinion of the Commission), at 23 (holding that "[b]ecause patients are likely willing to travel farther for more complex treatments . . . the geographic market for tertiary services could be larger than for primary and secondary services,"

and, thus, "the number of competitors that could constrain price increases . . . could be higher (although it would have little impact on prices for primary and secondary services)"). As a result, it would be incorrect – and misleading – to include such services in the GAC cluster market. Accordingly, courts, including the district court and the Seventh Circuit in the prior *Rockford* case, have repeatedly excluded tertiary and other high-end inpatient services from the GAC services market. 717 F.Supp. at 1276, *aff'd* 898 F.2d at 1285; *see also ProMedica*, No. 9346 (Opinion of the Commission), at 22 (holding that "tertiary services are not part of the GAC inpatient hospital services market . . . ."); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 141-42 (E.D.N.Y. 1997).

B. Primary Care Physician Services Sold to Commercial Health Plans

The second relevant service market is primary care physician services sold to commercial health plans – or PCP services. PCP services include services provided by physicians engaged in family practice, general practice, and internal medicine. *HTI Health Servs., Inc. v. Quorum Health Group, Inc.*, 960 F. Supp. 1104, 1116 (S.D. Miss. 1997); PX2515 (Capps, Expert Report) at ¶ 314. PCPs are generalists and serve as the most frequent point of contact for most patients; their primary roles include conducting routine tests, treating general ailments, and referring patients to specialists. PX2515 (Capps, Expert Report) at ¶ 314. The PCP market excludes services offered by pediatricians and OB/GYNs, who provide specialized services to children and pregnant women, respectively. *HTI Health*, 960 F. Supp. at 1115-17. As with the GAC services market, Respondents do not dispute that the PCP market is an appropriate service market in which to analyze the impact of the proposed Acquisition. PX1603 (Sched. Conf. Tr.) at 47:14-22.

PCP services constitute a relevant service market because a hypothetical monopolist of

all such services could readily and profitably implement a SSNIP. PX2515 (Capps, Expert Report) at ¶ 314. Substitution to non-primary care physicians could not prevent such a price increase because they are not trained as PCPs and are generally significantly more expensive than PCPs. *Id*. No other healthcare providers are substitutes for PCPs. *Id*. The competitive conditions in the PCP services market differ significantly from those in specialist physician services markets, as a number of different entities provide PCP services, including many independent providers. *Id*. at ¶¶ 314, 328. Notably, the same general bargaining dynamic exists between PCPs and health plans as exists between hospitals and health plans. *Id.* at ¶ 313; *see also* PX2509 (Petersen (Coventry), PI Hr'g Tr.) at 253:18-254:16. Accordingly, PCP groups gain bargaining leverage vis-à-vis health plans (and can extract higher prices) as they merge with other PCP groups that are close substitutes. PX2515 (Capps, Expert Report) at ¶ 313.

IV. RELEVANT GEOGRAPHIC MARKET IS NO BROADER THAN THE WINNEBAGO-OGLE-BOONE AREA

The relevant geographic market for both relevant services is no broader than the Winnebago-Ogle-Boone County – or WOB – area ("WOB Area"), the exact same relevant geographic market that the district court and Seventh Circuit found in the prior *Rockford* litigation. 717 F.Supp. at 1277-78; *aff'd* 898 F.2d at 1285. Indeed, the relevant geographic markets for GAC services and PCP services are each likely substantially narrower than the one in 1989. However, defining the geographic market broadly or narrowly does not change the fundamental fact that SAMC, RMH, and Swedish are the only meaningful competitors for GAC services, and the merger of SAMC and RMH is presumptively illegal by a wide margin. Moreover, the Acquisition would substantially increase concentration in either a broad or narrow market for PCP services, likely resulting in significant, additional competitive harm. The

geographic market is defined by the "practical alternative sources to which consumers of [the relevant service] would turn if the merger were consummated and the merged entity raised prices beyond competitive levels." *Butterworth*, 946 F. Supp. at 1291; *see also Polypore*, 2010 FTC LEXIS 97, at *48; PX0205 § 4.2. Defining the exact "metes-and-bounds" of the geographic market "is not necessary since the identification of the relevant competitors (i.e.[,] hospitals) is the aim of defining a geographic market in the first place." *Rockford Mem'l*, 717 F.Supp. at 1277; *see also* PX0205 § 4. Under the case law and Merger Guidelines, the relevant question is whether a hypothetical monopolist controlling *all* of the competitors in the relevant geographic market could profitably implement a SSNIP. *ProMedica*, 2011 LEXIS 294, at **75-76, 319-320; PX0205 § 4.2. There is no doubt – and no real debate in this litigation – that a hypothetical monopolist controlling the three hospitals in Rockford, let alone the entire WOB Area, could profitably raise prices by a SSNIP.[6]

Respondents' admissions and a wide array of other evidence confirm that the relevant geographic market is no broader than the WOB Area, and, in fact, is likely the narrower area within a 30-minute drive of downtown Rockford (the "30-Minute Drive Time Area"). *See* App. A (map comparing the WOB Area with the 30-Minute Drive Time Area). Respondents do not dispute that the relevant geographic market for GAC services includes only the three Rockford hospitals. Respondents' counsel stated to this Court that "our position is that there are three competitors in the relevant geographic market, and they are the three hospital – healthcare systems in Rockford." PX1603 (Sched. Conf. Tr.) at 46:18-47:5; *see also* PX4093 (Noether

[6] The only other hospital in the WOB Area besides SAMC, RMH, and Swedish is Rochelle Community Hospital ("RCH"). RCH is a small, critical access hospital with only 25 licensed beds located about 42 minutes by car south of Rockford in southern Ogle County. PX2515 (Capps, Expert Report) at ¶ 35. RCH currently has a share of only 0.9% of patient admissions and 0.5% of patient days in the WOB Area GAC services market. *Id*. at ¶ 179. Moreover, as a critical access hospital, RCH must be at least 35 miles from the nearest hospital and can maintain no more than 25 short-term acute-care beds. *Id*. at ¶¶ 35-36.

(Respondents' Expert), Dep.) at 39:4-13 (**{**

}); PX2263 (Noether, PI Expert Report) at Sections III, IX; PX2509 (PI Hr'g Tr.) at 54:9-55:7. Health plans confirm that SAMC, RMH, and Swedish are the only meaningful competitors in the Rockford area, and a network would clearly be unmarketable if it did not include any of them. As its CEO testified, Coventry of Illinois has never offered a hospital network that did not include a Rockford hospital, and it would never consider doing so in the future because "[n]obody would buy it." PX2509 (Petersen (Coventry), PI Hr'g Tr.) at 220:1-15, 221:17-223:7; *see also* PX2509 (Lobe (United), PI Hr'g Tr.) at 23:2-15, 31:12-22 (testifying that United could not win employer customers if it did not include any of the three Rockford hospitals in its network and that all of the outlying hospitals "are too far away for members to travel"). Residents in the relevant geographic market exhibit a strong preference for receiving care locally, just as they did in 1989 when the *Rockford* district court held that "patient preferences for nearby hospitals is the main reason for keeping the geographic area relatively small." 717 F.Supp. at 1277; PX2515 (Capps, Expert Report) at ¶ 160; PX0222 (Schertz (OSF), IHT) at 105:6-11; PX0227 (Stenerson (OSF), IHT) at 211:10-212:7; PX2511 (Kaatz (RHS), PI Hr'g Tr.) at 774:21-23. In fact, patient flow out of the Rockford area has declined since 1989. PX2515 (Capps, Expert Report) at ¶ 61.

Complaint Counsel's economic expert, Dr. Capps, conducted a quantitative analysis of patient drive times, which shows the most appropriate relevant geographic market is likely the 30-Minute Drive Time Area based on residents' strong preference to obtain GAC services

locally.[7] *Id*. at ¶¶ 3, 158, 160-161. Today, over 95 percent of hospitalized Rockford residents select a hospital within a 30-minute drive of their home zip code. *Id*. at ¶ 160. Whether measured by admissions or patient days, about 90 percent of residents in the 30-Minute Drive Time Area stay in the area for inpatient care. *Id*. at ¶ 161. This lack of patient outflow shows patients' strong preference for local care and, hence, the lack of competitive constraint that hospitals outside of Rockford impose on SAMC, RMH, and Swedish. *Id*. at ¶ 161. Regardless of whether the Acquisition is analyzed using the WOB Area or the 30-Minute Drive Time Area, the result is the same: one of only three significant competitors will be eliminated and local employers and residents will be harmed. *Id*. at ¶¶ 157, 175, 179.

Respondents repeatedly admit, both in sworn testimony and ordinary course business documents, that their primary competitors are each other and Swedish. PX2511 (Kaatz (RHS), PI Hr'g Tr.) at 774:17-20; PX0215 (Dillon (RHS), IHT) at 189:1-7, 189:11-15; PX0229 (Vayr (OSF), IHT) at 28:19-29:8; PX0327-001; PX0362-042; *see also* PX4051 (Gorski (Swedish), Dep.) at 207:5-14. For example, {

} PX0210-014. The fact that the Rockford hospitals do not view other hospitals as significant competitors is also clearly demonstrated in the contractual conditions SAMC places on health plans. SAMC requires health plans to exclude at least one Rockford hospital from their networks, but places no restrictions whatsoever on plans' ability to contract with outlying hospitals. PX1025-004-007; PX2510 (Schertz (OSF), PI Hr'g Tr.) at 6:21:11-6:24:12.

[7] Evidence shows that other, even smaller areas may constitute relevant geographic markets as well. *See* PX2515 (Capps, Expert Report) at ¶ 160 (Eighty percent of Rockford residents select a hospital within a 20-minute drive from their home zip code.).

A substantial amount of additional evidence confirms that hospitals outside of Rockford do not compete meaningfully with SAMC, RMH, and Swedish. The closest hospital outside of Rockford is Beloit Hospital, which is located about 34 minutes away in Wisconsin. PX2515 (Capps, Expert Report) at ¶ 163. Less than one percent of residents in the 30-Minute Drive Time Area receive inpatient care at Beloit Hospital, which draws the vast majority of its patients from Rock County, Wisconsin; moreover, very few people travel from that area to Rockford for services available at Beloit Hospital. *Id*. at ¶¶ 37, 163. Thus, Beloit Hospital does not view the Rockford hospitals as competitors. *Id*. at ¶¶ 37-38, 163. Indeed, none of the other hospitals outside of Rockford, including the only other hospital located in the WOB Area, Rochelle Community Hospital, views itself as competing substantially with the three Rockford hospitals. *Id*. Moreover, Dr. Capps' extensive diversion analysis confirms that SAMC, RMH, and Swedish compete closely with each other, but very little with any other hospitals. *Id.* at ¶¶ 198-199 (showing that for each Rockford hospital, if it were not available, more than 85% of its patients would choose one of the other two Rockford hospitals); PX2520 (Capps, Rebuttal Report) at ¶ 72 (explaining that the diversion to any individual hospital located outside of Rockford is well below 5%). Although a small number of patients might ultimately experience a condition that would cause them to leave the Rockford area, this does not mean that they do not place high value on access to local hospitals. PX2515 (Capps, Expert Report) at ¶ 3.

The fact that some outlying hospitals have been expanding their service offerings recently does not impact the relevant market definition in this case or the fact that the Acquisition will result in substantial competitive harm. PX2520 (Capps, Rebuttal Report) at ¶¶ 70, 71. The three Rockford hospitals, indeed most hospitals in the country, have also been expanding their services as medical technology has advanced. *Id*. at ¶ 71. Current market shares, as well as Dr. Capps'

diversion, patient outflow, and bargaining leverage analyses, *already* account for any success outlying hospitals have had in improving their services. *Id*. at ¶ 77. Those analyses, as well as Respondents' documents and other evidence, all show that little competition exists between the three Rockford hospitals and hospitals located in outlying areas. *See* PX2515 (Capps, Expert Report) at ¶¶ 174-179, 198-202, 216-223.

The relevant geographic market for PCP services is also no larger than the WOB Area and, in fact, is likely much smaller. Most patients visit their PCP more often than they visit a hospital and, thus, are even more likely to choose a convenient, local PCP. PX2515 (Capps, Expert Report) at ¶ 315; PX2520 (Capps, Rebuttal Report) at ¶¶ 132-133. Indeed, the evidence shows that patients are typically less willing to drive as far to receive PCP services as they are to receive inpatient hospital services. PX4075 (Ruggles (RHS), Dep.) at 177:4-179:7; PX2520 (Capps, Rebuttal Report) at ¶¶ 132-133; PX2515 (Capps, Expert Report) at ¶ 315; *see also* PX0223 (Schoeplein (OSF), IHT) at 178:10-17. Patients prefer to have access to nearby PCPs and, therefore, a provider network that had no PCPs in Winnebago or Boone County would be unacceptable to employers and employees in the Rockford area. PX2515 (Capps, Expert Report) at ¶ 315; PX2509 (Lobe (United), PI Hr'g Tr.) at 45:2-46:16 (testifying that United could not win business in the Rockford area if it had no PCPs in only Winnebago County). Based on this evidence, the most appropriate relevant geographic market for PCP services is likely the 30-Minute Drive Time Area. PX2520 (Capps, Rebuttal Report) at ¶¶ 132-135; *see also* PX2515 (Capps, Expert Report) at ¶ 315.

V. THE ACQUISITION VIOLATES SECTION 7 OF THE CLAYTON ACT

A. Legal Standard under Clayton Act Section 7

Section 7 of the Clayton Act prohibits any acquisition "where in any line of commerce . . . the effect of such acquisition *may be* substantially to lessen competition, or tend to create a monopoly." 15 U.S.C. § 18 (emphasis added); *see also ProMedica*, No. 9346 (Opinion of the Commission), at 13. "Congress used the words 'may be' . . . to indicate that its concern was with probabilities, not certainties" and to "arrest restraints of trade in their incipiency and before they develop into full-fledged restraints." *Brown Shoe*, 370 U.S. at 323, 323 n.39 ("[R]equirement of certainty . . . of injury to competition is incompatible" with Congress' intent of "reaching incipient restraints."); *see also United States v. Phila. Nat'l Bank*, 374 U.S. 321, 355, 367 (1963) (holding a "fundamental purpose of amending § 7 was to arrest the trend toward concentration, the tendency to monopoly, before the consumer's alternatives disappeared through merger"). "Thus, to establish a violation of Section 7, the FTC need not show that the challenged merger or acquisition *will* lessen competition, but only that the loss of competition is a 'sufficiently probable and imminent' result of the merger or acquisition." *ProMedica*, No. 9346 (Opinion of the Commission), at 13 (emphasis in original); *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 623 (1974); *ProMedica*, 2011 LEXIS 294, at *294; *CCC Holdings*, 605 F. Supp. at 35.

Courts generally analyze Section 7 cases using a burden-shifting framework. *ProMedica*, No. 9346 (Opinion of the Commission), at 13; *see also Chicago Bridge*, 534 F.3d at 423; *Heinz*, 246 F.3d at 715; *United States v. Baker Hughes Inc.*, 908 F.2d 981, 982-83 (D.C. Cir. 1990); *Polypore*, 2010 FTC LEXIS 97, at *25. Under this framework, Complaint Counsel can establish a *prima facie* case of a Section 7 violation by showing that the transaction will result in undue

concentration in one or both of the relevant markets. *Chicago Bridge*, 534 F.3d at 423; *Baker Hughes*, 908 F.2d at 982-83; *Polypore*, 2010 FTC LEXIS 97, at *25. As the Supreme Court explained: "a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in concentration of firms in that market, is *so inherently likely to lessen competition substantially* that it must be enjoined in the absence of evidence *clearly* showing that the merger is not likely to have such anticompetitive effects." *Phila. Nat'l Bank*, 374 U.S. at 363 (emphasis added). Thus, undue concentration in a relevant market creates a presumption that the transaction substantially lessens competition. *Id. See also Chicago Bridge*, 534 F.3d at 423; *United States v. Dairy Farmers of Am. Inc.*, 426 F.3d 850, 858 (6th Cir. 2005); *ProMedica*, No. 9346 (Opinion of the Commission), at 14 ("[T]he government can establish a presumption of liability by defining a relevant product market and geographic market and showing that the transaction will lead to undue concentration in the relevant market."). Complaint Counsel can establish a *prima facie* case quantitatively or qualitatively. *Polypore*, 2010 FTC LEXIS 97, at *25-26 ("[Q]ualitative evidence regarding pre-acquisition competition between the merging parties can in some cases be sufficient to create a *prima facie* case . . . .") (citing *In re Chicago Bridge & Iron Co.*, 138 F.T.C. 1024, 1053 (2004)). "The typical measure for determining market concentration is the Herfendahl-Hirschman Index[.]" *ProMedica*, No. 9346 (Opinion of the Commission), at 14 (citing *CCC Holdings*, 605 F. Supp. 2d at 37).

Once a *prima facie* case is established, the burden shifts to Respondents to rebut the presumption of illegality by producing sufficient evidence to clearly show that Complaint Counsel's evidence inaccurately predicts the likely competitive effects of the transaction. *Marine Bancorporation*, 418 U.S. at 631; *Phila. Nat'l Bank*, 374 U.S. at 363; *Chicago Bridge*,

534 F.3d at 423; *Univ. Health*, 938 F.2d at 1218-19; *Polypore*, 2010 FTC LEXIS 97, at *26; *ProMedica*, No. 9346 (Opinion of the Commission), at 14. The stronger the *prima facie* case, the greater Respondents' burden of production on rebuttal. *Polypore*, 2010 FTC LEXIS 97, at *26 (citing *Heinz*, 246 F.3d at 725; *Baker Hughes*, 908 F.2d at 991); *ProMedica*, No. 9346 (Opinion of the Commission), at 14, 27 ("[W]here concentration levels are high, Respondent bears the burden of demonstrating that the HHIs and market share data are unreliable in predicting a transaction's competitive consequences."). If Respondents meet their burden, the burden of production shifts back to Complaint Counsel, which retains the ultimate burden of persuasion. *Chicago Bridge*, 534 F.3d at 423 (citations omitted); *Polypore*, 2010 FTC LEXIS 97, at *27. Complaint Counsel "can bolster a *prima facie* case based on market structure with evidence showing that anticompetitive effects are likely." *ProMedica*, No. 9346 (Opinion of the Commission), at 14 (citing *Heinz*, 246 F.3d at 717). "Common sources of evidence include the merging parties, customers, other industry participants, and industry observers." *ProMedica*, No. 9346 (Opinion of the Commission), at 14.

B. The Acquisition is Presumptively Unlawful

The Acquisition undeniably would result in a vast increase in market concentration and, thus, is presumptively illegal by a wide margin. This strong presumption is only strengthened by a vast array of evidence from market participants and other sources, including Respondents themselves. In *Philadelphia National Bank*, the Supreme Court found that a firm's post-merger market share of 30 percent in a market with several remaining competitors violated Section 7 of the Clayton Act. 374 U.S. at 364. In this case, OSF would control more than 58 percent of the GAC services market post-Acquisition and face competition from only one other hospital. The Acquisition would also substantially increase concentration in the PCP services market, where

the combined firm would control a share of between 34 and 46 percent of the market. Accordingly, just as the district court in the 1989 *Rockford* case permanently enjoined that merger of two of the only three Rockford hospitals because the "the post-merger market [was] ripe for anti-competitive behavior" based on "the relevant market's concentration, barriers to entry, nature of competition, and market participants," so too should this Court prohibit the current proposed Acquisition. 717 F.Supp. at 1287.

1. The General Acute-Care Services Market is Already Highly Concentrated

There are only three meaningful competitors in the relevant market: SAMC, RMH, and Swedish. PX2511 (Kaatz (RHS), PI Hr'g Tr.) at 773:24-774:20; PX0215 (Dillon (RHS), IHT) at 189:1-7, 189:11-15. Based on patient admissions, SAMC currently controls 29.5 percent of the GAC services market in the WOB Area; RMH holds a 29.4 percent share; and Swedish has a share of 40.2 percent. PX2515 (Capps, Expert Report) at ¶ 179. Based on patient days, SAMC's share in the WOB Area is 34.3 percent; RMH's share is 29.6 percent; and Swedish controls 35.6 percent of the market. *Id*. All three of these hospitals control even larger shares in other plausible, narrower relevant geographic markets, such as the 30-Minute Drive Time Area. *Id*. at ¶ 175 (showing current market shares in the 30-Minute Drive Time Area as: 29.8%, 29.7%, and 40.6% for SAMC, RMH, and Swedish, respectively, as measured by admissions and 34.4%, 29.8%, and 35.8% as measured by patient days). These shares result in a pre-Acquisition HHI level in the GAC services market of *at least* 3,319, greatly exceeding the Merger Guidelines threshold of 2,500 for "highly concentrated" markets. *Id.* at ¶¶ 175, 179; PX0205 § 5.3.

2. The Acquisition Substantially Increases Concentration in the General Acute-Care Services Market Creating a Presumption of Illegality

The Acquisition would unquestionably result in a tremendous increase in the concentration level of the already highly-concentrated GAC services market, creating a strong presumption that it violates Section 7. *Phila. Nat'l Bank*, 374 U.S. at 363. Importantly, Respondents do not dispute that the Acquisition would reduce the number of competitors in the relevant market from three to two, nor do they dispute that it would increase concentration in the GAC services market to levels found to trigger the presumption of illegality by several courts.

Respondents readily admit that the only "meaningful competitors" for GAC services "in and around Rockford" are the three Rockford hospitals. PX2511 (Kaatz (RHS), PI Hr'g Tr.) at 774:17-20; *see also* PX0211 (Baker (OSF), IHT) at 46:21-47:5; PX0218 (McGrew (OSF), IHT) at 49:16-50:10; PX0215 (Dillon (RHS), IHT) at 189:1-7, 189:11-15. Moreover, Respondents' own economic expert, Dr. Noether, has stated **{**

} PX2263 (Noether, PI Expert Report) at Sections III, IX; *see also* PX4093 (Noether (Respondents' Expert), Dep.) at 39:4-13; DX1210 (Noether, Expert Report) at ¶¶ 8-9. **{**

} DX1210 (Noether, Expert Report) at ¶ 177 (**{**

}). Moreover, Respondents' ordinary course documents corroborate the fact that the GAC

services market is already highly concentrated and would become substantially more so post-Acquisition. PX4586-001 (**{**

}); PX0061-012 (**{**

}).

The market shares, HHI levels, and the increase in concentration resulting from the Acquisition far exceed those found in other cases to trigger a presumption of illegality. *Phila. Nat'l Bank*, 374 U.S. at 364; (enjoining acquisition with 30% combined share and where many competitors remained); *Univ. Health*, 938 F.2d at 1211 n.12, 1219 (holding *prima facie* case established where merger reduced competitors from five to four, combined share of 43%, HHI increase of 630, and a post-merger HHI of 3200); *FTC v. Bass Bros. Enters., Inc.*, No. C84-1304, 1984 U.S. Dist. LEXIS 16122, at *65 (N.D. Ohio June 6, 1984) (enjoining two mergers resulting in 200 and 300 point HHI increases). In this case, Respondents would have a combined share of at least 58.9 percent and only one significant competitor would remain in the GAC services market. PX2515 (Capps, Expert Report) at ¶¶ 175, 179.

Under the Merger Guidelines, a transaction that increases concentration by 200 points and results in a highly-concentrated market (*i.e.*, has a post-Acquisition HHI level above 2,500), is "presumed likely to enhance market power." PX0205 § 5.3; *see also ProMedica*, 2011 LEXIS 294, at *83. This Acquisition, if consummated, would far exceed these thresholds. As summarized in Table 1 below, in the GAC services market, the concentration level would rise by *at least* 1,736 points to a post-Acquisition HHI level of 5,088 *or more*. PX2515 (Capps, Expert Report) at ¶¶ 175, 179 (showing that the Acquisition could potentially increase GAC

concentration by as much as 2,052 points and result in a post-Acquisition HHI level of as much as 5,406). Thus, there is an overwhelming presumption of illegality in the GAC services market. Indeed, there is "by a wide margin, a presumption that [a three-to-two] merger will lessen competition" in a market with concentration levels like those in this case. *Heinz*, 246 F.3d at 716; *FTC v. PPG Indus., Inc.*, 798 F.2d 1500, 1505 (D.C. Cir. 1986).

Table 1[8]

GAC SERVICES IN THE WOB AREA		
HOSPITAL	**PRE-ACQUISITION MARKET SHARE**	**POST-ACQUISITION MARKET SHARE**
SWEDISHAMERICAN HOSPITAL	40.2%	40.2%
OSF'S ST. ANTHONY MEDICAL CENTER	29.5%	58.9%
ROCKFORD MEMORIAL HOSPITAL	29.4%	--
ROCHELLE COMMUNITY HOSPITAL	0.9%	0.9%
PRE-ACQUISITION HHI		3,352
POST-ACQUISITION HHI		5,088
HHI INCREASE		1,736

[8] PX2515 (Capps, Expert Report) at ¶ 179. The market shares in Table 1 are measured by patient admissions in the WOB Area and result in the most conservative estimation of the post-Acquisition HHI level. When measured by patient days in the WOB Area, the pre-Acquisition HHI level is 3,319 and the Acquisition would increase that number by 2,032 points to a total of 5,351. *Id*. The Acquisition would increase concentration measured by patient admissions in the 30-Minute Drive Time Area from 3,411 to a total of 5,179 (an increase of 1,767 points). *Id*. at ¶ 175. As measured by patient days, the Acquisition would increase the HHI level in the 30-Minute Drive Time Area by 2,052 points, from 3,353 to a total of 5,406. *Id*. Thus, the Acquisition is presumptively illegal by a wide margin regardless of whether it is analyzed in the WOB Area or the 30-Minute Drive Time Area or whether market shares are measured by admissions or patient days.

3. The Acquisition Also Substantially Increases Concentration in the Primary Care Physician Services Market

In the PCP services market, OSF currently has a market share of between 15.1 and 23.8 percent as measured by the number of PCPs in the 30-Minute Drive Time Area, and RHS has a share of between 22.1 and 24.4 percent. PX2520 (Capps, Rebuttal Report) at ¶ 136 (Respondents' shares vary based on whether PCPs are defined to include hospitalists, urgent care center physicians, and geriatric PCPs.). In the area encompassed by Winnebago, Ogle, and Boone Counties, which is likely overly broad, OSF controls a market share of approximately 13.5 percent and RHS possesses a share of roughly 20.8 percent. *See infra* note 10. The pre-Acquisition HHI level for the PCP services market is between 1,122 and 1,536, rendering it unconcentrated or moderately concentrated today under the Merger Guidelines. PX2520 (Capps, Rebuttal Report) at ¶ 136; PX0205 § 5.3; *see infra* note 10.

Post-Acquisition, however, Respondents would control a combined share of between 34.3 and 45.9 percent of the PCP services market. PX2520 (Capps, Rebuttal Report) at ¶¶ 126, 136; *see infra* note 10. The Acquisition would increase concentration by between 562 and 1,052 points to an HHI level of between 1,684 and 2,588, resulting in either a moderately-concentrated or a highly-concentrated market. PX2520 (Capps, Rebuttal Report) at ¶ 136; PX0205 § 5.3; *see infra* note 10.

Table 2[9]

PCP SERVICES IN THE 30-MINUTE DRIVE TIME AREA		
PCP SERVICES PROVIDERS	**PRE-ACQUISITION MARKET SHARE**	**POST-ACQUISITION MARKET SHARE**
OSF	23.8%	45.9%
RHS	22.1%	--
SAHS	18.7%	18.7%
UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT ROCKFORD	8.2%	8.2%
NORTH POINTE	1.7%	1.7%
GENOA MEDICAL CLINIC	1.7%	1.7%
PHYSICIANS IMMEDIATE CARE	1.1%	1.1%
INDEPENDENT PCPS	22.7%	22.7%
PRE-ACQUISITION HHI		1,536
POST-ACQUISITION HHI		2,588
HHI INCREASE		1,052

[9] PX2520 (Capps, Rebuttal Report) at ¶ 136. The market shares in Table 2 are measured using the broad definition of PCP which includes hospitalists, urgent care center physicians, and geriatric PCPs. These market shares, which are based on headcounts, likely understate the current shares of the three Rockford hospitals and the post-Acquisition share of the combined entity. *Id*. at ¶ 138. This is because PCPs in smaller practices, on average, likely provide a smaller volume of services than PCPs in larger practice groups. *Id*. When measured using the narrower definition of PCP, the Acquisition increases the HHI level in the 30-Minute Drive Time Area by 736 points from 1,397 to a total of 2,133. *Id*. at ¶ 136.

Table 3[10]

PCP SERVICES IN WINNEBAGO, OGLE, AND BOONE COUNTIES		
PCP SERVICE PROVIDERS	**PRE-ACQUISITION MARKET SHARE**	**POST-ACQUISITION MARKET SHARE**
OSF	{ }	{ }
RHS	{ }	--
SAHS	{ }	{ }
UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT ROCKFORD	{ }	{ }
NORTH POINTE	{ }	{ }
RMG	{ }	{ }
GENOA MEDICAL CLINIC	{ }	{ }
INDEPENDENT PCPS	{ }	{ }
PRE-ACQUISITION HHI		{ }
POST-ACQUISITION HHI		{ }
HHI INCREASE		{ }

According to the Merger Guidelines, "[m]ergers resulting in moderately concentrated markets that involve an increase in the HHI of more than 100 points potentially raise significant competitive concerns and often warrant scrutiny[,]" while "[m]ergers resulting in highly concentrated markets that involve an increase in the HHI of more than 200 points will be

[10] Table 3 provides market shares (based on PCP headcounts) and HHI calculations for Winnebago, Ogle, and Boone Counties because reliable, comprehensive data for PCPs in the WOB Area are unavailable. Market shares are conservatively measured using Respondents' expert's Tri-County Area PCP Count figures, with two modifications. *See* DX1210 (Noether, Expert Report) at Exhibit 22. First, PCPs practicing at Crusader have been excluded from Table 3 for the reasons described in PX2520 (Capps, Rebuttal Report) at ¶¶ 128-130. Second, the market share for the University of Illinois College of Medicine at Rockford has been modified as described in PX2520 (Capps, Rebuttal Report) at ¶ 131, Figures 9-10. To be conservative, independent PCPs are not included in the calculation of pre- or post-Acquisition HHIs.

presumed to be likely to enhance market power." PX0205 § 5.3. Thus, at a minimum, the Acquisition raises significant competitive concerns in the PCP services market; it may also lead to a presumption of illegality in the PCP services market, as it clearly does in the GAC services market.

4. A Heavy Burden Shifts to Respondents to Rebut the Presumption, Which They Cannot Overcome

Complaint Counsel has clearly established its *prima facie* case of a Section 7 violation, proving that the Acquisition would result in undue concentration in the GAC services market. *See Chicago Bridge*, 534 F.3d at 423; *Baker Hughes*, 908 F.2d at 982-83; *Polypore*, 2010 FTC LEXIS 97, at *25. Accordingly, the burden now shifts to Respondents to rebut the presumption that the Acquisition is illegal by producing sufficient evidence to clearly show that Complaint Counsel's evidence inaccurately predicts the likely competitive effects of the transaction. *See Marine Bancorporation*, 418 U.S. at 631; *Phila. Nat'l Bank*, 374 U.S. at 363; *Chicago Bridge*, 534 F.3d at 423; *Univ. Health*, 938 F.2d at 1218-19; *Polypore*, 2010 FTC LEXIS 97, at *26. Since Complaint Counsel has established an extremely strong *prima facie* case, Respondents' burden to overcome the presumption is extraordinarily high. *See Polypore*, 2010 FTC LEXIS 97, at *26. As discussed in detail in Section V.D., Respondents fall woefully short of rebutting the presumption of illegality.

Only if Respondents meet their heavy burden must Complaint Counsel provide any additional evidence showing that the Acquisition may substantially lessen competition. *See Chicago Bridge*, 534 F.3d at 423; *Polypore*, 2010 FTC LEXIS 97, at *27. Although Respondents unquestionably fail to meet their burden, Complaint Counsel turns now to the wealth of additional, direct evidence (*i.e.*, evidence that does not depend upon market definition,

market shares, and concentration) that supports the strong presumption of illegality to provide the Court a more complete understanding of the competitive harm that would result from the Acquisition. *See ProMedica*, No. 9346 (Opinion of the Commission), at 36 (finding additional evidence of competitive effects, "while unnecessary, particularly in light of the strength of Complaint Counsel's *prima facie* case . . . is nonetheless helpful because it is tailored to the unique competitive dynamics of hospital markets, stemming from the bargaining between hospitals and [health plans] over inclusion in [health plan] networks").

C. Competitive Effects Evidence Bolsters Strong Presumption of Harm and Illegality

A wealth of additional, direct evidence confirms and strengthens the presumption that the proposed Acquisition violates Section 7 and would significantly harm local employers and residents.

1. The Acquisition Will Eliminate Close Competition between OSF and RHS

For decades, OSF and RHS have competed vigorously with each other, and with Swedish, to gain access to health plan networks and to attract patients throughout the Rockford area. PX0213 (Breeden (OSF), IHT) at126:1-10, 164:21-166:16; PX0215 (Dillon (RHS), IHT) at 189:1-7, 189:11-15; PX4051 (Gorski (Swedish), Dep.) at 207:5-14; *see also ProMedica*, No. 9346 (Opinion of the Commission), at 6 ("Hospitals compete with one another for inclusion in [health plans'] provider networks because a hospital's commercially-insured patient volume is significantly affected by the provider networks in which it participates."). This competition has resulted in better pricing for health plans and employers and higher-quality services for area residents. PX0211 (Baker (OSF), IHT) at 97:24-100:5; PX2515 (Capps, Expert Report) at ¶ 106; PX4051 (Gorski (Swedish), Dep.) at 221:2-222:8. As the CEO of RHS (and future CEO of OSF

Northern) testified in the following excerpts from the preliminary injunction hearing, the three Rockford hospitals are each other's only meaningful competitors and competition among them is beneficial to patients because it results in the hospitals offering new programs and improving quality:

- "Q. For general inpatient care for all patients in and around Rockford, Saint Anthony's and SwedishAmerican are RHS's only meaningful competitors; is that correct? A. Correct." PX2511 (Kaatz (RHS), PI Hr'g Tr.) at 774:17-20.
- "Q. Competition with Saint Anthony's and SwedishAmerican sometimes spurs RHS to offer new programs? A. Correct." *Id*. at 775:7-9.
- "Q. And you agree that there's emerging quality competition among the three Rockford hospitals; is that right? A. I do." *Id*. at 775:13-15.
- "Q. You believe that competition on patient outcomes is beneficial to patients; isn't that right? A. I do." *Id*. at 775:10-12.
- "Q. And after the merger, there's no dispute . . . that RMH will no longer compete with Saint Anthony's; isn't that correct? A. That's correct." *Id*. at 776:7-10.

When contracting with commercial health plans, the three Rockford hospitals currently compete exclusively with one another. This fact was clearly demonstrated when Paula Dillon, RHS's Director of Managed Care, was asked under oath, "[w]hen you are contracting on behalf of the hospital, do you think about any other hospitals other than the three you just mentioned that are located in Rockford?" PX0215 (Dillon (RHS), IHT) at 189:11-14. She answered unambiguously, "I do not." *Id*. at 189:15; *see also* PX0210-014 (**{ }**). Testimony from OSF executives confirms that the three Rockford hospitals compete with only each other and that OSF and RHS compete head-to-head. For example, when asked who SAMC competes with "[f]rom a general acute hospital sense," OSF's President answered "Swedish American Hospital and Rockford Memorial Hospital." PX0218 (McGrew (OSF), IHT) at 49:16-20.

Similarly, **{**

} PX0211 (Baker (OSF), IHT) at 46:21-47:5.

Consistent with Respondents' testimony and ordinary course business documents, Dr. Capps' diversion analysis shows that SAMC and RMH, indeed, compete head-to-head and are currently close substitutes for one another. PX2515 (Capps, Expert Report) at ¶¶ 195-199; *see also* PX2520 (Capps, Rebuttal Report) at ¶¶ 87-95; PX0217 (Lobe (United), IHT) at 22:16-22, 23:17-23, 24:5-26:8; PX0327; PX0362-042; PX0210-014. If RMH were not available today, approximately 35 percent of its patients would seek care at SAMC. PX2520 (Capps, Rebuttal Report) at ¶¶ 87-95. Similarly, if SAMC were unavailable, roughly 34 percent of its patient volume would go to RMH. *Id*. The diversion analysis also shows that a little more than half of SAMC's and RMH's patients would divert to Swedish if either hospital were unavailable, and only a small percentage of patients would choose a hospital outside of Rockford. *Id*.

That Swedish, which is located geographically between SAMC and RMH, is a somewhat closer substitute for Respondents than they are for each other in no way changes the fact that the Acquisition would likely harm area residents substantially. PX2515 (Capps, Expert Report) at ¶ 203. The notion that a proposed merger must be the *most* anticompetitive merger imaginable in order to violate Section 7 defies common sense and has no basis in the law or in economics. *See id*. The law does not allow a merger to be consummated simply because it involves two close, but not closest, competitors. Indeed this Court recently addressed this issue in *ProMedica* and was upheld by the Commission. 2011 LEXIS 294, at *350 ("It is not necessary, for purposes of finding unilateral effects, to demonstrate that St. Luke's and ProMedica were the first and second choices for all consumers."); *ProMedica*, No. 9346 (Opinion of the Commission), at 47 (holding specifically that "merging parties do not need to be each other's closest rival for a merger to have

unilateral anticompetitive effects"). Similarly, the district court in *United States v. H&R Block* made this point abundantly clear when it held that "the proposed merger between HRB and TaxACT violates Section 7," even though "[u]sing a simple estimate of diversion based on market share would indeed suggest that HRB and TaxACT are each other's second closest rivals after Intuit." No. 11-00948, 2011 U.S. Dist. LEXIS 130219, at **126, 150 (D.D.C. Nov. 10, 2011) (citing the 2006 Commentary on the Horizontal Merger Guidelines which states that "[a] merger may produce significant unilateral effects even though a non-merging product is the 'closest' substitute for every merging product . . . ."). Moreover, the court in *H&R Block* permanently prohibited a merger that would have resulted in the combined entity possessing a market share of less than one-half of its only remaining competitor; in this case, Respondents would be substantially larger than Swedish. 2011 U.S. Dist. LEXIS 130219, at **9, 79.

Health plans, and in turn local employers and residents, have benefitted immensely from this close, head-to-head competition between OSF and RHS. Bilateral negotiations between each health plan and each Rockford hospital determine prices for GAC services. *See* PX2515 (Capps, Expert Report) at ¶¶ 88-89. The critical determinant of each hospital's bargaining leverage is the availability of substitute hospitals that the health plan can turn to if it cannot reach an agreement in negotiations. PX2515 (Capps, Expert Report) at ¶ 92. In this bargaining dynamic, health plans currently play OSF and RHS off each other (because they are close substitutes) to negotiate lower prices for GAC services. PX2509 (Petersen (Coventry), PI Hr'g Tr.) at 224:8-20; PX0211 (Baker (OSF), IHT) at 99:11-100:5; PX0218 (McGrew (OSF), IHT) at 144:21-145:9. The Acquisition would eliminate this beneficial competition between OSF and RHS, resulting in a substantial increase in the combined entity's bargaining leverage vis-à-vis health plans, and, thus, its ability to extract higher prices in negotiations.

2. The Acquisition Will Increase OSF's Bargaining Leverage Vis-à-vis Health Plans and Make it a Virtual "Must Have" Hospital System

Following the Acquisition, the combined OSF/RHS would gain substantial bargaining leverage because health plans would no longer have the option of contracting with RMH if they failed to reach an agreement with SAMC – or vice versa. PX2515 (Capps, Expert Report) at ¶ 211. This increased negotiating power fundamentally alters the dynamics of such negotiations, and would provide OSF the incentive and ability to increase prices to health plans. PX2515 (Capps, Expert Report) at ¶ 223; PX2509 (Lobe (United), PI Hr'g Tr.) at 40:18-41:21 and (Petersen (Coventry), PI Hr'g Tr.) at 247:7-23. Indeed, SAMC's CEO admitted during the preliminary injunction hearing that the Acquisition would increase the combined entity's bargaining leverage and acknowledged this could result in increased prices. PX2510 (Schertz (OSF), PI Hr'g Tr.) at 624:1-625:5.

Post-Acquisition, rather than having three competitors bidding with low rates to be included in a health plan's network, there would be only two. By eliminating close competition between SAMC and RMH and reducing the number of bidders for inclusion in each network, OSF would face significantly less pressure to compete on price, quality, and service than it does today. PX2510 (Capps, PI Hr'g Tr.) at 377:9-380:19. In the face of this lessened competition, the combined entity would have substantially greater bargaining clout and could extract higher prices from health plans, even those willing to attempt marketing a one-hospital network. *See* PX2520 (Capps, Rebuttal Report) at ¶¶ 47-56; *see also* PX0699-009 (**{**

}). As the Commission held in *ProMedica*:

> A hospital provider's bargaining leverage is affected by available substitutes for its hospitals. . . . If there are close substitutes, failure to conclude an agreement

> may have little impact on the [health plan's] marketability, so the hospital provider may have little bargaining leverage. . . . A merger may increase a hospital provider's bargaining leverage by removing substitute hospitals and thereby changing the [health plan's] cost of failing to reach an agreement. . . . When the merger reduces the value of the alternatives available if the [health plan] fails to reach an agreement with the first provider, it reduces the desirability of the [health plan's] walk-away network. . . [and] the [health plan] will be willing to pay more to have the hospital provider in its network.

No. 9346 (Opinion of the Commission), at 36-37.

Given the particular facts of the Rockford marketplace, the Acquisition would likely further enhance OSF's bargaining leverage by rendering it a virtual "must have" system for health plans. Indeed, residents in the Rockford area place a high value on having a choice of in-network hospitals; thus, they regard one-hospital networks as extremely unattractive. PX2509 (Lobe (United), PI Hr'g Tr.) at 30:19-23 (testifying that United's "[m]embers choose their health coverage because of access and cost, and generally one hospital does not satisfy enough of the membership to provide that access need for an employer group"); PX2515 (Capps, Expert Report) at ¶¶ 119, 212; PX2520 (Capps, Rebuttal Report) at ¶ 59; *see also ProMedica*, No. 9346 (Opinion of the Commission), at 6 (Health plan "customers (employers, directly, and their employees, indirectly) generally favor broad networks that do not restrict their choice of providers."). For this reason, all of the major health plans serving the area currently provide their enrollees a choice of two Rockford hospitals in their principal networks. PX4764-001 (HFN, a local health plan provider, stated that "you need two of the three hospitals to achieve any real measure of success in Rockford."); PX2515 (Capps, Expert Report) at ¶ 213 (showing also that each Rockford hospital previously offered its own health plan that featured itself as the only in-network hospital; however, over the last decade, each hospital sold its health plan and, either before or after its sale, each plan added a second hospital to its network); PX2520 (Capps,

Rebuttal Report) at ¶ 59; PX0909-001. Health plans force OSF, RHS, and Swedish to bid against each other for two of the three available in-network slots. PX2509 (Petersen (Coventry), PI Hr'g Tr.) at 231:10-233:3; PX0439-001-002; PX4708-001. Thus, each of the three Rockford hospitals faces the possibility that it will be excluded from a health plan's network, providing each hospital with a strong incentive to offer its best rates and the highest level of quality to win a slot in the plan's network. PX2509 (Petersen (Coventry), PI Hr'g Tr.) at 223:17-225:16, 231:10-232:8; *see also* PX0222 (Schertz (OSF), IHT) at 167:7-25.

The Acquisition would destroy this competitive dynamic and force health plans to accept the combined entity's demands for higher rates in order to offer a two-hospital network. PX2515 (Capps, Expert Report) at ¶ 213; PX2509 (Petersen (Coventry), PI Hr'g Tr.) at 247:7-19; PX4023 (McGrew (OSF), Dep.) at 37:22-39:5. Post-Acquisition, the only way a health plan could offer its members a two-hospital network would be to contract with the combined entity; the only alternative would be to try to market a one-hospital network with Swedish. PX2515 (Capps, Expert Report) at ¶ 213; PX2510 (Schertz (OSF), PI Hr'g Tr.) at 624:1-625:5. A wealth of evidence shows that a Swedish-only network currently is not marketable to local employers and residents. As the CEO of Coventry of Illinois testified in the preliminary injunction hearing, Coventry "would not [have] a viable product offering in the marketplace with just SwedishAmerican." PX2509 (Petersen (Coventry), PI Hr'g Tr.) at 248:20-249:6; *see also* PX2509 (Lobe (United), PI Hr'g Tr.) at 55:21-56:7 (testifying that United "would have to contract with OSF Northern Region after the affiliation"). In fact, Coventry previously tried marketing a network with only one hospital, but was "not able to successfully market a single network provider[;]" after adding a second hospital, it was "immediately then able to start to be competitive in the market" PX2509 (Petersen (Coventry), PI Hr'g Tr.) at 239:17-240:22; *see*

also PX4072 (Brand (ECOH), Dep.) at 60:20-61:12 (testifying that ECOH provided its RMH-only River Valley network until 2010, but added a second hospital (Swedish) at RMH's request because RMH was "disadvantaged by being in a network by themselves"). Other area health plans and employers confirm that their members demand networks that offer a choice of hospital providers, and, therefore, they would not purchase networks containing only Swedish. *See* PX2515 (Capps, Expert Report) at ¶¶ 117-122, 213 (summarizing health plan and employer testimony).

Whatever their lawyers may argue now, Respondents' own executives admit that today health plans must offer networks that include at least two of the three Rockford hospitals in order to be marketable. PX0213 (Breeden (OSF), IHT) at 95:4-18 (OSF's managed care negotiator testified that "to be marketable you have to have two hospitals in Rockford."); *see also* PX4763-002 (RHS's Director of Managed Care stated that one-hospital networks create "a serious access challenge for employers."). By making it a virtual "must have" system, the Acquisition would provide the combined entity substantially greater bargaining leverage than either OSF or RHS have independently today. PX2515 (Capps, Expert Report) at ¶ 213; PX4002 (Hitchcock (Humana), Dep.) at 111:12-112:12 (**{**

}). This increased bargaining leverage results form the fact that, post-Acquisition, the only alternative to the combined entity is an extremely unattractive Swedish-only network. The combined entity would undoubtedly use this increased leverage to extract higher prices from health plans. PX4021 (Seybold (RHS), Dep.) at 23:9-23; PX2510 (Schertz (OSF), PI Hr'g Tr.) at 620:18-24; PX0458-001 (**{**

}).

Dr. Capps performed a "Willingness to Pay" analysis ("WTP Analysis") that shows the Acquisition would, in fact, increase OSF's bargaining leverage substantially, allowing it to increase prices to health plans post-Acquisition. PX2515 (Capps, Expert Report) at ¶¶ 216-223. Importantly, this would be the case regardless of whether health plans sought to create one-hospital networks post-Acquisition. PX2520 (Capps, Rebuttal Report) at ¶¶ 47-56 (stating that health plans contracting for multiple-hospital networks is "*absolutely not necessary* for the merger to have substantial anticompetitive effects" (emphasis in original)). The WTP Analysis measures the amount by which the Acquisition would increase the combined entity's bargaining leverage relative to the leverage that SAMC and RMH possess independently based on the hospitals' closeness of substitution from the perspective of health plans. PX2515 (Capps, Expert Report) at ¶¶ 216-223. The analysis reveals that the Acquisition would increase the combined entity's bargaining leverage by 19% relative to what SAMC and RMH currently possess. *Id*. Thus, in all potential contracting scenarios, the end result of the Acquisition would be the same: higher prices for Rockford area health plans and employers and, in turn, higher premiums, deductibles, and co-pays for local residents. *Id*. at ¶¶ 132-137, 211, 223; *see also ProMedica*, No. 9346 (Opinion of the Commission), at 36-37 (concluding that "[g]enerally speaking, an increase in the hospital provider's bargaining leverage translates to an increase in its reimbursement rates").

3. The Acquisition Will Significantly Increase the Risk of Coordination

The Acquisition also significantly increases the likelihood that the two remaining Rockford hospital systems, OSF and Swedish, will engage in anticompetitive coordinated behavior that will harm local residents. Case law, the Merger Guidelines, and economic theory

all recognize that a merger to duopoly creates a high likelihood of anticompetitive coordinated effects. *See, e.g., Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1387-92 (7th Cir. 1986); *CCC Holdings*, 605 F. Supp. at 66-67; PX0205 § 7; *see also* PX2515 (Capps, Expert Report) at ¶ 3. As Judge Posner has explained, "[t]he fewer competitors there are in a market, the easier it is for them to coordinate their pricing." *Hosp. Corp. of Am.*, 807 F.2d at 1387. The court in *CCC Holdings* expounded on this point when it held that:

> '[I]t is easier for two firms to collude without being detected than for three to do so,' but price fixing is only one concern of the antitrust laws. A more common concern is 'the creation or reinforcement by merger of . . . oligopolistic market structures in which tacit coordination can occur.' With only two dominant firms left in the market, the incentives to preserve market shares would be even greater, and the costs of price cutting riskier, as an attempt by either firm to undercut the other may result in a debilitating race to the bottom.

605 F. Supp. at 66-67 (citing *Am. Hosp. Supply Corp. v. Hosp. Prods. Ltd.*, 780 F.2d 589, 602 (7th Cir. 1986) and *Heinz*, 246 F.3d at 725); *see also* PX0205 § 7 (explaining that coordination need not rise to the level of an explicit agreement, but rather may involve a "common understanding that is not explicitly negotiated[,]" or even merely "parallel accommodating conduct not pursuant to a prior understanding"). Price increases would not be the only harm from this merger to duopoly. The Acquisition would also increase the risk of coordination by the two remaining hospital systems to limit the scope and quality of the services and amenities they offer. PX2515 (Capps, Expert Report) at ¶ 3; *see also Rockford Mem'l*, 717 F.Supp. at 1285 ("Through a collusive exercise of market power the hospitals in the relevant area could also eliminate 'quality' competition that has been a major drain on the hospitals' budget.").

The risk that this Acquisition would result in coordinated effects is extremely high because there is a long history of anticompetitive coordination among the three Rockford hospitals. *H&R Block*, 2011 U.S. Dist. LEXIS 130219, at *109; PX0205 § 7.2; PX2515 (Capps,

Expert Report) at ¶ 3. In the 1989 *Rockford* case, the district court found that the three Rockford hospitals attempted a group boycott against Chicago Blue Cross, a health plan that sought to negotiate lower prices. 717 F.Supp. at 1286, 1304-06. To effectuate their boycott, "'all three [Rockford] hospitals . . . agreed to collectively refuse to sign a contract' with Chicago Blue Cross." *Id*. at 1305 (finding that SAMC had explicitly communicated to [Swedish] that "[i]f all three [Rockford] hospitals continue to stand firm in not signing a contract, we would continue to function in a similar environment [of being paid higher prices]. However, if one hospital in Rockford agrees to sign a contract, it creates a situation where it will force the remaining two hospitals to also sign a similar contract."). Since then, the record in this case reveals numerous instances of inappropriate communications between executives at the three Rockford hospitals, including correspondence about strategic plans and ongoing health plan negotiations. For example:

- **{**

  } PX0630-004; *see also* PX0556-003; PX2515 (Capps, Expert Report) at ¶¶ 238-239 (**{**

  }); PX2520 (Capps, Rebuttal Report) at ¶ 123.

- **{**

  } PX3151-001 (emphasis in original).

- **{**

  } PX4020 (Schertz (OSF), Dep.) at 116:3-125:8; PX0349-001-002; PX0350-001-002.

- **{**

} PX1265-001; PX4000 (Walsh (SAH), Dep.) at 69:13-71:8.

- **{** } PX0704-001.
- **{** } PX4626-002-003.

These examples of OSF, RHS, and Swedish explicitly sharing and monitoring each other's negotiations and strategic decisions show that effective coordination by the Rockford hospitals is already feasible. PX2515 (Capps, Expert Report) at ¶ 244; PX2520 (Capps, Rebuttal Report) at ¶ 124 (explaining that "there is no legitimate reason for executives from directly and closely competing hospitals to communicate regarding negotiations, strategic plans, and their interactions with health plans"). The Acquisition will only make coordination easier to effectuate and monitor in the future.

Post-Acquisition, OSF and Swedish would be able to reach a mutual understanding of the terms of coordination more easily than before. PX2515 (Capps, Expert Report) at ¶¶ 3, 247. They would also be able to detect any deviations from that understanding and to punish any cheating more easily than they could if three independent hospitals still operated in the market. PX2515 (Capps, Expert Report) at ¶¶ 3, 252. Quite simply, it is significantly easier to have a meeting of two minds than three. PX2515 (Capps, Expert Report) at ¶ 247. Moreover, to the extent that the hospitals would use overt communication to coordinate (as they have in the past), only one communication would be needed instead of the three that need to occur today. PX2515 (Capps, Expert Report) at ¶ 247.

Post-Acquisition, OSF and Swedish would be able to monitor and detect deviations from

their agreements more easily because: (1) it is inherently easier to monitor fewer firms; and (2) it is easier to correctly infer who has deviated from the plan when only two firms are coordinating. PX2515 (Capps, Expert Report) at ¶ 252. For coordination to work, each side must also be able to credibly threaten to punish any deviations by other participants in the scheme. PX2515 (Capps, Expert Report) at ¶ 252. The most natural punishment in this market is for the punishing firm to revert to contracting more aggressively with health plans to minimize the gains of the cheating hospital. PX2515 (Capps, Expert Report) at ¶ 255. The Acquisition would make it easier for the combined entity to punish Swedish because, as has already been shown, OSF would become a virtual "must have" system for health plans post-Acquisition. As such, OSF could convincingly threaten that it would require plans to exclude Swedish from their networks if Swedish attempted to deviate from the agreement the hospitals had reached. PX2515 (Capps, Expert Report) at ¶ 3.

4. Local Employers and Residents Will Be Seriously Harmed by Higher Prices, Diminished Quality, and Reduced Choice Resulting from the Acquisition

"In contract negotiations with [health plans], hospital providers seek to maximize the reimbursement they will receive . . . ." *ProMedica*, No. 9346 (Opinion of the Commission), at 6. Indeed, as discussed above, the evidence in this case shows OSF can fairly be expected to use the market power it gains from the Acquisition to extract higher prices from health plans. PX2510 (Schertz (OSF), PI Hr'g Tr.) at 620:18-24; PX4021 (Seybold (RHS) Dep.) at 23:9-23; PX0458-001. By eliminating the vigorous non-price competition between OSF and RHS, and increasing the risk of coordination between OSF and Swedish, the Acquisition may also result in fewer, lower-quality healthcare services available to area residents. PX2515 (Capps, Expert Report) at ¶¶ 1, 3, 106. Furthermore, the Acquisition will reduce the choices of GAC service providers and

PCP service providers in the community.

As the Commission acknowledged in *ProMedica*, "higher hospital reimbursement rates are passed on to employers and often to their employees . . . [and] higher rates would be passed on to the community-at-large." *ProMedica*, No. 9346 (Opinion of the Commission), at 7. Price increases for GAC services and PCP services are borne directly and immediately by self-funded employers because they pay most of their employees' healthcare costs directly and use health plans for negotiating and administrative purposes only. PX2515 (Capps, Expert Report) at ¶¶ 3, 62, 135. The majority of Rockford residents receiving plan coverage through their employers are enrolled in self-insured plans. *See* DX1210 (Noether, Expert Report) at ¶ 18; *see also* PX2509 (Lobe (United), PI Hr'g Tr.) at 25:17-25 (testifying that roughly 83% or more of United's Rockford business is self-insured). Fully-insured employers would also be harmed by OSF charging higher prices for GAC services and PCP services because health plans would pass along their increased costs to employers in the form of higher premiums. PX2515 (Capps, Expert Report) at ¶¶ 3, 62, 135. In fact, Rockford health plans confirm that if OSF extracted higher prices from them post-Acquisition, those price increases would be paid for immediately by self-insured employers, and their fully-insured customers would eventually pay for them with higher premiums. PX2509 (Lobe (United), PI Hr'g Tr.) at 25:17-27:9; PX2509 (Petersen (Coventry), PI Hr'g Tr.) at 218:11-219:8.

In turn, Rockford area employers would have little choice but to pass on at least some, if not all, of their increased healthcare expenses to their employees. PX2515 (Capps, Expert Report) at ¶¶ 132-137 (discussing academic studies, testimony from local employers, and other evidence showing that increases in employer healthcare costs would be borne primarily by workers). Higher healthcare costs also may cause employers to hire fewer workers, offer

healthcare coverage to fewer individuals, limit the benefits they cover, and reduce wages (or grow them more slowly). PX2515 (Capps, Expert Report) at ¶¶ 3, 132-134, 136; *see also* PX2513 (Romano, Expert Report) at ¶ 16 (explaining that patients often experience significant negative health consequences, including death, as a result of losing their medical insurance). Thus, the Acquisition and the price increases that it would create would have substantial and direct adverse effects on Rockford area residents, including employers and employees who purchase commercial health insurance, as well as those who would no longer be able to do so.

D. Respondents Cannot Overcome the Strong Presumption and Direct Evidence of the Acquisition's Harmful Anticompetitive Effects

In light of the strong *prima facie* case showing that the Acquisition is illegal under Section 7, Respondents face a heavy burden to rebut the strong presumption of competitive harm. Respondents do not come close to meeting their high burden.

1. OSF's Only Remaining Competitor Will Not Prevent Consumer Harm from the Acquisition

Respondents make the factually and theoretically unsupported argument that the presence of a single remaining hospital competitor in Rockford would completely prevent the combined entity from raising prices post-Acquisition. It is not a defense that all competition would not be eliminated by the Acquisition (*i.e.*, that some, lessened competition would remain). Indeed, this is simply a claim that only mergers to monopoly can harm competition and warrant antitrust scrutiny, which is legally and factually false. Moreover, the extent to which Swedish, OSF's sole remaining competitor, would be able to lessen the combined entity's ability to inflict harm on local residents is very limited, even assuming Swedish is motivated to compete with the merged entity. In fact, if the Acquisition is consummated, Swedish would have a significant incentive to coordinate with OSF to charge higher prices to health plans and to limit the number

and quality of services the two hospitals provide to local residents.

Post-Acquisition, OSF would be significantly more powerful and would have a substantially larger market share than Swedish. *See* PX2515 (Capps, Expert Report) at ¶¶ 175, 179 (showing that Swedish would be only approximately two-thirds the size of OSF post-Acquisition). As a virtual "must have" system, health plans would have no way to offer a two-hospital network except to contract with OSF post-Acquisition. The only alternative would be a wholly-unattractive Swedish-only network. Even if health plans could attract some customers with a Swedish-only network, Rockford area residents would still face significant harm because health plans would be faced with the unpalatable choice of either paying supracompetitive prices to offer a two-hospital network that included the merged entity's hospitals or offering a much less attractive plan that included only Swedish as an in-network hospital. PX2520 (Capps, Rebuttal Report) at ¶¶ 47-56 (OSF becoming a virtual "must have" system is not necessary for the Acquisition to harm local residents; rather, OSF's market power would be enhanced, in any event, by (1) the elimination of RMH, which competes closely with SAMC, and (2) the fact that competition remaining after the Acquisition between OSF and Swedish would be insufficient to replace the benefits of competition provided by RMH as an independent competitor.).

Given Rockford hospitals' propensity for coordination, Swedish can be expected not only to fail to prevent harm from the Acquisition, but also to exacerbate the Acquisition's negative impact on local residents. For example, Swedish and OSF could coordinate, tacitly or explicitly, to not target each other's key health plan customers or to reduce expenditures on new services or technologies. Thus, rather than Swedish preventing the Acquisition's consumer harm, there is a substantial risk that coordinated behavior between OSF and Swedish would increase prices in both relevant markets and limit the number and quality of services and amenities they offer local

residents.

2. Neither Entry nor Expansion Will Prevent Consumer Harm from the Acquisition

Entry or expansion must be timely, likely, and sufficient in magnitude and scope to deter or counteract the competitive harm from the Acquisition. *United States v. Visa U.S.A., Inc.*, 163 F. Supp. 2d 322, 342 (S.D.N.Y. 2001), *aff'd*, 344 F.3d 229, 240 (2d Cir. 2003); *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 55-58 (D.D.C. 1998); PX0205 § 9. Respondents must show that entry is likely (*i.e.*, not only possible, but economically sensible) and that it will replace the competition that existed prior to the merger. *See Cardinal Health*, 12 F. Supp. 2d at 56; *Chicago Bridge*, 138 F.T.C. at 1071. The higher the barriers to entry, the less likely it is that the "timely, likely, and sufficient" test can be met. *Visa*, 163 F. Supp. 2d at 342. Respondents cannot show, or even come close to showing, that entry would prevent the consumer harm created by the Acquisition.

The barriers to entry in the GAC services market are extremely high and, just as the court in the first *Rockford* litigation held, "[o]verall, the barriers to entry in the relevant market reinforce rather than diffuse the likelihood of anti-competitive tendencies marked by a concentrated market." 717 F.Supp. at 1282 (concluding that "[t]he Illinois Certificate-of-Need law presents a formidable barrier to persons wishing to provide new acute hospital inpatient care in the WOB area"). Entry into the GAC services market is an extremely costly, multiyear process that requires regulatory approval and an enormous amount of planning. *See* PX2515 (Capps, Expert Report) at ¶ 280; PX0226 (Seybold (RHS), IHT) at 236:4-17 (**{**

}); PX0222 (Schertz (OSF), IHT) at 20:19-22:2. Illinois' Certificate of Need ("CON")

law requires regulatory approval before constructing or significantly expanding or modifying a general acute-care hospital. PX0222 (Schertz (OSF), IHT) at 47:23-24; PX2515 (Capps, Expert Report) at ¶ 280. Given the amount of time it would take to obtain Certificate of Need ("CON") approval and to plan and construct a new general acute-care hospital in the Rockford area, it would likely take several years before a new hospital could enter the GAC services market. PX2515 (Capps, Expert Report) at ¶ 280. The history of entry "is a central factor in assessing the likelihood of entry in the future." *Cardinal Health*, 12 F. Supp. 2d at 56; PX0205 § 9. No new hospitals have been built in the Rockford area for decades, and no evidence suggests that any person or firm plans to construct one in the future. PX2515 (Capps, Expert Report) at ¶¶ 280-281. Thus, entry that is both timely and sufficient to prevent the consumer harm that would result from the Acquisition is extraordinarily unlikely.

The only potential source of expansion in the GAC services market is Swedish, which is extremely unlikely to expand its operations. Post-Acquisition, even if Swedish desired to grow its operations and reduce prices for GAC services (which is highly unlikely given the benefits of coordinating with OSF), such expansion would likely be significantly more expensive and less timely than entry by a new competitor. PX2515 (Capps, Expert Report) at ¶ 282. Any significant expansion by Swedish would require CON approval (which SAMC would almost certainly oppose); even if a proposed expansion were approved, it would be very time consuming to complete given the post-approval planning and building process. PX2515 (Capps, Expert Report) at ¶ 282. Swedish's per unit costs to expand its operations would likely be even greater than those of a new entrant because Swedish would have to shut down some of its operations during the construction process. PX2515 (Capps, Expert Report) at ¶ 282.

Entry into, and expansion in, the Rockford area PCP services market are difficult also.

PX2520 (Capps, Rebuttal Report) at ¶ 141. The greatest barrier to entry is the significant difficulty associated with recruiting and retaining new PCPs in the Rockford area. *See* PX0223 (Schoeplein (OSF), IHT) at 178:10-17 ("The challenge we have as an industry is recruiting and retaining primary care physicians."). Indeed, even Respondents have been unable to meet their PCP recruitment goals. PX3677-003-004 (**{**

}). The following testimony from SAMC's CFO clearly makes this point:

- "Q. So, I think I understand you to say that it's not by choice that you're not replacing the people that you're losing. . . . A. That would be the case, especially [in] the primary care realm. Not through lack of effort." PX0227 (Stenerson (OSF), IHT) at 213:25-214:4.
- **{** } *Id.* at 214:5-7.
- **{** **}** *Id.* at 214:8-9.

Based on the evidence, entry would not deter or constrain competitive harm caused by the Acquisition in either relevant market. PX2515 (Capps, Expert Report) at ¶¶ 279-282; PX2520 (Capps, Rebuttal Report) at ¶ 141. Thus, Respondents will fail to meet their burden of showing that purported entry or expansion would ameliorate the Acquisition's competitive harm.

3. Health Plans Will Not Prevent Consumer Harm from the Acquisition

Despite overwhelming evidence to the contrary, Respondents argue that health plans' size and sophistication would give them the ability to thwart anticompetitive price increases post-Acquisition. While it is true that each health plan currently possesses some measure of bargaining power (and some possess a substantial amount), this Acquisition does nothing to increase the negotiating clout of any health plan. PX2515 (Capps, Expert Report) at ¶¶ 211-223, 345. It does, however, enhance the combined entity's bargaining leverage immensely. PX2515

(Capps, Expert Report) at ¶¶ 211-223, 345. Thus, the combined entity would have substantially greater bargaining leverage relative to each health plan than either OSF or RHS has independently today. PX2515 (Capps, Expert Report) at ¶¶ 211-223, 345; *see also ProMedica*, No. 9346 (Opinion of the Commission), at 53 (concluding that health plans would not be able to prevent merging hospitals from exercising market power even though health plans "have leverage of their own in negotiations," because the merger "increases [the merging hospitals'] bargaining leverage – and concomitantly disadvantages [health plans] . . . [making] it considerably more difficult for [health plans] to walk away"). As already shown, OSF will use this increased bargaining leverage to extract higher prices from health plans in the Rockford area.

In particular, Respondents have suggested that large health plans, and especially the largest, BlueCross BlueShield of Illinois ("BCBS-IL"), could effectively resist post-Acquisition price increases because they possess more bargaining power than other plans. While it is true that BCBS-IL currently possesses more leverage than other plans in negotiations with Rockford hospitals, this in no way implies that it could protect itself from the anticompetitive effects created by the combined entity's enhanced market power, or render OSF's anticompetitive price increases unprofitable. PX2515 (Capps, Expert Report) at ¶ 345; *see also* PX4005 (Arango (BCBS-IL), Dep.) at 105:10-16. Indeed, Respondents confuse the *level* of bargaining power BCBS-IL currently has relative to other plans with the *change* in bargaining power between each plan and Respondents that would result from the Acquisition. PX2515 (Capps, Expert Report) at ¶ 345. Post-Acquisition, the fact that BCBS-IL has more leverage than other plans would only mean that BCBS-IL would continue to pay lower rates than other plans post-Acquisition, even though all health plans, including BCBS-IL, would pay more than they do today. PX2515

(Capps, Expert Report) at ¶ 345. This is true regardless of whether OSF became a virtual "must have" system (which it likely would), because the Acquisition would increase OSF's bargaining leverage vis-à-vis each health plan in all contracting scenarios.

4. Respondents' Purported Efficiencies Are Made-for-Litigation, Speculative, Not Merger-Specific, and Clearly Do Not Outweigh the Acquisition's Competitive Harm

To overcome the strong presumption that the Acquisition is illegal under Section 7, Respondents must prove the Acquisition would result in "significant economies and that these economies ultimately would benefit competition and, hence, consumers." *Univ. Health*, 938 F.2d at 1223; PX0205 § 10 (stating that federal antitrust "[a]gencies consider whether cognizable efficiencies likely would be sufficient to reverse the merger's potential to harm customers in the relevant market"). When evaluating efficiency claims, especially in markets with concentration levels as high as those present here, "the court must undertake a rigorous analysis of the kinds of efficiencies being urged by the parties in order to ensure that those 'efficiencies' represent more than mere speculation and promises about post-merger behavior." *Heinz*, 246 F.3d at 721. Under the Merger Guidelines, efficiencies must be merger-specific (*i.e.*, likely to be achievable only by *this* transaction), substantiated, and of such a character and magnitude that the transaction is not likely to be anticompetitive. PX0205 § 10. As the court in *H&R Block* held recently, merging parties asserting efficiencies claims face a substantial burden because they must "verify by reasonable means the likelihood and magnitude of each asserted efficiency, how and when each would be achieved (and any costs of doing so), how each would enhance the merged firm's ability and incentive to compete, and why each would be merger-specific." 2011 U.S. Dist. LEXIS 130219, at *142 ("In other words, a 'cognizable' efficiency claim must represent a type of cost saving that could not be achieved without the merger and the estimate of

the predicted saving must be reasonably verifiable by an independent party."); *see also FTC v. Staples Inc.*, 970 F. Supp. 1066, 1089-90 (D.D.C. 1997); PX0205 § 10. Respondents come nowhere close to meeting this high burden.

Respondents' efficiencies claims were not generated to assist OSF and RHS executives as they decided whether to enter into the Acquisition; rather, they were created at the direction of outside antitrust counsel expressly for this litigation. Case law and the Merger Guidelines dictate that, because Respondents' efficiencies claims were "generated outside of the usual business planning process," they must be "viewed with skepticism." *ProMedica*, 2011 U.S. Dist. LEXIS 33434, at *107; PX0205 § 10. Neither OSF nor RHS has ever conducted a comprehensive internal efficiencies analysis. PX2511 (Kaatz (RHS), PI Hr'g Tr.) at 762:14-17; PX0221 (Schertz (OSF), IHT) at 215:23-216:5; PX2516 (Dagen, Expert Report) at ¶ 24. Rather, virtually all of their efficiencies claims are based on a report created by FTI ("FTI Merger Report"), a firm hired by Respondents' outside antitrust counsel for purposes of the FTC's review of the Acquisition and this litigation. PX2516 (Dagen, Expert Report) at ¶¶ 24-33; PX2510 (Schertz (OSF), PI Hr'g Tr.) at 608:4-8); PX0681-001 ({

}); *see generally* PX0034. In fact, throughout the FTC's investigation and this litigation, Respondents have claimed attorney work product protection over FTI's efficiencies work, conceding that it was performed solely in anticipation of potential litigation and served no business purpose. PX0228 (Tosino (FTI), IHT) at 23:5-11 (Respondents' counsel explained that the basis for privilege objections relating to the FTI Merger Report was that "FTI was hired by Hinshaw & Culbertson and McDermott, Will &

Emery jointly, and that the work was done in anticipation of litigation."); *see generally* PX3048.[11] Accordingly, this Court should view Respondents' efficiencies claims with great skepticism.

In addition, Respondents' claims that the Acquisition would generate cost savings and other benefits, such as improved quality, are at best highly speculative. As this Court has held, "'[s]peculative, self-serving assertions' will not suffice." *ProMedica*, 2011 LEXIS 294, at *234 (citations omitted). Under the Merger Guidelines, "[e]fficiency claims will not be considered if they are vague, speculative, or otherwise cannot be verified by reasonable means." PX0205 § 10. Respondents have not decided whether to pursue any of the purported efficiencies identified in the FTI Merger Report, and it is unlikely that they ever will pursue many of them due to cultural, regulatory, and other practical complications. PX2516 (Dagen, Expert Report) at ¶¶ 16-17, 34-40, 42-79; PX2514 (McAnallen, Expert Report) at ¶¶ 39-41; PX2511-065 (Manning (Respondents' Expert), PI Hr'g Tr.) at 908:13-25; PX0227 (Stenerson (OSF), IHT) at 135:6-13. In fact, Respondents do not even plan to begin analyzing which, if any, integration efforts to pursue until after the Acquisition is consummated. PX2516 (Dagen, Expert Report) at ¶ 17; PX4020 (Schertz (OSF), Dep.) at 131:15-19. The consulting firm that will conduct the analysis to determine whether to proceed with such efforts has not even begun such an analysis; indeed,

[11] Additional documents recently produced by FTI pursuant to this Court's March 19, 2012 Order in response to Complaint Counsel's motion to compel also show that FTI's efficiency work served no business purpose. **{**

} Due to the fact that Complaint Counsel received these documents after filing its Final Proposed Exhibit List, copies of FTI00089308, Tab C2. Business Case of FTI00086556, and FTI00090719 are attached as Attachments A, B, and C, respectively.

that firm has not even been retained. PX2511 (Kaatz (RHS), PI Hr'g Tr.) at 749:10-753:16 (testifying that the consulting firm could begin to work on the approximately twelve-month integration planning process that must occur before Respondents could decide which, if any, clinical consolidations to implement; however, Respondents refuse to pay for such work at this time). Perhaps the clearest evidence of the speculative nature of Respondents' purported efficiencies is the following, unambiguous testimony provided by RHS's CEO (and the future CEO of OSF Northern Region) at the preliminary injunction hearing:

- "Q. Turning to what the merged entity will look like, no final decisions have been made about which, if any, clinical service lines may be consolidated following the merger; is that right? A. Correct." PX2511 (Kaatz (RHS), PI Hr'g Tr.) at 747:18-21.

- "Q. And no decision has been made regarding where any service line would be consolidated, if they're consolidated at all; is that right? A. That's correct." *Id.* at 748:1-4.

- "Q. In fact, it's possible that [if] the merger goes through, no service lines will be consolidated within the next two years; isn't that correct? A. It's possible." *Id.* at 748:22-25.

- "Q. In fact, no decisions have been made on what actions the merged entity will take in consolidating service lines, and you really can't commit to a timeline for when they will occur; isn't that right? A. At this point we can't." *Id.*at 749:1-5.

- Q. "It's possible that no service lines will ever be consolidated after the merger between Saint Anthony and Rockford; isn't that correct? A. It's possible." *Id.* at 749:6-9 (RHS's CEO also acknowledged that the combined entity would need to apply for a certificate of exemption to consolidate service lines and that no one has evaluated how this process may impact OSF's timing or ability to consolidate services.).

Respondents' claimed quality improvements are similarly theoretical and unsubstantiated. PX2513 (Romano, Expert Report) at ¶ 14 (concluding that the Acquisition would not result in any meaningful improvement in quality of care at either SAMC or RMH); PX2519 (Romano, Rebuttal Report) at ¶ 8; PX2511 (Kaatz (RHS), PI Hr'g Tr.) at 769:10-12 (The future CEO of OSF Northern Region testified that "very little, if anything, has been done to analyze the quality

implications of this merger. . . ."); PX0219 (Pagan (RHS), IHT) at 159:20-162:17. Indeed, both OSF and RHS currently have strong clinical quality and have undertaken numerous initiatives as independent hospital systems to improve their quality, including implementing electonric medical record systems. PX2509 (Lobe (United), PI Hr'g Tr.) at 32:6-10 (testifying that all three Rockford hospitals already have "excellent quality."); PX2511 (Manning (Respondents' Expert), PI Hr'g Tr.) at 926:24-927:6 (testifying that she understands RMH provides high-quality care today); PX2513 (Romano, Expert Report) at ¶¶ 23, 79-83.

Respondents' claimed efficiencies also lack merger-specificity and are overstated. *See generally* PX2516 (Dagen, Expert Report); PX2521 (Dagen, Rebuttal Report); *see also* PX2513 (Romano, Expert Report) at ¶ 14 (concluding that Respondents' could achieve their purported quality improvements without the Acquisition as well); PX2519 (Romano, Rebuttal Report) at ¶ 8. In fact, in February 2011, FTI created two "Performance Opportunities Reports," one for OSF and another for RHS, which indicated that Respondents could significantly reduce their costs (by at least **{ }** per year combined) and improve their productivity as standalone entities, without a merger. PX2516 (Dagen, Expert Report) at ¶ 18; PX4021 (Seybold (RHS), Dep.) at 186:25-187:15 (testifying that FTI's RHS Performance Opportunities Report "went slightly deeper" and "identified more specific areas of opportunity" than the FTI Merger Report); *see generally* PX2001; PX2000. To the extent that any savings identified in FTI's individualized reports for OSF and RHS are achievable, they are necessarily not merger-specific and should not be credited as efficiencies resulting from the Acquisition. PX2516 (Dagen, Expert Report) at ¶ 19. Moreover, RHS has recently achieved significant cost savings on its own, and SAMC has successfully created efficiencies and lowered its operating costs independently. PX2516 (Dagen, Expert Report) at ¶¶ 19, 84-88; *see also* PX2511 (Kaatz (RHS), PI Hr'g Tr.) at 769:19-770:10

(RHS's CEO testified that there is "no magic whatsoever" to achieving cost savings RHS has achieved on its own.). Executives from both hospitals concede they could continue to find ways to reduce costs and become more efficient without the Acquisition. PX2511 (Kaatz (RHS), PI Hr'g Tr.) at 765:20-22, 767:12-19; PX2510 (Schertz (OSF), PI Hr'g Tr.) at 630:1-631:13. Based on these facts, it is clear that Respondents need not merge with each other and eliminate the competition between them to achieve productivity gains and efficiencies.

To the extent that any of Respondents' claimed efficiencies are cognizable (which is extremely doubtful), they are almost certainly overstated. *See, e.g.*, PX2516 (Dagen, Expert Report) at ¶¶ 130-161 (Respondents claim savings from capital avoidance which, in addition to being speculative and not merger-specific, fail to consider costs that the combined entity would have to incur to achieve such savings.) For example, Respondents claim the Acquisition would enable RHS and OSF to avoid spending millions of dollars they would have spent if they continued to compete with one another. *Id*. at ¶ 130. However, RHS and OSF executives acknowledge under oath that their respective hospitals may not have actually made many of these expenditures absent the Acquisition. PX0211 (Baker (OSF), IHT) at 221:2-19 (**{ }**); PX0216 (Kaatz (RHS), IHT) at 221:13-24 (testifying that RHS has no plans to purchase a gamma knife).

Respondents' efficiency claims are virtually identical to the arguments the *Rockford* court rejected twenty years ago. 717 F. Supp. at 1289-91. The same claims that Respondents make today and the merging parties made in the 1989 include: clinical consolidations, standardization of clinical best practices, back-office integration, and avoiding capital expenditures. *Id. See generally* PX2516 (Dagen, Expert Report); PX2521 (Dagen, Rebuttal Report). Respondents'

claims in this case suffer the same shortcomings that caused the *Rockford* court to hold that the merging parties had "failed to clearly and convincingly demonstrate" efficiencies would "create a net economic benefit for the health care consumer." 717 F. Supp. at 1291. Likewise, Respondents will not meet their high burden to overcome the presumption that the Acquisition is illegal because it is clear that the Acquisition's competitive harm will greatly outweigh any cognizable efficiencies it may create.

5. Any "Flailing" Firm Defense is Meritless: Respondents Admit that Both OSF and RHS are Financially Sound

Respondents appear to argue that the financial or operational conditions of OSF and RHS somehow justify the Acquisition; however, it is undisputed that both hospitals are financially sound. *See* PX2516 (Dagen, Expert Report) at ¶¶ 169-181. OSF projects it will generate profits of more than **{** } this year alone on top of a more than **{ }** reserve in cash and investments. PX2516 (Dagen, Expert Report) at ¶ 174; PX0371-029-031 (**{**

}). According to its executives, RHS had its "best year ever from operations" in 2010 and is currently "an A-rated organization." PX0559-001; PX2511 (Kaatz (RHS), PI Hr'g Tr.) at 772:1-10; PX4021 (Seybold (RHS), Dep.) at 66:3-8. RHS anticipates it will be profitable in 2012 and maintains cash reserves of approximately **{**

} PX3682-004-005 (**{**

}); PX2516 (Dagen, Expert Report) at ¶ 179. Nevertheless, Respondents argue that the economic conditions of OSF and RHS "motivate" the Acquisition, without explaining why this fact, if true, is relevant. *See* DX1210 § XIII. This is clearly not a legitimate defense of the

Acquisition.

If Respondents were, in fact, pursuing a flailing firm defense, they would have to make a "substantial showing that the acquired firm's weakness, which cannot be resolved by any competitive means, would cause that firm's market share to reduce to a level that would undermine the government's prima facie case." *Univ. Health*, 938 F.2d at 1221 (11th Cir. 1991). There is not even a remote possibility of this happening. SAMC and RMH have competed against each other for decades, and both expect to remain vigorous competitors for the foreseeable future if the Acquisition is not consummated. "Financial weakness . . . is probably the weakest ground of all for justifying a merger" and it "certainly *cannot be the primary justification* of a merger." *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1339, 1341 (7th Cir. 1981) (emphasis added); *see also FTC v. Warner Commc'ns Inc*., 742 F.2d 1156, 1165 (9th Cir. 1984); *ProMedica*, No. 9346 (Opinion of the Commission), at 28 (holding a financial weakness defense imposes "an extremely heavy burden on defendants seeking to rebut the structural presumption on this ground"). Courts have strongly disfavored "a weak company defense" because it "would expand the failing company doctrine, a defense which has strict limits." *Warner Commc'ns*, 742 F.2d at 1164 (internal quotations omitted); *ProMedica*, 2011 LEXIS 294, at *396 ("[I]t is clear that the defense is strongly disfavored."). Here, Respondents do nothing more than cherry-pick a few financial facts regarding each hospital (none of which shows OSF or RHS is financially weak), while never even claiming that either hospital is flailing. This provides absolutely no basis for overcoming the presumption that the Acquisition is illegal under Section 7.

6. Economic Conditions in Rockford Will Not Prevent Consumer Harm from the Acquisition

Respondents also suggest that the general state of the economy in Rockford justifies the Acquisition; however, adverse demographic or economic conditions in the market as a whole do not provide a defense for the Acquisition. Antitrust merger analysis requires harm from lost competition to be weighed against the benefits of any cognizable efficiencies that may result, regardless of whether the area is thriving or distressed. *See generally* PX0205 § 10. Adverse economic conditions in the Rockford area are not directly relevant to analyzing the impact of the Acquisition. PX2515 (Capps, Expert Report) at ¶ 308; *see also* PX2510 (Schertz (OSF), PI Hr'g Tr.) at 632:5-7 (The Rockford area economy has improved since 2009.). To the extent that analyzing market-wide economic conditions is relevant at all, such analysis is already incorporated in the case law providing for a defense in cases where one or both merging parties would fail and exit the relevant markets absent the Acquisition. *See* PX0205 § 11. As has already been shown, Respondents admit (and a wealth of other evidence corroborates) that neither OSF nor RHS is flailing, let alone failing.

There is no basis in the law or economics to create a new "weak economy" defense to an unlawful merger, or to apply a more lenient standard for analyzing mergers in distressed markets. *See Rockford Mem'l*, 717 F. Supp. at 1289 ("To allow an anti-competitive merger to occur on [the] basis [of a failing market defense] is untenable."); PX2515 (Capps, Expert Report) at ¶ 308. Indeed, defendants in the prior *Rockford* litigation raised the same claim that the court should allow a merger of two of the only three hospitals in town due to the purportedly poor economic conditions in the area at the time. 717 F. Supp. at 1289. That court found "this 'failing market' or 'writing on the wall' defense too broad and ungainly to ward off a Section 7 violation." *Id.*

("The defendants' . . . defense poses the question of whether a solvent corporation should be allowed to merge on the basis of its prediction of future financial calamity in this relevant market. . . . The speculative nature of the defense allows for too much abuse.").

History has proven the *Rockford* court right. Despite defendants' claims to the contrary, all three hospitals have continued to thrive and compete in Rockford since 1989, and the evidence shows that they will continue to do so for the foreseeable future without the Acquisition. *See* PX0371-029-031; PX3682-004-005. Thus, based on the law and the facts of this case, Respondents' claims about the economic conditions in the Rockford area are clearly insufficient to overcome the presumption that the Acquisition violates Section 7.

In fact, poor economic conditions in the Rockford area would only increase the anticompetitive harm that would result from the Acquisition. PX2515 (Capps, Expert Report) at ¶ 308. As has already been shown, the Acquisition would result in higher healthcare costs, as well as reduced availability, choice, and quality of healthcare services for Rockford area residents. It may also result in a higher unemployment rate and lower wages in the community. An area already facing the challenges of a distressed economy would likely find the severe consequences of the Acquisition more difficult (not less) to bear than communities with more vibrant conditions.

7. Healthcare Industry Reforms Will Not Prevent the Acquisition's Harm to Consumers

Respondents also pursue an unprecedented, theoretically and factually flawed "healthcare reform" defense, which, like their other purported justifications, clearly fails to overcome the presumption of illegality. Respondents argue that regulatory changes such as those found in the Patient Protection and Affordable Care Act and related regulations, somehow render the

Acquisition benign. However, recent and anticipated healthcare reform initiatives do not lessen the importance or benefits of competition in the relevant markets. Nor do they change the fact that the Acquisition will seriously harm local residents. PX2520 (Capps, Rebuttal Report) at ¶¶ 5-6, 15, 151.

Respondents' argument has no basis in law, economic theory, or the facts of this case. No court has allowed the consummation of an otherwise anticompetitive merger on the basis of general, prospective industry reforms. As Respondents' health policy expert, Dr. Sage, admitted in deposition, while it is possible that reform initiatives may improve prices and quality of services offered throughout the healthcare industry, this will happen regardless of the Acquisition. PX4099 (Sage (Respondents' Expert), Dep.), at 224:16-225:4; *see also* PX2520 (Capps, Rebuttal Report) at ¶ 5. Healthcare reforms would do nothing to prevent the combined entity from using its increased bargaining leverage to raise prices to health plans. PX2520 (Capps, Rebuttal Report) at ¶¶ 5-6. At most, they could change the baseline above which OSF would increase prices post-Acquisition. PX2520 (Capps, Rebuttal Report) at ¶¶ 5-6 (explaining that reforms may reduce the rate at which healthcare prices grow absent the Acquisition, *e.g.*, from 5% per year to 2%, but this only means OSF would increase prices above the lower baseline achieved by reforms, not that reforms would prevent the Acquisition's anticompetitive effects).

The Acquisition is not necessary for OSF and RHS to participate in healthcare reform initiatives or to benefit from any quality or efficiency improvements such reforms may generate. RHS's CEO admitted under oath that "the proposed merger with OSF is not the only way RHS can address healthcare reform going forward." PX2511 (Kaatz (RHS), PI Hr'g Tr.) at 765:16-19; *see also* PX4099 (Sage (Respondents' Expert), Dep.), at 147:16-21. In fact, OSF and RHS

are already undertaking many of the types of activities contemplated by healthcare reform. *See* PX2515 (Capps, Expert Report) at ¶ 355 (describing pay-for-performance and member satisfaction bonus components in Respondents' health plan contracts; Respondents' efforts to independently implement electronic records systems; and OSF's selection as a Pioneer Accountable Care Organization); PX4099 (Sage (Respondents' Expert), Dep.), at 224:3-12. Moreover, Respondents do not expect reforms to prevent them from operating profitably and continuing to offer high-quality services absent the Acquisition. *See* PX0371-029-031; PX3682-004-005; PX2511 (Kaatz (RHS), PI Hr'g Tr.) at 722:2-15 (RHS has aggressively and successfully reduced its variable costs in 2009 and 2010 to position itself to respond independently to healthcare reforms.).

Healthcare reform initiatives focus primarily on vertical integration and coordination among different healthcare providers along the continuum of care – such as hospitals, physicians, rehabilitation facilities, and other healthcare providers – not horizontal consolidations between direct competitors like the Acquisition. *See* PX2515 (Capps, Expert Report) at ¶ 351. In fact, the Centers for Medicare and Medicaid ("CMS") and the federal antitrust agencies clearly recognize the benefits of competition among healthcare providers for both Medicare beneficiaries and commercial health plan enrollees. *See* PX1579-040 (Antitrust review of Accountable Care Organizations, or ACOs, "would maintain competition for the benefit of Medicare beneficiaries by reducing the potential for the creation of ACOs with market power . . . [and that] market power refers to the ability of an ACO to reduce the quality of care furnished to Medicare beneficiaries and/or to raise prices or reduce the quality for commercial health plans and enrollees."); PX1581-001 (The FTC and Department of Justice state that, "under certain conditions, ACOs could reduce competition and harm consumers through higher prices or lower

quality of care."); PX2515 (Capps, Expert Report) at ¶¶ 352-354; PX2520 (Capps, Rebuttal Report) at ¶¶ 26-28.

8. Respondents' Proffered Stipulation Will Not Prevent Consumer Harm from the Acquisition

Finally, Respondents proffered a toothless stipulation in the related federal court proceeding that does not lessen the competitive harm created by the Acquisition. Accordingly, this proposed stipulation does nothing to rebut the presumptive illegality of the Acquisition and the Court should ignore it. In fact, courts have rejected far more substantive stipulations than the one offered by Defendants and have even cited them as evidence that a merger is likely to harm competition. *Cardinal Health*, 12 F. Supp. 2d at 67 ("[T]he mere fact that such representations had to be made [in a stipulation] strongly supports the fears of impermissible monopolization."). Respondents proposed that, post-Acquisition: (1) OSF Northern Region would not explicitly require health plans to exclude Swedish from their provider networks as a contractual condition; and (2) OSF would not require health plans to contract with any of its hospitals other than SAMC and RMH as a condition of contracting with OSF Northern Region.

The Commission has squarely held that conduct-style remedies are an insufficient substitute for competition and thus are strongly disfavored and apply only in highly unusual circumstances.[12] As the Commission ruled in *ProMedica*, there are "usually greater long term costs associated with monitoring the efficacy of a conduct remedy than with imposing a structural solution[,]" thus, "a remedy is more likely to restore competition if the firms that engage in pre-merger competition are not under common ownership[.]" No. 9346 (Opinion of the Commission), at 57 (citing *Evanston*, 2007 WL 2286195, at *77). Indeed, here, the first part

[12] For example, in *Evanston*, the merger at issue had been consummated for several years and, according to the Commission, significant integration had occurred. 2007 WL 2286195, at **77-78. Here, the Acquisition has not been consummated and, even if the federal district court and the Seventh Circuit deny a preliminary injunction, consummation would not occur until the midst of the trial before this Court, at the earliest.

of the proposed stipulation does nothing to prevent OSF from raising prices post-Acquisition. The Acquisition would still reduce the number of hospital competitors in the Rockford area from three to two, eliminate direct and vigorous competition between SAMC and RMH, and thereby greatly increase the combined entity's bargaining leverage, allowing it to increase rates to health plans. The proposed stipulation does not even mention the rates OSF could or would charge health plans post-Acquisition.[13] Nor does it provide any meaningful limitation on how OSF Northern Region could use its increased bargaining leverage to extract higher prices. PX2511 (Kaatz (RHS), PI Hr'g Tr.) at 747:1-17; PX2510 (Schertz (OSF), PI Hr'g Tr.) at 629:13-25; PX2515 (Capps, Expert Report) at ¶ 363; PX2509 (Lobe (United), PI Hr'g Tr.) at 44:2-9; PX2509-067. Under the stipulation, OSF Northern Region could simply demand exorbitant rates from any health plan that sought to include Swedish in its network, allowing OSF to *de facto* exclude Swedish at will. PX2515 (Capps, Expert Report) at ¶¶ 363-364; PX2510 (Schertz (OSF), PI Hr'g Tr.) at 629:20-24 (SAMC's CEO admitted in sworn testimony that the stipulation would not prevent OSF from charging any rate it wanted to health plans that sought to add Swedish to their networks.).

The second prong of the proposed stipulation has no relevance to the competitive impact of the Acquisition whatsoever. PX2515 (Capps, Expert Report) at ¶ 365. None of the likely anticompetitive effects of the Acquisition derives from or hinges on OSF's ownership of hospitals in other markets. PX2515 (Capps, Expert Report) at ¶ 365. Thus, OSF's agreement to no longer engage in system-wide contracting simply has no impact on the competitive consequences of the Acquisition. PX2515 (Capps, Expert Report) at ¶ 365. For these reasons, this Court should reject Respondents' proposed stipulation.

[13] Of course, even if Respondents' stipulation contained a pricing provision it still could not fully replicate the benefits of competition.

VI. AN ORDER PROHIBITING THE ACQUISITION IS NECESSARY TO PROTECT THE BENEFITS OF COMPETITION

Once Complaint Counsel has established a violation of Section 7, "all doubts as to the remedy are to be resolved in its favor." *United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 334 (1961). In a consummated merger case, "[d]ivestiture is the usual and proper remedy where a violation of Section 7 has been found." *In re Polypore Int'l, Inc.*, No. 9327, 2010 FTC LEXIS 17, at *15 (F.T.C. Mar. 1, 2010). Here, the "principal purpose of relief is to restore competition to the state in which it existed prior to, and would have continued to exist but for, the illegal merger." *In re B.F. Goodrich Co.*, 110 F.T.C. 207, 345 (1988) (internal quotation omitted). "[I]n general, a remedy is more likely to restore competition if the firms that engage in pre-merger competition are not under common ownership. . . ." *ProMedica*, No. 9346 (Opinion of the Commission), at 57 (citing *Evanston*, 2007 WL 2286195 at *77).

In the Notice of Contemplated Relief, Complaint Counsel has specifically requested: (1) a prohibition against any transaction between OSF and RHS that combines their businesses in the relevant markets, except as may be approved by the Commission; (2) a requirement that, for a period of time, OSF and RHS provide prior notice to the Commission of acquisitions, mergers, consolidations, or any other combinations of their businesses in the relevant markets with any other company operating in the relevant markets; (3) a requirement to file periodic compliance reports with the Commission; and (4) any other relief appropriate to correct or remedy the anticompetitive effects of the transaction or to restore RHS as a viable, independent competitor in the relevant markets.[14] Rockford area residents have benefitted significantly from the

[14] Complaint Counsel has also requested that, if the federal district court denies a preliminary injunction and the Acquisition is consummated, this Court order the divestiture or reconstitution of all associated and necessary assets, in a manner that restores two or more distinct and separate, viable and independent businesses in the relevant markets, with the ability to offer such products and services as OSF and RHS were offering and planning to offer prior to the Acquisition.

competition between OSF and RHS and only a complete prohibition of the Acquisition will ensure that effective competition in the Rockford area for GAC services and PCP services is maintained in the future. This requested remedy is "reasonably calculated to eliminate the anti-competitive effects" of the Acquisition. *Chicago Bridge & Iron*, 534 F.3d at 442.

VII. CONCLUSION

For the foregoing reasons, which will be supported by evidence at trial, OSF's proposed Acquisition of RHS violates Section 7 of the Clayton Act. Therefore, we respectfully ask the Court to impose necessary and appropriate relief to prevent the substantial consumer harm that otherwise would result from the Acquisition.

Respectfully submitted,

s/ Matthew J. Reilly

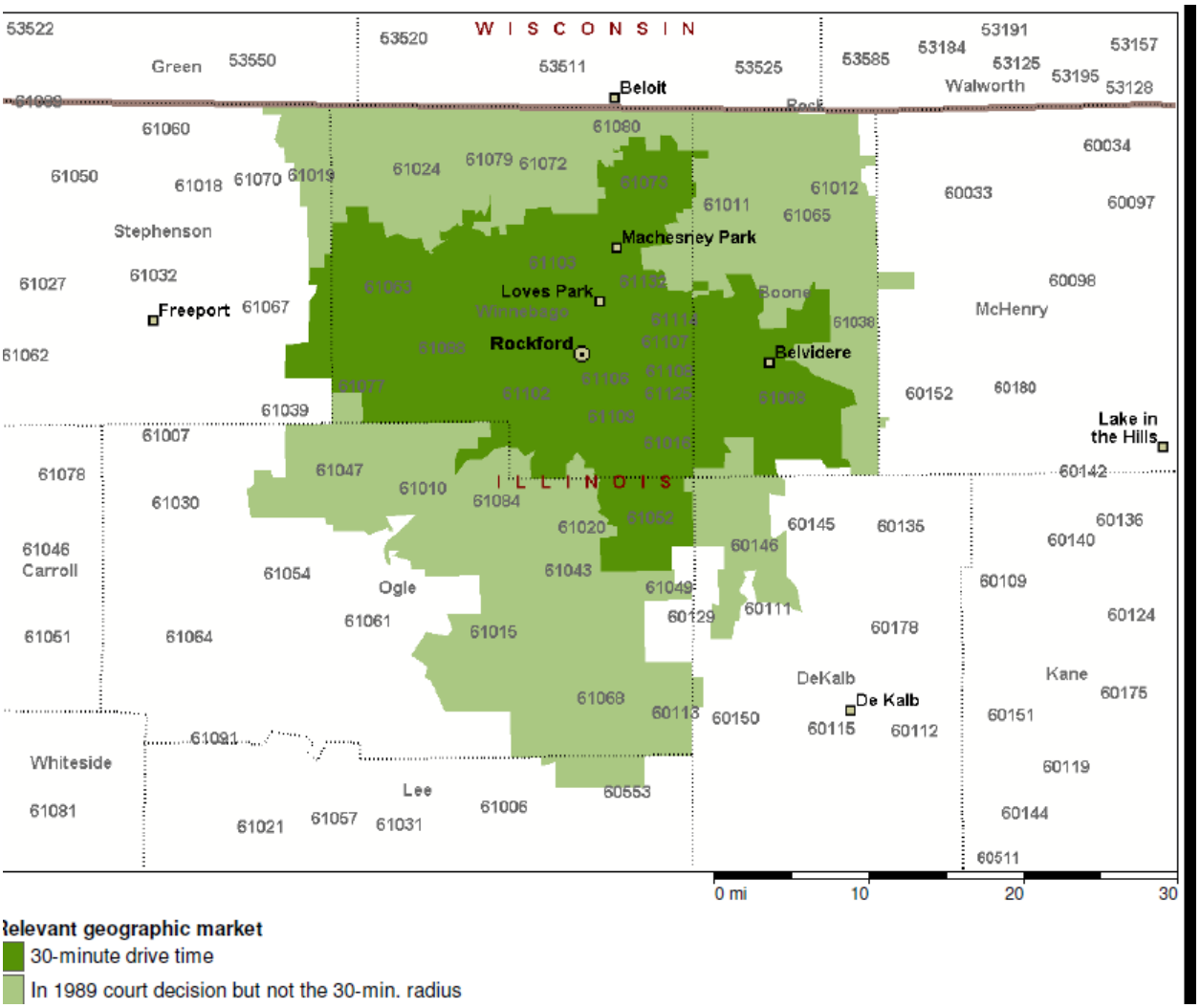
MATTHEW J. REILLY
JEFFREY H. PERRY
SARA Y. RAZI
DANIEL K. ZACH
KENNETH W. FIELD
DOUGLAS E. LITVACK
KATHERINE A. AMBROGI
JEREMY P. MORRISON
PAUL J. NOLAN
RICHARD H. CUNNINGHAM
JEANNE H. LIU
PETER C. HERRICK
KAJETAN M. ROZGA
SARAH K. SWAIN
KEVIN K. HAHM
STEPHANIE L. REYNOLDS
MATTHEW A. TABAS
ANDREA E. ZACH

Attorneys
Federal Trade Commission
Bureau of Competition
600 Pennsylvania Ave., N.W.
Washington, DC 20580
Telephone: (202) 326-2350
Facsimile (202) 326-2286
Email: mreilly@ftc.gov

Counsel Supporting the Complaint

Appendix A

Map Comparing the WOB Area with the 30-Minute Drive Time Area



Source: PX2515 (Capps, Expert Report) at Figure 20.

Note: In *United States v. Rockford Mem'l*, 717 F.Supp. 1251, 1277 (N.D. Ill. 1989), the court defined the geographic market to include Winnebago County, "essentially all" of Boone County, "the northeast portion of Ogle County" (Dr. Capps interpreted this to encompass zip codes 61052, 61049, 61020, 61068, 61084, 61010, 61015, 61047), and "small fractions of McHenry (zip code 61052), DeKalb (zip code 60146), and Stephenson (zip code 61019) counties."

CERTIFICATE OF SERVICE

I hereby certify that on April 4, 2012, I filed the foregoing document electronically using the FTC's E-Filing System, which will send notification of such filing to:

Donald S. Clark
Secretary
Federal Trade Commission
600 Pennsylvania Ave., NW, Rm. H-113
Washington, DC 20580

I also certify that I delivered via electronic mail a copy of the foregoing document to:

The Honorable D. Michael Chappell
Administrative Law Judge
Federal Trade Commission
600 Pennsylvania Ave., NW, Rm. H-110
Washington, DC 20580

I further certify that I delivered via electronic mail a copy of the foregoing document to:

Alan I. Greene
Hinshaw & Culbertson LLP
222 North LaSalle Street
Suite 300
Chicago, IL 60601
312-704-3536
agreene@hinshawlaw.com

Matthew J. O'Hara
222 North LaSalle Street
Suite 300
Chicago, IL 60601
312-704-3246
mohara@hinshawlaw.com

Kristin M. Kurczewski
222 North LaSalle Street
Suite 300
Chicago, IL 60601
312-704-3000
kkurczewski@hinshawlaw.com

Michael F. Iasparro
100 Park Avenue
P.O. Box 1389
Rockford, IL 61105
815-490-4945
miasparro@hinshawlaw.com

Rita Mahoney
222 North LaSalle Street
Suite 300
Chicago, IL 60601
312-704-3000
rmahoney@hinshawlaw.com

Paula Jordan
222 North LaSalle Street
Suite 300
Chicago, IL 60601
312-704-3000
pjordan@hinshawlaw.com

Counsel for OSF Healthcare System

David Marx, Jr.
McDermott Will & Emery
227 West Monroe Street
Chicago, IL 60606-5096
312-984-7668
dmarx@mwe.com

William P. Schuman
McDermott Will & Emery
227 W. Monroe Street
Chicago, IL 60606
312-372-2000
wschuman@mwe.com

Jeffrey W. Brennan
McDermott Will & Emery
600 13th Street, NW
Washington, DC 20005
202-756-8000
jbrennan@mwe.com

Carla A. R. Hine
McDermott Will & Emery
600 13th Street, NW
Washington, DC 20005
202-756-8000
chine@mwe.com

Nicole L. Castle
McDermott Will & Emery
600 13th Street, NW
Washington, DC 20005
202-756-8000
ncastle@mwe.com

Rachel V. Lewis
McDermott Will & Emery
600 13th Street, NW
Washington, DC 20005
202-756-8000
rlewis@mwe.com

Daniel G. Powers
McDermott Will & Emery
600 13th Street, NW
Washington, DC 20005
202-756-8000
dgpowers@mwe.com

James B. Camden
McDermott Will & Emery
600 13th Street, NW
Washington, DC 20005
202-756-8000
jcamden@mwe.com

Pamela Davis
McDermott Will & Emery
600 13th Street, NW
Washington, DC 20005
202-756-8000
pdavis@mwe.com

Counsel for Rockford Health System

CERTIFICATE FOR ELECTRONIC FILING

I certify that the electronic copy sent to the Secretary of the Commission is a true and correct copy of the paper original and that I possess a paper original of the signed document that is available for review by the parties and the adjudicator.

April 4, 2012

By: s/ Sarah Swain
Attorney

Attachment A - Filed *In Camera* & Redacted In Its Entirety

FTI00089308 - FTI00089311

Attachment B - Filed *In Camera* & Redacted In Its Entirety

Tab “C2. Business Case” of FTI00086556

Attachment C - Filed *In Camera* & Redacted In Its Entirety

FTI00090719 - FTI00090721