UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF IOWA
EASTERN DIVISION

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	Civil Action No. C94-1023
	)	
v.	)	Hon. Michael J. Melloy
	)	
MERCY HEALTH SERVICES and FINLEY TRI-STATES HEALTH GROUP, INC.,	)	
	)	
Defendants.	)	

The United States' Post-Trial Submission

Table of Contents

	Tab
Table of Conventions	1
Table of Authority Citation Conventions	2
Overview	3
Narrative Summary of the Case	4
Proposed Findings of Fact	5
A. Relevant Market	A
B. Existence of Market Power	B
C. Competitive Harm	C
D. Lack of External Brakes	D
E. Barriers to Entry	E
F. Lack of Efficiencies	F
G. Background on Mercy and Finley	G
H. Jurisdiction and Interstate Commerce	H
Proposed Conclusions of Law	
A. Evidentiary Standards	A
B. Definition of Relevant Market	B
C. Acquisition of Market Power	C
D. Anticompetitive Effect	D
E. The Efficiencies Defense	E
F. Jurisdiction and Interstate Commerce	F
G. The Appropriate Relief	G

Discussion of Witnesses 7

Discussion of Exhibits 8

Discussion of Defendants' Positions 9

Conclusion 10

Table of Conventions

T__:	Transcript Page(s)
E__:	Government's Exhibit(s)
ED___:	Defendants' Exhibit(s)
Name (date) ___:	Deposition Designation(s) (also E238-52A)[1]
Stip. ___:	Stipulation (Appendix A to Final Pretrial Order; also E14)
FOF___:	Proposed Finding(s) of Fact
COL___:	Proposed Conclusion(s) of Law

[1] The deponents are: Chesterman (Finley board member and proposed DRHS board member); Combes (Mercy vice president and CFO); Finnin (Finley board member and proposed DRHS board member); Fuller (Mercy board chairman and proposed DRHS board member); Grotnes (Mercy board member, proposed DRHS board member and SMHC vice president); Guetzko (Mercy vice president); Hendry (former Finley board member); Huewe (Mercy president and CEO); Maxwell (former Mercy COO); Moody (Finley board member and proposed DRHS board member); Rogols (Finley president and CEO); Schaller (Finley community relations director); Steele (Finley vice president and CFO); Tokheim (Mercy vice president); and Cremer (Medical Associates HMO executive director).

Table of Authority Citation Conventions

Baker Hughes	United States v. Baker Hughes, Inc., 908 F.2d 981 (D.C. Cir. 1990)
Brown Shoe	Brown Shoe Co. v. United States, 370 U.S. 294 (1962)
HCA	Hospital Corp. of Am. v. FTC, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987)
Philadelphia Nat'l Bank	United States v. Philadelphia Nat'l Bank, 374 U.S. 321 (1963)
Rockford	United States v. Rockford Mem. Hosp., 717 F. Supp. 1251 (N.D. Ill. 1989), aff'd, 898 F.2d 1278 (7th Cir.), cert. denied, 498 U.S. 920 (1990)
University Health	FTC v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991)

Overview

This submission has three main sections: (i) a narrative summary of what we believe the United States has proven as a matter of record; (ii) proposed findings of fact; and (iii) proposed conclusions of law. In addition, there are sections on witnesses, exhibits and defendants' positions. The narrative summary, with citations to the proposed findings and conclusions, gives an overview of what we believe the record shows and why the law supports a judgment in the Government's favor. It explains why this merger will result in the acquisition of market power in a properly defined market, the competitive harm that could and likely would flow therefrom, the lack of any external brakes to prevent the exercise of market power, and the lack of any defenses.

The proposed findings, through detailed reference to the record, set out each point we believe has been proven. In the main, the proposed findings are based on uncontradicted evidence or an admission of a defendant (albeit in many instances defendants attempted to retract or otherwise contradict their admissions); in all other instances, the proposed findings are based on what we believe represents the greater weight of the evidence or the more credible evidence.

The proposed conclusions, through reference to the appropriate authority, set out the applicable law as applied to this record. In all instances, the cited authority represents either settled law or the law of the highest court(s) to face the issue.

Next, there are sections on witnesses, exhibits and defendants' positions. The first gives an overview that goes to the weight of the testimonial evidence. The second highlights indisputable documentary evidence. And the third addresses the various contradictory and unrealistic positions taken by defendants both in arguments by counsel and testimony of their witnesses.

Narrative Summary of the Case

At base, this is a statutory case. The analysis turns on whether the United States has proven, or defendants have negated, that the consolidation of Mercy and Finley will result in the creation or enhancement of market power--the power to raise prices and lower quality. The motivation or intent of defendants' presently constituted boards of directors or officers is not relevant to this statutory analysis.

1. Overview. Both testifying economists agreed that a relevant geographic market consisting of Dubuque and its environs would be defined, and the creation of market power established, by a showing that DRHS profitably could raise prices. The Government presented four separate, independent proofs to support its proposed geographic market and the existence of market power in the creation of DRHS, including direct proof from several witnesses who testified and exhibits that explained that, after the merger, DRHS indeed was likely not only to possess market power, but also to exercise it:

First, we presented testimony from the two principal managed care payors in Dubuque (Heritage/Deere and Medical Associates HMO)--by far the most knowledgeable consumers in the Dubuque area--that the relevant geographic market is the Dubuque area. They explained that, if DRHS is created, they would not be able to shift a sufficient number of people either to the rural hospitals or the regional hospitals to make a price increase unprofitable. Instead, in their view, they expect managed care discounts to disappear (or at least be curtailed sharply), and there will be nothing they can do about it. This conclusion was supported by Drs. Runde and Schemmel, who identified a host of practical impediments to shifting patients to non-Dubuque hospitals.

Second, Dr. Noether took Dr. Harris' unlikely assumption (that DRHS would attempt only a 5% price increase, as opposed to eliminating the 15-30% discounts offered to manage care plans) and showed that, even under that assumption, the number of patients who possibly might shift to non-Dubuque hospitals is less than the 8% patient shift that Dr. Harris contends is necessary to make the price increase unprofitable. Indeed, as she explained, only 24% of DRHS' patients live "outside the core," and the total number of patients who possibly might shift at most is 6.5% of all patients. So, even if all 6.5% shifted for a 5% price increase (a most unlikely assumption), that would not be enough to make the price increase unprofitable.

Third, under the more realistic assumption--that, upon the creation of DRHS, prices would rise 15-30% through elimination or reduction of managed care discounts, the price increase would be even more likely to be profitable. Thus, it would take a 20-35% shift of all patients throughout the Dubuque area to make that price increase unprofitable, which no one at trial seriously suggested would occur. This point found dramatic support from Mr. Sesterhenn, who testified that, when Mercy raised prices to CyCare's employers by nearly 40%, no one shifted to a hospital outside of Dubuque (all shifting was between Mercy and Finley).

Fourth, even defendants conceded that there would be no impediment to DRHS' pricing at one level "within the core" while selectively contracting to prevent shifting "at the fringe." By thus price discriminating, DRHS could raise prices profitably to most if not all of the 76% within the relevant market, without raising prices, to the extent necessary to avoid shifting, to most of the remaining 24%.

These four proofs are buttressed by several practical indicia. For example, Mercy and Finley are distinctly aware of each other's activities and pricing, often making competitive

responses, but typically have little or no knowledge about the activities or pricing of the rural and regional hospitals, let alone engaging in competitive responses. Similarly, Mercy and Finley board members and others consider only each other's hospitals when thinking about market share and identify no other competitors in CON applications to the state authorities. And customers in the market, including managed care plans and employers, all include at least one of the two Dubuque hospitals in their networks.

Each of these proofs, by itself and without more, is sufficient. Thus, if any one of them is accepted, then the Government has proven its case and should prevail. We believe we have established all four.

2. Market Definition. The first inquiry in cases under section 7 (and section 1 in a merger context) is to define a proper relevant market--product and geographic. There was little genuine dispute as to product market. Geographic market was disputed vigorously.

a. Product market. Defendants' trial brief seemed to concede, and virtually every witness confirmed, that the product market consists of acute-care inpatient services. While there may have been some quibbling concerning whether a particular service or two (e.g., very complicated services such as open-heart surgery) were in that market, no dispute in that regard would appear to have any effect on the outcome of the case (i.e., Mercy and Finley compete on virtually all the services within this definition). In short, there is no question that the product market contains the broad range of overlapping acute-care inpatient services offered by both Mercy and Finley. [FOF A]

b. Geographic market. The Government's proposed geographic market of Dubuque County and a 15-mile radius into Wisconsin and Illinois was set out in economic terms by Dr.

Noether. Dr. Noether determined that this market, which is the most appropriate one, includes Mercy, Finley and Galena-Stauss as the only competitors (while explaining further that, even if the geographic market were twice this size [i.e., a 35-mile radius around Dubuque], it would include some additional rural hospitals as participants but none of the regional hospitals, the proposed merger still would lessen competition, and her conclusion that DRHS would have market power would not change). She drew support for that market definition from various sources, including: the testimony of buyers in that market; the testimony of physicians; statistics on physician privilege overlap; defendants' testimony and documents; patient origin and flow data; a likelihood-of-switching analysis; a cost-of-switching analysis; findings of geographic markets in other hospital cases, including University Health in which she testified; and other sources including hospital tours, interviews and pertinent economic literature. [FOF A]

Dr. Noether's market definition was confirmed and buttressed by the largest and most sophisticated buyer group in Dubuque--the managed care plans (Heritage/Deere and Medical Associates HMO). They testified that managed care plans could not switch people if DRHS was to reduce or eliminate their discounts. They drew on years of experience, including experiences where they have seen hospital mergers with beneficial effects, as well as hospital mergers that have led to higher prices. Hence, these are not people or entities that oppose hospital mergers for opposition sake--indeed they have supported hospital mergers in several other places. Most importantly, if their testimony is accepted, that by itself would establish the Government's proposed market (as well as constitute proof of market power). [FOF A-B; COL B]

These managed care plans made two essential points. First, should DRHS raise prices, they have no practical alternative hospital for switching patients: The rural hospitals not only

are inconvenient for most patients and physicians, but also do not offer the range or quality of services, because of limited facilities or staff, to perform the services offered by Mercy and Finley; and the regional centers are too far away for the bulk of inpatient services (especially services needing prompt admissions, including obstetrics). While the managed care payors noted that for large enough financial incentives some people likely will shift, they consistently said that, for the range of price increases relevant here, few if any would shift. Second, as to competition "at the fringe," they explained (as defendants' witnesses confirmed) that there is no impediment in such circumstances (e.g., where the Dean Clinic or other outreach clinics might compete for rural business) for DRHS to contract selectively with certain managed care plans, clinics or employers, and hence price discriminate. Thus, DRHS could maintain current or even lower prices to the relatively few rural people who might switch for a financial incentive, while raising prices to the majority of its customers "in the core," and thereby impose a general managed care (or broader) price increase without losing profitability. Moreover, once patients are captured by these clinics, they will be referred to the clinic's affiliated hospital regardless of relative hospital prices. [FOF C-D]

The expert and managed care testimony found confirmatory support in the Schemmel/Runde doctor testimony. These physicians painted in graphic terms the reasons neither the rurals nor the regionals were adequate substitutes: (i) while the rurals might provide fine care for the limited services they offer, they do not offer a sufficiently broad range of services, facilities or staff to compete effectively with DRHS; and (ii) the regionals are just too far away, particularly when considering that time and frequency of visits often are critical factors

in hospital admissions (e.g., for obstetrics as well as other conditions requiring a prompt hospital admission). [FOF A]

Defendants' admissions provide yet further support for the market proposed by the United States. For example: (i) a current Finley board member and the future DRHS board chairman looks only to Mercy and Finley when thinking of Finley's market share, and he does not view either the rural or regional hospitals as competitors; (ii) defendants' documents and witnesses acknowledged that they see the rurals as primary care facilities to cooperate with, and not as competitors, and that they see the regionals as close enough to provide sophisticated tertiary care but too far away to compete as secondary providers; (iii) defendants are acutely aware of each other's pricing and other activities and often adopt competitive responses, yet defendants have little awareness of non-Dubuque hospitals' pricing or other activities and do not respond competitively to them; (iv) defendants conceded that it would be infeasible for the hospitals to achieve consolidation-of-services efficiencies through a merger with any rural or regional hospital, which by the published writing of defendants' economist means that neither the rurals nor the regionals are in the same market as the Dubuque hospitals; and (v) defendants' so-called regional-competition expert conceded that, no matter how much regional competition grows, a core group of services (including routine obstetrics, emergency care and other conditions requiring prompt admissions (e.g., internal medicine admissions)) never will be the subject of regional competition. [FOF A]

In defining the geographic market, Dr. Noether specifically addressed whether it is even theoretically possible that enough people would switch to hospitals outside Dubuque to make a DRHS price increase unprofitable, and concluded that it is not. She explained that, even if

defendants' critical loss figure of 8% were taken as true (i.e., that an 8% patient shift would defeat a 5% price increase), the total number of possible patients who might switch was below that figure. Thus, she analyzed the 24% (rounded up from the actual number of 23.8%) of the Dubuque hospital patients residing outside her defined market, and showed that: (i) at most, as a practical matter, only 6.5% of all patients realistically might possibly shift (i.e., 100% less patients living inside the market (76.2%) less patients living outside the market but within 25 miles of Dubuque (10.6%) less others not likely to switch (6.6%) because they are members of Medical Associates HMO or because of their past admitting patterns (e.g., through emergency rooms or by primary care physicians, cardiologists or oncologists or for other reasons); and (ii) even as to that 6.5%, there is no way to know how many actually would shift (and, of course, even if they all did, it would not be enough to make the price increase unprofitable). [FOF A]

While Dr. Harris focused on an 8% critical loss figure based on a 5% price increase, it is important to keep in mind that: (i) Dr. Harris' critical loss figure would be 30% or more if the assumed price increase is 20% (as would be the case if the managed care discounts were eliminated); and (ii) his contribution margin was based on all commercial payors, and not solely upon managed care patients (who have lower contribution margins). In that event, to make a price increase unprofitable, the entire 24% from outside Dr. Noether's market, plus a significant number from inside her market, would have to shift. No evidence remotely supports such a mass exodus from the Dubuque market. [FOF A]

Moreover, Dr. Harris' proposed critical loss figure ignores a practical reality. If, as the managed care payors and several defense witnesses testified, DRHS can price discriminate (selectively contract with any group threatening to switch), then it could raise prices to the vast

majority of its customers (e.g, those in the "core") while meeting the competition for the few contested customers (e.g., those on the "fringe"), and thus raise prices profitably without losing any patients. This is true whether the selective contracting is done to a customer on the geographic fringe of the market or to a large customer with employees throughout the market. In short, the critical loss figure has no relevance if the hospitals can price discriminate and avoid significant losses of patients. In all events, the critical loss figure should not be computed for an average price increase to all commercial patients, but rather, it should be computed to reflect the economics of the specific group facing the price increase--in this case, one example is patients residing in the "core" (i.e., most of these patients would be victims of DRHS' exercise of market power while DRHS contracts selectively with the few, if any, who might shift). [FOF A-B]

Further quantitative proof of the Government's geographic market came from defendants' economist and the testimony of Mr. Sesterhenn. Dr. Harris testified that, if the residual demand elasticity (the percentage of people who would shift to a hospital outside Dubuque in response to a 1% price rise) faced by DRHS were lower than 1.6, then a narrow geographic market, like that proposed by the Government, would be correct. While Dr. Harris said that he "expects" DRHS would face a residual demand elasticity of 6.6, neither Dr. Harris nor anyone else contradicted Mr.Sesterhenn's testimony about CyCare's experiencing a one-third shift of patients from Finley to Mercy when Mercy lowered prices by about 28%. That testimony implies that Mercy's residual demand elasticity was approximately 1.2 (33÷28). Moreover, given that the residual demand elasticity for Mercy alone before the merger must be higher than the combined residual demand elasticity for Mercy and Finley will be after the merger (because Mercy's patients have the option of switching to Finley), DRHS can be expected to have an elasticity less

than 1.2. Further, Mr. Sesterhenn's testimony that, when Mercy eliminated the discount, effectively raising prices by nearly 40%, no attempts were made to shift CyCare's patients out of Dubuque. If the elasticity really were 6.6 as Dr. Harris supposed, Mercy should have lost most if not all of its CyCare patients. Based on this evidence, there can be no doubt that Dr. Harris' view of the market is incorrect. [FOF A][2]

Finally, common sense also teaches that the market cannot be the more than fourteen-county and sixteen-hospital (or even far larger) market, with round-trip drive times of five hours or more, suggested by defendants. Such a market exceeds even the ten-county market proposed by the defendants in the Rockford case, and rejected there as "ridiculous." It is no less so here. [COL B]

3. Existence of Market Power. With the market defined, the next question is whether the merger will create or enhance defendants' market power--the ability to raise prices. Looking at market concentration alone--where DRHS would have at least a 78% market share, and more realistically a market share approaching 100%--provides graphic evidence that the people of Dubuque will have no alternatives after the merger. These market share statistics vastly exceed the 30% market share found by the Supreme Court to show presumptive market power.

Confirming that conclusion, dispositive testimony also came from the managed care payors who said that there are no competitive alternatives in the market to which buyers practically can turn (again, because the rurals do not provide an adequate range of services and

[2] Dr. Harris' 6.6 estimate for DRHS' residual demand elasticity is an astounding number: It means that a 1% price increase would cause the hospitals to lose 6.6% of their patients, and that a 5% price increase would cause the hospitals to lose 33% of their patients. There is no record evidence to support Dr. Harris' estimate, which also defies the realities of this market and the testimony of the managed care plans and even defendants.

the regionals are too far away, and local Dubuque physicians will not admit patients to the rural hospitals and cannot admit patients to the regional hospitals). As a result, these payors explained, if DRHS raises prices (i.e., exercise market power), consumers would have no choice but to pay the higher prices. [FOF A-B; COL B-C]

Defendants attempted to counter this evidence principally with the argument that switching "on the fringe," although the number of people there is not large, is all that is needed to defeat a price increase. That argument was negated on the record: It is no different from defendants' geographic market arguments, and hence must fail for the same reasons. And, while defendants offered anecdotal hearsay testimony that people went to non-Dubuque hospitals in certain instances, no one so testifying could give any quantification or identify the reason for use of the other hospital (e.g., whether it was for a service not offered in Dubuque or for a condition better treated elsewhere upon a doctor's recommendation). [FOF B]

4. Competitive Harm. The evidence on competitive effects covered both the price increases and harm to quality of care that likely will result from the creation of DRHS, including especially the harm to 35,000 managed care plan enrollees (as testified to by the managed care plans themselves, and as reflected in defendants' documents and deposition testimony evidencing that a principal purpose of this merger is the reduction or elimination of the managed care plan discounts). With the stipulated fact of the growth of managed care, which is the leading force for cost containment in hospital markets today, this merger is particularly injurious for it threatens to stop managed care in its tracks in Dubuque. The merger also is likely to increase

prices and lessen quality for commercial payors in the long-run and to lessen quality for patients sponsored by the government payors. [FOF C][3]

5. Lack of External Brakes. While the mere possession of market power after the merger is all that need be shown to support a section 7 violation, if external market forces would prevent the exercise of market power, that could justify, in a proper case, a finding that a merger does not create or enhance market power. This is not such a case. [COL C]

The only supposed "brakes" on market power offered by defendants are DRHS' non-profit status, the community representation on its board, and alleged past procompetitive conduct. These are legally and factually unavailing. Indeed, none of them is an "external" or "market" brake at all--they are at best subjective matters of supposed personal and present intent (in essence a purported promise not to raise prices), involving issues the United States consistently has said should not have been tried at all.

a. Non-profit status. This defense never has shielded a hospital merger from antitrust liability. In this case, the irrelevancy of DRHS' non-profit status is highlighted by E1: Even Mercy does not see its non-profit status as making any difference. Nor could it in view of its "shareholder"--its out-of-state parent. Indeed, the only difference between Mercy's shareholder and the typical shareholder is that Mercy's shareholder gets to decide how much the "dividend"

[3] Proof of actual competitive harm is not necessary to a finding of market power. That is because the "wrong" addressed by section 7 is not the exercise of market power, i.e., not the actual raising of future prices that never can be proved (until after the merger), but rather the creation or enhancement of market power through a merger. Thus, if an entity acquires market power through a merger, it is illegal even if present management gives subjective assurances that it will not be used. [COL C]

will be each year. Finley board members saw Mercy the same way. This was a thin defense before the case began, and it evaporated at trial. [FOF D; COL E]

b. Community board. There is nothing about the proposed community board that would check a price rise. Whatever defendants' stated intentions, several points are dispositive: (i) they conceded they would raise prices if they felt it the right thing to do even if the community opposed a price increase; (ii) there can be no assurance as to future board representation and conduct; (iii) initially there are only three guaranteed community representatives on the 18-member board, with the remainder representing some health care provider or other interest; (iv) there is strong sentiment among board members against managed care plan discounts; and (v) in any event, the DRHS board will not have the final say on anything--that power resides with Mercy and Finley's parent corporations. This too was a thin defense before the case began, and it too evaporated at trial. [FOF D; COL E]

c. Past conduct. This issue was resolved in defendants' stipulating to our motion to strike the "past procompetitive conduct" or "benevolent monopolist" defense. [T1177-80]

6. Barriers to Entry. Although defendants made some efforts on this front, Mercy's president put any such contention to rest. She explained that any significant attempt at entry would run squarely into the CON statutes, DRHS would oppose any such attempt, and DRHS likely would be successful. Dr. Noether gave confirmatory testimony to the same effect. And, beyond CON obstacles, entry is difficult because it would require substantial time and capital to build or expand new facilities in Dubuque. [FOF E; COL E]

7. Lack of Efficiencies. Defendants did not come close to meeting any of the applicable tests or standards for an efficiencies defense, especially in view of the heavy burden on defendants to make out this defense. It should not be recognized here.

a. The clear and convincing standard. Whatever else might be said of the efficiencies proof, little about it was clear and nothing was convincing. The so-called efficiencies study, which changed over time and dramatically so just before trial, was riddled with defects. [FOF F; COL F][4]

b. Speculativeness. The problem here is not just that the efficiencies are projected for so far into the future that prediction is impossible (although that is the case for many of the alleged savings), but that there can be no assurance, much less the assurance required by University Health, that the claimed efficiencies are anything but speculative. The entire study offered by defendants' purported expert was based on what possibly could be achieved, while the people responsible for actually implementing the study were far less sanguine. Thus, as the future DRHS chairman candidly acknowledged, all the proposed consolidations were in the realm of speculation, leaving the stark conclusion that the claims fundamentally are rooted in the same kind of self-serving statements rejected in University Health. And the same was shown for the vast bulk of claimed best practice and capital avoidance savings. [FOF F; COL F]

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[4] We expect defendants to repeat their Baker Hughes burden argument that the clear and convincing standard should not apply to their efficiencies defense. Defendants have misanalyzed that case. Thus, rather than standing for the proposition that the clear-and-convincing standard cannot be imposed on defendants in a merger case as defendants suggest, the case stands simply for the proposition that, where the Government has the burden on its prima facie case, defendants'negating of particular elements of that case are under a preponderance standard. In sum, the Baker Hughes case does not relieve defendants of the clear-and-convincing standard on defenses (e.g., the efficiencies defense) where courts expressly have placed upon defendants that burden.

c. Necessity of a merger. Defendants' claims fail this prong in several ways. Most dramatically, there was no cogent explanation from defendants as to why a merger is necessary to achieve much of the claimed savings (particularly the purported savings from best practices). The rebuttal explained why it is not. [FOF F]

d. Passing on benefits. There is nothing defendants showed that would require them to pass on to consumers any benefits they might achieve, while at the same time there was credible testimony that savings very well might not be passed on in the absence of competition. And there is a strong force not to--the Michigan parent's pressure to transfer profits to Michigan. [FOF F]

e. Weighing benefits against harm. Defendants just punted on this--they say there is no competitive harm. In essence, they just are rearguing their expansive market. They do not even attempt to meet their burden of showing the economic quantification required by University Health. [FOF F; COL F]

In sum, we believe our case is very strong, and should prevail under any standard. When due regard is given to the actual burdens and standards applicable in section 7 cases, our case is overwhelming. [COL A]

Proposed Findings of Fact

A. Relevant Market.

1. The relevant product market is acute-care inpatient services. [T330-31 (Noether); E255]

2. The relevant products in this case are those acute-care inpatient services offered by both Mercy and Finley; the highly-sophisticated services offered by one and not the other will not be affected by the creation of DRHS, nor will long-term, psychiatric and substance abuse, and rehabilitation programs. [T332-33 (Noether)]

3. Highly sophisticated services (such as organ transplants and open-heart surgery), which are not implicated in this case, are viewed differently than the acute-care services offered by both Mercy and Finley, and patients are willing to travel further for such services to maximize the likelihood of successful treatment. [T333-34 (Noether), 2254 (Tracy) (people come from all over the state to the University of Iowa for tertiary and quaternary care)]

4. Inpatient services are sufficiently distinct from outpatient services as to be in a different product market. [T332-35 (Noether) (inpatient care is used only when patients cannot be treated in any other setting); Cremer 26, 164, Guetzko(4/7-8) 96, 98-99, Huewe 29-31 (managed care plans work with Mercy to ensure members are admitted on an inpatient basis only when medically necessary); Stips. 33-40]

5. The relevant geographic market is Dubuque County and an area approximately 15 miles around the City of Dubuque in Wisconsin and Illinois, although even if the market were extended to a 35-mile circle around Dubuque, it would make no difference (i.e., DRHS still would have market power). [T331, 336-37, 350-51 (Noether); E163 at 30 (Mercy's strategic plan concludes that "residents of Dubuque County do not seek care in other counties in significant numbers"), 255, 256; Schaller 35-36]

6. In defining the geographic market, the question is not whether patients could switch hospitals, but whether they would switch when faced with a price increase. [T404-05 (Noether)]

#. If DRHS could raise prices (reduce or eliminate discounts) to the managed care plans (while keeping prices level or even reducing them to other commercial payors), and the managed care plans could not switch sufficient patients to make that price increase unprofitable, that would be proof of the Government's proposed geographic market [T542-43 (Noether), 2573-80 (Harris)], which the Government proved was the case [T269-70, 274-75 (Thomson), 325-27 (Noether); Cremer 41-44, 161-63].

8. The only rural hospital arguably located within the relevant geographic market is Galena-Stauss, but neither it nor any of the other rural hospitals (all of which generally serve patients within their immediate locales for primary care needs) has the resources or breadth of services, facilities or staff to compete with DRHS or is sufficiently convenient for doctors from Dubuque to treat patients on an inpatient basis. [Stips. 122, 130-36; T343, 358-63, 365 (Noether), 724-26, 730-41, 748, 761-65 (Schemmel), 800-03, 807-11 (Runde); E255, 256, 260, 261]

9. Mercy and Finley see the rural hospitals more as sources for referrals to cooperate with, rather than as competitors. [T33 (Huewe), 1973-75 (Tokheim), 2147 (Tracy); Moody 136-37; E163 at 31-32]

10. When comparing the rurals to the Dubuque hospitals on the factors considered in choosing a hospital (e.g., composition of medical staff (range of specialists); range of services offered; proximity to home or work; quality; and price [T320-23 (Noether); E253]), the rurals are not realistic alternatives to Mercy and Finley. [T354-58 (Noether); E260]

11. Mercy and Finley are the closest and most convenient hospitals for people in the Dubuque area, and that convenience is important to people in selecting a hospital for inpatient acute care. [Stips. 114-17, 123; T1782-83 (Sesterhenn), 2289-90 (Tracy); Tokheim(5/10) 129-30, Schaller 155, Rogols (4/6) 111-12, 124-25]

12. While there is a high overlap in physician admitting privileges between Mercy and Finley, there virtually is no overlap between Dubuque physicians and other hospitals, and it is highly unlikely that would change with the creation of DRHS. [T339-43 (Noether); E258; Tokheim(5/10) 76]

13. The lack of physician overlap between Dubuque and non-Dubuque hospitals and physicians' reluctance to travel make it likely that patients would have to switch doctors to use a non-Dubuque hospital. [T339-44, 369-70 (Noether), 732-35, 758, 761, 770-71 (Schemmel), 803, 815-16 (Runde), 268-70 (Thomson); Cremer 44; E258, 263]

14. When a hospital is facing switching of patients to a nearby hospital, a 2-3% switch or even just the threat of a switch may be enough to deter a price increase, but that would not be the case with switching to far away hospitals. [T695-96 (Thomson)]

15. It would not be practical for most patients to switch to the rural hospitals if DRHS raised prices (because of limitations on the breadth of services, facilities and staff offered). [Cremer 41-43; T269 (Thomson), 352-65, 542 (Noether), 724-26, 730-41, 762-65 (Schemmel), 802-03, 807-11 (Runde); E260-61]

16. It would not be practical for most patients (and for virtually all patients for services requiring prompt admissions) to switch to the regional hospitals if DRHS raised prices (because of distance and time). [Cremer 44; T270 (Thomson), 366-76 (Noether); E263]

17. Patients electing to switch from a Dubuque hospital to a regional hospital must incur additional costs and efforts, including: travel related costs (for themselves, family and friends); lost time from work; and the need to find a new doctor. [T367-70 (Noether), 1783-84 (Sesterhenn); Cremer 44; Fuller(9/12) 72-75; E263]

18. Even if a patient would wish to switch from a Dubuque hospital to a regional hospital, such a switch would be even more difficult, if not impossible, if the admission were an emergency admission or for a condition that required an urgent admission to a hospital. [T370-71 (Noether), 801-02, 804-05, 817 (Runde), 2070-73 (Lengeling)]

19. A managed care plan that contracts with one or more of the rural hospitals and one or more of the regional hospitals, instead of with a Dubuque hospital, would not be marketable to purchasers of health care from the Dubuque area. [T338-39 (Noether); Cremer 47]

20. The inadequacy of the rural hospitals and the inconvenience of the regional hospitals make the kind of financial incentives proposed by defendants insufficient to cause DRHS consumers to switch to those hospitals to avoid a price increase by DRHS. [Cremer 161-63; T274-75 (Thomson) (characterizing as "pretty bizarre" the kind of incentives defendants suggested for shifting patients)]

21. The loyalty patients have to their doctors, together with patients' tendency to follow their doctors' recommendations as to hospitalization, increase the difficulty of switching patients. [T176 (Huewe), 273 (Thomson), 339-40 (Noether), 798 (Runde); Tokheim(8/17) 48-50, (5/10) 75-76]

22. A 5-10% percent price increase would cause an employer to take a "wait-and-see" attitude as opposed to trying to shift patients; indeed, even a 38% price increase might not cause an

employer to try to shift patients. [T1792-801, 1809-12 (Sesterhenn); Fuller(9/12) 93, 113-14 ("I don't know if five percent [above competitive prices] would bother me that much")]

23. A managed care plan that takes patients and their families out of the local community for significant health problems would not be well received. [T694-95 (Thomson); Cremer 47; ED7 at 3760]

24. The total number of patients now using Mercy or Finley who possibly might switch is 6.5% of all patients (i.e., 100% less patients living inside the market (76.2%) less patients living outside the market but within 25 miles of Dubuque (10.6%) less others not likely to switch because they are members of Medical Associates HMO or because of their past admitting patterns [through emergency rooms or by primary care physicians, cardiologists or oncologists] or otherwise (6.6%)).

25. The total number of patients who possibly might switch (6.5%) is below even the lowest "critical loss figure" (8%) calculated by Dr. Harris to make a 5% price increase by DRHS unprofitable. [T551-53 (Noether), 2418 (Harris); ED433]

26. The total number of potential candidates for switching (6.5%) is far below the more realistic "critical loss figure" (20-33%) calculated by Dr. Harris to make a 15-30% price increase (i.e., the price increase that would be the case with the reduction or elimination of managed care plan discounts) by DRHS unprofitable. [T552-53 (Noether) (20% price increase to managed care would be profitable for DRHS unless 30% of the patients shifted); ED433]

27. The "critical loss figure" would be even higher for managed care payors because of their lower contribution margins. [T2418-22 (Harris) (assuming a 5% price rise: 8% is the critical loss figure for commercial payors; 10% is the critical loss for managed care payors; ED433]

28. While defendants elicited testimony (usually anecdotal) to the effect that people from Dubuque travelled to regional medical centers, defendants offered no quantification of the number of such people that were doing so other than for services, procedures or conditions where it was felt that the regional medical center was medically the preferable place (e.g., because of quality or specialization)--while, at the same time, there was knowledgeable testimony that that was precisely the case; likewise, as to rural hospitals, defendants offered no quantification of people choosing those hospitals over Dubuque hospitals. [T42-45 (Huewe), 813-15 (Runde), 1320-22 (Moody), 766-70 (Schemmel), 1870-71, 1900-01 (Steele), 1449-50 (Guetzko), 928-29, 931 (Rogols), 1781-82 (Sesterhenn), 2257, 2259, 2319-20, 2330 (Tracy); Cremer 46-47, Fuller(9/12) 137-38]

29. Comparing hospitals through a simple comparison of DRG overlap can be quite misleading because DRG classifications do not account for the type of treatment within a DRG code or for the severity of condition or other factors--as a result of which, two hospitals can have a high DRG overlap but not be practical alternatives of choice for consumers. [T43-44 (Huewe), 359-61 (Noether), 2438 (Harris) (all admissions under a DRG are not the same), 1707-09, 1850-51 (Steele) (procedures under DRG 209 range from hip replacements to knee replacements to knee revisions; hospital stays under DRG 373 can range from 1-6 days), 1428 (Guetzko); ED484 (DRG overlap comparison erroneously indicates that the Dubuque hospitals treat more severely ill patients than does the University of Iowa)]

30. Comparing the services offered by Mercy and Finley with those offered by the rural hospitals demonstrates that the DRG data overstates the actual overlap, because: (i) if the overlap is confined to DRG's where both hospitals had three or more admissions (to eliminate

data recording errors and "fluke" admissions), the stated overlap decreases dramatically [T358-60 (Noether); E260]; and (ii) when one also looks at average length-of-stay data, it shows that even within the narrow range of overlapping DRGs, the rurals are treating the simpler cases whereas the more complicated cases are going to Dubuque [T363-64 (Noether); E261].

31. Managed care plans prefer hospitals with a broad range of services that are conveniently located, and that have on their staffs the physicians used by their enrollees. [T320-23 (Noether); Rogols(4/6) 111-12, 122]

32. None of the regional medical centers are within the relevant market because they are too far away for a vast array of services (e.g., obstetrics and other conditions needing prompt admissions) involved in this case, and in the main are used by Dubuque physicians as places to refer patients for procedures not available in Dubuque or second opinions or because the patient's condition is such that a higher level of medical or surgical care is in order. [Stips. 53-63; T2329 (Tracy) (regional competition is "not going to cover primary care, office visits, it's not likely to cover obstetrics"), 366, 370-72 (Noether), 766-70 (Schemmel), 813-17 (Runde), 2080-85 (Lengeling); Huewe 62-64; E163 at 39 (Mercy's strategic plan concludes that "University of Iowa Hospitals and Clinics is located close enough to provide convenient tertiary care and yet distant enough from Dubuque that it does not threaten Mercy as a secondary regional provider"), 262]

33. It would not be feasible for a Dubuque hospital to achieve savings through consolidation of services by merging with one or more of the surrounding rural or regional hospitals [T33-34, 157-58 (Huewe)], so, according to the published writings of defendants' economist, they are not in the same market as Mercy and Finley [T2584-85 (Harris); E58 at 3].

34. People in the Dubuque core are not realistic candidates for switching to non-Dubuque hospitals. [T346-50, 367-72 (Noether), 2210-12, 2221, 2267 (Tracy) (people living within 20 miles of Dubuque are likely to stay in Dubuque for hospitalization); Moody 132-33]

35. DRHS could raise prices to patients within the Dubuque core without fear of patients shifting at the fringe (i.e., from outside the core) because it could contract selectively with many of those fringe patients or their managed care plans or employers (i.e., price discriminate) to avoid them shifting. [T1983-85 (Tokheim) (price discrimination is a common practice in the hospital industry), 119 (Huewe) (DRHS would negotiate individual contracts with employers), 884-86, 1039-42 (Rogols) (Finley can give, and is considering giving, a discount to buyers at the fringe (i.e., HMO Wisconsin and Dean Care in Southwestern Wisconsin) to shift consumers back to Dubuque without giving the same discount to other buyers), 2306-09 (Tracy) ("there could be two different pricing strategies or price arrangements" for consumers at the fringe); Cremer 168-70 (Mercy has done selective contracting)].

36. If the hospitals could price discriminate against selected people in and around the Dubuque area, so those people on the fringe would not be affected by a price increase to people in the core who do not have any practical alternatives, then the Dubuque area would be a geographic market [T542-43 (Noether), 2592-94 (Harris)], which it is.

37. Clinic outreach programs in areas at the edge of DRHS' service area will not check DRHS' pricing, because: (i) these clinics will send patients to their associated hospitals regardless of a price increase [T2234-36, 2243-47, 2318-19 (Tracy), 2004 (Tokheim)]; and (ii) in any event, DRHS could employ a price discrimination strategy [T1983-85 (Tokheim), 119 (Huewe), 884-86, 1039-42 (Rogols), 2306-09 (Tracy); Cremer 168-70].

38. The future chairman of the DRHS board does not think of any regional hospital's market share when thinking of Mercy or Finley's market share. [T1216-18 (Moody)]

39. Finley's competitive advertising is directed "to the community," by which Finley means Dubuque and a 15-mile circle around Dubuque. [Finnin 15-16]

40. Patient origin data can be one useful piece in determining the geographic market. [T351-52 (Noether); E257] Here, the inflow/outflow analysis shows that 88% of patients in the market are using the hospitals in the market (Mercy, Finley and Galena-Stauss), which means that there is only a 12% "outflow" of patients from the market; moreover, 76% of Mercy, Finley and Galena-Stauss' patients come from within the market. [T344-51 (Noether); E259] This supports the conclusion that Dr. Noether's proposed market is reasonable and appropriate. [T344-51 (Noether); E259]

41. The patient inflow/outflow data confirm that there is substantial inflow from rural areas into Dubuque, but very little outflow, and the outflow to the regionals is for tertiary care not offered in Dubuque or for procedures or conditions where the medical recommendation is to obtain the service at a regional center of excellence. [T270, 693 (Thomson), 344-48 (Noether), 813-15 (Runde); Cremer 23, 45-47; E259]

42. If DRHS' residual demand elasticity (which gives the percentage of people who would leave Dubuque hospitals if DRHS were to raise prices 1% [T2595 (Harris)]) was less than 1.6, this would support the Government's market [T2595-96 (Harris)], which in fact appears to be the case [T2605-08 (Harris) (CyCare experience implies a residual demand elasticity for Mercy alone around 1.2)] (in fact, the residual demand elasticity for Mercy and Finley combined must

be less than for either of the hospitals alone because of the elimination of the possibility of shifting between Mercy and Finley).

B. Existence of Market Power.

1. The methodology used by the Government's economist to assess market power in this case [T327-30 (Noether); E254-55], was a proper methodology, as even defendants' economist acknowledged [T2375 (Harris)].

2. Managed care plan testimony about the defendants' ability to eliminate discounts after the merger (i.e., to raise prices) demonstrates that the merger will create or enhance market power. [T259, 261-62, 269-70, 274-75 (Thomson); Cremer 40-44]

3. If DRHS could raise prices (reduce or eliminate discounts) to the managed care plans (even while maintaining the prices to other commercial payors or even lowering them), and the managed care plans could not switch sufficient patients to make that price increase unprofitable, that alone would be proof of market power [T542-43 (Noether), 2573-80 (Harris)], which the Government proved was the case [T325-27 (Noether), 269-70, 274-75 (Thomson); Cremer 41-44, 161-63].

4. DRHS would have at least a 78% market share (i.e., if all the hospitals within 35 miles of Dubuque were included), and more realistically a virtual 100% market share, in the relevant geographic market. [T352-53, 377-79 (Noether); E255, 264]

5. Even if DRHS somehow were constrained from raising prices across-the-board (which is unlikely because of the extremely limited possibilities for patient shifting), it still could raise prices to consumers within the market who have no practical alternatives, while selectively contracting at lower prices with employers and managed care plans representing consumers at the fringe. [T884-86, 1039-42 (Rogols), 2306-09 (Tracy)] This also would prove that DRHS has the ability to exercise market power. [T542-43 (Noether), 2592-94 (Harris)]

6. The Finley board (as reflected in its minutes) expressed concern about the need to "convinc[e] the business community that [DRHS] will not be a quasi-monopoly." [E78]

7. It is difficult to switch patients in any circumstance even where switching doctors is not involved, as confirmed by defendants' testimony about the difficulty of switching between Mercy and Finley. [T2381-82, 2668 (Harris), 257-58 (Thomson)] However difficult switching might be within a market, switching patients to hospitals outside Dubuque or outside a market is even more difficult, and there are no close substitutes for Mercy and Finley patients to turn to outside Dubuque. [T326, 543-44, 546-51 (Noether), 270-74, 691, 695-96 (Thomson); Cremer 41-44, 47]

C. Competitive Harm.[5]

1. Mercy and Finley compete on price, quality and otherwise. [Cremer 32, 38-39 (ob services); T27, 29 (Huewe) (after Finley remodeled its obstetrics unit, Mercy updated its obstetrics rooms), 257 (Thomson) (Mercy and Finley compete for managed care business), 332, 340-41, 381-82 (Noether) (giving various examples of price and quality competition; also, high physician overlap shows that these two hospitals are each other's closest substitutes), 927-28, 958-62 (Rogols) (highly competitive on obstetrics; each other's most significant competitors for most services), 1991-92, 2014-16 (Tokheim) (discussing price and amenities competition), 1446-48, 1451 (Guetzko) (price competition for Beef America's business; Finley is Mercy's most significant competitor), 1859-62, 1873-77, 1929 (Steele) (discounts given by Finley to avoid switching to Mercy; Wal-Mart approached only Mercy and Finley for exclusive managed care contract), 1782-83 (Sesterhenn), 2379 (Harris), 2227, 2328 (Tracy); Finnin 17, 19-21, 181-82 ("Mercy is the biggest competition Finley has"), Schaller 168-70 (giving away baby seats was a competitive response, which will stop upon the creation of DRHS to save $40,000 per year), Fuller(9/12) 66-67 (Mercy competed with Finley for Blue Cross Alliance Select by matching Finley's discount), Guetzko (4/7-8) 337-38, Huewe 36, Tokheim(5/10) 146-49, 171-73; E140 at -84; Stip. 110 (Finley has tried to attract customers from Mercy)]

2. The creation of DRHS will end the competition between Mercy and Finley on price, quality and otherwise. [Stip. 29; T1240-41 (Moody); E42]

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[5] In referencing hospital price increases, it should be kept in mind that a 5% acute inpatient care hospital price increase translates into less than a 2% premium increase. [T540-41 (Noether)] The price effect might be diluted even more when a patient's plan covers people living in more than one market, e.g., for a person living in Lancaster insured by a state-wide Wisconsin health plan. [T553-55 (Noether)] This implies that patients will be very insensitive to hospitals' price changes and makes it easier for hospitals profitably to raise prices.

3. The competition between Mercy and Finley has produced lower prices and higher quality and enhanced efficiency. [Cremer 33-34; T381-83 (Noether); Finnin 40]

4. People in the Dubuque community have come to enjoy the choice they have had by virtue of there being two hospitals. [T168, 171-73, 177 (Huewe), 2086 (Lengeling); Fuller(9/12) 54-55, 60-61, Fuller(8/19) 125 ("we perceive people enjoy this choice"), Huewe 76; E4]

5. Managed care plans are "the most potent force of competition in terms of price competition" for hospital services. [T319 (Noether)]

6. Managed care plans, which represent the largest block of commercial payors, currently obtain discounts off full charges in the range of 20-33% for their approximately 35,000 enrollees, which translates into in excess of $3 million of consumer savings per year. [Cremer 28-31, 39-41; T72, 74, 124-25 (Huewe), 1349, 1366 (Guetzko), 1859, 1897 (Steele); E89, 90, 93, 106]

7. Managed care plans obtain savings through utilization review programs, which reduce health care costs by ensuring that appropriate health care services are provided in the most cost effective manner; utilization review programs are most effective when managed care plans are able to contract with hospitals for participation in the review programs, and other health care purchasers such as indemnity insurers or employers often lack the expertise or contracts necessary to develop and enforce such programs. [T238-42 (Thomson); Cremer 16-21]

8. Managed care enrollment is growing and, absent the creation of DRHS, can be expected to grow in the future in Dubuque. [Stips. 102-05 (managed care's percentage of commercial patients covered and revenues to the Dubuque hospitals are expected to grow); T319-20 (Noether) (although it started later than elsewhere, managed care is growing rapidly in Iowa); Cremer 21, Rogols(4/6-7) 206-07]

9. The people responsible for the Heritage/Deere and Medical Associates HMO managed care plans are knowledgeable on hospital issues. [T136 (Huewe); E15]

10. Medical Associates HMO has been able to obtain increased benefits for its enrollees by obtaining a favorable contract from one Dubuque hospital (e.g., ob services from Finley) that then are matched by the other hospital. [Cremer 38-39]

11. Defendants view managed care plans as not paying their "fair share"--with the result in defendants' view being that there is "cost shifting" to customers paying full charges. [T69 (Huewe), 2313 (Tracy) ("hospitals are concerned about managed care for the obvious reason that they're reimbursed less by managed care"); Chesterman 133-34; E1]

12. Defendants give managed care plans discounts, not because they want to, but because of the volume of business represented by managed care plans and their desire not to have that business go to the other Dubuque hospital. [T164 (Huewe), 253-54 (Thomson), 1445-46 (Guetzko), 1929 (Steele); Finnin 50 (discounts are given only if needed to meet competition), Guetzko(4/7-8) 167, 180 ("I would like all our payors to pay charges"), Cremer 30-32, Fuller(9/12) 69; E1, 11, 77]

13. In Ottumwa, before the merger of the only two hospitals, Heritage/Deere had "a very competitive, one of our lowest DRG base rate contracts," while, after the merger, "prices went up 20 percent" and "[w]e no longer have a contract"; and "[l]ikewise in Burlington," after the merger, "we have been unable to secure a contract with them, because again they feel no need to contract with us." [T259-62 (Thomson) (explaining that, despite this substantial price increase, Heritage/Deere has been unable to shift a significant number of patients to distant hospitals for services offered by the local hospital)]

14. The creation of DRHS, as has happened elsewhere (in Ottumwa and Burlington), likely will result in a reduction or elimination of the 20-33% discounts managed care plans have been able to negotiate in the current competitive market, which would raise prices by more than $3 million per year and represent even higher losses in future years in view of the conceded anticipated growth of managed care plans. [T259-61 (Thomson) ("operating as one hospital in regard to managed care, [DRHS] can raise [its] prices to whatever [it] want[s] to") , 325-27, 383-84 (Noether); Cremer 28-31, 39-41); E122; Stips. 102-05 (managed care plans are expected to grow in Dubuque)]

15. At least some people have stated (including Finley board members at board meetings), and a strong inference can be made from defendants' documents (including board minutes), that a purpose in creating DRHS is to stem managed care plan discounts. [E35, 77 (setting a strategy to deal with managed care because "Finley must protect its commercial payer mix base" while at the same time not "encourag[ing] other charge based payors to seek discounts"), 166 (identifying managed care contracts for special treatment by the DRHS board); T164 (Huewe) (Mercy would prefer not to give managed care plan discounts), 2313 (Tracy) ("anybody" would know that hospitals "are concerned about managed care for the obvious reason that they're reimbursed less by managed care"); Chesterman 132-34 (the Finley board discussed elimination of managed care discounts; giving discounts to managed care means that "someone else is probably making up the difference"); E157 at -74]

16. The creation of DRHS also could result in higher prices and lower quality to the other commercial payors. [Cremer 173 ("without competitive pressures," while public pressure might

hold down prices at first, "I would fear that it would start to trend back up again"); T325-27, 383-84 (Noether)]

17. The creation of DRHS likely will result in reduced quality of care. [T326-27, 383-84 (Noether), 817-18 (Runde) (expressing concern about "one entity being able to dictate clinical practice, location, and quality items with regard to clinical practice")]

18. For any services consolidated at one facility or the other, the creation of DRHS will eliminate the choice of hospital services that the people of the Dubuque community have come to enjoy. [Stip. 29; T121 (Huewe); Fuller(8/19) 125]

19. The creation of DRHS, particularly if managed care is curtailed or eliminated, could result in a reduction of cost efficiency. [T382-83 (Noether); Cremer 40 ("without the competition, there may be less emphasis on looking for ways to do things more efficiently"); Stip. 26 ("one of the effects of managed care payers not paying Mercy's full charges is to put incentives on Mercy to be more cost effective")]

20. The creation of DRHS could result in managed care being eliminated in Dubuque. [T275-77 (Thomson) (Heritage/Deere might "have to pull our resources and put them elsewhere"), 561 (Noether) (managed care does not work in the absence of competitive hospitals because there will be "no credible threat" to "shift that business")]

21. The experience in Ottumwa teaches that a merger that creates a one-hospital-town, without sufficiently close alternative hospitals, will lead to price increases (there about 20%), and that people will not travel 80 miles for services available in that town (although they will travel for services not locally available). [T259-62 (Thomson); E122]

D. Lack of External Brakes.

1. The non-profit status of DRHS will not provide an external brake on DRHS' exercise of market power because there is no proof that non-profit hospitals act differently than for-profit hospitals [T384 (Noether)], while there is proof that they do not act differently [E1 (the difference is one of "tax ... classification"--both "need to make a profit")].

2. The non-profit status of DRHS will not provide an external brake on DRHS' exercise of market power because Mercy's parent stands in the shoes of a shareholder in that it has an entitlement to dividends (in an amount set by the parent) and owns Mercy. [T384-85, 465 (Noether); Fuller (8/19) 40 (Mercy's payments to SMHC are comparable to payments to a holding company in the banking industry)]

3. The non-profit status of DRHS will not provide an external brake on DRHS' exercise of market power because DRHS will have to continue to generate profits to stay in business, make capital improvements, purchase equipment, and transfer money to Mercy's corporate parent (in a percentage amount determined by the parent and to be used in accordance with the parent's discretion). [T46-48, 57 (Huewe), 384-85, 465 (Noether); Chesterman 42-43 (Finley must make a profit to continue expansion, buy equipment and pay reasonable salaries); E1 (non-profit hospitals must make a profit--the term "non-profit" is a "tax exempt status classification")]

4. Mercy and Finley historically have generated greater profits than needed to cover their costs, without refunding excess profits to consumers. [T1879 (Steele); Chesterman 51-52; Finnin 163 (Finley chose not to lower prices for fear that it would create the impression in the community that its prices had been too high)]

5. A large segment, if not most, of the Finley board does not view Mercy as a true, local non-profit entity dedicated to the community. [E85; Chesterman 70-71, 77-78, Hendry 56-59]

6. The money transfers imposed on Mercy by its Michigan parent (consistently 25-30% of profits for the past few years) put added pressure on Mercy to generate profits (raise prices) because if Mercy could keep the money it transfers to its Michigan parent, it could use that money for capital improvements, equipment purchases or reducing prices or giving additional discounts. [T81 (Huewe); Fuller(8/19) 46-48 (payments to SMHC are lumped into Mercy's budget and treated as an expense in determining price increases for following year; absent money transfers to SMHC, "you would clearly have those dollars either to spend on other capital expenditures, to better fund your working capital needs or to simply pass on to the payers as a reduction of price"), Chesterman 80]

7. The so-called community-based board of DRHS will not provide an external brake on DRHS because the partners (Mercy and Finley's corporate parents), not the board, have the ultimate power over DRHS' operations. [T385-86, 468-71 (Noether); E166 (partnership agreement), 168 ("The presence of community representatives on the governance board does not reflect a relinquishment of control over the operations of the hospitals"); Chesterman 85-88 (would prefer that DRHS, rather than the partners, had the ultimate power to insure that DRHS would be "more community minded"), Fuller(8/19) 91, 93 (decisions on consolidation of services "would obviously come through in the form of a strategic plan and associated budget," with the partners having ultimate authority), Grotnes 239-40 (the partners can reject a managed care contract with DRHS on the basis of price)]

8. The so-called community-based board of DRHS cannot be relied on to provide an external brake on DRHS because there can be no assurance of its composition or intention in the future or any other assurance beyond the purported present commitment of the future board members.

[E166; T1246-47 (Moody) (no other assurance can be given); Hendry 67-74 (the DRHS is not a community-based board--rather, it is composed of "special interests")]

9. There is no evidence to suggest that a community-based board is better at controlling costs than other kinds of boards. [Finnin 142]

10. The purported community pressure against raising prices cannot be relied on to provide an external brake on DRHS because defendants concede that, in the final analysis, they have to abide by their duty of loyalty to DRHS, even in the face of community pressure. [T83, 87-89, 99-100 (Huewe), 1244-45, 1286-87 (Moody); Fuller(8/19) 39 (DRHS board members will have duty to look out for the financial viability of the partnership)]

11. The purported individual interest of any board member against raising prices must yield to that board member's duty of loyalty to and looking out for the financial viability of DRHS. [T1244-45 (Moody); Fuller(8/19) 38-39, Hendry 11; E172 at 9 (maintaining Mercy's financial viability is a board member's "number one priority")]

12. The purported community pressure to keep prices down cannot be relied on to provide an external brake on DRHS because there can be no assurance that the community would be informed adequately with the information they would need. [T1310-19 (Moody)]

13. The creation of outreach clinics and other competitive efforts outside Dubuque will not deter a price increase by DRHS because: (i) those clinics will send patients back to their affiliated hospitals regardless of relative prices [T2234-36, 2243-47, 2318-19 (Tracy) (a 5-10% price increase by DRHS will not cause Medical Associates' physicians to refer patients from the rural outreach clinics to any non-Dubuque regional hospital), 2004 (Tokheim)]; and (ii) DRHS' can price discriminate, i.e., offer such "at-risk" consumers lower prices while maintaining higher

prices in the closer-in Dubuque community [Cremer 168-70 (explaining that the Dubuque hospitals have done precisely that with Medical Associates HMO); T116-19 (Huewe) (Mercy selectively contracts and DRHS can continue to do so), 566 (Noether) (5% hospital price increase is too small to cause any shifting), 1042 (Rogols) (hospitals can negotiate different rates for consumers at the fringe); Guetzko (4/7-8) 232 (hospital could reach separate contracts with different employers), Tokheim(5/10) 191 (price discrimination for selected services)].

14. There is evidence from which to infer that the regional hospitals are 26-40% higher priced than the Dubuque hospitals and that they are perceived as higher-priced [E4, 42 (26%); T977-79, 1024-25 (Rogols) (E4 and 42 were based on the best available data and were published for the public to rely on and never retracted), 658, 697 (Thomson) (no managed care contracts in Cedar Rapids and prices therefore are 40% higher); Fuller (9/12) 90-91, 93, 113-14 (hospital people have told him that Mercy compares favorably with regionals on price), Rogols(8/16) 76-79; ED15 ("best available data suggest Mayo is 10% less expensive than University of Iowa--and 40% more expensive than local providers for hospital services")], which would provide DRHS with a price umbrella under which it could raise prices without causing a shift to the regional hospitals (even if the regionals were in the same market) and provides additional proof that there is no price competition between the regionals and the Dubuque hospitals giving rise to the inference that they are not in the same market.

E. Barriers to Entry.

1. There are no sufficiently likely new entrants to preclude DRHS from having a monopoly or near monopoly position in the relevant market. [T331-32, 379-80 (Noether); E255]

2. It is unlikely that any new hospital will be constructed in the foreseeable future that would be in a position to constrain DRHS. [Stips. 41-44]

3. CON approval would be needed for a birthing center in the Dubuque area. [T79-80, 219 (Huewe)]

4. DRHS would oppose any such CON application. [T79-80 (Huewe)]

5. There is no realistic possibility that doctors from Medical Associates or others will expand facilities at rural hospitals to compete with DRHS, even if they could obtain CON approval, which they likely could not. [T379-80 (Noether) (entry unlikely because Iowa, Illinois and Wisconsin have CON statutes that regulate both the entry of new hospitals and expansion of existing hospitals)]

F. Lack of Efficiencies.

1. There was only one person from Peat Marwick involved in defendants' efficiency study, and he was inexperienced in general, unknowledgable in critical areas (e.g., the CON requirements), and particularly inexperienced with best practices--this being the first time he ever attempted such an analysis, and much of the work was done by defendant-personnel who likewise never had done a study such as this. [T1576-82, 1620-22, 1665-79, 1686 (Gallagher), 1906, 1908-11, 1915-17 (Steele) (although he initiated "best practices" analysis and methodology for defendants' efficiencies study, Steele never before had used "best practices" to quantify potential savings, nor had he discussed his methodology with anyone who had done so); Guetzko(4/7-8) 310 (never before participated in a study to project cost savings)]

2. Whether or not there will be the consolidation of services outlined by defendants does not rise above the level of speculation. [T1261-68 (Moody) (some services definitely will not be consolidated, and it would be pure speculation to say if any of the services outlined in ED27 will be); Fuller(8/19) 160-63 ("I guess there is a possibility that [services] could not be consolidated but there is a possibility [they] could be consolidated"--"that's an option that has yet to be determined"), 142 (it is "premature" to say "what, if anything, would be consolidated"), Chesterman 96-99 ("I would speculate that perhaps there will be specialization on one campus of a certain activity"), 105-06 ("sure there would be disagreement" on the DRHS board about consolidations), 118 (it is "possible, certainly" that "the decision may be actually not to consolidate a particular service at one campus or the other"), 124-25 (decision-making process could take months or even years); Stips. 106-07 (no final decision has been made as to any consolidation of services), Grotnes 213-14 (could not now vote comfortably on the proposed service reconfigurations because of lack of information), Moody 54 (Finley must retain certain

services under the partnership including all manner of primary care, general surgery, and orthopedics, to retain its independence)]

3. Even if consolidation of services occurs, defendants' claimed savings therefrom are overstated and inaccurate. [T2861-74, 2879-902 (Taylor); E266 at 3-29, -32A]

4. It will take months or perhaps years to get the requisite community and physician input as to proposed consolidations of services before any decision can be made by the DRHS board, and those groups could present obstacles to achieving the claimed savings. [T1281-88 (Moody), 2902-08 (Taylor) (physician opposition can prevent savings being achieved), 1585-90 (Gallagher) (defendants have not sought physician input); Chesterman 103, 118, 124-25, Moody 72-75 (community planning process would not be completed until at least January 1996)]

5. Many services will not be consolidated and there can no be assurance that the community, the physicians or the DRHS board will approve any consolidation of services. [Chesterman 105-06, 118, Moody 52-54 (services that are necessary to maintain Finley's identity, such as general surgery and orthopedics, will not be consolidated)]

6. Final approval for "any change in service configuration" does not reside with the DRHS board--it resides with the partners because it "would have to be part of the budget and as a result it would require approval of Tri-State and Mercy's parent." [Fuller(8/19) 93, Moody 52 (similar)]

7. The creation of DRHS is not needed to obtain a substantial portion of the projected savings, including: the best practices savings (which account for more than 40% of the claimed operating savings); and the MRI savings (which account for more than 12% of the claimed operating savings and more than 40% of the capital avoidance savings for the years 1995-97). [Stip. 121;

T1487 (Guetzko), 1630 (Gallagher), 1909-11, 1918, 1926 (Steele) (previous best practices experience was in a non-merger context, without looking at another hospital's data; other hospitals are successful at joint venturing MRI services), 2843-47, 2879-90, 2948-49 (Taylor); Steele(5/11) 97-98, 104, Chesterman 61-62, Fuller(8/19) 113 (Mercy and Finley operate a clinic laboratory as a joint venture), Guetzko(9/7) 81-82, 84-92, 94-96; E266 at 18-19, 23-24, 28A, 32-33]

8. Best practices is a process by which hospitals seek to improve their delivery of services, usually by comparing their clinical practices with those of comparable hospitals, the foundation of which is the data base that a hospital uses as the basis for comparison. [E266 at 32] Although best practices might appear to be a "new area" in the hospital industry to some relatively inexperienced health care consultants [T1619-21 (Gallagher)], actually the analysis is rooted in hospitals' utilization review efforts beginning in the 1970s, which have helped hospitals control costs [T2840-43 (Taylor)].

9. Hospitals routinely engage in best practices without the need to merge with other hospitals, let alone with their only competitor in the city in which they are located, and in so doing, hospitals have a variety of data bases upon which they can draw. [T2843-47 (Taylor) (Finley belongs to Voluntary Hospitals of America (VHA), which has a data base that can be used by VHA members; health care consultants and other organizations have available data bases (e.g., Duke University Medical Center maintains the largest cardiovascular data base in the world, and Dana Farber Cancer Center has a data base for cancer treatment))]

10. Defendants have recognized the feasibility and value of doing best practices analysis without the need to merge. [T1630-33 (Gallagher), 1482-87 (Guetzko) (Mercy is working with

Burns & Associates, a health care consultant, on invasive cardiology best practices), 2843-45 (Taylor) (discussing the literature on best practices that documents successful best practices efforts by hospitals of the size of Finley)]

11. There was no instruction given to segregate claimed best practice savings attributable to the merger as opposed to those that might be achieved without the merger [T1487 (Guetzko)], and no analysis was done to quantify what best practices savings could be achieved without a merger [T1630 (Gallagher)].

12. The claimed best practices efficiencies are ill-conceived and speculative, particularly in view of Mr. Gallagher's lack of familiarity with the area, and overstated, particularly in view of how efficient Finley already is recognized to be (e.g., having won a national award for its efficiency). [T2840-43, 2847-63 (Taylor); E266 at 32-33; Stip. 10]

13. The alleged capital avoidance savings are miscalculated and overstated. [T1650-78 (Gallagher), 2879-902 (Taylor); E266 at 22-29] Specifically, defendants' calculation of capital avoidance savings based on their three-year budgets for capital expenditures and extrapolation from that data to future years, and their crediting the entire cash purchase price in the year of expenditure that is to be avoided as the annual capital savings [T1532-40 (Gallagher); ED475] is wrong for two fundamental reasons: (i) major components of the three-year capital avoidance savings relate to construction or renovation of facilities (obstetrics and emergency rooms) that will not recur as expenditures for many years to come [T2897-901 (Taylor); E266 at 27-29]; and (ii) the proper method of accounting for such capital avoidance savings is to use a depreciation expense for each year of their projected useful life, rather than a cash method, to reflect properly the likely impact of capital avoidance savings upon the prices paid by hospital consumers

[T2897-900 (Taylor); E266 at 25-29]. Correcting these errors reduces defendants' claimed capital avoidance savings for years 1995-97, even if achieved, from about $4.9 million to about $790,000. [E266 at 28]

14. The projecting of capital savings beyond three years is speculative. [Guetzko(4/7-8) 12-13 (speculative to budget beyond three years because of rapid changes in hospital industry)]

15. A merger is not required to obtain the claimed group purchasing savings (e.g., Finley could join another purchasing group), which savings in any event are overstated and inaccurate due in part to the failure to conduct a random sample to produce a probability sample base, so the most savings that reliably could be predicted in this regard is about $57,000 per year (and even this may be overstated substantially). [T1643-50 (Gallagher), 2874-78 (Taylor); E266 at 20]

16. Defendants' supposed capital avoidance savings (e.g., the MRI savings) derive from eliminating unnecessary duplication by Mercy and Finley, yet Iowa's CON statute would preclude such duplicative services anyhow, as well as additions of other such duplicative hospital facilities. [Stip. 14; T79-80, 201 (Huewe), 1565-75 (Gallagher), 2884-89 (Taylor); E266 at 23-24]

17. The "study" outlining the purported efficiencies is riddled with faulty assumptions and incorrect analyses (e.g., alleged savings attributed to best practices, the CT scanner, SPECT camera, and obstetric and emergency room renovation), requiring many downward revisions before and after defendants filed their revised claim in this action. [T1543-52, 1565-66, 1635-42, 1650-61, 1665-73, 1691-92, 1694-96 (Gallagher) (faulty assumptions re best practices data base, FTE savings, obstetrics and emergency room renovation and MRI), 2847-71, 2879-97,

2906-07, 2919-20, 2930-34 (Taylor) (explaining faulty assumptions), 1466-74, 1477-80 (Guetzko) (CT scanner and obstetrics renovation); Guetzko (9/7) 28-38, 60-66, 68-70, Rogols (9/1) 57, 59-60, 62-66, 68-74, 78-88, 90-93, 113-18, 137-44, 153-54 (CT scanner, SPECT camera and emergency room renovation); E24 at 2, 4-5 (miscalculation re MRI and obstetric beds), 27 at 18-19 (CT scanner and SPECT camera), 52 (CT scanner), 266 at 15, 23-24, 32-33, ED475]

18. When the faulty assumptions and other errors in analysis in defendants' cost savings estimates are corrected, defendants have an annual "maximum potential opportunity" of about $2 million ($1.6 million annually for operating savings, an average of about $263,000 annually for capital avoidance savings for years 1995-97, and an average of about $400,000 annually for capital savings thereafter). [T2836-39, 2897-902 (Taylor); E266 at 27-28, 32A]

19. Beyond the $2 million maximum savings calculated by the Government, none of the alleged savings have been established by clear and convincing evidence; and even most of the $2 million is highly speculative and not established by clear and convincing evidence (i.e., this figure represents what possibly could be achieved if everyone necessary [the board, hospital administrators, medical staffs, local providers and community-at-large] actually agreed to implement the consolidations and other savings, a speculative proposition at best [see FOF F2, 4]), so there can be no assurance that even this amount of savings will be attained (or passed on). [T2890-93, 2902-07 (Taylor), 1585 (Gallagher); E266]

20. Defendants have made no genuine effort to quantify the "net" savings after taking account of the likely competitive harm. In any event, the maximum savings (of $2 million) are below the

competitive harm (at least $3 million) that would flow just from the elimination of the managed care discounts promptly after the merger. [T386-88 (Noether)]

21. There is serious doubt that much of the claimed savings would be achieved absent the competitive pressure to be as efficient as possible. [T1612-14 (Gallagher) (in other hospital mergers where some savings were achieved, the merger did not eliminate competitive pressures); Cremer 170-71; E35 (suggesting that the efficiency study was done to satisfy DOJ)]

22. Even as late as the Spring of 1994, defendants could not explain to Heritage/Deere how the purported savings would be passed on to consumers. [T282 (Thomson)]

23. The out-of-state money transfers Mercy is (and will continue to be) obligated to make by its Michigan parent and over which the Michigan corporation has exclusive control, which equal up to 30% of its "profits" and total up to $2 million per year, create additional uncertainty about passing on any savings to the Dubuque community because the money being transferred out-of-state instead could be used for improving local hospital care, capital improvements, equipment purchases, and reduction of prices. [T81 (Huewe), 1221-23 (Moody), 1374-81, 1407-08, 1411-12 (Guetzko); Fuller(8/19) 46-49, 63, 70-71, 79, 82, Hendry 57-59 (would prefer the money to stay in Dubuque to improve local care), Guetzko(8/17) 47-48, 52-53, 99; E166 § 4.03(B)]

G. Background on Mercy and Finley.

1. Mercy and Finley, located six blocks apart, are the only general acute care hospitals in Dubuque and are the largest general acute care hospitals within a 70-mile drive of Dubuque. [Stip. 1]

2. Mercy has 302 licensed acute care beds and in 1993 had net inpatient revenues in excess of $40 million; Finley has 141 licensed acute care beds and for its fiscal year 1993 had net inpatient revenues of approximately $21 million. [Stips. 2-3, 119]

3. Mercy and Finley are each financially sound and viable institutions; they have fund balances in excess of $45 million and $30 million, respectively. [Stip. 4; Huewe 15, Finnin 37]

4. Finley was cited in 1994 as one of the 25 most efficient hospitals in the United States with fewer than 250 beds. [Stip. 10]

5. The creation of DRHS is not required to maintain the financial soundness or viability of either Mercy or Finley. [Stip. 11]

6. Mercy has more than 160 physicians, including at least 15 surgeons, on its active medical staff; Finley has more than 140 physicians, including at least 11 surgeons, on its active medical staff. [Stips. 12-13]

7. Mercy has approximately 8,000 acute care patient discharges per year and an average daily census of such acute care patients of approximately 110; Finley has approximately 4,500 acute care patient discharges per year and an average daily census of such acute care patients of approximately 67. [Stips. 14-15]

8. Mercy and Finley each provide high quality general inpatient acute care services and have reputations among local physicians and the public for doing so, and will continue to be able to provide such care even if DRHS is not created. [Stips. 23-24]

9. Mercy and Finley derive the bulk of their revenues from acute care inpatient services. [Stip. 119]

H. Jurisdiction and Interstate Commerce.

1. The parties have submitted to the jurisdiction of this Court. [Stip. 22]

2. The parties have stipulated that this Court has jurisdiction over the subject matter of this lawsuit as to the section 1 claim. [Stip. 21]

3. The Court has jurisdiction over the subject matter of the section 7 claim. University Health, 938 F.2d at 1214-15.

4. The Government has met its burden of proving the requisite effect on interstate commerce. [Stip. 20]

Proposed Conclusions of Law

A. Evidentiary Standards.

1. The Government has the burden to prove a relevant market and the existence of market power. University Health, 938 F.2d at 1218.

2. Once the Government proves, by a preponderance of the evidence, a relevant market and that defendants will possess a substantial share of that market, a presumption of illegality of the merger arises [Philadelphia Nat'l Bank, 374 U.S. at 362-64; University Health, 938 F.2d at 1218], which defendants may rebut by showing that the Government's market is inappropriate or that there are external brakes or other market forces that would prevent the exercise of market power [University Health, 938 F.2d at 1218-19; HCA, 807 F.2d at 1389-92].

3. Defendants have the burden to establish, by clear and convincing evidence, their efficiencies defense, as to which defense the following standards apply: (i) the efficiencies may not be speculative; (ii) the efficiencies must be attributable to the merger (i.e., only such efficiencies that could not be derived absent the merger qualify under this defense); (iii) defendants must show that the efficiencies both will be achieved and passed on to benefit their consumers; and (iv) defendants must show with an economic quantification that the efficiencies outweigh any competitive harms that might result from the merger. University Health, 938 F.2d at 1222-23; Rockford, 717 F. Supp. at 1289-91.

4. That certain evidence was admitted and may be probative on certain issues does not mean that evidence is admissible or probative on all issues. This conclusion applies even if the evidence would be the best available evidence on the point because even the best available evidence should be ignored if it does not make the point more likely so than not. [Fed. Rs. Evid. 401-02]

5. While patient-origin and migration data were admitted and were useful on certain points (such as identification of Mercy and Finley's service areas), they do not support defendants' proposed market definition because they do not explain why any of the so-called "at-risk" group chose the hospital they did, without which knowledge it is impossible to tell whether any of the at-risk patients would switch hospitals in response to a price increase. [T2610-11 (Harris)] As a result, it is impossible to determine the extent to which the size of the at-risk pool has been overstated by defendants or whether that pool in fact is even "at-risk." [T2620-23 (Harris)]

6. While DRG comparisons were admitted and were useful on certain points, defendants' use of such data does not support defendants' proposed market definition because the data do not reflect accurately the comparability of hospitals. In particular, defendants' economist notes that "all admissions under a particular DRG are not the same." [T2438 (Harris)] Thus, two hospitals can have high DRG overlaps notwithstanding: (i) the significant availability of services or procedures at one hospital that as a practical matter are not available at another (e.g., Mercy and Finley with University of Iowa [ED484]); and (ii) that sheer distance can make the purported overlap irrelevant (e.g., for obstetrics and admissions that must be made promptly upon diagnosis) [T802-03 (Runde), 2329 (Tracy) (there is not nor will there be regional competition for such services)].

7. Even within a DRG, there is substantial variation in the severity of the illness of particular patients. [T360-61, 363-64 (Noether) (for example, comparing lengths-of-stay for patients treated at the rural hospitals with those treated at Mercy and Finley shows that patients in a particular DRG tend to stay longer at Mercy and Finley, implying that these patients are sicker than those using the rurals)]

8. An expert may rely on facts and data that otherwise might not be admissible provided they are the kind of facts and data that such an expert typically relies on. [Fed. R. Evid. 703] The affidavits, declarations and other hearsay relied on at face value by defendants' economist without sufficient independent inquiry, including the survey which was shown to be fatally flawed [T2754-819 (Frankel)] and could not be sponsored by Dr. Harris [T2538-68 (Harris)], are not the kind of materials that an expert should rely on without taking steps to verify the soundness or completeness of their contents. As a result, and in view of Dr. Harris' testimony that the affidavits and declarations were the most influential evidence in forming his opinions [T2442-43 (Harris)], Dr. Harris' testimony deserves to be stricken or at least discounted substantially.

B. Definition of Relevant Market.

1. A relevant market includes a relevant product market and a relevant geographic market. Brown Shoe, 370 U.S. at 324; Rockford, 717 F. Supp. at 1258, 1261.

2. The relevant product market is inpatient acute care services. University Health, 938 F.2d at 1210-11 ("provision of in-patient services by acute-care hospitals"); Rockford, 898 F.2d at 1284 (same), aff'g, 717 F. Supp. at 1258-61 (excluding outpatient services); HCA, 807 F.2d at 1388 (same).

3. The relevant geographic market is Dubuque County and an area approximately 15-miles around the City of Dubuque in Wisconsin and Illinois. See University Health, 938 F.2d at 1210-11 (Augusta, Georgia area); Rockford, 717 F. Supp. at 1277 (Rockford and the county in which it is located, one other county and portions of a few surrounding counties); HCA, 807 F.2d at 1388 (Chattanooga, Tennessee).

4. Patient origin data supports the Government's proposed geographic market--thus, Dr. Noether's LIFO/LOFI analysis [E259], which shows that 88% of the patients in the market use hospitals in the market, and that 76% of those hospitals' patients reside in the market, is strikingly similar to the LIFO/LOFI percentages for the relevant geographic market found in Rockford, 717 F. Supp. at 1273, 1277 (85%/79%).

5. Practical indicia support the Government's proposed geographic market, including: Mercy and Finley's monitoring of each other's pricing but not that of others; the marketing strategies of managed care plans; the competitive responses of Mercy and Finley to each other's activities but not to those of other hospitals; and the substantially higher pricing of other regional hospitals compared to the Dubuque hospitals. [FOF A-D]

6. The relevant geographic market in a hospital merger context is different from a hospital's "service area," for the market inquiry focuses on the hospital providers and what substitutes to the merging hospitals exist in an area to which consumers can turn. [T335-36 (Noether), 2640-42 (Harris)]

7. The geographic market may be defined by considering whether a hypothetical monopolist in the proposed market would find it profitable to increase price. [T335 (Noether), 2388 (Harris)] This issue can be evaluated by computing how many patients would have to shift to hospitals outside the market to make the price increase unprofitable--the "critical loss." This number is then compared to the number of patients who likely would shift in response to the price increase. If the number who likely would shift is less than the "critical loss" number, then the price increase will be profitable and the proposed market is accepted as a market. Under this approach, the Government's proposed geographic market has been proved and is an appropriate market. [FOF A]

8. The managed care plans cannot as a practical matter shift patients in the event their discounts were reduced or eliminated after the creation of DRHS. [FOF A]

9. Although 24% of Mercy and Finley's customers come from outside the market, for the vast majority of them there are no adequate substitutes to which they can turn to defeat a price rise. [FOF B-D]

10. The pool of people using a Dubuque hospital who conceivably might switch to avoid a price rise is not large enough to defeat a 5% price increase, let alone a 15-30% price increase. [FOF A]

11. Even if enough switching candidates were available to defeat an across-the-board price increase (which there are not), because DRHS can price discriminate to raise prices in the Dubuque area and give favorable contracts to people who might switch from the fringe [FOF A], that is additional proof of the market proposed by the Government and a market perhaps even narrower than that suggested by patient inflow and outflow data [Philip Areeda & Herbert Hovenkamp, Antitrust Law ¶ 521'd (Supp. 1992) ("Price discrimination may not only provide direct evidence of market power, but may also help define the market") (footnote omitted); Rockford, 717 F. Supp. at 1267 ("The [Elzinga-Hogarty] test can overstate the market where geographic price discrimination is employed"); 1992 Horizontal Merger Guidelines §§ 1.12, 1.22 (reproduced in 4 Trade Reg. Rep. (CCH) ¶ 13,104 (1992)); FOF A].

12. The competition between physician clinics in certain distant rural communities will not cause the Dubuque hospitals to come into significant competition with other regional hospitals, and this competition by clinics for patients will not affect hospital prices because: (i) the clinics will refer the few admissions they have to their affiliated hospitals regardless of relative hospital prices; and (ii) the Dubuque hospitals could price discriminate in favor of those clinics while keeping prices high in the Dubuque core. [FOF A]

C. Acquisition of Market Power.

1. Market power is the ability to raise prices profitably. Rockford, 898 F.2d at 1283.

2. The Government has proven that the consolidation of Mercy and Finley will result in DRHS' having market power. [FOF B]

3. The Government has proven that DRHS will have a sufficiently large market share (78-100%) so as to make this merger presumptively unlawful [compare Philadelphia Nat'l Bank, 374 U.S. at 364 (combined 30% market share); University Health, 938 F.2d at 1219 (combined 43% market share); Rockford, 898 F.2d at 1283 (combined 64-72% market share); HCA, 807 F.2d at 1387 (reducing number of competitors from 11 to 7)], which presumption has not been overcome by defendants [FOF A-E].

4. DRHS' ability to eliminate or reduce managed care discounts and to price discriminate provides direct evidence of market power, and its ability to price discriminate in favor of consumers at the fringe is direct evidence that DRHS will be able to exercise market power in the geographic market. Philip Areeda & Herbert Hovenkamp, Antitrust Law ¶ 521'd (Supp. 1992).

5. Having proved that the merger creates or enhances market power, there is no need to prove that DRHS actually will exercise market power; thus the Government need not prove that prices necessarily will be raised--but rather, that the merger creates the ability to so raise prices. HCA, 807 F.2d at 1389; see also Philadelphia Nat'l Bank, 374 U.S. at 362-63.

6. In any event, the Government has shown that DRHS likely will exercise market power. [FOF C]

7. In all events, the Government has shown [FOF D], and defendants have failed to negate, that there are no external brakes (competitive or other market restraints) on DRHS' exercise of market power. University Health, 938 F.2d at 1218-19; HCA, 807 F.2d at 1389.

8. The present intentions or promises of possible future DRHS board members not to raise prices is not a defense available in this case, particularly in view of the partnership agreement that gives ultimate control over all DRHS matters to Mercy and Finley's parent corporations. See University Health, 938 F.2d at 1223-24; and Philadelphia Nat'l Bank, 374 U.S. at 366-67, as explained in the reply in support of United States' motion in limine nos. 3 and 4.

9. Defendants' contention that DRHS' non-profit status will serve as a check on the exercise of market power was proven wrong on the record, and is legally unavailing. Rockford, 717 F. Supp. at 1285-87 (rejecting argument that non-profit hospitals act differently than proprietary hospitals); HCA, 807 F.2d at 1390-91 (same); University Health, 938 F.2d at 1213-14, 1224 ("district court's assumption that University Hospital, as a nonprofit entity, would not act anticompetitively was improper").

10. Defendants' contention that DRHS' supposed community-based board and community pressure will serve as a check on the exercise of market power was proven wrong on the record, and is legally unavailing. Rockford, 717 F. Supp. at 1285-86 (rejecting similar contentions); University Health, 938 F.2d at 1224 (rejecting argument that public scrutiny would eliminate risk of anticompetitive conduct); HCA, 807 F.2d at 1387 (noting, as here, that board typically is subservient to hospital management); T1857-58 (Steele) (Finley board not involved in managed care pricing).

11. Defendants' contention regarding Mercy and Finley's purported past procompetitive conduct is not a defense on this record or as a matter of law. University Health, 938 F.2d at 1224; see T1179-80 (defendants' stipulation that they are not asserting that Mercy has been a "benevolent monopolist" in the past).

D. Anticompetitive Effect.

1. The creation of DRHS will end the competition between Mercy and Finley that has produced two outstanding, financially-viable, efficient, high-quality hospitals. [FOF C]

2. The creation of DRHS, particularly to the extent that any services are consolidated at one facility, will eliminate the choice of hospitals the people of Dubuque have come to enjoy. [FOF C]

3. The creation of DRHS likely will result in higher prices--at least in the first instance to managed care plan consumers. [FOF C]

4. The creation of DRHS likely will result in stemming the rise of and perhaps eliminating managed care plans from Dubuque. [FOF C]

5. The creation of DRHS likely will result in higher prices to all commercial payors. [FOF C]

6. The creation of DRHS likely will result in lower quality to all patients, those of both commercial and governmental payors. [FOF C]

7. The creation of DRHS, particularly if coupled with the diminution of managed care, will remove an important impetus that has existed to make the Dubuque hospitals as cost efficient as possible. [FOF C]

8. The creation of DRHS likely will result in reduction of patient amenities. [FOF C]

9. The creation of DRHS likely will cause consumers in Dubuque to pay more for hospital care. [FOF C]

E. The Efficiencies Defense.

1. Defendants have the burden to establish, by clear and convincing evidence, that their claimed efficiencies actually will be achieved and are not speculative [University Health, 938 F.2d at 1223], which they have not done [FOF F].

2. To be considered, the alleged efficiencies must be shown to be unobtainable other than through the merger [Rockford, 717 F. Supp. at 1289], which is not the case here with respect to the vast bulk of the claimed efficiencies, particularly those based on "best practices" [FOF F].

3. To be considered, the alleged efficiencies must result in savings that will be passed on to benefit DRHS' consumers [Rockford, 717 F. Supp. at 1289], which has not been shown here [FOF F].

4. To be considered, the alleged efficiencies must be shown in an economically quantitative way to produce a net economic benefit for the consumer, i.e., that they outweigh any competitive harm [Rockford, 717 F. Supp. at 1291; University Health, 938 F.2d at 1223], which has not been shown here [FOF F].

F. Jurisdiction and Interstate Commerce.

1. This Court has jurisdiction over the parties. [Stip. 22]

2. This Court has jurisdiction over the subject matter. [Stip. 21 as to the section 1 claim; under University Health, 938 F.2d at 1214-15 as to the section 7 claim]

3. The Government has met its burden of showing a sufficient effect on interstate commerce to meet the statutory requirement. [Stips. 18-20]

G. The Appropriate Relief.

1. The Government is entitled to judgment in its favor on its complaint.

2. Entry of a permanent injunction is appropriate to prevent the creation of DRHS (or any other merger, consolidation or partnership [however denominated] of Mercy and Finley). Rockford, 717 F. Supp. at 1292 (permanent injunction entered).

3. The Government is entitled to recover its costs, including trial transcripts, deposition costs and witness fees. Fed. R. Civ. P. 54(d) (prevailing party entitled to costs); 28 U.S.C. § 2412 (suits involving the Government); 28 U.S.C. § 1920(2-4) (trial transcripts; deposition costs; witness fees).

Discussion of Witnesses

A. Introduction.

The trial confirmed that defense counsel had engaged in various conduct with respect to non-party fact witnesses that deserves note. Specifically, defense counsel: (i) initiated the idea of representing non-party fact witnesses for free, including at least one witness (Sesterhenn) who already had counsel [T1779-80 (Sesterhenn)]; (ii) invoked that representation to prevent deposition questions from being answered on privilege grounds (e.g., Lengeling) [T2064 (Lengeling)]; (iii) invoked that representation to prevent the Government from interviewing such witnesses without defense counsel being present (Lally); (iv) put one witness (Tracy) forward as an "expert" who testified in large part as to supposed "facts" having nothing to do with any opinion and he was paid for that testimony [see discussion of Tracy below]; and (v) after aggressively obtaining scores of "cookie-cutter" affidavits prepared in large part by counsel, put forward an economist who first said that those affidavits were the "most direct evidence" for his opinions, and then tried to beat a hasty retreat [see discussion of Harris below]. This conduct raises some troubling issues. At the very least, it would seem proper for the Court to consider these circumstances in determining the weight to be given to defendants' supposedly independent witnesses and defendants' economist's testimony.

B. The Fact Witnesses.

1. The Buyer Witnesses. Messrs. Thompson and Cremer represent the most significant buyer group in Dubuque--the managed care plans. They are, and were acknowledged even by defendants to be [T136 (Huewe), 1237 (Moody)], the most knowledgeable purchasers of hospital services in the area. None of the witnesses produced by defendants could match these witnesses in experience or knowledge, and the only buyer witness produced by defendants

(Sesterhenn), represented a mere 320 employees in contrast to the 35,000 covered lives represented by the managed care plan witnesses. [T1746 (Sesterhenn), 541-42 (Noether)] In any event, Mr. Sesterhenn's testimony mirrored the managed care testimony on key points, including the fact that even a 38% price increase to his employees did not cause any switching to hospitals outside Dubuque. [T1809-12 (Sesterhenn)]

2. The Doctor Witnesses. Drs. Schemmel (a leading orthopedist) and Runde (a leading internist and Mercy's chief of staff) span a wide range of inpatient acute-care hospital services. They are top physicians in Dubuque, with in-depth knowledge on the pertinent issues to which they testified. Irrespective of qualifications, defendants' doctors at base did not contradict anything of substance that Drs. Schemmel and Runde said.

3. The Hospital Witnesses. These individuals certainly felt strongly that DRHS should be created, which may be explanatory of what otherwise is puzzling testimony in sharp contradiction to the unequivocal documentary evidence generated before defendants retained antitrust counsel. [See discussion of exhibits and defendants' positions below] At the same time, however, they made candid concessions about the relevant market, confirming that, as a practical matter, they see Mercy and Finley as the only viable competitors in that market. [T1216-18 (Moody) (considers only Mercy and Finley when thinking of Finley's market share), 1877, 1882 (Steele) (Wal-Mart looked to contract only with Mercy or Finley; in setting Finley's 1995 prices, Mercy's prices were important, but he did not look at prices of any other hospitals); Finnin 151-17, 181-82 (Finley's advertising targeted at local Dubuque community and competition with Mercy), Fuller(9/12) 137-38 (only a few of his employees have used other regional hospitals), Schaller 169-70 (Finley gives away infant car seats only because Mercy is doing so)]

C. The Expert Witnesses.

1. The Economists. Dr. Noether brought an independent approach, based on defendants' documents, economic literature, more than three years of patient origin and flow and other data, statistics on physician privilege overlap, a likelihood-of-switching analysis, a cost-of-switching analysis, findings of geographic markets in other cases including University Health in which she testified, economic literature, hospital tours, interviews and trial testimony. [T324-25, 541-42 (Noether)] Her methodology, which even Dr. Harris endorsed [T2375 (Harris); E254], would make a lot of sense in any context, but was especially persuasive in contrast to Dr. Harris' analysis (e.g., he admittedly: used just six months of data [T2392 (Harris)]; used a market test that put Mayo in the market with Mercy and Finley but would not put Mercy and Finley in the same market [T2599-601, 2667-68 (Harris) ("I never said Mercy and Finley were in the same market"; "a strict guidelines analysis would say they're not in the same market")]; relied on selective "cookie cutter" affidavits prepared in the main by defense counsel that he first characterized as the "most direct evidence" on market definition [T2442-43, 2520-21 (Harris), and then tried to beat a hasty retreat [T2521 (Harris) (affidavits were no longer the most influential or best available evidence, but just a piece)]; ignored managed care trial testimony and the regional hospitals' affidavits that controverted his opinions; advanced an "at-risk" analysis that he effectively conceded was overstated by an indeterminable amount [T2620-23 (Harris)]; and relied on a survey that he could not sponsor and later was shown to be fatally flawed) [T2539 (Harris)]. Perhaps most critically, unless one repudiates the testimony of Mercy's president (which even Dr. Harris did not try to do), applying Dr. Harris' efficiencies test (as set forth in his published writing) compels the market definition proposed by the Government (unless

one accepts the unstated "exception" Dr. Harris on redirect said should be read into his two-month old article).[6]

At bottom, it is not difficult to understand why Dr. Noether's approach has been endorsed by one of the leading appellate hospital merger cases and consistent with the others. Likewise, it is not difficult to understand why Dr. Harris' proposed market (which contains at least 16 hospitals and encompasses at least 14 counties [T2498-502, 2644-48 (Harris); ED429-30], and puts Mayo in the market today [T2529-30]), has not been accepted by any court and cannot be squared with Rockford (indeed, he did not even check to see if his analysis was consistent with that decision [T2653-54 (Harris)]) or those other appellate decisions.

2. Mr. Tracy. It is difficult to articulate precisely what field of expertise Mr. Tracy brought to the trial. Both he and defense counsel acknowledged that Mr. Tracy had no expertise in economics or hospital price competition. [T2294, 2296 (Tracy)] In large part, Mr. Tracy's testimony consisted of "facts" based on various out-of-court conversations and observations in his work as a promoter and broker for the establishment of outreach clinics. [T2126-27 (Tracy)] These "facts," as they related to the Dubuque hospitals, principally concerned very limited competition between physician groups, and did not concern competition among hospitals. [T2319-20 (Tracy); ED403] Indeed, Mr. Tracy conceded that such physician competition was not a substitute for, nor dependent upon, hospital price competition. [T2246-47, 2251-52, 2318-19 (Tracy)]

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[6] Dr. Harris had been working on this case long before this article was published in the Summer of 1994. In fact, he appeared with defendants and their counsel before the Department of Justice in April 1994.

Mr. Tracy's testimony was prone to obvious exaggeration and overstated conclusions premised on unfounded bases. For example, his principal example of "regional competition" with Dubuque was the purchase by Medical Associates of a physician practice in Elkader, about which Mr. Tracy concluded: "The Elkader purchase, which was just two or three months ago involving two physicians in Elkader, has dramatically changed the referral patterns of those two physicians ... from the direction of the University of Iowa to Dubuque." [T2129-30 (Tracy)] When asked about this "dramatic" change, Mr. Tracy admitted: "[I] don't have a specific measure [of how many patients shifted. I] called to find out whether anything has changed with regard to what we are getting from Elkader, in that mid range of service, and the answer is yes, it has changed. * * * I did not quantify it, I asked if it had happened" [T2319-20 (Tracy)]; and then further conceded that he had not quantified any of the other supposed referral shifts that he had testified about [T2319-20, 2152-53 (Tracy)]. Likewise, Mr. Tracy said he was "absolutely certain" that St. Mary's hospital in Madison would say it competed with the Dubuque hospitals, yet he never considered the St. Mary's affidavit which is precisely to the contrary. [T2207-09, 2261-62 (Tracy)] In addition, Mr. Tracy's postulation of regional competition by DRHS was premised on DRHS' having to add or expand services [T2323-25 (Tracy)], which is in direct contradiction to defendants' stipulation [Stip. 111 ("no present plans for [DRHS] to add additional services or upgrade any particular service")].

His market definition, if it can be called that, had no bounds, and would extend, through his so-called "vectors" reaching out, farther even than Dr. Harris'. [ED400A] Significantly, however, Mr. Tracy conceded that he was not testifying to an "antitrust geographic market," and had no knowledge of what that concept entailed. [T2333 (Tracy)] Moreover, while Mr.

Tracy said he believed that all Iowa hospitals need to expand their service areas to maintain or increase market share, he testified that he was neither advocating, nor even contemplating, that the local competition between Mercy and Finley be eliminated. [T2227-28, 2314-15 (Tracy) ("I did not say there should not be any competition [between Mercy and Finley] in town. I certainly did not say there shouldn't be any competition." "I have never said one should eliminate [local] competition under any circumstance")]

3. Survey Experts. Defendants produced no expert to sponsor the survey [E180]. Dr. Harris' attempt to validate it (through a few hearsay conversations with Messrs. Davis and Smith [T2544-45, 2549-50, 2554, 2558 (Harris)]) fell far short for Dr. Harris clearly had insufficient knowledge of even the most rudimentary statistical concepts and conceded he was not an expert on surveys [T2543 (Harris)]. On the other hand, Dr. Frankel provided powerful testimony (confirmed by defendants' employer witness [T1788-89 (Sesterhenn)] and even Dr. Harris in part [T2563 (Harris) (conceding the flaw with Q18a--in that it did not test doctor switching)]) why this survey: (i) did not test the appropriate decision-making (e.g., it did not explain that switching doctors would be required) nor otherwise was a valid predictor [T2762-63, 2779-80 (Frankel); E180]; (ii) did not sample the appropriate population (e.g., 30% of the respondents had used a non-Dubuque hospital for their last hospitalization [T2556-57 (Harris); E180]; (iii) was flawed by its poor question design and the failure to do a probability sample--so that, like a stopped clock which is right twice a day, there is no way to give validity to the results [T2770-73, 2781-89, 2817-18 (Frankel) (explaining loaded and biased questionnaire design defects and lack of a probability sample)]; and (iv) likely was doomed not to produce any meaningful results (e.g., there was insufficient time to design and implement a proper survey in view of the accelerated

schedule requested by defendants) [T2816 (Frankel) (it would take 3-4 months to do such a survey correctly)]. Most telling, in the end, defendants withdrew the survey, but Dr. Harris' reliance on it (as supposed evidence of people's willingness to shift doctors and hospitals [T2539, 2541-42 (Harris)]) further undermines his testimony.

4. Efficiencies Experts. Perhaps the sharpest contrast in the trial was that between Mr. Gallagher and Dr. Taylor. The former's experience was thin at best, and it showed. Particularly when it came to best practices, it was clear he really did not know what he was talking about. Even without rebuttal, it is difficult to see where the Gallagher testimony satisfied the heavy burden that was on defendants to make out this defense. But any doubt was put to rest with the convincing testimony of Dr. Taylor, a recognized leader in this field. [T2826-31 (Taylor); E266 at attachment]

Discussion of Exhibits

If there were no defendant witnesses in this case, but just the documents they wrote before litigation ensued, most of the Government's case could be made without more. This circumstance should be seen as especially compelling here in view of E205 (produced by Peat Marwick, not by Mercy), where Mercy's president made clear that antitrust questions were of concern all along, and instructions were given, which were expected to be carried out, to be careful in how documents were worded. [T208-10 (Huewe)] Here then is a synopsis of some of those documents:

E1: Although defendants are non-profit entities, they recognize that even non-profit hospitals must produce positive operating margins (profits) to stay in business. In addition, they see managed care plans as not paying their "fair share" toward those profits and hence a burden to the hospitals for which "someone has to pay."

E2 (and 4, 5, 8): Defendants promoted the creation of DRHS by stressing that consumers "will continue to have a choice of two facilities for their health care needs" and "independent identities of each hospital will be maintained," which would be true only to the extent to which services are not consolidated at one facility or the other. [Moody 53-54, 63-65] Also, while the question of money transfers and Mercy's community commitment were of substantial concern to Finley board members, these concerns were not shared with the public. [Fuller(8/19) 152-53]

E4 (and 42): Defendants represented to the public that Dubuque hospitals were 26% less expensive than other urban Iowa hospitals. In confirmatory testimony, defendants said they believe this information to be accurate and relied on by the public [T193-94 (Huewe), 977 (Rogols)], and in fact this was the best information available [T978 (Rogols)].

E6: Announcement of the national study showing Finley as one of the country's most efficient hospitals of its size.

E35: At least some people in the "community" see DRHS as not in the community's interest and question the reasons for its creation and the asserted efficiencies. Specifically, they see the creation of DRHS as a means to eliminate managed care plan discounts (i.e., "to enable the hospitals to negotiate with one voice for managed care contracts") and the claimed efficiencies as having been hypothecated to avoid antitrust scrutiny. The out-of-state money transfers and requirement to purchase services from Mercy's parent also are identified as issues of concern, as is the question of consolidation of services.

E58: This article by Dr. Harris explains that where, as Mercy's president testified, savings from consolidating services could not be achieved by merging with the rural or regional hospitals, those hospitals are not in the market.

E72 and 77: These Finley Executive Committee minutes and position paper highlight Finley's concern with managed care contracts and discounts. Also expressed are the views that managed care plans did not pay their fair share, and that Finley "must protect" its commercial payor base and avoid giving discounts.

E78: The Finley board decided that, upon "the release of cost efficiency estimates," "responses will be kept general, reflecting that substantial savings will be realized" which perhaps explains why Mr. Thomson was not given any specific assurance as to what would happen with any cost savings from the creation of DRHS. [T282 (Thomson)] The board also noted that "[a]nother issue of concern was convincing the business community that [DRHS] will not be a quasi-monopoly." And the out-of-state money transfer issue was raised again.

E85: Finley board members express the view that Mercy is a "for profit" institution "owned by an organization out of town," noting the out-of-state money transfers and the "reality ... that Mercy Health Center will not be turned over to the community." [Moody 98-100 (local business people on Finley board were concerned that Mercy allowed large amounts of their net revenue to flow out of the community)] One suggestion is to be sure the DRHS board has "complete control" in view of "SMHC['s] power," which of course did not occur. See also related testimony of Chesterman at 70-71 (Finley board "fear[ed] that ... community assets could be taken out of the city because we knew that there was no local true control by the Mercy advisory board") and 85-88 (would prefer that authority be vested in DRHS board rather than SMHC because SMHC would have "parochial interests that may not be in the best interests of the community").

E157: One of the early DRHS planning documents, which explains that one of the "focuses" for DRHS will be "strengthening the hospitals' position in contracting for managed care."

E163: Mercy's strategic plan which explains that the rural hospitals are seen as referral sources with which to cooperate and not to compete with, while the University of Iowa is "located close enough to provide convenient tertiary care and yet distant enough from Dubuque that it does not threaten Mercy as a secondary regional provider," which clearly would be the case with the other regionals as well.

E166: The partnership agreement sets out the complete understanding of the partners to DRHS (Mercy and Finley's parent). [T99-100 (Huewe)] By its plain terms, the control of DRHS in virtually every respect (expressly or by control over the budget) resides not with the

board, but with the partners, including the power over services reconfigurations. [T905 (Rogols), 1271 (Moody); Fuller(8/19) 91, 93] It also singles out managed care contracts as the only buyer contracts requiring approval by the parties. [Moody 112-13]

E168: Defendants represented to the IRS that the DRHS board did not represent a relinquishment of control by the partners to the board over the operations of the hospitals.

E172: Notwithstanding Mercy's non-profit status and community orientation, a Mercy board member's "number one priority" must be the financial viability of Mercy.

E189, 193-94: The instructions from Mercy's Michigan corporate parent as to how to calculate the percentage of profits to be transferred.

E205: Evidence of Mercy's concern that internal documents should be written with an eye toward antitrust issues.

E253-64 (the Noether exhibits): These set out Dr. Noether's basic methodology as to market definition and computation of market shares, and, as Dr. Harris noted, this was the proper methodology for analyzing a merger. [T2375 (Harris)]

E266: Dr. Taylor's revised report analyzing defendants' efficiency claims and the defects of the Peat Marwick study (ED27).

ED484: Defendants introduced this exhibit to show comparability, by DRG overlap, between the Dubuque hospitals and University of Iowa. Specifically, this exhibit was offered to suggest that Finley and Mercy treat patients with greater severity than are treated at the University of Iowa. [T2441-42 (Harris) ("the University of Iowa has a greater proportion of its admissions in the lower severity category than either Mercy or Finley")] Upon closer examination, however, it becomes evident that the data are for only 66 selected DRGs (the

identity of which are not revealed), and the exhibit fails to isolate those patients going from the Dubuque area to the University of Iowa. Thus, by "proving" that a regional center of excellence treats less severely ill patients than the Dubuque hospitals, this exhibit actually provides the best proof that the use of DRG level data, even if it is the "best data available," is not sufficiently precise to be relied on for the hospital comparisons made by defendants. For a complete description of the problem with DRG overlap comparisons, see T359-61 (Noether), and for a discussion related to University of Iowa see T565 (Noether) and Cremer 172.

Discussion of Defendants' Positions

The hallmark of the defense in this case is that, from the beginning (challenging interstate commerce in their answer), through the pretrial (e.g., taking a hard-line in responding to the first set of proposed stipulations), and to the end (their insistence through trial that every one of the rural hospitals, including Elkader and Galena, competes with DRHS), defendants argued virtually every conceivable point. The problem with such an approach (beyond its stretching credulity) is that often it is difficult to keep one's story straight. That certainly was the case here as witnesses contradicted each other, as well as tried to walk away from unequivocal documents and deposition testimony or otherwise tried to stick to untenable defenses while denying the undeniable.

a. Switching. Defendants contended that switching was easy from a Dubuque hospital to such places as Elkader and even Mayo. [T36, 42-43 (Huewe), 2498-99, 2529-30 (Harris); Defendants' Trial Brief at 9] At the same time, they argued that it was difficult to switch patients between Mercy and Finley. [T2381-82, 2599-601, 2668 (Harris); T1173-76 (defense counsel) (arguing that, while the rural and regional hospitals compete with Dubuque, there is only limited competition between Mercy and Finley); Defendants' Trial Brief at 18]

b. Market Definition. Defendants' economist testified that his market definition test would put the regionals in a market with Mercy and Finley, but that a strict application of the test he used would not put Mercy and Finley in the same market. [T2381-82, 2498-99, 2667-69 (Harris)] Further, contrary to defense counsel's insistence beginning at the June 22 scheduling conference that the Government must set out the precise physical limits of its proposed market, defendants' economist testified that the concept of geographic market does not involve line-drawing [T2640-42 (Harris)], and their regional witness testified that the market has no bounds–

the vectors multiply with the addition of each new clinic or doctor in a rural area [T2280, 2337-38 (Tracy) (a hospital's "service area" or "sphere of influence" extends as far as a physician is willing to travel or set up a clinic, or as far as a patient is willing to travel)]. Further, confronted with defendants' testimony that Mercy could not achieve consolidation savings through a merger with any rural or regional hospital [T33-34, 157-58 (Huewe)], defendants' economist had to explain that there was an unwritten "exception" to his two-month old written position that would take the rurals and regionals out of the market, although the market definition methodology was well-known to him at the time he wrote the article (in fact, Dr. Harris' work on this matter began no later than April 1994, six months before publication of his article). [T2584-85 (Harris); E58 at 3]. Finally, contrary to defendants' pretrial position [Defendants' Trial Brief at 6 ("a geographic market based solely upon the hospitals' patient origin data would not accurately reflect a relevant antitrust market")], Dr. Harris testified at trial that a relevant geographic market could be determined by "patient origin data alone" [T2521 (Harris)]).

c. Competition from the Rurals. Defense counsel maintained the argument that the rurals in their own right compete with Mercy and Finley [Defendants' Trial Brief at 12], and Finley's president tried to say that the rurals, including Galena, were the equal of Finley [T967-70 (Rogols)], notwithstanding unequivocal testimony and statistical realities to the contrary [see FOF A; see also Moody 135-37 (the Dubuque hospitals seek a cooperative relationship with the rurals)].

d. DRHS as a Regional Center. Mr. Tracy's testimony was premised on the notion that, to compete regionally, DRHS would have to add or at least expand services [T2324-25 (Tracy); see also T1807-09 (Sesterhenn) (similar)], which runs squarely counter to: (i)

defendants' claims that purported savings from the merger will be passed on to consumers; (ii) Stip. 111 ("no present plans for [DRHS] to add additional services or upgrade any particular service"); and (iii) the testimony of Mercy's president [T34 (Huewe) (DRHS would not have to add any services to compete regionally)].

e. Hospital Competition. Defendants contended throughout this case, albeit with no evidence, that there was vigorous price and quality competition between the Dubuque hospitals and the rural hospitals and between the Dubuque hospitals and the regional medical centers (even to the point of saying that Galena-Stauss competes with University of Iowa). [Defendants' Trial Brief at 8] At the same time, to attempt to get around the anticompetitive effects that would flow from the creation of DRHS, defendants argued that Mercy and Finley did not vigorously compete on price and otherwise [T2381-82, 2668 (Harris), 1173-76 (defense counsel)], even though this position was negated squarely by its own admissions and documents [FOF C(1)]. Indeed, the consistent testimony showed that Mercy and Finley were acutely aware of what each other were doing [FOF C(1)], but were profoundly unaware of the rurals and regionals. [T1872-73, 1881-83, 1897 (Steele) (unaware of rural and regional prices and discounts)]

f. Product Market. With every appellate case facing the question having defined the product market as the Government proposed here, defendants' trial brief appeared to concede the issue. Then, during the first few minutes of Mercy's president's testimony, there was an attempted retraction of unequivocal deposition testimony given just a few months before [T24-26 (Huewe)], followed near the trial's end with Dr. Harris' efforts to redefine the product market [T2373-74 (Harris)].

g. Regional Prices. Defendants promoted DRHS through a statistical presentation showing that the Dubuque hospitals were 26% less expensive than other urban hospitals in Iowa. [E4 & 42] Although Mercy and Finley's top officers confirmed that this information was intended to be accurate and relied on by the public [T193-94 (Huewe), 977-78 (Rogols) (calling it the best available data); Fuller(9/12) 90-91 (hospital staff people tell him that Mercy compares favorably to the regionals)], to avoid the implication of that never-retracted public representation--of giving DRHS a price umbrella under which it could raise prices--defendants sought to prove two conflicting points: (i) that public data did not exist to compare hospital prices [T2382-83 (Harris)]; and (ii) that all the regionals were priced the same [1922-23 (Steele)].

h. Managed Care Plans. Defendants' documents are riddled with suggestions that a purpose in the creation of DRHS is to produce a "united front" for dealing with the "problem" that managed care plans, in the view of Mercy and Finley, do not pay their "fair share" [E1, 72, 77, 157 (DRHS would serve the purpose of "strengthening the hospitals' position in contracting for managed care")] which third party observers have noted as well [E35]. While this point was acknowledged during pretrial depositions [Chesterman 133-34], defendants' trial testimony just ignored those documents and earlier testimony or indeed denied it [T70 (Huewe), 1366 (Guetzko), 1844, 1855 (Steele)].

i. Price Discrimination (Selective Contracting). Recognizing that the possibility of price discrimination (selective contracting) would negate their contention that outreach clinics could provide a competitive check on DRHS, near the end of trial, defendants had Dr. Harris hypothesize that price discrimination could not be accomplished. [T2504-05 (Harris)] Finally,

this testimony had to be retracted [T2586-90, 2665-67 (Harris)], even without regard to the testimony of the highest Mercy and Finley representatives who said that it was feasible, and indeed was a recognized practice throughout the region [T119 (Huewe), 884-86, 1039-42 (Rogols), 1983-85 (Tokheim), 2306-09 (Tracy)].

j. The Partnership Agreement. Although defendants conceded that the partnership agreement (E166) was intended to be the complete expression of the parties' agreement and was unequivocal in its terms [T99-100 (Huewe), 911-12 (Rogols)], they gave testimony in response to defense counsel and otherwise to the effect that the board had powers well beyond what was stated plainly in the writing [T217 (Huewe), 905 (Rogols), 1271(Moody)].

k. Competition with the Regionals. In an effort to make the argument of full competition between the Dubuque hospitals and the regional hospitals, Mercy and Finley's presidents took the position that such regional competition would extend into the City of Dubuque even for normal obstetric services. [T36-37 (Huewe), 928, 930-31 (Rogols)] But defendants' regional expert acknowledged the obvious: There is no such competition for normal obstetric services [T2266-67, 2329 (Tracy)], just as there cannot be for a whole range of services requiring frequent pre- and post-admission visits or immediate admission [T770-71 (Runde)]. Further, there is no regional competition for the people living within 20 miles of Dubuque for the full range of primary and secondary services. [T2210-12, 2221, 2267 (Tracy), 132-33 (Moody)]

l**. Likelihood of Achieving Efficiencies.** During cross-examination, consistent with his deposition testimony and the deposition testimony of other Mercy and Finley representatives [FOF F(1)], DRHS' future chairman acknowledged that, even without regard to the possible

resistance that might arise from physicians or the community, whether any consolidations actually would occur would be a matter of "pure speculation" [FOF F(2);T1261-68 (Moody)]. Then, on redirect, he simply changed his testimony [T1307-09 (Moody)], culminating with the explanation that, by the terms "pure conjecture" and "speculation" he meant "not definite or not firmly decided" [T1309 (Moody)].

m. Practical Approach. Dr. Harris urged the Court to take a "practical" approach about what will happen after the creation of DRHS, but then ignored the record evidence of price discrimination and the uncontroverted facts about Ottumwa (that prices rose 20% after it became a one-hospital town).

n. Patient-Physician Loyalty. Notwithstanding the contrary testimony from other defendant witnesses [T2290-91 (Tracy)], Dr. Harris insisted that people are not reluctant to switch doctors based on his view that the doctor-patient relationship is weakening [T2496-97 (Harris)], even though one of the surveys he relied on showed precisely the contrary [T2563-64 (Harris); E206 at 55, 61 (KCA survey done for Mercy)].

o. Money Transfers' Effect on Pricing. Defendants contended that the out-of-state money transfers did not affect Mercy's prices. To support that contention, Mr. Guetzko explained at trial that that is so because the money transfers come out of net cash flow. [T1380 (Guetzko)] The problem with this contention is that, if it is right, then capital expenditures and equipment purchases also do not affect prices, which is precisely the position Mr. Guetzko took. [T1411-12 (Guetzko)] Lest we be left to wonder if any Mercy expenditures can impact its pricing, Mr. Fuller confirmed that, just as any expense can affect pricing, so too the money transfers. [Fuller (8/19) 46-48]

p. The Ottumwa Hypothetical. Throughout the pretrial [see, e.g., Defendants' Trial Brief at 27; Chesterman 133-34], and into the trial, defense counsel took the position that elimination of managed care plan discounts would not constitute a competitive harm if the overall prices "to the community" were lower. However, when that scenario, in response to an inquiry from the Court, was posed to Finley's president--who refused to address it [T855-59 (Rogols)]--defense counsel disclaimed that the scenario represented defendants' position [T859-65]. That retreat hardly was surprising, because, if the scenario "worked," as Dr. Harris acknowledged [T2573-80 (Harris)], it would "work" only if the managed care plans could not shift their enrollees to other hospitals and, hence, the scenario itself was proof both of the Government's proposed market and the existence of DRHS' market power.

Conclusion

There is no question that there are people and groups in Dubuque who feel strongly that the merger should be permitted. Likewise, there is no question that there are people and groups in Dubuque who feel equally as strongly that this merger will be deleterious to the Dubuque community. In the final analysis, however, the breadth and depth of sentiment are not relevant to the statutory inquiry that is at the center of this dispute. It has been decades since Congress, through section 7 of the Clayton Act, spoke clearly and explicitly to the problem of mergers. In hindsight, it could have been speaking to this case.

November 10, 1994.

Respectfully submitted,

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