

**In the Matter of Evanston Northwestern Healthcare Corporation**  
**Docket No. 9315**

**OPINION OF THE COMMISSION ON REMEDY**

By ROSCH, Commissioner, For A Unanimous Commission:

**I. INTRODUCTION<sup>1</sup>**

On August 6, 2007, the Commission ruled that the acquisition by Evanston Northwestern Healthcare Corporation (“ENH”) of Highland Park Hospital (“Highland Park”) in 2000 was anticompetitive and violated Section 7 of the Clayton Act. Although the Commission recognized that “[s]tructural remedies are preferred for Section 7 violations,” it found that “this is the highly unusual case in which a conduct remedy, rather than divestiture, is more appropriate.” Op. at 89. Specifically, the Commission determined that a more appropriate remedy here would be to require ENH to establish separate and independent negotiating teams – one for Evanston Hospital and Glenbrook Hospital (collectively referred to as “Evanston”), and another for Highland Park – to “allow MCOs [managed care organizations] to negotiate separately again for those competing hospitals, thus re-injecting competition between them for the business of MCOs.” *Id.* at 90. The purpose of having separate and independent negotiating teams for Evanston and Highland Park is to replicate the competitive conditions that existed prior to ENH’s 2000 acquisition of Highland Park as much as possible, short of divestiture. The accompanying Order should be read in that light. Prior to the acquisition, MCOs had the ability to negotiate separately with each hospital. Our Order restores that ability to MCOs, and is designed to ensure that MCOs and patients in the Chicago North Shore suburbs will not have to pay supracompetitive prices.

Because the Commission lacked sufficiently detailed information about the personnel involved in ENH’s contract negotiations, or ENH’s overall business operations, to craft a remedial order with precision, in our liability decision we asked Respondent to submit a detailed proposal for implementing the type of injunctive relief selected by the Commission. Respondent submitted a proposed final order on September 17, 2007; complaint counsel submitted their

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<sup>1</sup> This opinion uses the following abbreviations:

CCFO - Complaint Counsel’s Comments on Respondent’s Proposed Final Order  
IDF - Numbered Findings of Fact in the ALJ’s Initial Decision  
Op. - Commission’s Liability Opinion  
RCAB - Respondent’s Corrected Appeal Brief  
RFO - Respondent’s Submission in Support of its Proposed Final Order  
RPTB - Respondent’s Post-Trial Brief  
RRFO - Respondent’s Corrected Response on Proposed Final Order  
TR - Transcript of Trial before the ALJ

comments on Respondent's proposal on October 29, 2007; and Respondent filed a reply on November 8, 2007.<sup>2</sup>

The principal issue in dispute between the parties at this juncture is whether the requirement that payors be allowed to negotiate separate managed care contracts for Highland Park and Evanston should apply only to inpatient services, as Respondent proposed, or instead whether, as complaint counsel argued, payors should be allowed to negotiate separately for the full range of hospital services – outpatient, as well as inpatient. The parties also disagreed on the definition of payors that will have the option to negotiate separate managed care contracts under the Order. Respondent wanted to exclude governmental payors, while complaint counsel proposed a broader definition of payors. In addition, we consider whether it would be better to make separate negotiations the default setting, to be employed unless payors opt out and instead elect to negotiate a single managed care contract for all ENH hospitals, rather than requiring payors to opt in to commence separate negotiations, which is what Respondent proposed. We also consider whether it is appropriate for the same negotiating teams who negotiate the separate managed care contracts also to be allowed to negotiate a single contract for all ENH hospitals when the payor opts to do so. Finally, there is disagreement between the parties over ENH's proposal for a dispute-settlement mechanism that the Commission requested in the event that the constituent hospitals and those negotiating with them cannot reach agreement when separate negotiations are elected.

We discuss our resolution of these issues, and other provisions of the Final Order we enter today, below.

## II. SEPARATE NEGOTIATIONS

### A. The Scope of the Order

In our Opinion on liability, we found that ENH's acquisition of Highland Park "eliminated the pre-merger price competition between Evanston and Highland Park, as well as the MCOs' option of contracting with one hospital but not the other."<sup>3</sup> We determined that, under the unique circumstances present in this particular case, this competitive harm would be best remedied by

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<sup>2</sup> Respondent filed a corrected reply on November 9, 2007.

<sup>3</sup> Op. at 89. *See also id.* at 16 (after the acquisition ENH "set about negotiating a single contract for all three of its hospitals with each MCO" and "did not offer the MCOs the option to enter into separate contracts for the hospitals, or to decline to use one or more of the three hospitals").

imposing injunctive relief that “will allow MCOs to negotiate separately again for these competing hospitals, thus re-injecting competition between them for the business of MCOs.” *Id.* at 90.

Respondent argued that it should be required to allow payors to negotiate separate managed care contracts with Highland Park only with regard to inpatient services, not outpatient services, because the relevant product market found by the Commission was acute inpatient hospital services. RFO at 2; RRFO at 2. Complaint counsel responded that limiting separate negotiations to inpatient services ignores the reality of competitive negotiations for hospital services, and deprives payors of the ability to weigh the benefits of contracting exclusively with one hospital on the basis of the total price for all hospital services. CCFO at 6-7.

Contrary to Respondent’s argument, our findings regarding the relevant product market do not constrain us to fashion so narrow a remedy.<sup>4</sup> The principal purpose of relief in a Section 7 case is to restore competition that would have existed but for the illegal merger. *In re RSR Corp.*, 88 F.T.C. 800, 893 (1976), *aff’d*, *RSR Corp. v. FTC*, 602 F.2d 1317 (9<sup>th</sup> Cir. 1979). To this end, the Commission has broad discretion to impose relief that is “necessary and appropriate in the public interest to eliminate the effects of the acquisition offensive to the statute.” *United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586, 607 (1957). *See also Chicago Bridge & Iron Co. N.V. v. FTC*, 515 F.3d 447, 476 (5<sup>th</sup> Cir. 2008)(“[A]ll doubts as to the remedy are to be resolved in the [Commission’s] favor.”)(quoting *United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 334 (1961)).

We agree with complaint counsel, and find that limiting separate negotiations to inpatient services would not effectively re-inject competition between Highland Park and Evanston for the business of MCOs because it does not comport with the reality of how payors contract for hospital services. It is clear from the record, and Respondent did not dispute (indeed, Respondent itself asserted), that MCOs typically do not contract separately for inpatient and outpatient services.<sup>5</sup> Rather, they negotiate and contract for the entire set of hospital services in one contract. TR 200 (Ballengee); TR 556-57 (Mendonsa), *in camera*; TR 1122 (Foucre), *in camera*; TR 1585 (Holt-

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<sup>4</sup> While Respondent asserted that we found that competitive harm occurred only with respect to inpatient services, RRFO at 2, in fact, we found that including hospital-based outpatient services in the relevant product market would not alter our findings of competitive harm. Op. at 57.

<sup>5</sup> *See* RPTB at 5 (“The undisputed evidence confirms that MCOs contract with hospitals for the entire bundle of inpatient and outpatient services that hospitals provide, often ‘trading off’ the price of inpatient and outpatient services against one another to get a deal done.”); *id.* at 17 (“[i]t is undisputed that payors contract with hospitals for the entire bundle of inpatient . . . and outpatient services that hospitals provide . . .”).

Darcy), *in camera*; TR 2299-300 (Spaeth). The evidence showing that payors make contracting decisions based on the price of the entire set of hospital services, sometimes trading off the price of inpatient services and outpatient services to get an acceptable total price, is not, as Respondent contended, inconsistent with our finding of a distinct inpatient services product market in which the competitive effects of this transaction can be assessed. TR 2663-65 (Haas-Wilson). It does, however, demonstrate that, for payors, the option to negotiate separately with Highland Park solely for inpatient services would be of dubious value. Accordingly, we find that, in order to meaningfully and effectively restore competition between Highland Park and Evanston for the business of MCOs, payors must be able to negotiate separately with Highland Park for all hospital services, not just inpatient services.

Complaint counsel also pointed out that there may be certain services that, prior to the merger, were furnished at Highland Park and Evanston, that are now provided by ENH on a centralized basis to patients discharged from any of the hospitals in the ENH system. The Order's definition of "Hospital Services," which includes all "services that are included as part of an admission of a patient to an inpatient bed" within the hospital and "all outpatient services that are related to the use of that hospital" is intended to make clear that if a payor elects to contract exclusively with one of the hospitals, it can obtain, through negotiations with that hospital's negotiating team, the full panoply of services needed to serve its plan enrollees, including any such services that are provided by ENH on a centralized basis.

The other question the parties have raised concerning the scope of our Order relates to the definition of a "payor" who must be allowed to negotiate separately with Highland Park and Evanston. Complaint counsel proposed a definition that has been used in other health care orders issued by the Commission, including the 2005 consent order in this matter that settled the allegations of physician price fixing in Count III of the administrative complaint.<sup>6</sup> Respondent argued that this definition should contain an exclusion for "government payors" because complaint counsel alleged, and the Commission found, harm only as to commercial MCOs and not to government payors such as Medicare and Medicaid. RRFO at 2-3.

We agree with Respondent that government insurance programs such as Medicare and Medicaid should not be brought within the scope of the Order.<sup>7</sup> We are concerned, however, that Respondent's proposed exclusion of all "government payors" is unduly broad. There are governmental entities that, wholly apart from public health insurance programs such as Medicare

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<sup>6</sup> See *Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc.*, Docket No. 9315, Decision and Order (issued May 17, 2005), at 3, available at <http://www.ftc.gov/os/adjpro/d9315/050520do.pdf>.

<sup>7</sup> Rates for Medicare and Medicaid are set unilaterally by the government, and are not determined by negotiation or contract. IDF 128.

and Medicaid, contract and pay for health care services. For example, a municipality may procure and pay for health care coverage for its employees as a self-insured entity, much in the same way that some private employers do. To the extent that such a governmental entity may seek to contract for hospital services, we see no reason to exclude it from the scope of the Order. Accordingly, we have modified Respondent’s proposed language to specify that the term “payor” excludes government payors for public health insurance programs, such as Medicare and Medicaid.

**B. Separate Negotiations Should Be the Default Setting**

Under Respondent’s proposed order, it would have no obligation to commence separate negotiations for Highland Park and Evanston, unless a payor affirmatively asks to negotiate separately. Respondent thus envisioned that the default setting for managed care contract negotiations should be the *status quo* as it exists now, putting the onus on payors to re-introduce competition between Highland Park and Evanston for their business. We do not think the onus should be on payors to re-introduce the competition our Order here seeks to remedy. We think our remedy will be more effective if we make separate negotiations the default setting. Under this approach, ENH will be required to commence separate negotiations when contacted by a payor to negotiate a managed care contract, unless the payor (after notification by ENH of the Order) states its intent to contract jointly for both Highland Park and Evanston. For current contracts, Respondent shall promptly offer all payors the option of re-opening and re-negotiating them under the terms of the Order.

This remedy is designed to ensure that competition between Highland Park and Evanston for the business of MCOs is re-established as the norm, rather than treated by ENH (and, more to the point, by its personnel responsible for negotiating managed care contracts) as a departure from ENH’s standard procedures for contract negotiations. This approach also will serve to minimize the risk that competitively sensitive information will be shared by the Evanston and Highland Park negotiating teams. Although the Order requires Respondent to put in place a firewall-type mechanism to prevent the sharing of such information, we think that such a firewall will be far more effective if separate negotiations are understood to be the baseline for managed care contract negotiations.

Of course, if a payor decides it is preferable to contract jointly for hospital services at both Highland Park and Evanston, it can communicate its intent to ENH and elect not to proceed with separate negotiations. But, by making separate negotiations the default setting, with payors able to opt out, we put the burden of restoring competition between Highland Park and Evanston squarely where it belongs – on ENH itself, not on the payors.

### **C. The Two Negotiating Teams Shall Remain Separate**

In our liability decision, we ordered Respondent to identify and describe a firewall-type mechanism that would prevent the Evanston and Highland Park negotiating teams (and other relevant personnel) from sharing any information that would inhibit them from competing with each other and with other hospitals. We are not satisfied with the firewall mechanisms that Respondent has proposed. Respondent defined the ENH negotiating team as the team responsible not just for the negotiations with Evanston when payors elect to negotiate for Evanston separate from Highland Park, but as the team also responsible for negotiating all services at all ENH hospitals when payors opt to negotiate for all three ENH hospitals together. The ENH negotiating team thus wears two hats. Respondent's firewall proposal did not discuss, much less explain, how the ENH negotiating team would be prevented from utilizing competitive information gained from its negotiations wearing one hat versus the other. For example, there is nothing to prevent the ENH negotiating team from using competitive information gained from negotiating with payors on behalf of all three hospitals in a strategic manner when that same negotiating team conducts negotiations with payors who elect to negotiate separately with Evanston Hospital (as separate from Highland Park).

This result is inconsistent with the Commission's purpose in creating the separate and independent negotiating teams on behalf of Evanston and Highland Park, and it undermines our determination that separate negotiations be the default setting. The teams are to be *separate and independent* so as to replicate as best possible, short of divestiture, the competitive conditions that would have existed without the merger of ENH and Highland Park. The negotiating teams cannot be "separate and independent" if the ENH negotiating team also negotiates on behalf of all three hospitals.

Consequently, we think the firewall mechanism will be effective only if the Evanston and Highland Park negotiating teams are not permitted to engage in negotiations with payors who opt to negotiate jointly for hospital services at all three ENH hospitals. Our Order in this respect defines the Evanston negotiating team as only negotiating contracts for the two Evanston hospitals, and not all three hospitals as Respondent proposes. This is consistent with the purpose of the Order to ensure that competition between Highland Park and Evanston for the business of MCOs is re-established as the norm, rather than treated by ENH (and, more to the point, by its personnel responsible for negotiating managed care contracts) as a departure from ENH's standard procedures for contract negotiations. This approach will minimize the risk that competitively sensitive information will be shared by the Evanston and Highland Park negotiating teams.

### **III. DISPUTE RESOLUTION MECHANISM**

In its Notice Of Contemplated Relief accompanying issuance of the Complaint in this matter, the Commission made it clear that if it did not order divestiture to remedy any violation it found, it would consider all alternatives that might be reasonably necessary and appropriate to

restore competition lost because of the merger. In its liability brief to the Commission, Respondent suggested the creation of separate negotiating teams as such a remedy. RCAB at 91-91. The Commission did not believe that remedy, standing alone, was sufficient. It was concerned that separate negotiating teams working for the same corporate entity might have overarching knowledge unavailable to separate negotiating teams working for different corporate entities, and that, in any event, the former might not have the same incentives as the latter to bargain against each other as would occur in a competitive market. For that reason, upon finding liability, the Commission issued an order asking Respondent and complaint counsel for their views respecting what measures might be reasonably necessary or appropriate, including a dispute resolution mechanism, to ensure compliance with the remedy proposed by Respondent.

Complaint counsel echoed the Commission's concern about the effectiveness of the separate negotiating team remedy standing alone, explaining that the separate negotiating teams would have no incentive to bargain against each other, since they would both ultimately be part of Respondent. CCFO at 3, 11. Complaint counsel also pointed out that a similar non-divestiture remedy, standing alone, did not work for the Department of Justice Antitrust Division in another context. *Id.* at 3 n.4. Respondent did not come to grips with complaint counsel's concerns in this regard. It simply said it disagreed with those concerns. RRFO at 1, n.1.

Notwithstanding that disagreement, Respondent recommended that disputes with payors be submitted to mediation, and then, if necessary, to binding arbitration; it drew an analogy to such arbitrations in many commercial contexts. Respondent explained that "[t]he first step in any controversy would be mediation under the Commercial Mediation Rules of the American Arbitration Association ("AAA"). In the event that the conflict persists, binding arbitration under a mutually-agreed upon arbitrator who would be charged with determining an appropriate resolution. These provisions are commonly-accepted methods of private dispute resolution in the commercial context and are, as a result, reasonable when applied in light of a disagreement between a Payor and the hospital(s)." RFO at 5.

Complaint counsel expressed concern that there not be an inappropriate delegation of the Commission's authority over ENH's compliance with the Order. CCFO at 9-10. However, complaint counsel stated that they would have no objection to the inclusion of such dispute resolution procedures to resolve purely private contractual issues that might arise in the ordinary course in ENH's contracts with payors. *Id.* at 9.

This background explains the reasons for the dispute resolution mechanism we adopt today. We continue to believe that a dispute-settlement mechanism is reasonably necessary and appropriate to restore the competitive conditions that existed prior to the merger – *i.e.*, that the separate negotiating teams negotiate with payors in good faith, and that when the constituent hospitals and those negotiating with them cannot reach agreement, there be a means to resolve the impasse. To this end, we adopt Respondent's suggestion that there be mediation, and then, if necessary, binding arbitration between ENH and payors as to disputes over the pricing and/or

other terms resulting from the separate negotiations required under the Order.<sup>8</sup> We consider this reasonably necessary and appropriate to stimulate compliance with Respondent's suggestion that separate negotiations be implemented. Lest there be any doubt about the Commission retaining jurisdiction over violations or possible violations of the Order, the Order provides that neither the mediator nor the arbitrator shall have any responsibility or authority to resolve issues concerning any violation or possible violation of the Order.

We require Respondent, at the option of the payor, to first try in good faith to settle the dispute by mediation in accordance with the Commercial Mediation Rules of the AAA. If the dispute cannot be settled by mediation, then it must be settled by binding arbitration in accordance with the AAA's Commercial Arbitration Rules. In order to best ensure that the arbitrator will be qualified to resolve such disputes, we order that the arbitration be held before a single arbitrator mutually agreed upon by Respondent and the payor. Unless otherwise agreed between the parties to the arbitration, the manner of binding arbitration will be Final Offer Arbitration (sometimes referred to as "baseball style arbitration"), whereby each side must submit its best and final offer and the mutually agreed arbitrator shall then be obliged to pick what it believes is the best offer. We consider Final Offer Arbitration to be attractive here because it has the "ability to induce two sides to reach their own agreement, lest they risk the possibility that a relatively extreme offer of the other side may be selected by the arbitrator."<sup>9</sup> The standard to be used by the arbitrator in making its decision shall be what pricing/terms are fair and reasonable assuming competition between the hospitals as would exist but for the merger. In order further to motivate the submission of fair and reasonable proposals, the loser shall pay the cost of the arbitration (excluding attorneys fees), unless the parties settle prior to final decision of the arbitrator or the method of arbitration adopted by mutual agreement is not Final Offer Arbitration. In that event, if the parties do not agree how the costs shall be divided, the arbitrator shall decide.

The dispute resolution mechanism described above is reasonably related and ancillary to the primary remedial purpose of the separate negotiating teams required in the Order. As previously described, Respondent itself suggested the remedy of separate negotiating teams to the Commission in its appeal brief as an effective means for the Commission to restore competition lost from the merger. RCAB at 91-92. Respondent itself also suggested mediation, and if necessary, binding arbitration, as its mechanism of choice for resolving disputes with payors, and explained that arbitration is common in many commercial contexts, as discussed above. RFO at 5. In sum, the binding arbitration provision we have ordered is aimed at overcoming the structural

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<sup>8</sup> The arbitration provision does not apply when a payor opts to negotiate jointly with all three hospitals.

<sup>9</sup>S TEVEN J. BRAMS, *NEGOTIATION GAMES: APPLYING GAME THEORY TO BARGAINING AND ARBITRATION* 264 (2d ed. 2003).

difficulties of an order requiring separate negotiations by teams which are part of a single corporate entity, and is thus reasonably necessary to promote the effectiveness of the Order.

Separate negotiations without a binding arbitration provision are a non-starter in this case. Our only other choice absent inclusion of binding arbitration would be to order divestiture, and that is not our preference, given the unique circumstances described in our liability decision.

#### **IV. THE FINAL ORDER**

We turn now to the specific provisions of our Final Order. Paragraph I defines the terms used in the Order. Paragraph II requires ENH to negotiate managed care contracts for hospital services at Evanston (defined to include both Evanston and Glenbrook Hospitals) separately from managed care contracts for hospital services for Highland Park, and vice versa. Paragraph II prohibits ENH from making a contract for Evanston contingent on entering into a contract for Highland Park, or vice-versa; it also prohibits ENH from making the availability of any price or term in a contract for Evanston contingent on agreeing to such prices or terms in a contract for Highland Park. Paragraph II allows ENH to negotiate a managed care contract for Evanston and Highland Park together with a payor that specifically elects to negotiate and contract jointly for both hospitals rather than to negotiate separately.

Paragraph II also requires Respondent, at the request of the payor, to submit disputes as to prices and/or terms obtained by payor as a result of the separate negotiations, first, to mediation and, if that is not successful, to binding arbitration. The terms of our Order require Respondent and a payor to first try to settle the dispute by mediation in accordance with the Commercial Mediation Rules of the AAA. If the dispute cannot be settled by mediation, then it must be settled by arbitration in accordance with the AAA's Commercial Arbitration Rules before a single arbitrator mutually agreed upon by Respondent and the payor. Unless the parties agree to an alternative manner of arbitration, the Order requires Final Offer Arbitration. The costs, excluding attorney's fees, are to be borne by the loser, unless the parties settle prior to final decision of the arbitrator or the method of arbitration adopted by mutual agreement is not Final Offer Arbitration. In that event, if the parties do not agree how the costs shall be divided, the arbitrator shall decide. Neither the arbitrator nor the mediator shall have any responsibility or authority to resolve issues concerning any violation or possible violation of the Order. The arbitration option of Paragraph II.D. does not apply to payors that choose to negotiate managed care contracts for all hospitals jointly. Paragraph II.D. states that the arbitrator shall determine fair and reasonable prices and/or terms, assuming competition between the hospitals, as would exist but for the merger.

Paragraph III requires ENH to establish separate and independent negotiating teams for Evanston, on the one hand, and Highland Park, on the other, and to negotiate managed care contracts in competition with each other and other hospitals. Paragraph III allows ENH to negotiate jointly for services at all three hospitals with payors who opt out of separate

negotiations, but the two teams used to negotiate for Evanston and Highland Park separately shall not be involved in the joint negotiations.

In order to ensure that these separate negotiating teams make independent contracting decisions, and to protect competitively sensitive contracting information, Paragraph IV of the Order requires ENH to maintain the confidentiality of that information and to establish and implement procedures and protections to accomplish that. In order to preserve the efficiencies of ENH's integrated contract administration, ENH's Corporate Managed Care Department will be permitted to obtain managed care contracting information from both negotiating teams, but that department will be prohibited from making managed care contracting information obtained from one negotiating team available to the other negotiating team.

In addition, Paragraph V of the Order requires ENH to allow payors with pre-existing contracts to re-open those contracts and re-negotiate separate managed care contracts for Highland Park and Evanston. This provision is needed so that ENH does not continue to benefit from its post-merger practice of denying payors the option of contracting with one hospital but not the other, which gave ENH the leverage to negotiate higher prices from payors. *See Op.* at 15-16.

Paragraph X requires ENH to give prior notification to the Commission for any future acquisitions of hospitals that ENH may make within the Chicago Metropolitan Statistical Area for the next ten years. The prior notification requirement is similar to those used in other hospital merger orders issued by the Commission. Compliance with this requirement will provide to the Commission information about future acquisitions that would not be subject to the reporting and waiting obligations of the Hart-Scott-Rodino Act.

Paragraph XII specifies that the Order will terminate after twenty years. Although Respondent urges us to terminate the Order after ten years, a 20-year sunset provision is consistent with the Commission's standard policy that core injunctive provisions of FTC administrative orders will ordinarily terminate after twenty years.<sup>10</sup> We see no reason to depart from that policy here. Respondent may, of course, seek to modify or set aside the Order, pursuant to Section 2.51 of the Commission's Rules of Practice,<sup>11</sup> at any time prior to the expiration of twenty years if the Order is no longer in the public interest.

Paragraphs VI and IX relate to ENH's requirement to notify affected persons of the existence of the Order. Paragraph VII imposes reporting obligations on ENH similar to those in

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<sup>10</sup> *See* Policy Statement Regarding Duration of Competition and Consumer Protection Orders, 60 Fed. Reg. 42,569 (Aug. 16, 1995); Duration of Existing Competition and Consumer Protection Orders, 60 Fed. Reg. 58,514 (Nov. 28, 1995).

<sup>11</sup> 16 C.F.R. § 2.51.

other Commission merger orders to aid the Commission in monitoring ENH's compliance with its obligations. Finally, Paragraphs VIII and XI are standard obligations in Commission orders relating to ENH's compliance with the Order.

#### IV. CONCLUSION

We acknowledge the criticisms of the remedy in this case, specifically that it does not require divestiture. We cannot stress enough, however, that the circumstances of this case are extraordinary. First, this is not a case in which the eggs were simply scrambled after the merger was consummated. That will almost never justify a remedy short of divestiture. Rather, this is a case in which a critical improvement was made to Highland Park after the merger was consummated (namely, the development and implementation of a cardiac surgery program). The record reflects that divestiture of Highland Park could have a substantial negative impact on Highland Park's cardiac surgery program. For example, Dr. Romano, complaint counsel's expert, testified that, standing alone, Highland Park might not have the volume that it needs to maintain the cardiac surgery program.<sup>12</sup> TR 3193 (Romano), *in camera*. Thus, if we were to order divestiture, and Highland Park were to lose the benefits of that program, Highland Park might not be an effective competitor, and competition might not be restored.

Second, and most important, this case involved a retrospective challenge that was made after the key improvement had already been made at Highland Park. We stress that divestiture will almost always be ordered when a merger is challenged, or faces the threat of a challenge, before the merger is consummated or before improvements are made at the acquired facility. As we indicated in our liability decision, in those circumstances, the acquiring party proceeds to close the transaction at its peril, and in taking any actions after consummation of the transaction, including making improvements to the acquired facility, it will be deemed to have assumed the risk that the acquired hospital or other facility will be ordered divested if liability is found. *See* Op. at 90-91. We emphasize that this was *not* the case for ENH's proposed acquisition of Highland Park. ENH did not "close its transaction at its peril," because at the time of its acquisition and the development of the cardiac program at Highland Park, there was no

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<sup>12</sup> A delay in reestablishing Highland Park's cardiac surgery program also puts at risk Highland Park's interventional cardiology services, which involve procedures that may be scheduled in advance. To have an interventional program, it is necessary to have a backup cardiac surgery program in case complications occur. TR 5306-07 (Chassin).

investigation underway by the Commission.<sup>13</sup> This is not to say if parties to a merger found to be illegal lack notice of a possible challenge, divestiture will not be ordered. As we noted in our liability decision, divestiture is still almost always the appropriate remedy in such cases.<sup>14</sup> Op. at 90-91. But given the unique circumstances in this case we believe that a remedy short of divestiture is appropriate.

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<sup>13</sup> By contrast, in *Chicago Bridge & Iron Co. N.V. v. FTC*, 515 F.3d 447 (5<sup>th</sup> Cir. 2008), where the Commission did order divestiture of assets after the transaction had been consummated, the parties *were* on notice that they closed at their peril, because the Commission had opened an investigation before the transaction closed, and the parties closed the transaction in the face of that investigation. *Chicago Bridge & Iron*, 515 F.3d at 455 (stating that “[p]rior to the acquisition, the Commission notified CB&I that it had significant antitrust concerns about the acquisition and was conducting an investigation.”).

<sup>14</sup> The Supreme Court has confirmed that divestiture, even if it imposes costs on the violator, is the preferred remedy. *United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 327 (1961). This is true notwithstanding the enactment of the Hart-Scott-Rodino Act (“HSR Act”). The purpose of the HSR Act is to enable the antitrust enforcement agencies to block unlawful mergers before they occur, in recognition that this is preferable to ordering divestiture after the fact. But the law is clear that the Commission has the authority to order divestiture in matters that are not challenged prior to consummation. Clayton Act, Section 11(b), 15 U.S.C. § 45(b); *see also California v. American Stores Co.*, 495 U.S. 271, 284-85 n. 11 (1990).