UNITED STATES DISTRICT COURT

IN THE DISTRICT OF IDAHO

SAINT ALPHONSUS MEDICAL CENTER - NAMPA, INC., TREASURE VALLEY HOSPITAL LIMITED PARTNERSHIP, SAINT ALPHONSUS HEALTH SYSTEM, INC., AND SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC. Plaintiffs, v. ST. LUKE'S HEALTH SYSTEM, LTD. Defendant.	Case No. 1:12-CV-00560-BLW (Lead Case) **FINDINGS OF FACT AND CONCLUSIONS OF LAW**
FEDERAL TRADE COMMISSION; STATE OF IDAHO Plaintiffs, v. ST. LUKE'S HEALTH SYSTEM, LTD.; SALTZER MEDICAL GROUP, P.A. Defendants.	Case No. 1:13-CV-00116-BLW

INTRODUCTION

The Court completed a bench trial in this case in October of 2013, and directed counsel to file proposed Findings of Fact and Conclusions of Law. Those have been filed and the case is at issue. For the reasons explained below, the Court finds for the plaintiffs and will order divestiture of the affiliation between St. Luke's and the Saltzer Medical Group.

SUMMARY

For years, health care costs have exceeded the inflation rate. Americans spend more on health care than the next 10 biggest spenders combined – a list that includes Japan, Germany, France and the U.K. – yet we lag behind many of them on quality and patient outcomes. In Idaho, the quality of our health care is outstanding, but we pay substantially more than the national average for that quality.

Among the experts, there is a rough consensus on a solution to the cost and quality concerns nationwide. They advocate moving away from our present fee-for-service health insurance reimbursement system that rewards providers, not for keeping their patients healthy, but for billing high volumes of expensive medical procedures. A far better system would focus on maintaining a patient's health and quality of life, rewarding successful patient outcomes and innovation, and encouraging less expensive means of providing critical medical care. Such a system would move the focus of health care back to the patient, where it belongs.

In fact, there is a broad if slow movement to such a system. It will require a major shift away from our fragmented delivery system and toward a more integrated system where primary care physicians supervise the work of a team of specialists, all committed to a common goal of improving a patient's health.

St. Luke's saw this major shift coming some time ago. And they are to be complimented on their foresight and vision. They started purchasing independent physician groups to assemble a team committed to practicing integrated medicine in a system where compensation depended on patient outcomes.

In Nampa, they acquired the Saltzer Medical Group ("the Acquisition"). The combined entity now includes 80% of the primary care physicians in Nampa. Its size, and the sterling reputations of Saltzer and St. Luke's, make it the dominant provider in the Nampa area for primary care, and give it significant bargaining leverage over health insurance plans.

These circumstances prompted the Federal Trade Commission (FTC), and a group of other health care providers including St. Alphonsus and Treasure Valley Hospital, to file this lawsuit claiming that the Acquisition violated the antitrust laws. They ask the Court to unwind the deal.

The antitrust laws essentially require the Court to predict whether the deal under scrutiny will have anticompetitive effects. The Court predicts that it will. Although possibly not the intended goal of the Acquisition, it appears highly likely that health care costs will rise as the combined entity obtains a dominant market position which will enable it to (1) negotiate higher reimbursement rates from health insurance plans that will be passed on to the consumer, and (2) raise rates for ancillary services (like x-rays) to the higher hospital-billing rates.

The Acquisition was intended by St. Luke's and Saltzer primarily to improve patient outcomes. The Court believes that it would have that effect if left intact, and St. Luke's is to be applauded for its efforts to improve the delivery of health care in the Treasure Valley. But there are other ways to achieve the same effect that do not run afoul of the antitrust laws and do not run such a risk of increased costs. For all of these

reasons, the Acquisition must be unwound. The Court will set forth its detailed Findings of Fact and Conclusions of Law below.

FINDINGS OF FACT

Plaintiff Saint Alphonsus

1. Saint Alphonsus Health System, Inc. ("St. Alphonsus") operates hospitals, outpatient clinics, and other health care facilities in the Treasure Valley of Idaho and eastern Oregon.
2. In Idaho, St. Alphonsus owns and operates plaintiff Saint Alphonsus Regional Medical Center, Inc., a 381-bed hospital located in Boise, and Saint Alphonsus Medical Center, Nampa, Inc. ("St. Alphonsus Nampa"), a 152-bed acute care hospital located in Nampa.
3. Saint Alphonsus Nampa is the only hospital in the City of Nampa. *Trial Tr.* at 324 (J. Crouch).
4. Saint Alphonsus employs over 200 physicians, who practice in what Saint Alphonsus calls the Saint Alphonsus Medical Group ("SAMG").
5. Over 60 of the SAMG physicians provide primary care services.
6. SAMG currently employs 20 primary care physicians in Canyon County, at least nine of whom practice in Nampa. *Trial Tr.* at 791 (N. Powell).
7. Saint Alphonsus is owned by Michigan-based Trinity Health, one of the largest Catholic health care systems in the United States. Trinity operates approximately 50 hospitals across the country. *Trial Tr.* at 855 (K. Keeler); *Trial Tr.* at 979-81 (B.Checketts); *Trial Tr.* at 650 (D. Pate)

Plaintiff Treasure Valley Hospital

8. Plaintiff Treasure Valley Hospital Limited Partnership, doing business as Treasure Valley Hospital ("TVH"), is a nine-bed, physician-owned, for-profit hospital in Boise, largely used for outpatient surgeries.

Partnership Between TVH and Saint Alphonsus

9. In the fall of 2012, Saint Alphonsus and TVH jointly opened a new outpatient surgery center in Nampa called the Treasure Valley Surgery Center ("TVSC").

St. Luke's

10. St. Luke's operates the following hospitals in Idaho: (1) St. Luke's Boise Medical Center, a 400-plus bed medical center in Boise; (2) St. Luke's Meridian Medical Center, a 165-plus bed hospital in Meridian; (3) St. Luke's Magic Valley Regional Medical Center, a 228-bed hospital in Twin Falls; (4) St. Luke's Wood River, a 25-bed critical-access hospital in Ketchum; (5) St. Luke's Jerome, a 25-bed critical-access hospital in Jerome; (6) St. Luke's McCall, a 15-bed critical access hospital in McCall; and (7) North Canyon Medical Center, a 15-bed critical access hospital in Gooding.

11. St. Luke's also operates an emergency clinic with outpatient services in Nampa.

12. St. Luke's employs or has entered into a professional services agreement ("PSA") with each of its 500 physicians in numerous medical specialties who are geographically dispersed across southern Idaho and eastern Oregon.[1]

13. Each of the physicians employed by or under a PSA with St. Luke's is part of the St. Luke's Clinic. *Trial Tr.* at 1863-64 (M. Johnson); *Trial Tr.* at 1879 (J. Kee).

14. Prior to the Saltzer transaction, no more than eight of the St.Luke's Clinic physicians who practiced adult primary care services did so in Canyon County. *Trial Tr.* at 2658 (A. Enthoven).

15. Prior to the fall of 2011, St. Luke's did not employ any primary care physicians in Nampa.

16. In the fall of 2011, seven physicians affiliated with the Mercy Physicians Group, who were employed by Saint Alphonsus in Nampa, decided to leave Saint Alphonsus and join St. Luke's. *See Jeffcoat Deposition (Dkt. No. 397)* at 66, 68; *Trial Tr.* at 871-72 (N.Powell).

[1] Under a professional services agreement ("PSA"), a physician practice group agrees to provide health care services exclusively on behalf of St. Luke's, and St. Luke's is reimbursed for the practice's services under contracts that St. Luke's enters into with payors. Although physicians practicing under a PSA do not have a direct employment relationship with St. Luke's, the PSA sets forth the compensation that St. Luke's pays the physician practice for services provided by the physicians on its behalf. For purposes of this case, a PSA arrangement creates a relationship functionally equivalent to employment to the extent that it provides, at the group level, the same clinical and financial alignment that employment provides at the individual level. Therefore, St. Luke's PSA-based relationships with physicians will be described and regarded as the same as "employment" by St. Luke's.

17. Prior to the closing of the Saltzer transaction, St. Luke's had recruited another primary care physician to join the seven who departed from Saint Alphonsus, for a total of eight St. Luke's primary care physicians practicing in Nampa. *Id.*

Saltzer Medical Group

18. Saltzer Medical Group consisted of 41 physicians, nearly three-quarters of whom provide adult or pediatric primary care services.

19. Specifically, 19 Saltzer physicians practice in the specialties of family medicine and internal medicine, while 10 Saltzer physicians are general pediatricians. Thirty-four of the Saltzer physicians, including 16 of the adult primary care physicians and 8 of the pediatricians, practice in Nampa.

20. Saltzer was the largest, independent, multispecialty physician group in Idaho. *Trial Tr.* at 465 (L. Duer).

21. Saltzer is a very prestigious group with a long history. *Trial Tr.* at 465 (L. Duer). Saltzer is "a reputable and long-standing significant player" in the Treasure Valley healthcare community. *See Castledine Deposition (Dkt. No. 262) at* 122; *see also Trial Tr.* 2001-02 (John Kee).

The Acquisition

22. For years before the transaction with St. Luke's, physician leadership at Saltzer saw that health care was demanding integrated services and high quality at reduced costs. *Trial Tr.* at 2371-72 (J. Kaiser); *see also Trial Tr.* at 808 (N. Powell).

23. Saltzer physicians were concerned that the traditional fee-for-service reimbursement model was no longer sustainable and that they needed to explore transitioning to a

value-based compensation model. *Trial Tr.* at 3344 (H. Kunz); *see also Savage Deposition (Dkt. No. 253)* at 65-66.

24. Saltzer believed that it needed to upgrade its medical record system and health information technology to keep pace with the industry, but could not afford to do so without partnering with a larger system. *Trial Tr.* at 3344 (H. Kunz).

25. Prior to making the decision to join St. Luke's, Saltzer made attempts to coordinate care with other health systems under less-formal affiliations. For example, Saltzer worked with the Mercy Medical Center (the former name of what is now Saint Alphonsus-Nampa) in an attempt to coordinate limited services. None of those projects came to fruition because Mercy's out-of-state parent, Catholic Health Initiatives ("CHI"), was unwilling to participate. *Trial Tr.* at 2372-74 (J. Kaiser).

26. After Saltzer's negative experience with Mercy and CHI, Saltzer determined that in order to work effectively towards a solution it would need a local partner in the Idaho community. *Trial Tr.* at 2374 (J.Kaiser).

27. In December of 2008, Saltzer and St. Luke's executed a memorandum of understanding ("MOU") establishing an informal partnership to begin more deliberate and focused efforts around a series of joint initiatives aimed at improving access to high quality medical care, enhancing coordination of medical services, and streamlining the health care delivery model in Ada and Canyon Counties. *Trial Tr.* at 2225-27 (C. Roth); Exhibit 2196.

28. The MOU also outlined five core areas of improvement sought to be achieved by the informal alignment. *Trial Tr.* at 2227 (C. Roth).

29. Although the parties made some progress in the five areas (*Trial Tr.* at 2228 (C. Roth)), and Saltzer physicians such as Dr. Kaiser testified that the relationship succeeded in getting the parties "finally talking about" integration, the parties did not get "a whole lot of things accomplished" (*Trial Tr.* at 2373 (J. Kaiser)), and what limited success was achieved often took years to develop. *Trial Tr.* at 2227-28 (C. Roth).

30. In 2009, Saltzer initiated discussions with St. Luke's regarding a closer affiliation. *Trial Tr.* at 2228-29 (C. Roth); *Trial Tr.* at 3345 (H. Kunz); *Trial Tr.* at 3081 (W. Savage). Negotiations between Saltzer and St. Luke's progressed over approximately three years (*Trial Tr.* at 2237 (C. Roth)) and "evolved significantly" during that time. *Trial Tr.* at 1712 (D. Pate).

31. Effective December 31, 2012, St. Luke's acquired the assets of Saltzer for an amount not to exceed $16,000,000. *See St. Luke's Answer (Dkt No. 100)* at ¶18. Pursuant to this transaction (the "Acquisition"), St. Luke's received Saltzer's intangible assets, personal property, and equipment.

32. In addition, Saltzer, on behalf of its physicians, entered into a five-year professional services agreement ("PSA") with St. Luke's. *See* Exhibit 24.

33. The PSA guarantees Saltzer physicians' annual compensation for the first two years after the agreement will be no less than the average for three years ending September 30, 2011. The PSA also specifies that Saltzer physicians will be compensated on the basis of work Relative Value Units ("wRVUs") for the procedures and services performed by the physicians. *See* Exhibit 24 at SLHS000787894.

34. The PSA contains an "exclusivity" provision that prohibits the Saltzer physicians from becoming employed by or financially affiliated with other health systems or hospitals during the term of the PSA. *Id.* at §§ 3.2, 3.3, 4.1.

35. The PSA also provides that "all Saltzer physicians may have privileges at any hospital and may refer patients to any practitioner or facility regardless of its affiliation with St. Luke's." *Id.* at § 2.2(a).

The parties to the PSA uniformly interpret that provision to mean that Saltzer physicians have complete freedom to refer patients wherever they choose. *Trial Tr.* at 773 (N. Powell); *Trial Tr.* at 1958-60 (J. Kee); *Trial Tr.* at 2241-42 (C. Roth); *Trial Tr.* at 2387 (J. Kaiser).

36. Saltzer physicians currently have a guaranteed salary with additional compensation based on RVUs. *Trial Tr.* at 3321 (T. Patterson).

37. A plan to implement quality-based incentives was referenced in the PSA, but specific quality incentives were not built into the contract at the outset because, according to Dr. Patterson, "it takes time to develop what the outcome measures would be, and so it wasn't something that could be established at the time." *Trial Tr.* at 1337.(T. Patterson).

38. However, it was expected that compensation for the Saltzer physicians would include quality-based incentives in the future. *Trial Tr.* at 3326-27 (T. Patterson).

39. Saltzer and St. Luke's have amended their initial PSA to include an addendum that provides for up to 20 percent of Saltzer's compensation being put at risk or otherwise tied to quality-based incentives. *See* Exhibit 2624; *Trial Tr.* at 3327 (T. Patterson).

40. There is nothing in the PSA that expressly ties compensation for the Saltzer physicians to where they make referrals or to the volume or revenue generated by Saltzer physicians for ancillary services, such as laboratory or imaging services.

41. Saltzer's primary motivation for affiliating with St. Luke's was to provide the best possible health care to the community. *Trial Tr.* at 3313 (T. Patterson); *Trial Tr.* at 3346 (H. Kunz).

42. Saltzer believed that becoming "tightly aligned" with St. Luke's increased the likelihood that St. Luke's would invest the time, resources, and risk to bring much-needed additional services and facilities to Canyon County. *See Page Deposition (Dkt. No. 270)* at 130-31.

43. Saltzer physicians also considered it important that an affiliation with St. Luke's would give them the ability to be "involved in all aspects of care rather than being fragmented as part of an outside system that works in concert with the health system but not integrated with the health system." *Trial Tr.* at 3315 (T. Patterson).

44. Additionally, Saltzer did not believe that by itself, it was big enough, or had sufficient financial reserves, to engage in capitation (or value-based billing) that will be discussed in more detail below. *Trial Tr.* at 2374-75 (J. Kaiser).

45. Saltzer leadership believed that a closer affiliation was necessary to permit Saltzer to transition to value-based compensation, and did not view a joint venture or looser affiliation with St. Luke's as sufficient. *Trial Tr.* at 3318, 3345-46 (T. Patterson).

46. It was also important to Saltzer that an affiliation with St. Luke's would increase access to medical care for the significant population of Medicaid and Medicare

patients in Canyon County by enabling Saltzer to move away from providing fee-for-service care as an independent group, which required many Saltzer physicians to manage their patient populations to limit the number of Medicaid or uninsured patients they could accept. *Trial Tr.* at 787 (N. Powell); *Trial Tr.* at 3323 (T. Patterson).

47. Saltzer received almost $9 million in payment for goodwill and intangibles as part of the Acquisition—which does not have to be paid back if the Acquisition is undone. *Trial Tr*. at 244:5-11 (John Kaiser).

Product Market

48. With regard to the FTC action, there is no dispute that the relevant product market is Adult Primary Care Services sold to commercially insured patients ("Adult PCP services"). *See Proposed Findings of Defendants (Dkt. No. 404)* at ¶ 598; *Proposed Findings of Plaintiffs (Dkt. No. 430)* at ¶ 47

49. Adult PCP services include physician services provided to commercially insured patients aged 18 and over by physicians practicing internal medicine, family practice, and general practice. *See Reinhardt Deposition (Dkt. No. 363)* at 134-35; *see generally Trial Tr*. at 1313 (Dr. Dranove).

Geographic Market

50. A proper geographic market is "an area of effective competition . . . where buyers can turn for alternate sources of supply." *Morgan, Strand v. Radiology Ltd*. 924 F.2d 1484, 1490 (9th Cir. 1991) (quotations omitted).

51. Plaintiffs bear the burden of proving that their definition of the relevant geographic market is correct. *United States v. Conn. Nat'l Bank*, 418 U.S. 656, 669 (1974).

52. Economists define a market by using the "hypothetical monopolist" or "SSNIP" test.

53. The SSNIP test evaluates whether all the sellers in the proposed candidate market would be able to impose a small but significant, non-transitory increase in price (SSNIP), which is generally 5 to 10 percent, and still make a profit. *Trial Tr.* at 1311-14 (Dr. Dranove).

54. When consumers are the direct purchasers of the product at issue, the SSNIP test evaluates whether the market sellers' price hike would cause consumers to travel to adjacent areas where sellers offer lower prices, thereby making the price hike unprofitable. If that is likely, the market definition would need to be broadened to include those adjacent areas. *Id.*

55. In this case, however, the vast majority of health care consumers are not direct purchasers of health care – the consumers purchase health insurance and the insurance companies negotiate directly with the providers. The consumers pay indirectly through their insurance premiums and more directly through co-pays and deductibles. *Id.*

56. Under these circumstances, the SSNIP test examines the likely response of insurers to a hypothetical demand by all the PCPs in a particular market for a significant non-transitory reimbursement rate hike. *Id.*

57. If it is likely that the insurers would reject the demand, drop those PCPs from their network, and depend on PCPs in adjacent regions to provide care for their insureds,

the definition of the relevant market would need to be broadened to include those adjacent regions. *Id.*

58. If, however, it is likely that the insurers would agree to the demand – that is, it is likely that the PCPs in that particular market could successfully demand a SSNIP – then the relevant market is the area where those PCPs practice. *Id.*

59. The largest insurer in Idaho is Blue Cross of Idaho (BCI). *Trial Tr.* at 305 (J. Crouch).

60. BCI has PCPs in-network in every zip code where they have enrollees. BCI does not require a single enrollee to travel outside of their zip code for primary care. *Trial Tr.* at 1329 (Dr. Dranove).

61. BCI considers "primary care services in the direct community that the member resides" to be a "threshold" consideration for an employer evaluating a potential health plan. *Trial Tr.* at 230 (J. Crouch).

62. In many instances, if a health plan does not have primary care physicians close to a potential client's employees, the health plan will not even be considered an eligible vendor for the employer. *Trial Tr.* at 235 (J.Crouch).

63. This applies to health plans offered to Nampa employers. St. Luke's System Director of Payer Contracting, Steve Drake, testified that the Board for St. Luke's Select Medical Network decided it should include Saltzer in the network because it needed providers in Nampa in order to market itself to employers. *See Drake Deposition (Dkt. No. 322)* at 181:19-183:3; Exhibit 1196

64. This is confirmed by the statistics showing where Nampa residents want to obtain their primary care.

65. 68% of Nampa residents get their primary care from providers who are located in Nampa. *Trial Tr.* at 1320 (Dr. Dranove).

66. Only 15% of Nampa residents obtain their primary care in Boise. *Trial Tr.* at 1320-21 (Dr. Dranove).

67. Those Nampa residents getting their primary care outside of Nampa "are getting their physician services near where they work. And this is basically confirming that patients like to get their medical care close to home." *Trial Tr.* at 1320 (Dr. Dranove).

68. St. Luke's Dr. Mark Johnson, a family practice physician with Mountain View Medical, a St. Luke's Clinic located in West Boise, does not consider Saltzer to be a competitor because of its "geographic separation." *See Johnson Deposition (Dkt. No. 249)* at 124:14-18; *Trial Tr*. at 1873:6-22 (Mark Johnson).

69. Because Nampa patients strongly prefer access to local PCPs, commercial health plans need to include Nampa PCPs in their networks to offer a competitive product. Health plans in the Treasure Valley consistently include Nampa-based PCPs in their provider networks. *See* Exhibit 1782 at Fig. 11; *Trial Tr*. at 1329-30 (Dr. Dranove).

70. A health plan could not successfully offer a network of PCP services to Nampa residents that only included Boise PCPs. As Dr. Dranove testified, that would be akin to the health plan saying to Nampa residents "I'm not going to have any doctors in Nampa, but don't worry, if you want to have a convenient PCP, just get a job in

Boise, like the other folks who are seeing doctors in Boise." *Trial Tr*. at 1324 (Dr. Dranove).

71. Given this dynamic – that health plans must offer Nampa Adult PCP services to Nampa residents to effectively compete – Nampa PCPs could band together and successfully demand a 5 to 10% price increase (or reimbursement increase) from health plans. *Trial Tr*. at 3434 (Dr. Dranove).

72. Thus, Nampa PCPs have the leverage with health plan networks to profitably impose a SSNIP in Nampa.

73. Nampa is therefore the relevant geographic market.

Anticompetitive Effects – Market Share

74. With the Acquisition, there is no dispute that St. Luke's became the largest provider of adult primary care services in Nampa. *See St. Luke's Answer (Dkt. No. 100)* at ¶3; *see also Saltzer's Answer (Dkt. No. 105)* at ¶3.

75. Under the FTC's *Merger Guidelines*, market concentration is "often one usual indicator of the likely competitive effects of a merger." *See Merger Guidelines § 5.3 (Appendix B1).*

76. In evaluating market concentration, the FTC looks at both the pre- and post-merger market concentration.

77. The preeminent measure of market concentration is the Herfindahl–Hirschman Index ("HHI"). It is calculated by squaring the market share of each firm competing in a market and then summing the resulting numbers. The FTC uses HHI numbers to determine thresholds for when an industry is considered highly concentrated or when

potential mergers require investigation. *Malaney v. UAL Corp.,* 2010 WL 3790296 (Sept. 27, 2010).

78. A particular HHI will range anywhere from zero (representing an infinite number of very small providers) to 10,000 (representing one pure monopolist). *Trial Tr.* at 1336 (Dr. Dranove).

79. A market is considered highly concentrated if the HHI is above 2500, and a merger that increases the HHI by more than 200 points will be presumed to be likely to enhance market power. *See Merger Guidelines § 5.3.*

80. Combined, St. Luke's and Saltzer account for nearly 80 percent of PCP services in Nampa. *Trial Tr.* at 1340 (Dr. Dranove); Exhibit 1789.

81. As a result of the merger between St. Luke's and Saltzer, the Nampa market has a post-merger HHI of 6,219 and an increase in HHI of 1,607, both of which are well above the thresholds for a presumptively anticompetitive merger (more than double and seven times their respective thresholds, respectively). *Trial Tr*. at 1340-41 (Dr. Dranove).

82. The Acquisition is therefore presumptively anticompetitive under § 7 of the Clayton Act.

Anticompetitive Effects – Saltzer Leverage pre-Acquisition

85. There is evidence in addition to the HHI numbers that the Acquisition will have anticompetitive effects.

83. Saltzer is the preeminent group of primary care physicians in Canyon County. *Trial Tr*. at 2230 (testimony of St Luke's CEO Christopher Roth that "Saltzer was and is an

incredibly well-respected group. They are the preeminent group, if you will, in the state of Idaho relative to multispecialty group practice. They know Nampa. They know Canyon County. They have the relationships. They have the trust of the community").

84. The largest health plan in Idaho – Blue Cross of Idaho – considers Saltzer "to be a must have provider for Blue Cross in Nampa." *Trial Tr*. at 331 (J. Crouch).

85. Ed Castledine (St. Luke's Director of Business Development) sent a list of names of Nampa physicians in an e-mail to Chris Roth (St. Luke's Regional Medical Center CEO) and remarked that "[t]his begins to show the dominance of Saltzer in the Nampa market . . . . Out of roughly 80 physicians in Nampa, Saltzer represents 47. If you add the [7 physicians St. Luke's hired from Nampa's] Mercy Group, we have the opportunity to work exclusively with 54 of the 80." *See* Exhibit 1281 at CON0007045; Castledine *Deposition (Dkt. No. 262)* at 120.

Anticompetitive Effects – St. Luke's Leverage pre-Acquisition

86. Between January 2007 and January 2012, St. Luke's acquired 49 physician clinics in the Treasure Valley and at least 28 physician practices in the Magic Valley. *See* Exhibit 2148 (identified at *Trial Tr*. 412-413 (J. Crouch)).

87. In 2007, according to BCI's statistics, St. Luke's Boise facility was receiving an average amount of reimbursement from BCI as compared to other facilities in Idaho, and St. Luke's had just one hospital in the top five highest paid in Idaho.

88. By 2012, St. Luke's had three of the top five highest paid hospitals, and its top hospital was receiving reimbursements 21% higher than the average Idaho hospital. *Trial Tr.* at 292 (J. Crouch); Exhibit 1300 at BCI368370.

89. If St. Luke's chose not to contract with BCI, then BCI would have an "immediately unsustainable product" in the markets where St. Luke's is a provider. *Trial Tr*. at 299 (J. Crouch).

Anticompetitive Effects – St. Luke's/Saltzer Leverage post-Acquisition

97. A prominent report from the School of Public Health at U.C. Berkeley concluded that the recent trend of physician employment by hospitals increases costs because "larger physician groups with added bargaining power can negotiate for higher [reimbursement] rates." *See Berkeley Forum, A New Vision* at p. 38 (Feb. 2013).

98. The Acquisition will increase substantially St. Luke's bargaining leverage with health plans.

99. The Acquisition is not only a merger of the first and second largest providers for primary care services but is also a merger of each of those providers' closest substitutes. *Trial Tr*. at 1437 (Dr. Dranove).

100. If St. Luke's Nampa patients could not see St.Luke's physicians, 50 percent of them would choose to go to Saltzer. *Trial Tr*. at 1351-52 (Dr. Dranove).

101. If Saltzer's Nampa location were unavailable, one-third of its patients would switch to St. Luke's – more than any other provider. *Trial Tr*. at 1352-53 (Dr. Dranove).

102. Thus, the Acquisition merges the closest substitutes for the two largest providers in Nampa. *Trial Tr*. at 1437(Dr.Dranove).

103. Moreover, as discussed, consumers of health care are typically not direct purchasers of health care, and it is health insurers that are negotiating with providers.

104. And so bargaining leverage is a function of the relative strength of the insurer and the provider.

105. Bargaining leverage consists largely of the ability to walk away.

106. A buyer has leverage if he has acceptable alternatives to a seller driving a hard bargain.

107. Stripped of acceptable alternatives, the buyer's leverage disappears.

108. Economists have an acronym for this process called BATNA – the best alternative to a negotiated agreement.

109. If a health plan were negotiating with Saltzer before the Acquisition, its best outside option for PCP services in Nampa was St. Luke's. The best outside option for a health plan negotiating with St. Luke's was Saltzer. For both examples, the merger takes away the health plan's best outside option and makes less desirable the health plan's BATNA. *Trial Tr.* at 1354 (Dr. Dranove); *Trial Tr*. 239 (J. Crouch).

110. After the Acquisition, if a health plan removed St. Luke's/ Saltzer from its network in Nampa, patients would be forced to choose their third best option. That is not an attractive option for a health plan trying to market that network to patients who live in Nampa. *Trial Tr*. at 1305-06 (Dr. Dranove).

111. The Acquisition adds to St. Luke's market power and weakens BCI's ability to negotiate with St. Luke's. As BCI's Jeff Crouch explained, St. Luke's is already the dominant provider in a number of markets, and the transaction extends their reach to the Nampa market. *Trial Tr*. at 311, 433 (J. Crouch).

112. BCI's concerns are supported by an e-mail written by Christopher Roth (St. Luke's Regional Medical Center CEO) to St. Luke's CFO and COO. *See* Exhibit 1093 at SLHS0000006605. The purpose of the e-mail, written in December of 2011, was to identify ways to improve St. Luke's financial performance in 2012. *Id.* The e-mail discussed revenue and volume shortfalls in 2011 and contained a plan for improvement. The e-mailed plan called for (1) reducing expenses, (2) increasing volume, and (3) a "Price Increase ($ Unknown)." *Id.* Under that heading of "Price Increase" was a bullet point stating: "Pressure Payors for new/directed agreements." *Id.* In explaining this e-mail, Roth claimed that he did not mean that St. Luke's could pressure payors for more reimbursement but rather could pressure them to direct more patients to St. Luke's high quality and low cost clinics. *Trial Tr.* at 2339 (Roth). That explanation is not credible, however, given that the "pressure" language quoted above was contained under a heading entitled "Price Increase" and was part of a discussion of how to increase income. The point being made in the e-mail was that St. Luke's should use its bargaining leverage to increase reimbursements from health plans.

113. Saltzer's documents likewise confirm that the Acquisition will enhance its negotiating leverage. In an internal exchange, Nancy Powell (who at the time was Saltzer's Chief Financial Officer) informed Dr. Page (Saltzer's Chairman of the

Contracting Committee) that BCI's changed policy on reimbursements for consults would cost Saltzer $22,000. *See* Exhibit 1361. Dr. Page responded that "this is a pretty big blow," and he speculated that "[i]f our negotiations w/luke's go to fruition, this will be something we could try to get back, i.e. consult codes, as there would be *the clout of the entire network*." *Id.* (emphasis added).

114. Dr. Dranove testified that Dr. Page's response in this e-mail informed his opinion that the Acquisition would enhance St. Luke's/Saltzer's bargaining leverage to the point where they could re-open past negotiations and take back past bargaining losses. *Trial Tr.* 1344-45 (Dr. Dranove).

115. St. Luke's bargaining tactic is common. In a study by Casalino et. al. entitled "*Benefits of and Barriers to Large Medical Group Practice in the United States,"* the authors interviewed 195 leaders of physician groups, hospitals and health insurance plans, and obtained further information from 6,000 physicians. The authors sought to cull from these surveys the main benefits and barriers to large group practices as cited by these medical provider participants. What they found was this: "Gaining negotiating leverage with health insurance plans was the most frequently cited benefit; it was cited 8 times more often than improving quality." *Trial Tr.* at 2671 (Dr. Enthoven)

116. St. Luke's itself confirmed the importance of gaining negotiating leverage with health insurance plans. In a 2009 presentation to the Board of Directors discussing a plan to integrate physician practices with the hospital, St. Luke's officials wrote that "St. Luke's Treasure Valley recognizes that market share in primary care is a key

success factor, critical to sustaining a strong position relative to payer contracting . . . ." *See* Exhibit 1461 at SLHS000039821.

Anticompetitive Effects – Twin Falls Example

117. In the Twin Falls Idaho market, the dominant provider of primary care services was the Physician Center, managed by St. Luke's. *Trial Tr.* at 241 (J. Crouch).

118. Between 2002 and 2009, BCI did not contract with this St Luke's group, believing that there remained sufficient coverage with about 20 primary care providers within 15 miles and almost 50 primary care providers within 30 miles, including the Burley area. *Trial Tr.* at 244-45 (J. Crouch).

119. But patients did not want to drive that distance for primary care, and thus employers were purchasing "very little" insurance from BCI in this market during this six year period. *Trial Tr.* at 241, 245 (J. Crouch).

120. Eventually, the St. Luke's negotiators had such leverage that BCI had no choice but to concede to their pricing proposal. *Trial Tr.* at 247 (J. Crouch).

Anticompetitive Effects – Hospital-Based Billing

121. It is likely that St Luke's will exercise its enhanced bargaining leverage from the Acquisition to charge more services at the higher hospital-based billing rates. *Trial Tr.* at 1347 (Dr. Dranove).

122. The Berkeley Forum Study concluded that the recent trend of physician employment by hospitals increases costs because "physician reimbursement may be higher for services rendered at hospitals than in physicians' offices . . . ." *See Berkeley Forum, supra* at p. 38.

123. St. Luke's own analysis of the Acquisition considered the possibility that it could increase commercial reimbursements by insisting that health plans pay higher "hospital-based" rates for routine ancillary services, such as X-rays and laboratory tests, even when those services are performed in the same physical location as before the Acquisition. *See* Exhibit 1277, SLHS000820291 at SLHS000820297; *Trial Tr*. at 252-53 (J. Crouch).

124. Prior to the Acquisition, Saltzer performed many routine ancillary services at its own facilities. Such services included laboratory and diagnostic imaging, as well as therapy services and specialized facility services for colonoscopies and minor outpatient surgeries. *Trial Tr*. 252-53 (J. Crouch).

125. After the Acquisition, if St. Luke's were to bill for these ancillary services at the higher "hospital-based" rates, BCI estimates that costs under its commercial contracts would increase by 30 to 35 percent. *Trial Tr*. 253-54 (J. Crouch).

126. St. Luke's own analysis projected that it could gain an extra $750,000 through hospital-based billing from Saltzer from commercial payers for lab work and $900,000 extra for diagnostic imaging. *See* Exhibit 1277 at SLHS000820291, SLHS000820297; see *also Trial Tr*. at 1347 (Dr. Dranove) (testifying that St. Luke's "thought that hospital-based billing alone could generate an extra $750,000 . . . .").

127. St. Luke's planned to fund a 30% pay raise for its physicians in connection with the Acquisition by obtaining "higher hospital reimbursement" from the health plans. *See* Exhibit 1262 at 7.

128. Consultant Peter LaFluer prepared an analysis at the direction of St. Luke's showing how office/outpatient visits could be billed for higher amounts if the visit was hospital-based rather than Saltzer-based. The hospital-based billings were more than 60% higher. *See LaFluer Deposition (Exhibit 54)* at 74; *Trial Tr.* at 735-36 (N. Powell); Exhibit 1480 at CON0000984-026, -027.

129. The leverage gained by the Acquisition would give St. Luke's the ability to make these higher rates "stick" in future contract negotiations. *Trial Tr.* at 1347-49 (Dr. Dranove).

130. By increasing St. Luke's relative leverage, the Acquisition will likely lead to higher reimbursements from health plans. *Trial Tr.* at 3425-26 (Dr. Dranove).

131. When health plans pay more, they pass that increase along to their customers in the form of higher premiums and higher out-of-pocket costs. *Trial Tr*. at 1309-10 (Dr. Dranove).

Anti-competitive Effects – Referrals

132. Patients largely accept the recommendations of their primary care physician as to what hospital, specialist, and ancillary services they should use. *Trial Tr*. at 1478-49 (D. Haas-Wilson) ("[T]he primary care providers are key to determining where patients receive their outpatient services, their ancillaries, and how they decide which hospital to use for their inpatient or outpatient services"); *Trial Tr.* at 3058 (D. Argue) ("[M]any patients do not have a preference about where they are hospitalized and will just follow their physicians' recommendations").

133. The Berkeley Forum Study concluded that the recent trend of physician employment by hospitals increases costs because "physicians may be influenced by hospitals to . . . increase referrals and admissions." *See Berkeley Forum, supra* at p.38.

134. It is true that Saltzer physicians have complete discretion under the terms of the PSA in referring patients. *See* Exhibit 24 (PSA) at Section 2.2(a) (stating that Saltzer physicians "may refer patients to any practitioner or facility regardless of its affiliation with St. Luke's"); *Trial Tr.* at 1649 (testimony of Dr. Pate, St. Luke's CEO, that "as a physician, I would find it completely objectionable for us to direct where our physicians are supposed to refer business").

135. While this complete discretion has been the rule for years, in practice that discretion has been exercised to favor the hospital where the physician was employed.

136. After St. Luke's purchased five specialty practices[2], "their business at Saint Alphonsus Boise dropped dramatically [and] the amount of business that they did at St. Luke's facilities increased dramatically." *Trial Tr.* at 1501 (D. Haas-Wilson).

137. For example, before Idaho Cardiothoracic and Vascular Associates was purchased by St. Luke's, 34% of their inpatient referrals were to St. Alphonsus in Boise. After

[2] The five specialty care clinics were (1) Boise Orthopedic Clinic, (2) Idaho Cardiothoracic and Vascular Associates, (3) Idaho Pulmonary Associates, (4) Intermountain Orthopedics, and (5) Idaho Cardiology Associates.

the purchase, none were referred there, and all their referrals were to St. Luke's. *See* Exhibit 1705.

138. Similarly, inpatient referrals from Boise Orthopedic Clinic to St. Alphonsus dropped from 57% to 6% after the purchase by St. Luke's. *Id.*

139. This pattern carries over to the use of imaging services. After the group of seven primary care physicians previously with the Mercy Medical Group went to work for St. Luke's, the percentage of imaging services they performed at St. Alphonsus fell from 81% to 19%. *Trial Tr.* at 1505 (D. Haas-Wilson).

140. After the Acquisition, it is virtually certain that this trend will continue and Saltzer referrals to St. Luke's will increase.

Anticompetitive Effects -- Conclusion

141. The Acquisition results in a substantial market share for St. Luke's in the Nampa market for primary care services.

142. After the Acquisition, St. Luke's will have 80 percent of PCP services in Nampa, and the HHI in the Nampa market will be 6,219.

143. This substantial market share will give St. Luke's a dominant bargaining position over health plans in the Nampa market.

144. It is highly likely that St. Luke's will use its bargaining leverage over health plan payers to receive increased reimbursements that the plans will pass on to consumers in the form of higher health care premiums and higher deductibles.

145. Services that used to be performed outside the hospital setting will increasingly be referred to St Luke's and billed out with the higher hospital-based billing rates, increasing the cost to the patient.

146. While the St. Luke's/Saltzer entity will continue its outstanding quality of care, the cost of that care will rise as a result of the Acquisition.

Efficiency Defense

147. St Luke's argues that the merger will create efficiencies that will far outweigh any anticompetitive effects.

148. As discussed further below in the Conclusions of Law section, the efficiencies must be merger-specific – that is, "they must be efficiencies that cannot be achieved by either company alone because, if they can, the merger's asserted benefits can be achieved without the concomitant loss of a competitor." *F.T.C. v. H.J. Heinz Co*, 246 F.3d 708, 722 (C.A.D.C. 2001).

149. St. Luke's recognizes this requirement that the efficiencies be merger-specific, and argues that "[t]he transaction's benefits are merger-specific because the transaction will enhance the ability of the combined St. Luke's/Saltzer to offer coordinated, patient-centered care; to support physicians in the practice of evidence-based medicine in an environment that rewards teamwork and value of care rather than volume of care; to accept risk and accountability for patients' outcomes; and to manage population health. Saltzer and St. Luke's could not achieve these benefits as effectively or as quickly by any looser affiliation or other means." *See Proposed Findings and Conclusions (Dkt. No.404)* at ¶ 646.

150. One of the driving forces behind the Acquisition is St. Luke's desire to improve quality and reduce costs by moving toward value-based or risk-based care and away from fee-for-service ("FFS") care.

151. The present system of fee-for-service reimbursement is a leading factor in rising health care costs.

152. Health care costs in the United States are at least twice that of other developed countries. *See Trial Tr.* at 191 (J. Crouch).

153. For example, in 2012, the per capita health expense in the United States was $8,233, more than twice the expense in France ($3974) or the United Kingdom ($3433), and nearly twice that of Germany ($4338) or Canada ($4445). *See OECD Health Data 2012 (June 28, 2012)*.[3]

154. Despite, such extraordinary expense, the health care delivered in the United States is decidedly ordinary. In virtually every study comparing the quality of health care delivered to consumers, the United States is consistently in the middle of the pack among developed nations. *See Why Not the Best? Results from the National Scorecard on U.S. Health System Performance (Oct. 2011)*.[4]

155. For example, the United States ranks last out of 16 industrialized countries on a measure of mortality amenable to medical care (deaths that might have been

[3] Found at http://www.oecd.org/health/healthataglance.

[4] Found at http://www.commonwealthfund.org/Publications/Fund-Reports/2011/Oct/Why-Not-the-Best-2011.aspx.

prevented with timely and effective care), with premature death rates that are 68% higher than in the best-performing countries. *Id.*

156. In Idaho, health care costs are above even the already-high national average.

157. Idaho's largest insurer, Blue Cross of Idaho (BCI), pays considerably more than what the average commercial insurance plans pays in the United States. *Trial Tr*. at 204 (J. Crouch).

158. Across the United States, the average commercial insurance plan pays about 120% of what Medicare pays. *Id.* For overnight hospital stays in Idaho, BCI pays between 150% to 200% more than Medicare pays. *Id*. at 211. For outpatient hospital services, BCI pays 300% more than Medicare. *Id*. For routine office visits, BCI pays 140% more than other commercial plans. *Id*. at 206.

159. Idaho's reimbursement rate for routine office visits is higher than 95% of the rates paid by other insurance plans across the country. *Id*. at 224-225; *see also* Baker, Bundorf & Royalty, *Private Insurers' Payments For Routine Physician Office Visits Vary Substantially Across The United States, in Health Affairs* (Sept. 2013) at 1583.

160. For other medical services, BCI pays between 175% and 200% more than Medicare. *Id*. at 204.

Efficiency Defense – Elimination of Fee-For-Service Reimbursement System

161. One reason – perhaps the principal reason – for the extraordinary cost of the U.S. health care system is our fee-for-service (FFS) reimbursement system. *Trial Tr.* at 191-92 (J. Crouch).

162. It is the primary way that health care providers are compensated under the current system in the U.S. and in Idaho. *Id.*

163. In the FFS system, providers are rewarded for doing more, whether or not more leads to better health outcomes. *See Trial Tr.* at 1608 (D. Pate).

164. The FFS system "incentivizes volume" because "the more services [physicians] perform, the more they can bill and the more they're compensated." *Trial Tr.* at 191-92 (J. Crouch).

165. For providers compensated on a FFS basis, there is no reward for teamwork or enhancing the value of care for patients. If a botched hip replacement must be redone, both surgeries will be paid for under the FFS system, providing no incentive to get it right the first time. *Trial Tr.* at 2578 (Dr. Enthoven).

166. Because of the focus on volume rather than value, the National Academy of Sciences estimates that 30% to 40% of health care spending is waste. *Id.* at 2573-74 (Dr. Enthoven).

167. The Berkeley Forum Report, endorsed by Dr. Enthoven at trial, concluded that "[o]ur predominately fee-for-service payment system often results in incentives that lead to uncoordinated care, fragmented care delivery, low-value services and sub-optimal population health." *See Berkeley Forum, supra,* at p. 40; *Trial Tr.* at 2606-10 (Dr. Enthoven).

168. To remedy this problem, the Berkeley Report recommended a movement toward integrated care and risk-based reimbursement. *Trial Tr.* at 2606-2610 (A. Enthoven).

169. The Berkeley Report concluded that "the few examples of fully-integrated delivery systems that exist today demonstrate that financial accountability for a population's health is a very effective motivator of innovative practices in prevention, chronic disease management and care for seriously ill patients." *Berkeley* at p. 13.

170. In an integrated delivery system, primary care physicians ("PCPs") and specialty physicians work as a team, with PCPs managing patient care and specialty physicians consulting and providing care as needed. *Trial Tr.* at 2585-2586 (Dr. Enthoven).

171. In this integrated system, the primary care physician acts "as the coordinator and team leader" to "review the whole thing, make sure what's needed is done and nothing falls between the cracks." *Id.*

Efficiency Defense – Move to Risk-Based Reimbursement System

172. In this integrated system, providers receive reimbursement from insurers in the form of a set amount for each patient rather than a payment for each service rendered. The set amount is based on the average expected health care utilization for the patients given such factors as their age and medical history. This set amount is often referred to as "capitation."

173. Capitation motivates providers to consider the costs of treatment as they will share in the savings if they can keep actual costs below the set amount they receive. *Trial Tr.* at 2576 (Dr. Enthoven)

174. For the same reason, providers have an incentive to practice preventative care and keep their patients healthy. *Id.* at 2572, 2574-2575 (Dr. Enthoven).

175. In the botched hip replacement example discussed above, capitation provides an incentive to get the operation done right the first time, and would financially punish providers whose shoddy work required a second surgery.

176. In addition to punishing errors, capitation promotes innovation. For example, when the Duke Medical School identified an improved procedure for treating coronary bypass patients that resulted in lower cost and better results for patients, reimbursement based on a capitation system would ensure that the innovation increased the School's revenue while reimbursement based on an FFS system would have the opposite effect (because the volume of services declined). *Trial Tr.* at 2574 (Dr. Enthoven).

177. In this way, incentives are properly aligned between providers and patients, so that providers have incentives to provide higher-value care at lower cost—not to provide higher volume of care without regard to value. *Id.* at 2586-2587 (Dr. Enthoven).

Efficiency Defense – Employed Physicians

178. Integrated medicine is "team-based medicine," and one way to create a committed and unified team of physicians is to employ them. *Trial Tr.* at 2611, 2616 (Dr. Enthoven).

179. Successful groups like Kaiser Permanente and the Cleveland Clinic have mostly employed physicians.

180. But physicians are committed to improving the quality of health care, and lowering its cost, whether they are employed or independent. *Trial Tr.* at 3524 (testimony of Dr. Kizer – board certified in six specialties and a professor at the

University of California at Davis – that physicians are committed to improving quality, and citing a study finding 95% of physicians "recognize they have a responsibility for lowering the cost of healthcare").

181. There is no empirical evidence to support the theory that St Luke's needs a core group of employed primary care physicians beyond the number it had before the Acquisition to successfully make the transition to integrated care. *Trial Tr.* at 3538-39 (Dr. Kizer).

182. Integrated care – and risk-based contracting – do not require a large number of physicians because the health plans "manage the level of risk proportionate to the level of the provider organization." *Trial Tr.* at 195 (J. Crouch).

183. In Idaho, independent physician groups are using risk-based contracting successfully. *Trial Tr.* at 195-96 (J. Crouch).

184. It is the committed team – and not any one specific organization structure – that is the key to integrated medicine. *Trial Tr.* at 3525 (Dr. Kizer).

185. Because a committed team can be assembled without employing physicians, a committed team is not a merger-specific efficiency of the Acquisition. *Trial Tr.* at 3558 (there are "alternative models [to employing physicians] . . . that are being widely utilized and can be utilized to achieve those same purposes") (Dr. Kizer).

Efficiency Defense – Shared Electronic Record

186. An important component of integrated care delivery is a shared electronic record. *Trial Tr.* at 3540 (Dr. Kizer).

187. When a patient sees multiple providers for treatment, the electronic health record enables those providers not only to communicate with one another in real time, but also to have a complete picture of the medical progress of that patient as they consider their own treatment approach. *See Trial Tr.* at 1920 (J. Kee).

188. When, for example, a patient suffers from multiple conditions like diabetes, coronary artery disease, and depression, which require him to see a primary care physician, endocrinologist, cardiologist, and psychiatrist, the physicians can ensure, via the electronic health record, that none of their prescribed medications conflict, and that all services that need to be provided are made available. *See Trial Tr.* at 2586 (Dr. Enthoven).

189. The electronic health record improves preventative care. Physicians can categorize and track who, for example, is due for a mammogram or suffers from diabetes and does not have their blood sugar under control. *See Trial Tr.* at 2590 (Dr. Enthoven). This monitoring seeks to avoid preventable, serious episodes that would otherwise require costly treatment.

190. An electronic health record "can make health care delivery more efficient, cost-effective, and safe because it makes practice guidelines and evidence databases available to health care providers and improves computerized patient record accessibility." *See Big Data, 99 Iowa L. Rev. 225 (Nov. 2013)* at 247-48.

191. Nevertheless, providers have generally "been slow to adopt [electronic health records] for financial reasons, since transitioning to electronic systems often entails high up-front costs for training and new infrastructure." *Id*. at 248.

192. St. Luke's is in the process of implementing Epic, an electronic health record that tracks, centralizes, and updates a patient's family and medical history and, in turn, improves the continuity and coordination of care the patient receives across multiple providers. Transcript at 2796:13-2797:23 (M. Chasin).

193. The Epic system is "generally recognized at or near the top of . . . enterprise-wide patient health records systems." *Trial Tr.* 1918-19 (J. Kee).

194. St. Luke's presently has 500 providers on the system and has spent $40 million installing the system. *Trial Tr.* at 1919-20 (J. Kee).

195. Epic allows patients to get more involved in their own health care. *Trial Tr.* at 2798-99 (M. Chasin). Through its patient portal, MyChart, patients have secure email access to their physicians, as well as the ability to track and manage their appointments, view their lab results, and refill their prescriptions. *Id.* Patients can increase their participation in their own care without increasing the amount of time they need to spend in a physician's office – or incur the costs of an office visit – to do so. *Trial Tr.* 2627-28 (Dr. Enthoven).

196. Furthermore, Epic allows physicians to share information across specialties, creating a complete picture of the patients' treatment experiences. *Trial Tr.* at 1920-22 (J. Kee). Physicians can view the entire health history of a patient, including all of his or her lab work and radiological images, all of the contemporaneous notes physicians have made on the patient, all of the tests pending, and all of the preventative care measures outstanding. *Trial Tr.* at 2807 (M. Chasin).

197. Epic reduces errors resulting from incomplete information, as well as duplicative testing. *Trial Tr.* 1621-22 (D. Pate); Trial *Tr.* 1922 (J. Kee).

198. Epic also improves communication between providers and enhanced coordination of care. *Trial Tr.* 2047-48; 2097 (J. Souza).

199. To achieve all of these benefits, it is crucial that all physicians – whether employed by St. Luke's or practicing independently – have access to Epic. *Trial Tr.* at 3549 (testimony by Dr. Kizer that "interoperability is both a business imperative as well as national policy"); *Trial Tr.* at 1658 (testimony by Dr. Pate, St. Luke's CEO, that "[t]he delivery system necessary to provide this population health management will include St. Luke's, but includes many independent physicians and facilities all working together around the state").

200. The numerous benefits of Epic listed above would be severely reduced if that system was off limits to independent doctors. *Trial Tr.* at 3546 (testimony by Dr. Kizer that "if one's intent is to optimize quality and lower costs, you want maximum ability of information, which means that you would want to be able to connect with as many other providers as possible and share information").

201. To ensure that Epic is accessible, St Luke's is developing the Affiliate Electronic Medical Records program that would allow independent physicians access to Epic. *Trial Tr.* at 3545 (Dr. Kizer).

202. The Affiliate program would allow independent physicians to share in Epic's health records so long as those physicians were willing "to adhere to very significantly rigid standards." *Trial Tr.* at 1961 (J. Kee).

203. St. Luke's plans to roll out the Affiliate program in April of 2014, and already has about 15 groups showing interest. *Trial Tr.* at 1964, 2006 (J. Kee).

204. These circumstances demonstrate that the efficiencies resulting from the use of Epic do not require the employment of physicians and hence are not merger-specific.

205. The same analysis applies to the White Cloud data analytics tool. *Trial Tr.* at 3562 (testimony from Dr. Kizer that "independent physicians currently use and have available to them a wide array of . . . data analytics tools . . . .").

206. For all of these reasons, the efficiencies resulting from Epic and White Cloud are not merger-specific.

Entry Defense

207. St. Luke's raises the defense that other providers will enter the Nampa market and compete, thereby mitigating any anticompetitive effects of the Acquisition.

208. As will be discussed further in the Conclusions of Law section below, St. Luke's must show that entry by competitors will be "timely, likely, and sufficient in its magnitude, character and scope to deter or counteract the competitive effects" of a proposed transaction. *See* Merger Guidelines § 9; *FTC v. Procter & Gamble, Co*., 386 U.S. 568, 579 (1967).

209. It is difficult to recruit family doctors to Canyon County. *Trial Tr*. at 1179 (David Peterman).

210. Younger doctors prefer to live and practice in Ada County. *Trial Tr*. at 1181 (David Peterman).

211. Recruiting general internists has been difficult because there is a tendency among internal medicine physicians who finish their residencies either to go into a hospitalist program, which is just inpatient medicine, or to go on to various subspecialties like cardiology or pulmonology. *Trial Tr*. at 714 (Nancy Powell).

212. In 2013, SAMG was not able to recruit any family practice doctors to Nampa. *Trial Tr*. at 715:5-7 (Nancy Powell).

213. SAMG has also been unable to recruit any pediatricians or general internists to Nampa in the last two years. *Trial Tr*. at 713-14 (Nancy Powell).

214. Given these circumstances, the Court cannot find that entry of competitors is likely to mitigate the anticompetitive effects of the Acquisition.

Conclusions of Law

Jurisdiction

1. This is a civil action arising under Section 7 of the Clayton Act, 15 U.S.C. § 18, and the Idaho Competition Act, Idaho Code § 48-106.[5]

2. This Court has subject matter jurisdiction over this action pursuant to Section 13(b) of the Federal Trade Commission Act ("FTC Act"), 15 U.S.C. § 53(b), and Section 16 of the Clayton Act, 15 U.S.C. § 26, and based upon 28 U.S.C. §§ 1331, 1337, and 1345.

[5] All plaintiffs challenge the Saltzer transaction under § 7 of the Clayton Act, 15 U.S.C. § 18, and the analogous Idaho state law, Idaho Code Ann. § 48-106. The private plaintiffs also challenge the transaction under § 1 of the Sherman Act, 15 U.S.C. § 1, and the corresponding Idaho state law, Idaho Code Ann. § 48-104. Claims under both Clayton Act § 7 and Sherman Act § 1 are generally adjudicated according to the same standards. *See, e.g., United States v. Rockford Mem'l Corp*., 898 F.2d 1278, 1283 (7th Cir. 1990).

3. The FTC is vested with authority and responsibility for enforcing Section 7 of the Clayton Act, 15 U.S.C. § 18.
4. The Idaho Attorney General, Lawrence G. Wasden, is the chief law enforcement officer of the State of Idaho, see Idaho Code §§ 67-1401 et seq., with the authority to bring this action on behalf of the State of Idaho pursuant to Section 16 of the Clayton Act, 15 U.S.C. § 26, and Idaho Code § 48-108 of the Idaho Competition Act.
5. Defendant St. Luke's Health System, Ltd. is, and at all relevant times has been, engaged in activities in or affecting "commerce" as defined in Section 4 of the FTC Act, 15 U.S.C. § 44, and Section 1 of the Clayton Act, 15 U.S.C. § 12 (2006). It has also engaged in "Idaho Commerce" as defined in Idaho Code Section 48-103(1) of the Idaho Competition Act.
6. Defendant Saltzer Medical Group, P.A. is, and at all relevant times has been, engaged in activities in or affecting "commerce" as defined in Section 4 of the FTC Act,15 U.S.C. § 44 (2006), and Section 1 of the Clayton Act, 15 U.S.C. § 12 (2006). It has also engaged in "Idaho Commerce" as defined in Idaho Code Section 48-103(1) of the Idaho Competition Act.
7. St. Luke's and Saltzer, by virtue of their engagement in activities in or affecting "commerce" as defined in Section 1 of the Clayton Act, are subject to the FTC's jurisdiction to enforce Section 7 of the Clayton Act. 15 U.S.C. § 21 (2006) (vesting authority to enforce compliance with 15 U.S.C. § 18 in the FTC "where applicable to all other character of commerce"); *FTC v. Univ. Health, Inc.,* 938

F.2d 1206, 1214–15 (11th Cir. 1991) (holding that 15 U.S.C. § 21 makes clear that the FTC's enforcement of Section 7 applies to asset acquisitions by nonprofit hospitals).

8. Because the FTC has jurisdiction to enforce Section 7 against St. Luke's and Saltzer, it has the authority under Section 13(b) of the FTC Act, 15 U.S.C. § 53(b), to bring this civil action asking this Court, "after proper proof," to issue a permanent injunction and grant other equitable relief. 15 U.S.C. § 53(b); *Univ. Health,* 938 F.2d at 1217 n.23 (holding that "Section 13(b) authorizes the FTC to seek injunctive relief against violations of 'any provision of law enforced by [it]'"); *see also FTC v. H.N. Singer, Inc*., 668 F.2d 1107, 1111 (9th Cir. 1982) (holding that "[Section] 13(b) gives the Commission the authority to seek, and gives the district court the authority to grant, permanent injunctions in proper cases even though the Commission does not contemplate any administrative proceedings").

9. St. Luke's and Saltzer transact business in the District of Idaho and are subject to personal jurisdiction here. *See St. Luke's Answer (Dkt. No. 100)* at ¶12; Saltzer's *Answer (Dkt. No. 105)* at ¶12. Venue is therefore proper in this district under 28 U.S.C. § 1391(b) and (c) and under 15 U.S.C. § 53(b).

Clayton Act

10. The Acquisition is illegal under Section 7 of the Clayton Act if "the effect of such acquisition may be substantially to lessen competition." 15 U.S.C. § 18.

11. Congress used the words "may be" "to indicate that its concern was with probabilities, not certainties." *Brown Shoe Co., Inc. v. United States*, 370 U.S. 294, 323 (1962).

12. A fundamental purpose of § 7 is "to arrest the trend toward concentration, the tendency to monopoly, before the consumer's alternatives disappeared through merger . . . ." *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 367 (1963).

13. At the same time, § 7 deals with "probabilities" and not "ephemeral possibilities" of anticompetitive effects. *Brown Shoe,* 370 U.S. at 323; *United States v. Marine Bancorporation, Inc*., 418 U.S. 602, 622–23 (1974) (rejecting claim that was "considerably closer to 'ephemeral possibilities' than to 'probabilities'").

14. Section 7 necessarily "requires a prediction" of a transaction's likely competitive effect, and "doubts are to be resolved against the transaction." *FTC v. Elders Grain, Inc*., 868 F.2d 901, 906 (7th Cir. 1989).

15. Although the burden of persuasion always remains firmly on the plaintiffs in a § 7 case, the burden of production shifts based on the plaintiffs' and defendants' showings. *See, e.g., United States v. Citizens & S. Nat'l Bank*, 422 U.S. 86, 120 (1975).

16. First the plaintiffs must show that the Acquisition would produce "a firm controlling an undue percentage share of the relevant market, and [would] result[ ] in a significant increase in the concentration of firms in that market." *Philadelphia Nat'l Bank*, 374 U.S. at 363.

17. Such a showing establishes a "presumption" that the merger will substantially lessen competition. *Heinz,* 246 F.3d at 715.

18. To rebut the presumption, the defendants must produce evidence clearly showing that the market's concentration inaccurately predicts the likely competitive effects of the transaction. *United States v. Marine Bancorporation, Inc*., 418 U.S. 602, 631 (1974).

19. This rebuttal evidence could take the form of a showing that "the anticompetitive effects of the merger will be offset by efficiencies resulting from the union of the two companies." *Heinz,* 246 F.3d at 715

20. Other forms of rebuttal evidence may include a showing of "ease of entry into the market, the trend of the market either toward or away from concentration, and the continuation of active price competition." *Heinz,* 246 F.3d at 715 n. 7.

21. If the defendant successfully rebuts the presumption of illegality, the burden of producing additional evidence of anticompetitive effect shifts to the plaintiffs, and merges with the ultimate burden of persuasion, which remains with the plaintiffs at all times. *Id.* at 715.

Idaho Competition Act

22. Like Section 7 of the Clayton Act, the Idaho Competition Act prohibits acquisitions that may substantially lessen competition. Idaho Code § 48-106. Because the provisions of the Idaho Competition Act "shall be construed in harmony with federal judicial interpretation of comparable federal antitrust

statutes," the antitrust analysis under the Clayton Act applies equally to the Idaho Competition Act. Idaho Code §§ 48-102(3), 48-106.

FTC's Prima Facie Case

23. Adult PCP services sold to commercially insured patients in Nampa constitutes the relevant product and geographic markets for purposes of analysis under § 7 of the Clayton Act.

24. The Acquisition will result in a post-merger HHI of 6,219 and an increase in HHI of 1,607, far above the levels necessary to trigger the presumption that the combined entity will lessen competition. *See Merger Guidelines § 5.3.*

25. Moreover, it is highly likely that the combined entity will use its substantial market share (1) to negotiate higher reimbursements with health plans, and (2) charge more services at the higher hospital billing rates. This will raise costs to consumers.

26. For all these reasons, the plaintiffs have established a prima facie case that the Acquisition is anti-competitive. *Heinz*, 246 F.3d at 716.

Defense – Ease of Entry

27. St. Luke's raises the defense that other providers will enter the Nampa market and compete, thereby mitigating any anticompetitive effects of the Acquisition.

28. To constitute a defense, St. Luke's must show that entry by competitors will be "timely, likely, and sufficient in its magnitude, character and scope to deter or counteract the competitive effects" of a proposed transaction. *See* Merger Guidelines § 9; *FTC v. Procter & Gamble, Co*., 386 U.S. 568, 579 (1967).

29. The higher the barriers to entry, as in this case, the less likely it is that the "timely, likely, and sufficient" test can be met. *United States v. Visa U.S.A., Inc*., 163 F.Supp.2d 322, 342 (S.D.N.Y.2001), *aff'd*, 344 F.3d 229, 240 (2d Cir.2003).

30. In assessing the evidence, the "history of entry into the relevant market is a central factor in assessing the likelihood of entry in the future." *F.T.C. v Cardinal Health*, 12 F.Supp.2d 34, 56 (D.C.D.Ct. 1998); *see also* Horizontal Merger Guidelines § 9 ("Recent examples of entry, whether successful or unsuccessful, generally provide the starting point for identifying the elements of practical entry efforts.").

31. That history, discussed in the Findings of Fact section above, demonstrates that entry into the market has been very difficult and would not be timely to counteract the anticompetitive effects of the Acquisition.

32. Those Findings demonstrated how difficult it is to recruit primary care physicians into Canyon County, and how difficult it is for new primary care physicians to open an office, hire staff, earn a reputation, and develop a practice with the quality to compete with St. Luke's/Saltzer.

33. St. Luke's has not carried its burden of proving that entry is likely and will be timely.

Defense – Efficiencies Defense

36. St. Luke's argues that the merger will create efficiencies that will far outweigh any anticompetitive effects.

37. This defense requires "convincing proof" of "significant" and "merger-specific" efficiencies arising as a result of the merger. *Areeda* at ¶ 971, p. 48.

38. Although the Supreme Court has not sanctioned the use of the efficiencies defense in a section 7 case, *see Procter & Gamble Co*., 386 U.S. at 580, the trend among lower courts is to recognize the defense. *See, e.g., F.T.C. v. H.J. Heinz Co*, 246 F.3d 708, 720 (C.A.D.C. 2001).

39. When high market concentrations will result from the merger, the defense requires "proof of extraordinary efficiencies." *Id*.

40. Professor Areeda explains that an "extraordinary" showing is necessary when the "post merger market's HHI is well above 1800 and the HHI increase is well above 100 . . . [because] the likelihood of a significant price increase is particularly large . . . ." 4A *Areeda, et al., Antitrust Law* ¶ 971f, at 48.

41. Moreover, given high concentration levels, "courts must undertake a rigorous analysis of the kinds of efficiencies being urged by the parties in order to ensure that those 'efficiencies' represent more than mere speculation and promises about post-merger behavior." *Heinz*, 246 F.3d at 721.

42. The efficiencies must be merger-specific – that is, "they must be efficiencies that cannot be achieved by either company alone because, if they can, the merger's asserted benefits can be achieved without the concomitant loss of a competitor." *Heinz*, 246 F.3d at 722.

43. The Merger Guidelines "credit only those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects." *See Merger Guidelines* at § 10.

44. St. Luke's believed that the best way to create the unified and committed team of physicians required to practice integrated medicine was to employ them.

45. St. Luke's followed this strategy to improve the quality of medical care.

46. However, the Findings of Fact demonstrate that while employing physicians is one way to put together a unified and committed team of physicians, it is not the only way. The same efficiencies have been demonstrated with groups of independent physicians.

47. There are a number of organizational structures that will create a team of unified and committed physicians other than that selected by the Acquisition, a structure that employs physicians and creates a substantial concentration of market power.

48. Moreover, the efficiencies of a shared electronic record can be similarly achieved even without the Acquisition, and thus these efficiencies are also not merger-specific.

49. The Court finds that St. Luke's has not carried its burden of showing convincing proof of significant and merger-specific efficiencies arising as a result of the Acquisition.

Remedy

50. Divestiture is "the remedy best suited to redress the ills of an anticompetitive merger." *California v. Am. Stores Co.,* 495 U.S. 271, 285 (1990).

51. Divestiture "should always be in the forefront of a court's mind when a violation of Section 7 has been found." *Ash Grove Cement Co. v. FTC*, 577 F.2d 1368, 1380 (9th Cir. 1978).

52. In *Garabet,* the Circuit stated that "the costs and complexities of unwinding a merger may be considered in evaluating prejudice to the affected parties." *Garabet*, 116 F. Supp. 2d at 1173.

53. However, in this case, St. Luke's represented to the Court that "we will not oppose divestiture on grounds that divestiture cannot be accomplished." *Transcript of Preliminary Injunction Hearing (Dkt. No. 49)* at 87–88; *see also* TX 2625 (letter by St Luke's to St. Al's stating that St. Luke's "would not argue that "the transaction should not be unwound because doing so would be costly or burdensome").

54. Thus, the cost and complexity of unwinding the transaction is no defense to divestiture.

55. St. Luke's argues, however, that an unwound Saltzer will be significantly and negatively affected due to the departure of seven surgeons from Saltzer to St. Al's.

56. While it is true that the loss of the seven surgeons was a financial hardship to Saltzer, *see Trial Tr.* at 3235 (L. Ahern), they left in large part because of the Acquisition. *See Trial Tr.* at 2486-97 (Dr. Williams).

57. If Saltzer's weakness (the loss of seven surgeons) was caused by the Acquisition, St. Luke's cannot raise that weakness as a reason to hold together the Acquisition.

58. Moreover, any financial hardship to Saltzer will be mitigated by St. Luke's payment of $9 million for goodwill and intangibles as part of the Acquisition, a payment that does not have to be paid back if the Acquisition was undone. *Trial Tr.* at 244 (J. Kaiser).

59. The Court also rejects St. Luke's proposal that divestiture be dropped as a remedy in favor of ordering that St. Luke's and Saltzer negotiate separately with health plans, *Trial Tr.* at 167-68 (Jack Bierig).

60. A similar proposal was rejected in *In re ProMedica Health Sys., Inc.,* No. 9346, 2012 WL 1155392, at *48 (FTC June 25, 2012).

61. In that case, two merging hospitals proposed maintaining two separate negotiating teams that would prevent anticompetitive effects while addressing concerns about the financial viability of one of the hospitals. The F.T.C. rejected the argument, citing case law favoring divestiture. Responding to an argument that the separate negotiating team remedy had been approved in a past case, the F.T.C. noted that the remedy had only been approved because the entities had fully integrated seven years earlier, making divestiture unworkable. The F.T.C. distinguished that past case on the ground that the parties in the case now before it – just like the parties here – had not fully integrated.

62. The Court finds *ProMedica* persuasive and will likewise reject the separate negotiating teams remedy.

Private Plaintiffs' Claims

63. The Private Plaintiffs (but not the Government Plaintiffs) allege anticompetitive effects in four additional markets: (1) general pediatric physician services sold to commercial payors in Nampa; (2) general acute care inpatient hospital services in Ada and Canyon Counties, (3) neurosurgery and orthopedic ("neuro+ortho")

outpatient surgical facility services in Ada and Canyon Counties, and (4) general surgery outpatient surgical facility services in Ada and Canyon Counties.

64. The Court need not resolve the issues raised by the private plaintiffs because the Acquisition is being unwound due to its effects in the Nampa market for primary physician services.

65. Thus, the Court need not address whether the Acquisition would have violated § 7 in other markets.

Conclusion

66. Health care is at a crisis point. Nationally, quality lags far behind the inexorable rise in prices. This has created a groundswell of demand for change.

67. One change universally recommended is to move away from fee-for-service reimbursement and toward integrated care and risk-based reimbursement, where payment is made on the basis of patient outcomes, not the volume of services.

68. This is a major change and is slowly being implemented.

69. This period of change might be best described as being in an experimental stage, where hospitals and other providers are examining different organizational models, trying to find the best fit.

70. To be part of this experimental wave moving toward integrated care, St. Luke's and Saltzer agreed on the Acquisition.

71. The Acquisition is an attempt by St. Luke's and Saltzer to improve the quality of medical care.

72. But the particular structure of the Acquisition – creating such a huge market share for the combined entity – creates a substantial risk of anticompetitive price increases.

74. More specifically, there is a substantial risk that the combined entity will use its dominant market share (1) to negotiate higher reimbursements with health plans, and (2) charge more services at the higher hospital billing rates. This will raise costs to consumers.

75. As discussed above, this has been the result in the past when St. Luke's has achieved bargaining leverage over health insurers.

76. In a world that was not governed by the Clayton Act, the best result might be to approve the Acquisition and monitor its outcome to see if the predicted price increases actually occurred. In other words, the Acquisition could serve as a controlled experiment.

77. But the Clayton Act is in full force, and it must be enforced. The Act does not give the Court discretion to set it aside to conduct a health care experiment.

78. For all of the reasons set forth above, the Court finds that the Acquisition violates § 7 of the Clayton Act and the Idaho Competition Act.

79. The Court will permanently enjoin the Acquisition under § 7 of the Clayton Act and the Idaho Competition Act.

80. The Court will order St. Luke's to fully divest itself of Saltzer's physicians and assets and take any further action needed to unwind the Acquisition.

81. While the plaintiffs ask the Court to order St. Luke's to notify the Government plaintiffs in advance of any future acquisitions of physician groups, the Court does not find such a remedy appropriate.

82. The Court will file a separate Judgment as required by Rule 58(a).

DATED: January 24, 2014

B. Lynn Winmill
Chief Judge
United States District Court