In the Matter of ProMedica Health System, Inc.
Docket No. 9346

Opinion of the Commission

By Commissioner Julie Brill

I. INTRODUCTION[1]

This case involves the consummated joinder ("the Joinder") of two hospital providers in Toledo, Ohio: ProMedica Health System, Inc. ("ProMedica"), a large multi-hospital system that operates three hospitals in the Toledo area; and St. Luke's Hospital ("St. Luke's"), formerly an independent community hospital located in Maumee, a suburb in the southwest sector of the Toledo area. In addition to ProMedica and St. Luke's, there are only two other hospital providers in Toledo: Mercy Health Partners ("Mercy"), which is also a multi-hospital system with three hospitals in the Toledo area; and the University of Toledo Medical Center ("UTMC"), a state-supported teaching hospital. The Joinder therefore reduced the number of competing hospital providers from four to three in Lucas County, Ohio, which encompasses the Toledo area. It also reduced the number of hospital providers offering obstetrical ("OB") services from three to two – a merger to duopoly in that market.

The Commission challenged the Joinder out of concern that it would significantly harm patients, employers, and employees in the Toledo area by eliminating significant, beneficial competition between ProMedica and St. Luke's through the creation of a combined hospital system with an increased ability to obtain supra-competitive reimbursement rates from commercial health plans, and, ultimately, from their members. We conclude that anticompetitive effects are indeed likely, resulting in higher health care costs for patients, employers, and employees in the Toledo area. The record compiled during a full administrative trial lasting

[1] This opinion uses the following abbreviations:

ID – Initial Decision of the Administrative Law Judge
IDF – Numbered Findings of Fact in the ALJ's Initial Decision
JX – Joint Exhibits
PX – Complaint Counsel's Exhibit
RX – Respondent's Exhibit
Tr. – Transcript of Trial before the ALJ.
RAppB – Respondent's Appeal Brief
RAnsB – Respondent's Answering Brief to Complaint Counsel's Appeal
RRB – Respondent's Reply Brief in Support of its Appeal
CCAppB – Complaint Counsel's Appeal Brief
CCAnsB – Complaint Counsel's Answering Brief
CCRB – Complaint Counsel's Reply Brief
JSLF – Joint Stipulation of Law and Fact (JX00002A)

more than thirty days confirms that eliminating a substantial competitor from two highly concentrated markets will substantially lessen competition. That record includes testimony and documents from the merging parties acknowledging ProMedica's pre-Joinder market dominance and demonstrating that increased bargaining leverage resulting in higher reimbursement rates was an objective and expected result of the Joinder; testimony from numerous health plans that the Joinder will enable ProMedica to extract higher rates; and economic and statistical analyses showing that significant price increases are likely.

Following the administrative hearing, Chief Administrative Law Judge D. Michael Chappell issued an Initial Decision in which he held that the Joinder is likely to substantially lessen competition in the market for the sale of general acute-care ("GAC") inpatient hospital services to commercial health plans in Lucas County, Ohio, in violation of Section 7 of the Clayton Act. He entered an order requiring ProMedica to divest St. Luke's. We affirm the ALJ's conclusion on liability, although we define GAC inpatient hospital services somewhat differently. We also conclude that the Joinder is likely to substantially lessen competition in a separate relevant market consisting of inpatient OB services sold to commercial health plans. Having found liability, we enter an order requiring ProMedica to divest St. Luke's to an approved buyer in accordance with established Commission procedures.

II. PROCEDURAL HISTORY

A. Investigation, Pleadings, and Preliminary Injunction

On May 25, 2010, ProMedica and St. Luke's entered into a Joinder Agreement, under which St. Luke's became part of ProMedica Health System.[2] In return, ProMedica agreed, *inter alia*, to pay St. Luke's parent a $5 million commitment fee at closing; to provide St. Luke's Hospital with at least $30 million in capital funding, payable in three $10 million annual installments due by the anniversary dates of the transaction's closing; and to permit St. Luke's to contract with and become an in-network hospital in Paramount Healthcare, ProMedica's commercial health plan, which previously had been closed to St. Luke's.[3]

FTC staff opened an investigation of the transaction in July 2010. On August 18, 2010, ProMedica entered into a limited Hold Separate Agreement that allowed the deal to close but restricted ProMedica from making certain changes to St. Luke's. *See* PX0069; IDF 12. Among other things, the Hold Separate Agreement prevents ProMedica from terminating St. Luke's contracts with health plans; eliminating, transferring or consolidating clinical services at St. Luke's; or terminating any St. Luke's employees without cause. The Hold Separate Agreement also allows health plans the option to extend their St. Luke's contracts past the termination date

[2] *See* PX0058. ProMedica became the sole corporate member or shareholder of St. Luke's Hospital and its affiliated entities. *Id*. at 009-012. Consequently, for antitrust analysis of the transaction, post-Joinder ProMedica controls St. Luke's.

[3] *Id*. at 021-023. As of the close of the administrative record on August 23, 2011, ProMedica had paid the $5 million to the St. Luke's Foundation and had made the first $10 million capital contribution to St. Luke's Hospital. IDF 980-83; Hanley, Tr. 4679.

rather than to negotiate new contracts with ProMedica. IDF 13. The Joinder Agreement was consummated on August 31, 2010. Answer ¶ 2.

On January 6, 2011, the Commission issued an administrative Complaint against ProMedica. The Complaint alleged that the Joinder threatens to substantially lessen competition for health care services in Lucas County, Ohio. Complaint ¶¶ 1, 2. Two relevant service markets were alleged: (1) GAC inpatient hospital services sold to commercial health plans; and (2) inpatient OB services. *Id.* ¶¶ 12-15. The alleged relevant geographic market is Lucas County, Ohio. *Id.* ¶¶ 16-19. In its Answer to the Complaint, Respondent admitted that GAC inpatient hospital services sold to commercial health plans constitutes a valid service market, but denied that OB services is a separate relevant market. Answer ¶¶ 12-15. Although the Answer denied that Lucas County, Ohio, is the relevant geographic market, Respondent subsequently admitted it. *See, e.g.*, Resp. to Compl. Counsel's Req. for Admiss. ¶ 7; Guerin-Calvert, Tr. 7683. Respondent denied all other material allegations of the Complaint.

The FTC and the State of Ohio also brought suit in the U.S. District Court for the Northern District of Ohio, seeking a temporary restraining order and preliminary injunction, because the Hold Separate Agreement was scheduled to expire. On March 29, 2011, Judge Katz, concluding that the FTC had satisfied its burden of proof, entered a preliminary injunction holding the parties to the terms of their Hold Separate Agreement pending the outcome of the administrative proceedings. *FTC* v. *ProMedica Health Sys., Inc*., No. 3:11 CV 47, 2011 WL 1219281 (N.D. Ohio March 29, 2011).

B. Initial Decision

On December 5, 2011, Judge Chappell issued an Initial Decision in which he concluded that the Joinder was likely to substantially lessen competition in violation of Section 7 of the Clayton Act. ID 6, 35, 137-43. He delineated a product market consisting of the sale of GAC inpatient hospital services to commercial health plans, referred to as managed care organizations ("MCOs"). Unlike the Complaint, however, the ALJ included in the GAC inpatient hospital services market tertiary services, which are generally not offered by St. Luke's. *See* ID 140; JSLF ¶ 6. He also rejected Complaint Counsel's contention that OB services constituted a separate relevant market. ID 6, 36, 143-44. The ALJ concluded that Lucas County, Ohio, was the relevant geographic market. ID 6, 37-38, 145.

Within the relevant GAC inpatient hospital services market, Judge Chappell found that the Joinder would significantly increase ProMedica's market share and market concentration, reducing the number of competing hospital providers from four to three and causing concentration levels to substantially exceed the thresholds in the 2010 Horizontal Merger Guidelines **(**U.S. Dept. of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines (Aug. 19, 2010), *available at* http://www.ftc.gov/os/2010/08/100819hmg.pdf ("2010 Horizontal Merger Guidelines")). ID 6, 40-43, 147-52. He concluded that by eliminating St. Luke's and ProMedica as separate options for MCOs, the Joinder would significantly enhance ProMedica's bargaining leverage in negotiations and would enable ProMedica to obtain higher reimbursement rates, which likely would be passed along to the customers of the MCOs, including employers and consumers. ID 6, 65-79, 162-74.

The ALJ found Respondent's defenses unpersuasive. First, he concluded that the evidence did not support Respondent's claims that excess hospital bed capacity in Toledo, repositioning by competitors, and steering patients away from high-priced hospitals by doctors, employers, or health plans would constrain post-Joinder price increases. ID 7, 80-86, 176-79. Second, he found that the procompetitive benefits and efficiencies Respondent asserted were not merger-specific, did not represent significant economies that would benefit competition, or were insufficient to outweigh the Joinder's likely anticompetitive effects. ID 7, 114-31, 192-204. Third, with respect to Respondent's claim that St. Luke's was financially weak and a limited competitor, the ALJ found that "St. Luke's clearly was struggling financially prior to the Joinder and faced significant financial challenges to remaining independent in the future." ID 190. At the same time, the ALJ determined that prior to the Joinder "St. Luke's [had] succeeded in significantly raising its patient volume and market share," and "was still competing in the market." ID 189. On balance, he ruled, Respondent's weakened competitor justification should be rejected. ID 189; *see* ID 91-112, 180-90.

Having found liability, the ALJ ordered divestiture of St. Luke's to a Commission-approved buyer. ID 204-11. He rejected Respondent's proposal to allow the Joinder to stand under terms requiring separate and independent negotiating teams for the pre-joinder ProMedica hospitals (the "legacy hospitals") and St. Luke's. Judge Chappell determined that extensive integration of St. Luke's into the ProMedica hospital system had not yet occurred and that unwinding the Joinder would be unlikely to involve substantial costs. He held that Respondent had failed to demonstrate that this case presents unusual circumstances sufficient to overcome the presumption that divestiture is the appropriate remedy. ID 7.

III. STANDARD OF REVIEW

Pursuant to 16 C.F.R. § 3.54, the Commission reviews the ALJ's findings of fact and conclusions of law *de novo*, considering "such parts of the record as are cited or as may be necessary to resolve the issues presented." The Commission may "exercise all powers which it could have exercised if it had made the initial decision."[4] *Id.* We adopt the ALJ's findings of fact to the extent that those findings are not inconsistent with this opinion.[5]

[4] The *de novo* standard of review is required by the Administrative Procedure Act, 5 U.S.C. § 557(b), and the FTC Act, 15 U.S.C. § 45(b), (c), and applies to both findings of fact and inferences drawn from those facts. *See Realcomp II, Ltd.*, No. 9320, 2009 WL 6936319 at *16 n.11 (FTC 2009), *aff'd, Realcomp II, Ltd. v. FTC*, 635 F.3d 815 (6th Cir. 2011).

[5] Respondent's appeal does not dispute the ALJ's findings and conclusions on the lack of procompetitive benefits and efficiencies from the Joinder; therefore, our Opinion does not address the issue other than to adopt the ALJ's findings.

IV. FACTUAL BACKGROUND

A. The Third-Party Insurance System

In most markets, vendors set or negotiate a price that is paid in full by their customers. However, the market for hospital services is more complex. Hospitals and their patients rarely negotiate directly over the price of hospital services, and few patients directly pay their hospital costs. Instead, the costs of hospital services are typically paid by various third-party payor insurers, both public and private.

The primary public insurance programs are the federal Medicare program which covers hospital costs for the elderly, and the federal/state Medicaid program which covers the costs of low-income patients. IDF 40-42. Reimbursement rates for patients covered under these programs are set by the government, are not subject to negotiation by the hospitals, and are generally lower than hospitals' costs of providing care. IDF 43, 292.

Most other patients are covered under various types of commercial health insurance plans, including PPOs and HMOs.[6] The insurers that offer such plans (MCOs) create provider networks and offer their plans to employers, which in turn offer them to their employees as part of their compensation packages. IDF 45, 251. Hospital charges incurred by the employee are then paid by the MCO, subject in some cases to copayments or deductibles depending on the specific terms of the plan.

In Lucas County, approximately 65 percent of the patients are covered under the government programs, and 29 percent are privately insured. The remaining 6 percent are self-pay or charity patients. IDF 39, 52.

B. The Competitive Dynamics of MCO Contracting

1. The MCOs

MCOs contract with hospitals, physicians, and other health care providers in a given geographic area to create provider networks that the MCOs then market to employers. The MCOs compete against one another to be included on the menu of health insurance products that employers offer to their employees, and then, after they are included as an option, they compete to attract the employee/members. IDF 234, 238.

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[6] IDF 44. In a traditional health maintenance organization ("HMO"), a patient can receive care only from a designated set of providers and must be referred by a primary care physician who acts as a "gatekeeper" to specialists. IDF 118-21. In a preferred provider organization ("PPO"), a patient can go to providers outside the network, but pays more if he or she does so. IDF 122-23. Some insurers also offer what are known as point-of-sale ("POS") plans, which are less restrictive than HMOs but more restrictive than PPOs, as well as traditional indemnity plans, where there are no restrictions on where patients can receive care, and the insurer pays whatever the hospital or other provider bills. IDF 125,127. While some insurers offer a choice of products, others offer only a more limited menu. *See, e.g.*, IDF 130, 148, 166.

MCOs seek to offer marketable plans to employers in terms of cost, geographical coverage, quality, and breadth of services, while at the same time staying competitive by, among other things, obtaining favorable rates from hospitals and other providers. IDF 278. They seek to offer within the network a complete complement of GAC inpatient services, from relatively simple primary and secondary services through more advanced services, including tertiary services. IDF 274. One important factor an MCO considers in creating its network is how broad to make it. On the one hand, narrower hospital networks, *i.e.*, networks that exclude certain hospitals in the market, drive more patient volume to the in-network hospitals. This, in turn, increases the network's value to those in-network hospitals and generally allows the MCO to obtain lower rates from those hospitals. IDF 269. On the other hand, the MCO's customers (employers, directly, and their employees, indirectly) generally favor broad networks that do not restrict their choice of providers. IDF 276. Thus, MCOs have to balance their customers' preference for broad networks against potentially higher rates. IDF 276-77.

2. The Hospitals

Hospitals compete with one another for inclusion in MCOs' provider networks because a hospital's commercially-insured patient volume is significantly affected by the provider networks in which it participates. IDF 240-41. In contract negotiations with MCOs, hospital providers seek to maximize the reimbursement they will receive from the MCOs for treating the MCOs' enrollees. The rates the provider will be able to achieve in negotiations are affected by its bargaining leverage, which, in turn, is dependent on its hospitals' relative attractiveness to employers and their employees: the more valued a provider's hospitals, the more important it is to the MCO's ability to market its network to employers, and the more bargaining leverage the hospital provider has in its negotiations with the MCO. IDF 295.

In negotiating reimbursement rates with commercial insurers, hospitals seek to cover their total patient care costs and an operating margin sufficient to fund needed capital expenditures and expansion, and to maintain a strong balance sheet. IDF 290. Because Medicare/Medicaid reimbursements do not cover actual patient care costs, hospitals try to make up the shortfall with rates charged to MCOs. IDF 292. Accordingly, it is critical for a hospital to be able to attract a sufficient volume of commercially-insured patients, and that, in turn, is affected by the MCO networks in which the hospital is a participating provider.

3. Employers and Employees

Most commercially-insured patients obtain health insurance through their employers. IDF 250. The employers do not negotiate directly with the hospitals on behalf of their employees, but rather rely on the MCOs to do so. IDF 248-49. While some employers have exclusive relationships with only one MCO, others offer their employees a variety of insurance options. IDF 252-53.

In selecting which MCOs to offer their employees, employers consider factors such as cost, the breadth of the network in terms of geographical coverage, the types of services offered, and the choice of providers. All else being equal, employers favor broad networks. Some are willing to pay more for broader network coverage, while others may consider the lower cost

associated with narrower networks to be more important. IDF 256-57. Generally, employers seek to satisfy the health-care coverage preferences of their employees, while keeping costs low. IDF 260.

4. The Bargaining Process for Reimbursement Rates

Reimbursement rates for hospital services are determined through the bargaining process between MCOs and hospitals. IDF 509. Although negotiations between hospitals and MCOs cover a variety of contractual terms (IDF 512), reimbursement rates and the contractual terms that affect rates are particularly important. IDF 513.

Both the parties and the MCOs acknowledged that higher hospital reimbursement rates are passed on to employers and often to their employees. IDF 596, 599, 655-63. Thus, the MCOs would not themselves absorb the higher rates; the higher rates would be passed on to the community-at-large.

C. Types of Hospital Services

Hospitals typically provide both inpatient services (those services requiring admission to the hospital for 24 hours or more) and outpatient services (which do not require an overnight stay). IDF 19. Within the category of inpatient services, different hospitals may provide different types of services along a continuum of care, ranging from primary services, which treat common conditions of mild to moderate severity, to quaternary services, such as organ transplants, which are the most complex and require the most specialized equipment and expertise. IDF 20-23, 25. Tertiary services include services such as neurological intensive care that are more complex than secondary services such as orthopedic surgery, but less complex than quaternary services. IDF 22-23. Hospitals that provide tertiary services also typically provide primary and secondary services, IDF 24, but many hospitals that provide primary and secondary services do not provide more complex tertiary services.[7] Thus, MCOs, in structuring their networks to attract employers and their employees, strive to enter into contracts with one or more hospitals that will give their covered enrollees access to various levels of care.

D. The Merging Parties

1. ProMedica

ProMedica is a non-profit, integrated health care system headquartered in Toledo, Ohio. IDF 1. It operates 11 hospitals in Ohio and southeast Michigan. IDF 3. It also owns and operates Paramount Health Care, which is one of the largest MCOs in Lucas County, Ohio. IDF 163. In 2009, ProMedica generated revenues of approximately $1.6 billion. Answer ¶ 8.

[7] The dividing line between various levels of services is not, however, precisely defined. IDF 26.

Prior to the Joinder, ProMedica operated three general acute-care hospitals in Lucas County.[8] The largest is The Toledo Hospital ("TTH"), which is located in downtown Toledo, and has between 700 and 800 licensed beds, 550 of which are staffed. IDF 55. It offers all basic acute care services, ranging from general medical-surgical to orthopedics and OB services, as well as tertiary care services. IDF 56-57. It is also one of only two Lucas County hospitals that offers more complex Level III OB services. IDF 58. TTH is the single largest general acute-care hospital in Lucas County.

In addition to TTH, ProMedica operates two smaller community hospitals in Lucas County. Flower Hospital is located in Sylvania, Ohio, in the northwest Toledo area, and has about 300 licensed beds, 250 of which are staffed. IDF 61, 65. Bay Park Hospital is located in Oregon, Ohio, in the eastern Toledo area, and has about 86 licensed beds. IDF 70-71. Both Bay Park and Flower offer OB services, but neither offers any tertiary services. IDF 63-64, 68-69.

ProMedica regards itself as the dominant hospital system in Lucas County, and that assessment is shared by others. PX00270 at 025; PX00319 at 001; PX00221 at 002. It is also among the most expensive hospital systems in Ohio, IDF 525; at the same time, however, some of its quality scores are "subpar." PX00153 at 001.

2. St. Luke's Hospital

Before the Joinder, St. Luke's was an independent not-for-profit community hospital. St. Luke's was a wholly owned subsidiary of OhioCare Health System, Inc., along with several other subsidiaries, including St. Luke's Hospital Foundation, Care Enterprises, Inc., Physician Advantage MSO, and OhioCare Physicians, LLC. IDF 10.

St. Luke's is located in Maumee, Ohio, a suburban area in southwest Lucas County. IDF 72. St. Luke's provides a broad range of outpatient and inpatient services, including Level 1 OB services, and limited oncology, neurosurgery and pediatric services. IDF 73, 75. St. Luke's was reputed to be a low-cost, high-quality provider. *See, e.g.*, Pugliese, Tr. 1443-48, 1521-22; McGinty, Tr. 1190-92, 1205-06. It has about 178 staffed beds. IDF 77.

E. Other Hospitals in Lucas County

In addition to the ProMedica hospitals and St. Luke's, there are four other hospitals in Lucas County. Three are owned and operated by the same hospital system, Mercy, which, in turn, is part of the Catholic Health Partners health care system headquartered in Cincinnati, Ohio. IDF 79; Shook, Tr. 887-90. The remaining hospital is UTMC, which is part of the University of Toledo and an instrumentality of the State of Ohio. IDF 103.

1. The Mercy System Hospitals

The Mercy system hospitals in Lucas County are Mercy St. Vincent, Mercy St. Anne, and Mercy St. Charles. IDF 81. St. Vincent is a large tertiary hospital with 568 registered beds, 445

[8] ProMedica also operates a specialty hospital, Children's Hospital, located on The Toledo Hospital's campus. IDF 53.

of which are staffed. IDF 82-83. In addition to basic acute care services, it also offers a variety of tertiary services, including a large cardiology center, and is the only Lucas County hospital other than TTH that offers Level III inpatient OB services. IDF 82, 84. St. Vincent is located in downtown Toledo. IDF 87.

Both St. Anne and St. Charles are smaller general medical-surgical hospitals. IDF 92, 99. St. Anne has 128 registered beds, 96 of which are staffed (IDF 93); St. Charles is somewhat larger with 350 registered beds, but fewer than 150 are staffed (IDF 101). Neither hospital offers any tertiary services. IDF 92, 100. St. Anne discontinued providing OB services in 2008 because of insufficient demand, IDF 94-95; St. Charles does offer OB services, including Level II services. IDF 99. St. Anne is located in west Toledo; St. Charles is located in Oregon, Ohio, just east of Toledo. IDF 92, 98.

2. UTMC

UTMC is a research and teaching hospital, located south of downtown Toledo. IDF 103; PX00900. It has about 300 registered beds, of which about 225 are staffed. IDF 111. It focuses primarily on providing tertiary and quaternary services as part of its teaching mission, IDF 109, and is the only hospital in Lucas County to provide quaternary services. IDF 108. It offers no inpatient OB services and has no plans to do so. IDF 110.

F. MCOs in Lucas County

Several MCOs market health insurance products to employers in Lucas County. The largest is Medical Mutual of Ohio ("MMO"), which offers a variety of PPO, HMO, and POS plans to Lucas County employers. IDF 130, 132. It covers about 100,000 lives in Lucas County. IDF 132. Its network includes all the Lucas County hospitals: Mercy, UTMC, and St. Luke's all have been in the MMO network for more than ten years; ProMedica has participated since 2008. IDF 135-39.

Anthem Blue Cross Blue Shield ("Anthem") is another large MCO operating in Lucas County, with about 30,000 commercially-insured members. IDF 147. In Lucas County, Anthem offers only a PPO network, which currently includes all the Lucas County hospitals. IDF 149, 156. ProMedica has participated in the Anthem network for at least 20 years; Mercy has participated since 2008; and UTMC has participated since 2003 or 2004. IDF 156-59. St. Luke's participated in Anthem's network prior to 2005, but was terminated effective January 31, 2005. IDF 160-61. It resumed participation in July 2009. IDF 162.

Paramount Healthcare ("Paramount") is also one of the largest MCOs operating in Lucas County, with about 85,000 to 90,000 covered lives in commercially insured products. IDF 163, 168. Paramount is a wholly-owned subsidiary of ProMedica and offers a closed or limited network of hospitals. IDF 172. Prior to the Joinder, Paramount's network included only the ProMedica hospitals and UTMC; pursuant to the Joinder Agreement, it now includes St. Luke's. IDF 177-79.

FrontPath Health Coalition ("FrontPath") is a membership organization composed of various corporate and other sponsors. IDF 183. It is one of the top three or four MCOs in Lucas County, with approximately 80,000 covered lives. IDF 188. All the Lucas County hospitals participate in the FrontPath network. IDF 191.

MCOs with a smaller presence in Lucas County include Aetna, United Healthcare, and Humana, all of which are large companies offering health insurance products throughout the United States. IDF 197, 209, 226. Aetna offers HMO, PPO, and POS plans. IDF 212-13, 216. It has contracted with all the Lucas County hospitals since 2006; prior to that time, its network did not include UTMC. IDF 222-23. United offers primarily PPO plans in Lucas County and has approximately 15,000 commercially insured members. IDF 198, 200. All Lucas County hospitals currently participate in its network. IDF 204. Humana offers only a PPO in Lucas County and covers about 2,000 commercially-insured lives. IDF 228, 230. It too includes all Lucas County hospitals in its network.[9]

At the time of the Joinder, ProMedica was in-network with MMO, Anthem, FrontPath, United, Paramount, and Aetna. IDF 521. St. Luke's at that time was in-network with MMO, Anthem, FrontPath, United, and Aetna. IDF 528.

G. St. Luke's Financial Condition

In the years prior to the Joinder, St. Luke's was experiencing significant financial difficulties. IDF 371-85; 785-86, 792-95, 799. St. Luke's experienced operating losses from 2007 until the month prior to the Joinder in 2010, *see* IDF 786, and its operating performance was below that of other comparable hospitals. IDF 787-89, 795. Responding to its financial needs, St. Luke's began deferring some capital projects in order to conserve cash. IDF 808. It also instituted a hiring freeze, cut pay and benefits, and froze pay. IDF 800-03. St. Luke's cash reserves declined, IDF 862-66, and its bond rating was downgraded from A2 to Baa2. IDF 873, 875, 880, 883. Although its bond debt was relatively low, IDF 916-18, and it still had enough in cash and investments to pay off all its outstanding debt, IDF 862, 919, St. Luke's was struggling. IDF 899, 901, 914-15.

In February 2008 St. Luke's hired a new chief executive officer, Mr. Daniel Wakeman, who had previously engineered successful turnarounds of several other community hospitals. IDF 920. In June 2008 Mr. Wakeman developed a three-year strategic plan that contained certain goals for St. Luke's centered on five strategic "pillars": "Growth, People, Quality, Service, and Finance/Corporate." *Id.* By August 31, 2010, St. Luke's had achieved its growth goals of increasing inpatient revenues by more than $3.5 million a year on average, and outpatient revenues by more than $5 million a year on average. IDF 924-25. It had also achieved its goal of obtaining more than a 40 percent market share in its core service area, IDF 928,[10] and its occupancy rate in the year prior to the Joinder increased by approximately [redacted]

[9] IDF 233. In addition, Blue Cross/BlueShield of Michigan covers some patients of Lucas County hospitals. *See* PX02148 at 103.

[10] St. Luke's "core service area" is the top eight zip codes from which St. Luke's draws 60 percent of its patient volume. *See, e.g.*, PX01235 at 5.

percent. IDF 930. However, St. Luke's overall cost coverage ratio remained below one, meaning that St. Luke's was not generating sufficient reimbursements to cover its costs across all payors. IDF 944, 947. St. Luke's management identified the primary source of St. Luke's financial problem as "extremely low reimbursement rates from third party payors." IDF 388, *quoting* PX01390 at 0002, ¶ 6, *in camera*.

St. Luke's financial position improved in 2010. IDF 949. Its operating losses declined and its operating margins improved, as patient volumes increased and expenses declined. IDF 950-54, 957-58. By August 2010 – the month the Joinder was consummated – St. Luke's was able to post a positive operating margin. IDF 948. In his monthly report for August 2010, CEO Wakeman reported that "[t]he high activity produced a positive operating margin of $7,000 on $36.7 million in gross revenue. It is not impressive, but it is better than a loss. This positive margin confirms that we can run in the black if activity stays high. After much work, we have built our volume up to a point where we can produce an operating margin and keep our variable expenses under control." *Id.*, *quoting* PX00170 at 001.

H. St. Luke's Decision to Affiliate with ProMedica

St. Luke's management pursued a number of options to address its financial condition. These included instituting various cost-cutting measures, IDF 800-03; exploring the interest of several out-of-market hospitals in acquiring St. Luke's, Wakeman, Tr. 2544-45; PX1016 at 024; entering discussions with ProMedica, Mercy, and UTMC about possible affiliation arrangements, IDF 404; and attempting to renegotiate MCO contracts to obtain more favorable reimbursement rates. IDF 541-45, 547-49.

In August 2009, Mr. Wakeman, in a document entitled "Options for St. Luke's – St. Luke's is now at a crossroads," presented three options to the Board: (i) "Remain independent. Surgically remove all financially losing services/programs until accepted margin is realized"; (ii) "Push the payors to . . . raise SLH reimbursement rates to an acceptable margin"; or (iii) merge with one of the other in-market hospitals. IDF 390, 393-95; PX01018 at 008, 009, 014-017, *in camera*. With respect to the first option, management noted that it would entail cutting "bone and muscle," not just fat, and would require that St. Luke's "cut major services and programs (downsizing), not just rightsizing." PX01018 at 008, *in camera*.

With respect to the second option, management noted that "St. Luke's is being grossly underpaid." IDF 391, *quoting* PX1018 at 003, *in camera*. It cautioned, however, that [redacted] PX1018 at 009, *in camera*.

The final option involved a merger with Mercy, UTMC, or ProMedica. IDF 395. St. Luke's management believed that affiliating with ProMedica had several potential advantages, including ProMedica's strong managed care contracts, a "huge" cash inflow (directly and indirectly through inclusion in ProMedica's MCO, Paramount), the likelihood of upgrades to the St. Luke's campus, improved information technology systems, a good history of execution, and a greater likelihood of local control. IDF 396; PX1018 at 014, *in camera*.

The Board rejected the possibility of service cuts, and began to focus on the affiliation options. IDF 401; Black, Tr. 5703-04. In an October 30, 2009 update on affiliation options, St. Luke's management detailed the advantages and disadvantages of affiliating with each of the in-market hospitals. IDF 402-05; PX01030, *in camera.* On December 15, 2009, senior management presented another affiliation update to the Board in which it detailed a variety of financial "pressing concerns" and again analyzed the pros and cons of affiliating with ProMedica, Mercy, or UTMC. IDF 409-14. The update acknowledged that any of the three options "could increase prices/cost to the community." IDF 419-21. As to affiliating with ProMedica, the update identified the pros as: favorable insurance contracts (noting access to ProMedica's MCO affiliate, Paramount); access to capital; investment in St. Luke's campus; potential for local governance and control; solid physician strategy and infrastructure; and financial stabilization of the organization's ability to serve and expand. IDF 421, *citing* PX01016 at 023, *in camera*. The cons were: "some quality measures are poor and history of poor relations with partners/affiliates." *Id.*

On December 15, 2009, Mr. Wakeman recommended to the St. Luke's Board of Directors that St. Luke's pursue an affiliation with ProMedica; the Board approved his recommendation that same day.[11] On May 25, 2010, the parties signed a Joinder Agreement and on August 31, 2010, consummated the transaction subject to the Hold Separate Agreement.

I. St. Luke's Pricing Objectives for the Joinder

At the time of the Joinder, commercial reimbursement rates paid to St. Luke's were significantly lower than those received by ProMedica and Mercy. IDF 530. In contrast, ProMedica's commercial reimbursement rates at the time of the Joinder were the highest in Lucas County, IDF 524, and among the highest in Ohio. IDF 525.

St. Luke's expected to be able to raise its rates after the Joinder. Indeed, one of the primary reasons it chose to affiliate with ProMedica was the expectation that St. Luke's would be able to significantly increase its reimbursement rates because of ProMedica's more favorable bargaining leverage with MCOs, which would be further enhanced with the deal. IDF 600-03. Highlighting this belief, a 2009 presentation regarding potential affiliation partners made to St. Luke's Board of Directors states: "An SLH affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout." IDF598; PX01030 at 020, *in camera*. The presentation conveyed management's belief that "ProMedica had a significant leverage on negotiations with some of the [health plans]" and that this leverage would allow St. Luke's to obtain higher reimbursement rates; it expressed concern

[11] IDF 422-23. St. Luke's cut off talks with Mercy and UTMC, which had remained interested in affiliating with St. Luke's, when St. Luke's decided to pursue an affiliation with ProMedica. Wakeman Tr. 2554-55, 2559. The Board decided not to pursue affiliation with Mercy based upon several issues, including concerns about lack of local governance. IDF 424. It decided not to pursue affiliation with UTMC principally because UTMC's proposed board structure was not acceptable to St. Luke's due to UTMC's desire to maintain full veto power. The Board was also concerned about the potential incompatibility between UTMC's state institution and union culture and St. Luke's culture. IDF 425.

that an affiliation with ProMedica could, in the short term, "harm the community by forcing higher hospital rates on them." IDF 598, *quoting* Wakeman, Tr. 2700, *in camera*.

J. The Joinder Agreement

Under the Joinder Agreement, ProMedica committed to "maintain[ing] St. Luke's using its current name and identity and at its current location for a minimum of ten (10) years . . . as a fully operational acute care hospital providing the following services: emergency room, ambulatory surgery, inpatient surgery, obstetrics, inpatient nursing and a CLIA certified laboratory." IDF 428, *quoting* PX00058 at 023, 045-046. ProMedica promised to pay $5 million at closing and to provide an additional $30 million in equal annual installments over a three-year period to fund various capital projects at St. Luke's, including converting semi-private rooms to private rooms, updating St. Luke's IT systems, constructing an outpatient lobby, renovating the heart center, moving administrative services, expanding surgical areas, and increasing the private postpartum and infant nursery. IDF 429-30, PX00058 at 021, 056. The Agreement also enabled St. Luke's to become a participating provider in the Paramount network, from which it previously had been excluded. IDF 432, PX00058 at 022-023. In return, ProMedica received the power to appoint two members of St. Luke's Board and to approve St. Luke's Board nominees, as well as certain important reserve powers, including the right to approve St. Luke's budgets and to appoint or remove St. Luke's management. IDF 434-35, PX00058 at 016-018.

V. LEGAL FRAMEWORK

Section 7 of the Clayton Act prohibits the acquisition of assets "where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. § 18. Section 7 prohibits acquisitions that create a reasonable probability of anticompetitive effects. "Congress used the phrase '*may be* substantially to lessen competition' to indicate that its concern was with probabilities, not certainties." *FTC* v. *H.J. Heinz Co.*, 246 F.3d 708, 713 (D.C. Cir. 2001), *quoting Brown Shoe Co.* v. *United States*, 370 U.S. 294, 323 (1962). "Thus, to establish a violation of Section 7, the FTC need not show that the challenged merger or acquisition *will* lessen competition, but only that the loss of competition is a 'sufficiently probable and imminent' result of the merger or acquisition." *FTC* v. *CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 35 (D.D.C. 2009), *quoting United States* v. *Marine Bancorp., Inc.*, 418 U.S. 602, 623 (1974).

Merger enforcement is therefore concerned with preventing the unlawful acquisition, maintenance, and exercise of market power. 2010 Horizontal Merger Guidelines § 1. Mergers that enhance market power can enable the merged firm to profitably alter its marketplace decisions to the detriment of consumers, for example, by raising prices, cutting output, or reducing product quality or variety. Mergers that enhance market power can also diminish incentives for innovation.

Courts have traditionally analyzed Section 7 claims under a burden-shifting framework. *See, e.g., Heinz*, 246 F.3d at 715; *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 982-83

(D.C. Cir. 1990). Under this framework, the government can establish a presumption of liability by defining a relevant product and geographic market and showing that the transaction will lead to undue concentration in the relevant market.[12] The typical measure for determining market concentration is the Herfindahl-Hirschman Index (the "HHI"). *CCC Holdings*, 605 F.Supp. 2d at 37.

"Once the Government establishes its *prima facie* case, the respondent may rebut it by producing evidence to cast doubt on the accuracy of the Government's evidence as predictive of future anticompetitive effects." *Chicago Bridge* & *Iron Co.* v. *FTC*, 534 F.3d 410, 423 (5th Cir. 2008); *Baker Hughes*, 908 F.2d at 982-983. The stronger the government's *prima facie* case, the greater the respondent's burden of production on rebuttal. *Heinz*, 246 F.3d at 725; *Baker Hughes*, 908 F.2d at 991. Factors that may be considered include "ease of entry into the market, the trend of the market either toward or away from concentration, and the continuation of active price competition." *Kaiser Alum. & Chem. Corp*. v. *FTC*, 652 F.2d 1324, 1341 (7th Cir. 1981). Rebuttal evidence may also include factors relating to competition in the relevant market or the competitive or financial weakness of the acquired company. *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 494-504 (1974); *Baker Hughes, Inc*., 908 F. 2d at 985 (*citing Lektro-Vend v. Vendo Co.*, 660 F.2d 255, 276 (7th Cir. 1981); *United States* v. *Int'l Harvester Co.*, 564 F. 2d 769, 773-79 (7th Cir. 1977); *FTC* v. *Nat'l Tea Co.*, 603 F.2d 694, 699-700 (8th Cir. 1979)).

Finally, if the respondent successfully rebuts the *prima facie* case, the burden of production shifts back to the government and merges with the ultimate burden of persuasion, which remains with the government. *Chicago Bridge*, 534 F.3d at 423. A plaintiff can bolster a *prima facie* case based on market structure with evidence showing that anticompetitive effects are likely. *Heinz*, 246 F.3d at 717. Common sources of evidence include the merging parties, customers, other industry participants, and industry observers. 2010 Horizontal Merger Guidelines § 2.2.

This traditional burden-shifting framework is not the only appropriate manner in which to conduct a proper merger analysis. The courts have recognized that in practice, evidence is often considered together and the burdens are not strictly demarcated. *Chicago Bridge*, 534 F.3d at 424-25. Accordingly, the burden shifting is regarded as describing a flexible analytical framework rather than an airtight rule. *Id*. at 424. As we said in *Evanston Nw. Healthcare Corp.*, 2007 WL 2286195 at *44 (FTC 2007), "[a]lthough the courts discuss merger analysis as a step-by-step process, the steps are, in reality, interrelated factors, each designed to enable the fact-finder to determine whether a transaction is likely to create or enhance existing market power." Moreover, we have noted in prior cases and the courts have also recognized that a framework derived from defining a relevant market and showing undue concentration in that market "does not exhaust the possible ways to prove a § 7 violation on the merits." *F.T.C. v. Whole Foods Market, Inc*., 548 F.3d 1028, 1036 (D.C. Cir. 2008); *see also Polypore Int'l, Inc.*, 2010 WL 5132519 at *14 (FTC Dec. 13, 2010); *Evanston*, 2007 WL 2286195 at *73-76.[13]

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[12] *See United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 363 (1963); *Baker Hughes*, 908 F.2d at 982-83.

[13] In a consummated merger, post-acquisition evidence of actual anticompetitive harm may in some cases be sufficient to establish Section 7 liability, without separate proof of market definition. *Evanston*, 2007 WL 2286195 at *81-84 (Comm'r Rosch, concurring).

The 2010 Horizontal Merger Guidelines further elaborate on this principle by explaining that merger analysis should not consist of uniform application of a single methodology. 2010 Horizontal Merger Guidelines § 1. Rather, the fact-specific nature of merger review necessarily entails a flexible analysis tailored to the nature of the market under examination, and there are a range of analytical tools that can be applied to the evidence to evaluate the competitive concerns from a transaction. *Id.* Definition of the relevant market is often a useful tool to begin the competitive analysis of a merger, but it need not always be the first step because evidence of competitive effects can often inform market definition. *Id.* § 4. Thus, in some merger cases, depending on the facts, it may make sense to begin the analysis with an examination of the competitive effects. *Id*.

In this case, based on the evidence before us, it is appropriate to begin the analysis utilizing the traditional burden-shifting framework.

VI. RELEVANT MARKETS

We begin our review of the Joinder by identifying the relevant markets to determine whether the transaction will substantially lessen competition "within the area of effective competition." *See United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586, 593 (1957) (internal quotation omitted). "The 'area of effective competition' must be determined by reference to a product market (the 'line of commerce') and a geographic market (the 'section of the country')," *Brown Shoe*, 370 U.S. at 324, for purposes of Section 7 of the Clayton Act. *See* 15 U.S.C. § 18.

A. Relevant Product Market

The relevant product market can be defined by examining the reasonable interchangeability of use by consumers or the cross-elasticity of demand between the product itself and substitutes for it. *Brown Shoe*, 370 U.S. at 325. As one court explained, "[i]nterchangeability of use and cross-elasticity of demand look to [1] the availability of products that are similar in character or use to the product in question and [2] the degree to which buyers are willing to substitute those similar products for the product." *FTC v. Swedish Match N. Am., Inc.*, 131 F. Supp. 2d 151, 157 (D.D.C. 2000) (citing *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 393 (1956)).

The 2010 Horizontal Merger Guidelines use a related test to define the relevant product market. Under those Guidelines, the product market is defined by asking whether a hypothetical monopolist of the proposed product market could impose a small but significant and nontransitory increase in price and not lose an amount of its sales to alternative products that would make the price increase unprofitable. If so, then the proposed market constitutes a relevant product market. *Id*. § 4.1.1 (explaining that the hypothetical monopolist test identifies a set of reasonably interchangeable products because the resulting product market contains enough substitutes so that it could be subject to a post-merger exercise of market power). Many courts have applied the 2010 Horizontal Merger Guidelines' hypothetical monopolist test. *See, e.g.*, *Whole Foods Market*, 548 F.3d at 1038; *Swedish Match*, 131 F. Supp. 2d at 160-66.

In this case, the parties agree that there is a relevant product market for GAC inpatient hospital services sold to commercial health plans.[14] Complaint ¶¶ 12-13; Answer ¶ 12 (ProMedica "admits that general acute-care inpatient hospital services sold to commercial health plans constitutes a valid service market"). Accordingly, Judge Chappell found that there is a relevant product market for GAC inpatient hospital services sold to commercial health plans. ID 145. The parties also agree that this relevant product market is properly described as a cluster market. ID 139-40. A cluster market for GAC inpatient hospital services has consistently been found to be the relevant product market in prior hospital merger cases. *See, e.g.*, *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995); *FTC v. Univ. Health Inc.*, 938 F.2d 1206, 1210-12 (11th Cir. 1991); *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990); *Evanston*, 2007 WL 2286195 at *40-41. In this proceeding, Judge Chappell concluded that the relevant market encompasses "all GAC inpatient hospital services – primary, secondary, and tertiary services – sold to commercial health plans." ID 143-45.

Complaint Counsel appeal two issues regarding the precise boundaries of the GAC inpatient hospital services cluster market. First, they argue that tertiary services should be excluded from the GAC inpatient hospital services market. Second, they argue that there is a separate relevant product market for inpatient OB services. Respondent defends the ALJ's product market. Resolution of these issues is important from the standpoint of analytical precision and guidance for future cases, but in this case it does not make a difference on the ultimate question of liability.[15] As discussed *infra* in Section VII, the market structure in this case generates a presumption of competitive harm regardless of whether the ALJ's or Complaint Counsel's markets are accepted.[16]

1. Two Proposed Approaches to Cluster Market Methodology

The parties present two differing approaches for defining a cluster market. Complaint Counsel's approach aggregates smaller relevant markets that, for reasons of analytical convenience, can be assessed collectively because they all involve the same competitive conditions. Respondent's approach does not focus on the competitive conditions of the smaller relevant markets, but rather, focuses on the aggregation of hospital services that MCOs tend to purchase as a package in single negotiated transactions.

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[14] The parties also agree that the relevant product market focuses on the sale of the services to commercial health plans rather than to government payors such as Medicare and Medicaid.

[15] For this reason our analysis should not give rise to accusations of "gerrymandering" the relevant product market so as to make it more susceptible to a structural presumption of liability, as Commissioner Rosch suggests in his concurring statement.

[16] Moreover, these issues affect only a small subset of the inpatient hospital services that are within the GAC inpatient hospital services market. Even if both OB services and tertiary services are excluded from the GAC inpatient market found by the ALJ, a substantial core group of GAC inpatient hospital services that the parties agree belong in a relevant product market remains and warrants analysis regarding possible anticompetitive effects arising from the Joinder.

The first step in Complaint Counsel's cluster market approach is to identify the individual inpatient hospital services (*e.g.*, knee surgery, appendectomy) for which there is an overlap in services provided by ProMedica and St. Luke's. *See* CCRB 2. Each individual inpatient hospital service is potentially a self-standing, relevant product market under the 2010 Horizontal Merger Guidelines because the individual services are not clinical substitutes for one another. CCAppB 22.

Complaint Counsel then collect into a cluster all of the individual relevant service markets that have similar competitive conditions – here, a common group of hospital providers. This is done merely for the convenience of analysis: as long as the competitive conditions for each individual product are alike, only a single analysis of competitive effects is necessary. Complaint Counsel argue that this approach, "allows the analysis to be done efficiently, without creating inconsistent or distorted results, precisely because GAC inpatient hospital services are offered under similar market conditions, by the same market participants, and within the same geographic market." CCAppB 22.

Applying this approach, Complaint Counsel define a cluster market consisting of the group of GAC inpatient hospital services (i) for which there is an overlap between ProMedica and St. Luke's *and* (ii) that are provided by all four Lucas County hospital competitors. Because St. Luke's generally does not provide tertiary services,[17] there is no tertiary overlap with ProMedica, and Complaint Counsel do not place these services into the GAC inpatient services market. Complaint Counsel also argue that because patients are willing to travel greater distances for tertiary and quaternary services, the set of available hospitals may be broader than for primary and secondary services. For this reason too, tertiary services would not be aggregated into the cluster that corresponds to Toledo hospitals. Similarly, because UTMC does not provide OB services, the competitive conditions (*i.e.*, the number of competing suppliers) differ from those for GAC inpatient services. Consequently, Complaint Counsel exclude OB services from their GAC inpatient hospital services cluster market and, instead, analyze OB services separately.

In contrast, Respondent proposes an approach to defining the GAC inpatient hospital services market cluster based on the idea of transactional complements – the bundle of complementary inpatient hospital services for which MCOs demand access for their commercially insured patients and for which MCOs generally negotiate and contract as a package. RAnsB 3-4. According to Respondent, a cluster based on transactional complements covers the full range of inpatient hospital services available to commercially insured patients that MCOs negotiate for as a package. It includes both tertiary and OB services because both are demanded by MCOs when they contract with hospitals.

The ALJ adopted Respondent's transactional complements approach. ID 140 (explaining that "MCOs demand, and contract for, a broad array of inpatient hospital services together . . . on behalf of the members they insure"). The ALJ included tertiary services because "MCOs

[17] *See* JSLF ¶ 6 ("St. Luke's currently performs few, if any, tertiary services and no quaternary services.").

contract for a broad array of primary, secondary, and tertiary inpatient services from hospitals together in a single negotiated transaction." ID 142-43; IDF 304. He found that limiting "the market to only those services that both St. Luke's and ProMedica actually provide is not what MCOs demand or contract to purchase." ID at 143. The ALJ similarly determined that inpatient OB services are included in the GAC inpatient hospital services market. ID 144 (explaining that "to carve out individual hospital services would be contrary to the logic upon which the inpatient services 'cluster market' rests").

2. Selecting the Appropriate Cluster Market Methodology – Facilitating the Analysis of Competitive Effects

a. Complaint Counsel's "Cluster for Analytical Convenience"

The primary purpose of defining a relevant product market is to facilitate the analysis of competitive effects of a transaction. We do not undertake market definition as an exercise in and of itself. *See du Pont*, 353 U.S. at 593 (citing *Standard Oil Co. v. United States*, 337 U.S. 293, 299 (1949)) ("Determination of the relevant market is a necessary predicate to a finding of a violation of the Clayton Act because the threatened monopoly must be one which will substantially lessen competition 'within the area of effective competition.' Substantiality can be determined only in terms of the market affected."); 2010 Horizontal Merger Guidelines §§ 4, 4.1.1 (noting "the overarching principle that the purpose of defining the market and measuring market shares is to illuminate the evaluation of competitive effects" and explaining that "[t]he measurement of market shares and market concentration is not an end in itself, but is useful to the extent it illuminates the merger's likely competitive effects").

With that purpose in mind, we find that cluster markets based on analytical convenience are useful and appropriate for evaluating competitive effects in this case. The identification of substitutes is at the core of product market definition. *See, e.g.*, *Brown Shoe*, 370 U.S. at 325 ("[t]he outer boundaries of a product market are determined by the reasonable interchangeability of use or the cross-elasticity of demand between the product itself and substitutes for it."). Viewed from this perspective, the individual service lines provided by the hospitals lack substitutes and each could be treated as a relevant product market. Both parties' expert witnesses agreed. *See* Guerin-Calvert, Tr. 7632-33 (Respondent's expert explaining that as a general matter, the individual service lines within the cluster are not substitutes for each other; from a demand-side analysis they can be considered separate product markets; and one could evaluate competitive effects within each individual service line); Town, Tr. 3665 (Complaint Counsel's expert explaining that individual services are not clinical substitutes for each other), 3667 (stating that "each of the services in the cluster [is its] own relevant product market"); *see also Rockford Mem'l*, 898 F.2d at 1284 (explaining that if you need a kidney transplant or have a heart attack, you will go to an acute-care hospital for inpatient treatment: "The fact that for other services you have a choice between inpatient care at such a hospital and outpatient care elsewhere places no check on the prices of the services we have listed, for their prices are not linked to the prices of services that are not substitutes or complements.").

We also find that the collection of individual hospital service relevant product markets into a cluster for purposes of evaluating competitive effects enables us to analyze efficiently the

Joinder's effect in hundreds of relevant product markets.[18] JSLF ¶ 57 ("the cluster market is used 'as a matter of analytical convenience [because] there is no need to define separate markets for a large number of individual hospital services . . . when market shares and entry conditions are similar for each,'" quoting *Emigra Group v. Fragomen*, 612 F. Supp. 2d 330, 353 (S.D.N.Y. 2009)); *see also* Commentary on the Horizontal Merger Guidelines (2006) at 8-9 ("when the analysis is identical across products or geographic areas that could each be defined as separate relevant markets using the smallest market principle, the Agencies may elect to employ a broader market definition that encompasses many products or geographic areas to avoid redundancy in presentation"). Collecting the service lines into a cluster based on whether they have similar market conditions enables an accurate assessment of competitive effects, which is our ultimate goal. As one commentator explains,

> when the same firms sell the same set of products, which do not happen to be substitutes, in the same geographic areas with similar market shares, and when each individual product would constitute a product market under the [Merger] Guidelines, the antitrust analysis of each would be so similar in practice that no loss of analytic power comes from treating the products as a collection. . . . If there is no compelling reason to believe demand and supply substitutability opportunities, entry conditions, or market shares differ significantly across individual products, then the antitrust analysis will be similar for each good so they may conveniently be analyzed as a collection.

Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 L. & Contemp. Probs., Spring 1988, at 93, 138.

Respondent, nonetheless, maintains that Complaint Counsel's approach to defining a cluster market introduces supply-side considerations into market definition, contrary to the instructions of the 2010 Horizontal Merger Guidelines. RAnsB 10-11 (citing 2010 Horizontal Merger Guidelines § 4 ("Market definition focuses solely on demand substitution factors")). According to Respondent, collecting services into clusters according to the number and identity of the competing hospitals relies improperly on a supply-side consideration. We disagree. Complaint Counsel's methodology considers demand-side substitution because each individual service line (*e.g.*, knee replacement, appendectomy) is found to be a relevant product market based on demand-side substitution. The grouping or collection of those services into clusters for analytical convenience is part of the competitive effects analysis. *See* Town, Tr. 3595.

This approach to defining a cluster market is generally consistent with prior cases that have found cluster markets. In *Philadelphia National Bank*, the Supreme Court found that "the cluster of products (various kinds of credit) and services (such as checking accounts and trust administration) denoted by the term 'commercial banking' composes" a relevant product market because the court determined that each of the products or services was effectively free from

[18] Of course, it is possible that out of the hundreds of services that are aggregated into the cluster, there may be a few services for which one Lucas County hospital did not have a patient with that diagnosis in a particular year. Such isolated instances at this level of detail during the aggregation into a cluster market would not meaningfully alter the relevant product market in this case.

competition from other financial institutions. 374 U.S. at 356-57. In short, the competitive conditions faced by commercial banks was the same for each of the products or services in the cluster. Similarly, in *United States v. Grinnell Corp.*, 384 U.S. 563 (1966), the Court found a cluster of central station services in which the dominant firm with a 73 percent market share faced 38 competitors; whether the remaining 27 percent of the market in each service (*i.e.*, fire alarm, waterflow alarm) was provided by 24 or 38 competitors, the competitive conditions were the same. *Id.* at 572-73 n.6.

An approach that groups product markets with competitive overlaps when competitive conditions are similar is consistent with the GAC inpatient hospital service markets defined in prior hospital merger cases. Thus, courts and adjudicators regularly exclude outpatient services from the cluster markets because the competitors for those services differ from the competitors for inpatient services. *See, e.g.*, *Evanston*, 2007 WL 2286195 at * 46-47; *Rockford Mem'l*, 898 F.2d at 1284; *FTC v. Butterworth Health Corp.* 946 F. Supp. 1285, 1290-91 (W.D. Mich. 1996). Also, in *Butterworth*, the court found a separate relevant product market for primary care inpatient hospital services in addition to the GAC inpatient hospital services cluster because the primary service lines were offered by a greater number of hospitals in competition with the merging hospitals.[19]

b. Respondent's "Transactional Complements" Cluster

In contrast, Respondent's approach to defining the cluster market does not facilitate the effective analysis of competitive effects. The fact that MCOs negotiate primary, secondary, and tertiary services in a single transaction may suggest a contracting efficiency, but it does not account for why the resulting cluster allows for an accurate assessment of competitive effects.

Respondent's attempt to elaborate – stressing that MCOs demand the full range of inpatient hospital services – provides no persuasive reason for defining a corresponding cluster market, given the manner in which MCOs assemble the combination of hospitals in their networks. MCOs do not demand the full range of inpatient services from *each* hospital or from *each* hospital provider in their network.[20] Rather, MCOs ensure that the full range of inpatient services is available to insured members at *some* hospital within the network. IDF 274 ("MCOs require at least one hospital in the network that offers advanced services, including tertiary services, but the network need not include more than one such hospital"), 449. Thus, the rationale on which Respondent's cluster is based – the cluster is the full range of inpatient

[19] *Butterworth*, 946 F. Supp. at 1291 (discussing analysis of product market). *But see California v. Sutter Health Sys.* 130 F. Supp. 2d 1109, 1119-20 (N.D. Cal. 2001) (defining a cluster market that included all primary, secondary, and tertiary services when some services faced competition from niche hospitals in addition to full-range hospital competitors).

[20] In Lucas County, MCOs contract with and include UTMC and Mercy St. Anne in their hospital networks despite the fact that those hospitals do not provide OB services. IDF 92, 110. Similarly, MCOs contract with and include St. Luke's and the ProMedica and Mercy community hospitals in the networks even though those hospitals do not provide most tertiary services. IDF 63, 68, 74, 92, 100.

services that MCOs demand when they negotiate with hospitals – is contradicted by the observation of actual services demanded by MCOs from each hospital or hospital provider.[21]

Worse, we find that treating all of the services within the contract in a single analysis of competitive effects likely obfuscates the competitive consequences of the transaction. Indeed, a cluster that mixes services with different geographic markets, or that groups together services for which the merger leaves different numbers of remaining rivals or has a different competitive impact, could easily confuse the competitive analysis unless great care were taken to separately analyze different aspects of the transaction's competitive effects. *See* Thomas L. Greaney, *Chicago's Procrustean Bed: Applying Antitrust Law in Health Care*, 71 Antitrust L. J. 857, 882-84 (2004).

In particular, when the prices of individual services within the cluster may be the subject of negotiation, treating all services in a single competitive analysis does not account for the relevant economic factors – the availability of substitutes – that would affect those individual prices. *See Rockford Mem'l Corp.*, 898 F.2d at 1284 (explaining that the price of an individual hospital service depends on the availability of substitutes for that service, and the prices are not linked to the prices of services that are not substitutes or complements). The record demonstrates that MCO/hospital negotiations consider individual terms that fall within the resulting contract and permit modifications to those individual contractual terms. *See* IDF 317 (explaining that contracts between MCOs and hospitals may contain "carve-outs" that price one hospital service differently from other hospital services); Randolph, Tr. 6953-56, 6960, *in camera*; Pirc, Tr. 2287; Radzialowski, Tr. 753. When each negotiating party may exert its bargaining power based on the availability of substitutes for a particular service and the number of substitutes differs for particular services, a cluster market that fails to account for such differences does not properly facilitate the analysis of competitive effects.

Respondent's approach has not been followed in prior cases. Respondent claims that the cluster is the entire group of services that a customer demands. Yet, in *Philadelphia National Bank*, where the Court defined a "commercial banking" cluster that it understood to include services as diverse as checking accounts and trust administration, 374 U.S. at 356, individual customers would hardly be expected to frequently purchase the entire group of services in a single transaction. In *Grinnell*, the Court found that Grinnell held majority control over three principal protective service suppliers: Holmes, which provided only burglary services; AFA, which supplied only fire protection services; and ADT, which provided both. 384 U.S. at 566. Certainly, customers who bought from Holmes or AFA were not demanding and negotiating for the entire group of central station protective services in a single transaction.[22]

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[21] Respondent notes that the contracts between hospitals and MCOs include prices for services that are not provided by the hospital. RAnsB 5. In light of MCOs' willingness to satisfy their networks' needs through a combination of hospital providers, we would not expect the listing of prices for unprovided services to be a meaningful determinant of the scope of the market relevant for assessing competitive effects on services that are provided.

[22] Although the Court suggested that customers often purchased more than one item in the protective services cluster, its point was that the cluster could be justified based on economies of scope – a supply-side consideration very different from Respondent's demand-oriented

Respondent's proposed approach to defining the cluster has previously been rejected by the FTC. In *Evanston*, the Commission rejected the analogous claim that the relevant product market included hospital-based outpatient services "because MCOs purchase both inpatient and outpatient services from hospitals." *Evanston*, 2007 WL 2286195 at *46-47. Indeed, earlier in that proceeding Administrative Law Judge Stephen J. McGuire explained:

> Respondent argues that the relevant product market should be determined by using a demand-side analysis, which looks at the products sold by each merging firm, and that where a customer purchases several services together, it is those services taken as a whole that constitute the relevant product market. . . . [T]he Court of Appeals for the Seventh Circuit has explicitly rejected an approach that defined the relevant product market as *all* the services provided by the merging parties and demanded by customers. . . . The reasoning of the Seventh Circuit in *Rockford Memorial* applies with equal force here.

Evanston Nw. Healthcare Corp., No. 9315, Initial Decision at 134 (Oct. 21, 2005), http://www.ftc.gov/os/adjpro/d9315/051020initialdecision.pdf, *aff'd*, 2007 WL 2286195 at 46-47 (FTC Aug. 6, 2007) (citing *Rockford Mem'l*, 898 F.2d at 1284).

Similarly, in this case, Judge Chappell found that the single hospital contract was not a basis to include outpatient services in the relevant product market even though those services are part of the single negotiation between an MCO and a hospital. *Compare* IDF 307, 308 (explaining that outpatient services are not part of the relevant product market) *with* ID 172-73 (explaining that complex negotiations and single contracts between MCOs and hospitals cover outpatient as well as inpatient services); *see also, e.g.*, *Butterworth Health*, 946 F. Supp. at 1290-91.

Thus, based on the facts of this case and this industry, and, consistent with precedent, we reject Respondent's approach to defining a cluster market.[23]

3. Defining the Relevant Markets

We now address the specific issues raised by Complaint Counsel's appeal. First, we conclude that tertiary services are not part of the GAC inpatient hospital services market in this case. Importantly, in its Answer to the Complaint, Respondent admitted that tertiary services are excluded from the GAC inpatient market. Answer ¶ 13. A party is bound by the admissions in

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transactional complements. *See Grinnell*, 384 U.S. at 573 (observing that customers utilized in combination different services provided from a single office).

[23] We do not conclude that Respondent's approach could not be appropriate under different factual circumstances. After all, market definition is a fact-specific exercise. We conclude only that a cluster market based on the scope of what MCOs demand and negotiate in single transactions with hospitals does not produce a meaningful relevant product market in which to assess competitive effects in this case.

its answer. *Gibbs ex rel. estate of Gibbs v. Cigna Group*, 440 F.3d 571, 578 (2d Cir. 2006); *Mahtui v. Bohrell*, 219 F.2d 642, 643 (9th Cir. 1955). The admissions in an answer help to focus the issues in the litigation; Complaint Counsel, the ALJ, and the Commission should be able to rely on those admissions. We will not allow a Respondent to admit things in its Answer and, post-discovery, change its position.

Even if Respondent were not bound by its Answer, we would exclude tertiary services from the relevant GAC inpatient hospital services market in this case. St. Luke's generally does not provide tertiary services. *See* JSLF ¶ 6; ID 140. Absent an overlap or potential overlap involving a given service line, there is no substantial lessening of competition, and, thus, no need to include the service in the relevant product market.[24] Moreover, inclusion of tertiary services could obscure the analysis of competitive effects. Because patients are likely willing to travel farther for more complex treatments, IDF 283, the geographic market for tertiary services could be larger than that for primary and secondary services. If so, the number of competitors that could constrain price increases for those tertiary services could be higher (although it would have little impact on prices for primary and secondary services), and an analysis limited to hospital providers in Lucas County might be inappropriate.[25] Under an analysis that takes care to group together only relevant service markets with similar competitive conditions, tertiary services should not be aggregated into the cluster for GAC inpatient hospital services.

Judge Chappell notes that prior hospital merger cases have been inconsistent regarding whether tertiary services are included in a GAC inpatient hospital services market. ID 141-42 (citing *Butterworth*, 946 F. Supp. at 1291 and *United States v. Long Island Jewish Med. Center*, 983 F. Supp. at 137, 140, as examples where tertiary services were excluded from the GAC inpatient hospital services market). This is not surprising because defining a relevant product market in any particular case is a fact-specific question. However, we disagree with the ALJ's description of the Commission's treatment of the market in *Evanston*. Although the complaint in *Evanston* excluded tertiary services from the alleged relevant product market, at trial counsel for both sides agreed that, based on the particular facts of that case, tertiary services should be part of the GAC inpatient hospital services market. *See* Compl. Counsel's Answering and Cross-Appeal Brief, *In the Matter of Evanston Northwestern Healthcare Corp.*, Docket No. 9315 at 37,

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[24] *See CCC Holdings*, 605 F. Supp. 2d at 37 ("the relevant product market identifies the product and services with which the defendants' products compete"); *Little Rock Cardiology Clinic v. Baptist Health*, 573 F. Supp. 2d 1125, 1140-41 (E.D. Ark. 2008) (finding that a firm cannot monopolize or create anticompetitive effects in a market where it does not participate); 2010 Horizontal Merger Guidelines § 4.1 (explaining that the antitrust Agencies begin market definition when a product of one merging firm competes with a product of the other merging firm); *cf. United States v. Mercy Health Servs.*, 902 F. Supp. 968, 976 (N.D. Iowa 1995) (explaining that parties agreed that the relevant product market was acute care inpatient services, limited "to those services for which Mercy and Finley currently compete for patients").

[25] Typically, a respondent seeks to expand the relevant product market to increase the number of competitors. Here, however, Respondent seeks to include tertiary services in the GAC inpatient market, but does not argue that there are additional competitors. Granting Complaint Counsel's appeal on this issue does not affect the number of competitors.

available at: http://www.ftc.gov/os/adjpro/d9315/060210ccattachmntpursuantrule.pdf. Thus, the issue of whether to include tertiary services in the relevant product market was not raised on appeal. Not surprisingly, the Commission decision included tertiary services in the GAC inpatient hospital services market without any analysis of the issue and focused instead on the disagreement between the parties over whether outpatient services should be included in the GAC hospital services market. *Evanston*, 2007 FTC LEXIS 210, at *146-151. The Commission is faced with a different situation here, and our decision to exclude tertiary services from the relevant GAC inpatient hospital services product market is based on the particular facts of this case.[26] Similarly, *FTC v. University Health Inc.*, 938 F.2d 1206 (11th Cir. 1991), is not inconsistent with our analysis. The Court of Appeals for the Eleventh Circuit expressly chose not to analyze whether the market was broader than the overlap services. It explained that determining the precise bounds of the relevant product market "would be of no moment for [its] purposes," and accepted the broader market merely "for ease of discussion." *Id.* at 1211 n.11.

Second, we conclude that inpatient OB services are not in the GAC inpatient hospital services cluster market but rather constitute a separate relevant product market. As with many of the individual inpatient hospital services grouped together in the GAC cluster market, OB services warrant delineation as a relevant product market under standard principles of analysis. No other services are interchangeable with OB services. IDF 313; Resp. to Compl. Counsel's Req. for Admiss. at 6. An OB services market passes the 2010 Horizontal Merger Guidelines test: a hypothetical monopolist could profitably impose a small but significant and non-transitory increase in price. 2010 Horizontal Merger Guidelines § 4.1.1. Respondent's economic expert conceded as much. Guerin-Calvert, Tr. 7679-80 (acknowledging that prices "could materially change" if ProMedica achieved a monopoly over OB services). Moreover, examination of "practical indicia," which courts use to augment the interchangeability analysis, *see, e.g.*, *Brown Shoe*, 370 U.S. at 325; *CCC Holdings*, 605 F. Supp. 2d at 38, indicates that OB services are a separate relevant product market. Obstetrics is recognized as a separate field of medicine with distinct providers of OB services. In addition, the merging hospitals track OB services market shares separately from GAC inpatient services. IDF 314; *see, e.g.*, PX01016 at 003, *in camera* (St. Luke's presentation regarding affiliation partners); PX00009 at 022 (ProMedica Credit Presentation to Standard & Poor's).

Respondent argues that OB services cannot be a separate relevant product market because there is no evidence that hospitals price discriminate with regard to OB services. We disagree: there is no requirement that price discrimination be proved to find a separate relevant market.

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[26] Commissioner Rosch's Concurring Opinion relies on *Evanston* for his conclusion that we should include tertiary services in the GAC inpatient hospital services market. In our view, the reasons set forth above for excluding tertiary services from the relevant market in this case outweigh an argument premised on another case with its own facts, particularly where the decision contained no analysis of the issue. Commissioner Rosch also cites Professor Baker in footnote 1 of his Concurring Opinion when he explains that market definition may be supported simply by "convenien[ce]." Yet Professor Baker is careful to explain that a cluster market may be used for "analytic convenience *in situations where it will not be misleading*." Baker, *supra*, at 137-38 (emphasis added). As Professor Baker explained, the cluster market is *not misleading* only when it collects services that have common market conditions, and in this case, that means excluding tertiary services from the relevant GAC inpatient hospital services market. *Id.*

The OB services market satisfies the hypothetical monopolist test in its own right – there is no need to look within it for a subset of customers who could be harmed by price discrimination. Respondent's reliance on Section 4.1.4 of the 2010 Horizontal Merger Guidelines is misplaced. The 2010 Horizontal Merger Guidelines describe a circumstance where a firm targets a particular group of customers within a single product market, not a cluster market as we have here. As we previously explained, the cluster market is a collection of properly-defined relevant product markets – here, lines of services at Lucas County hospitals – that were aggregated only to facilitate analyzing competitive effects.

Most important to the analysis here, OB services are offered under different competitive conditions than those applicable to the other services included in the GAC inpatient hospital services cluster market: one of the four Lucas County hospital providers (UTMC) does not offer OB services. *See* IDF 110; Answer ¶¶ 4, 15, 20. The availability of competitive alternatives for consumers of OB services therefore differs substantially from that for consumers of services in the cluster. Thus, including OB services in the GAC inpatient hospital services cluster market would be inconsistent with the goal of market definition: the accurate assessment of competitive effects.

Commissioner Rosch's concurring statement suggests that defining a separate relevant product market for OB services would be redundant, since OB services are part of the bundle of inpatient hospital services that MCOs purchase. We disagree. If we were to place inpatient OB services within the GAC inpatient hospital services cluster market, in analyzing anticompetitive effects we still would need to evaluate the effect of decreasing the number of OB suppliers from three to two. The record clearly shows that there are reimbursement rate carve-outs for OB services. *See* IDF 317-18; Sheridan, Tr. 6683-84 (during 2010 negotiations between ProMedica and United, case rates and per diem rates for OB services were the subject of separate negotiation); Radzialowski, Tr. 752 (Aetna specifically negotiates rates for maternity care); PX00365 at 030, *in camera* (contract between [redacted] and [redacted] for [redacted] contains [redacted]; PX00366 at 030, *in camera* (contract between [redacted] and [redacted] for [redacted] contains [redacted]; PX02520 at 003-005, *in camera* (update on negotiations between [redacted] and ProMedica shows [redacted]. This dictates that we must account for the different market conditions at some stage of our analysis. We believe the analysis will prove more transparent if we address the issue in defining the relevant product market rather than deferring it to the examination of competitive effects.

Commissioner Rosch's concurrence also expresses discomfort with the fact that there is no judicial precedent for defining a separate OB services market. We are not daunted by this observation, however, because every case that comes before the Commission is fact-specific and merits independent examination. Moreover, contrary to footnote 2 of Commissioner Rosch's concurring opinion, there is judicial precedent for the underlying rationale we use in this case to treat OB services as a separate relevant product market. This includes case law finding a separate cluster market for particular inpatient services in addition to the GAC inpatient hospital services market where the group of suppliers for that group of services differs from the suppliers of GAC inpatient hospital services. *See Butterworth*, 946 F. Supp. at 1291 (court agreeing with

FTC that there is a separate relevant product market for primary care inpatient hospital services in addition to the GAC inpatient hospital services market, based on the existence of a differing group of suppliers for those services).[27]

In any event, the outcome of this case is the same whether or not OB services are included in the GAC inpatient hospital services market.

B. Relevant Geographic Market

The ALJ found that the relevant geographic market for GAC inpatient hospital services is Lucas County, Ohio,[28] ID 145-46, and we agree. Moreover, there is agreement between the parties that the relevant geographic market for the GAC inpatient hospital services market is Lucas County, Ohio. Complaint ¶ 16; Resp. to Compl. Counsel's Req. for Admiss. 7; Tr. 7683 (Guerin-Calvert).

Similarly, we also conclude that the relevant geographic market for OB inpatient hospital services is Lucas County. *See* Town, Tr. 3593-94. The ALJ determined that for the "GAC inpatient services market, which includes OB services," the proper geographic market is Lucas County. ID 145. If patients do not travel beyond Lucas County for GAC inpatient hospital services such as scheduled diagnoses and surgeries, patients are even less likely to travel outside Lucas County for delivery of a baby. *See* Sheridan, Tr. 6682; *cf.* Town, Tr. 3632 (stating, "if you have an acute condition . . . time matters"), 3694-95 (finding average patient travel time for OB services was 11.3 minutes).

VII. THE JOINDER IS PRESUMPTIVELY ILLEGAL

Ultimately, whether we accept Complaint Counsel's or Respondent's definition of the relevant markets does not affect our analysis of this transaction's likely competitive effects. As the ALJ found, regardless of which market definition is used, market shares and concentration levels exceed the thresholds for presumptive illegality provided in the 2010 Horizontal Merger Guidelines and the case law. IDF 368-70; ID 151. Respondent does not dispute this.

In the GAC inpatient hospital services market as defined above, ProMedica's acquisition of St. Luke's reduced the number of competitors from four to three, combining St. Luke's 11.5 percent market share with ProMedica's 46.8 percent market share and giving ProMedica a post-

[27] The Sixth Circuit affirmed the district court's decision and in no sense rejected the district court's product market finding. *See FTC v. Butterworth Health Corp.*, 1997-2 Trade Cas. (CCH) ¶ 71,863 (6th Cir. 1997).

[28] Judge Chappell found that "the evidence establishes: no MCO has marketed a health plan to Lucas County customers without including at least one Lucas County hospital; a hypothetical monopolist controlling every hospital in Lucas County could increase the price of GAC inpatient services in Lucas County by at least 5 to 10 percent, a small but significant amount; with extremely rare exceptions, Lucas County residents do not use more distant providers of GAC inpatient hospital services; and hospitals in counties adjacent to Lucas County are not acceptable alternatives for one MCO's Lucas County members." ID 145-46.

acquisition market share of 58.3 percent based on patient days.[29] IDF 364. The acquisition increased the HHI in the GAC inpatient hospital services market by 1,078 points, resulting in an HHI of 4,391 based on patient days.[30] IDF 368. In the OB inpatient services market, the acquisition reduced the number of competitors from three to two, adding St. Luke's 9.3 percent market share to ProMedica's 71.2 percent market share and giving ProMedica an 80.5 percent market share based on patient days.[31] PX02148 at 143, *in camera*. The acquisition increased HHIs in the OB services market by 1,323 points, resulting in an HHI of 6,854. *Id.* These concentration data are more than sufficient to create a presumption that the merger is anticompetitive. *See Heinz*, 246 F.3d at 716 (increase in HHI of 510 in market with HHI of 4,775 created a presumption "by a wide margin"); *Univ. Health*, 938 F.2d at 1211 n.12, 1219 (*prima facie* case established where merger reduced competition from five to four and resulted in a combined market share of 43 percent, an HHI increase of 630 points, and a post-merger HHI of 3200); 2010 Horizontal Merger Guidelines § 5.3 (post-acquisition HHI above 2500 and HHI increase of more than 200 points "will be presumed to be likely to enhance market power").[32]

Of course, statistics concerning market share and concentration are not conclusive proof of competitive harm. *Gen. Dynamics*, 415 U.S. at 498. Nonetheless, where concentration levels are high, as they are in this case, Respondent bears the burden of demonstrating that the HHIs and market share data are unreliable in predicting a transaction's competitive consequences. *See Heinz*, 246 F.3d at 715; *Univ. Health*, 938 F.2d at 1218. As the Supreme Court has explained, "a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects." *Philadelphia Nat'l Bank*, 374 U.S. at 363. "The more compelling the prima facie case" – including other evidence presented by Complaint Counsel that reinforces the structural presumption – "the more evidence the defendant must present to rebut it successfully." *Baker Hughes*, 908 F.2d at 991; *accord Chicago Bridge & Iron*, 534 F.3d at 426.

[29] Patient days measure how long a patient stays in a hospital. IDF 346.

[30] IDF 364. Mercy's share was 28.7 percent; UTMC's share was 13.0 percent. *Id.*

[31] PX 02148 at 143, *in camera.* Mercy's share was 19.5 percent. *Id.*

[32] Although Respondent's expert did not calculate HHIs for the GAC inpatient hospital services market as she defined it, she conceded that, even under her relevant market definition, the acquisition increased concentration in an already highly concentrated market to levels deemed presumptively anticompetitive under the 2010 Horizontal Merger Guidelines. IDF 369; Guerin-Calvert, Tr. 7730. ProMedica's and St. Luke's own assessments of market shares in internal documents reinforce the conclusions that, however the relevant market is defined, it was highly concentrated before the acquisition, and the acquisition significantly increased concentration. IDF 361-63; PX00270 at 025-026; PX01236 at 002, 054.

VIII. RESPONDENT'S ATTEMPTED REBUTTAL: ST. LUKE'S AS A WEAKENED COMPETITOR

The ALJ found that "[t]he totality of the evidence supports the conclusions . . . that St. Luke's was struggling financially as a stand-alone entity during the years leading up to the Joinder and faced significant financial obstacles to going forward as an independent hospital." ID 186. However, he also found that St. Luke's financial position had improved prior to the Joinder; that its cash reserves would likely allow it to fund necessary capital projects and pay off its obligations; and that "the evidence does not warrant the conclusion that St. Luke's was likely to undertake service cuts absent the Joinder." ID 187-88, 188 n.24. On balance, he found that while St. Luke's "future viability beyond the next several years is uncertain" it "was not in imminent danger of failure." ID 188. He concluded that "current case law, applied to the facts of this case, does not provide support for allowing the Joinder to proceed on the basis of St. Luke's weakened financial condition." ID 190.

We agree. Since *General Dynamics*, 415 U.S. 486, evidence of an acquired firm's anticipated competitive weakness may, in certain cases, be sufficient to rebut the government's *prima facie* case. However, it is also clear that the courts have imposed an extremely heavy burden on defendants seeking to rebut the structural presumption on this ground. Thus, for example, in *FTC* v. *Arch Coal*, 329 F. Supp. 2d 109 (D.D.C. 2004), the case chiefly relied on by Respondent, the court explained that "the evidence of financial or other weakness must genuinely undercut the statistical showing of anticompetitive market concentration." *Id*. at 154. "[F]inancial difficulties," the court continued, "'are relevant only where they indicate that market shares would decline in the future and by enough to bring the merger below the threshold of presumptive illegality.'" *Id.* at 154, *quoting* 4 AREEDA ET AL., ANTITRUST LAW ¶ 963(a)(3), at 13 (1998)). "Indeed," the court summarized, "'[f]inancial weakness, while perhaps relevant in some cases, is probably the weakest ground of all for justifying a merger,' and 'certainly cannot be the primary justification' for permitting one." *Arch Coal*, 329 F. Supp. 2d at 154, *quoting Kaiser Aluminum*, 652 F.2d at 1339, 1341.

The Eleventh Circuit in *University Health* explained why this is so:

> Since weak firms are not in grave danger of failure – if so, they would be failing, rather than weak, companies, and the analysis might differ . . . it is not certain that their weakness "will cause a loss in market share beyond what has been suffered in the past, or that [such weakness] cannot be resolved through new financing or acquisition by other than a leading competitor…" Moreover, "[t]he acquisition of a financially weak company in effect hands over its customers to the financially strong, thereby deterring competition by preventing others from acquiring those customers, making entry into the market more difficult."

938 F.2d at 1221, *quoting* 4 P. AREEDA & D. TURNER, ANTITRUST LAW, p. 1221 ¶ 935b at 140 (1980) and *Kaiser Aluminum*, 652 F.2d at 1339. Thus, said the court, "[t]o ensure that competition and consumers are protected, we will credit such a defense only in rare cases, when the defendant makes a substantial showing that the acquired firm's weakness, which cannot be resolved by any competitive means, would cause that firm's market share to reduce to a level

that would undermine the government's prima facie case." *Univ. Health*, 936 F.2d at 1221; *see also FTC* v. *Warner Commc'ns, Inc*., 742 F.2d 1156, 1164 (9th Cir. 1984) (explaining that the financial weakness defense is disfavored because it "would expand the failing company doctrine, a defense which has strict limits").

Here, the record shows that St. Luke's was experiencing some financial difficulties in the years prior to the Joinder, and the ALJ so found. ID 182-87; IDF 784-919. However, it is also clear that St. Luke's, under Mr. Wakeman's leadership, was making significant improvements in its performance, and was *growing* prior to the Joinder. Thus, although Respondent asserts that St. Luke's market share will decrease, RAppB 38, it does not point to any evidence to substantiate that assertion. In fact, St. Luke's market share was increasing – not declining – in the years before the Joinder; [redacted]. *See* PX00159 at 005, 012 *in camera*; PX01235 at 003.

St. Luke's improved performance reflected its implementation of a strategic plan shortly after Mr. Wakeman was hired as St. Luke's CEO in February 2008. IDF 920. St. Luke's achieved most of the growth goals set out in that plan, increasing its "inpatient net revenue by more than $3.5 million per year on average" and its "outpatient net revenue by more than $5 million per year on average" (IDF 924-25), and achieving a 40 percent market share in its core service area. IDF 928. Its overall occupancy rate in the twelve months prior to the Joinder increased by about [redacted] percent. IDF 930. As patient volumes and patient care revenues improved, St. Luke's succeeded in getting its variable costs under control, and its operating margins consequently improved. IDF 949-54, 957-58.

Although St. Luke's did not achieve the financial goals set out in the strategic plan, IDF 936-41, it was making significant progress. In his last regular monthly report for St. Luke's as an independent hospital, Mr. Wakeman reported:

> We have experienced activity in excess of the Operating Financial Plan (OFP) and last years' activity. That activity has finally exceeded our fixed expense . . . .
>
> Inpatient, (up 7.5%) and outpatient, (up 6.1%), activity was running hot all month. While we still have capacity for outpatient, especially in the offsite centers, inpatient capacity is limited except for weekends. . . .
>
> . . . .
>
> If there was one pillar we attained a high level of success in our strategic plan in the past two years, it would be growth. The hard numbers prove that out, and almost every service. . . .
>
> Cardiac, pulmonary, surgery, emergency department, primary life systems, medical/surgical, imaging . . ., lab testing and especially obstetrics have experienced great growth in the past two years.

Significantly, Mr. Wakeman added:

> The high activity produced a positive operating margin of $7000 on $36.7 million in gross revenue. It is not impressive, but it is better than a loss. *This positive margin confirms that we can run in the black if activity stays high. After much work, we have built our volume up to a point where we can produce an operating margin and keep our variable expenses under control.*

PX000170, at 001, 006-007 (emphasis added). Summarizing what St. Luke's had accomplished, CEO Wakeman concluded:

> The entire St. Luke's family has much to be proud of with the accomplishments in the past three years. We went from an organization with declining activity to near capacity. Our leadership status in quality, service and low cost stayed firmly in place. In the past six months our financial performance has improved significantly. The volume increase and awareness of expense control were key.

Id. at 007. Other evidence likewise points to significant improvements in St. Luke's financial performance in the months prior to the Joinder. *See* Black, Tr. 5684-85 (St. Luke's Board of Directors Chairman testifying that St. Luke's financials were "looking up" in August 2010); PX01582, at 003, *in camera* ([redacted]).

Respondent does not deny that these improvements occurred. JSLF ¶¶ 27-36; Uyl Tr., 6562 (Respondent's expert testifying that St. Luke's financial performance had improved in the six months leading up to the Joinder); Hanley, Tr. 4701-02 (ProMedica's CFO testifying that St. Luke's had experienced a positive trend in patient revenues since 2008). Rather it downplays the significance of those improvements, contending that St. Luke's, while improving, was still operating at a loss throughout most of 2010; that its profit margin in August 2010 was only about $7,000; and that, although St. Luke's was able to increase its patient volumes in 2010, it continued to lose money on every patient it treated. RAppB 39; RRB 20. Additionally, Respondent argues that an independent St. Luke's would not have been able to fund necessary capital improvements in the future and that St. Luke's would have had to implement deep service cuts unless it affiliated with another hospital. RAppB 10, 39. Respondent also contends that St. Luke's "location in Lucas County will become less competitively significant." RAppB 38. Thus, Respondent argues, "It is likely that, absent the joinder, St. Luke's market share would be reduced to zero (if it exited the market) or nearly zero if it made the service cuts that it considered absent the joinder." RRB 19; s*ee also* RAppB 38, 40.

We find Respondent's arguments unpersuasive and lacking in evidentiary support. Although a $7,000 operating profit in August 2010 may be "not impressive" as Mr. Wakeman observed, PX 00170 at 001, the evidence shows that St. Luke's had made significant improvements and was on a positive trajectory at the time of the Joinder. Respondent asserts that St. Luke's achieved an operating profit in August 2010 only because of "two large, unusual, and non-recurring additions to St. Luke's operating income," RRB 20, but the record as a whole

suggests that St. Luke's was moving toward, not away from, a sustainable path.[33] *See* PX00171 at 001 (St. Luke's CEO Wakeman concluding, based on the results through the time of the Joinder, that St. Luke's "can run in the black if activity stays high").

Respondent's argument that "St. Luke's lost money, on average, for each patient that walked through its door" and that this undermined any showing that St. Luke's was "rebounding" in the months before the Joinder, RRB 20, is likewise unpersuasive. While the record shows that St. Luke's payments from all payors – MCOs, self-pay, and government – were too low to cover its costs, IDF 373, 377, St. Luke's cost coverage ratios, like other aspects of its financial performance, were improving significantly in the months before the Joinder.[34] Moreover, we are not persuaded that St. Luke's would not have been able to negotiate more favorable rates with the MCOs – especially with [redacted] which accounted for a significant portion of St. Luke's commercially-insured patient volume, but whose reimbursement rates were significantly below St. Luke's costs.[35] The [redacted] representative testified that [redacted]

[33] The increase in patient volumes and revenues for St. Luke's resulted largely from its successful physician recruiting efforts and its renewed participation in the Anthem network in July 2009. IDF 957. In 2005 ProMedica had persuaded Anthem to exclude St. Luke's from its network in return for greater rate discounts at ProMedica hospitals. *See* Wakeman, Tr. 2528-32, 3030-31. However, in July 2009 Anthem readmitted St. Luke's to its network, and Anthem-insured patients once again could receive care at St. Luke's. *Id.* at 2530-31. There is no reason to believe that St. Luke's will not continue to be able to participate in the Anthem network in the future. As to the recruiting of physicians, St. Luke's already had achieved what was necessary. *See* PX000170 at 001 ("we have built our volume up to a point where we can produce an operating margin"). Respondent offers no reason why, having achieved this recruiting success, the resulting volume and revenue benefits would be "non-recurring."

[34] St. Luke's overall cost coverage ratio for all payors was [redacted] for 2007, [redacted] for 2008, [redacted] for 2009 and [redacted] for the first eight months of 2010. IDF 373. However, there were significant disparities between the cost coverage ratios for different payors. St. Luke's cost coverage ratios for Medicare and Medicaid, which represented about [redacted] percent of St. Luke's revenues, were [redacted] IDF 375. According to one witness, [redacted] Sheridan, Tr. 6647-48, *in camera* (testifying that [redacted] **}** Among the MCOs, only [redacted] and [redacted] had below-cost reimbursement rates for St. Luke's in 2009, and in 2010 only [redacted] did. IDF 376. Negotiating a more favorable contract with only one large payor – [redacted] – would have gone a long way toward solving St. Luke's financial problems.

[35] In 1995, under its prior CEO, St. Luke's had negotiated a long-term contract with [redacted] which saddled St. Luke's with low rates that were insufficient to meet its costs of care. IDF 540; Black, Tr. 5580-81; [redacted] Tr. 2345-46, *in camera* ([redacted] . According to Mr. Black, St. Luke's Chairman of the Board, St. Luke's financial problems came to light after the prior CEO retired. Black, Tr. 5560-62.

[redacted][36] [redacted]} [37] Accordingly, we cannot conclude that St. Luke's would not have been able to negotiate rates sufficient to cover its costs if it had not decided instead to pursue the Joinder with ProMedica.

Respondent's argument that St. Luke's would not be able to fund capital projects and meet its other obligations also is unpersuasive. The record shows that at the time of the Joinder St. Luke's had enough cash reserves to fund its existing capital needs and to meet its financial obligations; that it had a low debt load; and that it could borrow at reasonable rates if it chose to do so.[38] While it is true that St. Luke's had been dipping into its cash reserves to fund its operating losses and capital improvements in the years before the Joinder, and that it could not continue to do so indefinitely, we cannot assume, based on the record before us, that St. Luke's could not have funded needed capital improvements in the future, especially in view of its significantly improved operating performance in 2010.

We likewise are unpersuaded by Respondent's argument that, in the absence of an affiliation, St. Luke's necessarily would have had to implement deep service cuts, and that this would have led to St. Luke's decline within, and even possible disappearance from, the Lucas County market. As the case law discussed above establishes, to prevail Respondent must show not only that the acquired firm's financial difficulties would result in a decline in its market share in the future, but also that those declines would be enough to bring the merger below the threshold of presumptive illegality. That means that St. Luke's market share of the GAC inpatient hospital services market would have to decline from 11.5 percent to 2.1 percent or less and that its share of the OB services market would have to decline from 9.3 percent to 1.4 percent or less. *See* CCAnsB 29. Respondent does not dispute either the legal standard or the underlying calculations. Rather Respondent argues that we should assume that, in the absence of the Joinder, St. Luke's would have had to implement deep service cuts and that such service cuts would result in a continuing deterioration in St. Luke's position sufficient to meet any required thresholds. RRB 19-21.

This we decline to do. In support of its argument on service cuts, Respondent relies primarily on one document, PX01018, *in camera*, an August 2009 presentation by Mr. Wakeman to the St. Luke's Board of Directors. That document identifies and discusses three options to

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[36] [redacted], Tr. 2229-36, *in camera*. The record shows that [redacted] *Id.* at 2354-55. [redacted] *Id.* at 2356; IDF 541-45. [redacted] *see* IDF 546-49, [redacted] Instead, St. Luke's pursued an affiliation with ProMedica.

[37] [redacted], Tr. 2353, *in camera.*

[38] ID 187. As of the date of the Joinder, St. Luke's owed less than $11 million in total outstanding debt, and held at least $65 million in cash and investments. JSLF ¶¶ 34-35.

address St. Luke's financial condition. The first of these options is to "[r]emain independent. Surgically remove all financially losing services/ programs until accepted margin is realized." *Id.* at 008. The presentation identified "Heart? Obstetrics? [redacted]" as possibilities for cuts. *Id.*

Mr. Wakeman's presentation, however, was made at the nadir of St. Luke's financial difficulties before St. Luke's significantly improved operating performance in 2010. Notably, Mr. Wakeman recognized this improvement in a memorandum to the St. Luke's Board in September 2010 when he identified both cardiac and OB services (two of the services identified as possibilities for cuts) as experiencing especially high growth during the two years prior to the Joinder. *See* PX000170 at 006. Moreover, the options presented to the Board in August 2009 were not limited only to service cuts or the Joinder with ProMedica, as Respondent suggests. RRB 19-21. Rather, the presentation also identified as options attempting to increase St. Luke's reimbursement rates and affiliating with Mercy or UTMC. PX01018 at 009-0013, 015-017, *in camera*. Critically, the evidence shows that the St. Luke's Board determined not to undertake service cuts. IDF 401. St. Luke's Chairman of the Board, James Black, testified that potential service cuts were not "a major topic of discussion" because the idea was distasteful to the Board. Black, Tr. 5703-04. Mr. Black further testified that pursuing rate increases was one of the major goals of the three-year plan implemented by Mr. Wakeman. Black, Tr. 5706.

Finally, even if St. Luke's would have made some service cuts in the absence of the Joinder, Respondent has not presented evidence to show that such cuts would have led to a decline in St. Luke's market shares *to the required levels*. For example, Mercy St. Anne offers neither OB services nor advanced heart services; yet there is no contention or evidence that St. Anne is not a viable competitor in the Lucas County market.

Thus, while PX01018 appears to reflect Mr. Wakeman's view in 2009 that cutting services was one option to address St. Luke's financial condition, it does not support Respondent's positions that, absent the Joinder with ProMedica, deep service cuts were inevitable, or that the depth of those cuts would render St. Luke's competitively insignificant. Notably, in late 2009 Mr. Wakeman advised the Board that St. Luke's would be able to survive three to five years under then current conditions, with no payor rate increases, and four to seven years if it was able to generate rate increases from two of its largest payors. Wakeman, Tr. 2624-25 (explaining that that was his estimate "[g]iven the information we had at the end of 2009"). Mr. Wakeman elaborated further that "[a]ll other issues being equal," improvements in the equity markets and in St. Luke's financial performance during the first eight months of 2010 "could have extended our time to stay independent." *Id*. at 2627.

Likewise, Respondent's contention that St. Luke's "location in Lucas County will become less competitively significant," RAppB 38, is contradicted by the evidence. As the ALJ found, the southwest sector of Lucas County has favorable demographic characteristics that make it a "desirable area for a hospital to be located." IDF 472-74. Witnesses, including Mr. Wakeman and Mr. Oostra, ProMedica's CEO, testified to St. Luke's favorable location. Wakeman, Tr. 2477, 2481 (St. Luke's is "in an optimal or better part of the community in the sense of growth and economic potential"); Oostra, Tr. 6037-38. MCO witnesses likewise testified to the importance of having geographic coverage in the growing and more affluent

southwest sector. *See, e.g.*, Pirc, Tr. 2195-96; Pugliese, Tr. 1442-43. Elsewhere in its briefs, Respondent recognizes that "[f]or ProMedica, the joinder provided an opportunity to expand its services in southwest Lucas County." RAppB 1. Respondent has failed to demonstrate that St. Luke's location will become competitively less significant, and one of its own rationales for acquiring St. Luke's belies its argument.

For all of these reasons, Respondent has not shown that St. Luke's financial condition so reduces its competitive significance as to undermine Complaint Counsel's *prima facie* case. Further, Respondent has not shown that there were no other competitive means by which St. Luke's could have addressed its financial difficulties. *See Univ. Health*, 938 F.2d at 1221 (requiring that "defendant make[] a substantial showing that the acquired firm's weakness, *which cannot be resolved by any competitive means*, would cause that firm's market share to reduce to a level that would undermine the government's *prima facie* case." (Emphasis added)).

The record shows that the primary source of St. Luke's financial weakness was its low reimbursement rates. ID 186, IDF 372-77. In light of St. Luke's reputation as a high-quality provider and its advantage of being the only hospital in the growing and more affluent sector of Lucas County, *see* IDF 472-74, it is likely that St. Luke's would have succeeded in negotiating more favorable reimbursement rates had it remained independent, especially since St. Luke's had identified negotiation of higher reimbursement rates as a major goal. Respondent concedes this. *See* RRB 15 ("it would be ridiculous to expect that St. Luke's prices will hold steady or decrease" in view of their low current levels); Oral Arg. Tr. 68-69 (Marx).[39] In addition, St. Luke's could have affiliated with an out-of-market hospital system, which would not pose competitive issues,[40] or with UTMC,[41] which would pose significantly fewer competitive concerns than a Joinder with ProMedica, the self-described dominant system in Lucas County.

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[39] *See also* [redacted] Tr. 2229-36, 2353, *in camera* ([redacted]). St. Luke's mixed record in negotiating higher rates before the Joinder is not persuasive as to the future. St. Luke's pre-Joinder efforts were made in the context of trying to *renegotiate* rates in existing contracts where St. Luke's bargaining leverage would presumably be less than it would be on contract expiration. *See* IDF 541-49.

[40] Respondent contends that "St. Luke's also investigated affiliating with other entities but either they were not interested or St. Luke's determined an affiliation was not in its or the community's best interest." RRB 21 n.11. Respondent identifies discussions with only three out-of-market systems – the University of Michigan, the Cleveland Clinic and McClaren Health Care. *See id.*; Wakeman, Tr. 2541-48. Mr. Wakeman also testified that St. Luke's held "general discussions" regarding a possible affiliation with other local community hospitals controlled by diverse organizations but did not pursue the arrangement after determining that it would have required unacceptably complex, time-consuming negotiations. Wakeman, Tr. 2548-51. The history of these limited efforts fails to establish that St. Luke's asserted competitive weakness cannot be resolved through affiliation with an out-of-market buyer.

[41] Prior to entering exclusive discussions with ProMedica in January 2010, St. Luke's had been engaging in on-going discussions with both Mercy and UTMC about possible affiliation

In sum, Respondent's "weakened competitor" showing falls far short of what the courts have demanded. Comparison to *Arch Coal*, 329 F. Supp. 2d 109, is telling. *Arch Coal* involved the acquisition of one coal company, Triton, by another, Arch Coal. There, as here, the defendant argued that the acquiree was a weak competitor and that its competitive significance was overstated. *Id.* at 153-57. The *Arch Coal* court concluded that the FTC's claims of Triton's competitive significance were in fact "far overstated." *Id.* at 157. The facts of *Arch Coal*, however, bear no resemblance to those here. For example, in *Arch Coal*, the presumption of competitive harm was weak (*id.* at 129, noting that "HHI increases are far below those typical of antitrust challenges brought by the FTC and DOJ" and that "the FTC's prima facie case is not strong"); here, in contrast, the presumption is very strong, and the evidence required to rebut the statistical case is accordingly greater. *Id.*, *quoting Baker Hughes*, 908 F.2d at 991 ("[t]he more compelling the prima facie case, the more evidence the defendant must present to rebut it successfully"). Whereas in *Arch Coal*, there were no prospects for improvement, 329 F.Supp. 2d at 157, St. Luke's was improving its financial performance, and its market share was increasing, not declining. Whereas in *Arch Coal* prospects for finding an alternative buyer were "dim," *id.* at 156, here that is far from clear.[42] In short, this is not one of those "rare cases," *Univ. Health*, 938 F.2d at 1221, where Respondent has met its burden of showing that financial weakness rebuts the presumption of illegality based on the government's structural case.

IX. SUBSTANTIAL RECORD EVIDENCE BUTTRESSES THE STRUCTURAL CASE

The evidence of market structure discussed above establishes a strong presumption that the Joinder will substantially lessen competition. Respondent has failed to present a showing of financial weakness sufficient to rebut that presumption. Nor, as discussed below, does Respondent provide evidence that entry or repositioning by competitors would be timely, likely or sufficient to deter or counteract the Joinder's likely anticompetitive effects or that other actions by market participants would be likely to constrain an exercise of market power.

Complaint Counsel, however, have not rested their case on market structure alone. They have gone on to present substantial evidence of likely competitive harm that buttresses their structural showing. This evidence includes documents, testimony, and business conduct of the merging parties that demonstrates their understanding that the Joinder will enhance market power. It includes a demonstration that the Joinder will increase the bargaining leverage of the

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arrangements, and the presentations made to the St. Luke's Board discussed the pros and cons of affiliating with each of them. *See* PX01018, *in camera*; PX01030, *in camera*; PX01016, *in camera*. In fact, St. Luke's and UTMC had drafted a Memorandum of Affiliation Terms in August 2009 (PX02205). Up to the time when St. Luke's cut off talks with them in late 2009, both Mercy and UTMC remained interested in pursuing an affiliation with St. Luke's. Wakeman, Tr. 2552-55, 2559.

[42] In *Arch Coal*, the court emphasized that the acquired firm had conducted a comprehensive, but ultimately unsuccessful, search for an alternate buyer over a multi-year period. 329 F. Supp.2d at 156-57. The same is not true here.

combined ProMedica/St. Luke's hospital system by detracting from the alternatives available to MCOs in negotiations with the combined system, and, consequently, can be expected to generate unilateral anticompetitive effects in the form of higher prices at both St. Luke's and the ProMedica legacy hospitals.[43] In addition, Complaint Counsel present econometric analysis quantifying the price impacts. This additional analysis – while unnecessary, particularly in light of the strength of Complaint Counsel's *prima facie* case – is nonetheless helpful because it is tailored to the unique competitive dynamics of hospital markets, stemming from the bargaining between hospitals and MCOs over inclusion in MCO networks.

A. Bargaining Leverage and Hospital Reimbursement Rates

The rates and terms of contracts that hospitals (or hospital systems) negotiate with MCOs are determined in large part by the bargaining leverage that each party brings to bear. IDF 554. The bargaining leverage of each party and, therefore, the terms of the agreement depend principally upon how each party evaluates the consequences of a failure to conclude an agreement with the other party. IDF 556; Town, Tr. 3641. The MCO's bargaining leverage will depend upon how the hospital provider would fare if it could not participate in the MCO (and therefore lacked ready access to the MCO's members as patients); the hospital provider's bargaining leverage will depend upon how the MCO would fare if its network did not include the hospital provider (and therefore became less attractive to potential members who prefer that provider's services).[44]

A hospital provider's bargaining leverage is affected by the available substitutes for its hospitals. Town, Tr. 3644. These are the hospitals to which the MCO can turn if it is unable to conclude an agreement with the first provider. If there are close substitutes, failure to conclude an agreement may have little impact on the MCO's marketability, so the hospital provider may have little bargaining leverage. *Id*. The less desirable the MCO's set of alternative hospitals, the more the MCO is injured if its network excludes the first provider, and the greater the hospital provider's bargaining leverage. *See* IDF 294, 298. The alternative network that the MCO can construct if it fails to reach an agreement with the first provider is referred to as the "walk-away network." Town, Tr. 3655.

A merger may increase a hospital provider's bargaining leverage by removing substitute hospitals and thereby changing the MCO's cost of failing to reach an agreement. *Id*. at 3651-52.

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[43] Unilateral competitive effects require no change in the behavior of non-merging parties. 2010 Horizontal Merger Guidelines § 1.

[44] Town, Tr. 3641-43, 3647-50. Thus, "MCOs estimate what it would cost to have a network without a particular hospital, *i.e.*, how much business would the MCO lose." IDF 287. The desirability and demand for a particular hospital provider affects the MCO's loss from forming a network without that provider, and hence affects the hospital provider's bargaining leverage. *See* IDF 295. The more hospitals that a provider controls, the more bargaining leverage it has. This is because failure to reach an agreement results in more hospitals leaving the network, which decreases the marketability of the MCO's network, and results in greater potential loss of business. IDF 298.

When the merger reduces the value of the alternatives available if the MCO fails to reach an agreement with the first provider, it reduces the desirability of the MCO's walk-away network. *Id*. at 3652.

The rates that emerge from a negotiation will be a function of the parties' bargaining leverage. *Id*. at 3641. If a merger increases the hospital provider's bargaining leverage by increasing the MCO's loss from failing to reach an agreement with the provider, the MCO will be willing to pay more to have that hospital provider in its network.[45] Generally speaking, an increase in the hospital provider's bargaining leverage translates to an increase in its reimbursement rates. *Id*. at 3649-50. IDF 293-94.

B. MCO Evidence Demonstrates That the Joinder Will Significantly Increase ProMedica's Bargaining Leverage

Even before the Joinder, ProMedica, as the dominant hospital system in Lucas County, had significant bargaining leverage, which allowed it to command among the highest rates, not only in Lucas County, but also the entire state of Ohio. IDF 524-25. MCO witnesses attributed ProMedica's ability to command such high rates to the size of its system and its market power, rather than to competitively-benign factors such as higher costs or better quality.[46] At the same time MCO witnesses characterized St. Luke's as a cost-effective, high quality hospital located in an especially desirable location. Pirc, Tr. 2194-96; McGinty, Tr. 1190-92, 1205; Pugliese, Tr. 1443-46.

The MCOs testified that the Joinder would further increase ProMedica's bargaining leverage, thereby leading to even higher rates. For example, an [redacted] representative testified that [redacted] Tr. 1524-25, *in camera;* PX01919 at 014 ([redacted] Dep. at 51), *in camera*. Aetna's witness testified that the Joinder has made the prospect of walking away from ProMedica substantially less attractive; post-Joinder, if Aetna failed to reach an agreement with ProMedica, it would face the loss of not only ProMedica's three legacy hospitals, but also the loss of St. Luke's, which would leave Aetna without coverage in southwestern Lucas County. IDF 570, Radzialowski, Tr. 664, 712-13, *in camera*; PX01917 at 020, 023 (Radzialowski, Dep. at 75-76, 86), *in camera*. A Humana representative testified that the Joinder increased ProMedica's "ability to leverage us [Humana] for rates for all of their hospitals and St. Luke's now as well." IDF 573, McGinty, Tr. 1209; PX02073 at 004 (¶ 15)

[45] *Id*. at 3655 (discussing the concept of "willingness to pay"); IDF 288 ("The reimbursement rates and other terms an MCO will agree to are based primarily on whether the MCO believes it can still sell its plans without that hospital in its network, and what losses the MCO would incur if the hospital were out of network."); *see Evanston Nw. Healthcare Corp.*, 2007 WL 2286195 at *61 (FTC 2007) ("If a significant portion of an MCO's members view a hospital that raises its prices as particularly important, the MCO likely will be more willing to pay some or all of the increase.").

[46] IDF 527; Pirc, Tr. 2238-42, *in camera; see also* McGinty, Tr. 1251, 1253; Radzialowski, Tr. 663, 696, *in camera*.

(McGinty, Decl.), *in camera.* Similarly, the [redacted] witness testified that "ProMedica would find its bargaining power greater after the acquisition than before," explaining that it would be more difficult for [redacted] to serve its membership without ProMedica and St. Luke's than without ProMedica's pre-Joinder hospital network in Lucas County. IDF 574, [redacted] Tr. 6687, 6698-6700, *in camera.*

The MCO witnesses also testified that a network composed only of UTMC and Mercy – the only two remaining providers in Lucas County after the Joinder – would not be commercially viable. Thus, the [redacted] witness testified that [redacted] Tr. 2261-63, *in camera*. Other MCO witnesses likewise testified that a network composed only of UTMC and Mercy would not be commercially viable. IDF 566-68; Radzialowski, Tr. 715-716, *in camera*; Pugliese, Tr. 1477-78; Sandusky, Tr. 1351, *in camera*. This is consistent with observed marketing patterns: as Respondent' s own expert acknowledged, no MCO has marketed a network composed only of UTMC and Mercy in at least the last ten years. Guerin-Calvert, Tr. 7895; IDF 565.

Respondent, however, urges us to disregard all the MCO testimony on the grounds that it is "[u]nsubstantiated, [b]iased, and [s]peculative." RAppB 30; RRB 14. In particular, Respondent contends that, because the MCOs "did not perform *any* analyses to support their beliefs about their ability to sell narrower networks or send their insureds to other hospitals in the event of a post-joinder price increase," their testimony "is speculative and unsupported by any analysis." RAppB 30-31; RRB 14.

We disagree. The mere fact that the MCOs had not performed tailor-made studies geared to litigation is no reason to discredit their testimony. The ALJ determined that "the MCOs used general market knowledge, feedback from the field, and/or claims utilization data to determine the attractiveness and marketability of their offerings and provided explanations to support their beliefs." ID 165 (citation omitted). The MCO witness testimony was based directly on years of relevant experience in designing and marketing networks in Lucas County. The MCO witnesses testified at length about how they rely on constant feedback from their sales and marketing teams regarding prospective enrollees' hospital coverage needs, as well as the analysis of various data sets, including utilization reports, claims data, Medicare cost reports, and hospital quality studies, in order to inform their assessments of which hospitals to include in their networks and what negotiating strategies to use with the hospitals. *See, e.g.*, Radzialowski, Tr. 582-83, 587-93, 600-04; Pirc, Tr. 2160-62, 2165-72; Pugliese, Tr. 1420-27.

The precedents relied on by Respondent in urging us to disregard the MCO testimony are clearly distinguishable. Thus, in *United States* v. *Oracle Corp*., 331 F. Supp. 2d 1098, 1131 (N.D. Cal. 2004), the court noted that the customer witnesses testified with a "kind of rote," offering "speculation" unsupported by "credible and convincing testimony" but "little or no" testimony about what they "would or could do or not do to avoid a price increase"; in *FTC* v. *Arch Coal*, 329 F. Supp. 2d 109, 145-46 (D.D.C. 2004), the court found that customer testimony simply reflected general "anxiety" about having one fewer supplier but provided no persuasive

reason for finding post-merger coordination more likely; and in *FTC* v. *Tenet Health Care Corp*., 186 F.3d 1045, 1054 (8th Cir. 1999), the court discredited MCO testimony that the MCOs could not resist price increases where the evidence showed that they could and that it was in their interest to do so. Here the MCO witnesses gave detailed testimony on why they believed that the Joinder would increase ProMedica's bargaining leverage and why they would not be able to resist rate increases sought by ProMedica in the future. We see no reason to discredit their testimony as a buttress to Complaint Counsel's structural case.

We likewise reject Respondent's contention that the "MCOs have an inherent bias against ProMedica" because "ProMedica owns Paramount, against which MCOs compete for members," and "have an interest in continuing to extract low, often below-cost rates from St. Luke's." RRB 16; RAppB 31. Respondent has offered no proof of bias, and the MCO witnesses testified under oath that they were appearing pursuant to subpoena, and that they had good business relationships with ProMedica and every incentive to maintain those relationships. Radzialowski, Tr. 611-12; Sandusky, Tr. 1299-1300; Pugliese, Tr. 1427-29; Pirc, Tr. 2162-64. In short, we have no reason to believe that the MCO witnesses gave false, misleading, or biased testimony against ProMedica, St. Luke's or the Joinder, or that any of the MCO testimony should be disregarded on that ground.

C. The Evidence Demonstrates that Prices Will Likely Increase at St. Luke's as a Result of the Joinder

The unilateral effects evidence is consistent with the presumption that the Joinder is likely to result in higher prices at St. Luke's. Testimony from St. Luke's officials, contemporaneous St. Luke's documents, MCO testimony, and economic evidence all confirm the presumption.

1. St. Luke's Anticipated that the Joinder Would Raise its Rates

St. Luke's own documents make it clear that one of the chief benefits expected from the Joinder was obtaining the significantly higher rates that the ProMedica hospitals were able to command. An August 10, 2009 St. Luke's planning document noted as one option [redacted] PX1390 at 002, *in camera*. A presentation made the following month to St. Luke's Board of Directors by CEO Wakeman and other members of St. Luke's leadership team states, "An SLH affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout." PX1030 at 020, *in camera*; IDF 598. As St. Luke's CEO testified, [redacted] Wakeman, Tr. 2698-2700, *in camera*. Other St. Luke's documents likewise establish that among the chief advantages of affiliating with ProMedica was the ability to [redacted] *See* PX01125 at 002, *in camera* (noting the advantages of ProMedica's [redacted]); PX01018 at 014, *in camera* (noting as "Option 3: Affiliate with

ProMedica. What do they bring? Strong managed care contracts."). Indeed, Respondent concedes that St. Luke's rates would increase after the Joinder and that St. Luke's thought that it would get more from affiliating with ProMedica than with other possible partners. *See* RRB 15; Oral Arg. Tr. at 37 (Marx).

Likewise, both Mr. Wakeman and Mr. Black, St. Luke's Chairman of the Board, testified to the hope or expectation that [redacted] Wakeman, Tr. 2685-86, 2700-01, *in camera*; Black Tr. 5714-15, 5718, *in camera*. Indeed, another St. Luke's document indicates that St. Luke's anticipated as much as [redacted] – as a result of joining ProMedica. PX01231, *in camera*; IDF 603. In short, St. Luke's clearly anticipated that its rates would increase as a result of the Joinder, and ProMedica's superior negotiating clout with the MCOs was among the primary reasons St. Luke's joined the ProMedica system.

2. MCOs Expect that the Joinder Will Raise St. Luke's Rates

Numerous MCO representatives similarly testified that they expect St. Luke's rates to rise as a result of the Joinder. Thus, Aetna expected that its post-Joinder rates for St. Luke's initially will rise to the level of Aetna's rates for ProMedica, and that all ProMedica rates will then rise above pre-Joinder levels based on the additional leverage gained from the Joinder. PX01938 at 023 (Radzialowski, Dep. at 88-89), *in camera*. An Aetna analysis of the impact of the initial change projected a [redacted] increase in rates to St. Luke's, accounting for differences of severity between ProMedica and St. Luke's. IDF 591; Radzialowski, Tr. 704, *in camera*. [redacted]: in early [redacted] Tr. 717, *in camera*.

Similarly, Humana believed that the Joinder would enable ProMedica to leverage rates for St. Luke's as well as for the ProMedica legacy hospitals. IDF 594. [redacted] expected rates at St. Luke's to rise because post-Joinder ProMedica would have greater bargaining power than pre-Joinder St. Luke's. IDF 595. [redacted] expected that after the Joinder, ProMedica could seek "extraordinary" rates because of the lessening of competition. IDF 587-88. And [redacted] expected rates at St. Luke's, which were [redacted] than the rates paid to ProMedica's community hospitals, to rise to the higher ProMedica rates. [redacted] Tr. 1506, 1517, *in camera*. An [redacted] analysis calculated that an [redacted] to the rate levels at ProMedica's Flower and Bay Park hospitals would be [redacted] roughly between [redacted] and [redacted], Tr. 1517-19, *in camera*; PX02380, *in camera*.

3. Economic Evidence Demonstrates that the Joinder Will Likely Raise Reimbursement Rates at St. Luke's

As discussed above, the reimbursement rates that a particular hospital provider can extract from an MCO depend on the alternative network of hospitals that the MCO would be able to assemble – the "walk-away network" – if the MCO fails to reach an agreement with that hospital provider.

As a result of the Joinder, the possible alternative network available to MCOs if they do not reach agreement with the combined ProMedica-St. Luke's has changed. Pre-Joinder, if an MCO failed to reach agreement with St. Luke's, the MCO could form a network consisting of the three ProMedica hospitals, the three Mercy hospitals and UTMC. IDF 576. After the Joinder, if an MCO fails to reach agreement with the combined ProMedica-St. Luke's, the MCO can form a network consisting of only the three Mercy hospitals and UTMC. IDF 578. "Because ProMedica's Lucas County hospitals are valued by health plan members, an MCO's failure to contract with St. Luke's has become much more costly for an MCO as a result of the Joinder, because their walk-away network must exclude both St. Luke's and ProMedica's Lucas County hospitals, and is less valuable than a network that excludes only St. Luke's." IDF 580. As part of the integrated ProMedica hospital system, reimbursement rates at St. Luke's would be expected to rise to the level that, based on the combined system's leverage, will be charged by ProMedica's community hospitals.

The price increase associated with this enhanced leverage would be substantial. Even prior to the Joinder, ProMedica had by far the highest prices for GAC inpatient services in Lucas County. IDF 606 (citing PX02148 at 143, 145, *in camera*). Complaint Counsel's economic expert, Professor Robert Town, examined pre-Joinder hospital prices in Lucas County. After controlling for case-mix, severity, and patient demographics across hospitals,[47] Professor Town found that ProMedica's average price was [redacted] higher than Mercy's, [redacted] higher than UTMC's, and [redacted] higher than St. Luke's. PX02148 at 037, 145, *in camera*. MCOs confirmed Town's analysis of relative prices; they testified that ProMedica's rates are the highest, and rates at St. Luke's the lowest, in Lucas County.[48]

[47] A case-mix adjustment controls for variation in case-mix, severity, and patient demographics across hospitals and allows an apples-to-apples comparison of prices. IDF 607 (citing PX02148 at 037, *in camera*). MCOs also utilize comparable case-mix adjustments in their analyses of hospitals. *See, e.g.*, Radzialowski, Tr. 684, 687-88, 698-700, *in camera*; Sandusky, Tr. 1338-48, 1350, *in camera*; Pugliese, Tr. 1512-13, *in camera*; Pirc, Tr. 2238-42, *in camera*; *see also* Wakeman, Tr. 3036-37.

[48] *See* Pirc, Tr. 2238–2242, *in camera*; Radzialowski, Tr. 684, 687-88, 698-700, *in camera*; Sandusky, Tr. 1338-48, 1350, *in camera*; PX02296 at 001, *in camera*; Pugliese, Tr. 1512-13, *in camera*; McGinty, Tr. 1210. Respondent, nonetheless, suggests that Professor Town's price analysis is flawed. Respondent's concern that the analysis "computed prices for patients at hospitals where the patients were not actually treated," RAppB 6, portrays a virtue as a sin: computing average prices for each hospital based on a hypothetical hospital population is precisely what controls for differences in case-mix, severity, and demographics that enables a valid comparison. Respondent's further point, that the results could vary when broken down

Moreover, Professor Town provided evidence linking pricing in Lucas County to market structure. Prior to the Joinder, ProMedica had the highest market share and the highest prices in Lucas County.[49] Professor Town linked ProMedica's high prices to its high market share. He demonstrated a close correlation between market shares and case-mix adjusted prices, PX02148 at 039, *in camera* (showing that Lucas County hospital providers' rank by market share was identical to their rank by price) and concluded that: "ProMedica's dominant share of the market has contributed to its significant bargaining power with MCOs. ProMedica leveraged this bargaining power to charge MCOs the highest case-mix adjusted prices of any hospital or hospital system in Lucas County." PX02148 at 037, *in camera*. Although, as Respondent argues, the correlation between market shares and price levels does not in itself rule out benign explanations for the price differences, Professor Town separately examined and rejected the chief alternative explanations, showing that the correlation cannot be explained either by quality[50] or cost differences.[51] MCOs confirmed the link between pricing and bargaining leverage. *See* IDF 583, 589, 594-95; Pirc, Tr. 2262, *in camera*.

As the Commission explained in *Evanston*, an analysis predicated on increases in bargaining leverage and the resulting higher prices is consistent with traditional unilateral effects theory. *See Evanston*, 2007 WL 2286195 at *51-52, *citing* U.S. Dept. of Justice & Fed. Trade Comm'n, Commentary on the Horizontal Merger Guidelines 34-36 (Mar. 2006), *available at* http://www.ftc.gov/os/2006/03/CommentaryontheHorizontalMergerGuidelinesMarch2006.pdf ("Commentary on the Horizontal Merger Guidelines") ("bargaining markets are quite common and fully consistent with unilateral effects theory" based on choices among substitutes and "for hospital markets . . . bilateral negotiations between MCOs and hospitals determine prices that often are unique to the particular negotiation."); *see also* Concurring Opinion of Commissioner J. Thomas Rosch, *In the Matter of Evanston Northwestern Healthcare Corp.*, Docket No. 9315 ("the law and the facts in this case squarely support complaint counsel's theory of anticompetitive effects. That theory is based on the unique competitive dynamics of hospital markets, stemming from the bargaining between hospitals and managed care organizations . . .

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hospital by hospital and MCO by MCO, RAppB 7, is to be expected. There are always data points above and below a computed average; the average, nonetheless, remains useful for overall comparison.

[49] Indeed, ProMedica acknowledged its market dominance in Lucas County in its ordinary course of business documents. *See, e.g.*, PX00270 at 025 (Standard & Poor's credit presentation); PX00319 at 001 (TTH Medical Executive Committee SWOT Analysis Results 2007).

[50] Hospital quality does not explain the ranking of average price levels at the Lucas County hospitals. St. Luke's was considered to be a high quality hospital, *see* IDF 758-64, 766; PX01018 at 012, *in camera*; Wakeman, Tr. 2482-83, 2494. It is "regularly recognized by third-party quality ratings organizations that rank St. Luke's within the top 10% of hospitals nationally, based on outcomes, cost, and patient satisfaction." PX00390 at 001 (ProMedica News Release May 26, 2010).

[51] *See* PX02148-038, *in camera* (citing documents that [redacted]); PX01850 at 057-059, *in camera*.

over inclusion in MCO networks . . .”). Combining competitors for which consumers view the firms’ products as significant substitutes may enable the merged firm profitably to increase prices. It reduces the value of an MCO’s walk-away network and consequently reduces its bargaining leverage. The extent of direct competition between the merging parties is the key: “Unilateral price effects are greater, the more the buyers of products sold by one merging firm consider products sold by the other merging firm to be their next choice.” 2010 Horizontal Merger Guidelines § 6.1.

In this case, both ProMedica and St. Luke’s CEOs testified that before the Joinder, St. Luke’s viewed ProMedica as a close competitor. IDF 440; Wakeman, Tr. 2511 (based on OB services market shares, ProMedica is St. Luke’s most significant competitor), 2523-27 (based on inpatient and OB services market shares, ProMedica is St. Luke’s most significant competitor in core service area); Oostra, Tr. 6040 (St. Luke’s viewed ProMedica as a significant competitor). Moreover, Mr. Wakeman testified that after joining St. Luke’s in 2008, one of his goals was to regain volume from ProMedica in St. Luke’s core and primary service areas. Wakeman, Tr. 2504-05. Discussion of its core service area in St. Luke’s internal analyses and documents similarly depicts ProMedica as St. Luke’s closest competitor. *See* IDF 494-95.

Indeed, Professor Town’s analysis of diversion rates shows that ProMedica is St. Luke’s closest substitute.[52] Based on claims data obtained from MCOs, Professor Town’s analysis determines the other hospitals to which patients would turn if the hospital they visited were not available; the diversion ratio measures the predicted share of a hospital’s patients that would go to a specific alternative. IDF 453. Professor Town found that for five of the six major health plans in Lucas County covered by his data,[53] ProMedica is St. Luke’s next-best substitute (*i.e.*, the highest share of those health plans’ St. Luke’s patients would go to a ProMedica hospital if St. Luke’s were unavailable). PX02148 at 047, 163, *in camera*; PX01850 at 020, *in camera*.

Respondent claims that the diversion analysis for the sixth health plan, [redacted] rebuts the conclusion that ProMedica is St. Luke’s next best substitute. We are not persuaded. First, although the diversion analysis shows that Mercy is the closest substitute for [redacted] enrollees at St. Luke’s, ProMedica is still a significant competitor; nearly [redacted] of [redacted] St. Luke’s patients would choose a ProMedica hospital if St. Luke’s were unavailable. *See* PX02148 at 163, *in camera*. Second, while Respondent is correct that [redacted] derives [redacted] from [redacted] than from any other MCO, [redacted]

[52] *See* Horizontal Merger Guidelines § 6.1 (“Diversion ratios between products sold by one merging firm and products sold by the other merging firm can be very informative for assessing unilateral price effects, with higher diversion ratios indicating a greater likelihood of such effects.”); *FTC v. Swedish Match N. Am., Inc.*, 131 F. Supp. 2d 151, 169 (D.D.C. 2000).

[53] The five health plans are [redacted]. Respondent claims that Professor Town omitted [redacted] RAppB 17. This claim is inaccurate. Professor Town reports diversion ratios for [redacted] and specifically discusses that result. *See* PX02148 at 047, *in camera*; PX01850 at 017-020, *in camera*.

[redacted] [54] PX01850 at 017, *in camera*. Respondent asks us to consider a minority, and ignore the majority, of St. Luke's patients. Finally, Respondent's analysis of [redacted] is based on [redacted] data, when [redacted] had just become an in-network hospital at [redacted] in [redacted] enrollees would be expected to modify their hospital choice and admission decisions over time in response to the availability of a broader network. ID 159 n.19; PX02148 at 047, *in camera*; PX01850 at 017-018, *in camera*. The data supports this explanation. From [redacted] diversion rates for [redacted] enrollees from [redacted] increased each year following [redacted] and the increased patient diversion to [redacted] precisely corresponded to [redacted] *See id.* at 017-019, *in camera*. Over time, as patients continue to adjust to the in-network availability of ProMedica, ProMedica is becoming a more significant alternative to St. Luke's among [redacted] enrollees, and [redacted]

Finally, Respondent contends that any price increases at St. Luke's would merely raise St. Luke's low rates to competitive levels and therefore would not cause competitive harm. Post-Joinder, absent action by the Commission, St. Luke's reimbursement rates can be expected to rise to the level that will be charged by ProMedica's community hospitals post-Joinder. This will likely result in a price increase that encompasses, and exceeds, ProMedica's pre-Joinder price levels, since the combined hospital system will have even greater leverage than ProMedica had pre-Joinder. Respondent's claim would thus require that we find that ProMedica's pre-Joinder hospital reimbursement rates did not reflect its substantial pre-existing market power. *See* PX02148 at 036-040, *in camera*. We would also have to conclude that (i) the rates at Mercy and UTMC, which are also substantially below ProMedica's rates, *see id.* at 145, *in camera* (case-mix adjusted prices); [redacted] Tr. 2238-2242, *in camera*, are also substantially below competitive levels; and (ii) rates at the vast majority of Ohio hospitals are all below competitive levels. *See* Oostra, Tr. 5996 (Anthem informed ProMedica that its rates were among the highest in the state); PX00153 at 001. We would also have to ignore St. Luke's own market assessment when it sought higher rates from MCOs before joining with ProMedica. St. Luke's approached MCOs with the argument that they could either pay St. Luke's the "little bit more" that it sought in order to sustain its position or pay later "at the other hospital system contractual rates."[55] In other words, St. Luke's believed, and thought MCOs would credibly accept, that the price increase from a potential merger would take reimbursement rates beyond a competitive level. For all these reasons, we are not persuaded that a price increase at St. Luke's to the price levels that will be charged by ProMedica's community hospitals would merely raise St. Luke's reimbursement rates to competitive levels.

[54] Revenues were calculated from St. Luke's discharge data for the year prior to the Joinder, third quarter 2009 through second quarter 2010. PX01850 at 017, *in camera*.

[55] *See* PX01018 at 009, *in camera* ("Push the payors. Provide compelling argument to raise SLH reimbursement rates to an acceptable margin; In essence, the message would be pay us now (a little bit more) or pay us later (at the other hospital system contractual rates).").

D. Evidence Demonstrates that, as a Result of the Joinder, Price Increases at ProMedica are Likely

1. MCOs Expect that the Joinder Will Likely Raise ProMedica's Rates

A number of MCO representatives testified that the Joinder likely will allow ProMedica to command higher rates at its legacy hospitals as well as at St. Luke's. Thus, an Aetna witness testified that additional leverage from the Joinder would give ProMedica the ability to raise reimbursement rates – as a first step, ProMedica will increase Aetna's rates to St. Luke's to the level of Aetna's rates to ProMedica, and, as a second step, it will use the additional leverage "to raise all of ProMedica's rates." Radzialowski, Tr. 712-13, *in camera*; PX01938 at 023 (Radzialowski, Dep. at 88-89, *in camera*). Similarly, a Humana representative testified that, prior to the Joinder, Humana had used its negotiated rates with St. Luke's as a benchmark in negotiations with ProMedica, and that the Joinder, by eliminating St. Luke's independence against ProMedica, increased ProMedica's "ability to leverage us [Humana] for rates for all of their hospitals and St. Luke's now as well." McGinty, Tr. 1209; PX02073 at 003 (¶ 11) (McGinty, Decl.), *in camera*. Likewise, an [redacted] witness testified that *ProMedica's* increased leverage from the Joinder would permit it to "really name their price" that is, to seek "extraordinary" reimbursement rates for inpatient services. [redacted] Tr. 2262, *in camera*; PX01944 at 013-014 ([redacted] Dep. at 49-50), *in camera*.

2. Economic and Course-of-Business Evidence Demonstrates that the Joinder Will Likely Raise ProMedica's Rates

As with the analysis of pricing at St. Luke's, bargaining theory suggests that the Joinder will enable ProMedica to extract higher reimbursement rates from MCOs. The Joinder alters the alternative network available if an MCO fails to reach an agreement covering ProMedica's legacy hospitals. Prior to the Joinder, MCOs that failed to reach agreement with ProMedica still would have been able to form a network composed of Mercy, UTMC, and St. Luke's. Post-Joinder, the walk-away network is limited to Mercy plus UTMC; without an agreement with ProMedica, an MCO no longer can offer a network that includes the first choice for the many patients who use St. Luke's. By decreasing the desirability of an MCO's walk-away network, the Joinder increases ProMedica's bargaining leverage. Exercise of this increased leverage would enable ProMedica to win higher rates for its legacy hospitals.

Unilateral effects evidence supports this conclusion. Again, the extent of direct competition between ProMedica and St. Luke's is a key. From the viewpoint of ProMedica's legacy hospitals, the competition provided by St. Luke's was substantial. While Mercy was the next best substitute for the legacy hospitals for the largest number of patients, St. Luke's was the next best substitute for a substantial and important fraction of ProMedica's patients, stemming from St. Luke's advantageous location in southwest Lucas County. IDF 472-498.

ProMedica's documents and business conduct both attest to its recognition that St. Luke's was a close and significant competitor. ProMedica's internal assessments reflected its understanding that St. Luke's was capable of taking significant patient volume from ProMedica's hospitals. IDF 467-69, 471. Thus, ProMedica estimated that [redacted] commercial inpatient

admissions at ProMedica hospitals would be diverted from ProMedica to St. Luke's in the first year if St. Luke's were added to Paramount's network. IDF 468; *cf.* IDF 470 (finding that St. Luke's also expected to gain patients from ProMedica if St. Luke's were readmitted to Paramount). Similarly, ProMedica estimated that St. Luke's readmission to Anthem's network would cost ProMedica [redacted] in gross margin annually. IDF 471; PX00333 at 002, *in camera*. In exchange for its loss of exclusivity with Anthem, ProMedica insisted that Anthem pay [redacted] higher rates at [redacted] when St. Luke's was added to Anthem's network in 2009. PX00231 at 015, *in camera*; Pugliese, Tr. 1497-98, *in camera*. This followed a four-year period in which ProMedica's contract with Anthem explicitly offered discounted rates conditional on Anthem's agreement not to include St. Luke's in Anthem's provider network, JSLF ¶ 18, a further indication that ProMedica believed St. Luke's would have taken patients from ProMedica.

Both parties' documents depict particularly intense competition within St. Luke's core service area. *See, e.g.*, PX01418 at 005, *in camera* (St. Luke's cost and revenue presentation showing that within its core service area, St. Luke's had the largest market share for GAC services and ProMedica had the second largest share); PX00333 at 002, *in camera* (showing ProMedica's expectation that [redacted] would lose patient volume within St. Luke's core service area if St. Luke's became a participating provider in the Anthem network). Similarly, analysis of market shares by zip codes shows that ProMedica and St. Luke's are the most important hospitals for patients in southwest Lucas County. *See* PX02148 at 042-044, 161, *in camera* (showing that St. Luke's and ProMedica have the highest market shares among patients located in the geographic area in southwest Toledo surrounding St. Luke's); Town, Tr. 3645-46, 3753-54, *in camera* (explaining that market shares reflect patient preferences).[56]

Professor Town's diversion analysis confirms that St. Luke's is a significant substitute for ProMedica's legacy hospitals. The analysis examined patient-level hospital claims data obtained from MCOs to predict to which other hospitals a specific hospital's patients would go if that hospital were not available. PX02148 at 047, *in camera*; IDF 453. The analysis shows that for five payors – [redacted] -- St. Luke's was the next closest substitute for between [redacted] percent and [redacted] percent of ProMedica's patients. PX02148 at 046-047 *in camera*; PX01850 at 018-019, *in camera*. For each of the MCOs analyzed, St. Luke's was the preferred alternative for the second largest number of ProMedica patients; only three-hospital system Mercy would draw a larger number if ProMedica were unavailable. *Id.*

[56] IDF 450-52. Respondent argues that we should not consider this limited geographic area because it is smaller than the relevant geographic market defined in this case. RRB 3-4. However, MCOs, as well as St. Luke's and ProMedica, focus on this area in the ordinary course of business. MCOs consistently testified about the importance of their ability to meet members' demand for hospital coverage in this area. IDF 477-81. In addition, both St. Luke's and ProMedica consider patients in this limited geographic area in their internal analyses of competition. *See, e.g.*, PX01418 at 005, *in camera*; PX00333 at 002, *in camera*. Our focus on this part of Lucas County appropriately parallels the focus of MCOs and the merging parties. *See generally* Concurring Opinion of Commission J. Thomas Rosch, *In the Matter of Evanston Northwestern Healthcare Corp.*, Docket No. 9315.

Thus, the parties' documents, their business conduct, market-share evidence, and diversion analysis all show substantial head-to-head competition between ProMedica and St. Luke's and demonstrate that St. Luke's was ProMedica's closest substitute for a large number of customers. Respondent attempts to refute this conclusion with two arguments. First, it insists that, because Mercy is a closer substitute for ProMedica,[57] unilateral anticompetitive effects at ProMedica's legacy hospitals are impossible. RRB 2, 13-14. Second, it argues that Complaint Counsel and the ALJ erred by analyzing substitution based on the preferences of patients, rather than MCOs. RAppB 14-15; RRB 2-3.

Both of these arguments are misplaced, for they fail to acknowledge the manner in which unilateral effects evidence is relevant in this case. In a more conventionally-structured market, in which sellers deal directly with the consumers of the goods in question, a unilateral effects analysis turns on whether the merged entity will enjoy a net benefit from a unilateral price increase. This will depend, in large part, on the relative numbers of sales that will be recaptured by the acquired entity, or lost to other players – and that, in turn, will depend importantly on various consumers' preferences in terms of which sellers are the closest substitutes. *See, e.g.*, 2010 Horizontal Merger Guidelines § 6.1. We recognize that, in such an analysis, the strong view of even a substantial minority of consumers that one seller is their next closest substitute *might* be outstripped by the preference of a majority for a different next closest substitute. Even in such a situation, however, the merging parties do not need to be each other's closest rival for a merger to have unilateral anticompetitive effects. Town, Tr. 3782, *in camera*. As the 2010 Horizontal Merger Guidelines explain, "[a] merger may produce significant unilateral effects for a given product even though many more sales are diverted to products sold by non-merging firms than to products previously sold by the merger partner." 2010 Horizontal Merger Guidelines at § 6.1. "Substantial unilateral price elevation post-merger," the Guidelines explain, "normally requires that a *significant fraction* of the customers purchasing that product view products formerly sold by the other merging firm as their next-best choice." *Id.* (emphasis added). There is no general necessity that that "significant fraction . . . approach a majority." *Id.* Cases and commentary have agreed. *See United States v. H & R Block*, 2011 WL 5438955, at *39 (D.D.C. 2011) ("The fact that [a third party] may be the closest competitor for both [merging parties] also does not necessarily prevent a finding of unilateral effects for this merger."); *Evanston*, 2007 WL 2286195, at *50 (explaining that if customers accounting for a "significant share of sales" view the merging parties as their first and second choices, a merger can enable the merged firm to raise prices unilaterally, and "it is not necessary for the merged firms to be the closest substitutes for all customers, or even a majority of customers"); Phillip E. Areeda & Herbert Hovenkamp, 4 Antitrust Law ¶ 914 at 77-80 (2009) (explaining that the merging parties need not be closest rivals for the merged firm to be able to increase price profitably and thereby cause unilateral anticompetitive effects); *see also* Concurring Opinion of Commission J. Thomas Rosch, *In the Matter of Evanston Northwestern Healthcare Corp.*, Docket No. 9315.

[57] No one, including Complaint Counsel, disputes that more ProMedica patients would be diverted to Mercy's three hospitals if ProMedica's three hospitals were not available. *See* PX01850 at 018 (Town Rebuttal Report), *in camera*.

But we are not analyzing whether ProMedica could sustain a unilateral price increase if it were selling directly to patients. We are analyzing the impact of the preferences of a substantial and important minority of patients within the market on the ability of ProMedica to sustain a unilateral price increase to MCOs, which depends on the Joinder's impact on ProMedica's bargaining leverage, which in turn depends on the effect on the value of the MCOs' walk-away networks of removing the preferred hospital of that substantial and important minority. And that inquiry, contrary to ProMedica's supposition, must begin with an examination of substitutability between hospitals at the patient level. As the Commission explained in *Evanston*, and the ALJ explained in the Initial Decision here, "an MCO's demand for hospital services is largely derived from an aggregation of the preferences of its employer and employee members." *Evanston*, 2007 WL 2286195, at *61; ID 156. Here, "the record demonstrates that . . . St. Luke's and ProMedica were close substitutes for employers and MCO's members, and thus for the MCOs." ID 157-58.[58]

Nonetheless, building on its MCO-oriented focus, Respondent advances the notion that MCO demand for hospitals must be analyzed in terms of one-for-one substitutions of hospital providers, *e.g.*, replacing ProMedica with St. Luke's. Respondent is correct that in fashioning hospital networks, no MCO would substitute one-hospital St. Luke's for the three-hospital ProMedica. Since ProMedica is much larger than St. Luke's and one of its three hospitals provides tertiary services, having access to ProMedica's three hospitals gives more value to patients than having access to St. Luke's alone. *See* Town, Tr. 228-29 (July 19, 2011). This is particularly true since MCOs require at least one hospital in their network to offer advanced services, including tertiary services. IDF 274. But Respondent's observation that MCOs would not accept a one-for-one swap of St. Luke's for the ProMedica system does not say anything about whether there nonetheless has been close and significant competition between St. Luke's and ProMedica over inclusion in MCO hospital networks. As we previously described, in order to satisfy the needs of employers who have employee members spread out across a geographic region and in need of access to a full range of hospital services, MCOs build networks that include multiple hospital providers. An MCO's decision on whether to include a hospital system in its network involves an assessment of whether the remaining alternative hospitals can constitute a marketable network. *See* Town, Tr. 3784-85, *in camera*; IDF 273-74, 276-77; ID 157. Thus, an MCO's selection of one hospital provider in its network need not result in excluding another provider. In fact, most MCO networks in Lucas County currently include all Lucas County hospitals. *See* IDF 135, 156, 191, 204, 222, 233.

[58] Respondent's contention that defining the relevant product market as GAC inpatient hospital services *sold to commercial health plans* requires a focus on MCO contracts rather than on demand for services and substitution at the patient level similarly lacks merit. The description "sold to commercial health plans" is not intended to define health plans as the only relevant actors for purposes of analyzing demand and substitution. Rather, the description is intended to exclude patients covered by Medicare and Medicaid from the analysis of competitive effects. Reimbursement rates for these patients are not negotiated by providers; they are established by the Centers for Medicare and Medicaid Services, IDF 43, and will not be affected by the Joinder.

Consequently, our conclusion that St. Luke's is ProMedica's closest substitute for a large and important number of Lucas County patients supports a finding of a unilateral anticompetitive effect.[59] The cost to most MCOs of failing to reach an agreement with ProMedica has been increased by removing from their walk-away network the hospital most preferred by [redacted] percent of their enrollees, too much to just dismiss as insignificant. Added to the substantial MCO testimony, the teachings of bargaining theory, the parties' business behavior and their contemporaneous, ordinary-course-of-business documents, all showing close head-to-head competition, we find ample basis to conclude that the Joinder is indeed likely to raise reimbursement rates at ProMedica's legacy hospitals.

3. Econometric Evidence

Economic evidence further supports the conclusion that price increases are likely at ProMedica as a result of the Joinder. Professor Town quantified the Joinder's effect on bargaining leverage and estimated the impact on price. While these analyses are not central to our reasoning – we would reach the same conclusions about the Joinder's anticompetitive effects even without these final pieces of evidence – their presence further confirms our conclusions.

As discussed above, a hospital provider's bargaining leverage depends on the value that it brings to the MCO's network. Professor Town measured the bargaining leverage of the hospital system by estimating the value that patients place on having access to that hospital system, given the alternative hospitals available. Town, Tr. 30-31 (July 19, 2011). His measure, labeled "willingness to pay," reflects the fact that the more desirable the hospital is to the MCO's enrollees, the higher the price an MCO is willing to pay to include a hospital in its network. *See* PX02148 at 105, *in camera*. Using patient-discharge data obtained from the MCOs, Town estimated the value that individual patients place on having access to different hospitals from the actual hospital choices made by patients with commercial health care coverage. Town, Tr. 35-37 (July 19, 2011). His model estimates patients' preferences for various hospitals given the geographic proximity to both patients and alternative hospitals, patients' diagnoses and demographics, and attributes of the hospital, such as capacity, technology, and perceived quality

[59] Commissioner Rosch's Concurring Opinion mistakenly takes the view that since all six testifying MCOs stated that Mercy, not St. Luke's, was ProMedica's next best substitute, a unilateral effects theory of liability does not apply in this case. For this conclusion he cites some of the same authorities we rely on -- the 2010 Horizontal Merger Guidelines § 6.1, *H & R Block*, 2011 WL 5438955, and *Evanston*, 2007 WL 2286195. As we point out above, however, each of these authorities specifically notes that a unilateral effects theory of liability does not require the merged firms be closest substitutes for the majority of customers. Moreover, the asymmetric relationship between competing firms that creates the situation in this case - where for the majority of patients, St. Luke's is not ProMedica's closest competitor, yet ProMedica is St. Luke's closest competitor - is not at all uncommon, particularly in markets involving competitors of varied size. The application of unilateral effects analysis in these situations merely takes into consideration the realities of the marketplace. We find the application of unilateral effects analysis particularly probative in this case, where the theory is supported by and consistent with the evidence, or the story told out of the mouths of the parties, as well as described in their documents.

that could influence patients' choice of hospital. PX02148 at 106-107, *in camera*; Town, Tr. 34-35 (July 19, 2011). He found that the bargaining leverage of a combination of ProMedica and St. Luke's increased by almost 13.5 percent as a result of the Joinder. Town, Tr. 41 (July 19, 2011); PX02148 at 165, *in camera*.

Professor Town then used these results to estimate the effect on hospital prices from the Joinder. He employed a linear regression model to determine the effect of willingness to pay per person and various control variables on case-mix adjusted prices. The control variables included a measure of MCO bargaining leverage; hospital costs (both case-mix adjusted cost and number of interns per bed); systematic differences across MCOs; and time trends.[60] To assess the impact of the Joinder, Professor Town compared the predictions of an estimation for a three-hospital, pre-Joinder ProMedica system with a recalculated result that included St. Luke's as a fourth hospital in ProMedica's system. PX02148 at 109-10, *in camera*. Town found that the increased bargaining leverage attributable to the elimination of competition between ProMedica and St. Luke's results in a 16.2 percent increase in prices, on an aggregate basis, for the four hospitals. PX02148 at 179, *in camera*; Town, Tr. 58-59 (July 19, 2011). This predicted price increase arises only from the change in bargaining leverage resulting from the Joinder. Town, Tr. 60-61 (July 19, 2011). When Town allocated that aggregate 16.2 percent price increase between ProMedica and St. Luke's, he found that prices at St. Luke's would be expected to rise by 38.38 percent from the pre-Joinder level, and prices at ProMedica's legacy hospitals would be expected to rise by 10.75 percent. PX02148 at 179, *in camera*; Town, Tr. 59-60 (July 19, 2011).

Professor Town's results provide additional confirmation that the Joinder will have anticompetitive effects, confirming the strength of the structural presumption and the substantial amount of buttressing evidence already discussed. Respondent launches a host of attacks on Town's regression analysis, but none of the claims deprives Town's study of all confirming weight, and in view of our finding of anticompetitive effects based on other evidence, none has an impact on our ultimate conclusion.

For example, Respondent argues that Professor's Town's work has not been peer-reviewed. Yet the methodology of his analysis has been peer-reviewed. *See* IDF 633; Town, Tr. 30 (July 19, 2011); Guerin-Calvert, Tr. 7172; PX02148 at 102 n.4, *in camera*; PX1850 at 059, 059 n.148, *in camera*. It is hardly persuasive to demand that the specific model and variables used for a particular merger litigation be peer-reviewed before they can be given weight as evidence – the model, variables, and data are necessarily case-specific.

Respondent also contends that the merger simulation fails to distinguish between Joinder and non-Joinder explanations for price. In fact, Town's simulation specifically isolates and identifies the effect of the Joinder on prices. The predicted price effect assesses only the change in bargaining leverage that arises from the Joinder, holding everything else constant. Town, Tr. 60-61, 65-66 (July 19, 2011); PX02148 at 058, 060, 110, *in camera.*

[60] Town, Tr. 52-54 (July 19, 2011). The model shows that willingness to pay per person – which, as described above, indicates a hospital's bargaining leverage derived from patients' preferences for the hospital or hospital system – is statistically significant for explaining case-mix adjusted prices. *See* PX02148 at 175, *in camera*.

Respondent argues that adding five variables would reduce the price effect of the willingness-to-pay variable from a statistically significant 16.2 percent to 7.3 percent, which would lack statistical significance at the 5 percent level. But the price effect would still be significant at the 5.5 percent level. *See* RX71(A) *in camera* at 000216 (indicating a p value equal to 1.92). Addition of the five variables is itself highly questionable: some of the added variables appear closely correlated with variables already in Town's regression. *See* PX1850 at 067-072, *in camera*; Town, Tr. 68-72 (July 19, 2011). For example, Respondent added case mix index as an explanatory variable, despite the fact that prices are already case-mix adjusted. *See* Town, Tr. 69-71 (July 19, 2011); PX01850 at 068-069; RX71(A) at 000216. To the extent that the added variables are correlated with the existing variables and fail to measure an additional causal relationship, adding them decreases the statistical significance of the existing variables without adding explanatory power. Town, Tr. 68-69 (July 19, 2011); PX01850 at 067, *in camera* (Professor Town's expert report stating that "[a] well-known means to challenge the size and significance of any regression coefficient is to include additional variables in the regression that are correlated with the variable of interest, but add no explanatory power that is not already captured by the variables already included in the model."). Moreover, adding even four of the variables would leave the willingness-to-pay result significant at the 5 percent level. *See* RX71(A) at 000216. Finally, some of the results with Respondent's specification are counter-intuitive. *See* Town, Tr. 73-75 (July 19, 2011); PX01850 at 070-071. For example, Respondent's expert adds variables for a hospital's percentage of discharges that are Medicare and Medicaid patients on the rationale that hospitals may increase commercial prices to cost-shift and cover these patients, but the revised model predicts that commercial prices would decrease as Medicare share increases, precisely the opposite of the rationale for including the variable. *See* PX01850 at 069-070, *in camera*. This suggests that the revised model, with the additional variables proposed by Respondent's expert, is not correctly specified.

Respondent's claim that Town was arbitrary in dividing the 16.2 percent aggregate result between ProMedica and St. Luke's is hardly compelling. Town explained that the allocation was calculated based on the diversion between the hospitals; that is, Town attributed a greater share of the predicted price effect to the hospital whose bargaining incentives are likely to change more, as measured by the estimated diversion to the other hospital. Town, Tr. 59-60 (July 19, 2011). Since the estimated diversions from St. Luke's to ProMedica are generally greater than those from ProMedica to St. Luke's, Town allocated a greater share of the predicted price effect to St. Luke's. *Id.*; PX02148 at 108, *in camera.* More fundamentally, however the price increase is allocated between the hospitals, Town's finding provides confirming evidence for the conclusion that the increased bargaining leverage created by the Joinder will lead to higher prices.

E. The Evidence Demonstrates that Prices Will Likely Increase for OB Services as a Result of the Joinder

The anticompetitive effects of the Joinder will, if anything, be even more severe in the OB services market than in the overall GAC market. Before the Joinder, there were three competing hospital providers of inpatient OB services. Now there remain only two – ProMedica and Mercy. Thus, the Joinder is a merger to duopoly in the Lucas County market for inpatient OB services.[61]

Moreover, for OB services, Mercy – now ProMedica's only remaining competition – is relatively weak in comparison with ProMedica. Post-Joinder Mercy has only a 19.5 percent market share of the OB inpatient services market in Lucas County; ProMedica has 80.5 percent. PX02148 at 143, *in camera* (Ex. 6) (Town Expert Report). In St. Luke's core service area, ProMedica's strength is even more pronounced – its share is about 87 percent. *Id.* at 161 (Ex. 11). Beyond the mere share statistics, one of the three Mercy hospitals, St. Anne, no longer provides any OB services[62] and the remaining two Mercy hospitals, as Catholic facilities, cannot offer a full complement of inpatient OB services. Shook, Tr. 1065-66. Accordingly, ProMedica, as a result of the Joinder, is now the *only* hospital provider in Lucas County that is able to offer a full complement of OB services.

The Joinder would eliminate head-to-head competition between ProMedica and St. Luke's for inpatient OB services. St. Luke's understood that it was a desirable alternative for some ProMedica OB patients. *See* Rupley, Tr. 2010, *in camera* (St. Luke's Marketing and Planning Director testifying that St. Luke's believed that if it were [redacted]. Indeed, St. Luke's was ProMedica's closest competitor with respect to OB services in St. Luke's core service area. Town, Tr. at 3760-61, *in camera*; PX01077 at 013 (2008 patient preference survey showing that the top three preferences for patients in St. Luke's core service area for OB services were St. Luke's and ProMedica's TTH and Flower). Similarly, for many OB patients in southwest Lucas County, ProMedica was the closest substitute for St. Luke's. *See* Rupley, Tr. 1946 (testifying, based on patient origin data, that if patients in St. Luke's primary service area do not go to St. Luke's, they are most likely to go to TTH); Wakeman, Tr. 2511 (testifying that ProMedica was St. Luke's most significant competitor in OB services in St. Luke's core service area). Thus, the Joinder removed a significant rival to ProMedica in the OB inpatient services market.

[61] UTMC does not offer inpatient OB services and has no plans to offer such services in the future. Gold, Tr. 60-62.

[62] Mercy St. Anne discontinued offering OB services in 2008 after it experienced a significant decrease in deliveries and no longer performed enough deliveries to maintain quality standards or break even financially. IDF 94, *citing* Shook, Tr. 901, 958, 1047. A Mercy representative testified that it is "highly unlikely" that St. Anne will reinstate OB services in the future. Shook, Tr. 958-60. St. Anne, located in west Toledo, is the closest hospital to ProMedica's Flower Hospital. Shook, Tr. 917; Oostra, Tr. 5802-03.

As the MCO witnesses made clear, OB services are an essential component for their networks, and the hospital's location is especially important for OB services because OB patients do not want to travel far from home. Radzialowski, Tr. 634; Pirc, 2182, 2186. Now that the Joinder has eliminated St. Luke's as an independent factor in the OB services market, the MCOs have essentially no alternative to ProMedica if they want OB services coverage in the southwest sector of Lucas County. *See* Town, Tr. 3807, *in camera* (describing west-side St. Anne, which has discontinued OB services, as "a hospital that would be probably most relevant for the patients residing in southwest Lucas County, of the Mercy system hospitals"). With respect to OB services, a network composed of Mercy and UTMC would not be nearly as attractive as a network composed of ProMedica and St. Luke's, because St. Anne, located proximally to ProMedica's Flower Hospital, and UTMC, the nearest hospital to St. Luke's, do not offer OB services. *See* PX01904 at 035 (Steele, IHT at 132-133), *in camera* (ProMedica's President of Acute Care testifying that [redacted]; Town, Tr. 3806-07, *in camera* (testifying that because UTMC and Mercy's St. Anne do not offer OB services, the disparity between ProMedica and the post-acquisition walk-away network of Mercy and UTMC is heightened); PX02148 at 069-070 (¶ 125) (Town Expert Report), *in camera.*

In considering its options in the fall of 2009, St. Luke's recognized that any affiliation with ProMedica in OB services would [redacted] PX01030 at 017, *in camera*. St. Luke's was right.

F. ProMedica's Claims that MCOs or Competitors Will Constrain any Price Increases Are Not Persuasive

1. MCOs' Inability to Prevent ProMedica from Exercising Market Power

Respondent argues that MCOs have countervailing bargaining leverage in their negotiations with hospitals and are well positioned to prevent ProMedica from exercising market power gained from the Joinder. To illustrate, Respondent cites instances in which MCOs have obtained favorable results in contract negotiations, including both pre-and post-Joinder contracts that MCOs negotiated with ProMedica and St. Luke's. Respondent further contends that a combination of factors – excess hospital capacity, patient willingness to travel, and the fact that most physicians have admitting privileges at competing hospitals – enables MCOs to credibly threaten to shift large volumes of patients away from ProMedica and thereby resist any post-Joinder supracompetitive price increase. RAppB 32-36.

There is no question that MCOs have leverage of their own in negotiations with hospitals. The record shows, however, that MCOs likely will find it harder to resist ProMedica's price demands after the Joinder. As already discussed, the Joinder increases ProMedica's bargaining leverage – and concomitantly disadvantages MCOs – because the addition of St. Luke's to the ProMedica hospital system makes it considerably more difficult for MCOs to walk away from ProMedica. *See supra* at Sections IX.C-D. Although Respondent suggests that MCOs will be able to obtain lower rates from ProMedica by threatening to enter into exclusive agreements with rival hospitals, the evidence shows that MCOs do not consider a network composed solely of

UTMC and Mercy – the only rivals remaining after the Joinder – to be commercially viable.[63] *See supra* at Section IX.B. This evidence likewise undermines Respondent's contentions that excess capacity and overlapping physician admitting privileges enable MCOs to exclude ProMedica from their networks and thereby defeat any supracompetitive price increase.

The record also fails to support the proposition that, without excluding ProMedica from their networks, MCOs can defeat price increases by ProMedica through "steering" – that is, by providing financial incentives to health plan members and physicians to use lower-cost hospitals. The evidence shows that MCOs have not employed steering in the past to discipline Lucas County hospital prices, including ProMedica's already-high prices. IDF 702, 704-05, 715-17.[64] MCOs testified that patients dislike steering and hospitals resist it. IDF 699-700. Significantly, ProMedica has used its leverage in the past to obtain anti-steering provisions in its contracts with [redacted] and [redacted] the [redacted] health plans in Lucas County along with ProMedica's own MCO, Paramount. IDF 718-19. Now that ProMedica has greater leverage in negotiations with MCOs as a result of the Joinder, it is even more likely to be able to obtain such contractual provisions to protect itself against steering in the future.

Additionally, we find no merit to Respondent's argument that contracts negotiated by ProMedica on behalf of St. Luke's after the Joinder demonstrate that the Joinder is not likely to result in supracompetitive prices. It is settled law that such post-acquisition evidence is of limited probative value because "violators could stave off such [Section 7] actions merely by refraining from aggressive or anticompetitive behavior when such a suit was threatened or pending." *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 504-05 (1974), *see Chicago Bridge & Iron Co.* v. *FTC*, 534 F.3d 410, 434-35 (5th Cir. 2008); *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381, 1384 (7th Cir. 1986). Although Respondent protests that no manipulation was involved in those contract negotiations, an absence of proof of actual manipulation is not

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[63] Respondent specifically mentions "most favored nations" ("MFN") provisions obtained by MCOs. RAppB 35. MFN provisions prohibit a hospital provider under contract with one MCO from agreeing to lower rates with a competing MCO without extending the same rates to the first MCO. IDF 502. The evidence, however, suggests that such provisions are not likely to be employed in the future. In 2008, the State of Ohio placed a moratorium on the use of MFN provisions in health care contracts. Pugliese, Tr. 1580. In addition, in 2010, the Antitrust Division of the U.S. Department of Justice filed a complaint challenging the MFN provisions in hospital contracts for Blue Cross Blue Shield of Michigan. *See* Complaint in *United States v. Blue Cross Blue Shield of Mich.*, Civil Action No. 2:10-cv-15155-DPH-MKM (E.D. Mich., filed Oct. 18, 2010). In light of the moratorium and pending DOJ suit, Anthem, which is the Blue Cross Blue Shield affiliate in Ohio, testified in this matter that [redacted] Pugliese, Tr. 1668-69, *in camera*.

[64] The sole exception to this lack of steering by MCOs – a small pilot program started by Aetna in January 2011 for up to 100 of its employees – has not yielded sufficient data to evaluate its success. IDF 708, 710. Although some MCOs provide pricing information to members and physicians to try to influence where care is provided (referred to as "soft steering, " IDF 682), such programs "don't have teeth, [so] they haven't had [an] impact." Radzialowski, Tr. 723-24; IDF 701, 706-07.

determinative – post-acquisition evidence "is deemed of limited value whenever such evidence *could arguably* be subject to manipulation." *Chicago Bridge*, 534 F.3d at 435 (emphasis in original). Such is the case here. Moreover, all post-Joinder rates here have been negotiated while the Hold Separate Agreement was in place. That agreement permits an MCO to continue its existing contract beyond expiration, rather than negotiating a new contract with new rates. *See* PX00069. Thus, the Hold Separate Agreement constrains ProMedica's bargaining leverage, with the result that the post-Joinder contracts do not reflect the full market power that ProMedica will be able to exercise as a result of the Joinder.

2. Repositioning By Competitors

Respondent also argues that repositioning by competitors will constrain post-Joinder price increases. RAppB 36-37. The 2010 Horizontal Merger Guidelines note that "[i]n some cases, non-merging firms may be able to reposition their products to offer close substitutes for the products offered by the merging firms" and thereby "deter or counteract what otherwise would be significant anticompetitive unilateral effects from a differentiated products merger." 2010 Horizontal Merger Guidelines § 6.1. Repositioning is evaluated like entry. *Id.* Thus, Respondent must show that the purported repositioning will be timely, likely, and sufficient to constrain prices post-Joinder. 2010 Horizontal Merger Guidelines §§ 6.1, 9; *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 55 (D.D.C. 1998). Respondent's burden is to produce evidence sufficient to show that the likelihood of entry "reaches a threshold ranging from 'reasonable probability' to 'certainty.'" *Chicago Bridge*, 534 F.3d at 430 n.10.

As evidence of repositioning, Respondent points to Mercy's so-called [redacted] a program to [redacted] *See* IDF 747-48. Respondent contends that Mercy's [redacted] will put approximately [redacted] of St. Luke's billed charges [redacted] and that this risk of loss will deter any anticompetitive price increase. RAppB 37. The ALJ found Respondent's argument unpersuasive, concluding that the evidence did not show that such repositioning is likely to replace the competition lost by the Joinder or would be either timely or sufficient. ID 177-78.

We likewise find that the record does not support Respondent's argument. Notably, Mercy's [redacted] IDF 750. Rather, Mercy's [redacted] purportedly will provide competition for inpatient services by [redacted] IDF 753. At the time of the hearing, however, the prospects for this program were very much in question. Mercy did not meet its 2010 [redacted] goals for [redacted] had not succeeded in [redacted] in furtherance of

[65] Respondent also makes passing reference to UTMC's facility renovations and "outreach activity," RAppB at 37 n.8, but makes no effort to show that these undertakings will constrain ProMedica's post-Joinder prices (and certainly not with regard to OB services, which UTMC does not provide).

its 2011 goals, and [redacted] Tr. 983-84, 987, *in camera* ([redacted]). Mercy had not yet [redacted] Tr. 986, *in camera*. Although Mercy initially had a tentative deadline [redacted] for accomplishing its [redacted] at the time of the hearing, it [redacted] IDF 754. This evidence casts doubt on whether Mercy is likely to accomplish such repositioning and suggests that its [redacted] will not provide a timely constraint to ProMedica's post-Joinder exercise of market power.[66]

Furthermore, regardless of whether such repositioning would be likely and timely, Respondent has failed to show that it would be sufficient to mitigate the Joinder's anticompetitive effects. There is no evidence that [redacted] even comes close to replicating the competition for GAC and OB inpatient hospital services eliminated by the Joinder. Respondent points to its expert's calculation of the potential diversion of billed charges from St. Luke's to Mercy *if* Mercy were to succeed in increasing its market share. Guerin-Calvert, Tr. 7389-92, *in camera*. Respondent implicitly invites us to *assume* that Mercy's limited repositioning activities will significantly increase its market share for inpatient hospital services.[67] But such assumption or speculation does not suffice to support an entry argument. *See Cardinal Health*, 12 F. Supp. 2d at 57 (rejecting entry argument that was "theoretical at best," noting that "the Court cannot engage in such speculation"). Respondent's further argument that the mere threat of repositioning by competitors is sufficient to constrain ProMedica's post-Joinder pricing likewise is theoretical only and devoid of actual evidentiary support. *See Chicago Bridge*, 534 F.3d at 430 n.10 (rejecting a claim that the mere threat of entry was sufficient to deter anticompetitive effects and stressing the need for evidentiary support).

Thus, we find that Respondent has failed to show that repositioning by competitors will be likely, timely, and sufficient to counteract any anticompetitive price increases.

X. REMEDY

To remedy Respondent's violation of Section 7, the ALJ ordered divestiture of St. Luke's to a Commission-approved buyer. ID 204-11. Respondent argues that, assuming we find liability, divestiture is not necessary to restore the competition eliminated by the Joinder. Respondent urges us, instead, to select an injunctive remedy that requires ProMedica to establish

[66] Respondent emphasizes that Mercy developed its [redacted] specifically in response to the Joinder, but, even if this is so, this does not suffice to show that such repositioning is likely to be accomplished or will be timely, particularly where evidence suggests otherwise.

[67] As of the time of the hearing, Mercy had not noticed any measurable market share impact [redacted] as a result of its [redacted] IDF 756. *See* [redacted], Tr. 987, *in camera* (describing Mercy's prospects for achieving a substantial market share increase [redacted] during the next two years as [redacted]).

separate and independent managed care contract negotiating teams for St. Luke's and ProMedica's legacy hospitals. Respondent asserts that its proposed remedy, which is patterned after the Commission's remedy in *Evanston*, cures any anticompetitive effects of the Joinder while addressing concerns about St. Luke's viability as an independent hospital. Respondent also argues that an order that requires ProMedica to divest St. Luke's to an acquirer, instead of allowing the parties simply to unwind the Joinder, goes beyond restoring competition to its pre-Joinder state and is, therefore, overbroad and punitive. RAppB 40-45.

The purpose of relief in a Section 7 case is to restore competition lost through the unlawful acquisition. *Ford Motor Co. v. Unites States*, 405 U.S. 562, 573 n.8 (1972); *United States v. E.I du Pont de Nemours & Co.*, 353 U.S. 586, 607 (1957). Structural remedies are preferred in such cases. *See United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 329 (1961) (calling divestiture "a natural remedy" when a merger violates the antitrust laws). As we explained in *Evanston*, "[d]ivestiture is desirable because, in general, a remedy is more likely to restore competition if the firms that engage in pre-merger competition are not under common ownership," and there are "usually greater long term costs associated with monitoring the efficacy of a conduct remedy than with imposing a structural solution." *Evanston*, 2007 WL 2286195 at *77. The manner and scope of divestiture are subject to the Commission's broad discretion. *See Jacob Siegel Co. v. FTC*, 327 U.S. 608, 611-13 (1946); *Chicago Bridge*, 534 F.3d at 440-42.

In accordance with these well-established principles, we conclude that divestiture is the most appropriate remedy to restore the competition eliminated by the Joinder. Unlike *Evanston*, this case does not present special circumstances that warrant a departure from the preferred structural remedy. In that case, the lengthy amount of time – seven years – that had elapsed since the merger, during which the acquired hospital had been fully integrated into the larger hospital system, led the Commission to conclude that divestiture would be a "complex, lengthy, and expensive process," *Evanston*, 2007 WL 2286195 at *79, and "much more difficult, with a greater risk of unforeseen costs and failure," *id*. at *78. The Commission was also concerned that divestiture could reduce or eliminate significant public benefits from improvements made to the acquired hospital during that time. *Id*. The Commission specified that its reasoning for an injunctive remedy in that case would not necessarily apply in a future challenge to a consummated merger, including a consummated hospital merger, and that, "where it is relatively clear that the unwinding of a hospital merger would be unlikely to involve substantial costs, all else being equal, the Commission likely would select divestiture as the remedy." *Id*. at *79.

The circumstances in this case are markedly different than *Evanston*. Here, the Hold Separate Agreement entered by ProMedica has limited the integration of St. Luke's into ProMedica's hospital system. *See* IDF 12-13. Indeed, the Commission staff sought the Hold Separate Agreement precisely for the purpose of preserving St. Luke's as an independent and viable competitor, should the transaction be found illegal.[68]

[68] *See* Compl. for TRO and Prelim. Inj. at 19, *FTC v. ProMedica Health System, Inc.*, No. 3:11-cv-00047-DAK (N.D. Ohio, filed Jan. 7, 2011), *available at* http://www.ftc.gov/os/caselist/1010167/110107promedicacmpt.pdf.

Respondent contends, however, that divestiture of St. Luke's would entail certain "unique costs." Specifically, Respondent argues that, if divestiture is ordered: (i) St. Luke's will not likely survive as a "full-fledged competitor," given its pre-Joinder financial difficulties; (ii) St. Luke's will not likely meet "meaningful use" requirements relating to the use of Electronic Medical Records ("EMR"), *see* IDF 822, and was not well-positioned for health care reform in general without significant capital assistance; and (iii) benefits from the shift of St. Luke's inpatient rehabilitation services to Flower will be lost. RAppB 43.

At the outset, we note that the first two items, premised as they are on St. Luke's pre-Joinder financial difficulties, are unlikely to present a concern if St. Luke's is divested to a third-party acquirer with adequate financial resources. But, even if the Joinder is merely unwound, we find that the record does not support Respondent's assessment of the costs.

As we have discussed at length, the evidence as a whole does not bear out Respondent's dire predictions of St. Luke's financial prospects and future competitiveness absent the Joinder. *See supra* Section VIII. Although we cannot say for certain what St. Luke's viability as an independent hospital will be over the long term, its viability in the foreseeable future is not seriously at risk. Going forward, St. Luke's will have various options available, as it did before the Joinder, to address its financial needs, fund needed capital improvements (including those required by health care reform), and remain competitive. *See, e.g.*, PX01018 at 009-013, 015-017, *in camera*.

Respondent's claims about St. Luke's purported inability, if divested, to meet the demands of health care reform are undermined by other evidence as well. For example, St. Luke's own assessment prior to the Joinder was that it was "uniquely positioned for a smooth transition to expected health care reform." PX01072 at 001 ("The hospital already focuses on quality and cost – key components of reform."). The evidence also shows that, prior to the Joinder, St. Luke's fully intended to begin implementing EMR in 2010 to meet "meaningful use" requirements and had budgeted [redacted] million for it in 2010, but stopped the process because of the Joinder.[69]

We are also unpersuaded by Respondent's argument concerning the cost of unwinding the consolidation of inpatient rehabilitation services at Flower.[70] That integration was undertaken by the parties knowing full well that, depending on the outcome of this case, it might be only temporary. Any unwinding of a consummated merger found to be unlawful is bound to entail some costs, but that in itself is not sufficient reason to forgo requiring divestiture. Respondent has not shown that the costs entailed by divestiture here are so substantial or

[69] IDF 838-40, 997. The ALJ was unable to conclude that St. Luke's could not have implemented these measures but for the Joinder. ID 193.

[70] Indeed, the ALJ found that there were countervailing costs as a result of this consolidation, because patients who had previously chosen to go to St. Luke's inpatient rehabilitation center no longer have that option and, instead, must now go to the more expensive Flower Hospital. ID 197; IDF 1063, 1065.

"unique" as to justify abandonment of the preferred structural remedy in favor of injunctive relief – which has its own costs, including the cost of monitoring compliance.

We turn finally to Respondent's argument that it should be allowed to unwind the Joinder, as opposed to divesting to a third-party acquirer. Complaint Counsel do not oppose an unwinding of the Joinder, but take the view that the ALJ's order already allows this because the acquirer under the terms of the order could be the previously-independent St. Luke's organization. CCAnsB 42. We agree with Complaint Counsel. The Final Order which the Commission is issuing in this case, like the ALJ's order, is sufficiently broad to permit an unwinding, with St. Luke's restored to its status as an independent hospital.[71] The merits of a specific divestiture proposal, including any proposal to unwind the Joinder, are appropriately examined when ProMedica applies for Commission approval of a proposed divestiture in accordance with the agency's established procedures. *See* 16 C.F.R. § 2.41(f).

XI. CONCLUSION

For the foregoing reasons, the Commission has concluded that the Joinder of ProMedica Health System, Inc. and St. Luke's Hospital is likely to substantially lessen competition in the market for the sale of general acute-care inpatient hospital services to commercial health plans – and in a separate relevant market consisting of inpatient OB services sold to commercial health plans – in Lucas County, Ohio, and therefore violates Section 7 of the Clayton Act, 15 U.S.C. 18. To remedy the violations found, the Commission has determined to issue the attached Final Order requiring ProMedica, *inter alia*, to divest St. Luke's to an approved buyer in accordance with established Commission procedures.

[71] We take issue, however, with Respondent's contention that an order requiring divestiture to a third-party acquirer would be "overbroad and punitive." The Commission is not bound to replicate precisely the pre-Joinder market but has the discretion to enter broader relief if it finds that such relief would serve the goal of restoring competition. *See Chicago Bridge*, 534 F.3d at 440-42.