Case No. 12-3583

In The United States Court of Appeals

For The Sixth Circuit

ProMedica Health System, Inc.,
Petitioner

– v –

Federal Trade Commission,
Respondent.

On Petition for Review of the Final Order of the
Federal Trade Commission

Public Brief of Petitioner
ORAL ARGUMENT REQUESTED

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DISCLOSURE AND CORPORATE AFFILIATION AND FINANCIAL INTEREST STATEMENT

Pursuant to Sixth Circuit Rule 26.1, Petitioner ProMedica Health System, Inc., makes the following disclosures:

1. ProMedica Health System, Inc., is not a subsidiary or affiliate of a publicly owned corporation.

2. There is no publicly owned corporation, not a party to the petition, that has a financial interest in the outcome.

Respectfully submitted,

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TABLE OF ABBREVIATIONS

ID=Initial Decision

IDF=Initial Decision Finding

OP=Opinion of the Commission

COP=Concurring Opinion of Commissioner Rosch

Tr.=Transcript of Testimony before the Administrative Law Judge

PX=Plaintiff's Hearing Exhibit

RX=Respondent's Hearing Exhibit

JA=Joint Appendix

STATEMENT IN SUPPORT OF ORAL ARGUMENT

This case presents important questions regarding the proper application of Clayton Act Section 7, particularly for hospital mergers. Petitioner will show that the Federal Trade Commission's ("Commission" or "FTC") opinion adopted a flawed analytical framework for assessing anticompetitive unilateral effects, and that this flawed framework creates virtually insurmountable obstacles for almost any conceivable hospital merger in all but the largest cities in the country. Petitioner believes that oral argument would meaningfully assist the Court in considering the legal and factual issues that this case presents, and accordingly Petitioner respectfully requests that the Court schedule oral argument.

STATEMENT OF JURISDICTION

On January 6, 2011, the Commission filed an administrative complaint pursuant to its authority under 15 U.S.C. § 45(b) challenging the joinder between ProMedica and St. Luke's. On March 22, 2012, the Commission issued its Opinion and Order. On May 18, 2012, ProMedica timely petitioned this Court, vesting the Court with jurisdiction under 15 U.S.C. §§ 45(c), (d).

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

1. Whether the Commission erred in (1) excluding tertiary services from the General Acute Care ("GAC") services cluster, and (2) defining a separate product market for inpatient obstetric ("OB") services, when managed care organizations ("MCOs") and hospitals routinely negotiate in a single transaction for all services that a given hospital can provide, including tertiary and OB.

2. Whether the Commission erred in its unilateral-effects analysis by: (1) imposing a strong presumption of anticompetitive effects based on market-concentration statistics, when substitutability of the merging parties, not market concentration, drives a unilateral-effects analysis; and (2) focusing on patients, rather than MCOs, in assessing substitutability, when MCOs are the only market participants that respond to hospital pricing.

3. Whether the Commission erred in failing to require evidence of an *anticompetitive* price increase.

4. Whether the Commission erred in mechanically imposing divestiture, when the Administrative Law Judge ("ALJ") found (and the Commission did not dispute) that a conduct remedy would address any competitive harm, while avoiding the severe consequences that divestiture may impose.

INTRODUCTION

This case involves an FTC challenge to a hospital merger in Lucas County (Toledo), Ohio. The Toledo hospital market is marked by vigorous competition among three large, well-capitalized competitors. ProMedica, a non-profit corporation headquartered in Toledo, operates eleven hospitals in northwest Ohio, including three in Lucas County. Catholic Health Partners, a non-profit headquartered in Cincinnati, likewise operates eleven hospitals in northern Ohio, including three Mercy hospitals in Lucas County. There is also the state-run University of Toledo Medical Center ("UTMC"). In addition to these vigorous competitors, until recently Toledo's hospital market also included an independent St. Luke's, a small non-profit community hospital located in a southwestern Toledo suburb.

With eight separate general acute care hospitals, Toledo is one of the nation's most heavily-bedded cities *per capita*—ranking eighth on a list of fifty similarly-sized cities. The competition engendered by this oversupply is fierce, and is only enhanced by Toledo's economic struggles. With the loss of several major employers, the unemployment rate remains high, meaning fewer commercially-insured patients. And as the area's population becomes poorer and older, more and more patients receive coverage through Medicare or Medicaid, which do not cover the full costs of hospital care. Simultaneously, federal

programs, including the Affordable Care Act, have mandated new capital investments, particularly in information technology.

Given this "perfect storm," St. Luke's was struggling to survive. By 2008, it was losing money, on average, for every patient it treated, a trend that continued through the joinder. Against this backdrop, St. Luke's and ProMedica agreed to join, providing St. Luke's access to resources it needed to continue as a community-focused healthcare institution.

Both pre- and post-joinder, the three main competitors in Toledo—ProMedica, Mercy and UTMC—remain the same. The Commission nonetheless found the joinder unlawful and ordered ProMedica to divest St. Luke's.

In doing so, the Commission defined the *wrong* markets, used the *wrong* anticompetitive-effects analysis, and imposed the *wrong* relief. As to the first, it is well-settled that product market definition turns on *demand-side* considerations. Yet, here, the Commission wrongly focused on *supply-side* characteristics, and thus improperly excluded tertiary and inpatient OB services from the product market.

As for anticompetitive effects, the FTC's sole theory is that the joinder creates "unilateral effects." The basic unilateral-effects theory is that for a given product (Product A), the closest substitute (Product B), is a price constraint. If Product A's price increases, consumers can switch to Product B. If the makers of

Products A and B merge, however, that constraint is removed, as both products are now owned by the same entity. As this description suggests, and as courts, commentators and the Commission's own *Horizontal Merger Guidelines* confirm, *substitutability* of the products, not market concentration, drives unilateral-effects analysis. And here the record evidence shows that the relevant buyers (*i.e.*, MCOs) do not consider St. Luke's and ProMedica as substitutes.

The Commission, however, focused heavily on market-concentration statistics, statistics more appropriate to a *coordinated-effects* case. This misplaced focus permeated every aspect of its analysis. First, the Commission wrongly adopted a strong *presumption* of harm based solely on such statistics. Second, having created an improper hurdle, the Commission again wrongly relied on market-concentration-based reasoning to prevent ProMedica from clearing it. Both of these were legal errors.

The Commission likewise relied on an inappropriate presumption in selecting a remedy. It wrongly believed it was essentially required to impose divestiture, unless ProMedica could show the case here mirrored an earlier hospital merger case, *Evanston Northwestern Healthcare*, in which the Commission had adopted a conduct remedy—*i.e.*, allowing the merger to proceed, subject to post-merger conduct restrictions.

Absent this flawed presumption, the correct remedy here was clear. As the ALJ agreed, a conduct remedy would eliminate any potential competitive effects, while preserving the benefits that a healthier St. Luke's provides Toledo. Divestiture, by contrast, is tantamount to a slow-motion death sentence, which may make sense to the Commission sitting in Washington, D.C., but does not serve those who live and work in Lucas County.

STATEMENT OF THE CASE

On May 25, 2010, ProMedica and St. Luke's executed a Joinder Agreement. In July 2010, before the joinder closed, the Commission began investigating. On August 18, 2010, ProMedica entered a limited Hold Separate Agreement with the Commission under which ProMedica agreed to certain conduct restrictions. The joinder closed August 31, 2010, with the investigation ongoing.

On January 6, 2011, the Commission issued an administrative complaint challenging the joinder under Clayton Act Section 7. After a hearing, the ALJ entered an Initial Decision (the "ID") on December 5, 2011. (ID–JA90-334). The ID rejected Complaint Counsel's proposed product market definition in favor of ProMedica's, but nonetheless found the joinder violated Section 7.

Both Complaint Counsel and ProMedica appealed. On March 22, 2012, the Commission entered an Opinion and Order overturning the ALJ's product market

determination as Complaint Counsel requested, and simultaneously rejecting ProMedica's appeal.

STATEMENT OF FACTS

I. Toledo Has Several Competing Hospitals.

ProMedica and St. Luke's both operate hospitals in Lucas County (Toledo), Ohio. (IDF ¶¶53, 72–JA109, 111). Toledo has a variety of hospital facilities that serve its residents. Pre-joinder, these included two major non-profit hospital systems (ProMedica and Mercy) and two independent hospitals (UTMC and St. Luke's, a small community hospital). (IDF ¶¶1, 6, 79, 103–JA103-04, 111, 113).

A. ProMedica Operates Three Toledo Hospitals.

ProMedica operates The Toledo Hospital ("TTH"), Flower Hospital ("Flower"), and Bay Park Community Hospital ("Bay Park"). (IDF ¶53–JA109). TTH is a large hospital in downtown Toledo with 550 staffed beds. (IDF ¶55–JA109). Flower, located in the northwest Toledo suburb of Sylvania, has 300 licensed beds. (IDF ¶¶61, 65–JA110). Bay Park is located in an eastern Toledo suburb and has 86 licensed beds. (IDF ¶¶70, 71–JA110).

All three hospitals provide GAC services, including OB. (IDF ¶¶56, 62, 66–JA109-10). TTH also provides tertiary services, which refer to more complicated acute care services such as open-heart surgery. (IDF ¶56–JA109).

B. Mercy Also Operates Three Toledo Hospitals.

Mercy's hospitals are part of Catholic Health Partners, a large healthcare system headquartered in Cincinnati, Ohio. (IDF ¶79–JA111). Mercy operates three hospitals in Lucas County: St. Vincent, St. Anne, and St. Charles. (IDF ¶81–JA111). Each is located near a corresponding ProMedica hospital. St. Vincent, in downtown Toledo, is Mercy's largest hospital with 445 staffed beds, (IDF ¶¶82-83, 87–JA112), and offers tertiary and OB services. (IDF ¶82–JA112). St. Anne's and St. Charles have 96 and 150 beds, respectively. (IDF ¶¶93, 101–JA112-13). Both are in suburban Toledo, with St. Anne's on the west and St. Charles in the east. (IDF ¶¶92, 98–JA112-13). Like St. Vincent, St. Charles offers OB. (IDF ¶¶92, 99-100–JA112-13).

C. UTMC Is Another Large Toledo Hospital.

The University of Toledo, a state university, operates UTMC, a large hospital with about 225 staffed beds. (IDF ¶¶103, 105, 111–JA113-14). UTMC is similar to ProMedica and Mercy in terms of services provided (including tertiary services) and patient mix (*i.e.*, patient acuity), but does not offer inpatient OB. (IDF ¶110–JA114; RX-71(A) at 15–JA1706, *in camera*; ID-153–JA249).

D. Unlike Other Competitors, St. Luke's Hospital Was A Small Community Hospital.

St. Luke's was a small, independent, community hospital, located in a southwestern Toledo suburb. (IDF ¶¶72-73–JA111). It has approximately 178 staffed beds. (IDF ¶77–JA111). St. Luke's provides a full range of GAC services, including OB, but offers lower acuity care than many of its competitors, though it does offer some tertiary services. (IDF ¶¶73-75–JA111).

II. Toledo Hospitals Face Difficult Economic And Demographic Issues.

A. Toledo Has Substantial Over-Capacity.

"Based upon the number of staffed beds per thousand area residents, which is a standard metric used in health-care, the Toledo metropolitan area, as compared to other similar metropolitan areas in the United States, has substantially more beds per thousand residents." (IDF ¶668–JA176). Indeed, among fifty similarly-sized metropolitan areas across the country, Toledo ranks eighth highest in beds per capita. (RX-71(A) at 58–JA1749, *in camera*). "Another metric of excess capacity is the occupancy rate …. Occupancy rates for hospital beds in Lucas County … are significantly below staffed bed capacity." (IDF ¶¶675-76–JA177).

This overcapacity is especially significant because travel times between facilities are low. A person can drive to any Toledo hospital within 20 minutes, meaning that in terms of convenience, hospitals compete on virtually even footing. (RX-71(A) at 186-88–JA1877-79, *in camera*).

B. Toledo Hospitals Will Continue To Face Difficulties.

"The population in the greater Toledo area is stagnant to declining, aging, and not forecast to grow." (IDF ¶737–JA183). This means "that there are fewer patients overall," and that the "number of commercially insured patients in the Toledo area has declined since 2004 to 2009 from 45,000 to 30,000." (IDF ¶¶738-39, 744–JA183). Given Toledo's aging population, this trend will only continue as "the percentage of hospital patients covered by Medicare will increase." (IDF ¶740–JA183). Exacerbating these difficulties, "Toledo has high unemployment and has had an exodus of employers, which leads to a decline in patients covered by commercial insurance." (IDF ¶741–JA183).

III. Pre-Joinder, St. Luke's Was Facing Significant Hardships.

Pre-joinder, St. Luke's was experiencing "significant financial difficulties." (OP-10–JA35). These difficulties inhibited its ability to fund needed capital improvements, and required St. Luke's to freeze hiring and cut employee pay and benefits. (OP-10–JA35). Moreover, Moody's had downgraded St. Luke's rating to "Baa2," near the bottom of "investment-grade," increasing interest costs. (IDF ¶¶873, 875–JA197). Federal healthcare reforms exacerbated these financial issues by requiring substantial investments in information technology. (IDF ¶¶821-27–JA192).

St. Luke's management identified "extremely low reimbursement rates from third party payors" as the "primary source" of St. Luke's difficulties. (IDF ¶388–JA141). This was reflected by its "overall cost coverage ratio" which remained below one, meaning that it lost money on average on each patient. (IDF ¶944–JA205). In the three years pre-joinder, St. Luke's managed only *one month* (the month before closing) in which revenues exceeded costs, and even then it managed to eke out only a $7,000 margin on nearly $36.7 *million* in revenues, a net margin of *one-hundredth of one percent*. (IDF ¶948–JA206). These results were substantially worse than any other Toledo hospital. (IDF ¶¶788-89–JA188). Not surprisingly, the ALJ found that St. Luke's "faced significant financial challenges going forward," and that "absent the Joinder, St. Luke's future viability beyond the next several years is uncertain." (ID-188–JA284).

IV. The Joinder.

Given the pressures St. Luke's faced, St. Luke's board, comprised of local community leaders, determined that a joinder with ProMedica would be in St. Luke's, and the community's, best interests. They believed the joinder would allow access to the more competitive pricing they thought larger systems like ProMedica and Mercy were receiving—pricing they hoped would allow St. Luke's to cover its costs. (Black, Tr. 5639-42, 5651–JA2501-04, 2505, *in camera*,; PX01929 at 38–JA2325, *in camera*).

Importantly, the record contains no evidence suggesting that *ProMedica* believed the joinder would give *it* greater pricing power.

Given St. Luke's long history as an independent community hospital, the joinder was structured to preserve much of St. Luke's independence. (Black, Tr. 5600-01–JA2499-500; PX00058 at 6-8, 23, 45–JA445-47, 462, 484). Unlike a typical subsidiary, St. Luke's retains the right to appoint the vast majority of its board (subject only to ProMedica's veto right). (Black, Tr. 5657–JA2506, *in camera*; PX00058 at 9, 16, 20-21–JA448, 455, 459-60). The board likewise retains significant management responsibility—only certain key decisions require ProMedica's approval. (PX00058 at 23, 45–JA462, 484).

V. Economics Of The Hospital Industry: Patients Do Not Negotiate Prices, MCOs Do.

Not only is the joinder structured differently from typical mergers, but, in assessing anticompetitive effects, it is important to note that *pricing* in the hospital industry likewise differs dramatically from most industries. As the Commission observed, "[h]ospitals and their patients rarely negotiate directly over the price of hospital services, and few patients directly pay their hospital costs." (OP-5–JA30). Rather, hospital costs are usually paid by third-party payors, either public or private. (OP-5–JA30). Patients do not typically even *know* hospital pricing. (*See, e.g.*, Lortz, Tr. 1782-83–JA2393-94; Neal, Tr. 2106–JA2403).

A. Two-Thirds Of Patients Are Medicare/Medicaid Patients, And The Government Sets Their Reimbursement Rates.

Two-thirds of the patients at Toledo-area hospitals are Medicare/Medicaid patients. (*See* OP-5–JA30 ("In Lucas County, approximately 65 percent of the patients are covered under the government programs, and 29 percent are privately insured.")). For these patients, hospitals must accept government-set prices, prices that "are generally lower than hospitals' costs of providing care." (OP-5–JA30). The joinder cannot have *any* price impact for these patients.

B. For Commercially-Insured Patients, MCOs Negotiate Hospital Pricing.

Only the 29 percent of patients who are privately-insured face any potential price impact. (IDF ¶39–JA107). These patients obtain insurance through MCOs, which build "networks" by contracting with hospitals, physicians and other providers. (IDF ¶273–JA128). The MCOs then compete to be included in the menu of healthcare benefits that area employers offer their employees, and, if selected, MCOs compete for the employees. (OP-5–JA30).

In constructing networks, MCOs face a tension. With narrower networks (*i.e.*, fewer providers), the MCOs can negotiate better rates, as the (fewer) included providers receive higher patient volumes. (IDF ¶269-70–JA127). Employers and employees, however, generally prefer broader networks. (IDF ¶¶281-82, 286–JA129).

Reflecting that tension, MCOs have succeeded in Toledo with both broad and narrow networks. Many Toledo-area MCOs include all hospitals in their networks. (IDF ¶¶204, 246–JA121, 125). But MCOs have also succeeded with narrower networks. (IDF ¶246–JA125; RX-71(A) at 6–JA1697, *in camera*).

The Commission correctly observed that "[r]eimbursement rates for hospital services are determined through the bargaining process between MCOs and hospitals." (OP-7–JA32). When constructing networks and setting prices, MCOs and hospitals typically undertake a single negotiation to set reimbursement rates for "the full range of inpatient services" a hospital provides. (IDF ¶¶305, 315–JA131, 133).

C. MCOs Consider ProMedica And Mercy To Be Each Other's Closest Substitutes.

"[A]ll MCOs agreed that Mercy and ProMedica are each other's primary competitor." (ID-157–JA253). "Because of their similar broad service offerings and geographic reach through the Toledo metropolitan area, MCOs believe that they must have either Mercy or ProMedica in their health plan." (*Id.*). "In contrast, St. Luke's is a small, stand-alone community hospital, offering a limited array of the least complex inpatient services." (*Id.*). Accordingly, the "evidence … establishes that MCOs could not substitute St. Luke's for the ProMedica system." (*Id.*). Rather, "from the perspective of the MCOs when constructing a

marketable network, the Mercy hospital system is the closest substitute to the ProMedica hospital system." (*Id.*).

VI. The Commission's Only Theory Of Harm Is A Differentiated-Products Unilateral-Effects Theory, For Which Substitutability Is the Key Issue.

The Commission's sole theory here is that the merger may cause anticompetitive "unilateral effects." (ID-155 n. 18–JA251 ("Complaint Counsel does not assert that the Joinder may have resulted in coordinated effects and, therefore, the likelihood of coordinated effects need not be and is not addressed.")). As the Commission's economics expert, Professor Town, explained, unilateral effects arise "when a merger or acquisition eliminates competition between two previously separate competitors, such that the combined entity is able to raise prices profitably, even in the absence of accommodating or collusive behavior by other competitors in the market." (PX02148 at 40–JA1089, *in camera*).

As Town also explained, unlike coordinated-effects cases, in which market concentration is a central inquiry: "The central variable in [a unilateral-effects] analysis is the degree to which the merging hospitals are substitutes for each other …. The higher the substitutability between two merging hospitals, the greater the competition among them, and the greater enhancement of bargaining power that results from their merger." (PX02148 at 40-41–JA1089-90, *in camera*).

VII. The ALJ Agreed With ProMedica On Product Market Definition.

In assessing the likelihood of unilateral effects, the ALJ's Initial Decision adopted ProMedica's proposed product market definition. (OP-3–JA28). Specifically, the ALJ concluded that the GAC product market—a cluster market of inpatient hospital services sold to MCOs—properly included both tertiary and inpatient OB services. (IDF ¶¶299-300–JA131; OP-3–JA28). The ALJ found, as a matter of fact, that the various GAC services (including tertiary and inpatient OB) are interdependent in that "[a]ll GAC inpatient services in the cluster market use the same assets, the same operating rooms, the same beds, the same wards, [and] the same nursing staff." (IDF ¶301– JA131). Moreover, "MCOs demand, and contract for, a broad array of inpatient services together …," (IDF ¶304–JA131), "including inpatient OB services." (IDF ¶315–JA133).

Despite adopting ProMedica's product market definition, the ALJ found that the merger violated Section 7 and ordered divestiture. (OP-4–JA29). Both Complaint Counsel (as to product market definition) and ProMedica (as to liability and remedy) appealed.

VIII. The Commission Overturned The ALJ On Product Market Definition, But Affirmed Liability.

On appeal, the Commission observed that the parties had "differing approaches" for defining a cluster market. (OP-16–JA41). ProMedica focused on

a demand-side approach, asserting that the cluster should reflect "the aggregation of hospital services that MCOs tend to purchase as a package in single negotiated transactions." (*Id.*). Complaint Counsel, by contrast, claimed that cluster market composition was purely for "analytical convenience," and that individual products should be included if they shared the same "competitive conditions," including supply-side characteristics. (*Id.*). Indeed, here, "competitive conditions" referred only to fewer *suppliers*, not to any differences in prices or terms of competition. The Commission adopted Complaint Counsel's framework, and excluded tertiary services and inpatient OB services from the GAC cluster. (OP-22-26–JA47-51).

As to liability, although this was *solely* a unilateral-effects case, the Commission began with a strong presumption of illegality based on market-concentration statistics. While conceding that such statistics were not "conclusive proof," the Commission held that ProMedica "bears the burden of demonstrating that the HHIs and market share data are unreliable." (OP-27–JA52).

The Commission then found that ProMedica failed to overcome that market-concentration-based presumption. First, the Commission rejected ProMedica's attempt to rely on St. Luke's weakened financial condition, concluding that such evidence was *legally irrelevant* unless, absent the joinder, St. Luke's weakened condition would have dropped its market share to "below the threshold of presumptive illegality." (OP-28–JA53. *See also* COP-3–JA87).

On the issue of substitutability—which the Commission's expert had correctly called "the central variable" in a unilateral-effects analysis—the Commission noted that the *Horizontal Merger Guidelines* focus on what the "buyers of products" consider to be the next-best substitute. (OP-43–JA68); U.S. Dept. of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines*, § 6.1 (2010). Yet, despite acknowledging that MCOs are the "buyers of the [hospital services]," the Commission focused on *patients*, who do not negotiate (or even know) prices. (OP-43-44–JA68-69). Even then, the Commission focused on only a *subset* of patients, those living within what the Commission called "St. Luke's core service area." (OP-46–JA71).

For the remedy, the Commission started from a strong presumption favoring divestiture. Only if "special circumstances that warrant a departure from the preferred structural remedy" existed, did the Commission consider itself free to adopt an alternative. (OP-57–JA82). Finding such "special circumstances" lacking, the Commission imposed divestiture, failing to meaningfully consider whether a conduct-based remedy might eliminate competitive harms, while preserving the joinder's substantial benefits for Lucas County residents. (*See* IDF ¶1061–JA218; Hanley, Tr. 4679–JA2496; Johnston, Tr. 5375–JA2498 (describing some of the benefits)).

SUMMARY OF ARGUMENT

The Commission bears the burden of proving a substantial likelihood of anticompetitive effects. The Commission did not meet its burden here, as it adopted a flawed legal framework, both in finding that the ProMedica/St. Luke's joinder violated Section 7, and in requiring ProMedica to divest St. Luke's.

First, the Commission erred in defining the product market. All agree that the relevant market is a so-called "cluster market" consisting of a collection of GAC services, but the parties dispute how to select individual services for inclusion in the cluster. ProMedica asserts that the cluster should reflect *demand-side* market realities—here, MCOs negotiate for (*i.e.*, demand) in a single transaction all GAC services (including tertiary and OB services) that a given hospital offers. The Commission, by contrast, wrongly eschews this market-based approach in favor of a *supply-side* "analytical convenience" approach.

Second, the Commission legally erred in its assessment of anticompetitive effects. In a unilateral-effects case, *substitutability* of the merging parties, not market concentration, is the critical factor. The Commission erred by relying on market-concentration statistics, both to *presume* harm, and to *reject* ProMedica's efforts to rebut that presumption.

When the Commission finally looked to substitutability, it relied on *the wrong consumers*. MCOs negotiate hospital prices, and they do not consider St.

Luke's a substitute for ProMedica. The Commission wrongly looked to *patients* in assessing substitutability—and only a subset of patients at that.

Moreover, a merger does not violate Section 7 unless it *causes* an *anticompetitive* price increase. Here, the Commission failed to address whether price increases would either (1) be *supra-competitive*, or (2) *result from* the joinder.

Finally, the Commission erred in ordering divestiture. A conduct remedy would eliminate any competitive harm while preserving important benefits. The Commission rejected that remedy because it wrongly treated divestiture as *mandatory* absent "special circumstances."

STANDARD OF REVIEW

Courts of appeals "review *de novo* all legal questions pertaining to Commission orders," *Chicago Bridge & Iron Co. N.V. v. FTC*, 534 F.3d 410, 422 (5th Cir. 2008) (citation omitted), as well as the correct application of the governing legal standards to the facts. *FTC v. Ind. Fed'n of Dentists*, 476 U.S. 447, 454 (1986).

Factual questions are reviewed "under the substantial evidence standard." *Chicago Bridge*, 534 F.3d at 422. "Substantial evidence is evidence that provides a substantial basis of fact from which the fact in issue can be reasonably inferred." *Id.* at 422 (quotation omitted). Under this standard, the Court must examine the

record as a whole, and "take into account whatever in the record fairly detracts from its weight." *See Schering-Plough Corp. v. FTC*, 402 F.3d 1056, 1063 (11th Cir. 2005). Where the Commission's findings differ from the ALJ's, the Court should review them more closely. *Thiret v. FTC*, 512 F.2d 176, 179 (10th Cir. 1975).

ARGUMENT

Businesses are generally free to merge with one another. Clayton Act Section 7, 15 U.S.C. § 18, condemns mergers *only* when, in a given "line of commerce," the "effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." The Commission bears the burden of proving both: (1) the line of commerce (*i.e.*, the relevant product and geographic market), and (2) the likelihood of "demonstrable and substantial anticompetitive effects" in that properly-defined market. *New York v. Kraft Gen. Foods, Inc.*, 926 F. Supp. 321, 358 (S.D.N.Y. 1995); *FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1072-73 (D.D.C. 1997); *United States v. E.I. du Pont de Nemours*, 353 U.S. 586, 593 (1957). Failure to prove either element dooms a Commission challenge. Yet, the Commission proved *neither*.

I. The Commission Erred In Its Definition Of The Relevant Product Market

The Commission must prove a relevant market. *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1289-90 (W.D. Mich. 1996), *aff'd.* 121 F.3d 708 (6th

Cir. 1997); *FTC v. Arch Coal, Inc.*, 329 F. Supp.2d 109, 122 (D.D.C. 2004) ("The burden … is squarely on plaintiffs to establish … a separate relevant market."). Here, the Commission applied an improper market-definition framework, both in excluding tertiary services and in finding "a separate relevant market consisting of inpatient OB services …." (OP-59–JA84). The Commission's failure to define the correct market undermines its entire analysis. *See generally Bathke v. Casey's Gen. Stores, Inc.*, 64 F.3d 340, 345 (8th Cir. 1995) ("Antitrust claims often rise or fall on the definition of the relevant market.").

A. As The ALJ Found, The GAC Cluster Should Have Included Tertiary And Obstetric Services.

All agree that a relevant product market may consist of a *cluster* of products, even if the individual products within the cluster are not substitutes, especially when the combination reflects the commercial realities of how the products are sold. A "cluster market" exists "where the product package is significantly different from, and appeals to buyers on a different basis from, the individual products considered separately." *Image Tech Servs. v. Eastman Kodak Co.,* 125 F.3d 1195, 1205 (9th Cir. 1997) (citations omitted).

For example, in *United States v. Grinnell Corp.*, 384 U.S. 563, 572 (1966), the Court treated fire and burglary alarm services as a single product market, even though consumers would not exchange fire-alarm service for burglary-alarm service. *See also, e.g.*, *JBL Enters., Inc. v. Jhirmack Enters., Inc.*, 698 F.2d 1011,

1016-17 (9th Cir. 1983) (product market included all beauty products sold to salons, not just shampoos and conditioners); *Staples*, 970 F. Supp. at 1074 (market included consumable office supplies generally).

For this joinder, as in past hospital-merger cases, all agree the product market is a cluster referred to as general "acute inpatient hospital services." *In re Evanston Nw. Healthcare Corp.*, 2007 FTC LEXIS 210, at *149 (FTC Aug. 6, 2007) (identifying cluster market of acute inpatient hospital services) (collecting cases). The Commission itself has explained the rationale for using cluster-market analysis in hospital-merger cases: even though "the treatments offered to patients within this cluster of services are not substitutes for one another … the services and resources that hospitals provide tend to be similar across a wide range of primary, secondary, and tertiary inpatient services." *Id.* (*quoting California v. Sutter Health Sys.*, 130 F. Supp.2d 1109, 1119 (N.D. Cal. 2001)).

While the parties agree that the GAC services cluster comprises the correct market, they disagree on how to determine what services should be included. The *Guidelines*—which the DOJ and the Commission issued to "describe the principal analytical techniques and the main types of evidence on which the Agencies usually rely" to analyze a merger, *Guidelines*, § 1—unequivocally state that market definition must focus "solely" on demand-side substitution, rather than supply-side factors, *id.*, § 4. In other words, product market definition turns on what

consumers *demand*. As applied to cluster markets, "[a] cluster market exists only when the 'cluster' is *itself* an object of consumer demand." *Green Country Food Market v. Bottling Group, LLC*, 371 F.3d 1275, 1284 (10th Cir. 2004).

Consistent with the *Guidelines* and precedent, ProMedica argued for defining the cluster through a *demand-side* analysis that examines the commercial realities of the market, and, specifically, the group of GAC services that MCOs seek as a single unit when negotiating with hospitals. The undisputed evidence showed that these "buyers," in the ALJ's words: "demand, and contract for, a broad array of inpatient hospital services *together* … on behalf of the members they insure." (OP-17–JA42; ID-140–JA236) (emphasis added).

The record evidence confirms that this "broad array" includes *both* OB and tertiary services. No MCOs contract for OB services separately from other GAC services, and no MCOs contract for OB services alone. Rather, as the ALJ found, "[n]egotiations between hospital providers and MCOs for inpatient services cover the full range of services that MCOs' members may need, *including inpatient OB services*." (ID-144–JA240 (emphasis added)). MCOs uniformly confirmed this. (Pugliese, Tr. 1550–JA2382; McGinty, Tr. 1240–JA2375; Town, Tr. 4049-50–JA2448-49; Randolph, Tr. 6960–JA2520).

The same was true of tertiary services, which are bargained for as part of the same GAC package. (ID-142-43–JA238-39). Precedent confirms this—in the

Commission's last fully-litigated hospital merger, the Commission specifically alleged a relevant product market of "general acute care hospital services, including primary, secondary, *and tertiary* services, sold to MCOs." *Evanston*, 2007 FTC LEXIS at *146 (emphasis added).

Given that buyers (*i.e.*, MCOs) treat *all* GAC services, including tertiary and OB, as a unit, the ALJ unsurprisingly found the relevant cluster here included those services. (ID-142-45–JA238-41). The Commission should have upheld that determination.

B. The Commission Erred By Utilizing A Supply-Side Analysis.

Although the ALJ's product-market definition was supported by precedent and the *Guidelines*, the Commission rejected the ALJ's analysis without citing *any* past hospital merger case in support. Indeed, Commissioner Rosch's concurrence disclaimed the majority's market definition, explaining that excluding tertiary services contradicted precedent and that OB services "are already reflected in the inpatient GAC cluster market," so that establishing a separate OB market was "redundant." (COP-1–JA85).

The Commission erred because, notwithstanding the *Guidelines'* focus on demand-side attributes, the Commission adopted a *supply-side* approach that included or excluded specific procedures based on whether "market shares and entry conditions" for them were similar to those of other procedures in the cluster.

It described this as an "analytical convenience" approach. (OP-19–JA44). The only case the Commission cited for this contorted product-market analysis was *Emigra Group, LLC v. Fragomen*, 612 F. Supp.2d 330 (S.D.N.Y. 2009). (OP-19–JA44). *Emigra*, however, was not a merger case, and, while *Emigra* briefly discussed cluster-market analysis, that discussion was irrelevant, as the case involved a non-compete issue that was merely "dressed in the raiment of an antitrust case." *Id.* at 337.

The only other "support" the Commission offered for straying from traditional demand-side market analysis was an article by Professor Baker. (OP-19–JA44). In that article, Baker argued that each individual service in a cluster (*e.g.*, appendectomies) still constitutes a separate product market, and thus the Commission can exclude any service from the cluster at will. *See* Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 L. & CONTEMP. PROBS. 93, 138 (1998). Because—Baker asserts—one can freely include or exclude individual services, the cluster should include only those services for which "demand and supply substitutability opportunities, entry conditions, or market shares" are generally the same. (*See* OP-18-19–JA43-44).

Baker's 14-year-old approach is contrary to the recently-revised *Guidelines*. The *Guidelines* focus on *demand-side* attributes, but Baker focuses on "supply

substitutability," "entry conditions" and "market shares," all of which are *supplier attributes*. (OP-19–JA44). Unsurprisingly, the Commission's own economists have criticized Baker's "analytical convenience" approach, explaining that:

> A new automobile, for example, is a cluster consisting of a wide variety of different types of automotive parts. A literal reading of Baker's proposal implies that one would not analyze a merger between General Motors and Ford in terms of its implications for an auto market; rather, one would analyze first the merger's impact on the individual markets for specific parts, like the engine, radiator, transmission, and headlights, … This approach is both cumbersome and incorrect.

Michael G. Vita, et al., *Economic Analysis in Health Care Antitrust*, 7 J. CONTEMP. HEALTH L. & POL'Y 73, 83 (1991). Yet, that "cumbersome and incorrect approach" is exactly what the Commission adopted here. That was error.

C. The Commission Erred By Limiting The Product Markets Only To The Services Offered By Both Hospitals.

The Commission then attempted to bolster its flawed cluster-construction framework by asserting that the cluster should be limited to only those *particular* GAC inpatient hospital services that *both* merging parties provided. (OP-23–JA48). While justifying its approach as "generally consistent" with cases such as *Philadelphia National Bank* and *Grinnell*, (OP-19–JA44), the Commission is wrong.

In fact, *Grinnell* made clear that the cluster market can include services that are not offered by every competitor. 384 U.S. at 572, n.6 (holding that market for

central alarm station services constitutes a relevant market even though not all firms offer same menu of alarm services). The court in *Sutter* similarly defined a cluster market of primary, secondary and tertiary services, even though not all hospital competitors offered all such services. 130 F. Supp.2d at 1119-20. Perhaps most tellingly, in *FTC v. University Health, Inc.*, 938 F.2d 1206, 1211 (11th Cir. 1991), the court upheld a product market of inpatient services provided by acute-care hospitals, even though the two merging hospitals did not provide every acute-care service.

In its most recent hospital merger case, the Commission *itself* rejected the notion that a cluster is limited to those services that both merging competitors provide. In *Evanston*, as Commissioner Rosch observed (COP-1JA85), the Commission alleged a cluster including tertiary services, even though the smaller hospital there, like St. Luke's here, did not provide the same tertiary services as the acquiring hospital. *Evanston*, 2007 FTC LEXIS 210, at *197.

As these cases show, a cluster cannot be defined by the subset of services a particular seller offers, but rather the "commercial realities" of what "the consumer—here the MCOs—want or contract for," (ID-142–JA238), namely a "broad array of inpatient hospital services together." (OP-17–JA42; ID-140–JA236). As the ALJ cogently observed, "to narrow the product market to only those services that both St. Luke's and ProMedica actually provide is *not*

what MCOs demand or contract to purchase from ProMedica, Mercy, or UTMC." (ID-143–JA239) (emphasis added).

The Commission's claim that competitive conditions for tertiary and inpatient OB services differ from other GAC services does not help the Commission's argument. (OP-23-25–JA48-50). In defining a product market, the number of competitors *providing* a service (a supply-side consideration) is irrelevant. Rather, one must determine how buyers *demand* services. (Guerin-Calvert, Tr. 7221–JA2522). The Commission's myopic focus on what St. Luke's and ProMedica *supply* in common is legally incorrect.

Even if the Commission were correct to limit the cluster to services that both hospitals provide, that still would not justify excluding tertiary services, as St. Luke's in fact performs some tertiary services. (OP-23–JA48). For example, St. Luke's performs open-heart surgery, which all agree is tertiary. (PX01077 at 4–JA592; PX01221 at 49–JA661, *in camera*; Shook, Tr. 892-93–JA2370-71; *see also* Wakeman, Tr. 2753–JA2419). Accordingly, the Commission did not even correctly apply its own flawed framework.

Moreover, the Commission's own expert, Dr. Town, refutes the conclusion that tertiary services are properly excluded or that OB services are a separate market. Town analyzed a market that included some primary, some secondary *and some tertiary* services, but excluded others. (Town, Tr. 3977-86–JA2432-41;

Guerin-Calvert, Tr. 7212–JA2521). For OB services, Town found the allegedly different competitive conditions between inpatient OB and other GAC services (*i.e.*, the fact that UTMC does not supply inpatient OB services) so irrelevant that he performed his competitive-effects analysis across all services, *combining inpatient OB services with all other GAC services*. (Town, Tr. 4292-96–JA2484-88). He did not separately analyze OB services.

D. The Commission Erred In Asserting Product Market Definition Does Not Matter.

Perhaps recognizing the flaw in its market definition, the Commission tries to downplay its significance. According to the Commission, "whether we accept Complaint Counsel's or Respondent's definition of the relevant market does not affect our analysis of this transaction's likely competitive effects." (OP-26–JA51). That is wrong.

First, the Commission must prove anticompetitive effects in a "line of commerce." 15 U.S.C. § 18. The only markets in which the Commission has even sought to do so is in the markets *that the Commission defined*. While it *asserts* that the analysis remains identical under either definition, it made no effort to *prove* that. The only thing it relies on in support of this claim is that "market shares and concentration levels exceed the thresholds for presumptive illegality" under either party's definitions. (OP-26–JA51). But, as explained below, that presumption

carries little, if any, weight in a differentiated-products unilateral-effects case, and thus provides no basis for asserting that differences in market definition are irrelevant.

Second, by separately defining an OB market, the Commission improperly raised the specter of a merger to duopoly (OP-52–JA77), allowing the Commission to assert that the joinder would give ProMedica more than an 80% market share. (OP-27–JA52). Given the Commission's flawed focus on concentration (also discussed below), this improper market definition created a virtually irrebuttable presumption of anticompetitive effects.

In short, the Commission's failure to correctly define the market mattered, and the Commission has thus failed to carry its burden of proof. *United States v. E.I. du Pont de Nemours*, 353 U.S. 586, 593 (1957).

II. The Commission Adopted An Erroneous Anticompetitive-Effects Framework.

In addition to defining the product market incorrectly, the Commission adopted a flawed analytical framework for assessing likely anticompetitive effects, an issue on which the Commission concedes it bears the ultimate burden of proof. (*See* OP-14–JA39 (*citing Chicago Bridge*, 534 F.3d at 423)). Generally, in assessing anticompetitive effects, courts have followed a burden-shifting approach. The Commission bears the initial burden to set forth a *prima facie* case, which creates a rebuttable presumption of harm. *See United States v. Baker Hughes, Inc.*,

908 F.2d 981, 982-83 (D.C. Cir. 1990). The stronger the *prima facie* showing, the stronger the presumption. *Id*. at 991. The burden then shifts to the respondent to rebut that presumption. If successful, the burden shifts back to the Commission, which at all times bears the ultimate burden of persuasion. *Id*. As the Commission noted, however, "in practice, evidence is often considered together and the burdens are not strictly demarcated." (OP-14–JA39 (*citing Chicago Bridge*, 534 F.3d at 424-25)).

The principal problem here is that, while the Commission alleges *only* differentiated-products *unilateral effects*, it analyzes the joinder as though this were a standard *coordinated-effects* case. Specifically, the Commission focuses heavily on market-concentration statistics, although all agree that product *substitutability*, not market concentration, is the key in a unilateral-effects case. Even when it finally addresses the correct issue—substitutability—the Commission looks to the wrong market participants. Finally, the Commission also erred in its assessment of likely post-joinder pricing—in particular, the Commission looked only for evidence of *any* price increase, rather than an *anticompetitive* price increase. But, absent the latter, there is no violation.

A. In A Differentiated-Products Unilateral-Effects Case, Product *Substitutability* Is The Key, And Buyers Do Not Consider ProMedica And St. Luke's Close Substitutes.

The Commission's expert concedes that product *substitutability*, not market concentration, drives a unilateral-effects analysis. (Town, Tr. 3749–JA2431, *in camera* ("in a unilateral effects analysis, the critical issue is, how substitutable are the products of the merging firm?")). Yet, the Commission adopted an inappropriate market-concentration-based presumption, imposing a hurdle that ProMedica should not have faced.

Until the past two decades, the FTC's theory of merger liability centered on coordinated effects. *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 906 (7th Cir. 1989) (Posner, J.) (describing coordinated effects as the prevailing theory of anticompetitive effects in merger cases). As the court noted in *United States v. H&R Block*, coordinated effects "rests upon the theory that, where rivals are few, firms will be able to coordinate their behavior, either by overt collusion or implicit understanding in order to restrict output and achieve profits above competitive levels." 833 F. Supp.2d 36, 77 (D.D.C. 2011) (citation omitted). In short, fewer rival firms means greater potential for coordination. Thus, in assessing whether the government has met its *prima facie* case, and the strength of the resulting presumption, courts focus on market-concentration statistics—the more

concentration, the stronger the presumption of coordinated activity. *See FTC v. H.J. Heinz Co.*, 246 F.3d 708, 724-25 (D.C. Cir. 2001).

"Unilateral effects," by contrast, refers to "the tendency of a horizontal merger to lead to higher prices simply by virtue of the fact that the merger will eliminate direct competition between the two merging firms, even if all other firms in the market continue to compete independently." *United States v. Oracle Corp.*, 331 F. Supp.2d 1098, 1113 (N.D. Cal. 2004). "A merger is likely to have unilateral anticompetitive effect if the acquiring firm will have the incentive to raise prices or reduce quality after the acquisition, independent of competitive responses from other firms." *H&R Block*, 833 F. Supp.2d at 81. *See also Guidelines* § 6.

Unilateral effects cases fall into two categories, homogeneous product and differentiated product. *See Guidelines* §§ 6.1, 6.3. It is undisputed that the joinder here involves differentiated products. (*See, e.g.*, Town, Tr. 4158-59–JA2463-64). In such cases, courts have identified three factors that must be present:

1. The products controlled by the merging parties are ***close substitutes for each other***, meaning that a substantial number of customers of one firm would turn to the other in response to price increases.

2. Other products must be sufficiently different from the products offered by the merging firms such that a merger would make a small but significant price increase profitable, and

3. Repositioning is unlikely.

Oracle, 331 F. Supp.2d at 1117. Noticeably absent from this list is reference to market concentration. Rather, *substitutability* is the key.

The *Guidelines* agree: "The extent of direct competition between the products sold by the merging parties is central to the evaluation of unilateral price effects." *Guidelines* § 6.1. "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***." *Id*. (emphasis added). Indeed, "[s]ubstantial unilateral price elevation post-merger for a product formerly sold by one of the merging firms 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).

An example illustrates: If Firms A and B merge, and their products are closest substitutes for each other, then Firm A can raise prices, knowing that if customers switch it will likely be to Firm B products (which Firm A now also owns). If, by contrast, competitor Firm C's products are a closer substitute, then the response to Firm A raising prices would be for customers to move to Firm C, meaning a merger with Firm B would not increase Firm A's pricing power.

The importance of substitutability, rather than market concentration, reduces the role of market-concentration statistics such as HHIs. According to the *Guidelines*, "[t]he Agencies rely much more on the value of diverted sales than on

the level of HHI for diagnosing unilateral price effects in markets with differentiated products." *Guidelines* § 6.1.[1] Or, as the court put it in *Oracle*, "a strong presumption of anticompetitive effects based on market concentration is especially problematic in a differentiated products unilateral effects context." 331 F. Supp.2d at 1122. Indeed, the *Oracle* court criticized the then-current *Guidelines* (*i.e.*, in 2004) for employing a unilateral-effects analysis that "closely mirror[ed] traditional structural analysis," and went on to observe that "[t]he biggest weakness in the *Guidelines'* approach appears to be its strong reliance on particular market share concentrations." *Id*. at 1122 (citing then-current *Guidelines* § 2.211).

Commentators likewise agree that market-concentration statistics are poor predictors of anticompetitive effects in differentiated-product unilateral-effects cases. *See, e.g.,* Jonathan B. Baker, *Merger Simulation in an Administrative Context*, 77 ANTITRUST L.J. 451, 457 (2011) ("an enforcement system that places heavy weight on market shares will likely perform poorly in evaluating unilateral effects"); Carl Shapiro, *The 2010 Horizontal Merger Guidelines: From Hedgehog to Fox in Forty Years*, 77 ANTITRUST L.J. 49, 70 (2010) ("economic theory relates unilateral price effects with differentiated products more directly to diversion ratios and margins than to the combined market share of the merging firms"); Jonathan

[1] Diversion is typically measured by a "diversion ratio," referring to the fraction of sales lost due to a price increase by supplier A, that are captured by supplier B.

B. Baker and David Reitman, *Research Topics in Unilateral Effects Analysis*, in RESEARCH HANDBOOK ON THE ECONOMICS OF ANTITRUST LAW (Einer Elhauge ed., 2012) ("[I]n the context of price-setting differentiated product markets, the Merger Guidelines presumptions are not directly linked to unilateral merger effects. Those presumptions are based on market shares, which may bear no relationship to the loss of direct competition between merging firms.").

Here, the record contains *no* evidence that buyers of GAC services, *i.e.*, MCOs, view ProMedica and St. Luke's as close substitutes. Rather, *every* MCO testified that it consider ProMedica and *Mercy* to be each other's closest substitutes. (RX-27 at 5–JA1376, *in camera*; Sheridan, Tr. 6616-18–JA2510-12; PX02067 at 3–JA2344, *in camera*; RX-46 at 8–JA1614, *in camera*).[2] ProMedica's and Mercy's documents confirm this, (PX02288–JA1245-49, *in camera*; PX02534 at 3, 6, 13, 20, 23–JA1256, 1259, 1266, 1273, 1276, *in camera*; RX-250 at 5, 13, 18–JA1939, 1947, 1952, *in camera*), and executives from both ProMedica and Mercy agree. (Shook, Tr. 1091-92–JA2373-74, *in camera*; Oostra, Tr. 5803-05–JA2507-09). Even the Commission's expert concedes that ProMedica and Mercy are each other's closest substitutes. (Town, Tr. 4058–JA2451).

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[2] [redacted] documents and testimony also indicate that it does not consider St. Luke's a peer hospital to ProMedica hospitals. [redacted] Tr. 1662-64–JA2390-92, *in camera*; PX02454 at 2–JA1251 , *in camera*).

Market behavior confirms this point. When MCOs rearranged their Lucas County hospital provider networks in the past, they successfully swapped Mercy for ProMedica, but never St. Luke's for ProMedica. ([redacted] Tr. 6691, 6710-6711–JA2517-19, *in camera*; PX01902 at 14–JA828, *in camera*; Buehrer, Tr. 3092–JA2424; Town, Tr. 4057, 4081–JA2450, 2452). Even Complaint Counsel conceded that St. Luke's is not a substitute for ProMedica as a system. (Closing Arguments, Tr. 54–JA2557).

Substitutability is the key factor in a unilateral-effects case, and the evidence shows that the relevant buyers do not view ProMedica and St. Luke's as close substitutes. Accordingly, their joinder is unlikely to create pricing power.

B. The Commission Committed Legal Error By Heavily Relying On Market-Concentration Statistics In A Differentiated-Products Unilateral-Effects Case.

The Commission found liability only because it relied on a flawed analytic framework. Although the potential for unilateral effects turns on substitutability, the Commission began its analysis by focusing on market-concentration statistics (*i.e.*, HHIs), and concluded that the HHIs created a presumption of anticompetitive harm. (OP-27–JA52). Moreover, ignoring the *Oracle* court's warning against "a strong presumption of anticompetitive effects based on market concentration," the Commission held that the *strength* of the presumption was directly correlated to *size* of the HHI increase. According to the Commission, the market-concentration

data was "more than sufficient to create a presumption," and reflected "concentration levels [that] are high" causing the Commission to observe that: "The more compelling the prima facie case … the more evidence the defendant must present to rebut it successfully." (OP-27–JA52). As explained above, however, narrowly focusing on market-concentration statistics to create a strong presumption in a unilateral-effects case constitutes legal error. *See, e.g., Oracle*, 331 F. Supp.2d at 1122. That flawed starting point dooms the Commission's entire anticompetitive-effects analysis.

To be sure, in some cases discussing differentiated-product unilateral-effects theories, courts have addressed market-concentration statistics, and have even discussed a presumption arising from such statistics. But in virtually all of those cases, the courts were *also* addressing possible *coordinated* effects. *See, e.g.*, *H&R Block*, 833 F. Supp.2d at 81 (noting court had "already found that the preponderance of the evidence shows a reasonable likelihood of coordinated effects"); *FTC v. CCC Holdings Inc.*, 605 F. Supp.2d 26, 67 (D.D.C. 2009) (concluding that FTC had raised sufficient likelihood of *coordinated effects* to justify relief). When a plaintiff asserts *both* coordinated *and* unilateral effects, market-concentration statistics may play a larger role. But here, Complaint Counsel expressly disclaimed *any* reliance on coordinated effects. Moreover, even if market-concentration statistics could play *some* role, they should not create a

strong presumption. See *Oracle*, 331 F. Supp.2d at 1122. In fact, the Commission's position here notwithstanding, in 2010 the Commission and the DOJ rewrote the *Guidelines* to reinforce that substitutability, not market concentration, is the key in differentiated-products mergers. *Compare* 2010 *Guidelines* § 6.1 *with* 1992 *Guidelines* §§ 1.5, 2.0.

Moreover, not only did the Commission's legally-erroneous fixation with market-concentration statistics lead to an inappropriate presumption, it also led the Commission to adopt a legally-erroneous rule that it relied on to reject ProMedica's attempts to rebut that presumption. A defendant can overcome a market-concentration-based presumption by showing that the market-concentration statistics overstate likely competitive harm. *See Chicago Bridge*, 534 F.3d at 423. One way a defendant can do that is by showing that its merger partner was a financially-weakened and diminishing competitor, such that its current market share overstates the merger partner's market significance on a going-forward basis. *See Arch Coal,* 329 F. Supp.2d at 153.

Given St. Luke's deteriorating financial condition, ProMedica made that argument here. In response, the Commission again leaned exclusively on its market-concentration crutch, and adopted a *per se* rule, expressly refusing to even *consider* evidence that St. Luke's was a weakened competitor unless ProMedica could "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 [based on HHI scores]." (OP-32–JA57). Because market shares do not create "thresholds of presumptive illegality" in unilateral-effects cases in the same way that they do in coordinated-effects cases, however, the Commission's legally-erroneous *per se* rule provides no proper basis for disregarding ProMedica's weakened-competitor evidence.

In short, the Commission's inappropriate focus on market-concentration statistics undercuts its entire competitive-effects analysis—from its initial flawed presumption to its unwarranted rejection of ProMedica's rebuttal.

C. The Commission's Substitutability Analysis Was Legally Flawed.

Even when the Commission turned to substitutability in an attempt to buttress its flawed market-concentration approach, it again committed legal error. First, it wrongly asserted that merging parties need not be next-best substitutes to give rise to unilateral effects. Second, and independently, it erred in assessing substitutability from the perspective of patients.

1. Products That Are Not Next-Best Substitutes Do Not Give Rise To Unilateral Effects.

Unable to show that MCOs consider ProMedica and St. Luke's to be close substitutes, the Commission instead argued that under *H&R Block* merging parties do not have to be closest substitutes to find likely unilateral effects. (OP-47–JA72,

citing H&R Block, 833 F. Supp.2d at 83). But, *H&R Block* does not prove the Commission's point. The unilateral-effects language upon which the Commission relies is *dicta*. *See H&R Block*, 833 F. Supp.2d at 81 ("Since the Court has already found that the preponderance of the evidence shows a reasonable likelihood of coordinated effects, the Court need not reach the issue of unilateral effects."). Moreover, both *Evanston* and *Oracle* contradict *H&R Block* on this point.[3] In *Evanston*, the Commission noted that "[a] merger between firms in a differentiated product market can enable the merged firm to raise prices unilaterally if customers accounting for 'a significant share of sales' view the merging parties *as their first and second choices*…." *Evanston*, 2007 FTC LEXIS 210, at *158 (emphasis added); *see also Oracle*, 331 F. Supp.2d at 1117-18. Here, the Commission has failed to show *any* buyers (MCOs) that consider ProMedica and St. Luke's to be their first and second choices, let alone a "significant share." (*See* COP-4–JA88 ("Each and every one of the six MCOs who testified admitted that Mercy, not St. Luke's, was ProMedica's next best substitute.")).

[3] Furthermore, *H&R Block* involved a merger to duopoly between the second and third largest competitors in the market. *H&R Block*, 833 F. Supp.2d at 36. Here, ProMedica joined with the *smallest* competitor, and still faces two strong competitors.

2. The Commission Erred In Assessing Substitutability From The Perspective Of Patients Rather Than MCOs.

Given that no MCO considered St. Luke's and ProMedica to be substitutes, the Commission instead elected to assess substitutability from the patients' perspective. This was yet again legal error.

Two products are close substitutes only if buyers respond to a price increase in one product by substituting it with the other. *Evanston*, 2007 FTC LEXIS 210, at *144-145; *Guidelines* § 6.1. Therefore, it is critical to focus on the correct "buyer," *i.e.*, the entity that can respond to price increases by substituting a different hospital. In a hospital merger case, it is MCOs that negotiate price and network access with hospitals, and accordingly MCOs that respond to price increases.

More specifically, the hospital services market is characterized by a two-stage bargaining framework.[4] At the first stage, hospitals compete with each other to become participating providers in MCO networks. *Evanston*, 2007 FTC LEXIS 210, at *19. Prices for hospital services are set at the first stage through hospital-MCO negotiations. *Evanston*, 2007 FTC LEXIS 210, at *14. These reimbursement rates are the basis for what MCOs charge patients, who themselves

[4] "[B]argaining models are appropriate for hospital markets because bilateral negotiations between MCOs and hospitals determine prices that often are unique to the particular negotiation." *Evanston*, 2007 FTC LEXIS 210, at *166.

are typically unaware of the prices that hospitals charge.[5] *Evanston*, 2007 FTC LEXIS 210, at *14.

As the MCOs are the only entities that would respond to price increases by substituting hospitals in or out of their networks, they are the relevant buyers. (*See* Town Tr. at 3637–JA2430, (MCO-hospital negotiations must be "focus of the competitive analysis")). Indeed, the ALJ himself, in line with precedent, correctly noted that "the 'consumers' of these services are commercial health plans," before he errantly turned to *patient* preferences. (ID-140–JA236; *see also* Compl. 4–JA431 (describing market as GAC services "sold to commercial health plans"); *Sutter,* 130 F. Supp.2d at 1129 (citing *Univ. Health,* 938 F.2d at 1213 n.13 (holding MCOs were true customers of acute-inpatient services))).

Unlike MCOs, *patients* are far removed from hospital pricing negotiations. For example, commercially-insured patients overwhelmingly receive health insurance from their employers, and do not negotiate prices with hospitals. (Town, Tr. 3609-10–JA2426-27; PX02148 at 10–JA1059, *in camera*). Their employers do not negotiate prices with hospitals, either. (Neal, Tr. 2095, 2106–JA2402-03; Pugliese, Tr. 1432-33, 1547–JA2379-81; Radzialowski, Tr. 748–JA2366; Buehrer,

[5] At the second stage of bargaining, hospitals compete on non-price dimensions for individual patients. Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 ANTITRUST L.J. 671 (2000).

Tr. 3089–JA2422). Indeed, some employers do not even negotiate prices directly with MCOs, instead relying on insurance brokers, (Buehrer, Tr. 3089-90–JA2422-23; Neal, Tr. 2092–JA2401; Caumartin, Tr. 1836, 1839, 1848-49–JA2395, 2397-99), inserting yet another layer between patients and hospital pricing. (Pugliese, Tr. 1432-33– JA2379-80). As patients do not even *know* hospital prices, they do not switch hospitals based on changes in pricing, and thus cannot be the relevant "buyers." (Neal, Tr. 2095, 2106–JA2402-03; Pugliese, Tr. 1432-33, 1547–JA2379-81; Radzialowski, Tr. 748-49–JA2366-67; Town, Tr. 3611-12–JA2428-29; Caumartin, Tr. 1838-39, 1873–JA2396-97, 2400; Buehrer, Tr. 3062, 3089–JA2421-22; OP-5–JA30).

Further confirming this—*patients do not even buy the relevant product*, which is a *cluster* of GAC services. (OP-5–JA30). Rather, they are either (1) purchasers of insurance (*i.e.*, access to a network of providers (often including multiple hospitals)), or, (2) at most, purchasers of a single service (*e.g.*, appendectomy). They certainly do not purchase the GAC *cluster*.

The Commission nonetheless focused on patients' preferences to assess substitutability for purposes of unilateral effects. (OP-45-47–JA70-72). This was legal error. Consequently, the Commission's substitutability analysis cannot demonstrate a likelihood of unilateral effects. Put differently, the Commission

cannot show a high cross-elasticity of demand between ProMedica and St. Luke's, because it focused on the wrong party's perspective.[6]

Even if patients were the proper parties, the Commission still erred: it ignored evidence that *from the patients' perspective* St. Luke's and *UTMC* are each other's closest substitutes. *Schering-Plough*, 402 F.3d at 1070 ("Substantial evidence requires a review of the *entire* record at trial," including any "evidence that contradicts the Commission's conclusion.") (emphasis included). Specifically, St. Luke's ordinary-course analysis of its patient discharge data from 2000-2007 indicates that UTMC, *not* ProMedica, gained most of St. Luke's lost patients—not what should happen if ProMedica was the patients' next-best choice. (RX-2162 at 1–JA2286). Furthermore, St. Luke's CEO testified that, when St. Luke's joined Paramount's network post-joinder (Paramount is ProMedica's affiliated MCO), St. Luke's gained most of its Paramount-insured inpatients *from UTMC,* not ProMedica. (Wakeman, Tr. 3025–JA2420, *in camera*). Both drive-time analysis and diversion data further confirm that ProMedica and St. Luke's are not each other's closest substitutes from patients' perspectives. (Guerin-Calvert, Tr. 7351-7352–JA2526-27; RX-71(A) at 22-34, 186–JA1713-25, 1877, *in camera*).

[6] "Cross-elasticity of demand measures the sensitivity of purchase of one good to change in the price of another …. The higher the value of cross-elasticities, the greater the substitutability of the products." *Lewis v. Philip Morris, Inc.*, 355 F.3d 515, 531, n.23 (6th Cir. 2004) (citation omitted).

Indeed, highlighting the weakness of the Commission's analysis, the Commission was forced to focus on only a small *subset* of patients in the geographic market to show substitutability. The Commission identified a "core-service area" which included only those patients in the zip codes geographically closest to St. Luke's and the nearest ProMedica hospital (Flower). (OP-10, n. 10, 43, 46–JA35, 68, 71). Nowhere, though, has the Commission identified precedent justifying further slicing an agreed relevant geographic market to focus only on a geographic subset of market participants.

In sum, the Commission lacks substantial evidence to find substitutability, even in patients' minds. Without substitutability, the Commission lacks any basis to find a substantial likelihood of anticompetitive unilateral effects.

D. The Commission Committed Legal Error In Assessing Likely Post-Joinder Price Increases.

The Commission cannot cure the problems created by its legally-flawed unilateral-effects framework by alternatively relying on other "evidence" allegedly predicting post-joinder price increases. The Commission held this evidence to the wrong standard. A merger violates Section 7 only if it raises prices *above the competitive level*. Here, the Commission concluded that the joinder violated Section 7 without examining whether the projected price increases would be supra-competitive. (OP-44–JA69). Had it done so, the Commission could not have concluded that any price increase would be supra-competitive, especially given the

Commission's explicit finding that St. Luke's prices were likely to increase *regardless of the joinder*. The Commission's failure to address this "ultimate issue" compels reversal.

1. The Commission Is Required To Show *Anticompetitive* Price Increases That *Result From* The Merger.

The "ultimate issue in a § 7 case is whether the merging firm acting unilaterally … will be able to increase prices *above the competitive price*." *Advocacy Org. for Patients & Providers v. Mercy Health Servs.*, 987 F. Supp. 967, 973 (E.D. Mich. 1997) (denying TRO to enjoin hospital merger) (emphasis added); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 136 (E.D.N.Y. 1997) (explaining that Section 7 forbids mergers that would enable the parties to "force price[s] above…the competitive level"). A potential future price increase, in and of itself, is not enough—the price increase must be supra-competitive. Moreover, the plaintiff must prove *causation*, *i.e.*, that the supra-competitive prices occurred *as a result of* the joinder. *See J.B.D.L. Corp. v. Wyeth-Ayerst Labs., Inc.*, 2005 U.S. Dist. LEXIS 11676, * 62 (S.D. Ohio June 13, 2005) ("[a]bsent proof of a causative link between the alleged monopolistic conduct and the alleged supracompetitive price, the 'but-for' … prices offered [by the plaintiffs were] untenable"), *aff'd.* 485 F.3d 880 (6th Cir. 2007). Here, the Commission addressed neither supra-competitive prices nor causation.

a. The Commission Failed To Show Anticompetitive Price Increases.

The Commission made no attempt to determine whether post-joinder prices would rise to *supra-competitive* levels. To be sure, the Commission's expert opined that prices would increase. (Town, Tr. 3600–JA2425). But the Commission failed to compare that projected post-joinder price increase to any benchmark of price increases that would likely occur *absent* the joinder. *See, e.g., Mercy*, 987 F. Supp. at 973. Specifically, the Commission should have considered, but failed to, what the prices would have been in a "'but for' market, free of the restraints and conduct alleged to be anticompetitive." *Concord Boat Corp. v. Brunswick Corp.*, 207 F.3d 1039, 1055 (8th Cir. 2000) (criticizing plaintiffs for not presenting a "but for" market to allow the court to separate unlawful conduct from lawful conduct). Given its failure to construct this benchmark, the Commission cannot "separate lawful from unlawful conduct," as it cannot rule out other *competitively-benign* market factors that may allow ProMedica to raise its and St. Luke's prices post-joinder. *Mercy*, 987 F. Supp. at 973.

Instead, the Commission adopted the legally-indefensible position that *any* post-joinder price increase is *per se* anticompetitive. (OP-44–JA69). *See Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 297-98 (2d Cir. 1979) (holding that even a monopolist is liable only for conduct *augmenting* monopoly power). The crux of the Commission's analysis was that prices at St. Luke's and

ProMedica's legacy hospitals will likely increase simply because ProMedica's market share will increase by joining with St. Luke's. (OP-44–JA69). But, this is not what the cases require to find liability. Indeed, the Supreme Court has cautioned that "statistics concerning market share and concentration … [are] 'not conclusive indicators of anticompetitive effects.'" *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 498 (1974).

Certainly, the Commission cannot simply adopt *pre-joinder* prices as "but for" prices in this market (and thus claim that *any* price increase is anticompetitive). This is so because the Commission expressly found that *even absent the joinder* St. Luke's prices were likely to increase. (OP-34–JA59). As the Commission noted, St. Luke's reimbursements from MCOs did not meet its costs of care. (OP-31, n. 34-35–JA56). This had been a focus of St. Luke's management, leading the Commission to expressly acknowledge that "it is likely that St. Luke's would have succeeded in negotiating more favorable reimbursement rates had it remained independent …." (OP-34–JA59). For example, one of St. Luke's major MCOs testified that pre-joinder it was prepared

to give St. Luke's the equivalent of a [redacted] increase.[7] ([redacted] Tr. 2229-36, 2350-56–JA2404-18, *in camera*).

Moreover, the record unequivocally shows that hospitals' costs—*e.g.,* the prices of nursing, pharmaceuticals and medical devices—rise annually. (Beck, Tr. 432–JA2359; Gold, Tr. 271–JA2358). Hospitals, therefore, seek corresponding price increases from MCOs. This is not unique to ProMedica or St. Luke's. Witnesses from area hospitals testified that their costs—and thus their rates—have increased over time. (*See* Gold, Tr. 271–JA2358 (UTMC's costs and rates increase over time); Beck, Tr. 432–JA2359 (same for Fulton County Medical Center); Korducki, Tr. 539–JA2362 (same for Wood County Hospital)).

Unsurprisingly, MCOs likewise testified that they expected hospital price increases, even absent the joinder. For example, [redacted] expected a [redacted] increase in the Cleveland/Toledo area in 2010, even without the joinder. (PX01917 at 28–JA861, *in camera*). Indeed, the MCOs' contracts with Toledo-area hospitals contain standard "escalator" clauses. (*See* PX00091 at 10–JA548, *in camera*; PX00093 at 10–JA568, *in camera*; PX00095 at 10–JA583, *in camera*). These cost-driven price increases are another potential *non-joinder-related reason* for

[7] Taking compounding and bonus payments into account, St. Luke's would have received an approximately [redacted] inpatient reimbursement increase. (Guerin-Calvert, Tr. 7425-26–JA2528-29, *in camera*).

future price increases that the Commission did not rule out prior to finding liability. *See Schering-Plough*, 402 F.3d at 1065 (holding Commission erroneously "made its decision before it considered any contrary conclusion").

By failing to construct a "but-for-the-joinder" benchmark, the Commission cannot distinguish between competitive and anticompetitive price increases. Thus, it has no legally-sufficient basis to answer the "ultimate question" of whether ProMedica can impose supra-competitive prices.

b. The Commission Failed To Show Causation.

The Commission also erred in finding that the joinder would *cause* the price increase that Town posited. The Commission relied principally on Town's conclusion that, pre-joinder, ProMedica had both the highest share among Toledo hospitals and the highest "constructed," not actual, prices. (*See* Town, Tr. 4151-52, 4155-56–JA2456-57, 2460-61; PX02148 at 145–JA1194, *in camera*). ("Constructed prices" were Town's effort to create a "normalized" price that removed from the pricing data certain patient characteristics (*e.g.*, average patient acuity) that varied from hospital to hospital, so that the "normalized" prices could be compared. (Town, Tr. 4148-57–JA2453-62).) From this correlation between share and price, Town asserted that an *increase* in share would cause an *increase* in prices. This, of course, is logically (and legally) flawed, as it confuses *correlation* with *causation*. *See Cornist v. B.J.T. Auto Sales, Inc.*, 272 F.3d 322, 328 (6th Cir.

2001) (criticizing "the logical fallacy of equating correlation with causation" in reviewing statistical evidence).

Moreover, relying on market shares to analyze purported competitive effects, as Town did here, is "especially problematic" when the transaction involves differentiated products, such as the GAC-services cluster. *See Oracle*, 331 F. Supp.2d at 1121-22. Indeed, the Commission's own economists have stated, "[i]n a market with differentiated products, different price levels are neither necessary, nor sufficient, to demonstrate the exercise of market power …." Deborah Haas-Wilson & Christopher Garmon, *Hospital Mergers & Competitive Effects: Two Retrospective Analyses*, 18 INT'L J. OF THE ECON. OF BUS. 17, 22 (2011). In other words, the fact that a competitor with a higher market share has a higher price does not *ipso facto* mean that the higher price *resulted from* the higher market share, and it certainly does not prove that an *increase* in market share will cause an *increase* in price. More is required. *See Kraft*, 926 F. Supp. at 366.

That is particularly true when neither the Commission nor its economic expert ever explained *why* ProMedica's pre-joinder "constructed" prices were higher than prices at other hospitals. (Town, Tr. 4151-52, 4155-56–JA2456-57, 2460-61; PX02148 at 145–JA1194, *in camera*). At trial, Town could not say whether ProMedica's prices were higher due to market power, anticompetitive

market conditions,[8] ProMedica's costs, patient preference for ProMedica over other area hospitals, or other competitively-benign reasons. (Town, Tr. 4159, 4165-72, 4197-4201–JA2464-77; McGinty, Tr. 1273–JA2376). Indeed, Town *admitted* that his constructed-price comparison did not explain *why* ProMedica's prices were higher. (Town, Tr. 4151-52, 4155-56–JA2456-57; PX02148 at 145–JA1194, *in camera*).

Absent evidence, even pre-joinder, of a causal linkage between market share and price, the Commission cannot simply assume that increasing market share post-joinder would increase ProMedica's pricing power. This lack of causation evidence dooms the Commission's determination.

c. MCO Testimony that Prices Will Increase Post-Joinder Lacks Foundation.

To buttress its faulty conclusion of anticompetitive price increases, the Commission relied on opinions from various MCO witnesses that rates at St. Luke's and ProMedica will increase post-joinder. (OP-40–JA65). This subjective testimony lacks foundation and is not "substantial evidence" of post-joinder anticompetitive effects. Indeed, the *Arch Coal* court dismissed similar

[8] The evidence shows market conditions pre-joinder were competitive. Specifically, MCOs testified that both ProMedica's and Mercy's pre-joinder rates were competitive. [redacted] Tr. 1381-82–JA2377-78, *in camera* [redacted] Tr. 1603-04–JA2384-85, *in camera* [redacted] Tr. 684–JA2363, *in camera*; [redacted] Tr. 6652-54–JA2514-16, *in camera*).

testimony despite claims, like here, that the testimony was based on personal experience, noting that customers do not have the expertise to state what will happen post-acquisition. *Arch Coal*, 329 F. Supp.2d at 146; *see also FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999) (dismissing market participants' testimony).

The MCOs' testimony here is no different from the testimony rejected in *Arch Coal* and *Tenet*.[9] Specifically, the MCOs' assessment of potential future pricing lacks foundation as it is not based on empirical analyses of the market and prices post-joinder, but is instead based on speculation or "conjecture." ([redacted] Tr. 824-25–JA2368-69, *in camera*). For example, [redacted] conducted no analysis of post-joinder conditions. Rather, it simply "imagine[d]" that the joinder would "cause [ProMedica] to ask for higher rates." ([redacted] Tr., 714–JA2364, *in camera*). Worse, [redacted] witness admitted that its "projected" [redacted] post-joinder rate increase for St. Luke's was "conjecture," and that asking three different people a [redacted] may result in three different answers. ([redacted] Tr. 824-25–JA2368-69, *in camera*). [redacted] likewise testified it had no reason to believe it would be unable to negotiate a mutually-agreeable contract with ProMedica post-joinder, like it has for twenty years. ([redacted] Tr.

[9] Similar to *Arch Coal* and *Tenet*, Petitioner is not suggesting that the MCOs' testimony was disingenuous, just that it does not constitute substantial evidence supporting the Commission's finding.

1649-50–JA2388-89, *in camera*). Large, sophisticated buyers, like the MCOs here—who have reams of detailed data on hospital utilization, hospital costs and revenues, and coordination of benefits—cannot simply rely on conjecture.

Nor does the MCOs' claim that they will be unable to market a network without ProMedica and St. Luke's cure this problem. (OP-38–JA63). This testimony is directly contrary to the MCOs' successful history with narrower networks in Toledo. (ID-157–JA253; IDF ¶¶157-61, 246–JA117-18, 125). For example, Paramount successfully marketed a network of just ProMedica and UTMC, and other MCOs have swapped Mercy for ProMedica in their past narrower networks. In short, MCOs can develop viable networks that do not include ProMedica and St. Luke's. (IDF ¶172–JA119; Sheridan, Tr. 6620–JA2513).

Indeed, the Commission's own expert opined that patients would find value in a Mercy/UTMC network. His model predicted positive "utils"—*i.e.*, the value patients place on a particular good or service[10]—for a Mercy/UTMC network. (Town, Tr. 4322-23–JA2489-90; PX02148 at 165–JA1214, *in camera*).

The Commission's reliance on MCO testimony thus does not meet the substantial evidence standard, as the Commission ignored competing evidence and

[10] (Town, Tr. 4249–JA2479).

testimony that fairly detracts from the weight of the testimony it cited. To the contrary, this evidence should be disregarded in its entirety, just as in *Arch Coal* and *Tenet*.

d. The Parties' Documents Do Not Show Likely Anticompetitive Price Effects.

The Commission also erred in purporting to find evidence of likely anticompetitive effects in the parties' documents. In its decision, the Commission cited documents in which St. Luke's management had raised ProMedica's bargaining leverage as a reason to merge. (OP-12-13, 40–JA37-38, 65). Once again, though, that provides *no* evidence of an *anticompetitive* price increase. To start, the record shows that St. Luke's management had no foundation to speculate about ProMedica's bargaining leverage—St. Luke's did not know what rates ProMedica was receiving, or what its MCO contracts looked like. (Black, Tr. 5639-42, 5651–JA2501-05, *in camera*; PX01929 at 38–JA2325, *in camera*). Moreover, even if St. Luke's thought it may obtain higher prices, St. Luke's was receiving *below-cost* prices pre-joinder, and everyone assumed St. Luke's prices would have risen even absent the joinder. (OP-11, 34–JA36, 59[redacted]Tr. 2229-36, 2352-56–JA2404-11, 2414-18, *in camera* [redacted]Tr. 1631, 1639–JA2386-87, *in camera*; PX02382 at 3–JA2352, *in camera*; RX-965 at 3–JA2355, *in camera*).

And certainly, the record contains *no* evidence suggesting that *ProMedica* thought the merger would increase *its* bargaining leverage.

2. The Commission Expert's Merger-Simulation Model Is Fatally Flawed.

The Commission likewise cannot rely on its expert's merger simulation model, which is inherently flawed, to buttress its anticompetitive-effects conclusion. Indeed, in his concurring opinion, Commissioner Rosch specifically chastised the majority for relying on Town's econometric modeling, noting that "[c]ritics have charged that [simulation] studies *always* predict a price increase if there is *any* degree of substitution between the merging parties' products," and therefore such studies are inconclusive and are not substantial evidence in support of unilateral effects from a merger. (COP-5–JA89 (citing Statement of J. Thomas Rosch on the Release of the 2010 *Horizontal Merger Guidelines*, 3-4 (Aug. 19, 2010)) (emphasis added)).

Even if an econometric model *could* support a liability finding, the one here does not. If an expert's opinion "is not supported by sufficient facts to validate it in the eyes of the law … it cannot support a decision." *Gen. Dynamics*, 415 U.S. at 498; *Tenet*, 186 F.3d at 1045, n.13; *see CCC Holdings*, 605 F. Supp.2d at 70-72 (dismissing expert's model because "the data and predictions cannot reasonably be confirmed by the evidence"). Here, Town's simulation fails to meet this test as it does not reflect competitive realities.

To begin, the model did not even purport to analyze the two product markets that the Commission defined. The Commission, for example, *excludes* all tertiary services from its GAC market. (OP-22-23–JA47-48). Town, by contrast, *includes* certain tertiary services in his GAC market (Town, Tr. 3995, 4011-15–JA2442-47; PX02148 at 22-23–JA1071-72, *in camera*), and even more tertiary services in his econometric model. (Town, Tr. 4291-95, 4357-58–JA2482-87, 2491-92). Likewise, while the Commission defined a *separate* inpatient OB market, (OP-52-53–JA77-78), Town's GAC inpatient services *included OB*, and he never analyzed a separate OB market. (Town, Tr. 4248, 4290-94–JA2478, 2482-86). Thus, the Commission relies on Town's model to predict unilateral effects *in markets that Town did not even analyze*. Accordingly, as Commissioner Rosch observed, Town's model is "not an appropriate basis on which to find that the transaction will result in unilateral effects." (COP-4–JA88).

The Commission also ignored other fundamental failings in Town's simulation. For example, Town omitted certain key variables, variables that economists (including FTC economists) routinely include in regressions seeking to explain hospital pricing. (Guerin-Calvert, Tr. 7505-06, 7510–JA2530-32). Including these variables indisputably alters Town's pricing predictions, undermining Town's conclusions. (Guerin-Calvert, Tr. 7510, 7512-33, 7539-40–JA2532-56; RX-71(A) at 79-82, Tables 9-10–JA1770-73, *in camera*).

The Commission seeks to explain away this error. It asserts that the additional variables are not appropriate because they are correlated with certain variables that Town had already included in his regressions, and that given the relatively small data pool, their addition would increase standard errors and reduce the precision of Town's estimates. (OP-49-51–JA74-77). But, the Commission offers no substantive rationale for excluding these factors that are known to affect hospital prices, such as case-mix index ("CMI"), Medicare and Medicaid discharges, and other measures of cost and quality—variables routinely used by FTC economists (and Town himself) in examining hospital price-setting. (Guerin-Calvert, Tr. 7505-06, 7510–JA2530-32; RX-71(A) at 77-79–JA1768-80, *in camera*). If there is insufficient data to allow analysis with all of the requisite variables, that is a failure of proof, not a reason for the Commission to cherry-pick certain variables to manufacture its desired result. (*See* OP-51–JA76).

Further highlighting the problems in Town's study and the Commission's selective exclusion of variables, the study is immediately undermined by the alternative specification that Town proposed. In particular, Town suggested replacing one key variable (willingness-to-pay) with another (an HHI-based variable) to prove his model's robustness. (PX02148 at 59, n. 184–JA1108, *in camera*). Running that alternative specification, however, and again including the same variables that Town had incorrectly omitted in his primary specification,

leads to a conclusion of no statistically-significant joinder-related price effect. (Guerin-Calvert, Tr. 7530–JA2551; RX-71(A) at 81, Table 9–JA1772, *in camera*) (noting that Town's alternative model predicts widely-ranging price effects from an increase to no effect at all). Thus, the model cannot support a conclusion that the joinder will substantially increase prices in Toledo.

On top of these econometric errors, the Commission failed to identify the time period over which the projected future price increases would occur. Town admitted that he could not even narrow the timeframe to less than 20 years. (Town, Tr. 4256-57–JA2480-81). Given that hospital prices generally increase anyway, without defining a timeline for Town's predicted increases, the Commission has no basis to conclude the joinder will lead to supra-competitive prices at any point in time. *See Mercy*, 987 F. Supp. at 973; *Kraft*, 926 F. Supp. at 358-59.

In short, Town's model does not constitute substantial evidence of unilateral effects.

* * *

For the above reasons, the Commission's anticompetitive-effects analysis is a house of cards. It rests on the legally-flawed foundation of an inappropriate market-concentration-based presumption, and then builds on that improper presumption by inappropriately rejecting ProMedica's evidence (often again

relying on legally-erroneous market-concentration-based presumptions) while crediting "evidence" from the Commission's expert that falls well short of reliability and from MCOs that is based on speculation and conjecture. Simply put, the Commission did not meet its burden of showing anticompetitive effects.

III. Even If The Joinder Is Anticompetitive, The FTC Erred In Ordering Divestiture.

The Commission also erred in fashioning a remedy. As this Court has noted, the Commission has "wide latitude" to fashion an appropriate remedy—one designed to restore the competition lost through a joinder. *Seeburg Corp. v. FTC*, 425 F.2d 124, 129 (6th Cir. 1970). Here, even if the Commission had met its burden on liability, the appropriate remedy is clear—a conduct-based remedy that ensures that St. Luke's independently negotiates with MCOs would eliminate any competitive harm, while simultaneously preserving St. Luke's future viability, a result divestiture needlessly puts at risk. (ID-207–JA303). The Commission selected a different remedy because it wrongly understood the law as essentially *requiring* divestiture absent "special circumstances."

The Commission is "clothed with wide discretion in determining the type of order that is necessary to bring an end to the unfair practices found to exist." *Chicago Bridge*, 534 F.3d at 441 **(***quoting FTC v. Nat'l Lead Co.*, 352 U.S. 419, 428 (1957)); s*ee also Toys "R" Us*, 221 F.3d at 940 (noting that the "remedial decree [there] falls within the broad discretion [the Commission] has been granted

under the FTC Act"). "The key to the whole question of an antitrust remedy is of course the discovery of measures effective to restore competition." *United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 326 (1961). To that end, decisionmakers must exercise their "sound discretion as to how the public and private interests in effective enforcement of the antitrust laws can best be effectuated …." *Cia. Petrolera Caribe, Inc. v. Arco Caribbean, Inc.*, 754 F.2d 404, 430 (1st Cir. 1985).

Here, had the Commission appropriately exercised its discretion, the proper result was clear. It is well settled that remedial orders must not be overbroad or punitive, *In re The Raymond Lee Org.*, No. 9045, 1978 FTC LEXIS 124 at *227-28, 337-52 (FTC Nov. 1, 1978); *N. Tex. Specialty Physicians v. FTC*, 528 F.3d 346, 371 (5th Cir. 2008), and must be "reasonably related to the violation found." *Seeburg*, 425 F.2d at 129. Moreover, where equally-effective remedies other than divestiture are available, "due regard should be given to the preservation of substantial efficiencies or important benefits to the consumer in the choice of an appropriate remedy." *In re Retail Credit Co.*, No. 8920, 1978 FTC LEXIS 246 at *260-61, *341 (FTC July 7, 1978).

ProMedica offered a remedy designed to ensure that St. Luke's would continue to act as a separate entity in negotiations with MCOs. Specifically, ProMedica proposed separate (and firewalled) MCO negotiation teams for its three

existing Toledo hospitals (TTH, Flower and Bay Park) on the one hand, and St. Luke's on the other, and further proposed additional constraints (*e.g.*, that St. Luke's could join a particular MCO network independent of other ProMedica hospitals) designed to ensure true independence. (ID-204–JA300). Accordingly, if St. Luke's acted as a pre-joinder pricing constraint on ProMedica, it would continue to do so.

Not surprisingly, the ALJ found that ProMedica made a "cogent argument" that its proposed remedy "would restore ProMedica's bargaining power to its pre-Joinder state and preserve St. Luke's as a competitive restraint." (ID-207–JA303). Further, the ALJ found that ProMedica's proposed remedy "would enable St. Luke's to continue to benefit from ProMedica's stronger financial resources, and, thereby, preserve St. Luke's viability, to the benefit of consumers." (ID-207–JA303).

The joinder's structural aspects further make it a particularly strong candidate for a conduct remedy. The joinder, which preserves a largely-independent St. Luke's board, includes separation not typically seen in corporate mergers. This separation will promote the independence the firewall is also designed to achieve.

Especially given this structural reality, the appropriateness of a conduct remedy is compelling. Indeed, the record is clear that divestiture would deprive St.

Luke's, and the community, of many of the joinder's already-realized efficiencies and benefits,[11] and also deprive St. Luke's and the community of future benefits.[12]

The Commission arrived at a different result—ordering divestiture—only because it improperly thought itself constrained to do so. And, while the Commission's remedial determinations are reviewed under an abuse of discretion standard, it is well settled that an agency abuses its discretion when "the agency, in making a discretionary determination, has misunderstood or misapplied the governing law." *Abu Hasirah v. Dep't of Homeland Sec.*, 478 F.3d 474, 476-77 (2d Cir. 2007) (citation omitted); *see also Billings v. Reich*, No. 92-3927, 1994 U.S. App. LEXIS 13250, *4 (6th Cir. June 1, 1994) ("Upon reviewing the agency's decisions, an abuse of discretion will be found if … the agency's decisions … [are] based on a misunderstanding of the law.") (citation omitted).

[11] Joinder benefits include: St. Luke's participation in ProMedica's obligated group, thereby lowering interest costs (Hanley, Tr. 4676-77–JA2493-94; RX-907–JA2159-70; RX-350 at 1–JA2156); reducing St. Luke's malpractice insurance costs (Hanley, Tr. 4680); contributions from ProMedica allowing St. Luke's to meet its underfunded pension-plan obligations (Hanley, Tr. 4678–JA2495; RX-1855 at 24–JA2220, *in camera*).

[12] In 2012 and 2013, St. Luke's will receive $20 million in additional capital under the joinder for projects, including electronic medical records necessary to meet government requirements. (Hanley, Tr. 4679–JA2496; Johnston, Tr. 5375–JA2498; RX-31 at 11-12–JA1416-17, *in camera*; RX-1858 at 17-18–JA2275-76, *in camera*, RX-1855 at 24–JA2220, *in camera*).

Here, the Commission misunderstood the law governing its remedial authority. Rather than recognizing its "wide latitude," it started from a virtual mandate in favor of divestiture, absent "special circumstances" identical to those present in *Evanston*. (OP-57-58–JA82-83 ("Unlike *Evanston*, this case does not present special circumstances that warrant a departure from the preferred structural remedy.")). According to the Commission, because "[t]he circumstances in this case are markedly different from *Evanston*," a conduct remedy was essentially off the table. (OP-57–JA82).

While some courts in merger cases have referred to divestiture as a "preferred remedy," *see California v. Am. Stores Co.*, 495 U.S. 271, 280-81 (1990), nowhere does case law suggest that divestiture is a *mandatory* remedy, or that courts (or the Commission) cannot fashion some *other* relief absent "special circumstances." Indeed, the Commission itself has stated that divestiture is not an "automatic sanction, mechanically invoked in merger cases." *In re Retail Credit*, 1978 FTC LEXIS at *260.

Belying a mandate for divestiture, courts and other antitrust enforcers have increasingly turned to conduct remedies (*i.e.*, remedies like the one ProMedica urged here). In June 2012, Geisinger Health System entered a Consent Order in the Middle District of Pennsylvania in which the Pennsylvania Attorney General ("AG") allowed Geisinger's acquisition of Bloomsburg Hospital to proceed subject

to certain conduct restrictions, including contracting restrictions between Geisinger and MCOs. The AG noted the conduct remedy was appropriate, in part, due to Bloomsburg's weakened financial condition.[13] *Commonwealth v. Geisinger Health Sys. Found.*, No. 4:12-cv-01081 (M.D. Pa. June 7, 2012). A past Commission Chairman has similarly noted that conduct remedies allow merger parties to achieve claimed efficiencies while providing the Commission the "opportunity to observe whether anticompetitive effects actually emerge." Robert Pitofsky, Chairman, Fed. Trade Comm'n, *A Slightly Different Approach to Antitrust Enforcement – Prepared Remarks before the Antitrust Section of the American Bar Association* (Aug. 7, 1995). On numerous other occasions, courts, the DOJ, and the Commission have determined that conduct remedies were appropriate, even absent "unique" or "special" circumstances.[14]

In short, the Commission should have freely considered all "measures effective to restore competition," but instead started from a nearly mandatory

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[13] Similarly, here, the ALJ noted ProMedica's conduct remedy would preserve St. Luke's financial viability. (ID-207–JA303).

[14] *See, e.g. Commonwealth v. Providence Health Sys., Inc.*, No. 4:94-cv-00772 (M.D. Pa. May 24, 1994) (consent decree authorizing hospital merger subject to restrictions on operations and pricing); *In the Matter of Talx Corp.*, 2008 WL 3587473 (FTC Aug. 8, 2008) (FTC Order imposing conduct restrictions in lieu of divestiture); *United States v. Northrop Grumman Corp.*, 2003 WL 21659404 (D.D.C. June 10, 2003) (consent decree settling antitrust claims based on conduct restrictions).

divestiture presumption. That was legal error. Accordingly, even if the Court finds that the joinder violates the Clayton Act (and it should not), ProMedica's conduct-based remedy is the appropriate remedy.

CONCLUSION

For the above reasons, the Court should reverse the Commission's determination that the joinder violates Clayton Action Section 7, or alternatively vacate the Commission's Order imposing divestiture and instead adopt ProMedica's proposed conduct remedy.

Respectfully submitted,

By: /s/ Douglas R. Cole

Counsel for Petitioner, ProMedica Health System, Inc.

CERTIFICATION OF COMPLIANCE

Pursuant to F.R.A.P. 32(a)(7)(C), the undersigned counsel hereby certifies that the attached brief, including headings, footnotes and quotations, and excluding the corporate disclosure statement, tables of contents and authorities, and the statement in support of oral argument, contains 13,985 words, as counted in Microsoft Word, and is, therefore, in compliance with F.R.A.P. 32(a)(7)(B).

/s/ Douglas R. Cole
Counsel for Petitioner, ProMedica Health System, Inc.

CERTIFICATE OF SERVICE

I hereby certify that on this 17th day of September, 2012, the undersigned caused the foregoing brief to be electronically filed with the Clerk of the United States Court of Appeals for the Sixth Circuit using the CM/ECF system, which will send by email a Notice of Docket Activity to all counsel of record in the electronic filing system. No other counsel were served.

/s/ Douglas R. Cole

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