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

Reply Brief of Petitioner ProMedica Health System, Inc.

ORAL ARGUMENT REQUESTED

Douglas R. Cole (OH0070665)
(drcole@ocslawfirm.com)
Erik J. Clark (OH0078732)
ORGAN COLE + STOCK LLP
1335 Dublin Road
Suite 104D
Columbus, Ohio 43215
614.481.0900
614.481.0904(f)

David Marx, Jr.
(dmarx@mwe.com)
Stephen Y. Wu
Erin C. Arnold
McDermott Will & Emery LLP
227 West Monroe Street, Suite 4400
Chicago, Illinois 60606
312.372.2000
312.984.7700 (f)

Attorneys for Petitioner
ProMedica Health System, Inc.

Jennifer L. Westbrook
(jwestbrook@mwe.com)
Carrie G. Amezcua
James B. Camden
McDermott Will & Emery LLP
600 13th Street, N.W.
Washington, D.C. 20005-3096
202.756.8000
202.756.8087 (f)

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

FTC Cases

Statutes

Government Publications

Other Authorities

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

INTRODUCTION

The FTC acts as though this case merely involves a substantial evidence review of FTC factual determinations, but that is not so. ProMedica is not asserting simply that the FTC reached the wrong *results*, but also that the FTC asked the wrong *questions*. More specifically, ProMedica showed that the FTC used the wrong analytical framework to address the three issues that ProMedica raises: (1) cluster-market definition, (2) the likelihood of anticompetitive effects, and (3) the appropriate remedy. Questions about analytical frameworks are *legal* questions, which this Court reviews *de novo*. On each of these issues, ProMedica's analytical framework is correct, and the FTC has not shown otherwise. Having asked the wrong questions, the FTC's answers carry no weight. The FTC thus failed to carry its burden, either in establishing a violation or selecting a remedy.

On the market-definition front, all agree that the relevant market is a cluster market consisting of general acute care ("GAC") inpatient services. The key dispute—a legal dispute—is the framework for determining which individual services to include in, and exclude from, that cluster. ProMedica showed that cluster markets, like product markets generally, must be defined by demand-side market realities. In particular, decisionmakers should look to how consumers *purchase* the cluster. Here, the undisputed evidence shows that MCOs purchase all GAC services that a given hospital provides—including tertiary and obstetric

("OB") services—as a single "cluster." The FTC, while disclaiming a supply-side approach, asks the Court to define the cluster based on a supply-side characteristic —the number of providers for a given service. Calling this characteristic a "competitive condition," *see* FTC Br. at 30, does not change that this is fundamentally a supply-side approach, and thus inconsistent with the FTC's own guidelines.

On anticompetitive effects, the FTC agrees that this is solely a unilateral-effects case. In such cases, as the FTC's own economists note, substitutability of the merging parties, not the parties' respective market shares, is the key. Both before and after the transaction, the relevant customers—managed care organizations ("MCOs")—found ProMedica and Mercy Health Partners ("Mercy"), each with three hospital locations and comprehensive services, to be each other's closest substitute and primary pricing constraint for the full GAC services cluster. No MCO found that St. Luke's, even when it was healthier, played that role.

With no good argument on substitutability, the FTC relies heavily on a strong market-share-based presumption of anticompetitive effects, and then asks whether ProMedica has overcome that presumption. But ProMedica's point—again a purely legal one—is that strong market-share-based presumptions have no place in differentiated-products unilateral-effects cases. In making this argument,

ProMedica is not asking this Court to "jettison" decades of antitrust law. (FTC Br. at 33). The "decades of case law" to which the FTC refers involve *coordinated-effects* cases. And, compounding its erroneous anticompetitive-effects analysis, the FTC fails to offer substantial evidence that prices would rise to *anticompetitive* levels, the only relevant inquiry in an antitrust case.

Finally, the FTC erred in selecting a remedy. While the FTC now *claims* that it did not start with a strong presumption that divestiture was required unless this case mirrored *Evanston Northwestern Healthcare*, the Opinion's language shows otherwise. Absent that inappropriate presumption, the proper remedy here is clear. The FTC admits that it must fashion a remedy that gives due regard to community benefits and restores competition without being punitive or overbroad. Here, a conduct remedy prevents *any* competitive harm, while preserving the important community benefits that St. Luke's provides, benefits that will almost certainly disappear under divestiture.

ARGUMENT

The FTC does not dispute that it must prove both (1) a relevant product market and (2) a substantial likelihood of "demonstrable and substantial anticompetitive effects" in that properly-defined market. *See, e g., New York v. Kraft Gen. Foods, Inc.*, 926 F. Supp. 321, 358 (S.D.N.Y. 1995). The Commission failed to prove either.[1] The Commission also erred in selecting a remedy.

I. The Commission Erred As A Matter Of Law In Its Product-Market Definition.

All readily acknowledge that no cross-elasticity of demand exists for different hospital services. Hip replacement patients do not substitute an appendectomy based on price. Thus, the Commission is correct that "each individual inpatient service is potentially a distinct relevant product market," at least from the patients' perspectives. (FTC Br. at 25). But that statement is irrelevant, for, as the Commission concedes, "the parties also agreed that rather than analyzing each service line separately, it is appropriate to define a cluster market consisting of GAC inpatient hospital services." (*Id*.).

[1] The Commission challenges the applicable standard of review when ALJ and Commission findings differ. (FTC Br. at 17). This Court has noted that "[w]here the Commission overturns findings of fact of a hearing examiner, this conflict in fact findings is to be considered by a reviewing court." *American Cyanamid Co. v. FTC*, 363 F.2d 757, 772-773 (6th Cir. 1966).

The relevant question, then, is how to define that cluster—that is, what individual services should be included or excluded? The analytical framework for assessing cluster-market composition is a legal question, which, the FTC concedes, receives *de novo* review. (*See* FTC Br. at 17). *See also Chicago Bridge & Iron Co. N.V. v. FTC*, 534 F.3d 410, 422 (5th Cir. 2008) (courts "review *de novo* all legal questions pertaining to Commission orders").[2]

Cluster-market definition, like product-market definition generally, requires a demand-side analysis. The proper question is: what collection of services do consumers treat as a single unit for purposes of negotiations and pricing? Indeed, "[a] cluster market exists only when the 'cluster' is *itself* an object of consumer demand." *Green Country Food Market, Inc. v. Bottling Group, LLC*, 371 F.3d 1275, 1284 (10th Cir. 2004). Stated alternatively, "[a] cluster market is recognized where the product package is significantly different from, and appeals to buyers on a different basis from, the individual products considered separately." *Lucas Automotive Engineering, Inc. v. Bridgestone/Firestone, Inc.*, 275 F.3d 762, 768 (9th Cir. 2001) (quotation omitted). And this analysis must turn on "trade

[2] The FTC's reliance on the district court's preliminary injunction opinion (FTC Br. at 3, 26) is misplaced, as that opinion lacks precedential value in this merits proceeding. *Univ. of Tex. v. Camenisch*, 451 U.S. 390, 394-395 (1981) ("the findings of fact and conclusions of law made by a court granting a preliminary injunction are not binding at trial on the merits").

realities." *See United States v. Philadelphia National Bank*, 374 U.S. 321, 357 (1963) (cluster must be "meaningful in terms of trade realities").

Here, the undisputed evidence regarding "trade realities" showed that the cluster that "appeals to buyers" (*i.e.*, MCOs), or that is the "object of consumer demand," is the group of *all* GAC services that a given hospital provides—including tertiary and OB services. MCOs demand all such services in a single transaction; they do not independently demand tertiary or OB services. From a demand-side perspective, MCOs include tertiary and OB services with appendectomies, orthopedic surgeries, and the other GAC services—all of which MCOs negotiate for as a single cluster, with common and interdependent pricing and discounting across that cluster. MCOs do not negotiate on an *a la carte* basis.

The Commission, however, remains steadfast both in its refusal to account for "market realities" and its unwillingness to address ProMedica's arguments directly. The FTC claims, for example, that OB services should be a separate market because OB services meet *Brown Shoe's* practical indicia for a separate product market. (FTC Br. at 27-28 (*citing Brown Shoe Co. v. United States*, 370 U.S. 294 (1962))). *Brown Shoe*, however, is about *product-market* definition, not *cluster-market* definition, and thus provides no assistance on the relevant question here. Certainly OB services are a different *product* from an appendectomy in the substitutability sense, but that does not determine whether OB services are

properly included in the GAC cluster. The FTC's argument that OB services pass the hypothetical monopolist test is likewise meaningless. (FTC Br. at 28). Each service in the GAC cluster would satisfy the test—medical procedures are not substitutable—but again that offers no assistance in defining cluster boundaries.

Nor does the FTC improve its argument by noting that the merging hospitals track shares in OB separately from certain other hospital services. (*Id*. at 28). The same is also true for cardiology and certain other services, (PX01077 at 004, PX00009 at 22), but no one has suggested that is a reason for removing those services from the cluster.

With these diversions out of the way, the FTC reveals its cluster-market analysis for what it really is—a supply-side exercise. The FTC claims that "OB services are offered under different competitive conditions," but the only "difference" it notes is that the joinder "leaves only two competitors offering inpatient OB services, compared to three competitors offering [other] GAC services." (FTC Br. at 29). Number of suppliers, however, is purely a supply-side consideration. Thus, while the FTC blithely *claims* that its reliance on "competitive conditions … does not transform the Commission's product market analysis into a supply-side definition," (*id*. at 30), its actual argument shows otherwise.

The FTC's assertion that precedent supports its count-the-suppliers approach is wrong. (*Id*. at 26). The court in *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290-91 (W.D. Mich. 1996), *aff'd* 121 F.3d 708 (6th Cir. 1997), did not exclude outpatient services from the cluster because "the competitors for those services differ" as the FTC claims. (FTC Br. at 26). Rather, it excluded outpatient services because substitutability between inpatient and outpatient services was based not on cost, but instead "is a function of medical judgment," meaning that a "small but significant increase in the price of the inpatient services" would not cause substitution to outpatient services. The same is true of both *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990), and *In re Evanston Nw. Healthcare Corp.*, 2007 FTC LEXIS 210 at *46-47 (FTC Aug. 6, 2007). (*See* FTC Br. at 26). The point of those cases is that, where two procedures—one inpatient and one outpatient—exist for treating a given condition, they should not be treated as the same product, as substitution does not occur based on price. Whatever the merits of that position, it has nothing to do with any question at issue here.

Besides mischaracterizing both its own argument and the case law, the FTC also misstates ProMedica's argument. The FTC characterizes ProMedica as claiming that MCOs demand that every hospital must provide every GAC service, when, the FTC notes, the market reality is that "MCOs do *not* demand the full

range of GAC services from each hospital provider." (FTC Br. at 30). That is a strawman. ProMedica has never asserted that the cluster should be defined as the group of services that every participant provides. Indeed, ProMedica argued directly the opposite, citing Supreme Court precedent. (*See* ProMedica Br. at 27 (*citing United States v. Grinnell Corp.*, 384 U.S. 563, 572, n.6 (1966))). Rather, ProMedica's point is that "commercial reality," *see id*. at 572, shows that MCOs undertake a single negotiation for every GAC service *that a given hospital provides*. And the record shows that no MCO purchases from ProMedica, Mercy, or the University of Toledo Medical Center ("UTMC"), just the particular GAC services subset that St. Luke's offers. (ID-143–JA239). From a demand-side perspective, the marketplace does not treat OB services or tertiary services differently from any other GAC service.[3] The FTC offers no evidence to the contrary. Moreover, the FTC made no findings that the "competitive conditions" of having fewer suppliers for OB services impacted the prices that MCOs paid.

[3] The FTC's argument that other services, such as outpatient and psychiatric services, are also included in that negotiation, but not in the GAC services cluster, proves nothing about market definition. To start, including GAC inpatient services with outpatient and psychiatric services in the same market would run counter to the cluster market analyzed in all modern hospital merger cases, GAC inpatient services. *Evanston*, 2007 FTC LEXIS 210 at *248. Moreover, neither the FTC nor ProMedica has ever asserted that these other services should be included in the GAC cluster. Finally, the evidence shows that MCOs negotiate and pay for outpatient and other services differently than they do for inpatient GAC services. (ID-143–JA219, Wachsman, Tr. 4900).

And, the record shows that MCOs negotiate and contract for tertiary services together with primary and secondary GAC services. (ID-142-43–JA238-39).[4]

Perhaps recognizing these flaws, the FTC downplays the significance of market definition, asserting that even under ProMedica's definition the market concentrations "exceed the thresholds for presumptive illegality." (FTC Br. at 23). That argument, however, fails for two reasons. First, as described below, the argument relies on the FTC's erroneous assertion that market shares create strong presumptions in differentiated-products unilateral-effects cases. (*See infra* 17-21). Second, the Clayton Act requires the FTC to prove a substantial likelihood of anticompetitive effects in an identified "line of commerce." 15 U.S.C. § 18. If the FTC fails to prove a proper "line of commerce," as it did here, it loses.

II. The Commission Committed Legal Error In Its Assessment Of The Likelihood Of Anticompetitive Effects.

In addition to the FTC's flawed cluster-market analysis, ProMedica showed the FTC's framework for assessing anticompetitive effects is also wrong, both as a matter of law and of economics. The FTC concedes that it relies solely on a differentiated-products unilateral-effects theory, and also admits that in such cases,

[4] The FTC's cluster-market analysis is not even internally consistent. St. Luke's did not offer high-risk OB services; only ProMedica and Mercy did. (Wakeman, Tr. 2755-2756; Shook, Tr. 1045). With fewer suppliers for high-risk OB services than non-high-risk OB services, under the FTC's theory the former should be a separate market.

substitutability is the key. Yet, the FTC's substitutability analysis is fatally flawed, as it focuses on the wrong consumer group—looking to *individual patients* when even the FTC's amicus concedes that *MCOs* are the relevant consumers for price-setting and network-formation purposes. Lacking any meaningful substitutability argument, the FTC instead presses for a strong market-share-based presumption of harm, but such presumptions have no place in cases such as this. Further compounding its error, the FTC fails to even ask whether prices will rise to *anticompetitive* levels, a necessary showing for a Clayton Act violation.

A. The FTC Concedes That This Is Solely A Differentiated-Products, Unilateral-Effects Case, And That Substitutability Is Thus Key.

A merger can lead to anticompetitive effects in two ways—coordinated effects and unilateral effects. The former refers to the potential for collusion among remaining post-merger competitors, while the latter rests on what the merged entity can do on its own. No one disputes that in coordinated-effects cases market concentration—typically measured by the Herfindahl-Hirshman Index ("HHI")—matters.[5] In other words, HHIs can have significant predictive value in assessing likely anticompetitive *coordinated* effects.

[5] The HHI is the sum of the squares of the individual firms' shares. U.S. Dept. of Justice and Fed. Trade Comm'n *Horizontal Merger Guidelines*, § 5.3 (2010) ("*Guidelines*").

In differentiated-products unilateral-effects cases the story is different. As DOJ's and FTC's own *Guidelines* and associated *Commentary* recognize, and economic literature confirms, HHIs play little role. "Indeed, market concentration may be *unimportant* under a unilateral effects theory of competitive harm." U.S. Dept. of Justice & Fed. Trade Comm'n, *Commentary on the Horizontal Merger Guidelines* (2006) (emphasis added).

The key issue, as the FTC agrees, is *substitutability*. (*See* FTC Br. at 48 ("Under a unilateral effects theory, the merger of close substitutes leads to increased bargaining leverage and higher prices.")). If close substitutes merge, they no longer act as price constraints on each other. If merger participants are *not* close substitutes, however, then no such concern exists, as the entities did not substantially constrain each other's pricing pre-merger. Thus, market-share statistics should give rise to, at most, a weak presumption of harm. The true focus must be substitutability.

B. The FTC's Substitutability Analysis Focused On The Wrong Market Participants, As The FTC's Own Amicus Confirms.

ProMedica showed that MCOs do not consider ProMedica and St. Luke's to be close substitutes. The FTC cannot dispute that fact, so it asks the Court to ignore MCOs and instead look to patients. But MCOs are the only "consumers" who negotiate pricing (moreover, as the FTC admits, they aggregate patient preferences). Thus, they are the relevant group for analytical purposes. In any

event, the FTC failed to show that even patients consider St. Luke's to be ProMedica's next-best substitute.

Antitrust law is concerned about competitive effects—principally the power to raise prices above competitive levels. *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 136 (E.D.N.Y. 1997). Thus, in merger analysis, the question is—how will consumers respond to price increases? Here, the only consumers who respond to price increases are MCOs. One need not take ProMedica's word for that. The FTC's amicus, AHIP, an MCO trade group, explains the central role that MCOs play in hospital rate-setting:

> In a competitive effects analysis of a hospital merger, health plans are relevant consumers in that they negotiate with the hospital for rates and other terms and conditions of service on behalf of their customers and their members.

(AHIP Br. at 7). AHIP further explains that "individuals and consumers receive the benefits of competition among hospitals *through negotiations undertaken by health plans*." (*Id*. (emphasis added)). In short, MCOs are the relevant consumers. *See FTC v. Freeman Hosp.*, 69 F.3d 260, 270 n. 14 (8th Cir. 1995) ("in health care, 'consumers' often means not individual patients but large purchasers of health care such as managed care coalitions").

The FTC does not dispute that MCOs testified that (1) they could not substitute St. Luke's for ProMedica in their networks, (2) that Mercy, not St. Luke's, was ProMedica's closest substitute, and (3) that ProMedica was Mercy's.

(ID-157–JA253). Thus, Mercy, not St. Luke's, constrained ProMedica's pricing. Faced with this testimony, the FTC punts—asking this Court to look to patients, notwithstanding its own amicus. It does so under the theory that "an MCO's demand for hospital services is largely derived from the aggregation" of patient preferences. (FTC Br. at 52-53). But that means that MCO preferences *already reflect* patient preferences, or, in AHIP's words, "[t]he plans' preferences necessarily reflect the preferences of the consumers." (AHIP Br. at 7). The FTC offers no reason to count the patients' preferences *twice*.

Moreover, even if patient preferences are recounted separately, the FTC has not shown that any particular ProMedica hospital and St. Luke's are next-best substitutes for any significant number of patients. Certainly, the FTC *asserts* that is the case (*see* FTC Br. at 49), but the FTC has never clearly indicated *which* ProMedica hospital is allegedly St. Luke's closest substitute. The record reflects the reason for the FTC's reluctance—St. Luke's *and UTMC* are actually each other's closest substitute hospitals. (ProMedica Br. at 46).

The FTC seeks to bolster artificially its claims of closeness by focusing on a "core service area" (*i.e.*, the zip codes around St. Luke's), in which it argues that "ProMedica and St. Luke's have the first and second-largest market shares." (FTC Br. at 49). That argument fails, however, for at least three independent reasons. First, the parties agree that the relevant geographic market is Lucas County, which

means that consumers view *all* hospitals in Lucas County as reasonable alternatives. The FTC cannot focus on only a portion of that agreed market. *See Morgan, Strand, Wheeler & Biggs v. Radiology, Ltd.*, 924 F.2d. 1484, 1490 (9th Cir. 1991). That is especially true here, as MCOs and hospitals do not set rates based on patient zip codes, meaning that hospitals have no way of charging "core service area" patients more than other patients. Thus, ProMedica could not achieve supra-competitive pricing from this subset, even if the FTC's substitutability claim were true. Second, the FTC offers no evidence that "core service area" share reflect each hospital's "relative appeal as a second choice" which is required for market shares to serve as proxies for substitutability. (*See infra* at 19-20). Third, the FTC core-service-area consumer surveys (*see* FTC Br. at 49) are fundamentally flawed. Most notably, (1) they canvassed only 400 residents out of the 138,000 in the "core service area," and, (2) nearly 40% of those surveyed were 65 or older, and thus presumably Medicare recipients, meaning they were not part of the relevant market.[6] (PX01352-006–JA2896; PX01169-003, 005–JA2829, JA2831).

[6] With respect to Professor Town's flawed diversion analysis (FTC Br. at 49-50), the FTC omitted his results for St. Luke's largest MCO, which accounted for more patients than the five other MCOs he analyzed combined. Those results showed that *Mercy* and St. Luke's were closer substitutes than ProMedica and St. Luke's. (RX-71(A) at 000191–JA1182; Town, Tr. 4338-40).

Stripped of its chaff, the FTC's real theory is clear—*any* change to a walk-away network is *per se* anticompetitive: "As a result of the Joinder, the possible alternative network available to MCOs if they do not reach agreement with the combined ProMedica-St. Luke's has changed." (FTC Br. at 47). But the ineluctable result of that reasoning is that no local hospital joinder would ever be lawful—joinders *always* change the walk-away network. That is not the law, nor should it be.

Changes in walk-away networks matter *only if* the change removes a substantial competitive constraint. Both pre- and post-joinder, Mercy was (and is) ProMedica's chief substitute, and thus constrained (and will constrain) ProMedica's pricing. The joinder does not change that competitive reality, and thus creates no likelihood of substantial anticompetitive unilateral effects. Indeed, the MCOs' past success in marketing narrow networks in Toledo (ProMedica Br. at 14) means that MCOs can resist supra-competitive rate increases. That MCOs have not specifically offered a Mercy-UTMC network in the past is immaterial, as the FTC's static analysis fails to consider "where consumers *could* practicably go for inpatient hospital services," *FTC v. Tenet Health Care Corp.*, 186 F.3d 105, 1054 (8th Cir. 1999) (emphasis added), nor does it account for the fact that a ProMedica-UTMC network has been successfully offered by two different MCOs. (IDF ¶¶157-162–JA117-118; 172-180–JA119).

C. The FTC Relied On An Improper Presumption In Finding Competitive Harm.

With no good substitutability argument, the FTC falls back on its improper structural presumption. Both in its opinion and its briefing, the FTC started from a strong presumption of anticompetitive harm based solely on HHIs, and then considered whether ProMedica had rebutted that presumption. ProMedica showed the FTC was wrong to impose that burden, which infected the FTC's entire analysis. (ProMedica Br. at 38-41).

In response, the FTC claims that ProMedica's attack on this strong market-share-based presumption in a differentiated-products unilateral-effects case—a challenge that rests squarely on the DOJ's and FTC's *Guidelines* and articles drafted by key DOJ and FTC economists—would somehow "jettison half a century of judicial precedent." (FTC Br. at 33). The FTC's hyperbole reveals the weakness of its argument.

To start, unilateral-effects theory is not even "half a century" old. It first appeared in the 1992 *Guidelines*. Cases from before then, of course, involved *coordinated effects*, and ProMedica agrees with using HHIs in such cases.

For the same reason, the FTC's cited cases on HHIs are irrelevant. In chastising ProMedica for ignoring "modern antitrust jurisprudence," the FTC cites *FTC v. H.J. Heinz Co.*, 246 F.3d 708 (D.C. Cir. 2001). That was a *coordinated-effects* case, and the court expressly tied the HHI-based presumption to that fact:

> Merger law 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. Increases in concentration above certain levels are thought to raise a likelihood of *interdependent* anticompetitive conduct.

Id. at 715-16 (emphasis added, citations and quotations omitted). Similarly, in *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1281 n.24 (11th Cir. 1991), (FTC Br. at 34), the court noted that "significant market concentration makes it easier for firms in the market to *collude*, expressly or tacitly …." Two of the remaining three cases the FTC cites, *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321 (1963), and *Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410, 423 (5th Cir. 2008), likewise do not analyze (or even mention) unilateral effects. Whatever the merits of these cases, they say *nothing* about using strong market-share-based presumptions in differentiated-products unilateral-effects cases.

The remaining case—the only case the FTC cites that discusses unilateral effects—*United States v. Oracle Corp.*, 331 F. Supp.2d 1098 (N.D. Cal. 2004), supports ProMedica. The *Oracle* court expressly notes that "a strong presumption of anticompetitive effects based on market concentration is especially problematic in a differentiated products unilateral effects context." *Id*. at 1122. The FTC tries to sidestep this language by asserting that it involves a separate market share benchmark "not at issue here," but that is not so. (FTC Br. at 34-35). The *Oracle* court criticizes the use of market concentration *generally* in unilateral-effects cases

(as quoted above), and also goes on to specifically note that a 35% benchmark is problematic, stating that anticompetitive effects should be presumed only if the merging parties "would have essentially a monopoly or dominant position," *id*., a position that ProMedica does not occupy given the strong competition from its chief rival, Mercy, and from UTMC.

The FTC similarly fails to refute the academic literature reinforcing this point. According to the FTC, both Jonathan Baker and Carl Shapiro state that market share "remains important," and that "[a]ll else equal, greater market share makes both coordinated effects and unilateral effects more likely …." (FTC Br. at 35, *quoting* Jonathan B. Baker & Carl Shapiro, *Reinvigorating Horizontal Merger Enforcement*, in HOW THE CHICAGO SCHOOL OVERSHOT THE MARK 239 (Robert Pitofsky ed., 2009)). But, the phrase "all else equal" masks much. In particular, as Shapiro explained more recently, market shares matter only if they are a *proxy* for substitutability. Carl Shapiro, *The 2010 Horizontal Merger Guidelines: From Hedgehog to Fox in Forty Years*, 77 ANTITRUST L.J. 49, 61-62 (2010). That proxy relationship exists, however, *only if* "certain conditions" are met—in particular that "each product's market share is reflective of not only its relative appeal as a first choice to consumers of the merging firms' product but also its relative appeal as a second choice, and hence as a competitive constraint to the first choice." *Id*.

The FTC provided no meaningful evidence on this issue. The FTC claims that "[t]he hospital with the second-highest market share in an areas is likely to be the closest substitute for the hospital with the highest market share," (FTC Br. at 49), but the sole citation it provides—Wakeman, Tr. 2507 (JA3194)—*shows no such thing*. Wakeman says *nothing* about whether GAC services market shares reflect patients' *second* choices. (Generally speaking, of course, market shares reflect the percentage of consumers for whom the firm is the *first* choice.) Moreover, St. Luke's actual losses and gains in patient volume (as St. Luke's left and re-entered MCO networks) came to and from *UTMC*, refuting the FTC's logical leap. Absent evidence on the second-choice issue, though, "there are no obvious systematic relationships among market shares and cross-price derivatives of demand." Shapiro, *Hedgehog* at 62. For just that reason, the 2010 *Guidelines*, which "reflect the substantial changes in economic learning and Agency practice since 1992," have "reduced emphasis on market shares." *Id*. at 65.

In sum, in differentiated-products unilateral-effects cases, market-share statistics generally do not create a strong presumption of anticompetitive effects absent evidence of certain specific "conditions" not shown here. *See FTC v. CCC Holdings, Inc.*, 605 F. Supp.2d 26, 70 (D.D.C. 2009) (rejecting market-share-based presumption in unilateral-effects case where there was no showing that market shares were good proxy for substitutability). Indeed, even in coordinated-effects

cases, antitrust jurisprudence has long understood that market shares are not the end of the story, only the beginning. *See generally United States v. General Dynamics Corp.*, 416 U.S. 486 (1974). In differentiated-product unilateral-effects cases, they are barely even a beginning. The FTC erred as a matter of law in imposing a strong market-share-based presumption.

Trying to minimize its error, the FTC now claims that this presumption was not integral to its liability finding, (FTC Br. at 36), and that the MCO testimony and Town's model are *independent* bases for establishing liability, (*id.* at 40). As shown below, that evidence does not establish an anticompetitive price increase. (*See infra* 23-28). But more fundamentally, in its opinion, the FTC merely noted that this evidence "*buttresse[d]* their structural showing." (OP-35–JA60). And even here, the FTC characterizes Town's model only as "highly *consistent with* the structural analysis." (*Id*. at 57 (emphasis added)). In short, at every turn, the FTC has reviewed the evidence through the lens of its (misplaced) strong structural presumption. Because the FTC put a thumb—or an entire arm—on the anticompetitive-effects scale through this unwarranted presumption, ProMedica's rebuttal evidence was held to the wrong standard, destroying the reliability of the FTC's entire analysis.

D. The Same Flawed Reliance On Market-Share Statistics Also Plagued The FTC's Handling Of The Weakened-Competitor Evidence.

The FTC's erroneous fixation on market-share statistics likewise caused the FTC to wrongly discount ProMedica's weakened-competitor evidence. According to the opinion below, to rely on weakened-competitor evidence, ProMedica "must show not only that the acquired firm's financial difficulties would result in a decline in its market share in the future, but also that those declines would be enough to bring the merger below the threshold of presumptive illegality." (OP-32–JA57). The FTC's *per se* rule is nonsensical, however, as market shares do not create "thresholds of presumptive illegality" in differentiated-products unilateral-effects cases in the same way they do in coordinated-effects cases.

In its brief, *the FTC does not defend its stated rule*. Rather, having clearly discounted the weakened-competitor evidence because of the presumption, the FTC *now* claims that, in fact, it "carefully examined [that] evidence" and found that St. Luke's was merely "experiencing some financial difficulties," but that the situation was not "bleak." (FTC Br. at 37).

This response fails on two fronts. First, given the FTC's presumption, the FTC's claim of "careful examination" is suspect at best. Second, characterizing St. Luke's as merely experiencing "some financial difficulties" ignores reality. St. Luke's was hemorrhaging money and faced dire prospects. (ProMedica Br. at 10-

11). The ALJ recognized that its very *viability* was in doubt beyond the next few years. (ID-188–JA284). In light of these facts, the FTC's claim that St. Luke's was trending upward rings hollow. Given that reality, St. Luke's was not a meaningful competitive constraint on ProMedica, and ProMedica was entitled to a fair review of the evidence supporting that argument.

E. The FTC Has Not Shown A Likelihood Of An *Anticompetitive* Price Increase.

The FTC's anticompetitive-effects analysis suffers another independently fatal flaw—the FTC failed to prove a likely *anticompetitive* price increase. While the FTC argues that prices will *rise*, it does not show that they will rise to *anticompetitive* levels, the only relevant inquiry. (*See* ProMedica Br. at 48 (citing cases)).

The FTC does not dispute that St. Luke's pre-joinder rates were below cost. On average, St. Luke's lost money on every patient it treated. (ProMedica Br. at 11). With or without a merger, St. Luke's was going to raise prices. Given this history of unsustainably low prices, a prediction that St. Luke's prices would increase post-joinder, even if true, fails to prove the resulting prices are anticompetitive; yet, the FTC has offered nothing else of substance.

The documents in which St. Luke's management asserted that ProMedica's "leverage" with MCOs would allow St. Luke's to achieve higher rates post-joinder, for example, are not probative. (FTC Br. at 41). The FTC concedes that St.

Luke's management did not even *know* ProMedica's rates or contracting strategies. More importantly, St. Luke's does not suggest in those documents that the rates it might achieve, even if higher, would be supra-competitive. St. Luke's desired to "raise reimbursement rates *to the level of our competitors*"; that is a far cry from proof of anticompetitive prices. (FTC Br. at 41, *citing* PX01390-002–JA2914) (emphasis added)).

The FTC's reference to MCO testimony likewise fails. The FTC has no good response to cases such as *FTC v. Arch Coal*, 329 F. Supp.2d 109, 145 (D.D.C. 2004), which note that "antitrust authorities do not accord great weight to the subjective views of consumers in the market." *See also id*. ("the concern articulated by the customers is little more than a truism of economics: a decrease in the number of suppliers *may* lead to a decrease in the level of competition in the market"). The FTC contends that the *Arch Coal* testimony merely reflected "general anxiety about having one fewer supplier," whereas here, the MCO witnesses provided "specific rationales." (FTC Br. at 46). But, cross-examination revealed that the MCO witnesses' fears here similarly lacked foundation and amounted to "conjecture" and "imagined" prices increases. (ProMedica Br. at 55-56). The substantial evidence standard requires more.

In any event, the MCO testimony proves nothing. As the FTC admits, the MCO witnesses merely testified that they expected "St. Luke's rates to rise to the

level of ProMedica's other hospitals." (FTC Br. at 44). Nowhere has the FTC established that ProMedica's pre-joinder rates were anticompetitive. Thus, even if the MCOs are correct, that still fails to show *anticompetitive* price increases.

Nor does the MCO testimony show that *ProMedica's* rates would rise post-joinder. At bottom, the FTC wants this Court to believe, based largely on the MCO testimony, that the acquisition of St. Luke's changed ProMedica from a nearly-must-have to a must-have hospital system—in other words, that pre-joinder the MCOs could fashion a viable network without ProMedica (by including St. Luke's), but that post-joinder the MCOs could not. Again, no actual *evidence* supports this view. The MCO's speculation that they could not market a Mercy/UTMC network is just that—speculation. And while they now claim that St. Luke's had great competitive significance, their actions—paying St. Luke's below-market rates, or excluding it altogether from their networks—paint a far different picture.[7] To be sure, MCOs likely needed either ProMedica *or* Mercy (and, as the FTC candidly admitted in its brief, the MCOs likely strong preferred having *both*, FTC Br. at 8), but that was true both pre- and post-joinder. Thus, the joinder did not *enhance* ProMedica's pricing power.

[7] By the FTC's own admission, MCOs' actions reflect the individual patients' perceived value of St. Luke's, and are a more reliable indicator of substitutability than simple shares in the "core service area."

Nor does Professor Town's econometric analysis provide the missing evidence. While he at least attempted to quantify the joinder's alleged price effect (16.2%, *see* FTC Br. at 55), without an understanding of how far below competitive levels St. Luke's started, evidence regarding an estimated increase is meaningless. Indeed, the record shows that, even absent the joinder, St. Luke's would likely have achieved significant rate increases from at least some of its MCOs, increases that would *exceed* Town's projections. (ProMedica Br. at 50-51).

Regardless, Town's model was fatally flawed. For example, Town did not analyze the GAC cluster market that the Commission defined (*i.e.*, GAC without OB or tertiary). (ProMedica Br. at 59). Demonstrating chutzpah if nothing else, the FTC treats this fatal defect as a benefit, claiming that Town's model "does not require a precisely defined product market, and that is one of its strengths." (FTC Br. at 55). A model whose predictions do not depend on what it purports to analyze, however, is not particularly reliable. Indeed, in *CCC Holdings*, the court rejected an expert's econometric model when there was insufficient evidence that the subset of data analyzed reflected the product market as a whole. 605 F. Supp.2d 70-72. Here, Town did not even *attempt* to make his model match the FTC's defined product market. Town's model is, as Commissioner Rosch observed, "not an appropriate basis on which to find that the transaction will result in unilateral effects." (COP-4–JA88).

The FTC likewise falls short in explaining away Town's failure to include certain necessary variables in his regression. (*See* FTC Br. at 56). As ProMedica showed, in massaging his model to manufacture the FTC's desired results, Town excluded variables that are commonly included *by the FTC's own economists* in hospital merger cases. (*See* ProMedica Br. at 59). The FTC claims he was right to do so, as those variables are "highly correlated" with variables that are included, and thus including them would dilute the predictive value of his model. (FTC Br. at 56). But, as ProMedica explained, if there is insufficient data to build a reliable regression model that accounts for all necessary variables, that is a failure of data, not a license to start excising variables. (ProMedica Br. at 60). Moreover, if two variables are highly correlated that does not explain which of the two to remove. Town, of course, removed variables that support ProMedica's view, but that sort of results-oriented data manipulation is inappropriate.

And the FTC's argument on the timing of price increases completely misses the point. (FTC Br. at 57). As ProMedica explained, Town's model was so non-specific that it merely predicted price increases at some point in the future. (ProMedica Br. at 61). Predicting that, at some undisclosed future time, prices may be higher—in a world in which hospital prices increase annually—is hardly earth-shattering proof of anticompetitive effects. The FTC's explanation that the

price increases "will occur closer to two years than to 20 years" (FTC Br. at 57 n.37), does not rectify that failing.

The FTC's failure to show a likely *anticompetitive* price increase, an issue on which it bears the burden of proof, independently dooms its case.

III. The FTC Committed Legal Error In Choosing Divestiture As The Remedy.

The FTC's brief fails to rehabilitate the FTC's flawed approach to remedy. As ProMedica showed, the FTC committed legal error by starting with a strong presumption in favor of divestiture that could be overcome only by a showing that this case mirrored *Evanston*. That flawed presumption undercuts its entire analysis.

The FTC now claims that its opinion did not reflect any belief that it was essentially required to adopt divestiture. (FTC Br. at 57-58). That argument is difficult to square with the opinion's actual language, in which the Commission stated that it would consider a non-divestiture-based remedy only if presented with "special circumstances that warrant a departure from the preferred structural remedy," and found such circumstances lacking here solely because this case is "markedly different from *Evanston*." (OP-57–JA82).

Had the Commission considered the appropriate remedy on a clean slate, it would have adopted a conduct remedy. As the FTC concedes in its brief, "the purpose of relief in a Section 7 case is to restore competition lost through the

unlawful acquisition." (FTC Br. at 58). The FTC does not dispute that, in doing so, remedial orders must not be overbroad or punitive. (*See* ProMedica Br.at 63 (*citing 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. 1978))). *See also Timken Roller Bearing Co. v. United States*, 341 U.S. 593, 601, 602-05 (1951) (Reed, J., concurring) (divestiture is "not to be used indiscriminately" where "less harsh" methods are available), *overruled on other grounds*, *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1983).

While the FTC refers to ProMedica's proposed conduct remedy—firewalled negotiating teams—as "potentially less effective," (*see* FTC Br. at 61), the FTC made no findings supporting that conclusion. The ALJ conceded that there was a "cogent argument" that this conduct remedy would address the competitive concerns, while at the same time "enabl[ing] St. Luke's to continue to benefit from ProMedica's stronger financial resources, and, thereby, preserv[ing] St. Luke's viability, to the benefit of consumers." (ID-207–JA303).

Moreover, it is important to recognize how narrow the alleged competitive harm here is. The Commission's complaint does not involve Medicare or Medicaid—approximately 60 percent of St. Luke's revenues. (Wakeman, Tr. 2751; Den Uyl, Tr. 6440, *in camera*). The Commission also "excludes outpatient services" as well as "tertiary and quaternary services" (Complaint at ¶ 13) and

concedes that the Joinder "is not likely to affect competition for tertiary services." (FTC Br. at 27). To put this in perspective, St. Luke's admitted only about ten commercially-insured GAC patients per day (only one of whom was an expectant mother), compared to twice that many non-commercially-insured GAC patients (*i.e.*, Medicare/Medicaid) and more than *fifty times that number* of outpatient visits. (PX02129 at 002; RX-71(A)-000201–JA1892, *in camera*). The Commission's proposed remedy is not tailored to meet the alleged violation. "Divestiture is an extremely harsh remedy," *Reynolds Metals Co. v. FTC*, 309 F.2d 223, 231 (D.C. Cir. 1962) (Burger, J.), which "cannot be had on assumptions." *United States v. Crowell, Collier, & Macmillan, Inc.*, 361 F. Supp. 983, 991 (S.D.N.Y. 1973).

Furthermore, in fashioning remedies, the "public interest" must be "paramount." *In re Ekco Products*, No. 8122, 1964 FTC LEXIS 115, at *127 (June 30, 1964). While the FTC cavalierly dismisses concerns that divestiture will harm local residents (FTC Br. at 62), community representatives are not quite so sanguine (*see* Brief of Amici Curiae 53 Business, Professional, Educational, Civic Organizations, Municipalities and Governmental Entities In Support of Petitioner). The "public interest" is best expressed by those who must endure the aftermath of divestiture. They have spoken clearly here.

CONCLUSION

For the above reasons, as well as those in the opening brief, the Court should reverse the Commission's determination that the joinder violates Clayton Act Section 7, or alternatively vacate the Commission's divestiture order.

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 tables of contents and authorities, contains 6,978 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 12th day of December, 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
Counsel for Petitioner, ProMedica Health System, Inc.