No. 14-____

IN THE
Supreme Court of the United States

PROMEDICA HEALTH SYSTEM, INC.,

Petitioner,

v.

FEDERAL TRADE COMMISSION,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The Affordable Care Act and accompanying changes in the health care industry have prompted a wave of consolidations. That trend reached Toledo, Ohio, when Petitioner acquired St. Luke's, a struggling local community hospital. Although the merger left Petitioner's two primary competitors in place, the transaction nonetheless attracted the attention of the Federal Trade Commission in Washington, D.C. The FTC attacked the merger, not on the theory that it would facilitate collusion among the remaining players (i.e., the "coordinated-effects" theory, historically the primary concern in merger cases), but rather on the theory that it would allow Petitioner to act unilaterally to raise prices. All agree that this more recently developed "unilateral-effects" theory turns principally on the *substitutability* between the acquired and acquiring firms, rather than on the firms' respective market shares (which are instead key variables under the traditional collusion-based theory of harm). The FTC nonetheless premised its challenge to the merger, and its order requiring divestiture, on a market-share-based analysis. The Sixth Circuit decision affirming the FTC's divestiture order raises three questions of recurring importance in the merger context on which lower courts are divided.

1. In defining the relevant product market for a merger analysis, is the FTC permitted to ignore the group of services that market participants actually negotiate for and purchase as a package, and instead define the product market based on supply-side considerations, thus allowing the FTC to

gerrymander the product market to artificially inflate market shares?

2. Where the FTC relies exclusively on a unilateral-effects theory in challenging a merger—a theory that turns on substitutability, not on market share—may a court nonetheless adopt a strong presumption of anticompetitive harm based solely on market-share statistics?

3. Assuming that the FTC can rely on a strong presumption of harm based on market-share statistics in unilateral-effects cases, can it then separately rely on market-share statistics to preclude consideration of the merger target's financial weakness to rebut that presumption?

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

Petitioner, ProMedica Health System, Inc., ("ProMedica") was the respondent in an administrative proceeding in the Federal Trade Commission (the "Commission" or the "FTC") and the petitioner in the court of appeals. There is no publicly-held company that owns 10% or more of ProMedica's stock.

Respondent, the Commission, was the respondent in the court of appeals.

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases **Page**

Other Authorities

PETITION

ProMedica respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit below.

OPINIONS BELOW

The Sixth Circuit opinion (App. 1a–29a) is reported at 749 F.3d 559. The court was reviewing the Commission's final order and opinion (App. 30a–206a).

JURISDICTIONAL STATEMENT

The Sixth Circuit entered judgment on April 22, 2014. ProMedica timely filed a petition for rehearing, which that court denied on July 24, 2014. On September 26, 2014, Justice Kagan extended the time to file a petition for certiorari to December 22, 2014. The Court has jurisdiction under 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant statutory and regulatory provisions are reproduced in the appendix. They include 15 U.S.C. 18 (the "Clayton Act") (App. 625a–627a), and 15 U.S.C. 21 (App. 627a–635a). The appendix also includes relevant portions of the Horizontal Merger Guidelines, published by the Department of Justice and the Federal Trade Commission. (App. 636a–687a).

INTRODUCTION

The decision below injects profound confusion into fundamental aspects of merger law, while simultaneously handing the FTC unbridled discretion to block local hospital mergers almost at whim. St. Luke's is a small standalone non-profit hospital in Toledo, Ohio. Like standalone hospitals everywhere, St. Luke's was struggling to survive in light of new mandates imposed by the Affordable Care Act and other federal statutes. St. Luke's board, comprised of local community leaders, concluded that merging with ProMedica offered St. Luke's its best chance of continuing its mission of providing high-quality care. But the FTC perceived a threat to competition in Toledo, and ordered a full divestiture of the already-consummated transaction.

In doing so, the FTC did not rely on the traditional theory of anticompetitive "coordinated effects," where the concern is that a merger reduces the number of competitors, thereby increasing market concentration and fostering collusion. Rather, the FTC challenged the merger solely on grounds that it would cause anticompetitive "unilateral effects," whereby a merger, in the *absence* of collusion and *regardless of concentration*, promotes supra-competitive pricing merely by eliminating the competition between the merged entities. As the FTC's own Horizontal Merger Guidelines emphasize, these concerns arise only when the merger participants offer *close substitutes*. In the words of the FTC's own expert, in "unilateral-effects" cases, *substitutability*, not market share, is the "central variable."

Both the FTC and the Sixth Circuit, however, heavily focused their analyses on market-share statistics, ignoring undisputed evidence that none of the relevant consumers considered the merging parties to be close substitutes for each other. That market-share driven analysis may have been appropriate in a "coordinated effects" case, but was misplaced and distortive in a purely unilateral-effects case like the one here.

In adopting that approach, the court of appeals created or deepened conflicts on three related questions of merger law. First, the decision creates confusion regarding how to define the product market, a vital issue in all mergers, and hospital mergers in particular. Hospitals offer a host of distinct services (e.g., appendectomies), each of which address differing needs. In evaluating hospital mergers, those individual services are not analyzed separately. Rather, services are grouped into a bundle (called a "cluster market") typically referred to as "general acute care services" or "GAC services." Unfortunately, in defining that cluster here, the court adopted an approach that put it in conflict with two other circuits, allowing the FTC virtually unfettered discretion to pick and choose which services are included or excluded from the bundle, in turn allowing the FTC to manipulate market-share statistics. Even one of the FTC's Commissioners observed in a concurrence that the Commission's product-market definition here was unprecedented and raised appearances of "gerrymandering" the product market to secure a desired result.

Second, by relying on market-share statistics to create a strong presumption of anticompetitive harm in a unilateral-effects case, the court below both creates a conflict in the lower courts about the propriety of such presumptions, and also deviates from the FTC's own guidance in the Horizontal Merger Guidelines. Moreover, as hospital services markets are distinctly local and thus relatively concentrated, this market-share based approach, in all but the largest cities, will empower the FTC to block mergers almost at will, even though the presumption does not reflect any real-world harm.

Finally, the Sixth Circuit compounded its wrongful fixation on market-share statistics by relying on a market-share-driven analysis to determine when a merger proponent can rely on evidence of the acquired firm's financial weakness to rebut the market-share-based presumption of harm, deepening a split of authority on this issue. The decision below thus emphasizes market share not once, but *twice*, an approach directly at odds with the unilateral-effects theory of harm, which turns on substitutability, not market share.

In short, the decision below exacerbates confusion over timely, recurring, and often outcome-dispositive aspects of merger analysis. It does so at a particularly problematic time. Under the crush of new federal regulations that both impose substantial capital requirements and mandate increased coordination in care, healthcare mergers are on a dramatic upswing. The deeply-flawed analysis below, which hands the FTC virtually unbridled discretion, threatens to chill many potentially beneficial

transactions. And, given that merger cases virtually never receive full appellate review—as such transactions typically are litigated only in a preliminary-injunction context or are abandoned if litigation arises—the decision below, rendered on a fully-developed record, provides the Court a rarely available opportunity to provide much-needed clarity.

STATEMENT OF THE CASE

1. This case involves a 2010 merger between two non-profit hospitals in Toledo. Toledo's hospital market is marked by over-capacity and vigorous competition among three well-capitalized providers. ProMedica, a non-profit, operates eleven hospitals in northwest Ohio and southeast Michigan, including (pre-merger) three in Toledo. (App. 227a, 236a). Catholic Health Partners ("Mercy"), another non-profit, likewise operates multiple hospitals in northern Ohio, including three in Toledo. (App. 240a). There is also the large, state-run University of Toledo Medical Center ("UTMC"). (App. 243a). Until the merger, the market also included St. Luke's, a standalone, non-profit community hospital.

With eight separate hospitals, Toledo has among the most hospital beds per capita of any metropolitan area in the country. This oversupply led to intense competition, which was only exacerbated by Toledo's ongoing economic struggles. As the area's population grows poorer and older, more and more patients receive coverage through Medicare or Medicaid, which do not cover the full costs of treatment. According to Commission findings, the number of commercially-insured patients in Toledo, the relevant

patients here, had fallen by nearly a quarter (from 45,000 to 35,000) between 2004 and 2009. (App. 370a). Toledo has also suffered high unemployment, suggesting the decline in commercially-insured patients is a long-term issue. The convenience of the hospitals' respective locations further intensified competition; any Toledo resident can drive to virtually any of the eight hospitals within 20 minutes. (App. 281a).

Coupled with strong competition for an ever-dwindling supply of commercially-insured patients, various federal statutes, including the Affordable Care Act, require hospitals to make substantial new capital investments. This is particularly true as to information technology and electronic medical records. (App. 385a).

2. Given these realities, St. Luke's, as the Commission conceded, was facing "significant financial difficulties." (App. 49a). In the three years pre-merger, St. Luke's lost more than $25 million. The only month in which revenues exceeded costs was the month immediately before the merger, and even then it managed to eke out a $7,000 margin on nearly $36.7 million in revenue, a net margin of one-hundredth of one percent. (App. 50a). The financial difficulties also affected St. Luke's access to capital; Moody's downgraded St. Luke's bond rating to "Baa2," near the bottom of investment grade, increasing its capital costs. (App. 49a).

3. St. Luke's non-profit board (the "Board"), comprised of local community leaders, determined that merging with ProMedica offered St. Luke's the

best opportunity to survive and continue its mission of providing high-quality healthcare to Toledo residents. The Board believed that joining ProMedica would give St. Luke's access to capital at better rates (App. 52a-54a), and also allow St. Luke's to overcome the below-cost reimbursement rates it was obtaining from some of its largest managed care organization consumers ("MCOs"). (App. 93a–94a).

Importantly, the record contains no evidence suggesting that *ProMedica* believed that the transaction would result in greater pricing power. Rather, all agree that, both pre- and post-merger, the identities of the three main competitors in the Toledo market—ProMedica, Mercy, and UTMC—will remain the same.

Moreover, the MCOs all agreed that ProMedica and Mercy were, and remain, each other's *primary* competitors. That is, the MCOs, who are the relevant consumers here, testified that they must have either Mercy or ProMedica in their health plans to market them in the Toledo area. (App. 307a). The MCOs further testified, and the Commission ALJ found, that "MCOs could not substitute St. Luke's for the ProMedica system." (*Ibid.*). Rather, both pre- and post-merger, "from the perspective of the MCOs when constructing a marketable network, the Mercy hospital system is the closest substitute to the ProMedica hospital system." (App. 490a). And the evidence also showed that UTMC, *not* ProMedica, was St. Luke's closest substitute. (6th Cir. Joint App. at 2286).

4. The FTC nonetheless challenged the transaction. This challenge was notable in three regards: first, the way the FTC defined the product market; second, the role market-share statistics played in the unilateral-effects analysis; and, third, the FTC's refusal to consider financial-weakness evidence.

a. As to the first, the FTC began by asserting that the merger created a substantial likelihood of anti-competitive effects in the "general acute care services" (or "GAC services") market. This is a "cluster market" comprised of a group of individual primary and secondary hospital services, such as, for example, an appendectomy, that are "sold to commercial health plans." (App. 61a).

The use of cluster markets, like GAC services, is common in evaluating hospital mergers. While individual services may be separate product markets under standard definitions (patients do not substitute appendectomies for hip replacements if the price of the former drops, (*see* App. 66a)), the disparate services sometimes must be grouped for analytical purposes to reflect "market realities." Here, for example, the Commission's ALJ found that "MCOs demand, and contract for, a broad array of inpatient services together," and that this array includes "inpatient OB services." (App. 65a). Thus, based on this demand-side reality of how buyers actually purchase the services, he treated the product market as consisting of a single cluster that included OB services. (*Ibid*.).

The full Commission, however, took a different approach that allowed it to artificially inflate ProMedica's market share. Specifically, the Commission focused on what it called the "administrative convenience" approach. This theory allows products to be clustered for analytical convenience when their "competitive conditions" are the same, as the same analysis would thus apply to each. From this "administrative convenience" theory, the Commission drew a potentially far-reaching corollary—if products *can be* clustered when their competitive conditions are the same, then they *must not be* when competitive conditions are different, even if that clustering is justified based on demand-side market realities.

Accordingly, focusing on supply-side considerations, the FTC held that as inpatient obstetrical ("OB") services had fewer suppliers in the market (here, one of the hospital systems did not provide inpatient OB services), that service must be excluded from the cluster and analyzed separately. (App. 65a–70a (explaining focus on supply-side considerations), 81a (excluding OB services from the GAC cluster on those grounds)). In so doing, the Commission simply ignored the unrebutted evidence of what services consumers actually purchase as a group. As a result, instead of analyzing a single cluster market, with ProMedica having a roughly 50% market share, the Commission separated out OB services, which allowed it to inflate ProMedica's alleged share in that separate market to almost 80%.

In a concurrence criticizing this approach, one Commissioner noted that the majority could not

"point to any judicial precedent for defining a obstetrical services market separate from an overall inpatient GAC market," and observed that, in doing so, "the Commission would not only depart from the case law, but also risk accusations of 'gerrymandering' the relevant product market so as to make it more susceptible to a structural presumption of liability." (App. 156a).

b. Having defined the product markets in a way that exaggerated ProMedica's market share, the Commission then turned to competitive harm. Importantly, the FTC's *sole* theory of competitive harm in either the GAC-services or OB markets was that the transaction would cause anticompetitive *unilateral effect*s. The FTC expressly disclaimed reliance on the more traditional coordinated-effects theory. (App. 487a–488a n.18).

The coordinated-effects theory reflects the possibility that a merger, by reducing the number of competitors and increasing market concentration, raises the likelihood of *collusion* among the remaining competitors. Not surprisingly, this theory relies heavily on market-share statistics. (App. 19a).

Starting in the 1990s, however, the Commission added a different theory of competitive harm to its arsenal, a theory referred to as "unilateral effects." Under this theory, the concern is that a merger between producers who are close substitutes will eliminate competition between them, allowing the combined entity to raise prices profitably, even absent collusive behavior with other market participants. As the Commission's expert explained,

unlike coordinated-effects cases, where market concentration is a key inquiry, "[t]he 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 the merger." (6th Cir. Joint App. at 1089–1090).

By way of example, assume three competing producers: Producers A, B and C. Assume further that consumers who prefer Producer A, when faced with a price increase from that producer, will respond one of three ways: pay the higher price, move to Producer B, or move to Producer C. Finally, assume that, of those who move in response to a price change, 90% move to Producer C, and only 10% to Producer B. That is, Producer C is the closest substitute for Producer A consumers.

The unilateral-effects theory recognizes that a merger between Producers A and C can cause competitive harm. Post-merger, the merged entity (now a combination of Producer A and Producer C) can raise prices on what were Producer A's products, obtaining supra-competitive profits from those who continue to purchase, and recapturing 90% of the customers who move in response to the price increase (as they move to their preferred substitute, Producer C, which is now part of the same merged entity). As the example shows, it is *substitutability* that drives the analysis.

Although the FTC asserted only the substitution-driven unilateral-effects theory here—and expressly disclaimed reliance on a coordinated-effects theory—it nonetheless applied the typical market-share based presumptions developed in the context of coordinated-effects cases. In particular, the FTC used market-share statistics to calculate the increase in concentration that the merger purportedly caused, compared that increase to certain thresholds, and then based on that result adopted a strong *presumption* of harm, which ProMedica was then required to overcome. (App. 84a–87a). And the FTC did so even while its expert conceded that substitutability, not market share, is the "central variable" in a unilateral-effects case.

c. The FTC then doubled down on its reliance on market share. Having first used market-share statistics to create the presumption of harm, it again used market-share statistics to prevent ProMedica from rebutting that presumption. In particular, ProMedica argued that, as a result of St. Luke's financial weakness, its pre-merger market share vastly overstated its competitive significance. The FTC found that ProMedica could not rely on such evidence, however, unless it could show that St. Luke's financial weakness would cause its market share to fall (in the absence of a merger) to the level at which no market-share-based presumption of harm would arise in the first instance. (App. 87–88a).

5. On appeal, the Sixth Circuit affirmed the FTC's approach to all three issues. On the first, it noted that "the parties … disagree on the principles that should govern which services are clustered and

which are not," and agreed that "[t]wo theories of clustering are pertinent here." (App. 12a). It embraced the FTC's theory, which focused on what the court called "competitive conditions" (i.e., excluding inpatient OB services from the cluster, and separately calculating market share for such services because one hospital system did not supply them), and ignored ProMedica's theory, which focused on what market participants in fact purchase as a single bundle. (App. 16a–18a).

On the second issue, the court acknowledged that "the two theories [i.e., coordinated-effects and unilateral-effects] are different," and that substitutability is "critical to unilateral-effects analysis." (App. 21a). It further conceded that ProMedica's argument that "the Commission was wrong to presume the merger illegal based on HHI data[1] alone," "is one to be taken seriously." (*Ibid.*). Yet, it nonetheless affirmed the use of the presumption, and relied on it to the exclusion of any analysis of whether the merger was likely to result in actual supra-competitive prices. (App. 24a).

Finally, the court rebuffed ProMedica's efforts to rebut the presumption through evidence of St. Luke's financial weakness. The court held that, as a matter of law, ProMedica could not rely on financial-weakness evidence absent a showing that the weakness "would cause [St. Luke's] market share to reduce to a level that would undermine the government's *prima facie* case," or, in other words,

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[1] "HHI data" refers to the Herfindahl-Hirschman Index, which is a standard market-share statistic.

unless ProMedica could show that St. Luke's financial weakness would cause its market share to fall, absent the merger, below the level needed to trigger market-share-based presumptions. (App. 28a).

REASONS FOR GRANTING REVIEW

The decision below contributes to growing conflicts on three closely-related issues that are fundamental to merger analysis. Perhaps nowhere is clarity on these issues more important than with regard to hospital mergers, which are on the rise for reasons including the dramatic changes mandated by the Affordable Care Act. As hospital geographic markets are inherently localized and concentrated, the decision below will have a substantial chilling effect on all such mergers, including those that are procompetitive and beneficial to the local community. This case presents the Court an ideal vehicle both for clarifying merger analysis generally, and for addressing that analysis in the context of hospital mergers. Failure to do so will leave market participants uncertain about the law, while also providing the FTC virtually unbridled discretion to block hospital mergers across the nation. Given the concentrated nature of such markets, the use of market-share-based presumptions, coupled with gerrymandered product markets, allows the FTC to block almost any merger it chooses, even though the market-share-based presumption bears no real relationship to the FTC's identified theory of harm.

I. THE COURT SHOULD GRANT REVIEW TO ADDRESS CONFUSION ON FUNDAMENTAL ISSUES OF MERGER LAW.

The Court has not had the opportunity to review a merger case on the merits since *United States v. General Dynamics Corp.*, 415 U.S. 486 (1974). That hiatus does not reflect that mergers or merger analysis lacks importance to the economy. Rather, it reflects in part that relatively few merger cases are fully litigated. Instead, mergers are often litigated in the context of preliminary injunctions or not at all; given timing and cost concerns, the mere threat of FTC intervention often is enough to deter a merger. As a result, a court of appeals decision like that issued below has an outsized impact on potential mergers. Much has happened in the forty years since *General Dynamics*, including the advent of the FTC's unilateral-effects theory in such cases. The decision below, which endorses the misplaced use of presumptions based on market share (gerrymandered market shares no less), contributes to confusion in the lower courts and has the potential to chill numerous beneficial mergers. This Court's review is badly needed.

A. The Court Should Resolve Confusion Over Cluster-Market Definition.

Merger analysis typically begins with defining the relevant product market or markets. All agree that, in a given case, the relevant product market may consist of a *cluster*, or, in other words, a collection of separate products. As the court below acknowledged, however, there are two separate approaches to

identifying which products to include in the cluster—what the court below referred to as the "administrative convenience approach" (which turns on "competitive conditions") and the "package-deal approach" (which focuses on the group of products that customers actually purchase as a unit). In rejecting the latter and endorsing a misguided view of the former to remove products from the cluster for separate treatment—thereby improperly inflating market shares—the decision below conflicts with decisions from two other Circuits, creates tension, if not outright conflict, with this Court's precedent, and hands the FTC enormous power to gerrymander product markets.

1. As a general matter, product-market definition for antitrust purposes turns on *demand-side* substitution. In assessing whether two products are in the same market, both the Horizontal Merger Guidelines and case law command that the decision-maker look to what *buyers* treat as substitute products. *See* Guidelines § 4 (App. 641a) (stating product market definition must focus "solely" on demand-side substitution). Of course, under this test, different hospital services constitute different products—patients do not substitute appendectomies for hip replacements based on price.

2. In cluster-market analysis, though, multiple different products from a given producer are grouped into a single bundle for antitrust analysis purposes. In other words, the *collection* of the manufacturer's products—products A, B and C, for example—is treated as a single product. Courts have identified

two approaches to determining the correct composition of cluster markets.

a. First, consistent with the demand-focused approach to product-market definition generally, courts have recognized that courts are *required* to group disparate products into a single cluster where consumers themselves treat that collection as a group. To use the Ninth Circuit's description of this approach: 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 Technical Servs., Inc. v. Eastman Kodak Co.*, 125 F.3d 1195, 1205 (9th Cir. 1997) (citations omitted). Or, as the Tenth Circuit has explained, "[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). Likewise, this Court itself explained as far back as *United States v. Philadelphia National Bank*, 374 U.S. 321, 356 (1963), a "cluster of products … and services" can "compose[] a distinct line of commerce," appealing to consumers on a different basis than individual products or services within the cluster. The decision below referred to this as the "transactional-complements" or "package-deal" theory, which it declined to apply here. (App. 16a).

b. Separately, courts (including the court below) have described an "administrative-convenience" or "similar-conditions" approach. This approach does not turn on any demand-side reality about consumer behavior in the market, but rather recognizes that, as a matter of analytical convenience, when

competitive conditions are substantially similar for two or more of a manufacturer's different products, there is no need to analyze each separately, as the same merger analysis would apply to all. As the court put it in *Emigra Group v. Fragomen*, 612 F. Supp.2d 330, 353 (S.D.N.Y. 2009), "there is no need to define separate markets for a large number of individual hospital services … when market shares and entry conditions are similar for each." Under this approach, clustering is *permissible* (although certainly not mandatory) when "the antitrust analysis of each would be so similar in practice that no loss on analytic power comes from treating the products as a collection." *See* Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 LAW & CONTEMP. PROBS. 93, 138 (Spring 1998).

In deciding whether sufficient similarity exists, a court looks to the competitive conditions under which the products (or in this case services) are *supplied.* So, for example, here the court focused on two supply-side facts. First, the number of hospital systems that supplied inpatient OB services in the market (three hospital systems, pre-merger) was different from the number that supplied other services, such as appendectomies, included in the GAC-services cluster (four hospital systems, pre-merger). Second (and relatedly), ProMedica's market share for inpatient OB services was higher than it was for the other services considered for inclusion in the GAC-services cluster.

The vital point, however, is that, as its name suggests, the "administrative convenience" approach

permits the *inclusion* of products into a cluster as a matter of *convenience*. It has not been, until the FTC and Sixth Circuit decisions here, a basis for *excluding* products from the cluster of products actually purchased by consumers as a unit, to allow one of the products to be treated separately so that a higher market-share number can be generated. In other words, the administrative convenience theory is another way to *build* a cluster (when "competitive conditions" are the same for each product), it is not a means to *remove* products from a cluster that was built based on demand-side analysis of what consumers actually purchase as a group.

c. The failing in the decision below was in using the "administrative convenience" approach to excise OB services from the bundle and subject it to separate analysis, despite unrebutted evidence showing that the relevant consumers in this market (i.e., MCOs), treated a *collection* of primary and secondary services, *including inpatient OB services*, as a single product during negotiations. That is, the MCOs testified that they did not separately negotiate for OB services in their negotiations with hospitals for primary and secondary services. Rather, those services were part of the single bundle of such services for which the MCOs negotiated *as a group* with a given hospital (if that hospital supplied such services). Under the approach of the Ninth and Tenth Circuits in cases such as *Image Technical Servs.* and *Green Country Food Market*, then, the court below was *required* to treat all of these services, *including OB*, as a single cluster. The court's failure to do so

puts the Sixth Circuit in conflict with the Ninth and Tenth Circuits.

Moreover, the court's reasoning in failing to employ what it called the "package-deal" approach also puts the court in tension, if not outright conflict, with the Court's decision in *United States v. Grinnell Corp.*, 384 U.S. 563 (1966). The sole reason the court offered for declining to use demand-focused clustering was its finding that the MCOs did not demand *exactly the same* package of services from each hospital. (App. 17a). That is, with regard to the hospital system that did not offer OB services, the MCOs' negotiated package did not include OB services. There was no dispute, however, that for hospital systems that *did* offer OB services, those services were part of the single negotiated package.

In *Grinnell*, the Court expressly *rejected* the idea that each competitor's package of services must be identical in order to justify cluster-market treatment. Specifically, the Court found that fire and burglary alarm services constituted a single cluster, even though not all market participants offered the same menu of alarm services. 384 U.S. at 572 n.6.

Moreover, consistent with *Grinnell*, previous hospital merger cases had rejected the principle, reflected below here, that only services uniformly offered by all market participants are properly included in the cluster. For example, in *California v. Sutter Health Sys.*, 130 F. Supp.2d 1109, 1119–1120 (N.D. Cal. 2001), the court defined a cluster market of primary, secondary and tertiary services, even though not all hospital competitors offered all such

services. And, in *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1211 n.11 (11th Cir. 1991), the court upheld a product market consisting of a cluster of the general set of inpatient services provided by acute-care hospitals, even though the two merging hospitals did not each provide the same set of acute-care services. The Sixth Circuit's approach is difficult, if not impossible, to square with such cases.

In short, under settled law from other circuits, the only permissible approach to clustering here was to respect the "package deal" of services that MCOs negotiated for as a group with a given hospital. The court's approval of the novel use of the "administrative convenience" approach to exclude services that MCOs bought as part of a single package thus creates conflict on the rules for cluster-market composition. And the use of the excluded product to generate a separate—and higher—market share is a formula for mischief.

d. This is especially problematic in the hospital merger context, as the FTC can readily use its novel methodology to generate artificially inflated market shares, as it did here, and use those inflated market-share statistics to block hospital mergers at will. Under the package-deal theory, the FTC is constrained by evidence about how MCOs actually make purchasing decisions. But, under the Sixth Circuit's approach, all the FTC need do is identify a single hospital service where the competitive conditions are somehow "different" (e.g., fewer suppliers or greater market share). It can then peel that service away from the cluster for separate treatment, thus creating an artificially-inflated

market share. In other words if the FTC can find a single hospital service, out of the scores of services typically included in the GAC-services cluster, where the merger participants have a high market share, the FTC can rely on that single service to create a strong presumption of anticompetitive harm. And that result will follow even absent evidence showing that the identified service had *any* impact on pricing negotiations in the real world.

Commissioner Rosch expressly acknowledged that defining the markets in this way raised "gerrymandering" concerns. (App. 156a). Those concerns were fully realized here. Despite unrefuted evidence that OB services were included as part of the package of GAC services during real-world negotiations, the Sixth Circuit specifically pointed to ProMedica's very high post-merger market share *in a separately-defined OB services market* (80%) as the key basis justifying a presumption of illegality. (App. 23a).

In sum, the Sixth Circuit's erroneous cluster-market framework resulted in an incorrect outcome, while also sowing confusion and creating conflict on product-market definition in cluster-market cases generally. And, not only is cluster-market analysis an integral part of virtually every hospital merger case, but it applies to antitrust cases in other industries as well. *See e.g., Gen. Indus. Corp., v. Hartz Mountain, Corp.*, 810 F.2d 795, 805 (8th Cir. 1987) (pet supplies); *JBL Enters. Inc. v. Jhirmack Enters., Inc.*, 698 F.2d 1011, 1016–1017 (9th Cir. 1983) (beauty supplies). Accordingly, absent the Court's

intervention, the decision below threatens substantial confusion in antitrust law generally.

B. The Court Should Clarify The Appropriate Role Of Market-Share-Based Presumptions Of Harm In Unilateral-Effects Cases.

1. Historically, the FTC's theory of competitive harm in merger cases has turned on so-called coordinated effects. "[T]he idea behind coordinated effects is that, 'where rivals are few, firms will be able to coordinate their behavior, either by overt collusions or implicit understanding in order to restrict output and achieve profits above competitive levels." (App. 20a (quoting *United States v. H&R Block, Inc.*, 833 F. Supp.2d 36, 77 (D.D.C. 2011))). *See also*, *e.g.*, *Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1386 (7th Cir. 1986) (Posner, J.) ("When an economic approach is taken in a section 7 case, the ultimate issue is whether the challenged acquisition is likely to facilitate collusion."). As collusion is the concern, market concentration is key. The fewer the competitors, and the greater their respective shares, the greater the potential for collusion. Market-share statistics have thus been a staple of coordinated-effects analysis, with courts adopting presumptions of anticompetitive harm when certain market-share thresholds are met.

Since the early 1990s, however, the FTC has added a new competitive-harm theory to its playbook. This newer so-called unilateral-effects theory does not turn on concerns about *coordination* among market participants, but rather focuses on what the

merged entity *itself* can do to exercise market power. In such cases, collusion, and indeed the rest of the market, is essentially irrelevant. In stark contrast to coordinated-effects cases, the focus in unilateral-effects cases is on the merging firms themselves. Specifically, the "central variable," as the FTC's expert referred to it, is whether the merging firms are *substitutes* for one another.

The key insight of this theory is that substitutes act as price constraints on one another. (*See* App. 20a–21a). In a merger involving close substitutes, the merged entity can increase prices with a much freer hand than it could pre-merger, as post-acquisition it will recapture those consumers who respond to a price increase by moving to their preferred substitute—as that preferred substitute is now also controlled by the same entity as a result of the merger.

Because the FTC expressly waived any reliance on coordinated-effects, and because *substitutability*, not *market share*, drives the unilateral-effects analysis, ProMedica argued that market-share statistics should not create a presumption of harm. The FTC, however, insisted on retaining its market-share-based presumptions in the very different unilateral-effects world. It did so despite (1) acknowledgements by its own expert witness that substitutability, not market share, is the "central variable," and (2) recent statements by an FTC Commissioner that, while "the presumption is a convenient litigation tool," it is not "supported by sound economics" in unilateral-effects cases, and "the Commission would do well to encourage courts to

abandon its use." *See* Remarks of Joshua Wright, available at http://www.ftc.gov/sites/default/files/documents/public_statements/ftc%E2%80%99s-role-shaping-antitrust-doctrine-recent-successes-and-future-targets/130924globalantitrustsymposium.pdf.

2. Despite some expressed concerns, the Sixth Circuit adopted the FTC's flawed approach. In doing so, the court created confusion regarding the appropriate role for market-share-based presumptions in unilateral-effects cases. In particular, the decision below stands in conflict with the leading case of *United States v. Oracle Corp.*, 331 F. Supp.2d 1098 (N.D. Cal. 2004). There, after an extensive analysis of unilateral-effects theory, the court identified three factors necessary to support such claims:

> 1. The products controlled by the merging parties must be *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.

Id. at 1117.

Two aspects of the *Oracle* analysis are striking. First, the use of the market-share presumption here obviated the need to consider these three factors, which the FTC could not have satisfied here given

the unrebutted evidence that the relevant consumers (MCOs) did not consider ProMedica and St. Luke's to be close substitutes. Second, noticeably absent from this list is any reference to market-share-based presumptions. That is no accident; the *Oracle* court expressly considered *and rejected* the use of such presumptions, noting that "a strong presumption of anticompetitive effects based on market concentration is especially problematic in a differentiated products unilateral effects context."[2] *Id*. at 1122. Indeed, the *Oracle* court criticized the then-current Horizontal Merger Guidelines (i.e., adopted in 1997) 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*. (citing then-current Guidelines § 2.211).

Commentators have likewise concluded that market-share 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*

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[2] Unilateral-effects theory has two distinct "flavors," (1) homogeneous product, and (2) differentiated product. (*See* App. 20a (describing differences)). All agree that this case, like *Oracle*, involves solely the differentiated-products unilateral-effects theory. (*Ibid*.).

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 B. Baker and David Reitman, *Research Topics in Unilateral Effects Analysis*, in RESEARCH HANDBOOK ON THE ECONOMICS OF ANTITRUST LAW at 29 (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.").

Despite all of this, the Sixth Circuit, although noting that ProMedica's argument "must be taken seriously," ultimately applied the market-share-based presumption to this differentiated-products unilateral-effects case. (App. 21a–24a).

3. The Sixth Circuit's decision does not just conflict with case law and commentary, but also creates tension with the FTC's own Horizontal Merger Guidelines. The current Guidelines, as revised in light of *Oracle's* criticisms and other commentary, expressly recognize that substitutability, not market share, is the key determinant for the unilateral-effects theory: "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 (App. 670a). "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." *Ibid*. (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*." *Ibid*. (emphasis added). As a result, "[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. In fact, according to the DOJ/FTC's 2006 Commentary to the Guidelines, "market share *may be unimportant* under a unilateral effects theory." Commentary on the Horizontal Merger Guidelines (2006) (emphasis added).

The FTC failed to explain its change in course here, yet that change grants the FTC extremely broad powers. As nearly all hospital markets are distinctly local and concentrated, a focus on market-share statistics, especially when coupled with a gerrymandered product market, provides the Commission essentially unbridled power to prevent any hospital merger it wants. Indeed, the court below affirmed divestiture here based solely on the presumption, without any separate analysis of whether the merger would allow ProMedica to raise prices above competitive levels, and notwithstanding the FTC's finding that St. Luke's rates would have risen *even without a merger*. (App. 93a–95a).

In sum, the decision below upheld the FTC's misplaced reliance on market-share presumptions in a unilateral-effects case. In the process, the decision heightens confusion about the appropriate role, if any, of market-share-based presumptions in unilateral-effects cases. Only the Court can rectify that confusion.

C. The Court Should Clarify The Appropriate Role Of Financial Weakness Evidence In Rebutting A Market-Share-Based Presumption Of Harm.

1. Compounding the flaws of adopting a market-share-based presumption of harm, the Sixth Circuit then conditioned ProMedica's ability to raise evidence of St. Luke's financial weakness to rebut that presumption on yet another market-share-driven analysis, thereby doubling down on the improper focus on market-share analysis in unilateral-effects cases, and rendering the unwarranted presumption virtually irrebuttable. In doing so, the court below contributed to growing confusion on the use of financial-weakness evidence in merger analysis.

All agree that a financial-weakness or "flailing firm" defense is different from the *failing* firm defense that the Court announced in *International Shoe Co. v. FTC*, 280 U.S. 291 (1930). The failing firm defense allows an otherwise impermissible merger to go forward if the target firm (1) is at imminent risk of failing to meet its financial obligations, (2) would be unable to reorganize successfully in bankruptcy, and (3) has made

unsuccessful good-faith efforts to elicit reasonable alternative offers to the proposed merger transaction. *See* Guidelines § 11 (App. 685a–686a).

The financial-weakness defense, by contrast, is not technically a *defense* to Clayton Act liability, but rather an argument that a merger proponent can use in seeking to rebut the government's prima facie case of competitive harm. The defense rests on the notion that if a firm faces significant financial weakness, its current market share overstates its competitive significance. Thus, a merger involving that firm would not pose the threat to competition that its market share would otherwise suggest.

The financial-weakness defense has its roots in *United States v. General Dynamics Corp.*, 415 U.S. 486 (1974). There, the FTC challenged General Dynamics' acquisition of United Electric Coal Companies on a coordinated-effects theory. All agreed that the market-concentration numbers there met the threshold needed "to support a finding of 'undue concentration' in the absence of other circumstances," or, in other words, to create a presumption of anticompetitive harm. *Id*. at 497–498.

To overcome that presumption, General Dynamics argued, and the district court agreed, that United Electric's weak coal reserves meant that its "probable future ability to compete" was much lower than its market share would suggest. General Dynamics pressed this argument despite acknowledging that it could not make the necessary showing to invoke the "failing firm" defense.

This Court affirmed. *Id*. at 503–504. In doing so, the Court made clear that it was not expanding the "failing firm" defense, but rather recognizing a different point—that a firm's weakness in some regard (there, coal reserves) may show that the current market share lacks the probative value that the government ascribes to it:

> The appellee's demonstration of United's weak reserves position … proved an entirely different point [from the failing firm defense]. Rather than showing that United would have gone out of business but for the merger …, the finding of inadequate reserves went to the heart of the Government's statistical prima facie case …. The failing company-defense is simply inapposite to this finding and the failure of the appellees to meet the prerequisites of that doctrine did not detract from the validity of the court's analysis.

Id. at 507–508.

In the forty years since *General Dynamics*, this Court has not had further opportunity to explicate the contours of the financial-weakness defense. While lower courts generally have recognized that evidence of financial weakness can be used to challenge a presumption of competitive harm, at least two distinct approaches to such evidence have emerged.

On one hand, some courts, including the Eleventh Circuit, have concluded that a merger proponent can invoke a financial-weakness defense to attack a presumption of harm *only if* the party can show that the financial weakness would cause the weakened

firm's market share to fall below the level at which the market-share-based presumption would arise in the first instance. In *University Health*, for example, the FTC was challenging a hospital merger on a coordinated-effects theory, and the FTC made the necessary prima facie showing to establish a market-share-based presumption of harm. The hospital sought to rebut that presumption by arguing that the merger target "is a weak competitor and that this this undermines the predictive value of the FTC's market share statistics." 938 F.2d at 1220. The Eleventh Circuit conceded that, under *General Dynamics*, "a defendant may rebut the government's prima facie case by showing that the government's market share statistics overstate the acquired firm's ability to compete in the future …." *Id*. at 1221. But the Eleventh Circuit then went on to severely circumscribe the use of this defense, explaining that it would "credit such a defense only in rare cases"—"when the defendant makes a substantial showing that the acquired firm's financial weakness, which cannot be resolved by any competitive means, *would cause the firm's market share to reduce to a level that would undermine the government's prima facie case*." *Ibid*. (emphasis added).

Lower courts in two other circuits have since followed suit, citing *University Health*. *See FTC v. Arch Coal, Inc.*, 329 F. Supp.2d 109, 154 (D.D.C. 2004), aff'd, 2004 WL 2066879 (Sept. 15, 2004); *FTC v. Tenet Healthcare Corp.*, 17 F. Supp.2d 937, 947 (E.D. Mo. 1998). Under this approach, a court will not even *consider* weakened-competitor evidence absent the showing noted above.

On the other hand, the Seventh Circuit imposes no such per se limitation on the use of financial-weakness evidence. In *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324 (7th Cir. 1981), for example, the FTC sought a divestiture order against Kaiser, and Kaiser argued, inter alia, that the market-share statistics overstated the target's competitive significance. The Seventh Circuit opined that "[n]onstatistical evidence which casts doubt on the persuasive quality of the statistics to predict future anticompetitive consequences may be offered to rebut the prima facie case made out by the statistics," and stated that such evidence "must be weighed by the trier of fact . . . ." *Id.* at 1341.

To be sure, the court observed that "the financial weakness of the acquired firm … certainly cannot be the primary justification of a merger," but at no point did the court suggest that such evidence would be relevant *only if* it showed that the market share would fall below the level needed to support the government's prima facie case. *Id*. at 1341; *see also Lektro-Vend Corp. v. Vendo Co.*, 660 F.2d 255, 274–276 (7th Cir. 1977) (relying on weakened competitor evidence to permit merger); *United States v. International Harvester Co.*, 564 F.2d 769, 776–779 (7th Cir. 1977) (same).

Echoing this more permissive approach, an Eighth Circuit decision likewise allowed a merger to proceed based in part on evidence that one of the merging parties was a "weak competitor in the relevant market," again with no suggestion of some kind of per se market-share based rule for considering such evidence. *See FTC v. National Tea*

Co., 603 F.2d 694, 700–701 (8th Cir. 1979). More recently, a district court in the Third Circuit cited the Seventh Circuit cases in considering (albeit rejecting on the merits) a weakened-competitor defense. *See United States v. United Tote, Inc.*, 768 F. Supp. 1064 (D. Del. 1991).

2. Exacerbating this split in authority, the decision below adopted the Eleventh Circuit's per se market-share-based approach to financial-weakness evidence, and did even though this is *solely* a unilateral-effects case, which turns on substitutability rather than market share. More specifically, ProMedica sought to rely on St. Luke's serious financial struggles to rebut the FTC's allegations of competitive harm. ProMedica asserted that St. Luke's was a diminished competitor, and that its current market share overstated its competitive significance. The Sixth Circuit, however, rejected this defense out of hand, asserting that a party cannot rely on the defense unless it can show that the financial weakness "would cause the firm's market share to reduce to a level that would undermine the government's prima facie case." (App. 28a (citing *FTC v. Univ. Health, Inc.*, 938 F.2d 1206 (11th Cir. 1991)).

Had the court below rejected this per se approach to financial-weakness evidence, it would have at least given serious *consideration* to that evidence in assessing competitive harm here. Instead, invoking the *University Health* rule, the court gave the defense the back of its hand—characterizing it as a "Hail-Mary," and failing to meaningfully engage with the issue. (App. 28a). The inappropriateness of that

approach is only heightened by the fact that this was a pure unilateral-effects case, where market share should have mattered little if at all.

II. THE DECISION BELOW RAISES IMPORANT AND RECURRING ISSUES THAT THREATEN DEVASTATING CONSEQUENCES FOR STRUGGLING LOCAL HEALTHCARE MARKETS.

A. The Sixth Circuit's Approach Provides The FTC Unbridled Discretion To Block Hospital Mergers.

The issues raised by the decision below carry far-reaching consequences for mergers generally. Those concerns take on special significance with regard to hospital mergers. Merger activity among hospitals is on a dramatic upswing. As one commentator observed: "The number of merger and acquisition transactions involving hospitals has grown from 56 in 2002 to 86 in 2011. In 2012, the number was even higher, totaling 105, over twice the number in 2009. In the third quarter of 2013, merger and acquisition activity increased 20 percent over the same period in the prior year." Jan Murray & Kathleen Burch, *Recent Trends in Academic Medical Center Mergers, Acquisitions and Affiliations*, HEALTH LAWYER, February 2014, at 29–30. This is largely the result of various federal mandates, mandates that require economies of scale and encourage greater integration among health care providers. *See generally* Toby G. Singer, *Antitrust Implications of the Affordable Care Act*, 6 J. HEALTH & LIFE SCI. L. 57, 76–77 (2013) ("It can be difficult for hospitals, especially small and

standalone hospitals, to access the capital necessary to meet the ACA's goals of containing costs and improving quality. … As revenue pressures increase, hospitals are seeking new ways to achieve economies of scale, and have argued that mergers can help them respond to market changes by providing greater access to capital and economies of scale.").

Moreover, unlike typical FTC merger analyses, which deal with national, or at least regional, markets, the geographic markets for GAC services tend to be distinctly local and concentrated. Patients rarely travel long distances to receive primary or secondary hospital care if local options are present. As the geographic reach of the markets tends to be small, in all but the largest cities, market concentrations are correspondingly high.[3]

Under the Sixth Circuit's flawed analysis, then, the market-share statistics inevitably will create a virtually irrebuttable presumption of anticompetitive harm, especially as the FTC claims the right to single out any GAC service as a separate market. This threatens drastic and effectively outcome-determinative impact on countless hospital mergers. Further, it hands the FTC broad power to pick and choose winners and losers in merger transactions. The only relevant question will be whether the FTC elects to challenge a particular transaction. That will be true even though, as the FTC concedes, market-

[3] A 2011 study by America's Health Insurance Plans (AHIP) found that, as of 2009, hospital ownership is "highly concentrated" in 80% of metropolitan areas. *See* http://www.ahipcoverage.com/wp-content/uploads/2011/06/ACOs-Cory-Capps-Hospital-Market-Consolidation-Final.pdf.

share statistics are largely irrelevant to the unilateral-effects theory of anticompetitive harm on which the FTC relies, a theory that instead turns on substitutability.

B. This Case Presents An Ideal Vehicle For Clarifying Issues That Are Rarely Litigated Through Appeal.

Not only does the Sixth Circuit's erroneous decision exacerbate confusion on fundamental aspects of merger analysis, but as a decision in a fully-litigated divestiture case, it will have an outsized effect on countless future contemplated mergers. It is thus vital that the Court address these issues now, rather than awaiting further percolation. This case is a rare and uniquely apt vehicle for consideration of the issues based on a fully-developed record.

Because of the costs associated with mergers, and the dynamic economic environment in which they occur, merger cases are rarely litigated through appeal. Instead, they are generally litigated in a preliminary injunction context, or not at all, as the very threat of litigation can scuttle the transaction. As a Department of Justice attorney explained: "Although merging firms can challenge an agency determination that a merger is anticompetitive in court, litigated Section 7 cases are relatively rare. Far more often, either a settlement is reached that allows the merger to go forward with certain conditions …, or the merging firms abandon the deal rather than go through the time and expense of litigation." Lawrence M. Frankel, *The Flawed*

Institutional Design of U.S. Merger Review: Stacking the Deck Against Enforcement, 2008 UTAH L. REV. 159, 181 (2008) (showing that of 161 transactions the government challenged in FY 1998–1999, only four were litigated). Or, as one commentator put it, "[b]oth the DOJ and the FTC do the great majority of their merger work extrajudicially through informal, intra-agency adversarial proceedings," and "[f]ully litigated government merger cases remain rare." Paul J. Stancil, *Atomism and the Private Merger Challenge*, 78 TEMP. L. REV. 949, 989 (2005). And given that those few cases that do reach appellate review typically arise in a preliminary injunction setting, legal analysis tends to be cursory, and undertaken through the lens of the reasonable-likelihood-of-success standard, rather than by consideration of the issues on a fully-developed record.

The dearth of merger cases makes it problematic to bypass review here to await further deliberation among the lower courts. That is particularly true as the decision adopts an exceedingly broad view of the FTC's power to defeat mergers. As a repeat merger litigator, the FTC has frequent opportunities to re-argue lower-court rulings that *it* contends are erroneous. But given the rarity of full-fledged litigation *challenging* FTC determinations, the erroneous framework below in the FTC's favor may be permanently insulated from the Court's review unless accepted for review now.

Moreover, even if the Court has an opportunity to provide review years down the road, during the intervening time, the erroneous framework below

will wrongfully doom mergers that create no meaningful prospect of competitive harm. And, given the localized nature of hospital markets, the decision hands the FTC a near veto over almost any proposed hospital merger in the nation. The chilling effect on hospital mergers is obvious, as is the need for this Court's plenary review.

CONCLUSION

For the above reasons, the petition should be granted and the judgment below reversed.

Respectfully submitted,

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December 22, 2014

APPENDIX

APPENDIX

TABLE OF CONTENTS

VOLUME 1

VOLUME 2

VOLUME 3 - (SEALED)

APPENDIX A

RECOMMENDED FOR FULL-TEXT PUBLICATION
Pursuant to Sixth Circuit I.O.P. 32.1(b)

File Name: 14a0083p.06

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

PROMEDICA HEALTH SYSTEM, INC., Petitioner,	)	
v.	)	No. 12-3583
FEDERAL TRADE COMMISSION. Respondent.	)	

On Petition for Review of a Final Order of the
Federal Trade Commission
No. 9346.

Argued: March 7, 2013
Decided and Filed: April 22, 2014

Before: KETHLEDGE, WHITE, and STRANCH, Circuit Judges.

COUNSEL

ARGUED: Douglas R. Cole, ORGAN COLE + STOCK LLP, Columbus, Ohio, for Petitioner. Michele Arington, FEDERAL TRADE COMMISSION, Washington, D.C., for Respondent. **ON BRIEF:** Douglas R. Cole, Erik J. Clark, ORGAN COLE + STOCK LLP, Columbus, Ohio, David Marx, Jr., Stephen Y. Wu, MCDERMOTT WILL & EMERY LLP, Chicago, Illinois, for Petitioner. Michele Arington, John F. Daly, FEDERAL TRADE COMMISSION, Washington, D.C., for Respondent. Beth Heifetz, Tara Stuckey Morrissey, JONES DAY, Washington, D.C., Mark J. Botti, Hyland Hunt, AKIN GUMP STRAUSS HAUER & FELD LLP, Washington, D.C., for Amici Curiae.

OPINION

KETHLEDGE, Circuit Judge. This is an antitrust case involving a proposed merger between two of the four hospital systems in Lucas County, Ohio. The parties to the merger were ProMedica, by far the county's dominant hospital provider, and St. Luke's, an independent community hospital. The two merged in August 2010, leaving ProMedica with a market share above 50% in one relevant product market (for so-called primary and secondary services) and above 80% in another (for obstetrical services). Five months later, the Federal Trade Commission challenged the merger under § 7 of the Clayton Act, 15 U.S.C. § 18.

After extensive hearings, an Administrative Law Judge and later the Commission found that the merger would adversely affect competition in violation of § 7. The Commission therefore ordered ProMedica to divest St. Luke's. ProMedica now petitions for review of the Commission's order, arguing that the Commission was wrong on both the law and the facts in its analysis of the merger's competitive effects. We think the Commission was right on both counts, and deny the petition.

I.

A.

Lucas County is located in the northwestern corner of Ohio, with approximately 440,000 residents. Toledo lies near the county's center; more affluent suburbs lie to the southwest. Two-thirds of the county's patients have government-provided health insurance, such as Medicare or Medicaid. Twenty-nine percent of the county's patients have private health insurance, which pays significantly higher rates to hospitals than government-provided insurance does. (Medicare and Medicaid reimbursements generally do not cover the providers' actual cost of services.) A relatively large proportion of the county's privately insured patients reside in the county's southwestern corner.

This case concerns the market—or markets, depending on how one defines them—for "general acute-care" (GAC) inpatient services in Lucas County. GAC comprises four basic categories of services. The most basic are "primary services," such as hernia surgeries, radiology services, and most

kinds of inpatient obstetrical (OB) services. "Secondary services," such as hip replacements and bariatric surgery, require the hospital to have more specialized resources. "Tertiary services," such as brain surgery and treatments for severe burns, require even more specialized resources. And "quaternary services," such as major organ transplants, require the most specialized resources of all.

Different hospitals offer different levels of these services. There are four hospital providers in Lucas County. The most dominant is ProMedica, with 46.8% of the GAC market in Lucas County in 2009. ProMedica operates three hospitals in the county, which together provide primary (including OB), secondary, and tertiary services. The county's second-largest provider is Mercy Health Partners, with 28.7% of the GAC market in 2009. Mercy likewise operates three hospitals in the county, which together provide primary (including OB), secondary, and tertiary services. The University of Toledo Medical Center (UTMC) is the county's third-largest provider, with 13% of the GAC market. UTMC operates a single teaching and research hospital, just south of downtown Toledo, and focuses on tertiary and quaternary services. It does not offer OB services. The remaining provider is St. Luke's Hospital, which before the merger was an independent, not-for-profit hospital with 11.5% of the GAC market. St. Luke's offers primary (including OB) and secondary services, and is located in southwest Lucas County.

B.

With respect to privately insured patients, hospital providers do not all receive the same rates for the same services. Far from it: each hospital negotiates its rates with private insurers (known as Managed Care Organizations, or MCOs); and the rates themselves are determined by each party's bargaining power. The parties' bargaining power depends on a variety of factors. An MCO's bargaining power depends primarily on the number of patients it can offer a hospital provider. Hospitals need patients like stores need customers; and hence the greater the number of patients that an MCO can offer a provider, the greater the MCO's leverage in negotiating the hospital's rates.

But MCOs compete with each other just as hospitals do. And to attract patients, an MCO's health-care plan must offer a comprehensive range of services—primary, secondary, tertiary, and quaternary—within a geographic range that patients are willing to travel for each of those services. (The range is greater for some services than others.) These criteria in turn create leverage for hospitals to raise rates: to the extent patients view a hospital's services as desirable or even essential—say, because of the hospital's location or its reputation for quality—the hospital's bargaining power increases.

But another important criterion for a plan's competitiveness is its cost. Thus, if a hospital demands rates above a certain level—the so-called "walk-away" point—the MCO will try to assemble a network without that provider. For example, rather

than include all four hospital providers in its network, the MCO might include only three. If a provider becomes so dominant in a particular market that no MCO can walk away from it and remain competitive, however, then that provider can demand—and more to the point receive—monopoly rates (*i.e.*, prices significantly higher than what the MCOs would pay in a competitive market).

Here, before the merger, MCOs in Lucas County had sometimes offered networks that included all four hospital providers, but sometimes offered networks that included only three. From 2001 until 2008, for example, Lucas County's largest MCO, Medical Mutual of Ohio, successfully marketed a network of Mercy, UTMC, and St. Luke's. Since 2000, however, no MCO has offered a network that did not include either ProMedica or St. Luke's—the parties to the merger here.

C.

The likely reason MCOs have historically found it necessary to include either ProMedica or St. Luke's in their networks is that those providers are dominant in southwest Lucas County, where St. Luke's is located. In that part of the county—relatively affluent, and with a high proportion of privately insured patients—ProMedica and St. Luke's were direct competitors before the merger at issue here. Indeed, St. Luke's viewed ProMedica as its "most significant competitor," while ProMedica viewed St. Luke's as a "[s]trong competitor"—strong enough, in fact, that ProMedica offered to discount its rates by 2.5% for MCOs who excluded St. Luke's from

their networks. But in this competition ProMedica had the upper hand. It is harder for an MCO to exclude the county's most dominant hospital system than it is for the MCO to exclude a single hospital that services just one corner of the county—a corner, moreover, that the dominant system also services. And that means the MCOs' walk-away point for the dominant system is higher—perhaps much higher—than it is for the single hospital. Here, the record bears out that conclusion: ProMedica's rates before the merger were among the highest in the State, while St. Luke's rates did not even cover its cost of patient care. That was true even though St. Luke's quality ratings on the whole were better than ProMedica's.

As a result, St. Luke's struggled in the years before the merger, losing more than $25 million between 2007 and 2009. To improve matters, St. Luke's hired Daniel Wakeman, a hospital-turnaround specialist, as its CEO. Wakeman implemented a three-year plan to reduce costs, increase revenues, and regain patient volume from ProMedica. Eventually St. Luke's fortunes began to improve: by August 2010, St. Luke's was out of the red (albeit barely), and Wakeman reported that "this positive margin confirms that we can run in the black if activity stays high."

By then, however, St. Luke's was contemplating other options. In August 2009, Wakeman presented three options to St. Luke's Board. The first was for St. Luke's to "[r]emain independent" by "cut[ting] major services" until an "accepted margin is realized." The second was for St. Luke's to "[p]ush the

[MCOs] . . . to raise St. Luke's reimbursement rates to an acceptable margin." Under this option, Wakeman noted, "the message [to MCOs] would be [to] pay us now (a little bit more) or pay us later (at the other hospital system contractual rates)." The third option was for St. Luke's to join one of the three other providers in Lucas County—ProMedica, Mercy, or UTMC.

Of all these options, Wakeman believed that a merger with ProMedica "ha[d] the greatest potential for higher hospital rates. A ProMedica-[St. Luke's] partnership would have a lot of negotiating clout." Wakeman also recognized, however, that an affiliation with ProMedica could "[h]arm the community by forcing higher hospital rates on them."

Three months later, Wakeman recommended to St. Luke's Board that it pursue a merger with ProMedica. The Board accepted the recommendation the same day. Six months later, on May 25, 2010, ProMedica and St. Luke's signed a merger agreement.

D.

In July 2010—less than two months after the agreement was signed—the FTC opened an investigation into the merger's competitive effects. A month later, the FTC and ProMedica entered into a "Hold Separate Agreement" that allowed ProMedica to close the deal, but that, during the pendency of the FTC investigation, barred ProMedica from terminating St. Luke's contracts with MCOs, eliminating or transferring St. Luke's clinical services, or terminating St. Luke's employees without

cause. With these restrictions in place, ProMedica and St. Luke's closed the merger deal on August 31, 2010.

In January 2011, the FTC filed an administrative complaint against ProMedica. Later that month, the FTC and the state of Ohio filed a separate complaint in federal district court in Toledo, seeking a preliminary injunction that would extend the Hold Separate Agreement pending the outcome of the FTC's administrative complaint. The district court granted the injunction.

Meanwhile, in the administrative proceeding, an ALJ held a hearing that lasted over 30 days and produced more than 8,000 pages of trial testimony and over 2,600 exhibits. In December 2011, the ALJ issued a lengthy written decision. The ALJ found that the merger would "result[] in a tremendous increase in concentration in a market that already was highly concentrated"; that the merger would eliminate competition between ProMedica and St. Luke's, thereby increasing ProMedica's bargaining power with MCOs; and that ProMedica would be particularly dominant in southwest Lucas County—an area with a relatively high proportion of privately insured patients. Thus, the ALJ found that the merger would allow ProMedica unilaterally to increase its prices above a competitive level. The ALJ also found that the merger did not create any efficiencies sufficient to offset its anticompetitive effects. Consequently, the ALJ concluded that the merger likely would substantially lessen competition in violation of § 7 of the Clayton Act. As a remedy, the ALJ ordered ProMedica to divest St. Luke's.

ProMedica appealed the ALJ's decision to the Commission, which found that the merger increased ProMedica's market share far above the threshold required to create a presumption that the merger would lessen competition. The Commission also found that a large body of other evidence—including documents and testimony from the merging parties themselves, testimony from the MCOs, and expert testimony—confirmed that the merger would have a substantial anticompetitive effect. The Commission therefore affirmed the ALJ's decision and ordered ProMedica to divest St. Luke's.

This petition followed.

II.

We review the Commission's legal conclusions de novo, and its factual findings under the substantial-evidence standard. 15 U.S.C. § 21(c); *Realcomp II, Ltd. v. FTC*, 635 F.3d 815, 823 (6th Cir. 2011). Substantial evidence is evidence that "a reasonable mind might accept as adequate to support a conclusion." *Realcomp II*, 635 F.3d at 824 (quoting *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 477 (1951)).

Section 7 of the Clayton Act prohibits mergers "where in any line of commerce . . . the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. § 18. As its language suggests, Section 7 deals in "probabilities, not certainties." *Brown Shoe Co. v. United States*, 370 U.S. 294, 323 (1962).

A.

"Merger enforcement, like other areas of antitrust, is directed at market power." *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 713 (D.C. Cir. 2001) (quoting Lawrence A. Sullivan & Warren S. Grimes, *The Law of Antitrust* § 9.1 at 511 (2000)). Market power is itself a term of art that the Department of Justice's Horizontal Merger Guidelines (which we consider useful but not binding upon us here) define as the power of "one or more firms to raise price, reduce output, diminish innovation, or otherwise harm consumers as a result of diminished competitive constraints or incentives." *Horizontal Merger Guidelines* (2010) ("Merger Guidelines") § 1 at 2.

Often, the first steps in analyzing a merger's competitive effects are to define the geographic and product markets affected by it. *See United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 510 (1974). Here, the parties agree that the relevant geographic market is Lucas County. The relevant product market or markets, however, are more difficult. The first principle of market definition is substitutability: a relevant product market must "identify a set of products that are reasonably interchangeable[.]" Horizontal Merger Guidelines § 4.1. Chevrolets and Fords might be interchangeable in this sense, but Chevrolets and Lamborghinis are probably not. *See* 2B Phillip E. Areeda, Herbert Hovenkamp & John L. Solow, Antitrust Law ¶ 533e at 259 (3d ed. 2007). "The general question is whether two products can be used for the same purpose, and if so, whether and to what extent purchasers are willing to substitute one

for the other." *F.T.C. v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 119 (D.D.C. 2004) (quotations omitted).

By this measure, each individual medical procedure could give rise to a separate market: "[i]f you need your hip replaced, you can't decide to have chemotherapy instead." *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990). But nobody advocates that we analyze the effects of this merger upon hundreds if not thousands of markets for individual procedures; instead, the parties agree that we should "cluster" these markets somehow. The parties disagree, however, on the principles that should govern which services are clustered and which are not.

Two theories of clustering are pertinent here. The first—which the FTC advocates and the Commission adopted—is the "administrative-convenience" theory. (A better name might be the "similar-conditions" theory.) This theory holds, in essence, that there is no need to perform separate antitrust analyses for separate product markets when competitive conditions are similar for each. *See Emigra Group v. Fragomen*, 612 F. Supp. 2d 330, 353 (S.D.N.Y. 2009). In *Brown Shoe*, for example, the Supreme Court analyzed together the markets for men's, women's, and children's shoes, because the competitive conditions for each of them were similar. 370 U.S. at 327-28.

The competitive conditions for hospital services include the barriers to entry for a particular service—*e.g.*, how difficult it might be for a new competitor to buy the equipment and sign up the

professionals necessary to offer the service—as well as the hospitals' respective market shares for the service and the geographic market for the service. *See* Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, Law & Contemp. Probs., Spring 1988, at 93, 138; *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 142-43 (E.D.N.Y. 1997). If these conditions are similar for a range of services, then the antitrust analysis should be similar for each of them. *Long Island*, 983 F. Supp. at 142-43. Thus, if the competitive conditions for, say, secondary inpatient procedures are all reasonably similar, then we can cluster those services when analyzing a merger's competitive effects.

Here, the Commission applied this theory to cluster both primary services (but excluding OB, for reasons discussed below) and secondary services for purposes of analyzing the merger's competitive effects. Substantial evidence supports that demarcation. The respective market shares for each of Lucas County's four hospital systems (ProMedica, Mercy, UTMC, St. Luke's) are similar across the range of primary and secondary services. A hospital's market share for shoulder surgery, for example, is similar to its market share for knee replacements. Barriers to entry are likewise similar across primary and secondary services. So are the services' respective geographic markets. Thus, the competitive conditions across the markets for primary and secondary services are similar enough to justify clustering those markets when analyzing the

merger's competitive effects. *See Emigra Group*, 612 F. Supp. 2d at 353.

But the same is not true for OB services, whose competitive conditions differ in at least two respects from those for other services. First, before the merger, ProMedica's market share for OB services (71.2%) was more than half-again greater than its market share for primary and secondary services (46.8%). And the merger would drive ProMedica's share for OB services even higher, to 80.5%—no small number in this area of the law. Second, and relatedly, before the merger there were only three hospital systems that provided OB services in Lucas County (ProMedica, Mercy, St. Luke's) rather than four; after the merger, there would be only two. (One might also suspect that the geographic market for OB services is smaller than it is for other primary services—one can drive only so far when the baby is on the way—but the record is not clear on that point.) The Commission therefore flagged OB as a separate relevant market for purposes of analyzing the merger's competitive effects. For the reasons just stated, substantial evidence supports that decision.

Finally, the Commission excluded tertiary services from its analysis of the merger's competitive effects. The competitive conditions for tertiary services differ from those for primary and secondary services, in part because patients are willing to travel farther for tertiary services (*e.g.*, a liver transplant) than they are for primary or secondary services (*e.g.*, hernia surgery). Indeed, UTMC's representative testified that, "[f]or the tertiary . . . services, we compete with . . . institutions such as the University

of Michigan, the Cleveland Clinic, University Hospital in Cleveland, and the Ohio State University." The geographic market for tertiary services is therefore larger than the geographic market for primary and secondary services. Moreover, the hospitals' respective market shares for these services are different than their respective shares for primary or secondary services; St. Luke's market share for tertiary services, for example, is nearly zero. Thus, the competitive conditions for tertiary services differ from those for primary and secondary services. (The same is undisputedly true for quaternary services, which the Commission likewise excluded from its analysis.)

To all this ProMedica offers two responses. The first concerns the 2010 Horizontal Merger Guidelines. Section 4 of the Guidelines provides that "[m]arket definition focuses solely on demand substitution factors"—that is, the extent to which consumers regard one product as a substitute for another. And ProMedica points out that the Commission's use of the administrative-convenience theory (to cluster the markets for primary and secondary services) focuses on market shares and entry conditions—both of which, ProMedica correctly observes, are "supply-side" considerations. (Entry conditions, for example, concern the ease with which new competitors can enter the relevant market and thus augment the supply for a particular product.) Thus, ProMedica concludes, the Commission's clustering methodology contradicts the Horizontal Merger Guidelines.

But ProMedica's conclusion does not follow. The reference to demand-side considerations in § 4 of the Guidelines concerns the manner in which one defines a relevant *market*, not the conditions under which one can cluster admittedly *different* markets when analyzing a merger's competitive effects. The administrative-convenience theory asks a different question (whether the competitive conditions for two markets are similar enough to analyze them together) than the one answered by § 4 of the Guidelines (how one defines an individual market in the first place). To analogize to a different area of law: ProMedica's argument is like saying that a district court should not certify a particular class because it includes different plaintiffs.

ProMedica's second response is to offer an altogether different approach to clustering, which in some quarters is known as the "transactional-complements" theory. (Per Orwell's admonition to use concrete terms instead of vague ones, *see* Orwell, *Politics and the English Language* (1946), we call this the "package-deal" theory instead.) The package-deal theory holds that, if "most customers would be willing to pay monopoly prices for the convenience" of receiving certain products as a package, then the relevant market for those products is the market for the package as a whole. 2B Areeda, *Antitrust Law*, ¶ 565c at 408. That is true even though the individual products in the package are not substitutes for each other. *Id*. For example, in *United States v. Grinell Corp.*, 384 U.S. 563, 572 (1966), the Supreme Court found that the relevant market for a package of

centrally monitored alarm services (burglar and fire) was the market for the package as a whole.

ProMedica argues that the package-deal theory applies here because MCOs typically bargain for all of a hospital's services in a single negotiation. That is true enough; but the specific "package" that ProMedica advocates is one comprising not only primary (excluding OB) and secondary services—which everyone agrees should be clustered when analyzing the merger's competitive effects—but also tertiary and OB services. And that makes the question presented by ProMedica's argument much narrower. To wit: whether the MCOs are willing to pay a premium to have a package of services *that includes tertiary and OB* delivered by a single provider. If so, the relevant market is the market for the package as a whole. *See* 2B Areeda ¶ 565c at 408.

But the record makes plain that the MCOs do not demand from each hospital a package of services that includes tertiary and OB. For example, St. Luke's offers virtually no tertiary services, and yet the MCOs still contract for the services that St. Luke's does offer. Likewise, UTMC does not offer OB services, and yet the MCOs still contract with UTMC. And as for the hospital systems that do provide all those services—*i.e.*, ProMedica and Mercy—there is no evidence that MCOs are willing to pay a premium to have all of those services delivered by either of those providers in a single package. It is true that MCOs must offer their *members* (*i.e.*, patients) a network that provides a complete package of hospital services. But the record shows that the MCOs do not need to obtain all of those services from a single

provider. There are no market forces that bind primary, secondary, tertiary, and OB services together like a single plywood sheet.

In summary, even ProMedica conceded in its answer to the FTC's complaint that the "more sophisticated and specialized tertiary and quaternary services, such as major surgeries and organ transplants, also are properly excluded from the relevant market[.]" Answer ¶ 13. ProMedica was correct to make that concession then, and incorrect to seek to retract it now. The relevant markets, for purposes of analyzing the merger's competitive effects, are what the Commission says they are: (1) a cluster market of primary (but not OB) and secondary inpatient services (hereafter, the "GAC market"), and (2) a separate market for OB services.

B.

ProMedica's next argument is that the Commission relied too heavily on market concentration data to establish a presumption of anticompetitive harm. Agencies typically use the Herfindahl-Hirschman Index (HHI) to measure market concentration. "The HHI is calculated by summing the squares of the individual firms' market shares, and thus gives proportionately greater weight to the larger market shares." *Merger Guidelines* § 5.3 at 18. Agencies use HHI data to classify markets into three types: "unconcentrated markets," which have an HHI below 1500; "moderately concentrated markets," which have an HHI between 1500 and 2500; and "highly concentrated markets," which have an HHI above 2500. *Id*. at 19. The Guidelines further

provide that "[m]ergers resulting in highly concentrated markets that involve an increase in the HHI of more than 200 points will be presumed to be likely to enhance market power." Thus, as a general matter, a merger that increases HHI by more than 200 points, to a total number exceeding 2500, is presumptively anticompetitive. *Id*. § 5.3 at 19; *see also, e.g.*, *Heinz*, 246 F.3d at 716 (merger that would have increased HHI by 510 points to 5,285 created presumption of anticompetitive effects by a "wide margin"); *United States v. H & R Block, Inc.*, 833 F. Supp. 2d 36, 72 (D.D.C. 2011) (merger that would have increased HHI by approximately 400 points to 4,691 created presumption of anticompetitive effects).

The merger here blew through those barriers in spectacular fashion. In the GAC market, the merger would increase the HHI by 1,078 (more than five times the increase necessary to trigger the presumption of illegality) to a total number of 4,391 (almost double the 2,500 threshold for a highly concentrated market). The OB numbers are even worse: the merger would increase HHI by 1,323 points (almost seven times the increase necessary for the presumption of illegality) to a total number of 6,854 (almost triple the threshold for a highly concentrated market). The Commission therefore found the merger to be presumptively illegal.

ProMedica responds that this sort of analysis—measuring HHI to apply a presumption of illegality—applies only in "coordinated-effects" cases, rather than in "unilateral-effects" ones. And the FTC admittedly challenges the merger only on unilateral-effects grounds here. The two theories are different:

the idea behind coordinated effects is 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." *H&R Block*, 833 F. Supp.2d at 77. A simple example might be parallel pricing by two gas stations located across the street from each other in a remote small town. Unilateral-effects theory, on the other hand, holds that "[t]he elimination of competition between two firms that results from their merger may alone constitute a substantial lessening of competition." *Merger Guidelines* § 6 at 20. The most obvious example of this phenomenon is a "merger to monopoly"—*e.g.*, where a market has only two firms, which then merge into one—but unilateral effects "are by no means limited to that case." *Id*. The Guidelines also distinguish between unilateral effects for "homogeneous products" and for "differentiated products." Homogeneous products are indistinguishable from each other—oil, corn, coal—whereas differentiated products are similar enough to compete in a relevant market, but different enough that some customers prefer one product over another. The market for cola products is an example. Here, the relevant markets involve differentiated products: hospitals have different doctors, facilities, and (perhaps above all) locations, which means that some patients prefer certain hospitals over others.

"The extent of direct competition between the products sold by the merging parties is central to the evaluation of unilateral effects." *Id*. § 6.1. "Direct competition," in this sense, does not mean merely

that products are within a relevant market; instead, it refers to the extent to which consumers regard the products as close substitutes. Thus, unilateral-effects analysis examines whether differentiated products are not merely substitutes for one another, but close substitutes for some fraction of consumers. In the market for upscale sedans, for example, Audi and Jaguar might be closer substitutes for some consumers than Audi and Lincoln are. (For other consumers in the same market–say, consumers who prefer domestic brands—Lincoln and Cadillac might be closer substitutes.) These hierarchies of consumer preference, which are themselves iridescent from consumer to consumer, are critical to unilateral-effects analysis. For "[u]nilateral 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*.

For a merger to raise concerns about unilateral effects, however, not every consumer in the relevant market must regard the products of the merging firms as her top two choices. Instead, "[s]ubstantial unilateral price elevation post-merger for a product 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*. at 20-21. That "significant fraction," moreover, "need not approach a majority." *Id*. at 21.

But none of this, in ProMedica's view, has much to do with market concentration *per se*. Thus, what the Commission should have focused on, ProMedica says, is the extent to which consumers regard

ProMedica as their next-best choice after St. Luke's, or vice-versa. And ProMedica therefore argues that the Commission was wrong to presume the merger illegal based upon HHI data alone.

The argument is one to be taken seriously. The Guidelines themselves state that "[a]gencies rely much more on the value of diverted sales [*i.e.*, in rough terms, the extent to which the products of the merging firms are close substitutes] than on the level of HHI for diagnosing unilateral price effects in markets with differentiated products." *Id*. But this case is exceptional in two respects. First, even without conducting a substitutability analysis, the record already shows a strong correlation between ProMedica's prices—*i.e.*, its ability to impose unilateral price increases—and its market share. Before the merger, ProMedica's share of the GAC market was 46.8%, followed by Mercy with 28.7%, UTMC with 13%, and St. Luke's with 11.5%. And ProMedica's prices were on average 32% higher than Mercy's, 51% higher than UTMC's, and 74% higher than St. Luke's. Thus, in this market, the higher a provider's market share, the higher its prices. In ProMedica's case, that fact is not explained by the quality of ProMedica's services or by its underlying costs. Instead, ProMedica's prices—already among the highest in the State—are explained by *bargaining power*. As the Commission explained: "the hospital provider's bargaining leverage will depend upon how the MCO would fare if its network did not include the hospital provider (and therefore became less attractive to potential members who prefer that provider's services)." Op. 36. Here, the record makes

clear that a network which does not include a hospital provider that services almost half the county's patients in one relevant market, and more than 70% of the county's patients in another relevant market, would be unattractive to a huge swath of potential members. Thus, the Commission had every reason to conclude that, as ProMedica's dominance in the relevant markets increases, so does the need for MCOs to include ProMedica in their networks—and thus so too does ProMedica's leverage in demanding higher rates.

The second respect in which this case is exceptional is simply the HHI numbers themselves. Even in unilateral-effects cases, at some point the Commission is entitled to take seriously the alarm sounded by a merger's HHI data. And here the numbers are in every respect multiples of the numbers necessary for the presumption of illegality. Before the merger, ProMedica already held dominant market shares in the relevant markets, which were themselves already highly concentrated. The merger would drive those numbers even higher—ProMedica's share of the OB market would top 80%—which makes it extremely likely, as matter of simple mathematics, that a "significant fraction" of St. Luke's patients viewed ProMedica as a close substitute for services in the relevant markets. On this record, the Commission was entitled to put significant weight upon the market-concentration data standing alone.

These two aspects of this case—the strong correlation between market share and price, and the degree to which this merger would further

concentrate markets that are already highly concentrated—converge in a manner that fully supports the Commission's application of a presumption of illegality. What ProMedica overlooks is that the "ultimate inquiry in merger analysis" is not substitutability, but "'whether the merger is likely to create or enhance *market power* or facilitate its exercise.'" Carl Shapiro, *The 2010 Horizontal Merger Guidelines: From Hedgehog to Fox in Forty Years*, 77 Antitrust L.J. 49, 57 (2010) (emphasis added) (quoting U.S. Dep't of Justice & Fed. Trade Comm'n, *Commentary on the Horizontal Merger Guidelines* (2006)). Here, as shown above, the correlation between market share and price reflects a correlation between market share and market power; and the HHI data strongly suggest that this merger would enhance ProMedica's market power even more, to levels rarely tolerated in antitrust law. In the context of this record, therefore, the HHI data speak to our "ultimate inquiry" as directly as an analysis of substitutability would. The Commission was correct to presume the merger substantially anticompetitive.

C.

The remaining question is whether ProMedica has rebutted that presumption. ProMedica argues on several grounds that it has; but more remarkable is what ProMedica does not argue. By way of background, the goal of antitrust law is to enhance consumer welfare. *See, e.g.*, *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 221 (1993); 2B Areeda ¶ 100 at 4 ("the principal objective of antitrust policy is to maximize consumer welfare by encouraging firms to behave

competitively") (cited in *Kirtsaeng v. John Wiley & Sons, Inc.*, 133 S. Ct. 1351, 1363 (2013)); *cf. Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979) ("Congress designed the Sherman Act as a 'consumer welfare prescription'") (quoting Bork, *The Antitrust Paradox* 66 (1978)). And the Merger Guidelines themselves recognize that "a primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products." *Merger Guidelines* § 10 at 29; *see also* Shapiro, *supra* at 80 ("Efficiencies generate *downward* pricing pressure that may outweigh the upward pricing pressure"). Thus, the parties to a merger often seek to overcome a presumption of illegality by arguing that the merger would create efficiencies that enhance consumer welfare. *See, e.g.*, *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1222 (11th Cir. 1991). But ProMedica did not even attempt to argue before the Commission, and does not attempt to argue here, that this merger would benefit consumers (as opposed to only the merging parties themselves) in any way. To the contrary, St. Luke's CEO admitted that a merger with ProMedica might "[h]arm the community by forcing higher rates on them." The record with respect to the merger's effect on consumer welfare, therefore, only diminishes ProMedica's prospects here.

That the Commission did not merely rest upon the presumption, but instead discussed a wide range of evidence that buttresses it, makes ProMedica's task more difficult still. On that score the

Commission's best witnesses were the merging parties themselves. Those witnesses established that ProMedica and St. Luke's are direct competitors: St. Luke's CEO testified that ProMedica was St. Luke's "most significant competitor," while a ProMedica witness testified that ProMedica viewed St. Luke's as a "[s]trong competitor"—strong enough that ProMedica offered at least one MCO a 2.5% discount off its rates if the MCO excluded St. Luke's from its network. St. Luke's management was also candid about the merger's potential impacts on its prices: its CEO stated that a merger with ProMedica "has the greatest potential for higher hospital rates" and would bring "a lot of negotiating clout." The parties' own statements, therefore, tend to confirm the presumption rather than rebut it.

The same is true of testimony from the MCO witnesses. Those witnesses testified that a network comprising only Mercy and UTMC—the only other providers who would remain after the merger—would not be commercially viable because it would leave them with a "hole" in the suburbs of southwest Lucas County. (That no MCO has offered such a network during the past decade corroborates the point.) Consequently, the MCO witnesses explained, they would have no walk-away option in post-merger negotiations with ProMedica—and thus little ability to resist ProMedica's demands for even higher rates. ProMedica responds that this testimony is self-serving, which might well be true (though one might construe ProMedica's response as an implicit admission of the MCOs' point). But ProMedica otherwise offers no reason to think the MCOs'

predictions are wrong—and the record offers plenty of reason to think they are right.

ProMedica's task, then, is to overcome not merely the presumption of anticompetitive effects, but also the statements of the merging parties themselves, and the MCOs' testimony, and ProMedica's failure to cite any efficiencies that would result from this merger. To that end, ProMedica argues that Mercy, rather than St. Luke's, is ProMedica's closest substitute—because Mercy, like ProMedica, offers tertiary services, whereas St. Luke's does not. But any argument about substitutes must begin with a definition of the relevant market; and ProMedica's argument is based upon a market definition that we have already rejected. That Mercy offers tertiary services, and St. Luke's for the most part does not, matters only if the relevant market is one for a primary, secondary, and tertiary services wrapped together *in a single packa*ge. That is not the relevant market here. *See supra* at 12-14. Instead, the relevant markets are those for GAC services and OB services, respectively—markets in which the merging parties' own statements show that ProMedica and St. Luke's are direct competitors. ProMedica's argument is meritless.

ProMedica also argues that MCOs, rather than patients, are the relevant consumers here, and that the Commission therefore erred by "assess[ing] substitutability from the patients' perspective." But this is an argument about semantics. MCOs assemble networks based primarily upon patients' preferences, not their own; and thus the extent to which an MCO regards ProMedica and St. Luke's as

close substitutes depends upon the extent to which the MCO's members do.

Finally, ProMedica argues that St. Luke's was in such dire financial straits before the merger that it "was not a meaningful competitive constraint on ProMedica." This argument is known as a "weakened competitor" one, and is itself "probably the weakest ground of all for justifying a merger." *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1339 (7th Cir. 1981). Courts "credit such a defense only in rare cases, when the [acquiring firm] makes a substantial showing that the acquired firm's weakness, which cannot be resolved by any competitive means, would cause that firm's market share to reduce to a level that would undermine the government's *prima facie* case." *Univ. Health*, 938 F.2d at 1221. In other words, this argument is the Hail-Mary pass of presumptively doomed mergers—in this case thrown from ProMedica's own end zone. The record demonstrates that St. Luke's market share was increasing prior to the merger; that St. Luke's had sufficient cash reserves to pay all of its obligations and meet its capital needs without any additional borrowing; and that, according to St. Luke's CEO, "we can run in the black if activity stays high." St. Luke's difficulties before the merger provide no basis to reject the Commission's findings about the merger's anticompetitive effects.

ProMedica has failed to rebut the presumption that its merger with St. Luke's would reduce competition in violation of the Clayton Act. We therefore need not address ProMedica's remaining

criticisms of various other evidence that merely buttressed that presumption.

D.

ProMedica argues that the Commission erred in ordering divestiture as a remedy. We review the Commission's choice of remedy for abuse of discretion. *Jacob Siegel Co. v. FTC*, 327 U.S. 608, 611-12 (1946). In doing so, we resolve "all doubts" in the Commission's favor. *United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 334 (1961).

Once a merger is found illegal, "an undoing of the acquisition is a natural remedy." *Id.* at 329. Here, the Commission found that divestiture would be the best means to preserve competition in the relevant markets. The Commission also found that ProMedica's suggested "conduct remedy"—which would establish, among other things, separate negotiation teams for ProMedica and St. Luke's—was disfavored because "there are usually greater long term costs associated with monitoring the efficacy of a conduct remedy than with imposing a structural solution." And the Commission found no circumstances warranting such a remedy here. We have no basis to dispute any of those findings. The Commission did not abuse its discretion in choosing divestiture as a remedy.

* * *

The Commission's analysis of this merger was comprehensive, carefully reasoned, and supported by substantial evidence in the record. The petition is denied.

APPENDIX B

Redacted Public Version

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

Opinion of the Commission

By Commissioner Julie Brill

I. INTRODUCTION[1]

This case involves the consummated joinder ("the Joinder") of two hospital providers in Toledo, Ohio:

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

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

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

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

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

II. PROCEDURAL HISTORY

A. Investigation, Pleadings, and Preliminary Injunction

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

FTC staff opened an investigation of the transaction in July 2010. On August 18, 2010, ProMedica entered into a limited Hold Separate Agreement that allowed the deal to close but restricted ProMedica from making certain changes to St. Luke's. *See* PX0069; IDF 12. Among other things,

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

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

the Hold Separate Agreement prevents ProMedica from terminating St. Luke's contracts with health plans; eliminating, transferring or consolidating clinical services at St. Luke's; or terminating any St. Luke's employees without cause. The Hold Separate Agreement also allows health plans the option to extend their St. Luke's contracts past the termination date rather than to negotiate new contracts with ProMedica. IDF 13. The Joinder Agreement was consummated on August 31, 2010. Answer ¶ 2.

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

The FTC and the State of Ohio also brought suit in the U.S. District Court for the Northern District of

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

B. Initial Decision

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

Within the relevant GAC inpatient hospital services market, Judge Chappell found that the Joinder would significantly increase ProMedica's market share and market concentration, reducing the number of competing hospital providers from four

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

The ALJ found Respondent's defenses unpersuasive. First, he concluded that the evidence did not support Respondent's claims that excess hospital bed capacity in Toledo, repositioning by competitors, and steering patients away from high-priced hospitals by doctors, employers, or health plans would constrain post-Joinder price increases. ID 7, 80-86, 176-79. Second, he found that the procompetitive benefits and efficiencies Respondent asserted were not merger-specific, did not represent significant economies that would benefit competition, or were insufficient to outweigh the Joinder's likely anticompetitive effects. ID 7, 114-31, 192-204. Third, with respect to Respondent's claim that St. Luke's was financially weak and a limited competitor, the ALJ found that "St. Luke's clearly was struggling financially prior to the Joinder and faced significant financial challenges to remaining independent in the

future." ID 190. At the same time, the ALJ determined that prior to the Joinder "St. Luke's [had] succeeded in significantly raising its patient volume and market share," and "was still competing in the market." ID 189. On balance, he ruled, Respondent's weakened competitor justification should be rejected. ID 189; *see* ID 91-112, 180-90.

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

III. STANDARD OF REVIEW

Pursuant to 16 C.F.R. § 3.54, the Commission reviews the ALJ's findings of fact and conclusions of law *de novo*, considering "such parts of the record as are cited or as may be necessary to resolve the issues presented." The Commission may "exercise all powers which it could have exercised if it had made the initial decision."[4] *Id*. We adopt the ALJ's findings

[4] The *de novo* standard of review is required by the Administrative Procedure Act, 5 U.S.C. § 557(b), and the FTC

of fact to the extent that those findings are not inconsistent with this opinion.[5]

IV. FACTUAL BACKGROUND

A. The Third-Party Insurance System

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

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

Most other patients are covered under various types of commercial health insurance plans,

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Act, 15 U.S.C. § 45(b), (c), and applies to both findings of fact and inferences drawn from those facts. *See Realcomp II, Ltd.*, No. 9320, 2009 WL 6936319 at *16 n.11 (FTC 2009), *aff'd*, *Realcomp II, Ltd. v. FTC*, 635 F.3d 815 (6th Cir. 2011).

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

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

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

B. The Competitive Dynamics of MCO Contracting

1. The MCOs

MCOs contract with hospitals, physicians, and other health care providers in a given geographic area to create provider networks that the MCOs then

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

market to employers. The MCOs compete against one another to be included on the menu of health insurance products that employers offer to their employees, and then, after they are included as an option, they compete to attract the employee/members. IDF 234, 238.

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

2. The Hospitals

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

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

3. Employers and Employees

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

In selecting which MCOs to offer their employees, employers consider factors such as cost, the breadth of the network in terms of geographical coverage, the types of services offered, and the choice of providers. All else being equal, employers favor broad networks. Some are willing to pay more for broader network coverage, while others may consider the lower cost associated with narrower networks to be more important. IDF 256-57. Generally, employers seek to satisfy the health-care coverage preferences of their employees, while keeping costs low. IDF 260.

4. The Bargaining Process for Reimbursement Rates

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

Both the parties and the MCOs acknowledged that higher hospital reimbursement rates are passed on to employers and often to their employees. IDF

596, 599, 655-63. Thus, the MCOs would not themselves absorb the higher rates; the higher rates would be passed on to the community-at-large.

C. Types of Hospital Services

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

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

D. The Merging Parties

1. ProMedica

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

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

In addition to TTH, ProMedica operates two smaller community hospitals in Lucas County. Flower Hospital is located in Sylvania, Ohio, in the northwest Toledo area, and has about 300 licensed beds, 250 of which are staffed. IDF 61, 65. Bay Park Hospital is located in Oregon, Ohio, in the eastern Toledo area, and has about 86 licensed beds. IDF 70-

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

71. Both Bay Park and Flower offer OB services, but neither offers any tertiary services. IDF 63-64, 68-69.

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

2. St. Luke's Hospital

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

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

E. Other Hospitals in Lucas County

In addition to the ProMedica hospitals and St. Luke's, there are four other hospitals in Lucas County. Three are owned and operated by the same hospital system, Mercy, which, in turn, is part of the

Catholic Health Partners health care system headquartered in Cincinnati, Ohio. IDF 79; Shook, Tr. 887-90. The remaining hospital is UTMC, which is part of the University of Toledo and an instrumentality of the State of Ohio. IDF 103.

1. The Mercy System Hospitals

The Mercy system hospitals in Lucas County are Mercy St. Vincent, Mercy St. Anne, and Mercy St. Charles. IDF 81. St. Vincent is a large tertiary hospital with 568 registered beds, 445 of which are staffed. IDF 82-83. In addition to basic acute care services, it also offers a variety of tertiary services, including a large cardiology center, and is the only Lucas County hospital other than TTH that offers Level III inpatient OB services. IDF 82, 84. St. Vincent is located in downtown Toledo. IDF 87.

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

2. UTMC

UTMC is a research and teaching hospital, located south of downtown Toledo. IDF 103;

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

F. MCOs in Lucas County

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

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

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

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

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

228, 230. It too includes all Lucas County hospitals in its network.[9]

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

G. St. Luke's Financial Condition

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

In February 2008 St. Luke's hired a new chief executive officer, Mr. Daniel Wakeman, who had previously engineered successful turnarounds of

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

several other community hospitals. IDF 920. In June 2008 Mr. Wakeman developed a three-year strategic plan that contained certain goals for St. Luke's centered on five strategic "pillars": "Growth, People, Quality, Service, and Finance/Corporate." *Id*. By August 31, 2010, St. Luke's had achieved its growth goals of increasing inpatient revenues by more than $3.5 million a year on average, and outpatient revenues by more than $5 million a year on average. IDF 924-25. It had also achieved its goal of obtaining more than a 40 percent market share in its core service area, IDF 928,[10] and its occupancy rate in the year prior to the Joinder increased by approximately 8 percent. IDF 930. However, St. Luke's overall cost coverage ratio remained below one, meaning that St. Luke's was not generating sufficient reimbursements to cover its costs across all payors. IDF 944, 947. St. Luke's management identified the primary source of St. Luke's financial problem as "extremely low reimbursement rates from third party payors." IDF 388, quoting PX01390 at 0002, ¶ 6, *in camera*.

St. Luke's financial position improved in 2010. IDF 949. Its operating losses declined and its operating margins improved, as patient volumes increased and expenses declined. IDF 950-54, 957-58. By August 2010 – the month the Joinder was consummated – St. Luke's was able to post a positive operating margin. IDF 948. In his monthly report for August 2010, CEO Wakeman reported that "[t]he

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

high activity produced a positive operating margin of $7,000 on $36.7 million in gross revenue. It is not impressive, but it is better than a loss. This positive margin confirms that we can run in the black if activity stays high. After much work, we have built our volume up to a point where we can produce an operating margin and keep our variable expenses under control." *Id., quoting* PX00170 at 001.

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

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

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

(downsizing), not just rightsizing." PX01018 at 008, *in camera*.

With respect to the second option, management noted that "St. Luke's is being grossly underpaid." IDF 391, *quoting* PX1018 at 003, *in camera*. It cautioned, however, that "[m]any payors [are] not in a good position to raise rates" and that "[i]f the payors raise our rates, competitor systems will react by offering discounts to lock out St. Luke's again." PX1018 at 009, *in camera*.

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

The Board rejected the possibility of service cuts, and began to focus on the affiliation options. IDF 401; Black, Tr. 5703-04. In an October 30, 2009 update on affiliation options, St. Luke's management detailed the advantages and disadvantages of affiliating with each of the in-market hospitals. IDF 402-05; PX01030, *in camera*. On December 15, 2009, senior management presented another affiliation update to the Board in which it detailed a variety of financial "pressing concerns" and again analyzed the pros and cons of affiliating with ProMedica, Mercy, or UTMC.

IDF 409-14. The update acknowledged that any of the three options "could increase prices/cost to the community." IDF 419-21. As to affiliating with ProMedica, the update identified the pros as: favorable insurance contracts (noting access to ProMedica's MCO affiliate, Paramount); access to capital; investment in St. Luke's campus; potential for local governance and control; solid physician strategy and infrastructure; and financial stabilization of the organization's ability to serve and expand. IDF 421, *citing* PX01016 at 023, *in camera*. The cons were: "some quality measures are poor and history of poor relations with partners/affiliates." *Id*.

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

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

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

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

St. Luke's expected to be able to raise its rates after the Joinder. Indeed, one of the primary reasons it chose to affiliate with ProMedica was the expectation that St. Luke's would be able to significantly increase its reimbursement rates because of ProMedica's more favorable bargaining leverage with MCOs, which would be further enhanced with the deal. IDF 600-03. Highlighting this belief, a 2009 presentation regarding potential affiliation partners made to St. Luke's Board of Directors states: "An SLH affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout." IDF598; PX01030 at 020, *in camera*. The presentation conveyed management's belief that "ProMedica had a significant leverage on negotiations with some of the [health plans]" and that this leverage would allow St. Luke's to obtain higher reimbursement rates; it expressed concern that an affiliation with ProMedica could, in the short term, "harm the community by forcing higher hospital rates on them." IDF 598, *quoting* Wakeman, Tr. 2700, *in camera*.

J. The Joinder Agreement

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

V. LEGAL FRAMEWORK

Section 7 of the Clayton Act prohibits the acquisition of assets "where in any line of commerce

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

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

Courts have traditionally analyzed Section 7 claims under a burden-shifting framework. *See, e.g.*, *Heinz*, 246 F.3d at 715; *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 982-83 (D.C. Cir. 1990).

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

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

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

1977); *FTC v. Nat'l Tea Co.*, 603 F.2d 694, 699-700 (8th Cir. 1979)).

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

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

violation on the merits." *F.T.C. v. Whole Foods Market, Inc.*, 548 F.3d 1028, 1036 (D.C. Cir. 2008); *see also Polypore Int'l, Inc.*, 2010 WL 5132519 at *14 (FTC Dec. 13, 2010); *Evanston*, 2007 WL 2286195 at *73-76.[13]

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

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

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

VI. RELEVANT MARKETS

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

A. Relevant Product Market

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

The 2010 Horizontal Merger Guidelines use a related test to define the relevant product market. Under those Guidelines, the product market is defined by asking whether a hypothetical monopolist of the proposed product market could impose a small

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

In this case, the parties agree that there is a relevant product market for GAC inpatient hospital services sold to commercial health plans.[14] Complaint ¶¶ 12-13; Answer ¶ 12 (ProMedica "admits that general acute-care inpatient hospital services sold to commercial health plans constitutes a valid service market"). Accordingly, Judge Chappell found that there is a relevant product market for GAC inpatient hospital services sold to commercial health plans. ID 145. The parties also agree that this relevant product market is properly described as a cluster market. ID 139-40. A cluster market for GAC inpatient hospital services has consistently been found to be the relevant product market in prior hospital merger cases. *See, e.g.*, *FTC v. Freeman Hosp.*, 69 F.3d 260,

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

268 (8th Cir. 1995); *FTC v. Univ. Health Inc.*, 938 F.2d 1206, 1210-12 (11th Cir. 1991); *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990); *Evanston*, 2007 WL 2286195 at *40-41. In this proceeding, Judge Chappell concluded that the relevant market encompasses "all GAC inpatient hospital services – primary, secondary, and tertiary services – sold to commercial health plans." ID 143-45.

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

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

[16] Moreover, these issues affect only a small subset of the inpatient hospital services that are within the GAC inpatient hospital services market. Even if both OB services and tertiary

1. Two Proposed Approaches to Cluster Market Methodology

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

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

Complaint Counsel then collect into a cluster all of the individual relevant service markets that have similar competitive conditions – here, a common

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services are excluded from the GAC inpatient market found by the ALJ, a substantial core group of GAC inpatient hospital services that the parties agree belong in a relevant product market remains and warrants analysis regarding possible anticompetitive effects arising from the Joinder.

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

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

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

exclude OB services from their GAC inpatient hospital services cluster market and, instead, analyze OB services separately.

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

The ALJ adopted Respondent's transactional complements approach. ID 140 (explaining that "MCOs demand, and contract for, a broad array of inpatient hospital services together . . . on behalf of the members they insure"). The ALJ included tertiary services because "MCOs contract for a broad array of primary, secondary, and tertiary inpatient services from hospitals together in a single negotiated transaction." ID 142-43; IDF 304. He found that limiting "the market to only those services that both St. Luke's and ProMedica actually provide is not what MCOs demand or contract to purchase." ID at 143. The ALJ similarly determined that inpatient OB services are included in the GAC inpatient hospital services market. ID 144 (explaining that "to carve out individual hospital

services would be contrary to the logic upon which the inpatient services 'cluster market' rests").

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

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

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

With that purpose in mind, we find that cluster markets based on analytical convenience are useful and appropriate for evaluating competitive effects in this case. The identification of substitutes is at the

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

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

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

> when the same firms sell the same set of products, which do not happen to be substitutes, in the same geographic areas with similar market shares, and when each individual product would constitute a product market under the [Merger] Guidelines, the

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

> antitrust analysis of each would be so similar in practice that no loss of analytic power comes from treating the products as a collection. . . . If there is no compelling reason to believe demand and supply substitutability opportunities, entry conditions, or market shares differ significantly across individual products, then the antitrust analysis will be similar for each good so they may conveniently be analyzed as a collection.

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

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

This approach to defining a cluster market is generally consistent with prior cases that have found cluster markets. In *Philadelphia National Bank*, the Supreme Court found that "the cluster of products (various kinds of credit) and services (such as checking accounts and trust administration) denoted by the term 'commercial banking' composes" a relevant product market because the court determined that each of the products or services was effectively free from competition from other financial institutions. 374 U.S. at 356-57. In short, the competitive conditions faced by commercial banks was the same for each of the products or services in the cluster. Similarly, in *United States v. Grinnell Corp.*, 384 U.S. 563 (1966), the Court found a cluster of central station services in which the dominant firm with a 73 percent market share faced 38 competitors; whether the remaining 27 percent of the market in each service (*i.e.*, fire alarm, water flow alarm) was provided by 24 or 38 competitors, the competitive conditions were the same. *Id*. at 572-73 n.6.

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

relevant product market for primary care inpatient hospital services in addition to the GAC inpatient hospital services cluster because the primary service lines were offered by a greater number of hospitals in competition with the merging hospitals.[19]

b. Respondent's "Transactional Complements" Cluster

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

Respondent's attempt to elaborate – stressing that MCOs demand the full range of inpatient hospital services – provides no persuasive reason for defining a corresponding cluster market, given the manner in which MCOs assemble the combination of hospitals in their networks. MCOs do not demand the full range of inpatient services from each hospital or from *each* hospital provider in their network.[20]

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

[20] In Lucas County, MCOs contract with and include UTMC and Mercy St. Anne in their hospital networks despite the fact that those hospitals do not provide OB services. IDF 92, 110. Similarly, MCOs contract with and include St. Luke's and the

Rather, MCOs ensure that the full range of inpatient services is available to insured members at *some* hospital within the network. IDF 274 ("MCOs require at least one hospital in the network that offers advanced services, including tertiary services, but the network need not include more than one such hospital"), 449. Thus, the rationale on which Respondent's cluster is based – the cluster is the full range of inpatient services that MCOs demand when they negotiate with hospitals – is contradicted by the observation of actual services demanded by MCOs from each hospital or hospital provider.[21]

Worse, we find that treating all of the services within the contract in a single analysis of competitive effects likely obfuscates the competitive consequences of the transaction. Indeed, a cluster that mixes services with different geographic markets, or that groups together services for which the merger leaves different numbers of remaining rivals or has a different competitive impact, could easily confuse the competitive analysis unless great care were taken to separately analyze different aspects of the transaction's competitive effects. *See* Thomas L.

ProMedica and Mercy community hospitals in the networks even though those hospitals do not provide most tertiary services. IDF 63, 68, 74, 92, 100.

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

Greaney, *Chicago's Procrustean Bed: Applying Antitrust Law in Health Care*, 71 Antitrust L. J. 857, 882-84 (2004).

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

Respondent's approach has not been followed in prior cases. Respondent claims that the cluster is the entire group of services that a customer demands. Yet, in *Philadelphia National Bank*, where the Court

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

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

> Respondent argues that the relevant product market should be determined by using a

[22] Although the Court suggested that customers often purchased more than one item in the protective services cluster, its point was that the cluster could be justified based on economies of scope – a supply-side consideration very different from Respondent's demand-oriented transactional complements. *See Grinnell*, 384 U.S. at 573 (observing that customers utilized in combination different services provided from a single office).

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

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

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

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

3. Defining the Relevant Markets

We now address the specific issues raised by Complaint Counsel's appeal. First, we conclude that tertiary services are not part of the GAC inpatient hospital services market in this case. Importantly, in its Answer to the Complaint, Respondent admitted that tertiary services are excluded from the GAC inpatient market. Answer ¶ 13. A party is bound by the admissions in its answer. *Gibbs ex rel. estate of Gibbs v. Cigna Group*, 440 F.3d 571, 578 (2d Cir. 2006); *Mahtui v. Bohrell*, 219 F.2d 642, 643 (9th Cir. 1955). The admissions in an answer help to focus the issues in the litigation; Complaint Counsel, the ALJ, and the Commission should be able to rely on those admissions. We will not allow a Respondent to admit things in its Answer and, post-discovery, change its position.

Even if Respondent were not bound by its Answer, we would exclude tertiary services from the relevant GAC inpatient hospital services market in this case. St. Luke's generally does not provide tertiary services. *See* JSLF ¶ 6; ID 140. Absent an overlap or potential overlap involving a given service line, there

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

is no substantial lessening of competition, and, thus, no need to include the service in the relevant product market.[24] Moreover, inclusion of tertiary services could obscure the analysis of competitive effects. Because patients are likely willing to travel farther for more complex treatments, IDF 283, the geographic market for tertiary services could be larger than that for primary and secondary services. If so, the number of competitors that could constrain price increases for those tertiary services could be higher (although it would have little impact on prices for primary and secondary services), and an analysis limited to hospital providers in Lucas County might be inappropriate.[25] Under an analysis that takes care to group together only relevant service markets with similar competitive conditions, tertiary services

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

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

should not be aggregated into the cluster for GAC inpatient hospital services.

Judge Chappell notes that prior hospital merger cases have been inconsistent regarding whether tertiary services are included in a GAC inpatient hospital services market. ID 141-42 (citing *Butterworth*, 946 F. Supp. at 1291 and *United States v. Long Island Jewish Med. Center*, 983 F. Supp. at 137, 140, as examples where tertiary services were excluded from the GAC inpatient hospital services market). This is not surprising because defining a relevant product market in any particular case is a fact-specific question. However, we disagree with the ALJ's description of the Commission's treatment of the market in *Evanston*. Although the complaint in *Evanston* excluded tertiary services from the alleged relevant product market, at trial counsel for both sides agreed that, based on the particular facts of that case, tertiary services should be part of the GAC inpatient hospital services market. *See* Compl. Counsel's Answering and Cross-Appeal Brief, *In the Matter of Evanston Northwestern Healthcare Corp.*, Docket No. 9315 at 37, available at: http://www.ftc.gov/os/adjpro/d9315/060210ccattachmntpursuantrule.pdf. Thus, the issue of whether to include tertiary services in the relevant product market was not raised on appeal. Not surprisingly, the Commission decision included tertiary services in the GAC inpatient hospital services market without any analysis of the issue and focused instead on the disagreement between the parties over whether outpatient services should be included in the GAC hospital services market. *Evanston*, 2007 FTC LEXIS

210, at *146-151. The Commission is faced with a different situation here, and our decision to exclude tertiary services from the relevant GAC inpatient hospital services product market is based on the particular facts of this case.[26] Similarly, *FTC v. University Health Inc.*, 938 F.2d 1206 (11th Cir. 1991), is not inconsistent with our analysis. The Court of Appeals for the Eleventh Circuit expressly chose not to analyze whether the market was broader than the overlap services. It explained that determining the precise bounds of the relevant product market "would be of no moment for [its] purposes," and accepted the broader market merely "for ease of discussion." *Id*. at 1211 n.11.

Second, we conclude that inpatient OB services are not in the GAC inpatient hospital services cluster market but rather constitute a separate relevant product market. As with many of the individual

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

inpatient hospital services grouped together in the GAC cluster market, OB services warrant delineation as a relevant product market under standard principles of analysis. No other services are interchangeable with OB services. IDF 313; Resp. to Compl. Counsel's Req. for Admiss. at 6. An OB services market passes the 2010 Horizontal Merger Guidelines test: a hypothetical monopolist could profitably impose a small but significant and non-transitory increase in price. 2010 Horizontal Merger Guidelines § 4.1.1. Respondent's economic expert conceded as much. Guerin-Calvert, Tr. 7679-80 (acknowledging that prices "could materially change" if ProMedica achieved a monopoly over OB services). Moreover, examination of "practical indicia," which courts use to augment the interchangeability analysis, *see, e.g.*, *Brown Shoe*, 370 U.S. at 325; *CCC Holdings*, 605 F. Supp. 2d at 38, indicates that OB services are a separate relevant product market. Obstetrics is recognized as a separate field of medicine with distinct providers of OB services. In addition, the merging hospitals track OB services market shares separately from GAC inpatient services. IDF 314; *see, e.g.*, PX01016 at 003, *in camera* (St. Luke's presentation regarding affiliation partners); PX00009 at 022 (ProMedica Credit Presentation to Standard & Poor's).

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

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

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

Commissioner Rosch's concurring statement suggests that defining a separate relevant product market for OB services would be redundant, since OB services are part of the bundle of inpatient hospital services that MCOs purchase. We disagree.

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

Commissioner Rosch's concurrence also expresses discomfort with the fact that there is no judicial precedent for defining a separate OB services market. We are not daunted by this observation, however, because every case that comes before the Commission is fact-specific and merits independent examination. Moreover, contrary to footnote 2 of Commissioner Rosch's concurring opinion, there is

judicial precedent for the underlying rationale we use in this case to treat OB services as a separate relevant product market. This includes case law finding a separate cluster market for particular inpatient services in addition to the GAC inpatient hospital services market where the group of suppliers for that group of services differs from the suppliers of GAC inpatient hospital services. *See Butterworth*, 946 F. Supp. at 1291 (court agreeing with FTC that there is a separate relevant product market for primary care inpatient hospital services in addition to the GAC inpatient hospital services market, based on the existence of a differing group of suppliers for those services).[27]

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

B. Relevant Geographic Market

The ALJ found that the relevant geographic market for GAC inpatient hospital services is Lucas County, Ohio,[28] 28 ID 145-46, and we agree.

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

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

Moreover, there is agreement between the parties that the relevant geographic market for the GAC inpatient hospital services market is Lucas County, Ohio. Complaint ¶ 16; Resp. to Compl. Counsel's Req. for Admiss. 7; Tr. 7683 (Guerin-Calvert).

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

VII. THE JOINDER IS PRESUMPTIVELY ILLEGAL

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

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acceptable alternatives for one MCO's Lucas County members." ID 145-46.

IDF 368-70; ID 151. Respondent does not dispute this.

In the GAC inpatient hospital services market as defined above, ProMedica's acquisition of St. Luke's reduced the number of competitors from four to three, combining St. Luke's 11.5 percent market share with ProMedica's 46.8 percent market share and giving ProMedica a post-acquisition market share of 58.3 percent based on patient days.[29] IDF 364. The acquisition increased the HHI in the GAC inpatient hospital services market by 1,078 points, resulting in an HHI of 4,391 based on patient days.[30] IDF 368. In the OB inpatient services market, the acquisition reduced the number of competitors from three to two, adding St. Luke's 9.3 percent market share to ProMedica's 71.2 percent market share and giving ProMedica an 80.5 percent market share based on patient days.[31] PX02148 at 143, *in camera*. The acquisition increased HHIs in the OB services market by 1,323 points, resulting in an HHI of 6,854. *Id*. These concentration data are more than sufficient to create a presumption that the merger is anticompetitive. *See Heinz*, 246 F.3d at 716 (increase in HHI of 510 in market with HHI of 4,775 created a presumption "by a wide margin"); *Univ. Health*, 938 F.2d at 1211 n.12, 1219 (*prima facie* case established where merger reduced competition from five to four

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

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

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

and resulted in a combined market share of 43 percent, an HHI increase of 630 points, and a post-merger HHI of 3200); 2010 Horizontal Merger Guidelines § 5.3 (post-acquisition HHI above 2500 and HHI increase of more than 200 points "will be presumed to be likely to enhance market power").[32]

Of course, statistics concerning market share and concentration are not conclusive proof of competitive harm. *Gen. Dynamics*, 415 U.S. at 498. Nonetheless, where concentration levels are high, as they are in this case, Respondent bears the burden of demonstrating that the HHIs and market share data are unreliable in predicting a transaction's competitive consequences. *See Heinz*, 246 F.3d at 715; *Univ. Health*, 938 F.2d at 1218. As the Supreme Court has explained, "a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have

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

such anticompetitive effects." *Philadelphia Nat'l Bank*, 374 U.S. at 363. "The more compelling the prima facie case" – including other evidence presented by Complaint Counsel that reinforces the structural presumption – "the more evidence the defendant must present to rebut it successfully." *Baker Hughes*, 908 F.2d at 991; *accord Chicago Bridge & Iron*, 534 F.3d at 426.

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

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

We agree. Since *General Dynamics*, 415 U.S. 486, evidence of an acquired firm's anticipated

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

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

> Since weak firms are not in grave danger of failure – if so, they would be failing, rather than weak, companies, and the analysis might differ . . . it is not certain that their weakness "will cause a loss in market share beyond what has been suffered in the past, or that [such weakness] cannot be resolved through new financing or acquisition by other than a

> leading competitor…" Moreover, "[t]he acquisition of a financially weak company in effect hands over its customers to the financially strong, thereby deterring competition by preventing others from acquiring those customers, making entry into the market more difficult."

938 F.2d at 1221, *quoting* 4 P. AREEDA & D. TURNER, ANTITRUST LAW, p. 1221 ¶ 935b at 140 (1980) and *Kaiser Aluminum*, 652 F.2d at 1339. Thus, said the court, "[t]o ensure that competition and consumers are protected, we will credit such a defense only in rare cases, when the defendant makes a substantial showing that the acquired firm's weakness, which cannot be resolved by any competitive means, would cause that firm's market share to reduce to a level that would undermine the government's prima facie case." *Univ. Health*, 936 F.2d at 1221; *see also FTC v. Warner Commc'ns, Inc.*, 742 F.2d 1156, 1164 (9th Cir. 1984) (explaining that the financial weakness defense is disfavored because it "would expand the failing company doctrine, a defense which has strict limits").

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

market share was increasing – not declining – in the years before the Joinder; indeed, some of St. Luke's gains were at ProMedica's expense. *See* PX00159 at 005, 012 *in camera*; PX01235 at 003.

St. Luke's improved performance reflected its implementation of a strategic plan shortly after Mr. Wakeman was hired as St. Luke's CEO in February 2008. IDF 920. St. Luke's achieved most of the growth goals set out in that plan, increasing its "inpatient net revenue by more than $3.5 million per year on average" and its "outpatient net revenue by more than $5 million per year on average" (IDF 924-25), and achieving a 40 percent market share in its core service area. IDF 928. Its overall occupancy rate in the twelve months prior to the Joinder increased by about 8 percent. IDF 930. As patient volumes and patient care revenues improved, St. Luke's succeeded in getting its variable costs under control, and its operating margins consequently improved. IDF 949-54, 957-58.

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

> We have experienced activity in excess of the Operating Financial Plan (OFP) and last years' activity. That activity has finally exceeded our fixed expense . . . .
>
> Inpatient, (up 7.5%) and outpatient, (up 6.1%), activity was running hot all month. While we still have capacity for outpatient, especially in

> the offsite centers, inpatient capacity is limited except for weekends. . . .
>
> . . . .
>
> If there was one pillar we attained a high level of success in our strategic plan in the past two years, it would be growth. The hard numbers prove that out, and almost every service. . . .
>
> Cardiac, pulmonary, surgery, emergency department, primary life systems, medical/surgical, imaging . . ., lab testing and especially obstetrics have experienced great growth in the past two years.

Significantly, Mr. Wakeman added:

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

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

> The entire St. Luke's family has much to be proud of with the accomplishments in the past three years. We went from an organization with declining activity to near capacity. Our leadership status in quality, service and low cost stayed firmly in place. In the past six

> months our financial performance has improved significantly. The volume increase and awareness of expense control were key.

Id. at 007. Other evidence likewise points to significant improvements in St. Luke's financial performance in the months prior to the Joinder. *See* Black, Tr. 5684-85 (St. Luke's Board of Directors Chairman testifying that St. Luke's financials were "looking up" in August 2010); PX01582, at 003, *in camera* (St. Luke's Vice President for Patient Care Services writing in September 2010 that St. Luke's was "growing, not downsizing").

Respondent does not deny that these improvements occurred. JSLF ¶¶ 27-36; Uyl Tr., 6562 (Respondent's expert testifying that St. Luke's financial performance had improved in the six months leading up to the Joinder); Hanley, Tr. 4701-02 (ProMedica's CFO testifying that St. Luke's had experienced a positive trend in patient revenues since 2008). Rather it downplays the significance of those improvements, contending that St. Luke's, while improving, was still operating at a loss throughout most of 2010; that its profit margin in August 2010 was only about $7,000; and that, although St. Luke's was able to increase its patient volumes in 2010, it continued to lose money on every patient it treated. RAppB 39; RRB 20. Additionally, Respondent argues that an independent St. Luke's would not have been able to fund necessary capital improvements in the future and that St. Luke's would have had to implement deep service cuts unless it affiliated with another hospital. RAppB 10, 39. Respondent also contends that St. Luke's

"location in Lucas County will become less competitively significant." RAppB 38. Thus, Respondent argues, "It is likely that, absent the joinder, St. Luke's market share would be reduced to zero (if it exited the market) or nearly zero if it made the service cuts that it considered absent the joinder." RRB 19; *see also* RAppB 38, 40.

We find Respondent's arguments unpersuasive and lacking in evidentiary support. Although a $7,000 operating profit in August 2010 may be "not impressive" as Mr. Wakeman observed, PX 00170 at 001, the evidence shows that St. Luke's had made significant improvements and was on a positive trajectory at the time of the Joinder. Respondent asserts that St. Luke's achieved an operating profit in August 2010 only because of "two large, unusual, and non-recurring additions to St. Luke's operating income," RRB 20, but the record as a whole suggests that St. Luke's was moving toward, not away from, a sustainable path.[33] *See* PX00171 at 001 (St. Luke's

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

CEO Wakeman concluding, based on the results through the time of the Joinder, that St. Luke's "can run in the black if activity stays high").

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

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recruiting success, the resulting volume and revenue benefits would be "non-recurring."

[34] St. Luke's overall cost coverage ratio for all payors was 0.91 for 2007, 0.90 for 2008, 0.86 for 2009 and 0.94 for the first eight months of 2010. IDF 373. However, there were significant disparities between the cost coverage ratios for different payors. St. Luke's cost coverage ratios for Medicare and Medicaid, which represented about 51 percent of St. Luke's revenues, were very low. IDF 375. According to one witness, {REDACTED} Sheridan, Tr. 6647-48, *in camera* (testifying that {REDACTED}. Among the MCO's, only MMO and United had below-cost reimbursement rates for St. Luke's in 2009, and in 2010, only MMO did. IDF 376. Negotiating a more favorable contract with only one large payor – MMO – would have gone a long way toward solving St. Luke's financial problems.

Luke's costs.[35] The {REDACTED} representative testified that {REDACTED}[36] {REDACTED}[37] Accordingly, we cannot conclude that St. Luke's would not have been able to negotiate rates sufficient to cover its costs if it had not decided instead to pursue the Joinder with ProMedica.

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

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

[36] Tr. 2229-36, *in camera*. The record shows that {REDACTED}. *Id*. at 2354-55. {REDACTED}. *Id*. at 2356; IDF 541-45. {REDACTED} *see* IDF 546-49, the proposed deal with MMO did not proceed further. Instead, St. Luke's pursued an affiliation with ProMedica.

[37] {REDACTED} Tr. 2353, *in camera*.

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

based on the record before us, that St. Luke's could not have funded needed capital improvements in the future, especially in view of its significantly improved operating performance in 2010.

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

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

Board of Directors. That document identifies and discusses three options to address St. Luke's financial condition. The first of these options is to "[r]emain independent. Surgically remove all financially losing services/ programs until accepted margin is realized." *Id*. at 008. The presentation identified "Heart? Obstetrics? Physical Rehab later on?" as possibilities for cuts. *Id*.

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

major goals of the three-year plan implemented by Mr. Wakeman. Black, Tr. 5706.

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

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

Likewise, Respondent's contention that St. Luke's "location in Lucas County will become less competitively significant," RAppB 38, is contradicted by the evidence. As the ALJ found, the southwest sector of Lucas County has favorable demographic characteristics that make it a "desirable area for a hospital to be located." IDF 472-74. Witnesses, including Mr. Wakeman and Mr. Oostra, ProMedica's CEO, testified to St. Luke's favorable location. Wakeman, Tr. 2477, 2481 (St. Luke's is "in an optimal or better part of the community in the sense of growth and economic potential"); Oostra, Tr. 6037-38. MCO witnesses likewise testified to the importance of having geographic coverage in the growing and more affluent southwest sector. *See, e.g.*, Pirc, Tr. 2195-96; Pugliese, Tr. 1442-43. Elsewhere in its briefs, Respondent recognizes that "[f]or ProMedica, the joinder provided an opportunity to expand its services in southwest Lucas County." RAppB 1. Respondent has failed to demonstrate that St. Luke's location will become competitively less significant, and one of its own rationales for acquiring St. Luke's belies its argument.

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

competitive means, would cause that firm's market share to reduce to a level that would undermine the government's *prima facie* case." (Emphasis added)).

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

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[39] *See also* Pirc, Tr. 2229-36, 2353, *in camera* (testifying that absent the Joinder, MMO's expectation was that it would have increased the reimbursement rates it paid St. Luke's, and that MMO was willing to pay St. Luke's more if it stayed independent). St. Luke's mixed record in negotiating higher rates before the Joinder is not persuasive as to the future. St. Luke's pre-Joinder efforts were made in the context of trying to *renegotiate* rates in existing contracts where St. Luke's bargaining leverage would presumably be less than it would be on contract expiration. *See* IDF 541-49.

[40] Respondent contends that "St. Luke's also investigated affiliating with other entities but either they were not interested or St. Luke's determined an affiliation was not in its or the community's best interest." RRB 21 n.11. Respondent

significantly fewer competitive concerns than a Joinder with ProMedica, the self-described dominant system in Lucas County.

In sum, Respondent's "weakened competitor" showing falls far short of what the courts have demanded. Comparison to *Arch Coal*, 329 F. Supp. 2d 109, is telling. *Arch Coal* involved the acquisition of one coal company, Triton, by another, Arch Coal. There, as here, the defendant argued that the acquiree was a weak competitor and that its competitive significance was overstated. *Id*. at 153-57. The *Arch Coal* court concluded that the FTC's claims of Triton's competitive significance were in fact "far overstated." *Id*. at 157. The facts of *Arch*

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identifies discussions with only three out-of-market systems – the University of Michigan, the Cleveland Clinic and McClaren Health Care. *See id*.; Wakeman, Tr. 2541-48. Mr. Wakeman also testified that St. Luke's held "general discussions" regarding a possible affiliation with other local community hospitals controlled by diverse organizations but did not pursue the arrangement after determining that it would have required unacceptably complex, time-consuming negotiations. Wakeman, Tr. 2548-51. The history of these limited efforts fails to establish that St. Luke's asserted competitive weakness cannot be resolved through affiliation with an out-of-market buyer.

[41] Prior to entering exclusive discussions with ProMedica in January 2010, St. Luke's had been engaging in on-going discussions with both Mercy and UTMC about possible affiliation arrangements, and the presentations made to the St. Luke's Board discussed the pros and cons of affiliating with each of them. *See* PX01018, *in camera*; PX01030, *in camera*; PX01016, *in camera*. In fact, St. Luke's and UTMC had drafted a Memorandum of Affiliation Terms in August 2009 (PX02205). Up to the time when St. Luke's cut off talks with them in late 2009, both Mercy and UTMC remained interested in pursuing an affiliation with St. Luke's. Wakeman, Tr. 2552-55, 2559.

Coal, however, bear no resemblance to those here. For example, in *Arch Coal*, the presumption of competitive harm was weak (*id*. at 129, noting that "HHI increases are far below those typical of antitrust challenges brought by the FTC and DOJ" and that "the FTC's prima facie case is not strong"); here, in contrast, the presumption is very strong, and the evidence required to rebut the statistical case is accordingly greater. *Id*., *quoting Baker Hughes*, 908 F.2d at 991 ("[t]he more compelling the prima facie case, the more evidence the defendant must present to rebut it successfully"). Whereas in *Arch Coal*, there were no prospects for improvement, 329 F.Supp. 2d at 157, St. Luke's was improving its financial performance, and its market share was increasing, not declining. Whereas in *Arch Coal* prospects for finding an alternative buyer were "dim," *id*. at 156, here that is far from clear.[42] In short, this is not one of those "rare cases," *Univ. Health*, 938 F.2d at 1221, where Respondent has met its burden of showing that financial weakness rebuts the presumption of illegality based on the government's structural case.

IX. SUBSTANTIAL RECORD EVIDENCE BUTTRESSES THE STRUCTURAL CASE

The evidence of market structure discussed above establishes a strong presumption that the Joinder will substantially lessen competition. Respondent has

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

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

Complaint Counsel, however, have not rested their case on market structure alone. They have gone on to present substantial evidence of likely competitive harm that buttresses their structural showing. This evidence includes documents, testimony, and business conduct of the merging parties that demonstrates their understanding that the Joinder will enhance market power. It includes a demonstration that the Joinder will increase the bargaining leverage of the combined ProMedica/St. Luke's hospital system by detracting from the alternatives available to MCOs in negotiations with the combined system, and, consequently, can be expected to generate unilateral anticompetitive effects in the form of higher prices at both St. Luke's and the ProMedica legacy hospitals.[43] In addition, Complaint Counsel present econometric analysis quantifying the price impacts. This additional analysis – while unnecessary, particularly in light of the strength of Complaint Counsel's *prima facie* case – is nonetheless helpful because it is tailored to the unique competitive dynamics of hospital markets,

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

stemming from the bargaining between hospitals and MCOs over inclusion in MCO networks.

A. Bargaining Leverage and Hospital Reimbursement Rates

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

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

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

A merger may increase a hospital provider's bargaining leverage by removing substitute hospitals and thereby changing the MCO's cost of failing to reach an agreement. *Id*. at 3651-52. When the merger reduces the value of the alternatives available if the MCO fails to reach an agreement with the first provider, it reduces the desirability of the MCO's walk-away network. *Id*. at 3652.

The rates that emerge from a negotiation will be a function of the parties' bargaining leverage. *Id*. at 3641. If a merger increases the hospital provider's bargaining leverage by increasing the MCO's loss from failing to reach an agreement with the provider, the MCO will be willing to pay more to have that

hospital provider in its network.[45] Generally speaking, an increase in the hospital provider's bargaining leverage translates to an increase in its reimbursement rates. *Id*. at 3649-50. IDF 293-94.

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

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

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

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

The MCOs testified that the Joinder would further increase ProMedica's bargaining leverage, thereby leading to even higher rates. For example, an {REDACTED} representative testified that {REDACTED}. {REDACTED} Tr. 1524-25, *in camera*; PX01919 at 014; {REDACTED} Dep. at 51), *in camera*. Aetna's witness testified that the Joinder has made the prospect of walking away from ProMedica substantially less attractive; post-Joinder, if Aetna failed to reach an agreement with ProMedica, it would face the loss of not only ProMedica's three legacy hospitals, but also the loss of St. Luke's, which would leave Aetna without coverage in southwestern Lucas County. IDF 570, Radzialowski, Tr. 664, 712-13, *in camera*; PX01917 at 020, 023 (Radzialowski, Dep. at 75-76, 86), *in camera*. A Humana representative testified that the Joinder increased ProMedica's "ability to leverage us [Humana] for rates for all of their hospitals and St. Luke's now as well." IDF 573, McGinty, Tr. 1209; PX02073 at 004 (¶ 15) (McGinty, Decl.), *in camera*. Similarly, the {REDACTED} witness testifies that "ProMedica would find its bargaining power greater after the acquisition than before," explaining that it would be more difficult for {REDACTED} to serve its membership without ProMedica and St. Luke's than without ProMedica's pre-Joinder hospital network in Lucas County. IDF 574, {REDACTED} Tr. 6687, 6698-6700, *in camera*.

The MCO witnesses also testified that a network composed only of UTMC and Mercy – the only two remaining providers in Lucas County after the Joinder – would not be commercially viable. Thus,

the MMO witness testified that prior to the Joinder MMO could have marketed (and in fact did market) an insurance product that excluded ProMedica's three Lucas County hospitals (while including St. Luke's), but that post-Joinder it could not market a product that excluded both ProMedica and St. Luke's. Pirc, Tr. 2261-63, *in camera*; Pugliese, Tr. 1477-78; Sandusky, Tr. 1351, *in camera*. This is consistent with observed marketing patterns: as Respondent's own expert acknowledged, no MCO has marketed a network composed only of UTMC and Mercy in at least the last ten years. Guerin-Calvert, Tr. 7895; IDF 565.

Respondent, however, urges us to disregard all the MCO testimony on the grounds that it is "[u]nsubstantiated, [b]iased, and [s]peculative." RAppB 30; RRB14. In particular, Respondent contends that because the MCOs "did not perform *any* analyses to support their beliefs about their ability to sell narrower networks or send their insureds to other hospitals in the event of a post-joinder price increase," their testimony "is speculative and unsupported by any analysis." RAppB 30-31; RRB 14.

We disagree. The mere fact that the MCOs had not performed tailor-made studies geared to litigation is no reason to discredit their testimony. The ALJ determined that "the MCOs used general market knowledge, feedback from the field, and/or claims utilization data to determine the attractiveness and marketability of their offerings and provided explanations to support their beliefs." ID 165 (citation omitted). The MCO witness

testimony was based directly on years of relevant experience in designing and marketing networks in Lucas County. The MCO witnesses testified at length about how they rely on constant feedback from their sales and marketing teams regarding prospective enrollees' hospital coverage needs, as well as the analysis of various data sets, including utilization reports, claims data, Medicare cost reports, and hospital quality studies, in order to inform their assessments of which hospitals to include in their networks and what negotiating strategies to use with the hospitals. *See, e.g.*, Radzialowski, Tr. 582-83, 587-93, 600-04; Pirc, Tr. 2160-62, 2165-72; Pugliese, Tr. 1420-27.

The precedents relied on by Respondent in urging us to disregard the MCO testimony are clearly distinguishable. Thus, in *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1131 (N.D. Cal. 2004), the court noted that the customer witnesses testified with a "kind of rote," offering "speculation" unsupported by "credible and convincing testimony" but "little or no" testimony about what they "would or could do or not do to avoid a price increase"; in *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 145-46 (D.D.C. 2004), the court found that customer testimony simply reflected general "anxiety" about having one fewer supplier but provided no persuasive reason for finding post-merger coordination more likely; and in *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999), the court discredited MCO testimony that the MCOs could not resist price increases where the evidence showed that they could and that it was in their interest to do so. Here the MCO witnesses

gave detailed testimony on why they believed that the Joinder would increase ProMedica's bargaining leverage and why they would not be able to resist rate increases sought by ProMedica in the future. We see no reason to discredit their testimony as a buttress to Complaint Counsel's structural case.

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

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

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

documents, MCO testimony, and economic evidence all confirm the presumption.

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

St. Luke's own documents make it clear that one of the chief benefits expected from the Joinder was obtaining the significantly higher rates that the ProMedica hospitals were able to command. An August 10, 2009 St. Luke's planning document noted as one option "enter[ing] into an affiliation/partnership with a local health system with the express purpose to raise reimbursement rates to the level of our competitors." PX1390 at 002, *in camera*. A presentation made the following month to St. Luke's Board of Directors by CEO Wakeman and other members of St. Luke's leadership team states, "An SLH affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout." PX1030 at 020, *in camera*; IDF 598. As St. Luke's CEO testified, "ProMedica had a significant leverage on negotiations with some of the managed care companies," which would allow St. Luke's to obtain higher reimbursement rates, so that an affiliation with ProMedica could, in the short term, "[h]arm the community by forcing higher hospital rates on them." Wakeman, Tr. 2698-2700, *in camera*. Other St. Luke's documents likewise establish that among the chief advantages of affiliating with ProMedica was the ability to increase St. Luke's reimbursement rates. *See* PX01125 at 002, *in camera* (noting the advantages of ProMedica's "incredible access to outstanding pricing on managed

care agreements"); PX01018 at 014, *in camera* (noting as "Option 3: Affiliate with ProMedica. What do they bring? Strong managed care contracts."). Indeed, Respondent concedes that St. Luke's rates would increase after the Joinder and that St. Luke's thought that it would get more from affiliating with ProMedica than with other possible partners. *See* RRB 15; Oral Arg. Tr. At 37 (Marx).

Likewise, both Mr. Wakeman and Mr. Black, St. Luke's Chairman of the Board, testified to the hope or expectation that an affiliation with ProMedica would allow St. Luke's to obtain the significantly higher reimbursement rates that the ProMedica hospitals were able to command. Wakeman, Tr. 2685-86, 2700-01, *in camera*; Black Tr. 5714-15, 5718, *in camera*. Indeed, another St. Luke's document indicates that St. Luke's anticipated as much as $12 to $15 million in additional revenues from only three payors – MMO, Anthem, and Paramount – as a result of joining ProMedica. PX01231, *in camera*; IDF 603. In short, St. Luke's clearly anticipated that its rates would increase as a result of the Joinder, and ProMedica's superior negotiating clout with the MCOs was among the primary reasons St. Luke's joined the ProMedica system.

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

Numerous MCO representatives similarly testified that they expect St. Luke's rates to rise as a result of the Joinder. Thus, Aetna expected that its post-Joinder rates for St. Luke's initially will rise to the level of Aetna's rates for ProMedica, and that all

ProMedica rates will then rise above pre-Joinder levels based on the additional leverage gained from the Joinder. PX01938 at 023 (Radzialowski, Dep. at 88-89), *in camera*. An Aetna analysis of the impact of the initial change projected a {REDACTED} increase in rates to St. Luke's, accounting for differences of severity between ProMedica and St. Luke's. IDF 591; Radzialowski, Tr. 704, *in camera*. {REDACTED}: in early {REDACTED} Tr. 717, *in camera*.

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

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

As discussed above, the reimbursement rates that a particular hospital provider can extract from an

MCO depend on the alternative network of hospitals that the MCO would be able to assemble – the "walk-away network" – if the MCO fails to reach an agreement with that hospital provider.

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

The price increase associated with this enhanced leverage would be substantial. Even prior to the Joinder, ProMedica had by far the highest prices for GAC inpatient services in Lucas County. IDF 606 (citing PX02148 at 143, 145, *in camera*). Complaint Counsel's economic expert, Professor Robert Town,

examined pre-Joinder hospital prices in Lucas County. After controlling for case-mix, severity, and patient demographics across hospitals,[47] Professor Town found that ProMedica's average price was {REDACTED} higher than Mercy's, {REDACTED} higher than UTMC's, and {REDACTED} higher than St. Luke's. PX02148 at 037, 145, *in camera*. MCOs confirmed Town's analysis of relative prices; they testified that ProMedica's rates are the highest, and rates at St. Luke's the lowest, in Lucas County.[48]

Moreover, Professor Town provided evidence linking pricing in Lucas County to market structure.

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

[48] *See* Pirc, Tr. 2238–2242, *in camera*; Radzialowski, Tr. 684, 687-88, 698-700, *in camera*; Sandusky, Tr. 1338-48, 1350, *in camera*; PX02296 at 001, *in camera*; Pugliese, Tr. 1512-13, *in camera*; McGinty, Tr. 1210. Respondent, nonetheless, suggests that Professor Town's price analysis is flawed. Respondent's concern that the analysis "computed prices for patients at hospitals where the patients were not actually treated," RAppB 6, portrays a virtue as a sin: computing average prices for each hospital based on a hypothetical hospital population is precisely what controls for differences in case-mix, severity, and demographics that enables a valid comparison. Respondent's further point, that the results could vary when broken down hospital by hospital and MCO by MCO, RappB7, is to be expected. There are always data points above and below a computed average; the average, nonetheless, remains useful for overall comparison.

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

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

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

link between pricing and bargaining leverage. *See* IDF 583, 589, 594-95; Pirc, Tr. 2262, *in camera*.

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

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[51] *See* PX02148-038, *in camera* (citing documents that "suggest that ProMedica's pre-acquisition variable costs were lower than St. Luke's"); PX01850 at 057-059, *in camera*.

profitably to increase prices. It reduces the value of an MCO's walk-away network and consequently reduces its bargaining leverage. The extent of direct competition between the merging parties is the key: "Unilateral price effects are greater, the more the buyers of products sold by one merging firm consider products sold by the other merging firm to be their next choice." 2010 Horizontal Merger Guidelines § 6.1.

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

Indeed, Professor Town's analysis of diversion rates shows that ProMedica is St. Luke's closest substitute.[52] Based on claims data obtained from

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[52] *See* Horizontal Merger Guidelines § 6.1 ("Diversion ratios between products sold by one merging firm and products sold by the other merging firm can be very informative for assessing

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

Respondent claims that the diversion analysis for the sixth health plan, MMO, rebuts the conclusion that ProMedica is St. Luke's next best substitute. We are not persuaded. First, although the diversion analysis shows that Mercy is the closest substitute for MMO enrollees at St. Luke's, ProMedica is still a significant competitor; nearly 28 percent of MMO's St. Luke's patients would choose a ProMedica hospital if St. Luke's were unavailable. *See* PX02148 at 163, *in camera*. Second, while Respondent is correct that St. Luke's derives more inpatient revenue from MMO than from any other MCO, St. Luke's combined inpatient revenue from other MCOs

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unilateral price effects, with higher diversion ratios indicating a greater likelihood of such effects."); *FTC v. Swedish Match N. Am., Inc.*, 131 F. Supp. 2d 151, 169 (D.D.C. 2000).

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

was 56 percent higher than its revenue from MMO,[54] PX01850 at 017, *in camera*. Respondent asks us to consider a minority, and ignore the majority, of St. Luke's patients. Finally, Respondent's analysis of MMO is based on 2009 data, when ProMedica had just become an in-network hospital at MMO in 2008. MMO's enrollees would be expected to modify their hospital choice and admission decisions over time in response to the availability of a broader network. ID 159 n.19; PX02148 at 047, *in camera*; PX01850 at 017-018, *in camera*. The data supports this explanation. From 2008 to 2010, diversion rates for MMO enrollees from St. Luke's to ProMedica increased each year following ProMedica's admission to MMO, and the increased patient diversion to ProMedica precisely corresponded to decreased diversion of St. Luke's patients to Mercy. *See id*. at 017-019, *in camera*. Over time, as patients continue to adjust to the in-network availability of ProMedica, ProMedica is becoming a more significant alternative to St. Luke's among MMO enrollees, and Mercy's role is diminishing.

Finally, Respondent contends that any price increases at St. Luke's would merely raise St. Luke's low rates to competitive levels and therefore would not cause competitive harm. Post-Joinder, absent action by the Commission, St. Luke's reimbursement rates can be expected to rise to the level that will be charged by ProMedica's community hospitals post-Joinder. This will likely result in a price increase

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

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

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

price increase at St. Luke's to the price levels that will be charged by ProMedica's community hospitals would merely raise St. Luke's reimbursement rates to competitive levels.

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

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

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

reimbursement rates for inpatient services. Pirc, Tr. 2262, *in camera*; PX01944 at 013-014 (Pirc, Dep. at 49-50), *in camera*.

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

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

Unilateral effects evidence supports this conclusion. Again, the extent of direct competition between ProMedica and St. Luke's is a key. From the viewpoint of ProMedica's legacy hospitals, the competition provided by St. Luke's was substantial. While Mercy was the next best substitute for the legacy hospitals for the largest number of patients,

St. Luke's was the next best substitute for a substantial and important fraction of ProMedica's patients, stemming from St. Luke's advantageous location in southwest Lucas County. IDF 472-498.

ProMedica's documents and business conduct both attest to its recognition that St. Luke's was a close and significant competitor. ProMedica's internal assessments reflected its understanding that St. Luke's was capable of taking significant patient volume from ProMedica's hospitals. IDF 467-69, 471. Thus, ProMedica estimated that 255 to 344 commercial inpatient admissions at ProMedica hospitals would be diverted from ProMedica to St. Luke's in the first year if St. Luke's were added to Paramount's network. IDF 468; *cf.* IDF 470 (finding that St. Luke's also expected to gain patients from ProMedica if St. Luke's were readmitted to Paramount). Similarly, ProMedica estimated that St. Luke's readmission to Anthem's network would cost ProMedica $2.5 million in gross margin annually. IDF 471; PX00333 at 002, *in camera*. In exchange for its loss of exclusivity with Anthem, ProMedica insisted that Anthem pay {REDACTED} higher rates at {REDACTED} when St. Luke's was added to Anthem's network in 2009. PX00231 at 015, *in camera*; Pugliese, Tr. 1497-98, *in camera*. This followed a four-year period in which ProMedica's contract with Anthem explicitly offered discounted rates conditional on Anthem's agreement not to include St. Luke's in Anthem's provider network, JSLF ¶ 18, a further indication that ProMedica believed St. Luke's would have taken patients from ProMedica.

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

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

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

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

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

analyzing substitution based on the preferences of patients, rather than MCOs. RAppB 14-15; RRB 2-3.

Both of these arguments are misplaced, for they fail to acknowledge the manner in which unilateral effects evidence is relevant in this case. In a more conventionally-structured market, in which sellers deal directly with the consumers of the goods in question, a unilateral effects analysis turns on whether the merged entity will enjoy a net benefit from a unilateral price increase. This will depend, in large part, on the relative numbers of sales that will be recaptured by the acquired entity, or lost to other players – and that, in turn, will depend importantly on various consumers' preferences in terms of which sellers are the closest substitutes. *See, e.g.*, 2010 Horizontal Merger Guidelines § 6.1. We recognize that, in such an analysis, the strong view of even a substantial minority of consumers that one seller is their next closest substitute *might* be outstripped by the preference of a majority for a different next closest substitute. Even in such a situation, however, the merging parties do not need to be each other's closest rival for a merger to have unilateral anticompetitive effects. Town, Tr. 3782, *in camera*. As the 2010 Horizontal Merger Guidelines explain, "[a] merger may produce significant unilateral effects for a given product even though many more sales are diverted to products sold by non-merging firms than to products previously sold by the merger partner." 2010 Horizontal Merger Guidelines at § 6.1. "Substantial unilateral price elevation post-merger," the Guidelines explain, "normally requires that a *significant fraction* of the customers purchasing that

product view products formerly sold by the other merging firm as their next-best choice." *Id*. (emphasis added). There is no general necessity that that "significant fraction . . . approach a majority." *Id*. Cases and commentary have agreed. *See United States v. H & R Block*, 2011 WL 5438955, at *39 (D.D.C. 2011) ("The fact that [a third party] may be the closest competitor for both [merging parties] also does not necessarily prevent a finding of unilateral effects for this merger."); *Evanston*, 2007 WL 2286195, at *50 (explaining that if customers accounting for a "significant share of sales" view the merging parties as their first and second choices, a merger can enable the merged firm to raise prices unilaterally, and "it is not necessary for the merged firms to be the closest substitutes for all customers, or even a majority of customers"); Phillip E. Areeda & Herbert Hovenkamp, 4 Antitrust Law ¶ 914 at 77-80 (2009) (explaining that the merging parties need not be closest rivals for the merged firm to be able to increase price profitably and thereby cause unilateral anticompetitive effects); see also Concurring Opinion of Commission J. Thomas Rosch, *In the Matter of Evanston Northwestern Healthcare Corp.*, Docket No. 9315.

But we are not analyzing whether ProMedica could sustain a unilateral price increase if it were selling directly to patients. We are analyzing the impact of the preferences of a substantial and important minority of patients within the market on the ability of ProMedica to sustain a unilateral price increase to MCOs, which depends on the Joinder's impact on ProMedica's bargaining leverage, which in

turn depends on the effect on the value of the MCOs' walk-away networks of removing the preferred hospital of that substantial and important minority. And that inquiry, contrary to ProMedica's supposition, must begin with an examination of substitutability between hospitals at the patient level. As the Commission explained in *Evanston*, and the ALJ explained in the Initial Decision here, "an MCO's demand for hospital services is largely derived from an aggregation of the preferences of its employer and employee members." *Evanston*, 2007 WL 2286195, at *61; ID 156. Here, "the record demonstrates that . . . St. Luke's and ProMedica were close substitutes for employers and MCO's members, and thus for the MCOs." ID 157-58.[58]

Nonetheless, building on its MCO-oriented focus, Respondent advances the notion that MCO demand for hospitals must be analyzed in terms of one-for-one substitutions of hospital providers, *e.g.*, replacing ProMedica with St. Luke's. Respondent is correct that in fashioning hospital networks, no MCO would

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

substitute one-hospital St. Luke's for the three-hospital ProMedica. Since ProMedica is much larger than St. Luke's and one of its three hospitals provides tertiary services, having access to ProMedica's three hospitals gives more value to patients than having access to St. Luke's alone. *See* Town, Tr. 228-29 (July 19, 2011). This is particularly true since MCOs require at least one hospital in their network to offer advanced services, including tertiary services. IDF 274. But Respondent's observation that MCOs would not accept a one-for-one swap of St. Luke's for the ProMedica system does not say anything about whether there nonetheless has been close and significant competition between St. Luke's and ProMedica over inclusion in MCO hospital networks. As we previously described, in order to satisfy the needs of employers who have employee members spread out across a geographic region and in need of access to a full range of hospital services, MCOs build networks that include multiple hospital providers. An MCO's decision on whether to include a hospital system in its network involves an assessment of whether the remaining alternative hospitals can constitute a marketable network. *See* Town, Tr. 3784-85, *in camera*; IDF 273-74, 276-77; ID 157. Thus, an MCO's selection of one hospital provider in its network need not result in excluding another provider. In fact, most MCO networks in Lucas County currently include all Lucas County hospitals. *See* IDF 135, 156, 191, 204, 222, 233.

Consequently, our conclusion that St. Luke's is ProMedica's closest substitute for a large and important number of Lucas County patients supports

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

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

3. Econometric Evidence

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

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

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

Professor Town then used these results to estimate the effect on hospital prices from the Joinder. He employed a linear regression model to determine the effect of willingness to pay per person and various control variables on case-mix adjusted prices. The control variables included a measure of MCO bargaining leverage; hospital costs (both case-mix adjusted cost and number of interns per bed); systematic differences across MCOs; and time trends.[60] To assess the impact of the Joinder, Professor Town compared the predictions of an estimation for a three-hospital, pre-Joinder ProMedica system with a recalculated result that included St. Luke's as a fourth hospital in ProMedica's system. PX02148 at 109-10, *in camera*. Town found that the increased bargaining leverage attributable to the elimination of competition between ProMedica and St. Luke's results in a 16.2 percent increase in prices, on an aggregate basis, for

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

the four hospitals. PX02148 at 179, *in camera*; Town, Tr. 58-59 (July 19, 2011). This predicted price increase arises only from the change in bargaining leverage resulting from the Joinder. Town, Tr. 60-61 (July 19, 2011). When Town allocated that aggregate 16.2 percent price increase between ProMedica and St. Luke's, he found that prices at St. Luke's would be expected to rise by 38.38 percent from the pre-Joinder level, and prices at ProMedica's legacy hospitals would be expected to rise by 10.75 percent. PX02148 at 179, *in camera*; Town, Tr. 59-60 (July 19, 2011).

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

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

evidence – the model, variables, and data are necessarily case-specific.

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

Respondent argues that adding five variables would reduce the price effect of the willingness-to-pay variable from a statistically significant 16.2 percent to 7.3 percent, which would lack statistical significance at the 5 percent level. But the price effect would still be significant at the 5.5 percent level. *See* RX71(A) *in camera* at 000216 (indicating a p value equal to 1.92). Addition of the five variables is itself highly questionable: some of the added variables appear closely correlated with variables already in Town's regression. *See* PX1850 at 067-072, *in camera*; Town, Tr. 68-72 (July 19, 2011). For example, Respondent added case mix index as an explanatory variable, despite the fact that prices are already case-mix adjusted. *See* Town, Tr. 69-71 (July 19, 2011); PX01850 at 068-069; RX71(A) at 000216. To the extent that the added variables are correlated with the existing variables and fail to measure an additional causal relationship, adding them decreases the statistical significance of the existing variables without adding explanatory power. Town, Tr. 68-69 (July 19, 2011); PX01850 at 067, *in camera*

(Professor Town's expert report stating that "[a] well-known means to challenge the size and significance of any regression coefficient is to include additional variables in the regression that are correlated with the variable of interest, but add no explanatory power that is not already captured by the variables already included in the model."). Moreover, adding even four of the variables would leave the willingness-to-pay result significant at the 5 percent level. *See* RX71(A) at 000216. Finally, some of the results with Respondent's specification are counterintuitive. *See* Town, Tr. 73-75 (July 19, 2011); PX01850 at 070-071. For example, Respondent's expert adds variables for a hospital's percentage of discharges that are Medicare and Medicaid patients on the rationale that hospitals may increase commercial prices to cost-shift and cover these patients, but the revised model predicts that commercial prices would decrease as Medicare share increases, precisely the opposite of the rationale for including the variable. *See* PX01850 at 069-070, *in camera*. This suggests that the revised model, with the additional variables proposed by Respondent's expert, is not correctly specified.

Respondent's claim that Town was arbitrary in dividing the 16.2 percent aggregate result between ProMedica and St. Luke's is hardly compelling. Town explained that the allocation was calculated based on the diversion between the hospitals; that is, Town attributed a greater share of the predicted price effect to the hospital whose bargaining incentives are likely to change more, as measured by the estimated diversion to the other hospital. Town, Tr. 59-60 (July

19, 2011). Since the estimated diversions from St. Luke's to ProMedica are generally greater than those from ProMedica to St. Luke's, Town allocated a greater share of the predicted price effect to St. Luke's. *Id*.; PX02148 at 108, *in camera*. More fundamentally, however the price increase is allocated between the hospitals, Town's finding provides confirming evidence for the conclusion that the increased bargaining leverage created by the Joinder will lead to higher prices.

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

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

Moreover, for OB services, Mercy – now ProMedica's only remaining competition – is relatively weak in comparison with ProMedica. Post-Joinder Mercy has only a 19.5 percent market share of the OB inpatient services market in Lucas County; ProMedica has 80.5 percent. PX02148 at 143, *in camera* (Ex. 6) (Town Expert Report). In St. Luke's core service area, ProMedica's strength is even more pronounced – its share is about 87 percent. *Id*. at 161

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

(Ex. 11). Beyond the mere share statistics, one of the three Mercy hospitals, St. Anne, no longer provides any OB services[62] and the remaining two Mercy hospitals, as Catholic facilities, cannot offer a full complement of inpatient OB services. Shook, Tr. 1065-66. Accordingly, ProMedica, as a result of the Joinder, is now the *only* hospital provider in Lucas County that is able to offer a full complement of OB services.

The Joinder would eliminate head-to-head competition between ProMedica and St. Luke's for inpatient OB services. St. Luke's understood that it was a desirable alternative for some ProMedica OB patients. *See* Rupley, Tr. 2010, *in camera* (St. Luke's Marketing and Planning Director testifying that St. Luke's believed that if it were readmitted to Paramount it would gain OB patients currently utilizing ProMedica's TTH). Indeed, St. Luke's was ProMedica's closest competitor with respect to OB services in St. Luke's core service area. Town, Tr. At 3760-61, *in camera*; PX01077 at 013 (2008 patient preference survey showing that the top three preferences for patients in St. Luke's core service area for OB services were St. Luke's and ProMedica's TTH and Flower). Similarly, for many OB patients in

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

southwest Lucas County, ProMedica was the closest substitute for St. Luke's. *See* Rupley, Tr. 1946 (testifying, based on patient origin data, that if patients in St. Luke's primary service area do not go to St. Luke's, they are most likely to go to TTH); Wakeman, Tr. 2511 (testifying that ProMedica was St. Luke's most significant competitor in OB services in St. Luke's core service area). Thus, the Joinder removed a significant rival to ProMedica in the OB inpatient services market.

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

St. Charles is Bay Park's competition. Flower doesn't really have competition."); Town, Tr. 3806-07, *in camera* (testifying that because UTMC and Mercy's St. Anne do not offer OB services, the disparity between ProMedica and the post-acquisition walk-away network of Mercy and UTMC is heightened); PX02148 at 069-070 (¶ 125) (Town Expert Report), *in camera*.

In considering its options in the fall of 2009, St. Luke's recognized that any affiliation with ProMedica in OB services would present regulatory concerns and "may need to be carefully reviewed." PX01030 at 017, *in camera*. St. Luke's was right.

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

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

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

patients away from ProMedica and thereby resist any post-Joinder supracompetitive price increase. RAppB 32-36.

There is no question that MCOs have leverage of their own in negotiations with hospitals. The record shows, however, that MCOs likely will find it harder to resist ProMedica's price demands after the Joinder. As already discussed, the Joinder increases ProMedica's bargaining leverage – and concomitantly disadvantages MCOs – because the addition of St. Luke's to the ProMedica hospital system makes it considerably more difficult for MCOs to walk away from ProMedica. *See supra* at Sections IX.C-D. Although Respondent suggests that MCOs will be able to obtain lower rates from ProMedica by threatening to enter into exclusive agreements with rival hospitals, the evidence shows that MCOs do not consider a network composed solely of UTMC and Mercy – the only rivals remaining after the Joinder – to be commercially viable.[63] *See supra* at Section

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

IX.B. This evidence likewise undermines Respondent's contentions that excess capacity and overlapping physician admitting privileges enable MCOs to exclude ProMedica from their networks and thereby defeat any supracompetitive price increase.

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

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which is the Blue Cross Blue Shield affiliate in Ohio, testified in this matter that {REDACTED} Pugliese, Tr. 1668-69, *in camera*.

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

to obtain such contractual provisions to protect itself against steering in the future.

Additionally, we find no merit to Respondent's argument that contracts negotiated by ProMedica on behalf of St. Luke's after the Joinder demonstrate that the Joinder is not likely to result in supracompetitive prices. It is settled law that such post-acquisition evidence is of limited probative value because "violators could stave off such [Section 7] actions merely by refraining from aggressive or anticompetitive behavior when such a suit was threatened or pending." *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 504-05 (1974), *see Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410, 434-35 (5th Cir. 2008); *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381, 1384 (7th Cir. 1986). Although Respondent protests that no manipulation was involved in those contract negotiations, an absence of proof of actual manipulation is not determinative – post-acquisition evidence "is deemed of limited value whenever such evidence *could arguably* be subject to manipulation." *Chicago Bridge*, 534 F.3d at 435 (emphasis in original). Such is the case here. Moreover, all post-Joinder rates here have been negotiated while the Hold Separate Agreement was in place. That agreement permits an MCO to continue its existing contract beyond expiration, rather than negotiating a new contract with new rates. *See* PX00069. Thus, the Hold Separate Agreement constrains ProMedica's bargaining leverage, with the result that the post-Joinder contracts do not reflect the full market power that

ProMedica will be able to exercise as a result of the Joinder.

2. Repositioning By Competitors

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

As evidence of repositioning, Respondent points to Mercy's so-called "Southwest Strategy," a program to increase Mercy's presence in southwest Lucas County by recruiting primary care physicians there and constructing a new outpatient facility to provide diagnostic and therapeutic services. *See* IDF 747-48. Respondent contends that Mercy's Southwest Strategy will put approximately 30 percent of St. Luke's billed charges at risk of loss to Mercy, which

has enough excess capacity to serve all of St. Luke's commercially-insured patients, and that this risk of loss will deter any anticompetitive price increase. RAppB 37.[65] The ALJ found Respondent's argument unpersuasive, concluding that the evidence did not show that such repositioning is likely to replace the competition lost by the Joinder or would be either timely or sufficient. ID 177-78.

We likewise find that the record does not support Respondent's argument. Notably, Mercy's Southwest Strategy does not include any plan to build an inpatient facility or offer any inpatient services. IDF 750. Rather, Mercy's Southwest Strategy purportedly will provide competition for inpatient services by generating referrals to Mercy's existing hospitals. IDF 753. At the time of the hearing, however, the prospects for this program were very much in question. Mercy did not meet its 2010 physician recruitment goals for southwest Lucas County, had not succeeded in recruiting any physicians in furtherance of its 2011 goals, and faced diminishing prospects for employing additional primary care physicians in southwest Lucas County. Shook, Tr. 983-84, 987, *in camera* ("We just don't seem to be making a whole lot of headway in the ability, our ability, to recruit primary care doctors, which would be at the base of any strategy that we would implement."). Mercy had not yet secured a location

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

for its outpatient facility. Shook, Tr. 986, *in camera*. Although Mercy initially had a tentative deadline through 2015 for accomplishing its Southwest Strategy, at the time of the hearing, it no longer had any time line in place. IDF 754. This evidence casts doubt on whether Mercy is likely to accomplish such repositioning and suggests that its Southwest Strategy will not provide a timely constraint to ProMedica's post-Joinder exercise of market power.[66]

Furthermore, regardless of whether such repositioning would be likely and timely, Respondent has failed to show that it would be sufficient to mitigate the Joinder's anticompetitive effects. There is no evidence that adding employed physicians and an outpatient facility even comes close to replicating the competition for GAC and OB inpatient hospital services eliminated by the Joinder. Respondent points to its expert's calculation of the potential diversion of billed charges from St. Luke's to Mercy *if* Mercy were to succeed in increasing its market share. Guerin-Calvert, Tr. 7389-92, *in camera*. Respondent implicitly invites us to *assume* that Mercy's limited repositioning activities will significantly increase its market share for inpatient hospital services.[67] But such assumption or

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

[67] As of the time of the hearing, Mercy had not noticed any measurable market share impact in southwest Lucas County as a result of its Southwest Strategy. IDF 756. *See* Shook, Tr. 987, *in camera* (describing Mercy's prospects for achieving a

speculation does not suffice to support an entry argument. *See Cardinal Heal*th, 12 F. Supp. 2d at 57 (rejecting entry argument that was "theoretical at best," noting that "the Court cannot engage in such speculation"). Respondent's further argument that the mere threat of repositioning by competitors is sufficient to constrain ProMedica's post-Joinder pricing likewise is theoretical only and devoid of actual evidentiary support. *See Chicago Bridge*, 534 F.3d at 430 n.10 (rejecting a claim that the mere threat of entry was sufficient to deter anticompetitive effects and stressing the need for evidentiary support).

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

X. REMEDY

To remedy Respondent's violation of Section 7, the ALJ ordered divestiture of St. Luke's to a Commission-approved buyer. ID 204-11. Respondent argues that, assuming we find liability, divestiture is not necessary to restore the competition eliminated by the Joinder. Respondent urges us, instead, to select an injunctive remedy that requires ProMedica to establish separate and independent managed care contract negotiating teams for St. Luke's and ProMedica's legacy hospitals. Respondent asserts that its proposed remedy, which is patterned after the Commission's remedy in *Evanston*, cures any

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substantial market share increase in southwest Lucas County during the next two years as "[v]ery difficult").

anticompetitive effects of the Joinder while addressing concerns about St. Luke's viability as an independent hospital. Respondent also argues that an order that requires ProMedica to divest St. Luke's to an acquirer, instead of allowing the parties simply to unwind the Joinder, goes beyond restoring competition to its pre-Joinder state and is, therefore, overbroad and punitive. RAppB 40-45.

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

In accordance with these well-established principles, we conclude that divestiture is the most appropriate remedy to restore the competition eliminated by the Joinder. Unlike *Evanston*, this case

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

The circumstances in this case are markedly different than *Evanston*. Here, the Hold Separate Agreement entered by ProMedica has limited the integration of St. Luke's into ProMedica's hospital system. *See* IDF 12-13. Indeed, the Commission staff sought the Hold Separate Agreement precisely for the purpose of preserving St. Luke's as an

independent and viable competitor, should the transaction be found illegal.[68]

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

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

As we have discussed at length, the evidence as a whole does not bear out Respondent's dire predictions of St. Luke's financial prospects and future competitiveness absent the Joinder. *See supra*

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

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

Respondent's claims about St. Luke's purported inability, if divested, to meet the demands of health care reform are undermined by other evidence as well. For example, St. Luke's own assessment prior to the Joinder was that it was "uniquely positioned for a smooth transition to expected health care reform." PX01072 at 001 ("The hospital already focuses on quality and cost – key components of reform."). The evidence also shows that, prior to the Joinder, St. Luke's fully intended to begin implementing EMR in 2010 to meet "meaningful use" requirements and had budgeted $6 million for it in 2010, but stopped the process because of the Joinder.[69]

We are also unpersuaded by Respondent's argument concerning the cost of unwinding the consolidation of inpatient rehabilitation services at Flower.[70] That integration was undertaken by the

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

[70] Indeed, the ALJ found that there were countervailing costs as a result of this consolidation, because patients who had

parties knowing full well that, depending on the outcome of this case, it might be only temporary. Any unwinding of a consummated merger found to be unlawful is bound to entail some costs, but that in itself is not sufficient reason to forgo requiring divestiture. Respondent has not shown that the costs entailed by divestiture here are so substantial or "unique" as to justify abandonment of the preferred structural remedy in favor of injunctive relief – which has its own costs, including the cost of monitoring compliance.

We turn finally to Respondent's argument that it should be allowed to unwind the Joinder, as opposed to divesting to a third-party acquirer. Complaint Counsel do not oppose an unwinding of the Joinder, but take the view that the ALJ's order already allows this because the acquirer under the terms of the order could be the previously-independent St. Luke's organization. CCAnsB 42. We agree with Complaint Counsel. The Final Order which the Commission is issuing in this case, like the ALJ's order, is sufficiently broad to permit an unwinding, with St. Luke's restored to its status as an independent hospital.[71] The merits of a specific divestiture

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previously chosen to go to St. Luke's inpatient rehabilitation center no longer have that option and, instead, must now go to the more expensive Flower Hospital. ID 197; IDF 1063, 1065.

[71] We take issue, however, with Respondent's contention that an order requiring divestiture to a third-party acquirer would be "overbroad and punitive." The Commission is not bound to replicate precisely the pre-Joinder market but has the discretion to enter broader relief if it finds that such relief

proposal, including any proposal to unwind the Joinder, are appropriately examined when ProMedica applies for Commission approval of a proposed divestiture in accordance with the agency's established procedures. *See* 16 C.F.R. § 2.41(f).

XI. CONCLUSION

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

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would serve the goal of restoring competition. *See Chicago Bridge*, 534 F.3d at 440-42.

APPENDIX C

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

Concurring Opinion of Commissioner J. Thomas Rosch

I concur with the Commission's decision finding that ProMedica Health System's acquisition of St. Luke's Hospital violates Section 7 of the Clayton Act. I also concur with the Commission's conclusion that the appropriate remedy for this violation is divestiture of St. Luke's. I write separately because (1) I would have affirmed the ALJ's finding that the general acute care inpatient services product market includes tertiary services, (2) I would have affirmed the ALJ's rejection of a separate market for inpatient obstetrical services, and (3) I would not have relied on any "willingness to pay" econometric models to establish liability, as the ALJ did.

I.

As to the first issue, the parties agreed, consistent with Commission and judicial precedent, that the relevant product market in this case consisted of general acute care (GAC) inpatient services sold to managed care organizations (MCOs). (Complaint ¶

12; Answer ¶ 12; IDF 299, 306; *Evanston Nw. Healthcare Corp.*, 2007 FTC LEXIS 210, at *146-151 (2007) (citing six hospital merger decisions).) The Commission has previously concluded that an inpatient GAC market includes tertiary services. In *Evanston*, the Commission defined the relevant product market to include all of the inpatient services provided by Evanston Northwestern Hospital, which offered primary, secondary, and tertiary care services, and Highland Park Hospital, which offered *only* primary and secondary services. *Id*. at *23-24. The ALJ's relevant product market definition thus accords with the prior teaching of the courts and of this Commission, and there was no need for the Commission to revisit this issue.[1]

II.

As to the second issue, I would have also affirmed the ALJ's conclusion that there is not a separate market for inpatient obstetrical services. These services are already reflected in the inpatient GAC cluster market. Defining a separate market for

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[1] The majority does not dispute that in *Evanston*, the Commission concluded that the relevant product market included tertiary care services even though only the acquiring hospital offered those services. The majority just asserts that the Commission did not need to reach that conclusion because the issue was not raised in the briefs. In fact, Jonathan Baker, on whom the majority relies, says that such a market definition may be supported simply by "convenience," even where there are "substantial" differences in market shares across services in the cluster market. Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 L. & Contemp. Probs. 93, 137-38 & n.212 (1988).

obstetrical services would therefore be redundant.[2] Furthermore, neither Complaint Counsel nor the majority can point to any judicial precedent for defining a obstetrical services market separate from an overall inpatient GAC market.[3]

In sum, insofar as the Commission would reverse the ALJ as to the role of tertiary and obstetrical services in the relevant market, the Commission would not only depart from the case law, but also risk accusations of "gerrymandering" the relevant product market so as to make it more susceptible to a structural presumption of liability.

III.

As to the third issue, Complaint Counsel and their economist Dr. Town proffered a study linking hospital concentration to prices in the relevant

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[2] The majority takes issue with the notion that inclusion of OB services with other inpatient services is redundant. But the majority acknowledges that whether OB services are included with other inpatient services makes no difference to the outcome of this case. The majority simply asserts that it would be more "transparent" to treat OB services as a separate market and cites to *Butterworth* as precedent for a separate OB market. However, neither the district court nor the Sixth Circuit (which, incidentally, did not affirm or even address the district court's conclusions regarding the relevant market) in that case held that a separate OB market could be carved out. *See FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290-91 (W.D. Mich. 1996), *aff'd*, 1997-2 Trade Cas. (CCH) ¶ 71,863 (6th Cir. 1997).

[3] If, as the majority says, getting the relevant market right is "important from the standpoint of analytical precision and guidance for future cases," it matters whether OB Services are a separate market. That is precisely why avoiding "gerrymandering" is important.

geographic market (IDF 605-11), an MCO "willingness-to-pay" econometric model (IDF 612-34), and a diversion analysis purporting to show that ProMedica was the closest substitute for St. Luke's patients (IDF 453-61). Respondent and its economist, Ms. Guerin-Calvert, disputed Dr. Town's "willingness to pay" model and adjusted its specifications in an attempt to correct some of its alleged flaws.[4] (RX 71(A).) Thus, there ended up being two competing econometric "willingness to pay" models. As a result, the parties presented competing, and very different, predictions respecting MCOs' "willingness to pay."

A.

Insofar as the Commission relies on Dr. Town's study linking concentration to prices, it supports a "structural" theory of Section 7 liability. *See United States v. Baker Hughes Inc.*, 908 F.2d 981 (1990). The traditional way of challenging a merger is to demonstrate that the merger is reasonably likely to lessen competition or create a monopoly by further concentrating an already concentrated market. If the change in concentration resulting from the merger is sufficiently high, this "structural" theory creates a presumption of liability. That presumption stands unless it is rebutted. *See United States v. Philadelphia Nat'l Bank*, 374 U.S. 321 (1963); *United*

[4] Ms. Guerin-Calvert's modifications to Dr. Town's "willingness to pay" econometric model do not constitute a waiver of arguments challenging the propriety of the model. As counsel for Respondent explained, Ms. Guerin-Calvert's modifications to Dr. Town's model were only submitted to rebut his model, and Ms. Guerin-Calvert continued to insist that Dr. Town's model was fatally flawed. (Oral Arg. Tr. 27.)

States v. Baker Hughes Inc., 908 F.2d 981 (1990). In this case, the pre-transaction and post-transaction HHIs and the increase in the same are more than sufficient to trigger the presumption of liability established by the Supreme Court. *See Philadelphia Nat'l Bank*, 374 U.S. at 363-67. The ALJ found that even using Respondent's proposed market definition, the pre-merger HHIs meet the Merger Guidelines' presumption of a highly concentrated market (IDF 368-69) and that "the Joinder significantly increases concentration in the already highly concentrated Lucas County GAC inpatient service market" (IDF 370).

Moreover, the majority correctly concluded that Respondent had failed to produce evidence that St. Luke's was in such bad shape that its market shares would be diluted enough in the future to fall below the level of presumptive illegality. *United States v. Gen. Dynamics Corp.*, 415 U.S. 486 (1974). For example, St. Luke's CEO informed his Board in August 2010—one month prior to the closing of the Joinder Agreement—that the hospital had "high activity" compared to the prior year and "produced a positive operating margin." (IDF 790-91, 948.) He also acknowledged that by the time of the Joinder, St. Luke's had achieved 4 of the 5 "pillars" set forth in its Three-Year Plan. (IDF 931; *see also* IDF 920-41.) Among other things, St. Luke's increased inpatient and outpatient net revenue, increased its occupancy rate, and increased its market share in its core service area. (IDF 924-28.) A variety of other financial metrics also improved in the two years leading up to the Joinder Agreements. (IDF 950-54.)

Finally, ProMedica's documents and testimony contradict its assertion that, absent the Joinder, it would need to build a costly new hospital at its Arrowhead property and a new tower at its Flower Hospital. (IDF 1122, 1124, 1126, 1127.)

The structural case—and indeed, the anticompetitive effects of this change in structure—was also buttressed by numerous admissions made by the merging parties in their testimony and documents. For example, ProMedica's CEO acknowledged that before the Joinder, the parties competed to attract patients and also competed to attract and retain physicians. (IDF 464-65.) ProMedica's internal assessments viewed St. Luke's as a capable competitor that could take away patient volume. (IDF 467-71, 1020.) St. Luke's CEO testified that after he came to St. Luke's in 2008, his goal was to regain volume from ProMedica in St. Luke's primary service area. (IDF 441.)

St. Luke's also acknowledged that it entered into the Affiliation Agreement with ProMedica in part based on its expectation of higher reimbursement rates from managed care organizations (MCOs). (IDF 396, 421, 597-603.) A presentation from St. Luke's CEO to the Board of Directors stated that an "affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-[St. Luke's] partnership would have a lot of negotiating clout." (IDF 598.) The same presentation noted that an affiliation with ProMedica could "[h]arm the community by forcing higher hospital rates on them." (IDF 598.) Other merger planning documents noted St. Luke's belief that a ProMedica affiliation would

allow it to "force[] high rates on employers and insurance companies" and lead to "outstanding pricing on managed care agreements." (IDF 599-600.)

B.

First, the "willingness to pay" model is not an appropriate basis on which to find that the transaction will result in unilateral effects.[5] The fundamental premise of the unilateral effects theory of liability has long been that customers accounting for a "significant share of sales" in the market must view the merging parties as each other's closest substitutes. *See* 1992 Merger Guidelines § 2.21 ("Substantial unilateral price elevation in a market for differentiated products requires that there be a significant share of sales in the market accounted for by consumers who regard the products of the merging firms as their first and second choices . . . ."); 2010 Merger Guidelines § 6.1; *United States v. H&R Block*, 2011 U.S. Dist. LEXIS 130219 (D.D.C. 2011) (unilateral effects in differentiated product market

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[5] The majority asserts that asymmetric unilateral effects – where only one party is the other's closest competitor – are "not at all uncommon particularly in markets involving competitors of varied size." But the majority has failed to cite a single case where a "willingness to pay" study was considered probative in a "bargaining" market like this one. Indeed, the majority ignores the teaching of *Evanston* that such a model "potentially creates sticky and unsettled issues for merger analysis [in such a market], most significantly, determining the percentage of the merged firm's revenues that must come from customers who are harmed by the merger for the transaction to violate Section 7." 2007 FTC LEXIS 210, at *167. Additionally, the majority ignores the other prudential reasons for eschewing such a study.

requires that "the products controlled by the *merging* firms must be close substitutes, *i.e.*, a substantial number of the customers of one firm would turn to the other in response to a price increase" (quoting *CCC Holdings Inc.*, 605 F. Supp. 2d 26, 68 (D.D.C. 2009), and *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1117-18 (N.D. Cal. 2004)); *Evanston*, 2007 FTC LEXIS 210, at *158 ("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 for a particular need."). In *Evanston*, the Commission explained that this principle applied to "bargaining markets" like hospital markets. *Evanston*, 2007 FTC LEXIS 210, at *167 ("In a bargaining market, a merger may allow the merged firm to exercise market power against a subset of customers who view the merging parties as their first and second choices . . . .").

This fundamental premise does not exist in this case. Each and every one of the six MCOs who testified admitted that *Mercy*, not St. Luke's, was ProMedica's next best substitute. (IDF 442-449; *see also* IDF 437.) Complaint Counsel do not seriously dispute this. (Complaint Counsel Answering Brief at 12 ("Complaint Counsel does not deny that Mercy is, in all likelihood, the ProMedica system's closest substitute.")) The ALJ also found that "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 at 157; *see also* ID at 159 ("MCOs, when

constructing a network, viewed the hospital systems of ProMedica and Mercy to be each other's closest substitute . . . .")

As stated above, in *Evanston* the Commission indicated that "willingness to pay" econometric models could apply in "bargaining" markets. But the Commission warned that "[t]he potential for a merger in a bargaining market to have disparate effects on different customers" was significantly different in such markets than it was in a "single-price market." *See Evanston*, 2007 FTC LEXIS 210, at *167. The Commission went on to warn that that "potentially creates sticky and unsettled issues for merger analysis, most significantly, determining the percentage of the merged firm's revenues that must come from customers who are harmed by the merger for the transaction to violate Section 7." *Id*.

C.

Second, the Commission should not needlessly resolve all of the thorny issues that surround the "willingness to pay" models or saddle an appellate court with those issues either. Those issues begin with the reliability of the models themselves. They are a form of "simulation" study. Critics have charged that such studies always predict a price increase if there is any degree of substitution between the merging parties' products. *See* Statement of Commissioner J. Thomas Rosch on the Release of the 2010 Horizontal Merger Guidelines at 3-4 (Aug. 19, 2010). And even the Commission has stated that such studies are not "conclusive" in themselves. *See* 2010 Guidelines § 6.1. For another thing, it is not

easy to choose between Dr. Town's model and the modifications that Ms. Guerin Calvert made to that model. Dr. Town's model in its original form and as modified predict very different levels of price increase and degrees of statistical significance. But these issues need not be resolved.

D.

Third and finally, the Commission has tried to persuade staff of the virtues of "telling a story" predominantly out of the mouths of the parties and their documents. This is how the top-flight plaintiff's lawyers try their cases. We have much to learn from them. The Commission should be reluctant to focus attention instead on economic models especially when the Commission has devoted so much time and effort to insisting that staff focus on the real world as contrasted with the theoretical world. *See generally* Vaughn R. Walker, *Merger Trials: Looking for the Third Dimension*, 5 Competition Policy Int'l 35 (2009) (observing that if economic evidence is to be persuasive, it must be communicated in a way that a generalist can understand it and must be consistent with other evidence).

APPENDIX D

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION

COMMISSIONERS: Jon Leibowitz, Chairman
J. Thomas Rosch
Edith Ramirez
Julie Brill

In the Matter of

Docket No. 9346

ProMedica Health System, Inc.

FINAL ORDER
[PUBLIC VERSION]

The Commission has heard this matter upon the appeals of Respondent and Complaint Counsel from the Initial Decision, and upon briefs and oral argument in support thereof and in opposition thereto. For the reasons stated in the accompanying Opinion of the Commission, the Commission has determined to sustain the Initial Decision, with certain modifications:

IT IS ORDERED that the Initial Decision of the administrative law judge be, and it hereby is, adopted as the Findings of Fact and Conclusions of Law of the Commission, to the extent not

inconsistent with the findings of fact and conclusions contained in the accompanying Opinion.

Other findings of fact and conclusions of law of the Commission are contained in the accompanying Opinion.

IT IS FURTHER ORDERED that the following Order to cease and desist be, and it hereby is, entered:

ORDER

I.

IT IS ORDERED that, as used in this Order, the following definitions shall apply:

A. "ProMedica" means ProMedica Health System, Inc., its directors, officers, employees, agents, representatives, successors, and assigns; and its joint ventures, subsidiaries (including, but not limited to, ProMedica Health Insurance Corporation), divisions, groups, and affiliates controlled by ProMedica Health System, Inc., and the respective directors, officers, employees, agents, representatives, successors, and assigns of each.

B. "St. Luke's Hospital" means the Acute-Care Hospital operated at 5901 Monclova Road, Maumee, Ohio 43537.

C. "Commission" means the Federal Trade Commission.

D. "Acquirer" means the Person that acquires, with the prior approval of the Commission, the St. Luke's Hospital Assets from ProMedica pursuant

to Paragraph II, or from the Trustee pursuant to Paragraph VII of this Order.

E. "Acquirer Hospital Business" means all activities relating to general Acute-Care Hospital services and other related health-care services to be conducted by the Acquirer in connection with the St. Luke's Hospital Assets.

F. "Acute-Care Hospital" means a health-care facility licensed as a hospital, other than a federally-owned facility, having a duly organized governing body with overall administrative and professional responsibility, and an organized professional staff, that provides 24-hour inpatient care, that may also provide outpatient services, and having as a primary function the provision of General Acute-Care Inpatient Hospital Services.

G. "Direct Cost" means the cost of direct material and direct labor used to provide the relevant assistance or service.

H. "Divestiture Agreement" means any agreement, including all exhibits, attachments, agreements, schedules and amendments thereto, that has been approved by the Commission pursuant to which the St. Luke's Hospital Assets are divested by ProMedica pursuant to Paragraph II, or by the Divestiture Trustee pursuant to Paragraph VII of this Order.

I. "Divestiture Trustee" means the Person appointed pursuant to Paragraph VII of this Order to divest the St. Luke's Hospital Assets.

J. "Effective Date of Divestiture" means the date on which the divestiture of the St. Luke's Hospital Assets to an Acquirer pursuant to Paragraph II or Paragraph VII of this Order is completed.

K. "General Acute-Care Inpatient Hospital Services" means a broad cluster of basic medical and surgical diagnostic and treatment services for the medical diagnosis, treatment, and care of physically injured or sick persons with short term or episodic health problems or infirmities, that includes an overnight stay in the hospital by the patient. General Acute-Care Inpatient Hospital Services include what are commonly classified in the industry as primary, secondary, and tertiary services, but exclude: (i) services at hospitals that serve solely military and veterans; (ii) services at outpatient facilities that provide same-day service only; (iii) those services known in the industry as specialized tertiary services and quaternary services; and (iv) psychiatric, substance abuse, and rehabilitation services.

L. "Hospital Provider Contract" means a contract between a Payor and any hospital to provide General Acute-Care Inpatient Hospital Services and related healthcare services to enrollees of health plans.

M. "Intangible Property" means intangible property relating to the Operation of St. Luke's Hospital including, but not limited to, Intellectual Property, the St. Luke's Hospital Name and Marks, logos, and the modifications or improvements to such intangible property.

N. "Intellectual Property" means, without limitation: (i) all patents, patent applications, inventions, and discoveries that may be patentable; (ii) all knowhow, trade secrets, software, technical information, data, registrations, applications for governmental approvals, inventions, processes, best practices (including clinical pathways), formulae, protocols, standards, methods, techniques, designs, quality-control practices and information, research and test procedures and information, and safety, environmental and health practices and information; (iii) all confidential or proprietary information, commercial information, management systems, business processes and practices, patient lists, patient information, patient records and files, patient communications, procurement practices and information, supplier qualification and approval practices and information, training materials, sales and marketing materials, patient support materials, advertising and promotional materials; and (iv) all rights in any jurisdiction to limit the use or disclosure of any of the foregoing, and rights to sue and recover damages or obtain injunctive relief for infringement, dilution, misappropriation, violation, or breach of any of the foregoing.

O. "Joinder" means the Operation of St. Luke's Hospital by ProMedica pursuant to the Joinder Agreement.

P. "Joinder Agreement" means the agreement by and among ProMedica Health System, Inc., OhioCare Health System, Inc., St. Luke's Hospital, and St.

Luke's Hospital Foundation, Inc., dated May 25, 2010, and all subsequent amendments thereto, including, but not limited to the First and Second Amendments, each dated August 18, 2010, the Third Amendment, dated August 31, 2010, and the Side Agreement, dated September 1, 2010.

Q. "Licensed Intangible Property" means Intangible Property licensed to ProMedica or to St. Luke's Hospital from a third party relating to the Operation of St. Luke's Hospital including, but not limited to, Intellectual Property, software, computer programs, patents, know-how, goodwill, technology, trade secrets, technical information, marketing information, protocols, quality-control information, trademarks, trade names, service marks, logos, and the modifications or improvements to such intangible property that are licensed to ProMedica or to St. Luke's Hospital ("Licensed Intangible Property" does not mean modifications and improvements to intangible property that are not licensed to ProMedica).

R. "Monitor" means the Person appointed pursuant to Paragraph VI of the Order and with the prior approval of the Commission.

S. "Monitor Agreement" means the agreement ProMedica enters into with the Monitor and with the prior approval of the Commission.

T. "Operation of St. Luke's Hospital" means all activities relating to the business of St. Luke's Hospital, operating as an Acute-Care Hospital,

including, but not limited to, the activities and services provided at outpatient facilities.

U. "Ordinary Course of Business" means actions taken by any Person in the ordinary course of the normal day-to-day Operation of St. Luke's Hospital that is consistent with past practices of such Person in the Operation of St. Luke's Hospital, including, but not limited to, past practice with respect to amount, timing, and frequency.

V. "Payor" means any Person that purchases, reimburses for, or otherwise pays for medical goods or services for themselves or for any other person, including, but not limited to: health insurance companies; preferred provider organizations; point-of-service organizations; prepaid hospital, medical, or other health-service plans; health maintenance organizations; government health-benefits programs; employers or other persons providing or administering self-insured health benefits programs; and patients who purchase medical goods or services for themselves.

W. "Person" means any natural person, partnership, corporation, association, trust, joint venture, government, government agency, or other business or legal entity.

X. "Physician" means a doctor of allopathic medicine ("M.D.") or a doctor of osteopathic medicine ("D.O.").

Y. "ProMedica Medical Protocols" means medical protocols promulgated by ProMedica, whether in hard copy or embedded in software, that have been in effect at any ProMedica Hospital, excluding St. Luke's Hospital, at any time since Joinder; provided, however, that "ProMedica's Medical Protocols" does not mean medical protocols adopted or promulgated, at any time, by any Physician or by any Acquirer, even if such medical protocols are identical, in whole or in part, to medical protocols promulgated by ProMedica.

Z. "Post-Joinder Hospital Business" means all activities relating to the provision of General Acute-Care Inpatient Hospital Services and other related health-care services conducted by ProMedica after Joinder including, but not limited to, all health-care services, including outpatient services, offered in connection with the St. Luke's Hospital Business.

AA. "Pre-Joinder St. Luke's Hospital Business" means all activities relating to the provision of General Acute-Care Inpatient Hospital Services and other related health-care services that St. Luke's Hospital was offering as an Acute-Care Hospital prior to Joinder.

BB. "Real Property of St. Luke's Hospital" means all real property interests (including fee simple interests and real property leasehold interests including all rights, easements and appurtenances, together with all buildings, structures, and facilities) that ProMedica acquired

pursuant to the Joinder Agreement, whether or not located at St. Luke's Hospital or whether or not related to the Operation of St. Luke's Hospital. Real Property of St. Luke's Hospital includes, but is not limited to, the assets which are identified and listed on Appendix 1 to this Order.

CC. "St. Luke's Hospital Assets" means all of ProMedica's right, title, and interest in and to St. Luke's Hospital and all related health-care and other assets, tangible or intangible, business, and properties, including any improvements or additions thereto made subsequent to Joinder, relating to the operation of the Post-Joinder Hospital Business, including, but not limited to:

1. All Real Property of St. Luke's Hospital;

2. All Tangible Personal Property, including Tangible Personal Property related to the Operation of St. Luke's Hospital, whether or not located at St. Luke's Hospital, and Tangible Personal Property located at the Real Property of St. Luke's Hospital;

3. All consumable or disposable inventory, including but not limited to, janitorial, office, and medical supplies, and at least thirty (30) treatment days of pharmaceuticals;

4. All rights under any contracts and agreements (*e.g.*, leases, service agreements such as dietary and housekeeping services, supply agreements, and procurement contracts), including, but not limited to, all rights to

contributions, funds, and other provisions for the benefit of St. Luke's Hospital pursuant to the Joinder Agreement;

5. All rights and title in and to use of the St. Luke's Hospital Name and Marks on a permanent and exclusive basis;

6. St. Luke's Medicare and Medicaid provider numbers, to the extent transferable;

7. All Intellectual Property; provided, however, that St. Luke's Hospital Medical Protocols do not include ProMedica Medical Protocols;

8. All governmental approvals, consents, licenses, permits, waivers, or other authorizations to the extent transferable;

9. All rights under warranties and guarantees, express or implied;

10. All items of prepaid expense; and

11. Books, records, files, correspondence, manuals, computer printouts, databases, and other documents relating to the Operation of St. Luke's Hospital, electronic and hard copy, located on the premises of St. Luke's Hospital or in the possession of the ProMedica Employee responsible for the Operation of St. Luke's Hospital (or copies thereof where ProMedica has a legal obligation to maintain the original document), including, but not limited to:

    a. documents containing information relating to patients (to the extent transferable

under applicable law), including, but not limited to, medical records, including, but not limited to, any electronic medical records system,

b. financial records,

c. personnel files,

d. St. Luke's Hospital Physician Contracts, Physician lists, and other records of St. Luke's Hospital dealings with Physicians,

e. maintenance records,

f. documents relating to policies and procedures,

g. documents relating to quality control,

h. documents relating to Payors,

i. documents relating to Suppliers, and

j. copies of Hospital Provider Contracts and contracts with Suppliers, unless such contracts cannot, according to their terms, be disclosed to third parties even with the permission of ProMedica to make such disclosure.

DD. "St. Luke's Hospital Contractor" means any Person that provides Physician or other health-care services pursuant to a contract with St. Luke's Hospital or ProMedica (including, but not limited to, the provision of emergency room, anesthesiology, pathology, or radiology services) in connection with the Operation of St. Luke's Hospital.

EE. "St. Luke's Hospital Physician Contracts" means all agreements to provide the services of a Physician in connection with the Operation of St. Luke's Hospital, regardless of whether any of the agreements are with a Physician or with a medical group, including, but not limited to, agreements for the services of a medical director for St. Luke's Hospital and joiner agreements with Physicians in the same medical practice as a medical director of St. Luke's Hospital.

FF. "St. Luke's Hospital Employee" means any individual who was employed by St. Luke's Hospital prior to Joinder or was employed by ProMedica after Joinder in connection with the Operation of St. Luke's Hospital, and who has worked part-time or full-time on the premises of St. Luke's Hospital at any time since Joinder, regardless of whether that individual has also worked on the premises of ProMedica.

GG. "St. Luke's Hospital License" means: (i) a worldwide, royalty-free, paid-up, perpetual, irrevocable, transferable, sublicensable, exclusive license under all Intellectual Property owned by or licensed to St. Luke's Hospital relating to operation of the Post-Joinder Hospital Business at St. Luke's Hospital (that is not included in the St. Luke's Hospital Assets) and (ii) such tangible embodiments of the licensed rights (including, but not limited to, physical and electronic copies) as may be necessary or appropriate to enable the Acquirer to utilize the rights.

HH. "St. Luke's Hospital Medical Protocols" means medical protocols promulgated by St. Luke's Hospital, whether in hard copy or embedded in software, that were in effect at any time prior to Joinder with ProMedica.

II. "St. Luke's Hospital Medical Staff Member" means any Physician or other health-care professional who: (1) is not a St. Luke's Hospital Employee and (2) is a member of the St. Luke's Hospital medical staff, including, but not limited to, any St. Luke's Hospital Contractor.

JJ. "St. Luke's Hospital Name and Marks" means the name "St. Luke's Hospital" and any variation of that name, in connection with the St. Luke's Hospital Assets, and all other associated trade names, business names, proprietary names, registered and unregistered trademarks, service marks and applications, domain names, trade dress, copyrights, copyright registrations and applications, in both published works and unpublished works, relating to the St. Luke's Hospital Assets.

KK. "Software" means executable computer code and the documentation for such computer code, but does not mean data processed by such computer code.

LL. "Supplier" means any Person that has sold to ProMedica any goods or services, other than Physician services, for use in connection with the Operation of St. Luke's Hospital; provided, however, that "Supplier" does not mean an employee of ProMedica.

MM. "Tangible Personal Property" means all machinery, equipment, spare parts, tools, and tooling (whether customer specific or otherwise); furniture, office equipment, computer hardware, supplies and materials; vehicles and rolling stock; and other items of tangible personal property of every kind whether owned or leased, together with any express or implied warranty by the manufacturers, sellers or lessors of any item or component part thereof, and all maintenance records and other documents relating thereto.

NN. "Transitional Administrative Services" means administrative assistance with respect to the operation of an Acute-Care Hospital and related health-care services, including but not limited to assistance relating to billing, accounting, governmental regulation, human resources management, information systems, managed care contracting, and purchasing.

OO. "Transitional Clinical Services" means clinical assistance and support services with respect to operation of an Acute-Care Hospital and related health-care services, including but not limited to cardiac surgery, oncology services, and laboratory and pathology services.

PP. "Transitional Services" means Transitional Administrative Services and Transitional Clinical Services.

II.

IT IS FURTHER ORDERED that:

A. ProMedica shall:

1. No later than one hundred and eighty (180) days from the date this Order becomes final and effective, divest absolutely and in good faith, and at no minimum price, the St. Luke's Hospital Assets to an Acquirer that receives the prior approval of the Commission and in a manner, including pursuant to a Divestiture Agreement, that receives the prior approval of the Commission;

2. Comply with all terms of the Divestiture Agreement approved by the Commission pursuant to this Order, which agreement shall be deemed incorporated by reference into this Order; and any failure by ProMedica to comply with any term of the Divestiture Agreement shall constitute a failure to comply with this Order. The Divestiture Agreement shall not reduce, limit or contradict, or be construed to reduce, limit or contradict, the terms of this Order; provided, however, that nothing in this Order shall be construed to reduce any rights or benefits of any Acquirer or to reduce any obligations of ProMedica under such agreement; provided further, that if any term of the Divestiture Agreement varies from the terms of this Order ("Order Term"), then to the extent that ProMedica cannot fully comply with both terms, the Order Term shall determine ProMedica's obligations under this Order. Notwithstanding any paragraph, section, or other provision of the Divestiture Agreement, any failure to meet any condition precedent to closing (whether waived or not) or

any modification of the Divestiture Agreement, without the prior approval of the Commission, shall constitute a failure to comply with this Order.

B. Prior to the Effective Date of Divestiture, ProMedica shall not rescind the Joinder Agreement or any term of the Joinder Agreement necessary to comply with any Paragraph of this Order.

C. Prior to the Effective Date of Divestiture, ProMedica shall restore to St. Luke's Hospital any assets of St. Luke's Hospital as of the date of Joinder that were removed from St. Luke's Hospital at any time from the date of Joinder through the Effective Date of Divestiture, other than Inventories consumed in the Ordinary Course of Business. To the extent that:

1. The St. Luke's Hospital Assets as of the Effective Date of Divestiture do not include (i) assets that ProMedica acquired on the date of Joinder, (ii) assets that replaced those acquired on the date of Joinder, or (iii) any other assets that ProMedica acquired and has used in or that are related to the Post-Joinder Hospital Business, then ProMedica shall add to the St. Luke's Hospital Assets additional assets (of a quality that meets generally acceptable standards of performance) to replace the assets that no longer exist or are no longer controlled by ProMedica;

2. After the date of Joinder and prior to the Effective Date of Divestiture, if ProMedica

terminated any clinical service, clinical program, support function, or management function (i) performed by the Pre-Joinder St. Luke's Hospital Business, or (ii) performed by the Post-Joinder Hospital Business, then ProMedica shall restore such service, program, or function (to a quality level that meets generally acceptable standards of care or performance), no later than the Effective Date of Divestiture of the St. Luke's Hospital Assets or any other date that receives the prior approval of the Commission.

Provided, however, that ProMedica shall not be required to replace any asset or to restore any service, program, or function described by Paragraphs II.C.1. or II.C.2. of this Order if and only if in each instance ProMedica demonstrates to the Commission's satisfaction: (i) that such asset, service, program, or function is not necessary to achieve the purpose of this Order; and (ii) that the Acquirer does not need such asset, service, program, or function to effectively operate the Acquirer Hospital Business in a manner consistent with the purpose of this Order, and if and only if the Commission approves the divestiture without the replacement or restoration of such asset, service, program, or function.

D. No later than the Effective Date of Divestiture, ProMedica shall grant to the Acquirer a St. Luke's Hospital License for any use in the Acquirer Hospital Business, and shall take all actions necessary to facilitate the unrestricted use of the St. Luke's Hospital License.

E. ProMedica shall take all actions and shall effect all arrangements in connection with the divestiture of the St. Luke's Hospital Assets necessary to ensure that the Acquirer can conduct the Acquirer Hospital Business in substantially the same manner as St. Luke's Hospital has operated as the Post-Joinder Hospital Business, and in full compliance with the March 29, 2011, order issued by Judge Katz in *Federal Trade Commission, et al. v. ProMedica Health System*, Civil No. 3:11 CV 47, at St. Luke's Hospital, with an independent full-service medical staff capable of providing General Acute-Care Inpatient Hospital Services, and an independent full-service hospital staff and management, including, but not limited to, providing:

   1. Assistance necessary to transfer to the Acquirer all governmental approvals needed to operate the St. Luke's Hospital Assets as an Acute-Care Hospital;

   2. Transitional Services;

   3. The opportunity to recruit and employ St. Luke's Hospital Employees; and

   4. The opportunity to recruit, contract with, and extend medical staff privileges to any St. Luke's Hospital Medical Staff Member, including as provided in Paragraphs II.I, II.J, and II.K of this Order.

F. ProMedica shall convey as of the Effective Date of Divestiture to the Acquirer the right to use any Licensed Intangible Property (to the extent

permitted by the third-party licensor), if such right is needed for the Operation of St. Luke's Hospital by the Acquirer and if the Acquirer is unable, using commercially reasonable efforts, to obtain equivalent rights from other third parties on commercially-reasonable terms and conditions.

G. ProMedica shall:

1. Place no restrictions on the use by the Acquirer of the St. Luke's Hospital Assets;

2. On or before the Effective Date of Divestiture, provide to the Acquirer contact information about Payors and Suppliers for the St. Luke's Hospital Assets;

3. Not object to the sharing of Payor and Supplier contract terms relating to the St. Luke's Hospital Assets: (i) if the Payor or Supplier consents in writing to such disclosure upon a request by the Acquirer, and (ii) if the Acquirer enters into a confidentiality agreement with ProMedica not to disclose the information to any third party; and

4. With respect to contracts with St. Luke's Hospital Suppliers, at the Acquirer's option and as of the Effective Date of Divestiture:

   a. if such contract can be assigned without third-party approval, assign its rights under the contract to the Acquirer; and

   b. if such contract can be assigned to the Acquirer only with third-party approval, assist and cooperate with the Acquirer in obtaining:

(1) such third-party approval and in assigning the contract to the Acquirer; or

(2) a new contract.

H. At the request of the Acquirer, for a period not to exceed twelve (12) months from the Effective Date of Divestiture, except as otherwise approved by the Commission, and in a manner (including pursuant to an agreement) that receives the prior approval of the Commission:

1. ProMedica shall provide Transitional Services to the Acquirer sufficient to enable the Acquirer to conduct the Acquirer Hospital Business in substantially the same manner that ProMedica has conducted the Post-Joinder Hospital Business at St. Luke's Hospital; and

2. ProMedica shall provide the Transitional Services required by this Paragraph II.H. at substantially the same level and quality as such services are provided by ProMedica in connection with its operation of the Post-Joinder Hospital Business.

Provided, however, that ProMedica shall not (i) require the Acquirer to pay compensation for Transitional Services that exceeds the Direct Cost of providing such goods and services, (ii) terminate its obligation to provide Transitional Services because of a material breach by the Acquirer of any agreement to provide such assistance, in the absence of a final order of a

court of competent jurisdiction, or (iii) include a term in any agreement to provide Transitional Services that limits the type of damages (such as indirect, special, and consequential damages) that the Acquirer would be entitled to seek in the event of ProMedica's breach of such agreement.

I. ProMedica shall allow the Acquirer an opportunity to recruit and employ any St. Luke's Hospital Employee in connection with the divestiture of the St. Luke's Hospital Assets so as to enable the Acquirer to establish an independent, full-service medical staff, hospital staff and management, including as follows:

1. No later than five (5) days after execution of a divestiture agreement, ProMedica shall (i) identify each St. Luke's Hospital Employee, (ii) allow the Acquirer an opportunity to interview any St. Luke's Hospital Employee, and (iii) allow the Acquirer to inspect the personnel files and other documentation relating to any St. Luke's Hospital Employee, to the extent permissible under applicable laws.

2. ProMedica shall (i) not offer any incentive to any St. Luke's Hospital Employee to decline employment with the Acquirer, (ii) remove any contractual impediments that may deter any St. Luke's Hospital Employee from accepting employment with the Acquirer, including, but not limited to, any non-compete or confidentiality provisions of employment or other contracts with ProMedica that would affect the ability of the St. Luke's Hospital

Employee to be employed by the Acquirer, and (iii) not otherwise interfere with the recruitment of any St. Luke's Hospital Employee by the Acquirer, including, but not limited to, by refusing or threatening to refuse to extend medical staff privileges at any ProMedica Acute-Care Hospital.

3. ProMedica shall (i) vest all current and accrued pension benefits as of the date of transition of employment with the Acquirer for any St. Luke's Hospital Employee who accepts an offer of employment from the Acquirer no later than thirty (30) days from the Effective Date of Divestiture and (ii) if the Acquirer has made a written offer of employment to any key personnel, as identified and listed on confidential Appendix 2 to this Order, provide such key personnel with reasonable financial incentives to accept a position with the Acquirer at the time of the Effective Date of Divestiture, including, but not limited to (and subject to Commission approval), payment of an incentive equal to up to three (3) months of such key personnel's base salary to be paid only upon such key personnel's completion of one (1) year of employment with the Acquirer.

4. For a period ending two (2) years after the Effective Date of Divestiture, ProMedica shall not, directly or indirectly, solicit, hire, or enter into any arrangement for the services of any St. Luke's Hospital Employee employed by the Acquirer, unless such St. Luke's Hospital Employee's employment has been terminated

by the Acquirer; provided, however, this Paragraph II.I.4 shall not prohibit ProMedica from: (i) advertising for employees in newspapers, trade publications, or other media not targeted specifically at the St. Luke's Hospital Employees, (ii) hiring employees who apply for employment with ProMedica, as long as such employees were not solicited by ProMedica in violation of this Paragraph II.I.4, or (iii) offering employment to a St. Luke's Hospital Employee who is employed by the Acquirer in only a part-time capacity, if the employment offered by ProMedica would not, in any way, interfere with that employee's ability to fulfill his or her employment responsibilities to the Acquirer.

J. ProMedica shall allow the Acquirer an unimpeded opportunity to recruit, contract with, and otherwise extend medical staff privileges to any St. Luke's Hospital Medical Staff Member in connection with the divestiture of the St. Luke's Hospital Assets so as to enable the Acquirer to establish an independent, complete, full-service medical staff, including as follows:

1. No later than the date of execution of a divestiture agreement, ProMedica shall (i) identify each St. Luke's Hospital Medical Staff Member, (ii) allow the Acquirer an opportunity to interview any St. Luke's Hospital Medical Staff Member, and (iii) allow the Acquirer to inspect the files and other documentation relating to any St. Luke's Hospital Medical

Staff Member, to the extent permissible under applicable laws.

2. ProMedica shall (i) not offer any incentive to any St. Luke's Hospital Medical Staff Member to decline to join the Acquirer's medical staff; (ii) remove any contractual impediments that may deter any St. Luke's Hospital Medical Staff Member from joining the Acquirer's medical staff, including, but not limited to, any non-compete or confidentiality provisions of employment or other contracts with ProMedica that would affect the ability of the St. Luke's Hospital Medical Staff Members to be recruited by the Acquirer; and (iii) not otherwise interfere with the recruitment of any St. Luke's Hospital Medical Staff Member by the Acquirer, including, but not limited to, by refusing or threatening to refuse to extend medical staff privileges at any ProMedica Acute-Care Hospital.

K. With respect to each Physician who has provided services to St. Luke's Hospital pursuant to any St. Luke's Hospital Physician Contract in effect at any time preceding the Effective Date of Divestiture ("Contract Physician"), ProMedica shall not offer any incentive to the Contract Physician, the Contract Physician's practice group, or other members of the Contract Physician's practice group to decline to provide services to St. Luke's Hospital, and shall eliminate any confidentiality restrictions that would prevent the Contract Physician, the Contract Physician's practice group, or other

members of the Contract Physician's practice group from using or transferring to the Acquirer of the St. Luke's Hospital Assets any information relating to the Operation of St. Luke's Hospital.

L. Except in the course of performing its obligations under this Order, ProMedica shall:

1. not provide, disclose, or otherwise make available any trade secrets or any sensitive or proprietary commercial or financial information relating to the Acquirer or the Acquirer Hospital Business to any Person other than the Acquirer, and shall not use such information for any reason or purpose;

2. disclose trade secrets or any sensitive or proprietary commercial or financial information relating to the Acquirer or the Acquirer Hospital Business to any Person other than the Acquirer (i) only in the manner and to the extent necessary to satisfy ProMedica's obligations under this Order and (ii) only to Persons who agree in writing to maintain the confidentiality of such information; and

3. enforce the terms of this Paragraph II.L as to any Person and take such action as is necessary, including training, to cause each such Person to comply with the terms of this Paragraph II.L., including any actions that ProMedica would take to protect its own trade secrets or sensitive or proprietary commercial or financial information.

M. No later than the Effective Date of Divestiture, ProMedica shall assign to the Acquirer any Hospital Provider Contract for the provision of services in connection with the Operation of St. Luke's Hospital that is in effect as of the date the divestiture provisions of this Order become final and effective; provided, however, that nothing in this Paragraph II.M. shall preclude ProMedica from completing any post-termination obligations relating to any Hospital Provider Contract.

N. The purpose of the divestiture of the St. Luke's Hospital Assets is to ensure the continued Operation of St. Luke's Hospital by the Acquirer, independent of ProMedica, and to remedy the lessening of competition resulting from ProMedica's acquisition of St. Luke's Hospital.

III.

IT IS FURTHER ORDERED that:

A. From the date this Order becomes final and effective (without regard to the finality of the divestiture requirements herein) until the Effective Date of Divestiture, ProMedica shall not:

1. Sell or transfer any St. Luke's Hospital Assets, other than in the Ordinary Course of Business;

2. Eliminate, transfer, or consolidate any clinical service offered in connection with the Post-Joinder Hospital Business;

3. Fail to maintain the employment of all St. Luke's Hospital Employees or otherwise fail to keep the Post-Joinder Hospital Business staffed with sufficient employees; provided,

however, that ProMedica may terminate employees for cause consistent with the Operation of St. Luke's Hospital on the day before Joinder (in which event ProMedica shall replace such employees);

4. Modify, change, or cancel any Physician privileges in connection with the Post-Joinder Hospital Business; provided, however, that ProMedica may revoke the privileges of any individual Physician consistent with the practices and procedures in place in connection with the Operation of St. Luke's Hospital on the day before Joinder; or

5. Terminate, or cause or allow termination of any contract between any Payor and St. Luke's Hospital. For any contract between a Payor and St. Luke's Hospital that expires during the term of this Order, ProMedica shall offer to extend such contract at rates for services in connection with the Post-Joinder Hospital Business that shall be increased no more than the highest year-over-year escalator percentage as provided in such contract.

IV.

IT IS FURTHER ORDERED that:

A. From the date this Order becomes final and effective (without regard to the finality of the divestiture requirements herein) until the Effective Date of Divestiture, ProMedica shall take such actions as are necessary to maintain the viability, marketability, and competitiveness of

the St. Luke's Hospital Assets and the Post-Joinder Hospital Business relating to the St. Luke's Hospital Assets. Among other things that may be necessary, ProMedica shall:

1. Maintain the operations of the Post-Joinder Hospital Business relating to the St. Luke's Hospital Assets in the Ordinary Course of Business and in accordance with past practice (including regular repair and maintenance of the St. Luke's Hospital Assets).

2. Use best efforts to maintain and increase revenues of the Post-Joinder Hospital Business relating to the St. Luke's Hospital Assets, and to maintain at budgeted levels for the year 2010 or the current year, whichever are higher, all administrative, technical, and marketing support for the Post- Joinder Hospital Business relating to the St. Luke's Hospital Assets.

3. Use best efforts to maintain the current workforce and to retain the services of employees and agents in connection with the Post-Joinder Hospital Business relating to the St. Luke's Hospital Assets, including payment of bonuses as necessary, and maintain the relations and goodwill with patients, Physicians, Suppliers, vendors, employees, landlords, creditors, agents, and others having business relationships with the Post-Joinder Hospital Business relating to the St. Luke's Hospital Assets.

4. Assure that ProMedica's employees with primary responsibility for managing and operating the Post-Joinder Hospital Business relating to the St. Luke's Hospital Assets are not transferred or reassigned to other areas within ProMedica's organization, except for transfer bids initiated by employees pursuant to ProMedica's regular, established job-posting policy (in which event ProMedica shall replace such employees).

5. Provide sufficient working capital to maintain the Post-Joinder Hospital Business relating to the St. Luke's Hospital Assets as an economically viable and competitive ongoing business and shall not, except as part of a divestiture approved by the Commission pursuant to this Order, remove, sell, lease, assign, transfer, license, pledge for collateral, or otherwise dispose of the St. Luke's Hospital Assets.

B. No later than thirty (30) days from the date this Order becomes final and effective (without regard to the finality of the divestiture requirements herein), ProMedica shall file a verified written report to the Commission that identifies (i) all assets included in the St. Luke's Hospital Assets, (ii) all assets originally acquired or that replace assets originally acquired by ProMedica as a result of Joinder, (iii) all assets relating to the Post-Joinder Hospital Business that are not included in the St. Luke's Hospital Assets, and (iv) all clinical services, support functions, and management functions that ProMedica

discontinued at St. Luke's Hospital after Joinder (hereafter "Accounting").

V.

IT IS FURTHER ORDERED that no later than five (5) days from the date this Order becomes final and effective (without regard to the finality of the divestiture requirements herein), ProMedica shall provide a copy of this Order and Complaint to each of ProMedica's officers, employees, or agents having managerial responsibility for any of ProMedica's obligations under Paragraphs II, III, and IV of this Order.

VI.

IT IS FURTHER ORDERED that:

A. At any time after this Order becomes final and effective (without regard to the finality of the divestiture requirements herein), the Commission may appoint a Person ("Monitor") to monitor ProMedica's compliance with its obligations under this Order, consult with Commission staff, and report to the Commission regarding ProMedica's compliance with its obligations under this Order.

B. If a Monitor is appointed pursuant to Paragraph VI.A of this Order, ProMedica shall consent to the following terms and conditions regarding the powers, duties, authorities, and responsibilities of the Monitor:

   1. The Monitor shall have the power and authority to monitor ProMedica's compliance with the terms of this Order, and shall exercise such power and authority and carry out the

duties and responsibilities of the Monitor pursuant to the terms of this Order and in a manner consistent with the purposes of this Order and in consultation with the Commission or its staff.

2. Within ten (10) days after appointment of the Monitor, ProMedica shall execute an agreement that, subject to the approval of the Commission, confers on the Monitor all the rights and powers necessary to permit the Monitor to monitor ProMedica's compliance with the terms of this Order in a manner consistent with the purposes of this Order. If requested by ProMedica, the Monitor shall sign a confidentiality agreement prohibiting the use or disclosure to anyone other than the Commission (or any Person retained by the Monitor pursuant to Paragraph VI.B.5. of this Order), of any competitively-sensitive or proprietary information gained as a result of his or her role as Monitor, for any purpose other than performance of the Monitor's duties under this Order.

3. The Monitor's power and duties under this Paragraph VI shall terminate three (3) business days after the Monitor has completed his or her final report pursuant to Paragraph VI.B.8. of this Order or at such other time as directed by the Commission.

4. ProMedica shall cooperate with any Monitor appointed by the Commission in the performance of his or her duties, and shall

provide the Monitor with full and complete access to ProMedica's books, records, documents, personnel, facilities, and technical information relating to compliance with this Order, or to any other relevant information, as the Monitor may reasonably request. ProMedica shall cooperate with any reasonable request of the Monitor. ProMedica shall take no action to interfere with or impede the Monitor's ability to monitor ProMedica's compliance with this Order.

5. The Monitor shall serve, without bond or other security, at the expense of ProMedica, on such reasonable and customary terms and conditions as the Commission may set. The Monitor shall have the authority to employ, at the expense of ProMedica, such consultants, accountants, attorneys, and other representatives and assistants as are reasonably necessary to carry out the Monitor's duties and responsibilities. The Monitor shall account for all expenses incurred, including fees for his or her services, subject to the approval of the Commission.

6. ProMedica shall indemnify the Monitor and hold the Monitor harmless against any losses, claims, damages, liabilities, or expenses arising out of, or in connection with, the performance of the Monitor's duties, including all reasonable fees of counsel and other expenses incurred in connection with the preparation for, or defense of, any claim, whether or not resulting in any liability,

except to the extent that such losses, claims, damages, liabilities, or expenses result from the Monitor's gross negligence or willful misconduct. For purposes of this Paragraph VI.B.6., the term "Monitor" shall include all Persons retained by the Monitor pursuant to Paragraph VI.B.5. of this Order.

7. If at any time the Commission determines that the Monitor has ceased to act or failed to act diligently, or is unwilling or unable to continue to serve, the Commission may appoint a substitute to serve as Monitor in the same manner as provided by this Order.

8. The Monitor shall report in writing to the Commission (i) every sixty (60) days from the date this Order becomes final and effective (without regard to the finality of the divestiture requirements herein), (ii) no later than thirty (30) days from the date ProMedica completes its obligations under this Order, and (iii) at any other time as requested by the staff of the Commission, concerning ProMedica's compliance with this Order.

C. ProMedica shall submit the following reports to the Monitor: (i) no later than twenty (20) days after the date the Monitor is appointed by the Commission pursuant to Paragraph VI.A. of this Order, a copy of the Accounting required by Paragraph IV.B. of this Order; and (ii) copies of all compliance reports filed with the Commission.

D. ProMedica shall provide the Monitor with: (i) prompt notification of significant meetings,

including date, time and venue, scheduled after the execution of the Monitor Agreement, relating to the regulatory approvals, marketing, sale and divestiture of the St. Luke's Hospital Assets, and such meetings may be attended by the Monitor or his representative, at the Monitor's option or at the request of the Commission or staff of the Commission; and (ii) the minutes, if any, of the above-referenced meetings as soon as practicable and, in any event, not later than those minutes are available to any employee of ProMedica.

E. The Commission may, on its own initiative or at the request of the Monitor, issue such additional orders or directions as may be necessary or appropriate to assure compliance with the requirements of this Order.

F. The Monitor appointed pursuant to this Order may be the same Person appointed as Divestiture Trustee pursuant to Paragraph II of this Order.

VII.

IT IS FURTHER ORDERED that:

A. If ProMedica has not divested, absolutely and in good faith, the St. Luke's Hospital Assets pursuant to the requirements of Paragraph II of this Order, within the time and manner required by Paragraph II of this Order, the Commission may at any time appoint one or more Persons as Divestiture Trustee to divest the St. Luke's Hospital Assets, at no minimum price, and pursuant to the requirements of Paragraph II of

this Order, in a manner that satisfies the requirements of this Order.

B. In the event that the Commission or the Attorney General of the United States brings an action pursuant to § 5(l) of the Federal Trade Commission Act, 15 U.S.C. § 45(l), or any other statute enforced by the Commission, ProMedica shall consent to the appointment of a Divestiture Trustee in such action. Neither the appointment of a Divestiture Trustee nor a decision not to appoint a Divestiture Trustee under this Paragraph VII shall preclude the Commission or the Attorney General from seeking civil penalties or any other relief available to it, including appointment of a court-appointed Divestiture Trustee, pursuant to § 5(l) of the Federal Trade Commission Act, or any other statute enforced by the Commission, for any failure by ProMedica to comply with this Order.

C. If a Divestiture Trustee is appointed by the Commission or a court pursuant to this Paragraph VII, ProMedica shall consent to the following terms and conditions regarding the Divestiture Trustee's powers, duties, authority, and responsibilities:

1. Subject to the prior approval of the Commission, the Divestiture Trustee shall have the exclusive power and authority to effect the divestiture pursuant to the requirements of Paragraph II of this Order and in a manner consistent with the purposes of this Order.

2. Within ten (10) days after appointment of the Divestiture Trustee, ProMedica shall execute an agreement that, subject to the prior approval of the Commission and, in the case of a court-appointed Divestiture Trustee, of the court, transfers to the Divestiture Trustee all rights and powers necessary to permit the Divestiture Trustee to effect the divestiture and perform the requirements of Paragraph II of this Order for which he or she has been appointed.

3. The Divestiture Trustee shall have twelve (12) months from the date the Commission approves the agreement described in Paragraph VII.C.2. of this Order to accomplish the divestiture, which shall be subject to the prior approval of the Commission. If, however, at the end of the twelve-month period the Divestiture Trustee has submitted a plan of divestiture or believes that divestiture can be achieved within a reasonable time, the divestiture period may be extended by the Commission, or, in the case of a court appointed Divestiture Trustee, by the court.

4. ProMedica shall provide the Divestiture Trustee with full and complete access to the personnel, books, records, and facilities related to the assets to be divested, or to any other relevant information, as the Divestiture Trustee may request. ProMedica shall develop such financial or other information as the Divestiture Trustee may reasonably request and shall cooperate with the Divestiture

Trustee. ProMedica shall take no action to interfere with or impede the Divestiture Trustee's accomplishment of the divestiture. Any delays in divestiture caused by ProMedica shall extend the time for divestiture under this Paragraph in an amount equal to the delay, as determined by the Commission or, for a court-appointed Divestiture Trustee, by the court.

5. The Divestiture Trustee shall use his or her best efforts to negotiate the most favorable price and terms available in each contract that is submitted to the Commission, but shall divest expeditiously at no minimum price. The divestiture shall be made only to an Acquirer that receives the prior approval of the Commission, and the divestiture shall be accomplished only in a manner that receives the prior approval of the Commission; provided, however, if the Divestiture Trustee receives bona fide offers from more than one acquiring entity, and if the Commission determines to approve more than one such acquiring entity, the Divestiture Trustee shall divest to the acquiring entity or entities selected by ProMedica from among those approved by the Commission; provided, further, that ProMedica shall select such entity within ten (10) business days of receiving written notification of the Commission's approval.

6. The Divestiture Trustee shall serve, without bond or other security, at the cost and expense of ProMedica, on such reasonable and

customary terms and conditions as the Commission or a court may set. The Divestiture Trustee shall have the authority to employ, at the cost and expense of ProMedica, such consultants, accountants, attorneys, investment bankers, business brokers, appraisers, and other representatives and assistants as are necessary to carry out the Divestiture Trustee's duties and responsibilities. The Divestiture Trustee shall account for all monies derived from the divestiture and all expenses incurred. After approval by the Commission of the account of the Divestiture Trustee, including fees for his or her services, all remaining monies shall be paid at the direction of ProMedica, and the Divestiture Trustee's power shall be terminated. The Divestiture Trustee's compensation may be based in part on a commission arrangement contingent on the Divestiture Trustee's divesting the assets.

7. ProMedica shall indemnify the Divestiture Trustee and hold the Divestiture Trustee harmless against any losses, claims, damages, liabilities, or expenses arising out of, or in connection with, the performance of the Divestiture Trustee's duties, including all reasonable fees of counsel and other expenses incurred in connection with the preparation for, or defense of any claim, whether or not resulting in any liability, except to the extent that such liabilities, losses, damages, claims, or expenses result from gross negligence or

willful misconduct by the Divestiture Trustee. For purposes of this Paragraph VII.C.7., the term "Divestiture Trustee" shall include all Persons retained by the Divestiture Trustee pursuant to Paragraph VII.C.6. of this Order.

8. If the Divestiture Trustee ceases to act or fails to act diligently, the Commission may appoint a substitute Divestiture Trustee in the same manner as provided in this Paragraph VII for appointment of the initial Divestiture Trustee.

9. The Divestiture Trustee shall have no obligation or authority to operate or maintain the assets to be divested.

10. The Divestiture Trustee shall report in writing to the Commission every sixty (60) days concerning the Divestiture Trustee's efforts to accomplish the divestiture.

D. The Commission or, in the case of a court-appointed Divestiture Trustee, the court, may on its own initiative or at the request of the Divestiture Trustee issue such additional orders or directions as may be necessary or appropriate to accomplish the divestiture required by this Order.

E. The Divestiture Trustee appointed pursuant to this Paragraph may be the same Person appointed as the Monitor pursuant to Paragraph VI of this Order.

VIII.

IT IS FURTHER ORDERED that:

A. ProMedica shall file a verified written report with the Commission setting forth in detail the manner and form in which it intends to comply, is complying, and has complied with this Order (i) no later than thirty (30) days from the date this Order becomes final and effective (without regard to the finality of the divestiture requirements herein), and every thirty (30) days thereafter until the divestiture of the St. Luke's Hospital Assets is accomplished, and (ii) thereafter, every sixty (60) days (measured from the Effective Date of Divestiture) until the date ProMedica completes its obligations under this Order; provided, however, that ProMedica shall also file the report required by this Paragraph VIII at any other time as the Commission may require.

B. ProMedica shall include in its compliance reports, among other things required by the Commission, a full description of the efforts being made to comply with the relevant Paragraphs of this Order, a description (when applicable) of all substantive contacts or negotiations relating to the divestiture required by Paragraph II of this Order, the identity of all parties contacted, copies of all written communications to and from such parties, internal documents and communications, and all reports and recommendations concerning the divestiture, the date of divestiture, and a statement that the divestiture has been accomplished in the manner approved by the Commission.

C.

IX.

IT IS FURTHER ORDERED that ProMedica shall notify the Commission at least thirty (30) days prior to (1) any proposed dissolution of ProMedica, (2) any proposed acquisition, merger, or consolidation of ProMedica, or (3) any other change in ProMedica that may affect compliance obligations arising out of this Order, including but not limited to assignment, the creation or dissolution of subsidiaries, or any other change in ProMedica.

X.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this Order, and subject to any legally recognized privilege, and upon written request with reasonable notice, ProMedica shall permit any duly authorized representative of the Commission:

A. Access, during office hours of ProMedica, and in the presence of counsel, to all facilities and access to inspect and copy all books, ledgers, accounts, correspondence, memoranda, and all other records and documents in the possession, or under the control, of ProMedica relating to compliance with this Order, which copying services shall be provided by ProMedica at its expense; and

B. To interview officers, directors, or employees of ProMedica, who may have counsel present, regarding such matters.

By the Commission.

Donald S. Clark
Secretary

ISSUED: March 22, 2012

Final Order Appendix 1

3113 Dustin Road, Oregon
9246 Dutch Road, Whitehouse
210 South Hallet St., Swanton
5635 Monclova Road, Maumee
5705 Monclova Road, Maumee
5755 Monclova Road, Maumee
5757 Monclova Road, Maumee
5759 Monclova Road, Maumee
5805 Monclova Road, Maumee
5901 Monclova Road, Maumee
5959 Monclova Road, Maumee
6001 Monclova Road, Maumee
6005 Monclova Road, Maumee
6009 Monclova Road, Maumee
6011 Monclova Road, Maumee
8404 Monclova Road, Maumee
3000 Regency Court, Toledo
28442 East River Road, Perrysburg
3900 Sunforest Court, Toledo
1103 Village Square, Perrysburg
900 Waterville-Monclova Road, Waterville

Final Order Appendix 2

Daniel Wakeman