IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

SAINT ALPHONSUS MEDICAL CENTER - NAMPA, INC., et al., Plaintiffs, v. ST. LUKE'S HEALTH SYSTEM, LTD. and ST. LUKE'S REGIONAL MEDICAL CENTER, LTD., Defendants.	)	No. 1:12-cv-00560-BLW (Lead Case) PUBLIC VERSION
FEDERAL TRADE COMMISSION and STATE OF IDAHO, Plaintiffs, v. ST. LUKE'S HEALTH SYSTEM, LTD. and SALTZER MEDICAL GROUP, P.A., Defendants.	)	No. 1:13-cv-00116-BLW

PLAINTIFFS' AMENDED CORRECTED PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW (PUBLIC VERSION)

RECORD REFERENCES

References to the record are made using the following citation forms and abbreviations:

TX 1234 at 001 – Citations to Trial Exhibits

TX 1234 at 001 [*AEO*] – Citations to *AEO* Trial Exhibits

Trial Tr. at 0000 (Witness) – Citations to Trial Testimony

Trial Tr. at 0000 (Witness) [*AEO*] – Citations to *AEO* Trial Testimony

Dkt. No. 0000 (Witness Dep. Tr.) at 00 – Citations to Deposition Testimony

Dkt. No. 0000 (Witness Dep. Tr.) at 00 [*AEO*] – Citations to *AEO* Deposition Testimony

Dkt. No. 0000 (Defendant Answer) at ¶ 00 – Citations to Saltzer's or St. Luke's Answer to a Complaint or other pleading in the record

TABLE OF KEY DEFINED TERMS

Term	Definition	Citation
ACN	Advantage Care Network, now called Saint Alphonsus Health Alliance, is a physician hospital organization that is wholly owned by Saint Al's Health System. It includes the Saint Al's hospitals, West Valley hospital in Caldwell, and has included the Weiser hospital, the Cascade hospital, and the Mountain Home hospital, and the Jerome hospital. ACN physicians include physicians employed by Saint Al's and independent physicians.	Dkt. No. 365 (Sonnenberg Dep. Tr.) at 13:17–22, 22:8–11, 22:22–23:11, 25:6–11, 53:2–24; Trial Tr. at 3386:23–3387:3 (Gregory Sonnenberg).
ACO	Accountable Care Organization	Trial Tr. at 3452:20–3455:3 (David Dranove).
BATNA	Best Alternative to a Negotiated Agreement	Trial Tr. at 239:9–16 (Jeff Crouch); Trial Tr. 1300:8–12 (David Dranove).
BCI	Blue Cross of Idaho	Trial Tr. at 1329:11–22 (David Dranove).
BOC	Boise Orthopedics Group	Trial Tr. at 582:23–583:1 (Patrick Otte).
CMS	Center for Medicare and Medicaid Services	Trial Tr. at 1029:17–18 (Nicholas Genna).
CoPartner	Care of Patient at-risk Program	Trial Tr. 1925:18–19 (John Kee).
CVA	Cardiothoracic & Vascular Associates	Trial Tr. at 1561:20–23 (Deborah Haas-Wilson).
EMR	Electronic Medical Record	Trial Tr. at 1029: 9–24 (Nicholas Genna).
EOB	Explanation of Benefits	Dkt. No. 365 (Sonnenberg Dep. Tr.) at 236:22–25.

Term	Definition	Citation
IHDE	Idaho Health Data Exchange	Trial Tr. 2833:23–25 (Marc Chasin).
IPA	Individual Physician Association, also referred to as Independent Practice Association or Independent Physician Association	Trial Tr. at 1916:24–1917:22 (John Kee).
IPN	Idaho Physicians Network	Trial Tr. at 460:1–19 (Linda Duer).
MedPar	Medical Database assembled by Dartmouth Atlas	Trial Tr. at 1943:10–12 (John Kee).
MHPN	Micron Health Partners Network	Trial Tr. at 556:21–22 (Patrick Otte).
MGMA	Medical Group Management Association	Trial Tr. at 3234:3–18 (Lisa Ahern).
MSSP	Medicare Shared Savings Program	Trial Tr.at 1992:25–1993:2 (John Kee).
PHMG	Primary Health Medical Group	Trial Tr. at 1190:9–17 (David Peterman).
PHO	Physician Hospital Organization, a provider group which brings independent physicians together to contract with insurance companies and major employers to provide health care to their constituents in a health plan design that has benefit differentials that steers to those providers.	Dkt. No. 365 (Sonnenberg Dep. Tr.) at 22:12–21.
PPO	Preferred Provider Organization	Trial Tr. at 64:15–25, 73:13-17 (Opening).
PSA	Professional Service Agreement	Trial Tr. at 15:20–25 (Opening).
SAMG	Saint Alphonsus Medical Group	Trial Tr. at 466:8–19 (Linda Duer).
SARMC	Saint Alphonsus Regional Medical Center	Trial Tr. at 1250:25–1251:1 (Blaine Petersen).
SIHC	Southern Idaho Healthcare Cooperative	Trial Tr. 2159:6–9 (Brian Fortuin).
SLHS	St. Luke’s Health System	Trial Tr. at 387:18–388:5 (Jeff Crouch).

Term	Definition	Citation
SLIPA	St. Luke's Idaho Pulmonary Associates	Trial Tr. at 3002:4–15 (David Argue).
SLRMC	St. Luke's Regional Medical Center	Trial Tr. at 1574:8–17 (Deborah Haas-Wilson).
SLMVRMC	St. Luke's Magic Valley Regional Medical Center	Trial Tr. at 2163:15–17 (Brian Fortuin).
SMN	Select Medical Network	Trial Tr. at 1661:20–1662:5 (David Pate).

PROPOSED FINDINGS OF FACT

I. EXECUTIVE SUMMARY

1. Defendant St. Luke's Health System, Ltd. ("St. Luke's") is a not-for-profit health system that operates six hospitals in Idaho and employs several hundred physicians, including 450 in the Treasure Valley. Defendant Saltzer Medical Group, P.A. ("Saltzer") is a for-profit, multispecialty physician group based in Nampa, Idaho, with additional clinics in Boise, Meridian and Caldwell. At the time of the Acquisition, Saltzer had 44 physicians, including a large number of primary care physicians. In Defendants' own words, St. Luke's is the "dominant" health system in the Treasure Valley, and Saltzer is the "dominant" medical group in Nampa. *See infra* Sections II, IV.

2. Effective December 31, 2012, St. Luke's acquired Saltzer's intangible assets, personal property, and equipment, and Saltzer's physicians entered into a five-year professional services agreement ("PSA") with St. Luke's (the "Acquisition"). [redacted] *See infra* Section III.

3. The Acquisition is unlawful under Section 7 of the Clayton Act and the Idaho Competition Act. Courts analyze mergers among head-to-head competitors (known as "horizontal" mergers) under a burden-shifting framework. Plaintiffs meet their initial burden by showing that the Acquisition will result in undue concentration in a relevant market, creating a rebuttable presumption of illegality. Once Plaintiffs' *prima facie* case is established, the burden shifts to Defendants to rebut the presumption of illegality with evidence clearly showing that the

market's concentration level inaccurately predicts the Acquisition's likely competitive effects. *See infra* Section VIII.

4. In this case, Defendants do not dispute that adult primary care physician services ("Adult PCP services") is a relevant product market. Multiple forms of consistent evidence confirm that Nampa is a relevant geographic market for Adult PCP services: testimony from health plans, including St. Luke's health plan partner; testimony from numerous providers, including St. Luke's physicians and independent providers; St. Luke's own strategic planning documents; and empirical analysis of patient claims data. Defendants contend that the market is much larger than Nampa, but they have been unable to identify any alternative geographic market. *See infra* Section IV.A.2.

5. By combining the two largest providers of Adult PCP services in Nampa, the Acquisition gives the merged St. Luke's/Saltzer a nearly 80 percent share of the market. In fact, Acquisition results in market concentration that is more than double the level needed to create a presumption of competitive harm under established antitrust law. Even if the market were much broader than Nampa, encompassing Caldwell and Meridian, the Acquisition would still be presumptively unlawful. *See infra* Section IV.B.3.

6. Beyond the strong presumption of competitive harm associated with Plaintiffs' *prima facie* showing, a wide range of evidence confirms that the Acquisition will enhance St. Luke's market power, allowing it to extract higher reimbursements from health plans at the expense of local employers and healthcare consumers. Ordinary-course documents and sworn testimony from Defendants' own witnesses reveal that they expect the Acquisition to increase their bargaining leverage with health plans and employers, giving St. Luke's the ability to demand higher payments. These health plans and employers agree: the Acquisition further

strengthens St. Luke's already considerable market power and will likely result in higher healthcare costs for Idaho consumers. *See infra* Section IV.B.4.

7. In light of the evidence of high market concentration and likely anticompetitive effects, Defendants must present "extraordinary" evidence showing that the Acquisition is unlikely to harm competition. Their defense is heavily focused on one "efficiencies" defense: the Acquisition will purportedly allow St. Luke's and Saltzer to provide higher quality, lower cost care. But Defendants have failed to show that these purported efficiencies are verifiable and merger-specific, as the law requires. *See infra* Sections IV.C.1, VIII.E.1.

8. Much of Defendants' efficiencies defense is speculative and relies on promises and good intentions. Notably, however, St. Luke's has a track record of acquiring a large number of physician groups over the last several years, and yet it has failed to identify any measurable cost savings or quality improvements from these acquisitions. In fact, an unrebutted economic analysis of St. Luke's prior primary care physician acquisitions suggests just the opposite conclusion, showing no evidence that St. Luke's has been able reduce the total cost of care for patients of its acquired PCPs; if anything, the evidence shows that total healthcare costs have increased following St. Luke's acquisition of primary care practices. *See infra* Section IV.B.4.

9. Moreover, Defendants have failed to show that the Acquisition is necessary to achieve the various claimed benefits they described at trial. Documents and sworn testimony confirm that St. Luke's can pursue its cost and quality goals, pursue risk-based contracting opportunities, and implement a health IT infrastructure with independent providers. Likewise, the evidence shows that independent physician groups like Saltzer can provide integrated patient

care, participate in risk-based contracting, and implement health IT tools without becoming employed by a large health system. *See infra* Section IV.C.1.

10. Defendants have also failed to show that the threat of entry by new providers or expansion by existing providers would be "timely, likely, or sufficient" to counteract the Acquisition's likely anticompetitive effects. *See infra* Sections IV.C.3, VIII.E.2.

11. Other defenses raised by defendants, such as the "healthcare reform" defense, the "trust us" defense, and the "board member" defense, are likewise speculative and, in any event, insufficient to rebut the strong *prima facie* case and other evidence of harm to competition. *See infra* IV.C.2.

12. The Private Plaintiffs (the Saint Alphonsus plaintiffs and the Treasure Valley Hospital) also contend that the Saltzer acquisition will harm competition in four other relevant markets: general pediatric primary care physician services in Nampa sold to commercial insurers and employers; general acute care inpatient hospital services in Canyon and Ada counties sold to commercial insurers and employees; and neuro+orthopedic and general surgery outpatient facility services, respectively, in Ada and Canyon counties, sold to commercially insured patients.

13. The acquisition will harm competition in these markets or alternative geographic markets by: (a) eliminating competition between St. Luke's and Saltzer with regard to general pediatric care, (b) foreclosing competition for referrals by Saltzer physicians; and (c) eliminating or severely harming competition between competing provider networks in the Treasure Valley. Multiple sources of evidence show that Saltzer will shift its referrals to St. Luke's facilities if the transaction goes forward. Moreover, St. Luke's plans to pull its physicians from competing networks, and Saltzer is critical to network competition in the Treasure Valley.

14. These actions, coupled with other acquisitions by St. Luke's, are very likely to further increase St. Luke's dominance in the highly concentrated hospital and surgical facilities

markets; diminish the competitive constraints supplied by Saint Alphonsus and Treasure Valley Hospital, the only significant constraints to St. Luke's in these markets; limit the availability to consumers of the lower priced, higher quality care provided by Treasure Valley Hospital; and increase the incentives for further acquisitions to occur in the future. The result will be less competition, and higher prices, across these markets.

15. Given the likely anticompetitive effects, the appropriate remedy is complete divestiture through unwinding of the Acquisition and rescission of the Professional Services Agreement. *See infra* Section VI.

II. THE PARTIES TO THE TRANSACTION

A. ST. LUKE'S HEALTH SYSTEM

16. Defendant St. Luke's Health System, Ltd. ("St. Luke's") is a not-for-profit health system organized under and by virtue of the laws of Idaho. St. Luke's is headquartered at 190 W. Bannock Street, Boise, Idaho 83702. Dkt. No. 100 (St. Luke's Answer) at ¶ 16; Dkt. No. 35 at ¶ 1.

17. St. Luke's owns and operates six hospitals: St. Luke's Boise Medical Center, a 399-bed hospital in Boise; St. Luke's Meridian Medical Center, a 167-bed hospital in Meridian; St. Luke's Magic Valley Medical Center, a 228-bed hospital in Twin Falls; St. Luke's Wood River Medical Center, a 25-bed hospital in Ketchum; St. Luke's Jerome Medical Center, a 25-bed hospital in Jerome; and St. Luke's McCall, a 15-bed hospital in McCall. St. Luke's also owns and operates an emergency room facility in Nampa, as well as a children's hospital, the Mountain States Tumor Institute, and more than 100 clinics throughout central and southwest Idaho and eastern Oregon. Dkt. No. 100 (St. Luke's Answer) at ¶ 16; Dkt. No. 35 at ¶ 1.

18. [redacted] TX 2148 (identified at Trial Tr. 412:13-413:11 (Jeff Crouch)).

19. St. Luke's employs or is affiliated with approximately 630 physicians across Idaho – of whom 450 practice in the Treasure Valley. TX 1310 at 11.

20. St. Luke's is a billion dollar corporation. TX 1139 at SLHS000025964. In fiscal year 2012, St. Luke's generated $182.6 million in total cash flow and possessed $116.5 million in cash and $269.5 million in board-designated funds. Dkt. No. 100 (St. Luke's Answer) at ¶16.

B. SALTZER MEDICAL GROUP

21. Defendant Saltzer Medical Group, P.A. ("Saltzer") organized as a professional association under the laws of Idaho, is a for-profit, physician-owned multispecialty group located at 215 E. Hawaii Avenue, Nampa, Idaho 83686. Dkt. No. 100 (St. Luke's Answer) at ¶ 17; Dkt. No. 105 (Saltzer's Answer) at ¶ 17.

22. Saltzer is the largest, independent, multispecialty physician group in the State of Idaho. Trial Tr. at 465:6–11 (Linda Duer). Saltzer is based in Nampa, and it has small clinics in Boise, Meridian, and Caldwell. Trial Tr. at 705:1–4 (Nancy Powell).

23. Saltzer is a multispecialty practice of 44 doctors predominantly made up of primary care physicians in pediatrics, family practice, and internal medicine. Saltzer also has subspecialties like cardiology, pulmonology, rheumatology, neurology, ophthalmology, dermatology, orthopedics, and general surgery. Trial Tr. at 704:15–23 (Nancy Powell); Dkt. No. 35 at ¶ 2; TX 1453 at SLHS00000103; Dkt. No. 100 (St. Luke's Answer) at ¶ 17; Dkt. No. 105 (Saltzer's Answer) at ¶ 17.

24. Saltzer is a very prestigious group with a long history. Trial Tr. at 465:9–11 (Linda Duer). Saltzer is "a reputable and long-standing significant player" in the Treasure Valley healthcare community. Dkt. No. 262 (Castledine Dep. Tr.) at 122:4–12; *see* Trial Tr. at 2001:21–2002:10 (John Kee).

25. In February 2012, St. Luke's learned that its proposed acquisition of Saltzer was the subject of a government antitrust investigation. Dkt. No. 67 (St. Luke's Answer) at ¶ 49.

III. THE ACQUISITION

26. Effective December 31, 2012, St. Luke's acquired the assets of Saltzer for an amount not to exceed $16,000,000. Dkt. No. 100 (St. Luke's Answer) at ¶ 18. Pursuant to this transaction (the "Acquisition"), St. Luke's received Saltzer's intangible assets, personal property, and equipment. In addition, Saltzer, on behalf of its physicians, entered into a five-year professional services agreement ("PSA") with St. Luke's. TX 24. Saltzer received almost $9 million in payment for goodwill and intangibles as part of the Acquisition—which does not have to be paid back if the Acquisition were undone. Trial Tr. at 2444:5–11 (John Kaiser).

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

28. On August 29, 2013, less than four weeks before trial began, Defendants amended the PSA, adding a "good faith" agreement to modify the compensation system to include a portion contingent on "improvements in value." TX 2624. Other than imposing a 20 percent cap on the percentage of physician compensation that can be contingent on such improvements, the

amended PSA does not include any specific changes to the compensation system or eliminate wRVU-based compensation. *Id.*

IV. THE ACQUISITION WILL SUBSTANTIALLY LESSEN HEAD-TO-HEAD COMPETITION FOR PRIMARY CARE PHYSICIAN SERVICES IN NAMPA

A. COMPETITION AMONG PROVIDERS OCCURS IN TWO STAGES

1. Stage 1: Providers Compete For Network Inclusion

29. Vibrant competition among healthcare providers helps facilitate the goals embodied in the "Triple Aim," including lower prices, greater efficiency, and improved quality. Trial Tr. at 3419:13–21 (David Dranove). But thirty years ago, health insurers played a passive role in healthcare competition. Trial Tr. at 1297 (David Dranove).

30. Back then, health insurers began negotiating directly with providers in what is known as "selective contracting." Insurers now develop networks of providers—providers agree to give the insurers discounted prices and in exchange, insurers give patients low cost-sharing for visiting those preferred providers. When this practice was first instituted approximately thirty years ago, it led to dramatic reductions in prices. Trial Tr. at 1298:21–1299:14 (David Dranove).

31. Today, when health plans create networks, their goal is to offer convenient networks for their enrollees. Trial Tr. at 1329:8–14 (David Dranove); *see also* Dkt. No. 100 (St. Luke's Answer) at ¶ 21; Dkt. No. 105 (Saltzer's Answer) at ¶ 21. For example, in Idaho, BCI has a network of providers. A provider is considered "in-network" for BCI if it has a contract with BCI to perform services for a specified payment allowance. Trial Tr. at 228:12–25 (Jeff Crouch).

32. Employees pay higher out-of-pocket costs when they see a non-contracted or out-of-network provider. Trial Tr. at 229: 1–11(Jeff Crouch).

33. As St. Luke's Steve Drake testified, in selling their health plans, it is important to insurers/payers to have an attractive network of providers. Dkt. No. 322 (Drake Dep. Tr.) at 67:11–16, 67:18. The size and breadth of the provider network is an important factor for the payer. Dkt. No. 322 (Drake Dep. Tr.) at 68:2–4, 68:6.

34. Employers select insurance plans on behalf of their employees, who prefer to have a choice from a variety of providers in convenient locations, particularly close to home. Trial Tr. at 3333:15–17 (Thomas Patterson).

35. In Idaho, employers have generally not embraced narrow networks because employers cannot appeal to only one or two employees who might be willing to sign up for the narrow network. Employers need to offer a health plan that appeals to all of their employees. Trial Tr. at 1326:12–22 (David Dranove); see Dkt. No. 322 (Drake Dep. Tr.) at 22:13–23:4.

36. Providers, on the other hand, benefit from in-network status by gaining access to that health plan's members as patients. Dkt. No. 100 (St. Luke's Answer) at ¶ 21; Dkt. No. 105 (Saltzer's Answer) at ¶ 21. Accordingly, providers compete in "Stage 1 competition" to be selected as "in-network" by healthcare payers. Dkt. No. 100 (St. Luke's Answer) at ¶ 21; Dkt. No. 105 (Saltzer's Answer) at ¶ 21.

2. Stage 2: Providers Compete For Selection By Health-Plan Members

37. When enrollees sign up to a plan, they almost always choose in-network providers. Within a health plan network, in what Professor Dranove described as "Stage 2 competition," patients are insulated against prices paid to providers, do not have a lot of transparency about those prices, and do not shop around on the basis of price. Trial Tr. at 1302:19–1303:13 (David Dranove).

38. For example, BCI's Jeff Crouch estimates that only 10 percent of BCI's membership is composed of informed, price-sensitive consumers, who will research prices online. Trial Tr. at 366:3–16 (Jeff Crouch).

39. Because of this, price reductions within networks simply "don't drive demand very much," or impose pricing discipline on the market. Trial Tr. at 1361:15–21, 1373:10–15 (David Dranove).

40. Instead, patients choose among in-network providers in stage 2 based on factors other than price, such as the reputation or the location of the provider. Trial Tr. at 1303:14–20 (David Dranove); *see also* Dkt. No. 100 (St. Luke's Answer) at ¶ 23.

3. Bargaining Dynamics Shape Contracts Between Providers And Health Plans And Determine Prices

41. Pricing discipline does not take place from the point of view of insured patients choosing with their feet based on slight changes in prices. Trial Tr. at 1394:4–12 (David Dranove).

42. Rather, as Professor Dranove's 25 years of experience with healthcare negotiations has shown, bargaining dynamics shape contracts between providers and health plans and determine prices. Trial Tr. at 3428:20–3429:9 (David Dranove).

43. When health plans negotiate with providers, the leverage in those negotiations depends on the health plan's outside option. If the health plan could drop that provider and still have an attractive network that it could sell to its customers, the health plan is going to have a stronger bargaining position. Trial Tr. at 1300:2–1301:24, 1304:1–1305:4 (David Dranove).

44. [redacted]

[redacted] Dkt. No. 271 (Reiboldt Dep. Tr.) at 72:16–73:12.

45. Because payer-provider negotiations take place over a wide set of services for an entire system of providers, what parties in a negotiation care about is the total expected reimbursements for all of those services—i.e., the "bottom right-hand number" in a spreadsheet of negotiated services. Trial Tr. at 1302:4–11 (David Dranove); *see also* Dkt. No. 100 (St. Luke's Answer) at ¶ 21; Dkt. No. 105 (Saltzer's Answer) at ¶ 21.

46. Indeed, Defendants' economic expert, Dr. Argue, agreed that negotiations between payers and providers focus on the "percentage change in the total payments," or the "lower-right-hand corner." Trial Tr. at 2899:16–2900:14, 3021:16–18 (David Argue).

B. PLAINTIFFS MORE THAN SATISFY THEIR *PRIMA FACIE* BURDEN

1. There Is No Material Dispute Over The Relevant Product Markets

a) Adult Primary Care Physician Services Sold To Commercial Health Plans Is A Relevant Product Market

47. There is no dispute that Adult Primary Care Services sold to commercially insured patients ("Adult PCP services") is a relevant product market. Trial Tr. at 1311:1–3 (David Dranove); Trial Tr. at 2886:18–2887:3 (David Argue).

48. Adult PCP services include physician services provided to commercially insured patients aged 18 and over by physicians practicing internal medicine, family practice, and general practice. Dkt. No. 363 (Reinhardt Dep. Tr.) at 134:4–135:1; *see generally* Trial Tr. at 1313:1–21 (David Dranove).

49. In antitrust analysis, the relevant product market includes firms selling products that are close substitutes. Trial Tr. at 1311:3–10 (David Dranove).

50. To determine if products are close substitutes, economists perform a "hypothetical monopolist" test for a product market, which evaluates whether all the sellers in the proposed candidate market would be able to impose a small but significant, non-transitory increase in price (SSNIP), which is generally 5 to 10 percent. Trial Tr. at 1311:11–1312:2 (David Dranove).

51. If the hypothetical monopolist could increase profits by instituting a SSNIP, then economists would consider the proposed product market to be properly defined. Trial Tr. at 1312:3–15 (David Dranove).

52. Adult PCP services is a relevant product market. If all Adult PCPs acted as a monopolist, they could profitably raise reimbursements paid by health plans by 5 to 10 percent. A hypothetical monopolist of Adult PCP services could make such a price increase stick because a health plan would not be able to offer a competitive product if its network did not include *any* Adult PCPs. Trial Tr. at 1313:1–21 (David Dranove).

53. Adult PCP services is a relevant product market even though some patients may receive primary care services from other types of specialists. Trial Tr. at 1313:22–1314:17 (David Dranove). For example, some patients may see a cardiologist to receive an annual physical, but a health plan could not offer a competitive product that included cardiologists but no PCPs. Trial Tr. at 1314:1–17 (David Dranove).

b) Pediatric Services Sold To Commercial Health Plans Is A Relevant Product Market

54. There is no dispute that Pediatric Primary Care Physician Services is a relevant product market. *See infra* Section V.A.1.

2. Nampa Is The Relevant Geographic Market For Adult PCP Services

55. To analyze the relevant geographic market, economists perform the same "hypothetical monopolist" or "SSNIP" test that is used to evaluate product market. For this case,

the question is whether all Nampa Adult PCPs could profitably impose a SSNIP—i.e., a price increase to health plans of 5 to 10 percent. Trial Tr. at 1315:5–18 (David Dranove).

56. As Professor Dranove explained and as set forth below, multiple, consistent forms of evidence—including documents, testimony, and statistical evidence—confirm that a hypothetical monopolist controlling all Adult PCP services in Nampa could profitably impose a SSNIP. Trial Tr. at 1315:2–4, 1315:16–18, 1330:24–25 (David Dranove).

57. Nampa is therefore a well-defined geographic market. Trial Tr. at 1315:2–4, 1315:16–18 (David Dranove).

a) Nampa Patients Demand Access To Local Primary Care Services

58. An overwhelming amount of evidence shows that patients demand access to local primary care services. Documents and testimony from providers (including St. Luke's and Saltzer), health plans (including St. Luke's partner, Select Health), and other market participants confirm that patients demand local access to primary care services. Accordingly, there is no dispute that patients prefer to get their medical care close to home, and that is especially true for primary care. *See, e.g.*, Trial Tr. at 1315:25–1316:7 (David Dranove); Dkt. No. 290 (Souza Dep. Tr.) at 167:12–168:1; Dkt. No. 318 (Butterbaugh Dep. Tr.) at 33:1–16; Trial Tr. at 462:9–18 (Linda Duer); TX 1114 at WipFli00000107; Dkt. No. 320 (Amended Stright Tr.) at 147:6–23.

59. Indeed, a wide range of market participants confirm Dr. Dranove's conclusion that health plans need to include Nampa PCPs in their networks to offer a competitive product, and that Nampa is an appropriate geographic market. Trial Tr. at 3434:11–19 (David Dranove).

60. As Professor Dranove explained, this evidence fits squarely within the antitrust analysis in healthcare markets. Because patients strongly prefer access to local PCPs, health plans need to include Nampa PCPs in their networks to offer a competitive product. As a result, a hypothetical monopolist over all PCPs in Nampa would be able to profitably impose a SSNIP,

and Nampa is therefore a properly defined relevant market. Trial Tr. at 3434:11–19 (David Dranove).

61. In contrast, Defendants have offered little to no evidence in ordinary course documents or sworn testimony suggesting that Nampa should not be considered a relevant geographic market, instead relying almost exclusively on Dr. Argue's patient flow analysis.

(1) Evidence From St. Luke's Executives And Physicians And Its Health Plan Partner Demonstrates That Nampa Is The Relevant Geographic Market For Adult PCP Services

62. According to St. Luke's Vice President for Network Operations, John Kee, "patient-centered" care includes providing physician services close to patients' homes. Trial Tr. at 2003:15–22 (John Kee).

63. Defendants' economic expert, Dr. Argue, agreed, acknowledging that there was a "lot of testimony" that patients prefer to receive primary care services close to home, explaining that "patients like to receive primary care services in a convenient location," such as close to where they live or work. Trial Tr. at 2942:9–21 (David Argue).

64. Dr. Kurt Seppi—St. Luke's Executive Director of Physician Services—acknowledged that, if he were a patient in Nampa, he would prefer to see a primary care physician located in Nampa. Dkt. No. 371 (Seppi Dep. Tr.) at 21:3–5, 21:10–11.

65. As Dr. Seppi testified, "patients don't necessarily want to travel 30 or 40 miles to see a primary care physician. They would like to see a physician in their **immediate vicinity**." Dkt. No. 371 (Seppi Dep. Tr.) at 21:21–22:10 (emphasis added).

66. St. Luke's Dr. Adebayo Crownson, a Nampa-based primary care physician, testified that he keeps an office in Nampa to be close to his Nampa patients because "I believe that it's important to keep care close to home, yes." Trial Tr. at 2220:12–19 (Dr. Adebayo Crownson). He further testified that patients in northern or southern parts of Nampa prefer to

obtain imaging in that part of the community, rather than traveling even to the other part of Nampa. Trial Tr. at 2217:20 (Adebayo Crownson).

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

68. In an email, St. Luke's Vice President of Medical Affairs, Dr. James Souza responded to an email from a Meridian physician who complained of receiving a referral of a Nampa patient. The Meridian doctor wrote that "folks in Nampa want care in Nampa, generally." Endorsing that view, Dr. Souza wrote that primary care should be easy to access and thus the St. Luke's Nampa Emergency Department should refer patients needing primary care follow-up to providers in Nampa, *not Boise or Meridian*. Dkt. No. 284 (Moore Dep. Tr.) at 45:8–46:5; TX 1113 at SLHS001181408–09.

69. Kathy Moore, Chief Operating Officer for St. Luke's Regional Medical Center, agreed that St. Luke's intended policy was to refer patients needing primary care follow-up from the Nampa Emergency Department to primary care physicians in Nampa or Caldwell, *not Boise or Meridian*. Dkt. No. 284 (Moore Dep. Tr.) at 46:6–20.

70. Peter LaFleur, a St. Luke's consultant who evaluated the Saltzer acquisition and other St. Luke's physician practice acquisitions, testified that it makes "good business sense" to serve Nampa patients with primary care services in Nampa "[b]ecause patients would prefer not to travel large distances to – to receive services." Dkt. No. 288 (LaFleur Dep. Tr.) at 196:11–22.

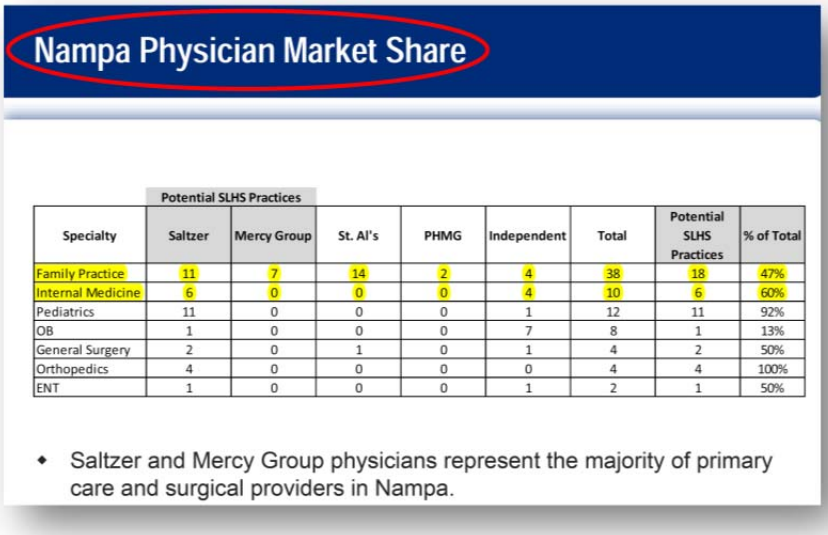
71. In a physician meeting, a St. Luke's doctor "voiced concern regarding [St. Luke's Clinic Family Medicine's] ability to refer to St. Luke's physicians *without people having to travel to Boise or Meridian . . . .*" TX 1445 at SLHS001146556 (emphasis added).

72. Even a St. Luke's Board member who claimed that patients were willing to travel across the Treasure Valley for primary care admitted that his own primary care physician was only a half-mile from his home. Trial Tr. at 2787:23–2788:5 (Arthur "Skip" Oppenheimer).

73. Testimony from St. Luke's health plan partner, SelectHealth confirms that patients demand local access to primary care services. Patricia Richards of SelectHealth testified that accessibility means "close to home, within a few miles, 10 to 15 minutes." That is "a kind of market acceptability" standard that SelectHealth tries to achieve. Trial Tr. 1764:6–1765:19 (Patricia Richards).

(2) Defendants' Strategic Planning Documents Confirm That Nampa Is A Distinct Geographic Market

74. St. Luke's own strategic planning documents reveal that St. Luke's considers the Nampa market to be competitively relevant. In a PowerPoint presentation prepared by a St. Luke's consultant that was sent to the Board for St. Luke's Treasure Valley, *see* Dkt. No. 288 (LaFleur Dep. Tr.) at 179:15–180:7, St. Luke's analyzed market shares for the "Nampa Physician Market." TX 1473 at 6 ("Nampa Physician Market Share"); see also TX 1472; TX 1262.



Nampa Physician Market Share

Specialty	Potential SLHS Practices: Saltzer	Mercy Group	St. Al's	PHMG	Independent	Total	Potential SLHS Practices	% of Total
Family Practice	11	7	14	2	4	38	18	47%
Internal Medicine	6	0	0	0	4	10	6	60%
Pediatrics	11	0	0	0	1	12	11	92%
OB	1	0	0	0	7	8	1	13%
General Surgery	2	0	1	0	1	4	2	50%
Orthopedics	4	0	0	0	0	4	4	100%
ENT	1	0	0	0	1	2	1	50%

- Saltzer and Mercy Group physicians represent the majority of primary care and surgical providers in Nampa.

75. This PowerPoint presentation calculates the potential share of the Nampa Market that St. Luke's could obtain through its prior acquisition of the "Mercy Group" physicians future acquisition of and Saltzer. TX 1473 at 6. The presentation describes the combined shares of these two physician groups: "Saltzer and Mercy Group physicians represent the majority of primary care and surgical providers in Nampa." *Id*.

76. In discussing the possibility of acquiring Saltzer, St. Luke's Ed Castledine told other St. Luke's officials that his list of Nampa physicians began to show "the dominance of Saltzer in the *Nampa market*." Dkt. No. 262 (Castledine Dep. Tr.) at 119:15–120:17 (emphasis added); TX 1281 at CON0007045. Mr. Castledine also testified that the acquisition of Saltzer represented more market share for St. Luke's in Nampa. Dkt. No. 262 (Castledine Dep. Tr.) at 122:17–23, 122:25–123:3.

77. [redacted] TX 1114 at WipFli00000087–88, 105.

78. Recognizing the importance of Nampa (the second-largest city in Idaho), St. Luke's changed the planned location of its Canyon county hospital from Caldwell to Nampa because Saltzer said it was important for the facility to be inside Nampa city limits. Trial Tr. at 2233:24–2234:11, 2235:4–25 (Christopher Roth).

79. The competitive importance of Nampa is also reflected in Saltzer documents. Saltzer and its Coker Group consultants were concerned about "competition within Nampa" that would occur if St. Luke's acquired the 7-physician Mercy Medical Group. Dkt. No. 271 (Reiboldt Dep. Tr.) at 81:17–82:11; TX 1152 at COKER-P-0000023.

80. Before St. Luke's acquired the Mercy Medical Group of Nampa, "[t]here was definitely concern [at Saltzer] that St. Luke's would move into Canyon County" and compete with Saltzer. Dkt. No. 271 (Reiboldt Dep. Tr.) at 82:13–15.

(3) Evidence From Other Providers Confirms That Nampa Is A Distinct Geographic Market

(a) Primary Health Medical Group

81. Dr. David Peterman of Primary Health Medical Group offered concrete examples of the local nature of primary care services. Two of Primary Health's clinics in Boise are located only 2.8 miles apart—one on Broadway and another on Myrtle Street, in downtown Boise. Notwithstanding their proximity to each other, the two clinics tend to attract patients from different neighborhoods and with different needs. Trial Tr. at 1165:9–19 (David Peterman). [redacted] *Id.* at 1166:10–11, 1168:6–14, 1169:16–1170:7.

82. Dr. Peterman explained that Primary Health has observed similarly local patterns in Nampa. Primary Health has two clinics in Nampa, one on the main boulevard in Nampa and a newer clinic on 12th Avenue, in South Nampa. Trial Tr. at 1165:20–25, 1170:8–12 (David Peterman). [redacted] *Id.* at 1166:10–11, 1167:10–1168:5, 1170:13–15. Primary Health's success with these neighborhood clinics stands in stark contrast to claims from Defendants' economist that the geographic market for Adult PCP services extends all the way from Caldwell to Boise, and possibly beyond.

83. [redacted] Trial Tr. at 1177:5–8, 1177:13–17 (David Peterman).

84. [redacted] Trial Tr. at 1173:3–21 (David Peterman). [redacted] Trial Tr. at 1174:21–1175:23, 1177:5–12 (David Peterman).

(b) Saint Alphonsus Medical Group

85. [redacted] When SAMG decides where to place its clinics, it looks for a location that is a 5- to 10-minute (15-minute at the maximum) drive from patients to provide "convenient care close to home." Trial Tr. 711:7–712:1 (Nancy Powell); TX 1952.

86. Indeed, SAMG has four primary care clinics in Nampa alone, spaced anywhere from one to six miles apart from each other. Trial Tr. 712:15–25 (Nancy Powell).

87. SAMG has learned from studies of families that "the mother makes the decisions for the care, of who is going to receive care in the home and so it's really for the convenience of the -- of the woman in the home." Trial Tr. 711:19–712:1 (Nancy Powell).

88. As Ms. Powell explained, patients want a primary care clinic that is convenient. For example, if a mother has to take a child out of school and take the child to the doctor, she does not want to spend her "entire day trying to get to a physician's office." Trial Tr. 712:2–14 (Nancy Powell).

(4) Evidence From Health Plans And Other Market Participants Confirms That Nampa Is A Distinct Geographic Market

89. Likewise, Linda Duer of IPN testified that the location of providers is especially important for primary care physicians. People do not want to drive forever to go to a doctor when they are sick. Trial Tr. at 462:23–463:3 (Linda Duer).

90. Even though the employees of a self-funded employer in Nampa may drive to Boise for a surgery, they do not want to leave Nampa for primary care. They want to stay where their home is and where a lot of them work. Trial Tr. at 464:16–465:1 (Linda Duer).

91. Given this strong demand for primary care services in Nampa, health plans must include sufficient numbers of Nampa PCPs in their provider networks to offer a competitive product. Health plans in the Treasure Valley consistently include Nampa-based PCPs in their provider networks. TX 1782 at Fig. 11; Trial Tr. 1329:8–1330:2 (David Dranove).

92. In fact, St. Luke's appears to have acknowledged this fact in assembling its own provider network, Select Medical Network. St. Luke's System Director of Payer Contracting, Steve Drake, testified that the Board for St. Luke's Select Medical Network decided it should include Saltzer in the network because it "needed providers in Nampa in order to market itself to employers." Dkt. No. 322 (Drake Dep. Tr.) at 181:19–183:3; TX 1196 at SLHS243740.

93. Even Dr. Argue was unable to identify any payer in the Treasure Valley that had ever even tried to sell a network without Nampa primary care physicians. Trial. Tr. at 3057:9–12 (David Argue). If a health plan is going to market a network in Nampa, it needs to have doctors in Nampa.

94. Blue Cross of Idaho's (BCI) experience confirms the importance of including local PCPs in order to offer a competitive product to employers.

95. BCI has PCPs in-network in every zip code where they have enrollees. BCI does not require a single enrollee to travel outside of their zip code for primary care. Trial Tr. at 1329:15–22 (David Dranove).

96. BCI's Jeff Crouch explained the need for local PCPs to offer a competitive provider network. From the perspective of individual members, "everybody is concerned about primary care access in their community." Trial Tr. at 230:15–16 (Jeff Crouch). In contrast with PCP services, members are more willing to drive further or take more time to get to specialized services. Trial Tr. at 230:17–22 (Jeff Crouch).

97. BCI therefore considers "primary care services in the direct community that the member resides" to be a "threshold" consideration for an employer evaluating a potential health plan. Trial Tr. at 230:2–9 (Jeff Crouch). [redacted] Trial Tr. at 235:16–24 (Jeff Crouch).

98. To illustrate the importance of local PCP access, Mr. Crouch provided an illustrative example from the Magic Valley, [redacted]

[redacted]

Trial Tr. at 243:10–245:9 (Jeff Crouch).

99. [redacted] Trial Tr. at 244:2–5 (Jeff Crouch); *see also id.* at 310:3–24.

100. [redacted] Trial Tr. at 308:18–22 (Jeff Crouch).

101. Linda Duer of Idaho Physicians Network (IPN) offered a similar perspective on the importance of local primary care coverage. IPN provides employers with information on the location of providers through a program called GeoAccess match. Employers will give IPN a list of all the providers whom the members have seen over a period of time, and then IPN does a match based on geographic location. Trial Tr. at 463:10–23 (Linda Duer).

102. [redacted]IPN does not believe it could successfully market a network to self-funded employers in Nampa that did not include Nampa primary care physicians. Tr. at 464:16–19 (Linda Duer).

b) Empirical Evidence Further Supports Nampa As A Distinct Geographic Market

103. In addition to the wide range of evidence above, Professor Dranove also performed an empirical analysis to examine where patients go for their medical care. Trial Tr. at 1322:17–23 (David Dranove).

104. Using data from commercial payers, Professor Dranove's zip code analysis revealed a stark bifurcation between patients living in Nampa and Canyon County, on the one hand, and patients living in Boise and Ada County, on the other—in both cases, patients receive Adult PCP services close to home. Trial Tr. at 1321:18–1322:11 (David Dranove); TX 1784.

105. Two-thirds of Nampa residents get their primary care physician services from providers who are located in Nampa. Trial Tr. at 1320:4–23 (David Dranove). And another 16 percent of Nampa residents get their primary care in a zip code that is adjacent to Nampa. Trial Tr. at 1320:4–23 (David Dranove). In total, 84.3 percent of Nampa residents select a PCP in Nampa or in an adjacent zip code. TX 1783.

106. The data also showed overwhelmingly that patients in Boise and Meridian tend to go to doctors in Boise and Meridian. Trial Tr. at 1321:10–1322:3 (David Dranove).

107. In short, the data shows that, indeed, patients do not like to travel for PCP services. Trial Tr. at 1323:19–20 (David Dranove).

108. The empirical analysis, along with other testimonial evidence and regular course documents are "all pointing in the same direction" that "Nampa is a well-defined market." Trial Tr. at 1322:15–16; 1323:12–20 (David Dranove).

c) Defendants Have Failed To Advance A Relevant Geographic Market For Adult PCP Services

109. For their part, Defendants have failed to offer a viable alternative geographic market. While Dr. Argue believes the geographic market includes at least Nampa, Caldwell, Meridian, and West Boise, Trial Tr. at 1331:8–14 (David Dranove), Dr. Argue never states what he believes the geographic market is. Trial Tr. at 1331:11–12 (David Dranove).

110. Dr. Argue's primary criticism of plaintiffs' geographic market analysis is based on "patient flow analysis," an approach to market definition based on strict adherence to

percentage thresholds. If more than a given percentage of patients travel outside an area to receive services—i.e., "patient outflows"—this strict form of patient flow analysis concludes that the market must be expanded. Trial Tr. at 1322:25–1323:7 (David Dranove).

111. Although Dr. Argue claimed in his report that an area with 40 percent patient outflows cannot possibly constitute a relevant geographic market, he acknowledged on cross-examination that the Nampa/Caldwell/Meridian/West Boise area he initially claimed was the relevant geographic market—and used to calculate market shares and HHI statistics—had very similar patient outflow percentages. Trial Tr. at 3056:18–3057:3 (David Argue); Trial Tr. at 3451:4–3452:19 (David Dranove).

112. As Professor Dranove explained, strict adherence to patient outflow percentages is not a reliable basis for defining the relevant geographic market. Indeed, the patient outflows from Dr. Argue's Nampa/Caldwell/Meridian/West Boise geographic market are even higher than from the Nampa market. So by Dr. Argue's own reasoning, his Nampa/Caldwell/Meridian/West Boise cannot possibly be an appropriate geographic market either. Trial Tr. at 1332:10–1334:4 (David Dranove).

113. So, while Dr. Argue claimed that the relevant geographic market for Adult PCP Services was "at least as big" as the areas specified in his report, he admitted that he "can't put [his] finger on an exact boundary" for the relevant geographic market in this case. Trial Tr. at 3057:4–8 (David Argue) (emphasis added); see also Trial Tr. at 2893:10–2894:6, 2951:5–15 (David Argue) (testifying that he had not "put an outside bound" on the relevant geographic market).

114. Moreover, the approach followed by Dr. Argue does not reflect how healthcare negotiations actually work or how health plans put together their networks. *See* Trial Tr. at

1323:21–1325:24 (David Dranove). For example, even if some Nampa patients receive care in Boise, a health plan is unlikely to offer a network to employers by saying, "I'm not going to have any doctors in Nampa, but don't worry, if you want to have a convenient PCP, just get a job in Boise, like the other folks who are seeing doctors in Boise." Trial Tr. at 1324:7–14 (David Dranove).

115. Common sense likewise shows the limitations to Dr. Argue's patient flow analysis. If one accepts Dr. Argue's patient flow analysis, then health plans would be willing to market a network to Treasure Valley residents without *any* PCPs between Caldwell and West Boise, rather than pay a five to ten percent price increase. Trial Tr. at 1333:12–22 (David Dranove). This proposition is not plausible.

d) Micron Is Not An Appropriate "Natural Experiment" For Evaluating The Geographic Market

116. In opening statements, St. Luke's counsel told the Court that Micron provided a "natural experiment" that could should light on the relevant geographic market. Trial Tr. at 128:24–129:12 (Jack Bierig).

117. But Micron's tiered benefit plan does not (and cannot) show whether a hypothetical monopolist would be able to impose a small reimbursement increase (a five to ten percent SSNIP) because the financial incentives faced by Micron enrollees far exceeded this threshold. And defendants failed to adduce any evidence—from Micron or any other source—that patients would switch to non-Nampa providers in response to a small increase in the prices they face. Trial Tr. at 1355:25–1356:18 (David Dranove).

118. Furthermore, Micron's unique circumstances limit the ability to extrapolate general insights from its specific experience. Micron instituted its health benefit plan during a time of immense financial pressure, when Micron employees feared they may lose their jobs.

And Micron has a unique on-site clinic that provides a convenient primary care option for many Micron employees. Trial Tr. at 1357:7–25 (David Dranove).

119. In 2008, Micron instituted a "tiered" health benefit plan. That plan includes three benefit options for Micron employees. In descending order, from most generous employee benefits to lowest, those "tiers" are: (1) the high performance network, MHPN; (2) the PPO network; and (3) out-of-network providers. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 12:1–8, 13:21–15:3, 17:11–18, 38:4–8, 52:3–7. Currently, Saint Al's is in the MHPN. Saltzer is in the middle (PPO) tier, and most St. Luke's providers are out of network. Trial Tr. at 558:6–11 (Patrick Otte). At no point since the Micron network's inception have both Saltzer and St. Luke's recently acquired Mercy Group physicians been out-of-network for Micron's enrollees. Trial Tr. at 915:13–24 (Lannie Checketts) (testifying that Mercy Group was in Saint Al's ACN network); Trial Tr. at 567:17–568:22 (Patrick Otte) (testifying that Micron used Saint Al's ACN network for its PPO tier).

120. Undisputed evidence shows that the price differences patients face between these tiers far exceeds the 5–10 percent SSNIP threshold. According to Micron's Vice President of Human Resources, Patrick Otte, Micron employees pay ten percent of the cost for care received in the MHPN, 15–18 percent for the second tier PPO, and 40 percent for out-of-network care. In addition to the Imagine Health benefit structure, Micron employees may use the on-site Micron clinic, which charges only a $10 flat fee. Trial Tr. at 558:12–559:2, 560:22–561:4, 598:16–599:9, 615:23–616:5 (Patrick Otte).

121. Similarly, Jackie Butterbaugh of Imagine Health, which assembled the Micron network, testified that a Micron employee who went to an out-of-network provider such as St. Luke's would pay double what they would pay if they visited an MHPN provider and four times

as much as what they would pay if they visited the on-site Micron clinic. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 78:16–80:1.

122. [redacted] Trial Tr. at 560:22–561:9 (Patrick Otte). [redacted] Trial Tr. at 561:5–9 (Patrick Otte).

123. As Professor Dranove explained, these prices differences Micron patients face far exceed the 5 to 10 percent threshold used for the "SSNIP" test, and therefore simply are not informative in evaluating the relevant geographic market. Trial Tr. at 1355:25–1356:18, 1412:10–18 (David Dranove).

124. Even Defendants' expert, Dr. Argue, admitted that the out-of-pocket costs facing Micron patients "is substantially greater" for out-of-network providers than the cost for in-network providers and much more substantial than the 5 percent threshold typically used for the SSNIP test. Trial Tr. at 3043:7–16 (David Argue).

125. Indeed, the facts on the ground for Micron's health plan undermine Dr. Argue's conclusions. For starters, Dr. Argue has not identified any percentage of patients who would travel for PCP series in response to a small (5 percent) price increase. Trial Tr. at 3043:17–20 (David Argue).

126. Even putting that aside, Dr. Argue did not consider any factors other than price—such as convenience—that may have explained some of the shift in patients when Micron launched its network. Trial Tr. at 3042:2–3043:1 (David Argue).

127. For example, one of the key providers of primary care services for Micron enrollees is the on-site clinic—the Micron Family Health Center—which is very popular with Micron's employees. According to Mr. Otte, it is "very convenient for the employees because it

is on-site" and has "extensive" hours. Trial Tr. at 559:13–22 (Patrick Otte). The certainty of the $10 flat fee at the clinic also plays a role in employees' preferences. Trial Tr. at 559:23–560:21 (Patrick Otte). But Dr. Argue did not even consider this option in his analysis. Trial Tr. at 3042:2–19 (David Argue).

128. Dr. Argue also did not have "any specific information" on the effect Micron's employees' concerns about their jobs may have influenced their willingness to change providers after Micron launched its network in 2008. Trial Tr. at 3054:14–19 (David Argue).

129. Professor Dranove explained that these factors may further limit the ability extrapolate from Micron's experience. Trial Tr. at 1357:7–25 (David Dranove).

3. The Acquisition Is Presumptively Unlawful By A Wide Margin

a) Market Concentration Levels In The Adult PCP Services Market Far Exceed Presumptively Illegal Thresholds

(1) Market Share, HHI Concentration

130. St. Luke's acquisition of Saltzer will lead to a substantial increase in St. Luke's market share, which a long history of economic theory and empirical research indicate will be likely to harm competition. Trial Tr. at 1335:19–25 (David Dranove).

131. After the Acquisition, St. Luke's is the largest provider of adult primary care services in Nampa. Dkt. No. 100 (St. Luke's Answer) at ¶ 3; Dkt. No. 105 (Saltzer's Answer) at ¶ 3.

132. In antitrust cases, market concentration is typically measured using the Herfindahl-Hirshman Index ("HHI"), which is calculated from market shares. The index ranges anywhere from zero (representing an infinite number of very small providers) to 10,000 (representing one pure monopolist). Trial Tr. at 1336:17–23 (David Dranove).

133. The HHI formula, which is the sum of the squared market shares, incorporates information about the relative concentrations of market power. For example, a four-firm market where one firm has a 70 percent share and three firms each have 10 percent share would typically pose greater competitive concerns than a market with four firms each with a 25 percent share. Trial Tr. at 1338:18–25 (David Dranove).

134. In conjunction with leading academic economists, the antitrust agencies—the FTC and the Department of Justice —have developed HHI thresholds to identify transactions that are potentially or presumptively anticompetitive. Trial Tr. at 1336:24–1337:22 (David Dranove).

135. Based on these thresholds, an acquisition is presumptively anticompetitive when the post-merger HHI is over 2500 and increases by 200 or more points as a result of a merger. Trial Tr. at 1336:24–1337:8, 1340:17–21 (David Dranove).

136. In Nampa, Saltzer is the dominant provider for adult PCP services, with two moderately sized competitors, St. Luke's and Saint Al's, and then a number of smaller competitors. Trial Tr. at 1339:17–21 (David Dranove).

137. Combined, St. Luke's and Saltzer account for nearly 80 percent of PCP services in Nampa. Trial Tr. at 1340:9–15 (David Dranove); TX 1789.

138. The Acquisition will lead to a substantial increase in market concentration. As a result of the merger between St. Luke's and Saltzer, the Nampa market has a post-merger HHI of 6,219 and an increase in HHI of 1,607, both of which are well above the thresholds for a presumptively anticompetitive merger (more than double and seven times their respective thresholds, respectively). Trial Tr. at 1340:9–1341:1 (David Dranove).

139. As Professor Dranove explained, this acquisition greatly exceeds the objective thresholds set forth in the Merger Guidelines. Trial Tr. at 3429:10–3430:7 (David Dranove).

b) Under Any Plausible Geographic Market The Acquisition Is Presumptively Unlawful

140. Although Nampa is the proper geographic market, Professor Dranove also considered potential Nampa/Caldwell and Nampa/Caldwell/Meridian markets. Trial Tr. at 1332:1–9 (David Dranove).

141. Even if the geographic market is extended to Nampa/Caldwell or Nampa/Caldwell/Meridian, St. Luke's and Saltzer still account for over 60 percent and over 55 percent of PCP services in those respective markets, and the HHIs would still be well above the Merger Guidelines thresholds. TX 1790 at Fig. 19; TX 1791 at Fig. 20; Trial Tr. at 1341:11–1342:15 (David Dranove).

142. In Nampa/Caldwell, the Acquisition results in HHI of 4,150 with an increase of 900 points (i.e., 1.5 times and four times the presumptively illegal thresholds, respectively). TX 1790. Similarly, in Nampa/Caldwell/Meridian, the Acquisition results in HHI of 3,606 with an increase of 1,437 points (i.e., nearly 1.5 times and seven times the presumptively illegal thresholds, respectively). TX 1791.

143. Even the sweeping Nampa/Caldwell/Meridian/West Boise area used in Dr. Argue's calculations, he admits that the post-acquisition HHIs are high enough to "raise some significant competitive concerns." Trial Tr. at 2952:1–13 (David Argue).

144. In fact, in the vast majority of the potential geographic markets that Dr. Argue considered in his expert report, the calculations showed an increase in concentration that exceeded the Merger Guidelines thresholds. Trial Tr. at 3430:22–3431:8 (David Dranove).

145. So, even if Dr. Argue were right that the geographic market should extend beyond Nampa, this would not fundamentally alter the competitive analysis of the acquisition. Professor Dranove analyzed two broader candidate markets—Nampa/Caldwell and Nampa/Caldwell/Meridian—and still concluded that the acquisition would substantially lessen competition even if the market were expanded to include these broader areas. Trial Tr. at 3430:8–21 (David Dranove).

4. The Acquisition Enhances St. Luke's Market Power And Will Likely Lead To Higher Healthcare Costs

a) <u>The Acquisition Eliminates Important Competition Between Healthcare Providers</u>

(a) St. Luke's Engages In System-Wide Negotiations With Payers

146. St. Luke's Director of Payer Contracting acknowledges that St. Luke's is a "single contracting entity" and that payers know that if they do not enter into a contract for facility rates that is satisfactory to St. Luke's, they will also lose the St. Luke's physicians. Dkt. No. 322 (Drake Dep. Tr.) at 79:23–80:1, 80:3–10.

147. [redacted] TX 1213 at Slide 31.

148. [redacted] Dkt. No. 321 (Amended Billings Tr.) at 89:19–90:1.

149. St. Luke's uses its geographic breadth of coverage for facilities and professional services (*i.e.*, hospitals in many communities and both primary care and specialist physicians in many localities accessible to members) to accomplish that goal. Having a broad range of

professional services can help St. Luke's negotiate. Dkt. No. 322 (Drake Dep. Tr.) at 72:2–6, 73:10–23, 79:1–11; TX 1181 at SLHS000592002.

150. [redacted] Trial Tr. at 431:5–19 (Jeff Crouch).

(b) Bargaining Dynamics Remain Constant Across All Types Of Contracts

151. Bargaining dynamics apply equally in negotiations for fee-for-service contracts and risk-based contracts. For example, in a full risk-based contract where the provider is paid on a per member per month ("PMPM") basis, a provider with enhanced bargaining leverage would negotiate a higher PMPM payment. Trial Tr. at 1308:12–1309:8 (David Dranove); Dkt. No. 322 (Drake Dep. Tr.) at 104:9–105:19, 105:22–23.

152. The bargaining dynamics of selective contracting apply to negotiations for narrow and "tiered" networks as well. A provider who gains bargaining leverage can exert its leverage to command higher prices in whichever tier it is in, or to demand placement in a certain tier on a "take it or leave it" basis. Trial Tr. at 1327:14–1328:25 (David Dranove); see also Trial Tr. at 1438:22–1439:12 (David Dranove). Indeed, a powerful provider can exercise market power by refusing to participate in anything but the most preferred tier. Trial Tr. at 1356:22–1357:6 (David Dranove).

153. So powerful providers have the ability to influence what happens going forward even if narrow networks begin to emerge. Trial Tr. at 1329:1–6 (David Dranove). A powerful

provider can also limit innovation if they resist contracts that include pay-for-performance quality metrics. Trial Tr. at 1440:23–1441:12 (David Dranove).

154. Dr. Pate admitted at trial that if healthcare providers are paid based on performance or value, there will still be negotiations between payers and providers as to how much to pay. Trial Tr. at 1682:6–17 (David Pate).

155. Dr. Pate also admitted that if a system like St. Luke's were the "only provider in town," it would be in in a very good negotiating position in negotiations over pay-for-value contracts in comparison with a market where it had competitors who were good alternatives to St. Luke's. Trial Tr. at 1682:20–1683:20 (David Pate).

(2) The Acquisition Enhances St. Luke's Bargaining Leverage, Likely Leading to Higher Reimbursements From Commercial Payers

(a) A Provider's Rates Reflect Its Relative Bargaining Leverage Against Health Plans

156. BCI is the largest health insurer in Idaho. Trial Tr. at 305: 14–15 (Jeff Crouch).

157. [redacted] Trial Tr. at 358:4–19 (Jeff Crouch).

158. [redacted] Trial Tr. at 286:10–287:14, 295:18–296:11 (Jeff Crouch); TX 1300 at BCI368370.

159. [redacted]

[redacted] Trial Tr. at 292:3–9 (Jeff Crouch); TX 1300 at BCI368370.

160. [redacted] Trial Tr. 351:6–14, 354:16–20 (Jeff Crouch); TX 10 at SLHS000804543. [redacted] Trial Tr. at 281:15–21, 351:6–17 (Jeff Crouch); TX 1299 at Slide 5.

161. [redacted] Trial Tr. at 299:17–23 (Jeff Crouch).

162. [redacted] Trial Tr. at 275:22–276:14 (Jeff Crouch) (emphasis added).

163. [redacted] Trial Tr. at 298:15–299:1 (Jeff Crouch); TX 1301 at BCI368366.

(b) Saltzer's Rate Negotiations With Payers Reflect Its Importance To Health Plan Networks

164. As an independent physician group, Saltzer rejected an offer from Regence Blue Shield of Idaho to participate in Regence's statewide PPO network at rates that were five to six percent less than what Saltzer had been receiving for participation in the Regence traditional network. Trial Tr. at 721:5–14 (Nancy Powell); Dkt. No. 252 (Clement Dep. Tr.) at 17:18–18:5, 18:14–19:9, 155:4–25. Regence initially walked away from the negotiations, but then came back and agreed to give Saltzer the higher, traditional rates in exchange for its participation in the PPO network. Trial Tr. at 721:15–25 (Nancy Powell).

165. Regence's Scott Clement remarked that it was "rare" to negotiate fees with independent physician groups in Idaho that were different from the statewide fee schedule. Dkt. No. 252 (Clement Dep. Tr.) at 43:12–44:4. In contrast with Saltzer, less than five percent of Idaho providers refused to accept the statewide PPO schedule proposed by Regence. Dkt. No. 252 (Clement Dep. Tr.) at 192:24–193:1.

166. Despite BCI's uniform statewide fee schedule, Saltzer attempted to negotiate with BCI on its physician fee schedule, and on some occasions Blue Cross would change the statewide fee schedule to accommodate Saltzer's request for higher rates. Trial Tr. at 722:1–23 (Nancy Powell).

167. And Saltzer was able to negotiate contract language with BCI that would increase the total payments it received, for example, by strengthening the language of "medical necessity" to make it harder for BCI to deny a claim. The revised language would be implemented as an amendment to BCI's standard contract. Trial Tr. at 723:10–724:9 (Nancy Powell).

b) St. Luke's And Saltzer Are Dominant Providers

(1) St. Luke's Is The Dominant Health Provider In Idaho

168. The vision of St. Luke's Health System when David Pate arrived in August 2009 "was to be the indispensable provider for the regions we served." Trial Tr. at 1612:2–19 (David Pate); TX1048 at SLHS000482832. As the evidence shows, St. Luke's has made substantial progress in achieving that goal.

169. [redacted] Trial Tr. at 292: 3–12, 294:19–295:11 (Jeff Crouch).

170. And Saltzer took note of this development. In an email to other Saltzer physicians, Dr. Randell Page said of St. Luke's, "we all know they are and will likely remain the dominant provider in the valley." Dkt. No. 271 (Reiboldt Dep. Tr.) at 147:22–148:25; TX 1150 at COKER0006233; TX 1366 at SMG000033688; Dkt. No. 270 (Page Dep. Tr.) at 103:11–14 (confirming that nothing in the document was inaccurate).

171. Tellingly, Dr. Page testified that he would have used different words besides "dominant" and "control" in his letter to his fellow Saltzer physicians supporting the St. Luke's transaction if he had known that his choice of words would have been questioned in a court proceeding. Trial Tr. at 2865:8–13 (Randell Page); Dkt. No. 270 (Page Dep. Tr.) at 101:5–15.

172. Regarding the contemplated acquisition of Saltzer by St. Luke's, Dr. Page told Ms. Duer at an IPN board meeting that "**I'm damned if I do, I'm damned if I don't**. If I do it, everyone will be mad, everyone will be upset. If I don't, St. Luke's will build a clinic wherever I go. They have more money, they have more resources…there is no way I can compete with that." Trial Tr. at 474:1–8, 476:4–12, 477:3–5 (Linda Duer) (emphasis added).

173. In reference to Ms. Duer's conversation with Dr. Page about St. Luke's dominance, even Dr. Page acknowledged that Ms. Duer "appeared as though she was recalling word for word a conversation that we had." Trial Tr. at 2855:10–12 (Randell Page).

174. The reasons that Dr. Page gave Ms. Duer for completing a transaction with St. Luke's were – even according to Dr. Page – "entirely inconsistent" with the reasons now proffered by Saltzer to defend this litigation. Trial Tr. at 2857:17–21 (Randell Page).

175. In another transaction, an Idaho Pulmonologist affiliated with St. Luke's because St. Luke's is better positioned to become the dominant player in the market for the foreseeable future. Trial Tr. at 2090:2–2091:2 (James Souza).

176. It's not surprising then, that St. Luke's touts its dominance in this market based on perception of quality and scope of network. Dkt. No. 365 (Sonnenberg Dep. Tr.) at 68:7–10.

177. [redacted]

Dkt. No. 321 (Amended Billings Tr.) at 74:20–76:7; TX 1219 at SLHS000581528.

178. Moreover, St. Luke's believes "[b]ecause contract pricing is driven by size and volume, as well as effective and efficient operations, St. Luke's is well positioned to successful [sic] negotiate with [BCI] and other payers." TX 1599 at SLHS000036431.

(2) Saltzer Is Dominant Among Physician Groups In Nampa

179. Saltzer has the most primary care physicians in Nampa, and there is not a close second. Trial Tr. 705: 5–12 (Nancy Powell); Trial Tr. at 465:6–11 (Linda Duer); Trial Tr. at 1296:1–10 (David Dranove); ; TX 1262 at Slide 6; *see also* Dkt. No. 366 (Brown Dep. Tr.) at 91:4–5.

180. TX 1261 at SLHS0000005427.

181.

[redacted] TX 1281 at CON0007045; Dkt. No. 262 (Castledine Dep. Tr.) at 120:10–17.

182. Mr. Castledine grew up in Nampa and professes a solid personal knowledge that Saltzer is "a reputable and long-standing significant player in that – that community in healthcare." Dkt. No. 262 (Castledine Dep. Tr.) at 122:4–12.

183. Indeed, St. Luke's recognized that in Saltzer it was buying a very significant player in the Nampa market. Dkt. No. 262 (Castledine Dep. Tr.) at 122:17–21.

184. According to the CEO of St. Luke's Regional Medical Center, Christopher Roth, "Saltzer was and is an incredibly well-respected group. They are the preeminent group, if you will, in the state of Idaho relative to multispecialty group practice. They know Nampa. They know Canyon County. They have the relationships. They have the trust of the community." Trial Tr. at 2230:12–21 (Christopher Roth); *see also* Dkt. No. 286 (Roth Dep. Tr.) at 8:1–3.

185. St. Luke's is certainly aware of this dynamic. [redacted] Dkt. No. 321 (Amended Billings Tr.) at 97:4–11.

c) St. Luke's And Saltzer Are Each Other's Closest Competitors For Adult PCP Services In Nampa

186. Professor Dranove's diversion analysis shows that St. Luke's and Saltzer are each other's closest competitors for Adult PCP Services in Nampa. Trial Tr. at 1437:3–8 (David Dranove); TX 1794 at Fig. 23.

187. Diversion analysis looks at substitution patterns and does not rely on specific thresholds or percentages to reach a conclusion. Trial Tr. at 1351:16–21 (David Dranove). Diversion analysis is also not sensitive to a specific geographic market. Trial Tr. at 1354:22–1355:2 (David Dranove).

188. Professor Dranove (like many other economists) uses diversion analysis as a complement to market share analysis by measuring the extent to which firms or products are close substitutes for each other. A merger of close competitors increases the likelihood that the merged entity can make a price increase "stick." Trial Tr. at 1349:21–1351:8 (David Dranove).

189. Here, diversion analysis shows that St. Luke's and Saltzer PCPS are each other's closest substitutes, confirming the market share analysis and reinforcing concerns about the merger. Trial Tr. at 1353:23–1354:5 (David Dranove); TX 1794 at Fig. 23.

190. Looking at substitution patterns, if St. Luke's Nampa patients could not see St. Luke's physicians, 50 percent of them would choose to go to Saltzer. If, after the merger, those patients also could not see Saltzer physicians, then that 50 percent would have to see their third-most-preferred option. Trial Tr. at 1351:22–1352:19 (David Dranove); *see also* TX1794 at Fig. 23.

191. At the same time, St. Luke's is Saltzer's closest competitor. If Saltzer's Nampa location were unavailable, one-third of its patients would switch to St. Luke's – more than any other provider. Trial Tr. at 1352:25–1353:7 (David Dranove); *see also* TX 1794.

192. In other words, the analysis shows that the Acquisition is not only a merger of the first and second largest providers for primary care services but also a merger of those providers' closest substitutes. Trial Tr. at 1437:3–8 (David Dranove).

d) The Acquisition Enhances St. Luke's Negotiating Leverage And Allows It To Extract Higher Reimbursements From Commercial Payers

193. Although defense witnesses claimed otherwise, documents generated before Defendants were informed that the FTC and State of Idaho were investigating the Saltzer acquisition reveal that both St. Luke's and Saltzer expected that the transaction would increase negotiating leverage with health plans.

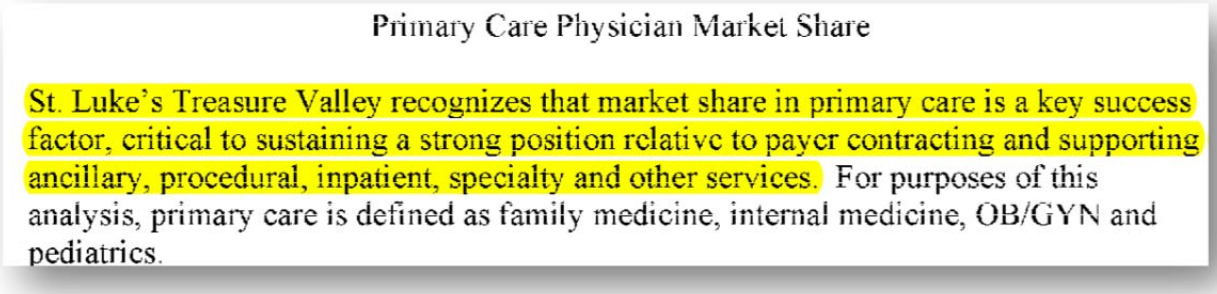
194. At trial, the CEO of St. Luke's Regional Medical Center, Chris Roth, claimed that "[t]here was no purpose of the transaction to gain market share." But a memo from St. Luke's CFO, Jeff Taylor, to Mr. Roth conveying a Saltzer "transaction update" for the St. Luke's Treasure Valley board included an analysis of "Nampa Physician Market Shares," showing that St. Luke's Mercy Group and Saltzer would have the majority of the PCPs in Nampa after the acquisition. Trial Tr. at 2307:9–2310:20, 2344:7–15 (Christopher Roth); TX 1473 at Slide 6.

195. Dr. Pate testified that the St. Luke's system board did not consider how the acquisition would increase St. Luke's market share – contending that implementing the "Triple Aim" was "virtually the total basis" for approving the transaction." Trial Tr. at 1639:9–1640:12 (David Pate). But St. Luke's deal consultant, Peter LaFleur testified that a presentation analyzing how St. Luke's prior planned acquisition of Saltzer would enhance the system's market share was given to the St. Luke's Treasure Valley board. Dkt. No. 288 (LaFleur Dep. Tr.) at 179:15–180:7.

196. Likewise, Dr. Pate claimed that the possibility of increasing reimbursements from commercial payers did not factor into the board's decision making in any way. Trial Tr. at 1640:4–7 (David Pate). But, as Mr. LaFleur testified, St. Luke's performed extensive modeling of how the Acquisition could generate increased reimbursement through hospital-based billing. Dkt. No. 288 (LaFleur Dep. Tr.) at 74:10–16.

197. Dr. Pate also admitted on cross-examination that the SLHS Board in deciding whether to approve the Saltzer acquisition considered the revenue stream and costs associated with the agreement. Trial Tr. at 1676:1–10 (David Pate).

198. Notably, St. Luke's own ordinary course-documents recognize the importance of primary care market share:



Primary Care Physician Market Share

St. Luke's Treasure Valley recognizes that market share in primary care is a key success factor, critical to sustaining a strong position relative to payer contracting and supporting ancillary, procedural, inpatient, specialty and other services. For purposes of this analysis, primary care is defined as family medicine, internal medicine, OB/GYN and pediatrics.

TX 1461 at SLHS000039821.

199. Likewise, Saltzer acknowledges that it "felt it was necessary to be part of a larger system" to help negotiate reimbursement rates. Trial Tr. at 2850:22–23 (Randell Page).

200. [redacted] Dkt. No. 271 (Reiboldt Dep. Tr.) at 72:16–73:12.

201. [redacted] TX 1143 at SMG000033851.

(1) Post-Acquisition, Payers Do Not Have A Viable Outside Option To Saltzer/St. Luke's, Giving The Combined Firm's Greater Bargaining Leverage

202. If a health plan were negotiating with Saltzer before the acquisition, its best outside option for PCP services in Nampa was St. Luke's. The best outside option for a health plan negotiating with St. Luke's was Saltzer. The merger has taken away each health plan's best outside option and lessened its BATNA. Trial Tr. at 1354:10–15 (David Dranove). "BATNA" is the best alternative to a negotiated agreement. Trial Tr. at 1300:8–12 (David Dranove); Trial Tr. 239:9–16 (Jeff Crouch).

203. In the post-acquisition bargaining dynamic, St. Luke's/Saltzer's leverage is greater because removing the combined entity from a network in Nampa would force many patients to choose their third best option. That is not an attractive option for a health plan trying to market that network to patients who live in Nampa. Trial Tr. at 1305:15–1306:15 (David Dranove).

204. After the transaction, health plans lose their first and second-best options if they walk away from St. Luke's/Saltzer, and that enhances St. Luke's/Saltzer's leverage above what each had on its own—i.e., it is "superadditive"—and allows St. Luke's/Saltzer to get more in the "bottom right cell." Trial Tr. at 1306:18–1307:22 (David Dranove).

205. One concern of insurers is that if they fail to reach a deal with St. Luke's and have a lot of members who depend on a St. Luke's facility or a St. Luke's doctor, and did not have good alternatives to St. Luke's, the members would be unhappy and may want to use a different health plan. Dkt. No. 322 (Drake Dep. Tr.) at 66:18–25, 67:3–4; *see also* Dkt. No. 365 (Sonnenberg Dep. Tr.) at 230:1–17.

206. For example, IPN does not believe it could successfully market a network to self-funded employers in Nampa that did not include Saltzer or St. Luke's. Trial Tr. at 465:2–5, 473:3–9 (Linda Duer).

207. IPN explained why the other primary care providers in the Nampa area were not adequate alternatives:

- Saint Al's Medical Group PCPs are not a viable substitute for Saltzer in IPN's rental network because there are not enough of them to service Saltzer's huge primary care base. Trial Tr. at 466:5–11, 466:18–22 (Linda Duer).
- Primary Health does not have enough primary care providers in Nampa to service a large employer like the Nampa School District, and hence would not be a viable substitute for Saltzer in IPN's rental network. Trial Tr. at 467:24–468:9 (Linda Duer).
- West Valley Medical Group has one or two primary care doctors in Nampa and therefore would not be viewed as a substitute for Saltzer PCPs in IPN's rental network from the standpoint of a self-funded employer in Nampa. Trial Tr. at 468:10–16 (Linda Duer).
- Terry Reilly Health Services is a federally qualified health clinic that serves a mostly indigent population. Trial Tr. at 465:15–20 (Linda Duer). As Ms. Duer explained, Terry Reilly PCPs are not a viable substitute for Saltzer PCPs in IPN's rental network because most people with commercial health insurance choose not to go to Terry Reilly. Trial Tr. at 465:21–466:4 (Linda Duer).

(2) Post-Acquisition Saltzer/St. Luke's Has More Clout In Negotiations With Health Plans

208. [redacted]

[redacted]TX 1361 (SMG000315458) (emphasis added); Dkt. No. 270 (Page Dep. Tr.) at 17:18–18:4; 58:8–12. In other words, after the acquisition, Dr. Page believes that the combined

entity can get better terms because Saltzer now has the "clout"—i.e., bargaining power—of the entire St. Luke's network. Trial Tr. at 1344:12–1345:2 (David Dranove).

209. Similarly, the President of Saltzer, Dr. John Kaiser, testified that one of the reasons that Saltzer wanted to enter into the transaction with St. Luke's was so that Saltzer would not be excluded from contracts with third-party payers, acknowledging that this could be perceived as Saltzer seeking additional "clout" through the deal. Trial Tr. at 2434:11–17 (John Kaiser). Dr. Kaiser admitted that one of the reasons that was "brought forward" for Saltzer to pursue a deal with a large hospital system was the advantages of "combined contracting" with that system. Trial Tr. at 2435:23–2436:5 (John Kaiser).

210. And in an internal meeting at Saltzer to discuss the St. Luke's transaction attended by several members of Saltzer's leadership team, the Saltzer leaders listed the "fundamental reasons" why Saltzer should do a deal with St. Luke's. The first reason listed above all others was "control market share." Among the other reasons listed were "facility fee for Medicare" and "one competition compared to two." Notably, of the several reasons listed, no where did the Saltzer leaders list a desire to enhance Saltzer's electronic health record or to improve the quality of its practice. TX 1369 at SMG00039311–12; Trial Tr. at 2416:6–2420:13 (John Kaiser).

211. In a letter circulated and signed by most Saltzer physicians, Saltzer itself acknowledges that a purpose of the transaction was to "**control** and co-develop" services in Canyon County. TX 1366 at SMG000033689 (emphasis added); Trial Tr. at 2865:18–22 (Randell Page). While he testified that nothing in the letter was inaccurate, Dr. Page now says that when he wrote "control," what he meant to say was "participate." Dkt. No. 270 (Page Dep. Tr.) at 103:11–14, 169:17–22, 170:10–22.

212. Dr. Page further testified that believes that St. Luke's is a "stronger partner" for Saltzer than Saint Al's in terms of contracting with health plans. Dkt. No. 270 (Page Dep. Tr.) at 69:6–16.

213. [redacted] Trial Tr. at 311:7–15, 433:1–8 (Jeff Crouch).

214. [redacted] TX 1093 at SLHS0000006605. In his testimony, Roth claimed that he was not referring to increased reimbursement rates, but on cross-examination, he acknowledged that the heading for St. Luke's strategy was "*Increase Prices* ($ unknown)." TX 1093 at SLHS0000006605 (emphasis added); Trial Tr. at 2314:7–2315:1, 2338:22–2340:1, 2345:1-22 (Christopher Roth).

215. Despite the importance of provider-payer negotiations to St. Luke's defense of the Acquisition, St. Luke's decided not to call as live witnesses Randy Billings, Steve Drake, or Linda House, who are the St. Luke's employees most directly involved in contract negotiations with commercial payers.

(3) St. Luke's Newfound Leverage Allows It To Extract Higher Reimbursements

216. Market power gained from the Acquisition will be exercised in the bottom right hand corner—i.e., total payments by payers to St. Luke's. Trial Tr. at 1347:1–5, 1393:14–21 (David Dranove).

217. Even Professor Enthoven, when asked about having two "mega-systems" in the Treasure Valley, candidly acknowledged: "Well, I think it's problematic. . . . [T]he conditions for competition are not very well fulfilled in Idaho . . . . So this is the most promising strategy, but I'll grant you that it does—**the concentration aspect does—does lead to reasonable concerns**." Trial Tr. at 2713:4–2714:18 (Alain Enthoven) (emphasis added). Yet, Professor Enthoven does not know what level of market share would raise a concern for him. Trial Tr. at 2694:5–7 (Alain Enthoven). He also has not attempted to evaluate the anticompetitive effects that may result from the Acquisition. Trial Tr. at 2693:2–6 (Alain Enthoven).

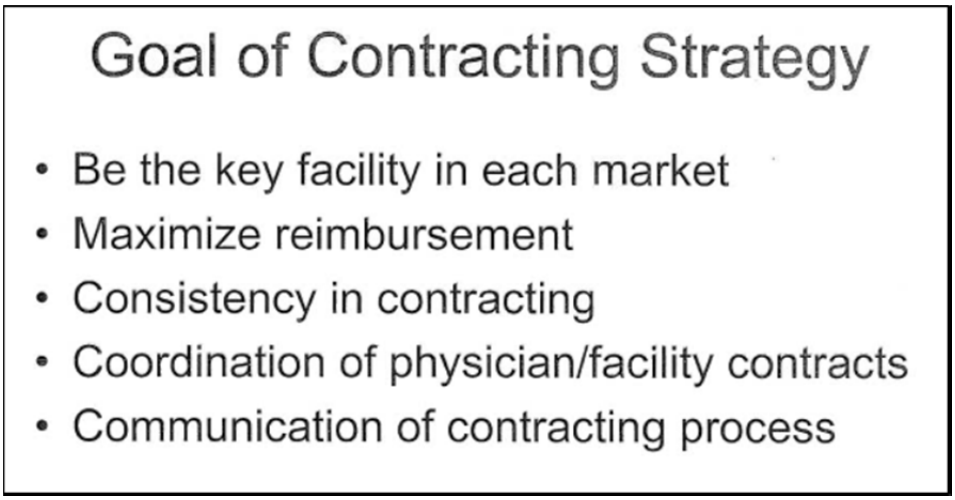
218. Nonprofits, including St. Luke's, seek to maximize revenues and profits. In negotiations with payers, St. Luke's tries to get the maximum increase possible. Dkt. No. 322 (Drake Dep. Tr.) at 84:3–15, 84:23–84:25; TX 1182 at SLHS000258149. And so, St. Luke's being a not-for-profit institution does not fundamentally alter the economic analysis. Trial Tr. at 3501:18–3502:8 (David Dranove).

219. [redacted] Dkt. No. 267 (House Dep. Tr.) at 27:17–21, 27:24–28:1, 28:3–8. [redacted] Dkt. No. 267 (House Dep. Tr.) at 28:9–13, 29:5–10, 29:11–30:1.

(4) St. Luke's Will Apply Its Additional Bargaining Leverage From The Acquisition To Obtain Higher Reimbursements

220. Following an increase in market power, providers can increase payments in a number of ways, including increased rates, moving patients to settings with higher rates, or changing to hospital-based billing. Trial Tr. at 1347:1–16 (David Dranove).

Indeed, a St. Luke's Payer Contracting Strategy Discussion Presentation stated:



TX 1184 at SLHS000031764.

221. Because St. Luke's negotiates with health plans for all services system-wide, higher negotiated rates could, but will not necessarily, involve increased rates for Adult PCP Services in Nampa. *See* Trial Tr. at 1346:18–1349:6 (David Dranove). Alternatively, St. Luke's could exercise its enhanced market power by increasing reimbursements in other ways.

222. [redacted]

See TX 1277, SLHS000820291 at SLHS000820297; Trial Tr. at 252:12–253:14 (Jeff Crouch). As Professor Dranove explained, hospital-based billing is one way in which St. Luke's can exercise its enhanced bargaining leverage from the Acquisition, and it is that newfound leverage that gives St. Luke's the ability to make these higher rates "stick" in future contract negotiations. Trial Tr. at 1347:22–1349:6 (David Dranove).

(a) BCI "Hospital-Based" Billing Analysis

223. [redacted] Trial Tr. 249:10–15 (Jeff Crouch); TX 1302. [redacted] Trial Tr. 257:21–258:9 (Jeff Crouch); TX 1302; *see also* Trial Tr. 391:1–24 (Jeff Crouch).

224. For commercial payers, this practice is often referred to "hospital-based" billing, to distinguish it from Medicare reimbursement known as "provider-based" billing, although conceptually they are similar practices. Trial Tr. at 426:20–427:20 (Jeff Crouch); Trial Tr. at 1349:7–16 (David Dranove).

225. BCI has modeled how St. Luke's acquisition of Saltzer could increase reimbursements if St. Luke's begins billing "hospital-based" rates for "ancillary services," such as laboratory tests, imaging, and other non-professional, non-hospital services. Trial Tr. 252:12–253:14. (Jeff Crouch).

226. Prior to the Acquisition, Saltzer performed many routine ancillary services such as laboratory and diagnostic imaging, as well as therapy services and specialized facility services for colonoscopies and minor outpatient surgeries, at Saltzer's facilities. Trial Tr. 252:22–253:15 (Jeff Crouch).

227. After the Acquisition, if St. Luke's were to bill for these ancillary services at the higher "hospital-based" rates as BCI expects, BCI has estimated that the costs under its commercial contracts would increase by [redacted] to [redacted] percent. Trial Tr. 253:10–15, 254:9–17 (Jeff Crouch).

228. BCI calculated that costs for: (i) drugs would increase by roughly $[redacted]; (ii) labs would increase by $[redacted]; (iii) physical therapy and occupational therapy would increase

by $[redacted]; and (iv) imaging would increase by $[redacted]. Trial Tr. 261:17–23, 263:4–265:11 (Jeff Crouch); TX 1302.

229. Adding up the various components of ancillary services, BCI estimated that that the annual cost for these services would increase by $[redacted], which represents at [redacted] percent increase as a result of the Acquisition. Trial Tr. 265:2–11 (Jeff Crouch); TX 1302.

230. These estimates illustrate one likely way in which the combined St. Luke's–Saltzer may exercise its enhanced market power. As BCI's Jeff Crouch explained, "Hospitals buy physician practices not to increase physician reimbursement. They buy physician practices to increase hospital reimbursement," through increased referrals and hospital-based billing for "commodity" services. Trial Tr. 425:15–426:6; 428:20–429:25 (Jeff Crouch).

(b) St. Luke's "Hospital-Based" Billing Analysis

231. [redacted] TX 1277 at SLHS000820291, SLHS000820297; *see also* Trial Tr. at 1347:17–21 (David Dranove). [redacted] Dkt. No. 262 (Castledine Dep. Tr.) at 74:1–11; TX 1277 at SLHS000820294–98; TX 54 (LaFleur Dep. Tr.) at 282:25–285:20; TX 1480 at CON0000984-026.

232. [redacted] TX 54 (LaFleur Dep. Tr.) at 74:10–16; Trial Tr. 735:23–736:7 (Nancy Powell); *see also* Trial Tr. at 332:3–17 (Jeff Crouch); TX 54 (LaFleur Dep. Tr.) at 49:2–51:4;

TX 1466 at 8–9 [redacted]; TX 1480 at CON0000984-026, -027.

233. [redacted] TX 54 (LaFleur Dep. Tr.) at 50:1–15 (describing TX 1466 as a [redacted] & 54:21–55:6 [redacted]

234. [redacted] *Compare* TX 1466 at 8 *with* TX 1480 at CON0000984-027 [redacted] *compare* TX 1466 at 9 *with* TX 1480 at CON0000984-026 [redacted]

e) Evidence From St. Luke's Prior Conduct And Other Acquisitions Confirms St. Luke's Ability To Leverage Its Market Power To Obtain Higher Reimbursements

(1) Past Is Prologue: St. Luke's Leveraged Its Market Power From PCP Acquisitions In The Magic Valley

235. [redacted] Trial Tr. at 241:3–12 (Jeff Crouch).

236. [redacted] Trial Tr. at 243:10–245:9 (Jeff Crouch).

237. [redacted] Trial Tr. at 244:2–5 (Jeff Crouch); *see also id.* at 310:3–24.

238. [redacted] Trial Tr. at 246:9–247:18 (Jeff Crouch).

239. [redacted] Trial Tr. at 279:24–280:18 (Jeff Crouch); TX 1299 at Slide 3.

240. Wanting to share his insights from the Magic Valley, John Kee told Nancy Powell about his experience negotiating with BCI in Twin Falls, where the strength of St. Luke's network gave it more negotiating power with BCI than maybe it had in other areas of the state. Trial Tr. at 726:9–14 (Nancy Powell).

241. Analogizing his experience in Twin Falls, John Kee told Nancy Powell that he felt Saltzer had more negotiating power than it was utilizing when dealing with BCI. Trial Tr. at 725:10–20 (Nancy Powell).

242. [redacted] Dkt. No. 371 (Seppi Dep. Tr.) at 214:3–6, 214:12–17, 215:21–24, 216:1–2, 220:24–221:4, 221:6–11, 227:18–22.

243. [redacted] TX 1956 at SLHS0000012710.

244. St. Luke's was also able to negotiate a favorable deal with IPN in the Magic Valley, securing a raise in fees up to the maximum allowed by the statewide fee schedule. Trial Tr. at 505:5–8 (Linda Duer). St. Luke's was able to raise the fees because IPN had "no other alternative to go to if [St. Luke's] would term[inate] the contract in the Twin Falls Magic Valley area." *Id.* at 499:23–500:9.

245. Given the number of physicians that St. Luke's had in Twin Falls, IPN had to accede to St. Luke's demands: "[Y]ou can't do business in this state without Twin Falls. You have to have Twin Falls." Trial Tr. at 504:4–11 (Linda Duer).

246. Even St. Luke's economic expert, Dr. Argue, admitted that, following St. Luke's acquisitions in the Magic Valley, hospital prices in that area increased at a faster rate than in other areas of the state. Trial Tr. at 3029–3030:2 (David Argue).

247. BCI is concerned that St. Luke's acquisition of a dominant share of the PCPs in Nampa could cause a "repeat" of the Magic Valley experience, [redacted]

[redacted] Trial Tr. at 251:23–252:4 (Jeff Crouch).

248. Likewise, IPN is concerned about the transaction between St. Luke's and Saltzer because of the experience IPN had negotiating with St. Luke's in Twin Falls. [redacted] As IPN's Linda Duer explained, "**it's going to happen again in Nampa. It's just a matter of time.**" Trial Tr. at 472:15–473:2 (Linda Duer) (emphasis added).

249. [redacted] Dkt. No. 322 (Drake Dep. Tr.) at 11:25–12:13, 142:2–143:15, 145:3–7, 145:9–13, 145:15; TX 1181 at SLHS592012.

(2) Micron's Experience Confirms That St. Luke's Has Market Power And That It Will Be Enhanced By The Acquisition

(a) Micron's Decision To Create A Tiered Health Plan

250. Micron Technology, Inc. ("Micron") is one of the largest employers in the state. It employs just under 6,000 people in the Treasure Valley. Trial Tr. at 545:9–15 (Patrick Otte).

251. Micron manufactures memory products (DRAM and NAND) that go into devices like iPods and MP3 players. Headquartered in Boise, Micron competes in a global market against companies like Samsung, Hynix, and Toshiba. Trial Tr. at 545:16–17, 547:3–12 (Patrick Otte).

252. In 2008, average selling prices for DRAM and NAND declined 50 percent and 65 percent, respectively, from 2007, with an overall decline from 2006 of 65 percent and 85 percent, respectively. Trial Tr. at 550:8–12, 550:19–552:3 (Patrick Otte).

253. Micron also had operating expenses that were twice as high as the industry standard, leading Micron to feel like it was "spotting a lead" to its competition all the time. Trial Tr. at 549:7–25 (Patrick Otte).

254. In 2008, Micron reported a net loss of $1.6 billion. The loss had a widespread effect on Micron's operations, reinvestment, total employment and employee compensation. Trial Tr. at 552:18–553:8 (Patrick Otte). Among other things, Micron was forced to close a large production facility in Boise that had employed 3,000 people. Trial Tr. at 553:14–554:5 (Patrick Otte).

255. According to Patrick Otte, Vice President of Human Resources at Micron, "everything was on the table," including selling off portions of the business or eliminating entire product lines and all the people associated with that. Trial Tr. at 554:6–16 (Patrick Otte).

256. In this context, Micron turned to Imagine Health and the Wise Network in an effort to make Micron more competitive by controlling its rising healthcare costs. Trial Tr. at 556:18–557:17 (Patrick Otte).

257. Imagine Health is a managed care company that develops and manages preferred provider networks (PPO networks) and narrow networks of physicians and hospitals. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 7:10–15.

258. Imagine Health's customers are employer groups that self-fund their employee health insurance plans. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 9:23–10:3. [redacted]

[redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 17:19–18:16. Accordingly, Imagine Health builds narrow, high performance network of providers for self-funded employers, providing an alternative to insurers like Blue Cross or Regence Blue Shield. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 10:5–14; 16:2–15.

259. A PPO network is a preferred provider organization that generally includes a majority of physicians and hospitals in a given area that are contracted to be part of a network. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 8:17–25. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 16:2–15.

260. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 9:1–5, 14:10–20. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 11:10–17, 16:18–22. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 16:23–17:10.

261. A high performance network is composed of hospitals and physicians who demonstrate superior quality and performance outcomes compared to their peers in the local marketplace. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 9:6–22. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.)

at 10:15–11:9. The narrow, high performance network for Micron is called the Micron Health Partner Network, or MHPN. Trial Tr. at 557:18–22 (Patrick Otte).

262. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 11:10–25, 13:11–20.

263. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 20:18–20, 40:12–18.

(b) St. Luke's Resists Micron's Efforts To Create A Tiered Plan

264. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 21:2–25.

265. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 27:19–24. [redacted] Trial Tr. at 566:2–6 (Patrick Otte). [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 27:25–28:7; TX1006 at IMAGINE233. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 27:11–13.

266. [redacted] Trial Tr. 566:12–567:2 (Patrick Otte).

267. On the eve of the Micron network's launch, however, St. Luke's backed out, telling Micron that it did not want to compete with Saint Al's on price. Trial Tr. 566:7–11 (Patrick Otte); TX 1229 (SLHS000152677); *see also* TX 1228 at SLHS000153571.

268. Micron's Patrick Otte recalls meeting with St. Luke's CEO, Ed Dahlberg, and CFO, Chuck Pomeroy, who told him that "we don't play second fiddle and **we will not be called tier two to anybody**." Trial Tr. at 571:14–20 (Patrick Otte) (emphasis added). Mr. Otte understood this to mean that St. Luke's was unwilling to be in the PPO tier if Saint Al's was in Micron's preferred, MHPN tier. Trial Tr. at 571:21–24 (Patrick Otte).

269. FirstHealth was initially slated to provide the PPO network for Micron. But after St. Luke's and FirstHealth withdrew, Imagine Health had to contract directly with physicians to build its own PPO network for Micron. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 39:14–40:11. The network was originally called the Wise provider network, and was later rebranded as the Imagine Health Network. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 48:19–49:1.

270. Losing access to the First Health PPO put Micron and Imagine Health in a tough situation as it "was done at the very final hour and [was] difficult to adjust and react to." Dkt. No. 318 (Butterbaugh Dep. Tr.) at 38:9–13, 38:16–19. The timing of the reversal gave St. Luke's "a lot of leverage." Dkt. No. 318 (Butterbaugh Dep. Tr.) at 38:20–23.

271. [redacted] Trial Tr. at 567:17–568:22 (Patrick Otte).

272. [redacted] Trial Tr. at 568:10–22 (Patrick Otte). [redacted] Trial Tr. at 579:17–580:1 (Patrick Otte).

273. [redacted] Trial Tr. at 572:24–573:16 (Patrick Otte). [redacted] Trial Tr. at 573:9–11 (Patrick Otte).

274. Micron's decision to drop St Luke's from its network rather than accede to its rate demands is consistent with the exercise of market power. Basic economic theory predicts that a firm with market power will raise its price to the point where at least some customers balk; otherwise, the firm could increase its profits by raising its price even further. Trial Tr. at 1355:12–24 (David Dranove). As Professor Dranove explained, given Micron's financial difficulties and its unique on-site clinic, it is not surprising that Micron would be the customer willing to balk at the pricing of a powerful provider like St. Luke's. Trial Tr. at 1357:9–22 (David Dranove).

(c) St. Luke's Refuses To Compete On Price

275. [redacted] Dkt. No. 321 (Amended Billings Tr.) at 102:5–8, 102:12–103:2; TX 1226 at SLHS000291534. [redacted] Dkt. No. 321 (Amended Billings Tr.) at 104:3–17, 111:23–112:13,140:5–16; TX 1226 at SLHS000291534; TX 1229 at SLHS000152677 [redacted]

[redacted] Dkt. No. 321 (Amended Billings Tr.) at 103:1–2, 103:4, 103:6–8, 112:14–19.

276. St. Luke's and its Select Medical Network were concerned that with the growth of the Treasure Valley, other companies like Micron's agent, Wise, would try to get deep discounts from Boise area providers in exchange for preferential treatment. Dkt. No. 267 (House Dep. Tr.) at 77:10–25; TX 1165 at SLHS243830 ("with the growth of the Treasure Valley, SELECT will be seeing other companies like WISE making their presence in Boise").

277. Although Linda House, a member of the St. Luke's Contracting Committee, has said that St. Luke's was not interested in discounts-for-volume offers because St. Luke's wanted to focus on clinical integration, she cannot explain how, if at all, agreeing to discounts for volume would interfere with St. Luke's clinical integration efforts. Dkt. No. 267 (House Dep. Tr.) at 87:3–7, 87:9–18, 87:20–24.

278. [redacted] Trial Tr. at 561:10–15, 564:22–566:1 (Patrick Otte).

279. Micron has saved approximately $27 million per year on hospital services for its employees as the result of the plan constructed by Imagine. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 41:3–15.

280. Although the Imagine program successfully incentivized Micron employees to use Saint Al's for hospital services instead of St. Luke's, neither Saltzer nor St. Luke's have ever approached Imagine about bidding for the Micron narrow network business. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 41:8–22, 138:1–11.

281. By July 2010, Ms. House recognized that St. Luke's acquisition of physician practices had improved St. Luke's bargaining position with Micron, as did another member of the Contracting Committee, Dr. Geoff Swanson. Dkt. No. 322 (Drake Dep. Tr.) at 225:14–17, 226:10–227:3; TX 1202 at SLHS592022 (House, "Today, St. Luke's has more physicians") and SLHS592024 (Swanson, [redacted] She reported that Micron employees were upset that St. Luke's was not included in the Micron network because the employees had a preference to use St. Luke's physicians. Dkt. No. 322 (Drake Dep. Tr.) at 227:24–228:10; TX 1202 at SLHS592022.

282. That same year, St. Luke's and Select Medical Network met with Micron representatives. St. Luke's did not want Imagine or Wise to be present at any meeting with Micron and was unwilling to contract with Wise or Imagine. If St. Luke's did a deal for Micron's business, it had to be a negotiation separate from Wise or Imagine and a direct contract with Micron. Dkt. No. 267 (House Dep. Tr.) at 113:4–9, 118:4–19. Ms. House thought it was obvious that Wise and Imagine had a strategy to disrupt competition in the market, which she opposed. Dkt. No. 267 (House Dep. Tr.) at 118:20–22, 118:25–119:2, 119:4–11. And St. Luke's told Micron that it was "not interested in discounting for volume, [or] participating in the Wise network." Dkt. No. 267 (House Dep. Tr.) at 110:15–25, 111:20–112:25; TX 1169 at SLHS000316469.

283. In mid-2012, Imagine learned from Micron that St. Luke's had direct discussions with Micron, but St. Luke's told Micron it was not willing to work with or even communicate with Imagine. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 55:9–56:5; Dkt. No. 321(Amended Billings Tr.) at 119:4–9. [redacted]

[redacted] Dkt. No. 321 (Amended Billings Tr.) at 120:1–12.

284. [redacted] Trial Tr. at 575:4–21 (Patrick Otte).

(d) St. Luke's Physician Acquisitions Cause Costly Gaps In Micron's Network

285. [redacted] Trial Tr. at 581: 3–582:2, 583:3–18 (Patrick Otte).

286. [redacted] Trial Tr. at 581:11–14 (Patrick Otte). [redacted] Trial Tr. at 582:11–583:1 (Patrick Otte). The loss of Boise Orthopedic created a serious disruption for Micron. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 135:10–23.

287. [redacted] Trial Tr. at 581:3–582:2, 583:3–18 (Patrick Otte). [redacted] Trial Tr. at 581:3–582:2 (Patrick Otte).

(e) St. Luke's Acquisition of Saltzer is a "Shockwave" for Micron, and Micron Has Put Its Health Plan on Hold

288. [redacted] Trial Tr. at 592:5–8 (Patrick Otte) (emphasis added).

289. [redacted] Trial Tr. at 592:1–4 (Patrick Otte). Saltzer was initially out-of-network but became an in-network, PPO-tier provider in 2011 when it joined the Saint Al's Advantage Care Network ("ACN"). Trial Tr. at 594:6–13 (Patrick Otte). So Micron employees currently have access to Saltzer as a PPO provider. Trial Tr. at 585:20–22 (Patrick Otte).

290. [redacted] Trial Tr. at 586:8–18 (Patrick Otte).

291. [redacted] Trial Tr. at 591:2–8 (Patrick Otte). [redacted] Trial Tr. at 592:9–19 (Patrick Otte). As Professor Dranove explained, this fact shows that the Acquisition could be "game changing in terms of how employers think about their networks going forward." Trial Tr. at 3433:10–13 (David Dranove).

292. If the Acquisition caused Micron to change course, it could also have significant consequences for Micron and the local economy. [redacted] Trial Tr. at 578:4–9 (Patrick Otte).

(f) Micron's Success With A Narrow Network Is Unlikely To Be Replicated, Especially As St. Luke's Continues To Gain Market Power

293. For Micron, St. Luke's tactics always evoked the word "**bully**." Trial Tr. at 573:15–16 (Patrick Otte) (emphasis added).

294. Imagine Health has faced large challenges trying to lease the Micron network to other employers in the Treasure Valley. Elsewhere, Imagine Health has successfully offered networks for multiple self-funded employers in San Antonio, Texas and Albuquerque, New Mexico. It has recently developed networks in Chicago, Illinois, Houston, Texas, and Dallas, Texas. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 18:20–25, 19:3–24.

295. Imagine tried to bring other employers into its Boise area network, meeting with brokers in the community to show them Imagine's model and the results for Micron. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 57:8–25. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 58:1–23, 121:21–122:24. [redacted] Dkt. No. 318 (Butterbaugh) at 122:4–24, 123:7–24.

296. [redacted] Dkt. No. 318 (Butterbaugh) at 136:6–12.

297. In no other market has Imagine Health experienced the kind of disruptions like it has experienced in Boise with St. Luke's. Dkt. No. 318 (Butterbaugh) at 151:20–152:8.

298. St. Luke's is determined not to allow Imagine's success with Micron to spread. As Steven Drake, St. Luke's Director of Payer Contracting, explained, he was concerned that if Imagine continued to be successful, it would enlist other Boise-area employers, taking even more volume from St. Luke's and putting it into an aggressive bidding situation. Dkt. No. 322 (Drake Dep. Tr.) at. 218:23–219:3, 219:5–7.

299. Nevertheless, Dr. Argue has tried to draw analogies to other employers with narrow networks, but the employers he identified provide little support for his conclusions. Dr. Argue also acknowledged that few employers have followed Micron's example by pursuing "narrow" or "directed benefits" networks. *See* Trial Tr. at 3053:2–3054:3 (David Argue). For example, among the handful of employers he identified, Dr. Argue admitted that two of those examples—Boise Schools and Idaho Power—actually discontinued their directed benefits program. Trial Tr. at 3053:2–3054:3 (David Argue). Dr. Argue also did not know whether Paul's Market has had more than one claim under its contract or how small Thomas Cuisine is. Trial Tr. at 3052:25–3053:12 (David Argue). Dr. Argue also admitted that Woodgrain has a wide (rather than narrow) physician network through IPN, unlike Micron. Trial Tr. at 3053:21–25 (David Argue). And Dr. Argue acknowledged that Walmart just started its program in 2013, five years after Micron launched its network. Trial Tr. at 3055:3–8 (David Argue).

300. Importantly, Dr. Argue admitted that he does not "know what [other] employers are going to do in the future" or "what they will want to do" concerning narrow networks like Micron's. Trial Tr. at 3054:4–13 (David Argue). As Dr. Argue put it, "I can't read their minds." Trial Tr. at 3054:9–13 (David Argue). And he does not know if it will take five or ten more

years or even longer, if ever, until a substantial number of Treasure Valley employees will be covered by tiered plans or narrow networks. Trial Tr. at 3055:9–14 (David Argue).

f) The Acquisition Will Likely Increase Healthcare Costs For Local Employers And Consumers

301. The Acquisition substantially lessens competition among PCPs in Nampa, even if the number of large hospital systems in the Treasure Valley remains the same. Trial Tr. at 3423:21–3424:13 (David Dranove).

302. Likewise, although some of the larger health plans may have a certain degree of negotiating leverage with St. Luke's, that leverage is the same before and after the Acquisition. By increasing St. Luke's relative leverage, the Acquisition will lead to higher reimbursements. Trial Tr. at 3425:4–3426:3 (David Dranove).

303. If providers gain leverage and negotiate higher reimbursements, health plans will pay more, and the plans will pass that increase along to their customers in the form of higher premiums, lower wages, and higher out-of-pocket costs. Trial Tr. at 1309:12–1310:2 (David Dranove).

304. [redacted] Dkt. No. 271 (Reiboldt Dep. Tr.) at 136:7–137:11; TX 1160 at COKER0009508. [redacted] TX 1262 at 7.

305. Even before St. Luke's acquired Saltzer, Boise-area employers were concerned that "St. Luke's acquisition of numerous practices" would lead to "St. Luke's having a monopoly and raising prices." Dkt. No. 267 (House Dep. Tr.) at 49:10–50:18.

306. As Ms. House wrote in a January 2011 internal email to John Kee and other senior St. Luke's executives, "employers are expressing their concerns regarding St. Luke's acquisitions of numerous practices. It seems there is some concern over St. Luke's having a monopoly and raising prices." TX 1164 at SLHS001053775.

307. [redacted] *See* Trial Tr. at 311:20–312:14 (Jeff Crouch).

g) Market Dynamics Will Not Constrain St. Luke's Exercise Of Market Power

(1) Other Providers and Large Health Plans Will Not Counteract The Acquisition's Harm To Competition And Consumers

308. Defendants contend that two hospital systems would provide enough competition. However, their expert, Dr. Argue, admitted that a market consisting only of two competitors would involve an HHI of at least 5,000, double the level at which market power is presumed. Trial Tr. at 3048:14–3049:18 (David Argue). Moreover, the Acquisition substantially lessens competition among PCPs in Nampa, even if the number of large hospital systems in the Treasure Valley remains the same. Trial Tr. at 3423:21–3424:13 (David Dranove).

309. Likewise, although some of the larger health plans may have a certain degree of negotiating leverage with St. Luke's, that leverage is the same before and after the Acquisition. By increasing St. Luke's relative leverage, the Acquisition will lead to higher reimbursements. Trial Tr. at 3425:4–3426:3 (David Dranove).

310. If providers gain leverage and negotiate higher reimbursements, health plans will pay more, and the plans will pass that increase along to their customers in the form of higher

premiums, lower wages, and higher out-of-pocket costs. Trial Tr. at 1309:12–1310:2 (David Dranove).

(2) Dr. Argue's Critical Loss Analysis Is Inappropriate, Incomplete, And Incorrect

(a) Critical Loss Is Inappropriate For Analyzing Competition In Healthcare Provider Markets

311. As noted above, reimbursements in healthcare markets are determined through Stage 1 negotiations between payers and providers, and patients do not respond to small changes in price. Trial Tr. at 1303:14–20, 3436:12–3437:3 (David Dranove).

312. Critical loss analysis is predicated on the idea that patients are sensitive to small differences in price, which in healthcare markets is contradicted by theory, experience, and common sense. Trial Tr. at 3421:13–3423:3 (David Dranove).

313. Insured patients are insulated against price changes paid by health plans to providers. Trial Tr. at 3422:1–3 (David Dranove).

314. For some insurers, including the two largest in Idaho, BCI and Regence, patients face no differences in the price they face for physician services. Trial Tr. at 3445:5–3446:1 (David Dranove).

315. Indeed, Dr. Argue admitted that patients of BCI and Regence do not choose physicians on the basis of price differences. Trial Tr. at 3031:20–3032:16 (David Argue); *see also* [redacted]. As a result, Dr. Argue cannot identify "any evidence" that the BCI and Regence patients travel for PCP services because of price. Trial Tr. at 3032:17–24 (David Argue).

316. Reimbursements for healthcare services are not transparent, making it difficult for patients to comparison shop on the basis of price. Trial Tr. at 3422:4–9 (David Dranove).

317. Patients often make their healthcare decisions under duress, such as when they are sick or injured, further reducing the likelihood that small differences in price will influence their decision-making. Trial Tr. at 3422:10–16 (David Dranove).

318. Indeed, Dr. Argue could not identify any other litigated case involving a physician acquisition where critical loss was used to establish a geographic market. Trial Tr. at 3037:21–25 (David Argue).

(b) Dr. Argue Did Not Perform A Complete Critical Loss Analysis

319. Dr. Argue did not perform a complete critical loss analysis under the *Merger Guidelines*, as he failed to calculate the "actual loss" that is necessary to compare to the critical loss. Trial Tr. at 3437:4–3438:3 (David Dranove). A complete critical loss analysis first must calculate the "critical loss," which is "the percentage of patients that [a provider] would have to lose to make a particular price increase unprofitable." Trial Tr. at 3437:12–15 (David Dranove). Second, one must calculate the "actual loss," which is "how many patients will [the provider] actually lose if [it] raise[s its] price by that amount." Trial Tr. at 3437:16–18 (David Dranove). If the "actual loss" exceeds the "critical loss, so the theory goes, [the provider] would not increase price because that price increase would be unprofitable." Trial Tr. at 3437:18–21 (David Dranove).

320. Dr. Argue acknowledged that in order to perform a complete critical loss analysis, one needs "to be able to understand what the balance is between the critical loss and the actual loss." Trial Tr. at 3030:16–20 (David Argue). But Dr. Argue admitted that "there is no way to put your finger on a specific number" for the actual loss in this case. Trial Tr. at 3031:2–8, 3037:11–12 (David Argue). And on its own, the "critical loss" calculation is—to use Dr. Argue's words—"just a number." Trial Tr. at 3037:13–16 (David Argue).

321. As a result, Dr. Argue has not provided a "methodology to examine . . . what [the] actual loss would be and determine whether Dr. Argue's claim that the actual loss exceeds the critical loss is correct." Trial Tr. at 3437:22–3438:1 (David Dranove). As Professor Dranove explained, "we don't know what [Dr. Argue] believes the actual loss is or how he has calculated it." Trial Tr. at 3438:1–3 (David Dranove).

(c) Dr. Argue's Assumptions Underlying His Critical Loss Analysis Are Flawed And Lead To Artificially Low Critical Loss Estimates

322. Dr. Argue also made unrealistic assumptions about variable costs, particularly for the most important component of his critical loss calculation: variable costs for physician services. Trial Tr. at 3438:17-3441:4 (David Dranove).

323. Based on criticisms outlined in Professor Dranove's reply report, Dr. Argue realized that he had not been "thorough enough" in his critical loss calculations, and decided that he should go back and revise his assumptions. Trial Tr. at 3034:8-3035:19 (David Argue).

324. For this revised analysis set forth in his surrebutal report, Dr. Argue relied on some interviews and a worksheet provided by St. Luke's Joni Stright. But other than his general experience and some articles, Dr. Argue did not review any evidence to substantiate the information provided by Ms. Stright. Trial Tr. at 3036:3-18 (David Argue).

325. And Dr. Argue admitted that his surrebutal report contained another analysis – responding to a different aspect of Professor Dranove's reply report – that "appeared to be wrong." Trial Tr. at 3041:6-19 (David Argue). At trial, he could not offer any explanation for this apparent error. *Id.*

326. Importantly, Dr. Argue's critical loss threshold is highly sensitive to small changes in his assumptions. Revisions he made in response to Professor Dranove's criticisms raised the critical loss threshold by approximately 30 percent. Trial Tr. at 3441:11-3442:3

(David Dranove); *see also* Trial Tr. at 3035:8-14 (David Argue) ("Well, I was concerned that maybe I had been not thorough enough in relying on the interview entirely in the first place. So, I went back and looked at it and agreed that he is right, I should have gotten the detailed numbers there to prove up what I was relying on.").

(d) Even If Dr. Argue's Critical Loss Analysis Were Appropriate For Analyzing Healthcare Competition, And Even If Dr. Argue Had Performed A Complete Critical Loss Analysis, And Even If Dr. Argue's Critical Loss Calculations Were Correct, The Evidence Does Not Support His Conclusions

327. In any event, the evidence does not support Dr. Argue's conclusion that the actual loss would be higher than the 8.8 percent threshold he calculated for a 5 percent price increase, as patients simply do not respond in large numbers to small differences in price. Trial Tr. at 3442:4-3443:21 (David Dranove).

328. For some insurers, including the two largest in Idaho (BCI and Regence), patients face no differences in price for physician services. Because only a small fraction of patients are price sensitive, a very large percentage of those price-sensitive patients would have to switch providers to make a price increase unprofitable. Trial Tr. at 3445:5-3446:1 (David Dranove).

329. On direct examination, Dr. Argue asserted that if ten percent of the Blue Cross membership were price sensitive, that would be a "very significant number relative to the critical loss." Trial Tr. at 2962:10-16 (David Argue). But Dr. Argue admitted on cross-examination that for his 8.8 percent critical loss threshold to be met, **88 percent** of those price sensitive patients would have to switch providers in response to a 5 percent price increase for that increase to be unprofitable. Trial Tr. at 3052:1-24 (David Argue).

330. Dr. Argue relies extensively on the Micron experience, but as noted above, Micron patients face financial incentives that vastly exceed the five to ten percent price increases Dr. Argue used for his critical loss analysis. Trial Tr. at 3444:16-3445:4 (David Dranove).

331. Dr. Argue also cited several surveys as purported evidence that patients are willing to switch providers, but none of these surveys show that a sufficiently large number of patients will switch providers in response to a *small difference in price*. The Deloitte survey cited by Dr. Argue, for example, actually shows that only a small percentage of patients (13 percent) switched providers for any reason, and only a fraction (6-8 percent) of that 13 percent changed providers because of price—i.e., approximately **one percent** of patients switched PCPs because of price. Trial Tr. at 3446:2-3447:23 (David Dranove).

C. DEFENDANTS HAVE NOT OVERCOME THE STRONG PRESUMPTION AND ADDITIONAL EVIDENCE OF ANTICOMPETITIVE EFFECTS

1. Defendants' Purported Efficiencies Are Not Verifiable Or Merger-Specific

a) Defendants' Efficiencies Claims Are Speculative And Not Verifiable

(1) Employing Physicians Provides No Greater Measurable Benefits (e.g., higher quality, lower costs) Than Other Affiliations

332. Like the majority of U.S. healthcare systems, St. Luke's aspires to achieve the "Triple Aim": higher quality of care; lower cost care; and better population health. *See* Trial Tr. at 3523:4-17 (Kenneth Kizer). But to achieve that goal, St. Luke's has a "long and complicated path before it." Trial Tr. at 2686:24-2687:2 (Alain Enthoven). As St. Luke's efficiencies expert—Professor Enthoven—acknowledged, "others who have tried to take this perilous route have tripped and fallen." Trial Tr. at 2687:3-8 (Alain Enthoven). And even assuming

counterfactually that this Acquisition will result in efficiencies, Professor Enthoven admitted that they will not occur for at least a decade or more. Trial Tr. at 2687: 9-11 (Alain Enthoven).

333. In pursuit of the "Triple Aim," St. Luke's has acquired many independent physician practice groups across Idaho. *See infra* Section IV.B.4. Defendants assert that employment of physician practices yields greater benefits of integrated care than other affiliation models. But that assertion is unsupported by empirical or experiential evidence. Indeed, employment has not been shown to be a superior organizational structure. Trial Tr. at 3525:4-7 (Kenneth Kizer).

334. The research literature on financial integration in healthcare does not provide reliable evidence that employment of physicians will generate measureable benefits—to use Professor Dranove's phrase, this research in this area is "unambiguously ambiguous." Trial Tr. at 1364:10-13, 3460:25-3461:18 (David Dranove).

335. Both theory and economic evidence are mixed about vertical integration (i.e., hospital and physician integration) in healthcare: it might sometimes lead to efficiencies that could get passed on to consumers, might sometimes fail to lead to efficiencies, might sometimes lead to higher costs and higher prices that also get passed on to consumers in a harmful way. Trial Tr. at 1363:25-1364:13 (David Dranove).

336. As such, anyone who looks at the literature on vertical integration in healthcare and says they know what the outcome will be is engaged in "wishful thinking." Trial Tr. at 1364:18-21 (David Dranove).

337. In the 1990s, integration was "all the rage," and integrating provider organizations were given a "pass" with the "view that integration was a panacea." Trial Tr. at 1430:24-1431:5 (David Dranove). As a result, a "substantial number of mergers" were approved by courts, and

research studies have now shown those mergers to have produced "higher healthcare spending without offsetting benefits." Trial Tr. at 1431:6-9 (David Dranove). Here, "there is this notion of déjà vu; we have been here before." Trial Tr. at 1431:10-18 (David Dranove).

338. The Allegheny Health Education and Research Foundation, for example, was a very large integrated system that was formed through numerous healthcare acquisitions in Pennsylvania in the 1990s. That health system became what was at the time the largest nonprofit bankruptcy in U.S. history. Trial Tr. at 1445:20-1446:6 (David Dranove).

339. Nevertheless, Defendants' primary efficiencies expert—Professor Alain Enthoven—cited several studies during his trial testimony that purportedly support his opinion that fully financially integrated systems provide the greatest benefits of integrated care. Closer examination of those studies, however, reveals that they do not support Professor Enthoven's conclusions.

340. First, for example, Professor Enthoven relied upon the Gillies study, but that study stated "[t]hese findings should be considered as exploratory, providing information for further research." Trial Tr. at 2668:23-2669:3 (Alain Enthoven). And one of the primary authors of the Gillies study has expressed concern that healthcare provider mergers may entrench dominant providers with significant market power. Trial Tr. at 3462:22-3464:19 (David Dranove).

341. Second, Professor Enthoven relied on the Casalino study, which states "**gaining negotiating leverage with health insurance plans** was the most frequently cited benefit from being in a large medical group practice." Trial Tr. at 2671:9-16 (Alain Enthoven) (emphasis added).

342. Third, Professor Enthoven relied on the Berkeley Forum, which expresses a concern that provider consolidation and integration may threaten the competitive market. The article also states that even in a market with many providers, some providers may be able to set higher prices depending on their reputation for quality and their position within an insurer's contractual networks. Trial Tr. at 2674:24-2675:5 (Alain Enthoven). And the Berkeley Form points out that "one study examining the repeat trend towards more physician employment by hospitals showed that although there may be improvement in clinical integration and care coordination, the cost of that care may increase." Trial Tr. at 2675:14-21 (Alain Enthoven). Moreover, the article found that consolidation of individual physician practices can also potentially lead to higher prices as larger physician groups with added bargaining power can negotiate for higher capitation rates. Trial Tr. at 2676:6-11 (Alain Enthoven).

343. And fourth, Professor Enthoven was unaware of any studies with statistically significant results relating to quality of care or cost comparing employed physician groups to other affiliation forms. *See* Trial Tr. at 2665:15-2666:23 (Alain Enthoven).

344. To the contrary, a 2013 study—McWilliams et al,—found that independent physician groups provided higher quality, lower cost care compared to physicians employed by hospitals. Trial Tr. at 3535:24-3536:7 (Kenneth Kizer).

345. If anything, the literature on integrated care in recent years shows that there are a number of key organizational functionalities—not the organizational structure or form—that are important to providing integrated care. Trial Tr. at 3524:23-3525:12 (Kenneth Kizer). Indeed, employment of physicians does not automatically lead to more integrated care. Trial Tr. at 3527:12-15 (Kenneth Kizer).

346. In recent literature, evidence suggests that integrated delivery systems ("IDSs") may produce high quality, lower cost care. But this research does not support the claim that hospitals must employ physician to forms IDSs. There are many different models and governance structures that qualify as IDSs. Trial Tr. at 3528:12-22 (Kenneth Kizer). That is, IDSs come in lots of different shapes and sizes. Trial Tr. at 3535:12-22 (Kenneth Kizer). *See also* Trial Tr. at 2575:16-19 (Alain Enthoven).

347. Indeed, there are many ways of achieving the benefits of integrated care. Trial Tr. at 3534:19-24 (Kenneth Kizer); Trial Tr. at 2291:7-15; 2293:14-2294:1 (Richard Armstrong).

348. In fact, two of the systems highlighted during the trial—Advocate Health System in Illinois and Intermountain Healthcare in Utah—actually illustrate how IDSs can work effectively with independent physicians. Advocate Health System is an example of an IDS that provides integrated care—high quality, low cost care. *See* Trial Tr. at 3531:12-18 (Kenneth Kizer). Under Advocate's Physician Hospital Organization model, it achieves the benefits of integrated care by working closely with mostly independent physicians and a relatively small number of employed physicians. Trial Tr. at 3531:12-18 (Kenneth Kizer); *see also* Trial Tr. 1370:15-1371:10 (David Dranove). Moreover, Intermountain Healthcare is another example of a successful IDS that utilizes a "mixed-model" organizational strategy— i.e., working closely with employed and independent physicians. Trial Tr. at 3531:19-23 (Kenneth Kizer).

349. Notably, however, IDSs do not automatically produce integrated patient care. For example, the VA healthcare system—a fully-financially integrated delivery system that employed all of its physicians—was providing "less than ideal quality of care, costs were increasing rapidly, and care was highly fragmented." Trial Tr. at 3525:18-3526:14 (Kenneth Kizer).

350. In short, employing physicians is neither necessary nor sufficient to providing integrated care. As illustrated by the VA healthcare system, one cannot equate any particular organizational form—particularly physician employment—with providing integrated care. Trial Tr. at 3526:15-3527:4 (Kenneth Kizer).

351. Dr. Brent James, Chief Quality Officer of Intermountain Healthcare (which owns SelectHealth), explained that Intermountain's success hinged on its work with independent physicians:

> The majority of the physicians involved in executing Intermountain's key clinical processes are independent, community-based practitioners. This protected Intermountain from a classic blunder: We didn't try to control physicians' practice behavior by top-down command and control through an employment relationship. Instead, we relied on solid process and outcome data, professional values that focused on patients' needs, and a shared culture of high quality.

Trial Tr. 1772:24–1773:2, 1774:8–1775:16 (Patricia Richards); TX 3040 at 1189.

352. Professor Enthoven relies heavily on the single example of Kaiser Permanente, but has failed to show that this unique experience can be generalized to other systems or that Kaiser's success is driven by its employment model. Kaiser is successful in part because its physicians have a different mindset and practice medicine in a different way, not because they are employed by Kaiser. Trial Tr. at 1433:1-17 (David Dranove). Notably, there is no legal or contractual requirement for exclusivity between the Kaiser Permanente physician group and the Kaiser hospitals. Trial Tr. at 2658:2-5 (Alain Enthoven). Kaiser's success is unlikely to be replicated. Indeed, Kaiser tried to move out of the West Coast, it was not as successful. Trial Tr. at 1433:10-1434:2 (David Dranove).

(a) No Evidence Of Cost Savings Or Quality Improvements From This Transaction Or Prior Physician Group Acquisitions

- **No Evidence Of Quality Or Cost Improvements From St. Luke's Prior Acquisitions**

353. St. Luke's has acquired numerous PCP practices over the past several years, but they have been unable to identify measureable cost or quality improvements from these acquisitions. In fact, St. Luke's efficiencies expert, Professor Enthoven, acknowledged that he has no opinion as to whether St. Luke's past acquisitions have improved quality or cost. Trial Tr. at 2687:12-15 (Alain Enthoven). Nevertheless, St. Luke's has asserted that its prior physician group acquisitions have lowered the overall spending for healthcare services rendered to patients under St. Luke's care. Trial Tr. at 1364:22-13:65:8 (David Dranove).

354. To test this assertion, Professor Dranove performed an economic study known as "difference-in-differences" analysis to determine whether St. Luke's past acquisitions of PCPs have in fact led to reduced total healthcare spending for patients who are being managed by those acquired physicians, as St. Luke's and its experts claim. Trial Tr. at 1365:2-1366:15 (David Dranove); *see also* Trial Tr. at 1428:5-12 (David Dranove).

355. To examine this issue, Professor Dranove analyzed the data in a number of different ways. Regardless of the statistical approach he took, Professor Dranove found no evidence that the healthcare expenditures for patients whose doctors were acquired by St. Luke's were lower than healthcare expenditures for patients whose doctors had not been acquired by St. Luke's. Trial Tr. at 1366:16-1367:10 (David Dranove); *see also* TX 1819.

356. The differences-in-differences analysis showed that prior acquisitions of PCPs did not seem to be associated with a reduction in total healthcare expenditures. Trial Tr. at 1444:18-1445:2 (David Dranove).

357. If St. Luke's had generated meaningful reductions in utilization without offsetting increases in prices, Professor Dranove's difference-in-differences analysis would have reflected that change as a reduction in overall expenditures. Trial Tr. at 1445:13–19 (David Dranove).

358. In other words, no systematic evidence exists that St. Luke's prior vertical integration efforts have led to lower spending for the patients of St. Luke's PCPs. Trial Tr. at 1366:16–1367:10 (David Dranove).

359. Defendants have offered no contrary evidence in rebuttal to Professor Dranove's difference-in-differences analysis.

360. In contrast, Defendants' economic expert, Dr. Argue, has not even attempted to measure the purported efficiencies from this Acquisition, let alone measure the efficiencies from St. Luke's prior acquisitions. Trial Tr. at 3027:24–3028:1 (David Argue).

361. Dr. Argue acknowledged that St. Luke's began acquiring physician practices in 2007. Trial Tr. at 3076:17–19 (David Argue). Despite this lengthy track record of acquiring physician practices, he could not identify "any specific quality improvements" relating to St. Luke's previous acquisitions. Trial Tr. at 3028:11–18 (David Argue).

362. In fact, in 2011 St. Luke's Chief Operating Officer noted that St. Luke's Health Grades report showed that much of St. Luke's performance was average, and it was losing ground relative to quality improvements achieved by other hospitals. Dkt. No. 284 (Moore Dep. Tr.) at 30:21–31:18; TX 1973 at SLHS001189489.

363. Furthermore, Dr. Argue has not performed a systematic evaluation of whether St. Luke's prior acquisitions have improved quality, reduced cost, or reduced utilization. Trial Tr. at 3028:19–3029:3 (David Argue). In fact, Dr. Argue has not been able to quantify "any benefits" from St. Luke's previous physician group acquisitions. Trial Tr. at 3029:4–8 (David Argue).

- **No Evidence That This Acquisition Will Lead To Efficiencies**

364. Peter LaFleur, St. Luke's consultant for the Saltzer acquisition, told Nancy Powell that he was having a hard time finding any efficiencies that Saltzer would gain from the

acquisition. Instead, he told her that Saltzer was a very lean and efficient organization. Trial Tr. at 742:2–14 (Nancy Powell).

365. Moreover, another St. Luke's consultant hired to analyze capacity needs projected that St. Luke's will not achieve significant reductions in inpatient hospital costs—*i.e.*, number of admissions or average length of stay. Dkt. No. 286 (Roth Dep. Tr.) at 156:12–25, 157:15–23, 158:8–159:5, 164:18–165:8, 167:8–168:7; TX 1079 at SLHS000783019, 16; TX 1057 at SLHS000920868; TX 1083 at SLHS000892216; Trial Tr. at 1716:12–20 (David Pate).

- **The Acquisition Is Not Motivated By Quality Improvements**

366. Although Defendants claimed at trial that the Acquisition was motivated by the desire to pursue the "Triple Aim," the evidence suggests otherwise.

367. As a St. Luke's Board Member put it:

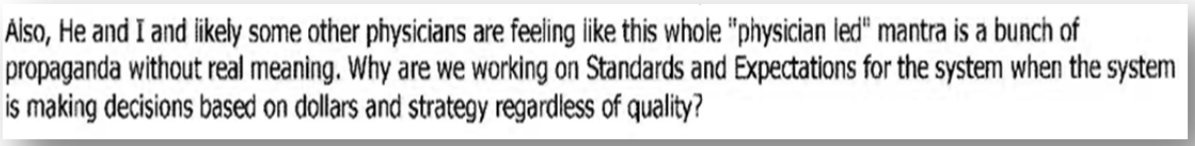
> Better cost is a worthy goal and I totally back that. I also understand market forces involved. But- let's be realistic. Employing physicians is not achieving better cost, it's achieving better profit.

TX 1052 at SLHS000054078.

368. During the negotiations with St. Luke's, there was no discussion about the ability of the Acquisition to improve the quality of care delivered by Saltzer. Trial Tr. at 2493:20–24 (Steven Williams).

369. The primary focus of the discussions about the Acquisition was on revenue, namely, what the differences could be "for primary care to increase the revenue" and what the future would be with a new St. Luke's hospital in Nampa. Trial Tr. at 2493:25–2494:8 (Steven Williams).

370. In fact, several St. Luke's employed physicians, including Dr. Souza, expressed concern regarding the motives of the Acquisition writing in an e-mail to St. Luke's COO:


Also, He and I and likely some other physicians are feeling like this whole "physician led" mantra is a bunch of propaganda without real meaning. Why are we working on Standards and Expectations for the system when the system is making decisions based on dollars and strategy regardless of quality?

TX 1136 at SLHS0000004617.

(2) Defendants' "Core" Theory Is "Unsupported" And Therefore Cannot Be Verified

371. Defendants admit that St. Luke's cannot employ every physician in the Treasure Valley and must work effectively with independent physicians. But they have asserted a novel theory that a "core" of employed physicians is necessary to provide the full benefits of integrated care. Dkt. No. 194 (Defendants' Pretrial Memorandum) at 18. But as Professor Enthoven admitted, the "core theory" is "**a judgment out of unsupported opinion**." Trial Tr. at 2737:8–16 (Alain Enthoven) (emphasis added); Trial Tr. at 3538:5–14 (Kenneth Kizer). Indeed, Defendants' "core" theory is just that, a theory. Trial Tr. at 3522:10–14 (Kenneth Kizer). Notably, Dr. Kizer is unaware of *any* study that supports the "core" theory. Trial Tr. at 3539:2–6 (Kenneth Kizer) (emphasis added).

372. It also is unclear how many physicians are necessary to satisfy the "core" theory espoused by Professor Enthoven and others at St. Luke's. Trial Tr. at 3538:5–18 (Kenneth Kizer).

373. Professor Enthoven does not even know how many physicians are needed to satisfy his "core" theory, asserting that it "depends on the circumstances." *See* Trial Tr. at 2737:17–21 (Alain Enthoven).

374. At trial Professor Enthoven could not provide a consistent answer with respect to his "core" theory. Indeed, he sought to change his "core" theory from four to six physicians in each specialty, he could not identify a specific number for Canyon County, initially estimating "30 or 40—say 30 primary care docs on the payroll, on the salary, to carry out the kinds of functions that I described." Trial Tr. at 2736:10–2737:2 (Alain Enthoven). But Professor Enthoven was also unable to specify the appropriate number of independent physicians, and then asserted that "the employed needs to be substantial . . . . And all I can say is it's a judgment out of unsupported opinion, but you've got to have something like 30 or something to be able to interact and be a force for innovation and improvement." Trial Tr. at 2737:8–16 (Alain Enthoven).

375. St. Luke's executives also have claimed that the system needs a "core" group of employed physicians. But St. Luke's CEO—Dr. Pate—admits that he is unaware of anyone at St. Luke's having quantified the number of physicians that would need to be in that core group. Trial Tr. at 1690:23–1691:8 (David Pate). Likewise, St. Luke's Vice President of Clinical Integration, John Kee, does not know how many employed physicians would be needed to satisfy St. Luke's "core" theory. Dkt. No. 254 (Swanson Dep. Tr.) at 115:1–16, 116:25–117:6.

376. St. Luke's also has not identified the appropriate "critical mass" of providers that it believes is necessary to deliver managed care. Dkt. No. 254 (Swanson Dep. Tr.) at 69:11–18, 71:10–15; *see also* TX 1956 at SLHS0000012710; TX 1097 at SLHS000921034.

377. Despite St. Luke's heavy reliance on purported quality improvements and clinical integration benefits from the Acquisition, St. Luke's did not call as live witnesses either its Chief Quality Officer, Dr. Barton Hill, or its Vice President of Clinical Integration, Dr. Geoffrey Swanson.

(3) Purported Benefits To Saltzer From Using St. Luke's Health IT Tools Are Speculative

- **St. Luke's Has Not Fully Implemented Epic And Will Not Do So For Several Years**

378. One of Defendants most prominent efficiencies claims is that the Acquisition will provide Saltzer with access to St. Luke's health IT tools, like its EMR system. For example, Defendants assert that Saltzer using St. Luke's Epic system will yield greater benefits to Saltzer physicians and patients than using eClinicalWorks. But St. Luke's has not even fully implemented its Epic EMR system across the vast majority of settings within the St. Luke's Health System. Trial Tr. at 2825:17–19 (Marc Chasin).

379. Although St. Luke's has implemented the ambulatory components of the Epic system in the Treasure Valley, it has not yet implemented any of the inpatient components, such as the emergency department, nursing documentation, perioperative, the obstetrical unit, anesthesia, home health, interventional cardiology, and medical oncology. Trial Tr. 2826:8–2827:8 (Marc Chasin); Trial Tr. at 1919:4–6 (John Kee); Trial Tr. at 2334:23–25 (Christopher Roth).

380. St. Luke's hopes to complete implementation for most (but not all) of these inpatient components by September or November of 2015, but Dr. Chasin—St. Luke's Chief Information Officer—is not sure whether this target date will be met. Trial Tr. at 2827:9–21 (Marc Chasin). In fact, some of St. Luke's critical care units, including Dr. Souza's group, do not use EMR at all, still relying on paper records. Trial Tr. at 2335:8–17, 2336:8–14 (Christopher Roth).

381. St. Luke's also uses Centricity, Soarian, and other EMR systems, just in the Treasure Valley. Trial Tr. 2335:18–2336:5 (Christopher Roth).

382. And in Twin Falls, St. Luke's uses a different system for its ambulatory EMR (Centricity), and yet another system for its inpatient EMR. Trial Tr. at 2828:13–20 (Marc Chasin); Trial Tr. at 2125:3–8 (Brian Fortuin).

383. St. Luke's does not have a target date for implementing Epic in its Twin Falls facilities, and the money to do so has not yet been budgeted. As a result, Dr. Chasin expects that St. Luke's will not implement Epic in Twin Falls until some point later than 2017. Trial. Tr. at 2827:22–2829:22 (Marc Chasin). Indeed, Twin Falls was "chosen last" because "the physicians prior to the St. Luke's merger had already put significant time and energy into the Centricity product . . . , and it just made sense to let that system that was more mature stand as the last one we converted." Trial Tr. at 1919:13–19 (John Kee). Even if access to a single, system-wide EMR system were a cognizable efficiency, St. Luke's has admitted that this goal cannot possibly be accomplished until 2017 at the very earliest. *See* Trial. Tr. at 2827:22–2829:22 (Marc Chasin).

- **Defendants Have Not Identified Any Measurable Benefits To Putting Saltzer on Epic**

384. Defendants cannot point to any quantifiable or measureable benefits from Saltzer switching from eClinicalWorks to Epic. Trial Tr. at 3044:7–10 (David Argue); *see also* Trial Tr. at 2687:16–20 (Alain Enthoven); Trial Tr. 3027:24–3028:1 (David Argue).

385. Prior to the Acquisition, Saltzer's use of eClinicalWorks satisfied the federal government's "Meaningful Use" requirements. Trial Tr. at 3375:19–23 (Harold Kunz).

386. In fact, Saltzer went to an EMR system back in 2003, well before St. Luke's did. Tr. at 743:6–11 (Nancy Powell). Saltzer originally had used the Amicore EMR system, with which the physicians were not completely happy. So Saltzer switched to eClinicalWorks, a

nationally recognized product, and the physicians were very happy with it compared with what they had before. Trial Tr. at 2473:25–2474:17 (Steven Williams).

387. Saltzer subsequently adopted eClinicalWorks as its EMR system, which was the same system that had been adopted by St. Luke's physician offices, Primary Health Medical Group, and the Mercy Physician Group followed. Trial Tr. at 742:21–743:5 (Nancy Powell).

388. According to Nancy Powell, Saltzer physicians generally expressed mostly satisfaction with eClinicalWorks. Trial Tr. at 742:15–20 (Nancy Powell). Indeed, Saltzer believes its eClinicalWorks EMR system was "state-of-art" when it purchased the system. Trial Tr. at 3376:17–20 (Harold Kunz). And Saltzer advertises its use of eClinicalWorks on its website. Trial Tr. at 3377:3–5 (Harold Kunz).

389. Moreover, a number of significant groups in the Treasure Valley, including Primary Health and Idaho Physical Medicine and Rehabilitation, use eClinicalWorks. Trial Tr. at 2092:21–2093:4 (James Souza); Trial Tr. at 742:21–743:5 (Nancy Powell). And Dr. Souza would not be surprised if 80,000 physicians throughout the United States currently used eClinicalWorks. Trial Tr. at 2093:8–15 (James Souza).

390. Saltzer's IT Committee has not undertaken any comparison between eClinicalWorks and Epic. Dkt. No. 269 (Djernes Dep. Tr.) at 78:20–23. In addition, neither of Defendants' experts have attempted to measure or quantify the purported benefits of using Epic compared to eClinicalWorks. *See* Trial Tr. at 3044:7–10 (David Argue); Trial Tr. 2702:1–2703:25 (Alain Enthoven).

391. Although Dr. Souza testified that using eClinicalWorks was analogous to practicing "horse and buggy medicine," he admitted that he had "no idea what eClinicalWorks does today." Trial Tr. at 2043:24–2044:7, 2098:9–15 (James Souza). Indeed, Dr. Souza had not

used eClinicalWorks since June 2012 and was unaware of the current version's functionalities. Trial Tr. at 2095:2–6 (James Souza). For example, Dr. Souza was unaware that the current version of eClinicalWorks has an automated process that sends patient care information and test results automatically to the primary care physician. Trial Tr. at 2095:2–6, 2096:11–14 (James Souza).

392. There also is no current plan to switch Saltzer from eClinicalWorks to Epic. Trial Tr. at 2830:8–14 (Marc Chasin). Because of St. Luke's representation to this Court during the preliminary injunction hearing, it is unable to currently switch Saltzer onto Epic. This Court's ruling on during the preliminary injunction hearing, however, did not preclude St. Luke's and Saltzer from devising a plan for switching Saltzer onto Epic if the Acquisition were approved by the Court. Dkt. No. 47 (Memorandum Decision and Order).

393. And a St. Luke's Administrator wrote that "Saltzer will stay on their eCW [eClinicalWorks] system for approx. two years." TX1660 at SLHS001368640.

394. Dr. Brian Fortuin also testified that the Centricity system allows him to deliver care in a manner consistent with the goals of the Triple Aim. Trial Tr. at 2125:9–2128:10 (Brian Fortuin).

- **Defendants Have Failed To Identify Verifiable Evidence Of WhiteCloud's Purported Benefits**

395. Defendants claim that the Saltzer physicians' use of the WhiteCloud data analytics tool will allow them to provide higher quality, lower cost care. But there is no evidence that Saltzer's use of WhiteCloud has or will positively impact the care that is being provided by the Saltzer physicians. Trial Tr. at 3558:5–11 (Kenneth Kizer).

396. Bob Lokken is the founder and CEO of WhiteCloud, and since approximately October 2012, Mr. Lokken has also been a member of the St. Luke's Health System Board of

Directors. Trial Tr. at 2010:3–13 (John Kee). Meanwhile, St. Luke's has invested approximately $14–15 million in Mr. Lokken's product thus far. Trial Tr. at 1940:24–1941:3 (John Kee). But as John Kee acknowledged, St. Luke's WhiteCloud tool remains a "work in progress." Trial Tr. at 2014:17–20 (John Kee).

397. As Mr. Kee testified, "all we have today is small sample groups. We don't have definitive, statistically significant data . . . ." Trial Tr. at 1939:8–10 (John Kee). And Mr. Kee could not say whether the data in the WhiteCloud tool was accurate. Trial Tr. at 2014:21–2015:2 (John Kee).

398. To do population health management, WhiteCloud exclusively relies on data from BCI's TrueBlue Medicare Advantage plan, which covers only Medicare patients who have chosen that plan. Trial Tr. at 2013:18–2014:1 (John Kee). The TrueBlue plan covers only "slightly more" than 4,000 patients for St. Luke's, while St. Luke's "probably" treats between 100,000 and 500,000 patients annually. Trial Tr. at 2014:2–16 (John Kee).

399. Meanwhile, other widely-used and proven data analytics tools engage in population health management by comparing not only individual healthcare systems' patients, but also other healthcare systems' patients as well. Trial Tr. at 3631:9–3632:25 (Robert Polk); *see also* Trial Tr. at 2015:3–7 (John Kee). In fact, the Explorys data analytics tool—that Saint Al's plans to use—engages in population health management by comparing over 35 million patients in its database. Trial Tr. at 3634:21–3635:4 (Robert Polk). Unlike WhiteCloud, Explorys is a proven data analytics tool which is currently being used by almost 300 hospitals around the United States. Trial Tr. at 3634:21–3635:4 (Robert Polk).

400. Mr. Kee, whom St. Luke's offered to testify at trial about the WhiteCloud tool, could not name any other health system—besides St. Luke's—that is currently using the

WhiteCloud tool for population health management or clinical improvement. Trial Tr. at 2010:14–17, 2011:6–9 (John Kee). Mr. Kee also did not know whether St. Luke's considered using any other data analytics tool aside from WhiteCloud. Trial Tr. at 2015:21–2016:9 (John Kee). And Mr. Kee has heard that other data analytics tools, such as Explorys, are able to pull data from other EMRs, although he does not understand the technology of it. Trial Tr. at 2017:12–16 (John Kee).

401. A key functionality of a data analytics tools is interoperability with multiple different databases, including claims payment databases, different electronic health record information, and pharmaceutical use data. Trial Tr. at 3556:9–21 (Kenneth Kizer). Although WhiteCloud is able to pull data from multiple platforms like Epic, Centricity, and eClinicalWorks, it appears cumbersome and costly to pull such data from their respective platforms. Trial Tr. at 2180:5–8 (Brian Fortuin); Trial Tr. at 1960:7–24 (John Kee). In contrast, other widely-used and proven data analytics tools, like Explorys, are seamlessly interoperable with multiple platforms. *See* Trial Tr. at 3630:19–3632:20 (Robert Polk).

(4) Defendants' Risk-Based Contracting Claims Are Speculative and Inconsistent With The Evidence

- **St. Luke's Will Be Unable To Engage In Risk-Based Contracting For Several Years**

402. In a fee-for-service system, providers are rewarded for doing more whether or not more leads to better outcomes. Trial Tr. at 2575:6–8 (Alain Enthoven). The fee-for-service payment model incentivizes costly, often wasteful services that are unsupported by evidence as the best course of treatment. Trial Tr. at 2572:9–21 (Alain Enthoven); *see also* Trial Tr. at 1829:6–10 (Marshall Priest). Indeed, payment-for-volume, not value or quality, does not align a physician's or hospital's financial rewards with successful outcomes for the patient at efficient costs. Trial Tr. at 2572:9–21, 2677:7–20 (Alain Enthoven).

403. In recognition of the incentives of fee-for-service payment, health systems and health plans across the United States are transitioning away from fee-for-service to value-based, pay-for-performance contracts. Dkt. No. 361 (Reider Dep. Tr.) at 104:12–16; *see also* Trial Tr. at 2655:2–7 (Alain Enthoven). In that vein, Saint Al's expects to move away from reimbursement based just on fee-for-for service toward a system that controls utilization and costs. Dkt. No. 365 (Sonnenberg Dep. Tr.) at 153:17–154:8, 154:13–155:15, 156:7–22.

404. St. Luke's claims that it is invested in moving away from fee-for-service reimbursement, but it has made relatively little progress in this direction.

405. Indeed, St. Luke's is still just "getting geared up" to engage in full risk-based contracting and it will not be ready to enter into value-based contracts for the majority of its business until 2015. Trial Tr. at 1627:12–15, 1629:8–19 (David Pate).

406. As Dr. Pate has explained to payers, St. Luke's is not ready to take risk because St. Luke's does not "have the balance sheet to . . . take the total financial risk." Trial Tr. at 1629:5–13 (David Pate).

407. For example, when St. Luke's had contract discussions with Micron in 2012, and Micron told St. Luke's that it wanted St. Luke's in the Micron network, St. Luke's did not offer a risk proposal to Micron and was not prepared to take risk with Micron at that time. Trial Tr. at 1695:22–1696:21 (David Pate).

408. Moreover, St. Luke's Vice President of Clinical Integration, Dr. Geoffrey Swanson, cannot put a timeline on when St. Luke's will achieve accountable care, testifying: "**Will we be done by 2020? I – I don't know the answer to that. That window is too far outside of my horizon from dealing with the details of how you accomplish this transformation**." Dkt. No. 254 (Swanson Dep. Tr.) at 112:8–113:3 (emphasis added).

409. Nor was Dr. Swanson able to identify the criteria St. Luke's will use to determine whether it has achieved accountable care. Dkt. No. 254 (Swanson Dep. Tr.) at 111:23–112:7.

- **St. Luke's Affiliation With SelectHealth Is Not Risk-Based**

410. Patricia Richards of SelectHealth has no personal knowledge of "any significant benefits from having Saltzer be directly affiliated and highly integrated with St. Luke's." Trial Tr. at 1767:15–20 (Patricia Richards).

411. Nor has Patricia Richards had a specific discussion with St. Luke's about "any significant benefits from having Saltzer be directly affiliated and highly integrated with St. Luke's." Trial Tr. at 1767:15–20 (Patricia Richards).

412. Likewise, Ms. Richards has not had any conversations with any Saltzer physician about the benefits of the Acquisition. Trial Tr. at 1768:4–8 (Patricia Richards). Indeed, she had never even talked to anyone from Saltzer prior to meeting the president of Saltzer on the day that she testified at trial. *Id*. at 1778:25–1779:4.

413. Patricia Richards believes that fee-for-service payments will always be a component of the arrangement between SelectHealth and St. Luke's and that it is unrealistic to expect fee-for-service to go away. Trial Tr. at 1780:5–9 (Patricia Richards).

414. The current payment arrangement is primarily fee-for-service because SelectHealth is in the very early stage of development, has small numbers of members, and do not have sufficient experience or claim history or data to move into a risk-bearing arrangement. Trial Tr. at 1782:2–14 (Patricia Richards).

415. SelectHealth and St. Luke's do not yet have an agreement on how St. Luke's will participate in trying to get quality improvements incorporated as part of their relationship. Trial Tr. at 1780:16–22 (Patricia Richards).

416. Any value-based payments under the agreement between SelectHealth and St. Luke's will not occur until at least year three of their contract. Trial Tr. at 1780:23–1781:1, 1793:3–5, 1794:10–17 (Patricia Richards).

417. Neither St. Luke's nor BrightPath has the capacity to handle full risk. Trial Tr. at 1781:2–5 (Patricia Richards). When SelectHealth and St. Luke's first started talking, SelectHealth was proposing a full-risk percent-of-premium approach, but St. Luke's chose to move away from that because it realized it was not ready for full risk. *Id.* at 1781:6–12.

418. Defendants have offered no evidence that the Acquisition has encouraged or will encourage SelectHealth's entry into the Idaho health insurance market.

- **St. Luke's Only Recently Started Entering Into Pay-For-Performance Contracts With Its Employed Physicians**

419. Only recently, after the FTC and state of Idaho began investigating St. Luke's, did they include a value-based component in three of the St. Luke's physician groups' compensation schemes. Trial Tr. at 1868:22–1869:8 (Mark Johnson).

420. St. Luke's witnesses, such as John Kee, provided almost no details on any of the claimed value-based compensation models for three groups of St. Luke's employed physicians. *See, e.g.*, Trial Tr. at 1923:23-1924:5 (John Kee). According to Mr. Kee, in two of these groups, 20 percent of compensation is value-based and in the third it is a smaller percentage. Trial Tr. at 1923:23-1924:5 (John Kee). St. Luke's Mr. Kee "suspect[s] it'll be at least two-plus years, two to three years to get all the groups" to have a component of compensation that is value-based. Trial Tr. at 1925:3-4 (John Kee).

421. St. Luke's has approximately 500 physicians in the St. Luke's Clinic. Trial Tr. at 1999:19-21 (John Kee). But St. Luke's John Kee was not aware of any physician who had failed to meet the quality component of his or her compensation. Trial Tr. at 1999:22-25 (John Kee).

422. According to the CEO of St. Luke's Regional Medical Center, Chris Roth, the "vast majority" of compensation to St. Luke's Clinic physicians is based on productivity, and most of their compensation is based on wRVUs. Dkt. No. 286 (Roth Dep. Tr.) at 78:20-79:9; *see also* Trial Tr. at 2336:17-22 (Christopher Roth). To the extent physicians are compensated based on wRVUs, "the more work they do, they more money they make." Dkt. No. 286 (Roth Dep. Tr.) at 79:16-20. And there are no physicians within the St. Luke's Clinic whose compensation is based primarily on quality or utilization measures. Dkt. No. 286 (Roth Dep. Tr.) at 80:6-10; Trial Tr. at 2337:12-18 (Christopher Roth).

423. Indeed, as St. Luke's Dr. Mark Johnson acknowledged, St. Luke's family practice doctors are mostly compensated based on WRVUs: they have a base pay that is based on the assumption that they will produce a certain amount of work. Trial Tr. at 1868:13-21 (Mark Johnson).

424. Moreover, St. Luke's has not implemented any quality-based compensation in Twin Falls despite having employed the vast majority of physicians there for a number of years. Trial Tr. at 2000:1-3 (John Kee).

- **The Transaction Does Not Provide Saltzer With The Incentives To Provide High Quality, Low Cost Care**

425. Defendants assert that the Acquisition will provide Saltzer with the proper incentives to provide high quality care at the lowest cost. Dkt. No. 194 (Defendants' Pretrial Memorandum) at 21. Employment of physicians, however, does not a priori align provider incentives (i.e., provide the proper incentives to improve quality, and lower cost of care). Trial Tr. at 3558:12-24 (Kenneth Kizer). Indeed, Saltzer's PSA with St. Luke's is a fee-for-service contract. Trial Tr. at 1372:18-22 (David Dranove).

426. Specifically, the St. Luke's/Saltzer PSA does not align incentives to provide quality care. Trial Tr. at 3558:12-24 (Kenneth Kizer). Under the PSA that governs the St. Luke's/Saltzer relationship, the Saltzer physicians are compensated on a fee-for-service basis and that remains true today. Trial Tr. at 1997:21-1998:25 (John Kee); Trial. Tr. at 3455:4-19 (David Dranove); *see also* Dkt. No. 286 (Roth Dep. Tr.) at 87:2-10; TX 24 at SLHS000787894. Nor does St. Luke's PSA with Saltzer address or provide for risk-based contracting. Trial Tr. at 1992:20-24 (John Kee). When the PSA was signed, there was no proposal on how to compensate Saltzer physicians based on quality. Trial Tr. at 1998:19-22 (John Kee); *see also* Trial Tr. at 2251:4-11, 2237:3-9 (Christopher Roth).

427. Accordingly, there is nothing in the St. Luke's/Saltzer PSA that focuses on improving quality or changing the incentives. *See* Dkt. No. 100 (St. Luke's Answer) at ¶ 63. Instead, the PSA reinforces the same volume based incentives that existed prior to the Acquisition. Trial Tr. at 3559:12-21 (Kenneth Kizer); *see also* TX 24 at SLHS000787894.

428. In fact, the St. Luke's/Saltzer PSA does nothing to encourage quality improvements or otherwise change present practices. Trial Tr. at 3559:2-9 (Kenneth Kizer); *see also* TX 24. Even Saltzer's President—Dr. John Kaiser—admitted that during its negotiations with St. Luke's, it was important to Saltzer to obtain a guaranteed rate on an RVU basis for the entire five-year term of the deal—a compensation structure that remains in place today. Trial Tr. at 2433:12-2434:3 (John Kaiser).

429. Defendants recently amended the PSA shortly before trial, but the amendment does not implement any concrete changes in the compensation model—Saltzer physicians will continue to be compensated on a fee-for-service basis. Trial Tr. at 1999:5-7 (John Kee); Trial Tr. at 3455:20-3456:9 (David Dranove); TX 2624. Instead, the amended PSA indicates that a

small portion of the compensation will be performance based at some point in the future, but it is vague. Trial Tr. 1372:23-1373:6 (David Dranove).

430. Notably, St. Luke's claims that if the Saltzer transaction is unwound, it would be in Saltzer's economic interest to practice fee-for-service medicine, but that is also true of St. Luke's. Trial Tr. at 2021:7-20 (John Kee).

b) Defendants' Efficiencies Claims Are Not Merger Specific

(1) The Acquisition Is Not Necessary For Saltzer Or St. Luke's To Provide Integrated Patient Care Or Achieve The "Triple Aim

431. Defendants claim that the Acquisition is necessary for Saltzer to provide integrated care. They also argue that the Acquisition enhances St. Luke's ability to achieve the "Triple Aim." Trial Tr. at 119:3-8 (Defendants' Opening Statement). But St. Luke's has failed to demonstrate that employing physicians is superior to other affiliation models in terms of providing high quality, low cost care. Trial Tr. at 3524:23-3525:12 (Kenneth Kizer).

432. Indeed, physician acquisitions are unnecessary to achieve the goals of clinical integration. Hospitals and independent physicians can have relationships that result in clinical integration and reductions in spending. Trial Tr. 1368:17-1369:3, 1370:11-14 (David Dranove).

433. The presence of a number of key organizational functionalities—not a specific organizational structure— is essential to integrated care. These key functionalities include clear objectives and goals, health IT tools, and aligned provider incentives. Trial Tr. at 3563:7-3564:8 (Kenneth Kizer).

434. None of the functionalities of providing integrated care is dependent on employing physicians. That is, these functionalities can be accomplished by working with large numbers of independent physicians. Trial Tr. at 3564:9-15 (Kenneth Kizer).

435. In order to "deeply integrate" physicians with a health system—i.e., to "get them involved with our communication network, get them hooked into our quality initiatives, quality tracking, quality measurement"—it is "not a necessity" for the physicians "to be acquired and employed." Dkt. No. 364 (Roach Dep. Tr.) at 138:24-139:25, 140:4-10.

436. By working closely with an independent Saltzer, St. Luke's could achieve reduced spending without increasing market power, having the best of both worlds: the benefits of any efficiencies while sustaining competition. Trial Tr. at 1369:4-18 (David Dranove). Accordingly, it is unnecessary to employ physicians to achieve the Triple Aim. Trial Tr. at 3524:19-22 (Kenneth Kizer).

(a) St. Luke's Works With Independent Physicians To Provide Integrated Care Belies Its Claimed Need To Employ Saltzer-Physicians

- **St. Luke's Can Achieve The Acquisition's Purported Benefits By Working With Independent Physicians**

437. St. Luke's works closely with independent physicians to provide integrated care. Even St. Luke's CEO, David Pate, has repeatedly recognized the importance of working with independent physicians to realize its goal of achieving the "Triple Aim." Trial Tr. at 1658:6-25 (David Pate). Accordingly, St. Luke's employment of Saltzer through this transaction is "not necessary to provide integrated patient care." Trial Tr. at 3522:4-9 (Kenneth Kizer).

438. St. Luke's and its St. Luke's physician leadership group have "defined clinical integration [i.e., integrated care] as 'health care providers in separate legal entities working together in an interdependent and mutually accountable fashion.'" Dkt. No. 321 (Amended Billings Tr.) at 24:21-25:2, 25:8-26:3.

439. St. Luke's ability to be clinically integrated does not depend on a specific threshold of employed physicians. Trial Tr. at 2004:18-21 (John Kee). Rather, integrating

healthcare is about the methodologies by which patients can have the information to provide them with safe, timely, and effective care when they need it. Trial Tr. at 2003:23-2004:6 (John Kee).

440. Numerous St. Luke's executives have admitted that these system can pursue its clinical goals effectively with independent physicians. As St. Luke's, Mr. Kee testified, clinical integration can occur in multiple ways, including with employed physicians and with independent physicians. Trial Tr. at 2004:7-17 (John Kee); *see also* Trial Tr. at 2291:7-2294:17 (Richard Armstrong). Indeed, he could not identify a single St. Luke's quality initiative that does not involve at least some independent physicians. Trial Tr. at 1979:18-1980:7, 2000:18-2001:1 (John Kee); Dkt. No. 289 (Fletcher Dep. Tr.) at 64:17-20, 64:22-24. And none of St. Luke's quality improvement programs requires St. Luke's to employ over 70 percent of the PCPs in Nampa. Trial Tr. at 2001:9-12 (John Kee).

441. Randy Billings, St. Luke's Vice President of Payor and Provider Relations, writing at the invitation of St. Luke's CEO David Pate, stated that the "Triple Aim" requires a clinically integrated network, but that the providers do not necessarily have to be under common financial ownership, and that government-approved accountable care organizations can consist of "financially independent provider competitors that are clinically integrated." Trial Tr. at 1662:9-15, 1663:18-22 (David Pate); TX 1212.

442. In fact, Randy Billings wrote that "Clinical integration with independent providers is clearly the essential building block of accountable care." Dkt. No. 321 (Amended Billings Tr.) at 24:21-25, 28:2-7; Trial Tr. at 1665:4-9 (David Pate); TX 1212.

443. Similarly, St. Luke's Director of Family Medicine for the Treasure Valley believes that in order for St. Luke's to be able to deliver accountable care to a population of

patients, it is "crucial" that St. Luke's network with and clinically integrate with independent physicians." Dkt. No. 249 (Johnson) at 14:21-25, 15:4-24; Trial Tr. at 1874:4-19 (Mark Johnson).

444. Consistent with that, Dr. Geoffrey Swanson – St. Luke's Vice President of Clinical Integration – testified that St. Luke's cannot achieve accountable care "purely in an employed model." Dkt. No. 254 (Swanson Dep. Tr.) at 115:1-9; *see also* TX 1102 at SLHS001093741. He believes St. Luke's faces many of the same challenges with independent physicians as it does with its employed physicians. Dkt. No. 254 (Swanson Dep. Tr.) at 216:18-217:3; TX 1102.

445. According to Dr. Pate, St. Luke's recognizes "the value of partnerships and being able to work collaboratively to solve very challenging problems in healthcare." In connection with such collaboration, Dr. Pate states that St. Luke's "recognize[s] the importance of working with aligned physicians and other providers, whether employed or independent." Dr. Pate also observes that the delivery system necessary to provide total care management to a population in a way that "can be accountable for . . . outcomes and costs" will include not only St. Luke's, but also "many independent physicians and facilities all working together around the state." Trial Tr. at 1657:12-14, 1658:6-17, 1658:22-1659:2.

446. Indeed, the very purpose of St. Luke's Select Medical Network—St. Luke's clinically integrated network—"is to involve sufficient numbers of independent physicians with our St. Luke's Clinic through clinical integration to permit our successful management of populations of patients throughout our Health System geographic area (and through BrightPath for members requiring care outside of our geographic service area, but within the state)." Trial Tr. at 1661:10-1662:7 (David Pate); TX 1510.

447. As recently as August 2013, Dr. Pate acknowledged both that St. Luke's must work with independent physicians in order to take accountability for clinical outcomes and for the cost of care and that independents are willing to participate in a clinically integrated and accountable network:

> In order to prepare our organization to take not only the accountability for clinical outcomes, but also for the cost of that care, *we must add aligned independent physicians to the core physician group we have within the St. Luke's Clinic*. By developing relationships with independent physicians who are willing to participate in evidence-based medicine, agree to share quality data, and agree to hold themselves accountable for the performance of the network, we increase our ability to provide clinically integrated, accountable care to the patients we all serve. We have already established this network of St. Luke's Clinic physicians and independent physicians and it is called Select Medical Network.

Trial Tr. at 1659:3-1660:1 (David Pate), TX 1658.

448. As Dr. Pate acknowledged, however, it was not until very recently that St. Luke's started to test its ability to achieve its goals by working with independent physicians—St. Luke's did not "devote sufficient resources" toward working with independents until the beginning of 2013. Trial Tr. at 1690:4-7 (David Pate).

449. In August 2013, Dr. Pate appointed John Kee to become Vice President of Network Operations stating "Select Medical Network is critical to the success" of St. Luke's "transformation of healthcare." TX1658. Dr. Pate also noted that a main purpose of Mr. Kee's new position is "to focus on fostering strong physician relationships and supporting the alignment and clinical integration efforts with independent physicians across the System. Trial Tr. at 1660:2-17 (David Pate); TX 1658. Indeed, John Kee admitted that his new job was to integrate St. Luke's Clinic physicians with the independent physicians. Trial Tr. at 2018:22-25 (John Kee).

450. Put simply, Mr. Kee's new job is to work with independent physicians to achieve the Triple Aim. Trial Tr. at 2019:19-23 (John Kee). That includes: (i) applying shared analytics, the WhiteCloud tool, to the independent physicians and allowing them to use that tool; (ii) working with independents so they adopt standardized ways of practicing medicine; (iii) working with independents so they adopt best practices; (iv) working with independents to achieve care coordination; and (iv) working with independents so they can participate in value-based contracting. Trial Tr. at 2019:7-21 (John Kee).

451. St. Luke's CoPartner program—a chronic disease management program—for example, involves the participation of both employed and independent physicians. Trial Tr. at 2000:10-17, 2020:3-9 (John Kee). As such, it is not necessary to have an employed physician to carry out such a program. Trial Tr. at 2000:10-17, 2020:3-9 (John Kee). And other hospitals around the country—including Saint Al's—have diabetes programs with no requisite number of employed physicians to operate a successful diabetes clinic. Trial Tr. at 2020:18-2021:6 (John Kee).

452. Similarly, St. Luke's Center for Spine Wellness—a program designed to reduce the number of unnecessary and costly spine surgeries— involves the participation of both independent and employed physicians. In fact, one of the leaders of the Center for Spine Wellness, Dr. Johans, is an independent physician. Trial Tr. at 2038:19-2039:1 (John Kee).

453. The Management Services Organization (MSO) is partly owned by St. Luke's and partly owned by orthopedic surgeons. Trial Tr. at 1688:2-5 (David Pate). The MSO was tasked with managing service lines of the orthopedic and neurosurgical services. Dkt. No. 255 (Walker Dep. Tr.) at 23:12-24:22. Notably, virtually all of St. Luke's quality and cost achievements in

orthopedics have been accomplished through its MSO rather than through the acquisition of orthopedic surgeons. Dkt. No. 291 (Heggland Dep. Tr.) at 28:13-19.

454. Although St. Luke's may claim that it requires employed physicians to direct its various clinics, such as the congestive heart failure clinic, Dr. Marshall Priest admitted that the same function (i.e., clinic director) could be fulfilled by an independent physician employed part-time as a service line director. Trial Tr. at 1834:5-1835:14, 1845:19-1847:17 (Marshall Priest).

455. And, as Dr. Fortuin testified, it is also important to have independent physician members on the clinical integration committees. *See* Trial Tr. at 2128:23-2130:13, 2187:2-15 (Brian Fortuin).

456. As Dr. Pate acknowledged, an independent physician may participate effectively in clinical integration with a system without being exclusively aligned with that system. Trial Tr. at 1688:12-16 (David Pate). He also believes it is possible for physicians who are aligned with one hospital in the Treasure Valley to work closely on clinical issues with hospitals and physicians in the other system. Trial Tr. at 1688:17-21 (David Pate); Dkt. No. 284 (Moore Dep. Tr.) at 134:11-135:1, TX 1120.

- **St. Luke's Can "Clinically Integrate" With Saltzer, If the Acquisition Were Unwound**

457. Defendants' economic expert, Dr. David Argue testified that St. Luke's could "accomplish all or most" of the purported benefits—vertical integration, improvements in quality of care, and reductions in cost—without acquiring Saltzer. Trial Tr. at 3027:11-17 (David Argue).

458. If the acquisition were unwound, St. Luke's would still go forward with its clinical integration strategy, putting "effort into working with the independent physician community to move along some quality- and performance-improvement initiatives." Trial Tr.

2004:22-2005:2 (John Kee). And St. Luke's would continue working with Saltzer and "would try to find opportunities to work with Saltzer. They have been a good community partner." Trial Tr. 2005:3-9 (John Kee). Dr. Pate, asked if he would expect some version of clinical alignment with Saltzer if the deal is unwound, "would want to work with Saltzer Medical Group, or whatever part of it survives, . . . as long as it is consistent with the judge's order." Trial Tr. at 1674:1-1675:12 (David Pate).

459. Even Saltzer's President admitted that Saltzer can achieve at least some of the goals with St. Luke's under looser forms of affiliation. He specifically noted that Saltzer could achieve clinical integration under a looser affiliation with St. Luke's. Trial Tr. at 2431:9:-2432:15 (John Kaiser). Likewise, Saltzer's Dr. Randell Page testified that even if the transaction with St. Luke's "doesn't work out," that St. Luke's is committed to working with Saltzer in "whatever ways could be beneficial." Trial Tr. at 2862:7-14 (Randell Page).

460. In a statement sent to the Idaho Statesman by St. Luke's during this trial, Dr. Page noted that St. Luke's "made clear to [Saltzer] on many occasions that if no merger occurred, [St. Luke's] would still want to work with us in whatever ways could be beneficial." TX 3033; Trial Tr. at 2862:3-6 (Randell Page).

461. In a similar vein, Christopher Roth, CEO for St. Luke's Treasure Valley, explained that there are two independent OB/GYN practices that—despite not being financially integrated or employed with St. Luke's—are clinically aligned with St. Luke's "to a great extent." Dkt. No. 286 (Roth Dep. Tr.) at 132:8-133:19. As Mr. Roth testified, "[t]hose groups are engaged with [St. Luke's] on clinical improvement. They serve in various committee roles. They have served in leadership roles in the past, help[ed] advise us on planning and facilities and recruitment of staff. And so they are, I'd say, aligned strategically or towards our mission. They

are aligned clinically to a great extent. They are not aligned financially." Dkt. No. 286 (Roth Dep. Tr.) at 133:6-14.

(b) Saltzer Can Provide High Quality, Low Cost Care Without The Transaction

462. The evidence shows that Saltzer was providing high quality, low cost care before the Acquisition. For example:

- Saltzer had a quality assessment committee that evaluated its performance on quality metrics. Trial Tr. at 3373:24-3374:23 (Harold Kunz).
- St. Luke's consultants who evaluated Saltzer, including Peter LaFleur, found that Saltzer was efficient. Dkt. No. 323 (Kaiser Dep. Tr.) at 113:7-15.
- St. Luke's personnel told Saltzer's Dr. Kaiser that they thought Saltzer provided good care. Dkt. No. 323 (Kaiser Dep. Tr.) at 113:16-24.
- Saltzer physicians engaged in various quality improvement initiatives to improve population health in the area it serves. For example, Saltzer's Dr. Patterson engaged in initiatives to advance child health and welfare. Trial Tr. at 3336:3-11 (Thomas Patterson).

463. Saltzer's President, employed there since 1999, is not aware of any data showing that Saltzer physicians ordered or performed unnecessary tests, such as labs or MRIs. Dkt. No. 323 (Kaiser Dep. Tr.) at 264:3-13.

464. Despite the cost and time involved, independent clinics like Primary Health and Saltzer are also involved in quality improvement initiatives. Trial Tr. at 3337:4-3339:10 (Thomas Patterson). For example, Dr. Patterson was engaged in the state wide immunization quality improvement as an independent physician. In fact, he is the president of the American Academy of Pediatrics Idaho Chapter. This initiative cost time and money, yet Dr. Patterson and other independent physicians, chose to participate. The purpose of the initiative was to improve outcomes related to childhood immunizations. And the goal was to inform the participating

physicians about best past practices with respect to immunizations. Trial Tr. at 3337:4-3339:10 (Thomas Patterson); s*ee also* TX 1835 at 182.

465. On its own, Saltzer has participated in quality incentive programs with Blue Cross of Idaho such as a QIPS program providing monetary incentives for meeting various quality metrics like administering the hemoglobin A1c diabetes blood test and a program encouraging the prescription of generic drugs. Trial Tr. at 724:10-25 (Nancy Powell).

466. Individual Saltzer physicians implement and utilize evidence-based medicine in their departments or fields of specialty. Dkt. No. 323 (Kaiser Dep. Tr.) at 266:11-17. Saltzer physicians also follow procedural guidelines issued by the hospitals. Dkt. No. 323 (Kaiser Dep. Tr.) at 266:11-23.

467. For example, most Saltzer obstetricians adopted the practice of not inducing labor before 39 weeks without a medical indication because of a study several years ago indicating that inducing before 39 weeks increased the risk of the baby being admitted to the NICU. Dkt. No. 323 (Kaiser Dep. Tr.) at 266:24-267:10.

468. Likewise, other independent multi-specialty physician groups in the Treasure Valley have independently achieved quality improvements. For example, in 2009, David Pate emailed Primary Health's Dr. David Peterman to compliment Primary Health on fulfilling the Triple Aim. Trial Tr. at 1139:5-22 (David Peterman). Notably, Primary Health's immunization rate of 2-year-olds is 92 percent, better than the national standard of 90 percent, and far better than the average rate in the state of Idaho. Trial Tr. at 1136:17-1137:7 (David Peterman).

469. Saltzer's stated goals of affiliation, as described to Saint Al's Dr. Steven Brown, were to remain independent; instead of being employed, they just wanted to be part of a network. Dkt. No. 366 (Brown Dep. Tr.) at 87:16-23; TX 2131 at ALPH00008475.

470. Indeed, Dr. Brown hoped Saltzer would remain independent because they were already successful and because "it is almost always better to create voluntary alignment mechanisms rather than to actually own or employ a physician." Dkt. No. 366 (Brown Dep. Tr.) at 90:22-91:11.

471. [redacted] Dkt. No. 366 (Brown Dep. Tr.) at 153:7-154:19; *see also* TX 2131 at ALPH00008477-78 [redacted]; TX 2131 at ALPH00008482 and ALPH00008488 [redacted]

(c) Health Systems, Like Saint Al's, Successfully Work With Independent Physicians To Improve Quality and Lower The Cost of Care

472. An employment relationship between a hospital and a physician is not necessary for physicians and hospitals to work together to improve care. Trial Tr. at 3613:20-24 (Robert Polk). Indeed, physician alignment does not require employment at all. In fact, alignment with independents provides the physician with flexibility, where the hospital is still able to have a productive relationship with the physician. Dkt. No. 363 (Reinhardt Dep. Tr.) at 17:19-19:1.

473. Saint Al's believes it can work productively with independent physicians making it unnecessary to employ physicians who want to remain independent. Dkt. No. 363 (Reinhardt Dep. Tr.) at 20:22-21:8.

474. Saint Al's is establishing an Alliance of employed and independent physicians to provide integrated patient care—the "Saint Al's Health Alliance." TX 2140 at BDC0023651-652. Saltzer is part of the Alliance. Dkt. No. 366 (Brown Dep. Tr.) at 230:22-231:14. Saint Al's is working towards full clinical integration through the Alliance using an accountable board of independent and employed physicians. Dkt. No. 366 (Brown Dep. Tr.) at 130:20-131:15.

475. Saint Al's Alliance is composed of approximately 1200 physicians, of which 75 percent are independent and 25 percent are employed. Trial Tr. at 3612:3-10 (Robert Polk).

476. Importantly, hospital systems like Saint Al's involve independent physicians in their quality initiatives. For example, Dr. James Souza served on three ad hoc committees at Saint Al's when he was an independent physician with Idaho Pulmonary Associates. One was to establish a mandatory intensivist consult in the intensive care unit. Another was to look at pulmonary function in the hospital and at IPA to try to coordinate those efforts. A third was a council to which the Saint Al's CEO invited physician group leaders. Dkt. No. 290 (Souza Dep. Tr.) at 12:15-13:8.

477. It is unnecessary to pay independent physicians to participate in evidence-based medicine programs. *See* Trial Tr. at 3620:12-16 (Robert Polk). Instead, independent physicians are willing to participate in such programs because it's the right thing to do. Trial Tr. at 3618:4-15 (Robert Polk).

478. Putting aside that it is unnecessary to pay independent physicians to engage in quality improvement initiatives, physicians – independent or employed – can and do participate in such initiatives and are paid for leadership roles focused on improving quality and lowering the cost of care. Trial Tr. at 36:20-12-24 (Robert Polk). For example, Saint Al's Dr. Polk explained that an independent physician can be paid an hourly rate for his or her time that is spent leading quality initiatives. Trial Tr. at 3621:4-10 (Robert Polk). At Saint Al's, Medical Directors are almost never employed physicians. Trial Tr. at 3620:25-3621:3 (Robert Polk).

479. To provide just one notable example, Dr. Julie Foote is an independent physician who is a Medical Director at Saint Al's. Dr. Foote's responsibilities as Medical Director include creating order sets, and implementing evidence-based practices. Because of Dr. Foote's efforts,

Saint Al's was the only hospital in Idaho certified in advanced inpatient diabetes care by the Joint Commission. Trial Tr. at 3621:24-3623:16 (Robert Polk).

480. The 100,000 Lives Campaign is another example of a quality improvement initiative that involved working with independent physicians. The 100,000 Lives Campaign was a nationwide effort based upon certain evidence-based practices that were known to save lives in hospitals. During this campaign, Saint Al's saved 62 lives by working almost entirely with independents physicians. Trial Tr. at 3615:12-15 (Robert Polk).

481. The Surgical Care Improvement Program ("SCIP") is yet another example of a quality improvement initiative at Saint Al's that involved independent physicians. Saint Al's took a team of physicians that included two independents physicians to Washington, D.C. to participate in meetings that identified best practices for surgical care. By working with independent physicians, Saint Al's went from 30 percent to 100 percent compliance on the SCIP quality metric known as "antibiotics within one hour of cut time." Trial Tr. at 3615:16-3617:10 (Robert Polk).

482. While the group was independent, and prior to being acquired by St. Luke's, the Boise Surgical Group was involved in quality initiatives and measurement conducted by St. Alphonsus, measuring such factors as the timing of antibiotic delivery prior to surgery, the number of readmissions to the OR, the amount of blood loss and the length of stay, by practitioner. Dkt. No. 370 (Barresi Dep. Tr.) at 96:4-97:4. After the acquisition, St. Luke's measured the surgical group by virtually the same metrics. Dkt. No. 370 (Barresi Dep. Tr.) at 98:1-14.

483. Lastly, the federal government provides financial incentives for all physicians – employed and independent – to improve the quality and lower the cost of their care. Trial Tr. at 3623:21-3624:1 (Robert Polk).

(2) Even If The Core Theory Were Verifiable, St. Luke's Already Has A "Core" Of Employed PCPs Without Saltzer

484. Even assuming counterfactually that St. Luke's "core" theory were supported by reliable evidence, St. Luke's already has a "core" of employed primary care physicians in Canyon County. Trial Tr. at 3539:7-17 (Kenneth Kizer).

485. Using its clinical integration scorecard as an example, St. Luke's CEO Dr. Pate admits that St. Luke's already has a "core group of physician leaders," consisting of two to three dozen physicians from the Treasure Valley, the Magic Valley, and the Wood River Valley, that can be used to spearhead clinical integration initiatives. Trial Tr. at 1691:14-1692:5 (David Pate).

486. In Nampa, St. Luke's already employs seven primary care physicians as part of St. Luke's Family Medicine [formerly Mercy Medical Group], and these physicians could serve as part of the "core" group even if Saltzer remained independent. Trial Tr. at 1692:25-1693:8 (David Pate).

(3) The Transaction Is Not Necessary For Saltzer To Achieve The Benefits Of Using Health IT Tools

487. Defendants assert that a benefit of the transaction is Saltzer's use of St. Luke's health IT tools—Epic and WhiteCloud. A multi-specialty physician group, like Saltzer, however, can easily acquire access to health IT tools. *See* Trial Tr. at 3557:21-3558:4 (Kenneth Kizer). Indeed, health IT tools are widely used by physician practices of varying sizes and are "part of the basic [healthcare] landscape going forward." Trial Tr. At 3557:21-3558:4 (Kenneth Kizer).

488. Independent providers of healthcare services have available to them a variety of electronic medical record ("EMR") systems and data analytics tools that can be used to support or facilitate integrated patient care. Trial Tr. at 3522:15-21 (Kenneth Kizer).

(a) Benefits to Saltzer of Electronic Health Records are not Merger Specific

489. An independent Saltzer would have many available alternative data analytics tools that it could use to effectively engage in population health management. Trial Tr. at 3553:1-12 (Kenneth Kizer).

490. Saltzer's Electronic Medical Record (EMR) system is eClinicalWorks, Version 9. TX 1835 at 192; Trial Tr. at 1960:3-6 (John Kee).

491. Relatedly, Saltzer uses other health IT tools to support its EMR including:

- [redacted] TX 1835 at 192.
- [redacted] TX 1835 at 192.
- [redacted] TX 1835 at 192.
  - [redacted] TX 1835 at 193.
  - [redacted] TX 1835 at 193.

492. Despite testifying that "it would be challenging" for eClinicalWorks to "actively interoperate" with Epic, St. Luke's John Kee was unaware of whether eClinicalWorks can in fact interoperate with Epic. Trial Tr. at 2008:14-23 (John Kee).

493. As Defendants' expert, Dr. Argue, acknowledged, access to an EMR system is not a merger-specific benefit from the acquisition. Trial Tr. at 3044:2-6, 3045:9-21 (David Argue).

(b) Primary Health Has Achieved the Full Benefits of Electronic Health Records Using eClincalWorks

494. Primary Health uses eClinicalWorks for its EMR system. Trial Tr. at 1140:7-9 (David Peterman).

495. Primary Health has been able to implement patient registries, evidence-based medicine, and other quality initiatives as an independent group with the eClinicalWorks EMR system. Trial Tr. at 1157:21-1158:13 (David Peterman).

496. Primary Health has been very satisfied with eClinicalWorks. Trial Tr. at 1151:20-22 (David Peterman). [redacted] Trial Tr. at 1159:6-13 (David Peterman). When Primary Health chose eClinicalWorks in 2007, it was influenced by the fact that St. Luke's was planning to use that system as well. Trial Tr. at 1160:2-10 (David Peterman).

497. Using eClinicalWorks, Primary Health has been able to create templates for disease management and coordination of care. Trial Tr. at 1141:19-1143:21 (David Peterman).

498. Primary Health also uses its eClinicalWorks EMR to hard wire evidence-based practices on how to achieve the best possible patient outcomes. *See* Trial Tr. at 1157:15-1158:2 (David Peterman).

499. For example, Primary Health created a registry for children with asthma using eClinicalWorks. In 2012, one of the payers identified 33 patients on that registry, and zero of the 33 were in the emergency room for asthma. Trial Tr. at 1154:12-1155:20 (David Peterman).

500. E-Prescriptions via eClinicalWorks also eliminate errors based on trying to interpret written prescriptions and builds in safeties so that there is less chance of prescribing the wrong dose. Trial Tr. at 1151:2-15 (David Peterman).

(c) Saltzer Could Achieve Any Purported Benefits Of Using St. Luke's Epic EMR System Without The Transaction

501. St. Luke's intends to make its Epic EMR available to independent physicians through its Affiliate EMR Program, which will provide independent physicians full access to St. Luke's Epic system without being employed by St. Luke's. Trial Tr. at 2831:23-2832:1 (Marc Chasin); Trial Tr. at 2006:12-2007:6 (John Kee); Trial Tr. 1875:7-15 (Mark Johnson).

502. St. Luke's Affiliate EMR Program is designed to allow independent physicians in the community to share a common electronic health record platform with all St. Luke's physicians, "employed or otherwise." Trial Tr. at 1961:7-12 (John Kee); Trial Tr. at 2832:2-6 (Marc Chasin); Trial Tr. at 3549:2-9 (Kenneth Kizer); *see also* TX 1011 at SLHS000193386. "[T]o the extent a physician is interested in that, [St. Luke's is] going to offer that opportunity to the community." Trial Tr. at 1961:18-20 (John Kee). To avoid any concerns about disclosing trade secrets, "financial records are firewalled, and they're unique to that physician group in the affiliate strategy." Trial Tr. at 1961:23-25 (John Kee).

503. St. Luke's has finalized its plan to roll out an affiliate EMR strategy and expects to be able to offer it in April 2014. St. Luke's has had interest from about 15 groups, all but one of which is currently using only paper records. Trial Tr. at 1964:13-18, 2006:14-17 (John Kee).

504. Among others, Women's Health Associates, an independent OB/GYN group, has decided to enroll in St. Luke's affiliate program. Trial Tr. at 2007:17-2008:9 (John Kee). The affiliate strategy will allow independent physician groups like Women's Health Associates to share the same master patient index, firewalls, financial data, and clinical data across the

enterprise. Trial Tr. at 2006:18-23 (John Kee). Independent physicians who participate will have full access to the full capability of Epic and will be able to access the complete patient record. Trial Tr. at 2006:24-2007:6 (John Kee). In fact, as an independent group, Women's Health Associates will have the full capability of St. Luke's Epic EMR system, just like a St. Luke's Clinic doctor. Trial Tr. at 2008:5-9 (John Kee); Trial Tr. at 3545:12-18 (Kenneth Kizer).

505. One of the 15 independent physician groups planning to join St. Luke's affiliate program is, like Saltzer, currently on eClinicalWorks and already qualifies for Meaningful Use payments. Trial Tr. at 1964:19-1965:3 (John Kee).

506. In the view of St. Luke's Treasure Valley CEO, Christopher Roth, the only hurdle to full clinical alignment with independent physicians is access to the Epic EMR system. Trial Tr. at 2333:22-2334:10 (Christopher Roth). Mr. Roth agreed that once these groups participate in the Affiliate EMR program, they will be as clinically aligned as St. Luke's employed physicians. Trial Tr. at 2334:11-22 (Christopher Roth).

507. An independent group like Saltzer would have to pay only a fraction of the costs associated with the affiliate EMR program, as St. Luke's has agreed to pay 85 percent of the startup licensure costs. Trial Tr. at 2820:18-24 (Marc Chasin), Trial Tr. at 2007:7-10 (John Kee).

508. St. Luke's estimates for these upfront costs have varied. According to Dr. Chasin's trial testimony, the cost for the pilot group amounted to $20,000 per physician, which he thought was a "general estimate" for what the program would cost for other independent providers. Trial Tr. at 2823:3-17 (Marc Chasin). At his deposition, which St. Luke's later designated as Rule 30(b)(6) testimony, he estimated that the upfront cost would be $4500-$5250 per physician (15 percent of $30,000-$35,000). Trial Tr. at 2832:7-21 (Marc Chasin).

509. An independent physician group participating in the Affiliate EMR Program would also be responsible for paying ongoing maintenance costs, but a group like Saltzer that already has an EMR system would save the money it is currently paying to maintain its system. Trial Tr. at 2832:22-2833:22 (Marc Chasin).

510. St. Luke's plans to make its Epic ambulatory system available to independent physician providers through its Affiliate EMR Program as quickly as possible. Trial Tr. at 2831:23-2832:1 (Marc Chasin).

511. If the Saltzer acquisition is unwound, St. Luke's would "absolutely" welcome Saltzer to participate in the St. Luke's affiliate EMR program. Trial Tr. at 2008:10-13 (John Kee). Mr. Kee's "best guess" is that installation of Epic through the affiliate strategy at Saltzer would be approximately $20,000 per physician. Trial Tr. at 1963:14-20 (John Kee).

512. Defendants' economic expert, Dr. Argue, identified healthcare IT among the purported benefits of the transaction, but he could not recall any of the details regarding St. Luke's Affiliate EMR Program. Trial Tr. 3043:21-3045:1 (David Argue). Furthermore, Dr. Argue admitted that having an EMR could not be a merger-specific benefit, as Saltzer already has an EMR system, and he could not state whether the ability to share information between EMR systems would be a merger-specific benefit. Trial Tr. at 3044:2-6, 3045:9-21 (David Argue).

(d) Idaho Health Data Exchange Facilitates Information Sharing Between Providers On Different EMR systems

513. A Health Information Exchange ("HIE") connects different hospitals, medical groups, and clinics in a community, a city, and a state, so that they can share information between and among them like an electronic health record within a hospital. Trial Tr. at 3510:9-19 (Kenneth Kizer); Trial Tr. 1427:4-11 (David Dranove).

514. By 2016-2017, the federal government expects that providers will be able to exchange comprehensive health information through HIEs. Trial Tr. at 3510:20-3511:3 (Kenneth Kizer).

515. HIEs support the exchange of information between providers who are using different types of electronic health records, such as might occur in the case of independent physicians interfacing with hospitals of different types. Trial Tr. at 3546:17-24 (Kenneth Kizer).

516. The Idaho Health Data Exchange ("IHDE") is an HIE tool that facilitates interoperability between different types of electronic health records that may be used by providers. Trial Tr. at 3546:8-16 (Kenneth Kizer).

517. The IHDE is best described as a "hub." It is a connection in which the providers, or those taking care of patients, can access information that is directly related to the patient. Trial Tr. at 1152:19-1153:20 (David Peterman).

518. Primary Health has an interface with the IHDE so that information to a certain degree can populate electronic health records directly. Primary Health is working directly with IHDE to provide bi-directional information sharing so that information will be sent both to and from Primary Health automatically. Trial Tr. at 1210:22-1211:16 (David Peterman).

519. There is an encouragement from the Governor, the Director of Health and Welfare, and the state legislature to get all hospitals and all providers who are on electronic health record to feed their information on patients through the IHDE hub. Trial Tr. at 1153:4-11 (David Peterman).

520. The IHDE can help facilitate the coordination of care among different providers, including providers on a different EMR system. Trial Tr. at 2834:12-18 (Marc Chasin). For

example, IHDE can provide transcribed notes to users on different EMRs. Trial Tr. at 3652:8-10 (Robert Polk).

521. Indeed, as described by a St. Luke's ordinary course-document, IHDE "enables cross region interoperability between Epic and non-Epic health record systems." TX 1575 at SLHS000193299.

522. Although Dr. Chasin attempted to minimize the scope and significance of the Idaho Health Data Exchange in his trial testimony, *see* Trial Tr. at 2812:23-2813:18, 2814:14-2815:1 (Marc Chasin), he admitted at his deposition that the "same data" is available through the IHDE as through Epic. Trial Tr. at 2838:5-25 (Marc Chasin).

523. There is no meaningful difference between accessing electronic health information from being on the same EMR system compared to accessing the information from the IHDE. Trial Tr. at 3547:24-3548:2 (Kenneth Kizer).

524. Both Saint Al's and St. Luke's share their information with IHDE. Trial Tr. at 3650:6-9 (Robert Polk); Dkt. No. 361 (Reider Dep. Tr.) at 105:10-23; Trial Tr. at 1147:16-1148:1 (David Peterman).

525. St. Luke's is building an interface to the IHDE that will facilitate data transfer and better coordination of care as clinicians will have access to critical information from other places care is rendered, including non-St. Luke's facilities such as Saint. Al's. Trial Tr. at 2834:6-11 (Marc Chasin); TX 1021 at SLHS000342628.

526. According to Dr. Chasin, the interface through IHDE is relatively easy to use, and the cost per physician is less than $200 per month. Trial Tr. 2836:20-2837:2 (Marc Chasin)

527. As members of the IHDE, Primary Health can download information from the exchange. So, if a Primary Health patient is seen in the emergency room at St. Luke's or Saint

Al's, Primary Health can go on IHDE the next morning and see what services they received. Trial Tr. at 1147:16-1148:1 (David Peterman).

528. Similarly, an independent group with an existing EMR system, like Saltzer, could access the data in St. Luke's Epic system through the Idaho Health Data Exchange (IHDE). Trial Tr. at 2833:23-2834:18 (Marc Chasin).

529. Primary Health has an interface with St. Luke's for labs. If a lab is ordered at St. Luke's it can be sent electronically through the system and populates in Primary Health's system in the right lab fields. Trial Tr. at 1145:21-1146:11 (David Peterman).

530. Primary Health also has an interface with St. Luke's for pediatric patients. If a Primary Health pediatric patient is admitted at St. Luke's, the pediatric hospitalist can look at the Primary Health electronic record and see what medicines the patient is taking. Trial Tr. at 1146:12-1147:1 (David Peterman).

531. Similarly, Primary Health has a digital interface for imaging with Saint Al's. X-rays and EKGs are taken digitally and then sent to Saint Al's to be read. The results come back to Primary Health physicians and populate into the eClinicalWorks system. Trial Tr. at 1147:2-9 (David Peterman).

(e) Saltzer Would Use A Data Analytics Tool, including WhiteCloud, Without Employment By St. Luke's

532. WhiteCloud is a local company that offers a data mining and reporting tool. Trial Tr. at 1939:17-1940:13 (John Kee). It can mine data from various EMR systems, including Centricity, eClinicalWorks and Epic. Trial Tr. at 1941:9-1942:3, 2006:7-11, 2012:20-24 (John Kee).

533. St. Luke's plans to roll out its WhiteCloud tool to independent physicians in the Select Medical Network. Trial Tr. at 3552:20-23 (Kenneth Kizer). Prior to the Acquisition, Saltzer was a member of the Select Medical Network. Trial Tr. at 1991:19-21 (John Kee).

534. Dr. Pate believes that the clinical integration scorecards that St. Luke's has developed using the WhiteCloud tool will work with independent physicians. Trial Tr. at 1690:8-22 (David Pate).

535. The WhiteCloud tool is currently able to extract EMR data from the Centricity system as well as the Epic system. Trial Tr. at 2138:23–2139:9, 2155:22–24 (Brian Fortuin). Dr. Fortuin understands that there is work going on to enable the tool to extract EMR data from Saltzer's eClinicalWorks system as well. Trial Tr. at 2168:3-8 (Brian Fortuin). According to John Kee, "WhiteCloud is working actively to figure out how to gather whatever data it can from various EMRs." Trial Tr. at 2012:15-19 (John Kee).

536. John Kee acknowledged that WhiteCloud is "one of many systems" being used in healthcare for data analytics. Trial Tr. at 2015:8-11 (John Kee). In fact, health systems and other providers all around the country are implementing data analytics tools, including Saint Al's use of Explorys. Trial Tr. at 2015:12-15 (John Kee); *see also* Trial Tr. at 1941:4-8 (John Kee).

537. Saint Al's has used the Crimson data analytics tool with both employed and independent physicians since 2010 (Trial Tr. at 3629:17-3630:6 (Robert Polk); Trial Tr. at 3635:14-20 (Robert Polk)). In addition, Saint Al's plans to roll out the Explorys data analytics tool to all the members of the Saint Al's Health Alliance, including both employed and independent physicians, in December 2013. Trial Tr. at 3630:11-18, 3633:17-20 (Robert Polk).

538. To use Explorys, physicians need not be on the same EMR system. Trial Tr. at 3632:14-20 (Robert Polk). In terms of improving quality and lowering the cost of care, most

physicians want to do the right thing regardless of whether they are employed or independent. Trial Tr. at 3618:4-15 (Robert Polk).

539. Saint Al's will first roll out the Explorys data analytics tool to Primary Health Medical Group – an independent physician group, that, like Saltzer, uses the eClinicalWorks EMR system. Trial Tr. at 3634:4-12 (Robert Polk).

540. Saint Al's plans to roll out Explorys to other eClinicalWorks EMR users within the Saint Al's Health Alliance, like Saltzer. Therefore, if Saltzer remains independent, it will have access to all the benefits of the Explorys data analytics tool. Trial Tr. at 3634:7-12 (Robert Polk). This benefit will likely be lost if the Acquisition is permitted to stand.

541. The advantage of Explorys is that it can pull data from many different EMR systems. Trial Tr. at 3632:8-13 (Robert Polk). WhiteCloud, in contrast, appears to have some difficulty communicating with common EMR platforms. Trial Tr. at 2180:5-8, 2181:16-21 (Brian Fortuin), 1960:7-24 (John Kee).

(4) The Transaction Is Not Necessary For St. Luke's Or Saltzer To Successfully Transition Away From Fee-For-Service Payments

542. Defendants assert that the acquisition is necessary to align the Saltzer physicians incentives to provide higher quality, lower cost care. Trial Tr. at 1535:21-1536:10 (Deborah Haas-Wilson). Employment, however, is neither necessary nor sufficient to move away from fee-for-service contracting and make incentives more aligned for providing higher- quality, lower-cost care. Trial Tr. at 3522:22-3523:3 (Kenneth Kizer).

543. Even St. Luke's CEO Dr. Pate acknowledges that it is possible to design incentives that improve quality without employment and believes his efforts in Houston were successful in improving quality because they were able to design quality incentives without

employment. Trial Tr. at 1665:10-12, 1665:18-1666:2, 1666:24-25, 1667:16-1669:3, 1671:20-1673:21 (David Pate); TX 3006.

(a) Independent Physicians Can Engage in Pay-For-Performance Compensation Contracts

544. Commercial payers across the United States are building pay-for-performance into contracts with independent physician groups and clinically integrated networks of independent physicians and hospitals. *See* Trial Tr. at 2655:2-7 (Alain Enthoven).

545. Saint Al's has pay-for performance contracts with independent physicians, which means that if an independent physician group hits a certain quality target it will get paid a bonus. Trial Tr. at 3625:18-3626:3 (Robert Polk). In Orthopedics, for example, Saint Al's has a co-management group, which is comprised of six independent physicians and three employed physicians. These physicians are paid a bonus dependent on achieving patient satisfaction, cost, and quality metrics. Trial Tr. at 3626:17-25 (Robert Polk).

546. In fact, Saint Al's has had pay-for-performance agreements with independent physicians dating back to 2004. The groups of physicians on pay-for-performance include, orthopedics, pulmonology, emergency room, and anesthesia. Trial Tr. at 3626:4-16 (Robert Polk).

547. Before St. Luke's acquired the twelve Idaho Cardiology Associates (ICA) physicians, St. Luke's had a co-management agreement with independent cardiologists, including the ICA physicians. This co-management agreement with independent physicians paid the physicians out of a "pot of money" based on quality metrics and patient satisfaction metrics. More than 20 such metrics were applied with independent physicians. Trial Tr. at 1844:5-20 (Marshall Priest).

548. The core quality indicators used by St. Luke's for cardiologists are used by "scores of hospitals" across the United States to evaluate independent physicians. Trial Tr. at 1845:2-13 (Marshall Priest). These core quality indicators are also used by health plans that make payments to networks of independent physicians or directly to independent physicians to reward them for quality performance. Trial Tr. at 1845:13-17 (Marshall Priest).

549. Idaho Pulmonogists likewise were compensated based on quality metrics as an independent physician group (i.e., before being employed by St. Luke's). Trial Tr. at 2091:8-15 (James Souza).

550. Before his employment at St. Luke's, Randy Billings was employed at Advocate Health, where he worked with Advocate Physician Partners, an organization made up of physicians and hospitals in the Chicago area. Advocate Physician Partners is a super physician hospital organization (PHO), made up at the time of nine PHOs. Dkt. No. 321 (Amended Billings Tr.) at 13:3-24.

551. The contracts Advocate Health System negotiated for physicians provided financial incentives to physicians, including independent physicians, to meet or exceed certain clinical integration metrics. Each physician, both independent and employed, was scored based on clinical innovative metrics and then the incentives were paid out based on each physician's score compared to his or her peers. Dkt. No. 321 (Amended Billings Tr.) at 17:3-18.

(b) The Transaction Is Not Necessary For Saltzer Or St. Luke's To Engage In Risk-Based Contracts

- **Saltzer Can Engage In Risk-Based Contracts With Health Plans Without Being Acquired By St. Luke's**

552. Defendants' economic expert, Dr. Argue, could not state whether risk-based contracting is a merger-specific benefit of the transaction. Trial Tr. at 3023:3-11 (David Argue). Dr. Argue admitted that St. Luke's could pursue risk-based contracting without Saltzer. Trial Tr.

at 3022:8-12 (David Argue). Dr. Argue also admitted that an independent Saltzer could already engage in forms of value-based contracting, such as gain-sharing programs that would reward Saltzer for reducing costs or improving quality. Trial Tr. at 3077:17-22 (David Argue).

553. Risk-based contracting requires a direct relationship between the payer, who is assuming the risk, with the physician or hospital, who is also assuming risk. Trial Tr. 484:12-16 (Linda Duer). But it does not necessarily have to be an ownership position. *Id.* 484:3-11

554. A large physician group, like Saltzer, could also enter into a direct risk-based contract with an insurance company. Trial Tr. 1371:16-23 (David Dranove).

555. Professor Enthoven admitted that an independent Saltzer would be able to take on some forms of risk-sharing, like gain sharing. Trial Tr. at 2644:20-24 (Alain Enthoven).

556. Saltzer has sufficient scale to participate in risk-based products; in fact, it has participated in risk-based contracting with BCI through its Medicare Advantage product. Trial Tr. 194:4-17 (Jeff Crouch).

557. Saltzer could participate in risk-based contracting through BrightPath or Saint Alphonsus's Health Alliance. Trial Tr. at 2444:5-2445:16 (John Kaiser).

- **Employed and Independent Physicians In Saint Al's Health Alliance Will Engage In Risk-Based Contracts With Health Plans**

558. Saint Al's Health Alliance is Saint Al's mechanism for shifting away from volume-based reimbursement to value-based reimbursement. Dkt. No. 361 (Reider Dep. Tr.) at 105:10-23.

559. [redacted] Dkt. No. 366 (Brown Dep. Tr.) at 222:20-223:8; TX 2142 at BDC0009844, 854.

- **Saltzer Would Be Part Of St. Luke's Purported Risk-Based Arrangement With SelectHealth If It Remained Independent**

560. St. Luke's claims that it plans to use its relationship with SelectHealth to move away from a fee-for-service model to risk-based contracting, although it remains a fee-for-service contract and has not done away with that fee-for-service component. Trial Tr. at 1979:18-1980:7, 1988:12-1989:12 (John Kee); TX 41. BrightPath is the provider network for St. Luke's affiliation with SelectHealth. Trial Tr. at 1989:21-24 (John Kee). Select Medical Network is part of BrightPath, and both Select Medical Network and BrightPath include independent physicians. Trial Tr. at 1989:25-1990:2 (John Kee). There is no limitation in St. Luke's agreement with SelectHealth on the participation of independents through the BrightPath network. Trial Tr. at 1990:9-1991:12 (John Kee).

561. Before the Acquisition, Saltzer was already part of the BrightPath Network and part of the Select Medical Network. Trial Tr. at 1991:19-24 (John Kee). So Saltzer would have been subject to St. Luke's risk-based SelectHealth agreement even without the acquisition. Trial Tr. at 1991:25-1992:9 (John Kee).

562. For the SelectHealth product, Dr. Argue acknowledged that when he wrote his report, he did not even know whether an independent Saltzer would still be subject to the SelectHealth contract, and he admitted that St. Luke's could offer an attractive network in Nampa without Saltzer. Trial Tr. at 3026:1-16 (David Argue).

- **Saltzer Would Be Part Of St. Luke's MSSP If It Remained Independent**

563. Saltzer also could participate in the Medicare Shared Savings Program (MSSP) if it remained independent. Trial Tr. at 1997:6-13 (John Kee).

564. St. Luke's has been approved as a participant in the Medicare Shared Savings Program (MSSP), which includes a risk-sharing component. Trial Tr. at 1993:3-9, 1993:23-1994:5 (John Kee). St. Luke's application to participate in MSSP was not contingent on its acquisition of Saltzer. Trial Tr. at 1994:10-13 (John Kee).

565. St. Luke's accountable care organization ("ACO") in MSSP includes a number of independent physicians. TX 1573 at SLHS000679554.

566. And experience from physician groups around the country confirms that an independent practice of Saltzer's size and scale could participate in risk-based contracts and form or participate in an ACO without being acquired by a large hospital system. Trial Tr. at 3452:20-3455:3 (David Dranove).

567. St. Luke's is currently the only approved Medicare ACO in Idaho, but there is no single model for an ACO. There are ACOs formed through numerous different organizational forms, including independent physician groups, multispecialty groups, and looser affiliations among physicians and hospitals. Trial Tr. at 3452:20-3455:3 (David Dranove).

568. And Saltzer could participate in risk-based arrangements without forming or participating in a Medicare ACO. Trial Tr. at 3500:18-3501:10 (David Dranove).

- **Independent Physicians, Regardless of Size, Engage In Risk-Based Contracts With Health Plans**

569. John Kee, St. Luke's VP for Network Operations, conceded that independent physicians could enter into risk-based contracts with commercial payers. Trial Tr. at 1992:14-19 (John Kee). But Mr. John Kee does not know one way or the other whether independent physician groups are engaging in risk-based contracting. Trial Tr. at 2038:2-13 (John Kee).

570. Indeed, providers do not need a "large number of physicians" to engage in risk-based contracting. Health plans are able to design risk-based contracts to "manage the level of risk proportionate to the level of the provider organization." Trial Tr. at 195:13-15 (Jeff Crouch).

571. BCI's Jeff Crouch explained that even small independent physician practices can participate in risk-based contracts. For example, BCI has a risk arrangement in Boise with a

practice of two physicians. Trial Tr. at 185:3-7 (Jeff Crouch). Despite its small size, this group frequently outperforms the rest of BCI's risk-based networks. Trial Tr. at 193:7-24 (Jeff Crouch).

572. Although smaller provider groups may lack the capacity to assume full risk for catastrophic services, health plans can design contractual provisions (such as a "corridor" on the risk faced by the group) to allow these smaller groups to participate in risk-based contracting. Trial Tr. at 186:4-187:5, 193:7-24 (Jeff Crouch).

573. Smaller providers can also participate in other risk-based products that fall short of full capitation (payment on a per member, per month basis), such as gain-sharing arrangements in which the provider shares in any savings. Trial Tr. at 186:12-187:5, 192:17-193:6 (Jeff Crouch).

- **The Acquisition Is Unnecessary For St. Luke's To Engage In Risk-Based Contracts With Health Plans**

574. Among health systems, BCI has observed successful risk-based contracting through both an "employed physician model" and an "independent physician model." As an example of the independent physician model, Mr. Crouch cited the North Idaho Health Network, which "has developed a level of integration within their community and their system so that the employers and the [North Idaho] marketplace are willing to buy their product." Trial Tr. at 195:25-197:11 (Jeff Crouch).

575. When Randy Billings was employed by Advocate Health, it successfully negotiated risk-based contracts with healthcare plans on behalf of 3,800 physicians, three-quarters of whom were independent physicians. Dkt. No. 321 (Amended Billings Tr.) at 13:3-14:21, 15:4-11.

576. Advocate had a clinical structure that included clinical integration metrics that were measured across all physicians, independent and employed, and measurements for

hospitals. Advocate tied all those together and coordinated the care across the contracts in negotiated. Dkt. No. 321 (Amended Billings Tr.) at 15:12-16:1.

577. [redacted]or effective risk-based contracting, dedication and hard work are more important than the specific organizational model, as BCI's Jeff Crouch explained: "It's just the hard work of getting together and making the programs work [that] differentiates the systems. The ownership is not what differentiates success in the system." Trial Tr. at 196:6-19 (Jeff Crouch).

578. St. Luke's has sufficient size and scale to engage in risk-based contracting without acquiring Saltzer; in fact, St. Luke's already participates in BCI's "most aggressive" risk-based product in Idaho. Trial Tr. at 194:22-195:3 (Jeff Crouch).

579. That has not always been the case. At times, St. Luke's has refused to participate in risk-based programs proposed by BCI. For example, BCI approached St. Luke's about a "bundled payment" program for maternity care. In a such a bundled payment, the health plans takes all the services associated with an episode of care (e.g., maternity care) and bundles them into a single-payment allowance, regardless of which services are delivered (e.g., a C-section vs. a traditional delivery). Through such a bundled payment for maternity services, Cassia Medical Center in Burley was able to reduce their C-section rate from around 25 percent to 18 percent in less than a year. [redacted]. Trial Tr. at 198:9-200:22 (Jeff Crouch).

580. [redacted]

[redacted]Trial Tr. at 225:14-226:19 (Jeff Crouch).

2. Other Defenses Such As "Healthcare Reform," "Trust Us," And "Board Member," Do Not Justify The Acquisition

a) HealthCare Reform Defense

581. Defendants have offered no verifiable evidence to support a healthcare reform justification for the Acquisition.

b) The "Trust Us" Defense

582. As noted above, vibrant competition among healthcare providers helps facilitate the goals embodied in the "Triple Aim," including lower prices, greater efficiency, and improved quality. Trial Tr. at 3419:13-21 (David Dranove).

583. An influential report from the Brookings Institution written by 18 of the nation's top health policy analysts across the political spectrum recommended enhanced scrutiny of healthcare provider mergers. Trial Tr. at 3461:19-3463:19 (David Dranove).

584. Defendants have suggested a "wait-and-see" approach, but an acquisition that helps entrench a dominant health system could be very difficult to unwind, as the Brookings Institution report cautions. Trial Tr. at 3456:10-19, 3463:20-3464:11, 3500:1-17 (David Dranove).

585. By enhancing St. Luke's market power, this acquisition may allow St. Luke's to become "entrenched" as a dominant system, reducing its incentive to innovate. Trial Tr. at 3420:7-116 (David Dranove).

586. Compared to mergers, looser affiliations involving contractual relationships between hospitals and physician groups could facilitate the benefits of integration without the same degree of risk that a merger will create an entrenched, dominant system. Trial Tr. at 3463:20-3465:12 (David Dranove).

c) The "Board Member" Defense

587. St. Luke's asks the Court to rely on its Board to act as a check on its anticompetitive behavior. In opening statements, counsel for St. Luke's claimed: "We will show . . . through the testimony of board member Skip Oppenheimer that St. Luke's is

committed to keeping the price of healthcare down." Trial Tr. at 146:16-20. Counsel further stated: "[I]f the board learns that St. Luke's is pricing in a way that is inconsistent with the Triple Aim or with the mission of St. Luke's, it can and will take action." Trial Tr. at 147:9-12. Yet, Mr. Oppenhimer testified that he could not "think of one discussion on pricing at the board or any committee level, anything I can remember being involved in that had to do with pricing." Trial Tr. at 2768:5-7 (Arthur "Skip" Oppenheimer). In addition, despite the price increases that occurred in the Magic Valley after St. Luke's acquisitions there, there is no evidence the Board took any action in response. Trial Tr. at 2780:3-8 (Arthur "Skip" Oppenheimer); Trial Tr. at 3029:20-3030:5 (David Argue). [redacted] Trial Tr. at 307:1-16 (Jeff Crouch).

588. It is clear that the St. Luke's Board has far from complete information. For example, Dr. Pate testified that he purposely did not bring the option of a "looser affiliation" with Saltzer to the Board for its consideration because that was "really not on the table." Trial Tr. at 1644:1-23; 1676:11-15 (David Pate).

589. When asked whether the Board considered a looser affiliation with Saltzer before approving the transaction, however, St. Luke's Board member Arthur "Skip" Oppenheimer contradicted Dr. Pate, agreeing that the Board did consider a looser affiliation and stating that the Board "discussed different options." Trial Tr. at 2780:22-25 (Arthur "Skip" Oppenheimer). Mr. Oppenheimer also testified—after stating repeatedly that he thought the question irrelevant—that he thought that the percentage of primary care physicians that St. Luke's now commands in Nampa as a result of the transaction is approximately 60 percent, Trial Tr. at 2783:10-2784:1 (Arthur "Skip" Oppenheimer), a figure off by almost 20 percent. TX 1789.

590. In its opening statement, St. Luke's also claimed that its Board has several representatives from the business community "who have a material interest in keeping their employees' healthcare costs low" so that they would hold St. Luke's management accountable. Trial Tr. at 146:23-25 (Defendants' Opening Statement). But the St. Luke's executive in charge of implementing St. Luke's strategy testified that he "absolutely" does not take the interests of Board members into account when he takes action. Trial Tr. at 2012:11-14 (John Kee).

591. Dr. Pate claimed that if St. Luke's engaged in "any effort" to charge "unreasonable" prices, he can "guarantee" that he would hear from the Board. Trial Tr. at 1646:7-12 (David Pate).

592. Of course, Dr. Pate acknowledged, as he must, that St. Luke's management, not its Board, sets prices. Trial Tr. at 1645:18-20 (David Pate).

593. Moreover, as Dr. Pate explained, the St. Luke's Board has to rely on his "good judgment" to present issues for their consideration. Trial Tr. at 1678:2-9 (David Pate). And St. Luke's own internal ordinary-course documents suggest that management considers whether it should share complete information with the board: "never show the board the true information." TX 1091 at HCF0001118.

594. As Dr. Pate explained to a public audience, in considering whether to continue this litigation, the board is "going to turn and look to the CEO for the direction." Trial Tr. at 1679:7-1680:8 (David Pate).

595. Not surprisingly, the St. Luke's Board has never voted against a physician practice acquisition approved by St. Luke's senior management. Trial Tr. at 2779:10-15 (Arthur "Skip" Oppenheimer). Indeed, every vote by the St. Luke's Board regarding whether to approve

a physician practice acquisition has been a unanimous vote in favor of the acquisition. Trial Tr. at 2770:10-19 (Arthur "Skip" Oppenheimer).

596. According to minutes from a June 2009 meeting of St. Luke's Health System's Project Leadership Team, John Kee and Chris Roth (who was at the time COO of St. Luke's Treasure Valley) "proposed that at least *a few trusted board members* are shown the true economics of the physician division and explain to them how the practice losses are made up in hospital and other downstream revenues for the system." TX 1091 at HCF0001116 (emphasis added); Trial Tr. at 2024:4-2026:14 (John Kee).

d) The "Medicaid Access" Defense

597. Defendants stated in their opening statement that Director Armstrong will testify that the transaction will increase access for Medicaid patients in Idaho. Trial Tr. at 116:8-14. But Director Armstrong testified that he is not aware of any requirement that physician practices affiliate with a hospital to treat Medicaid patients, and that many physician groups in the Nampa area do in fact treat Medicaid patients despite no affiliation between the physician practice and a hospital. Trial Tr. at 2290:10-17.

598. Director Armstrong also pointed out that there are no access issues for Medicaid patients in Nampa. Trial Tr. at 2290:18-22 (Richard Armstrong). Specifically, Director Armstrong testified that many physician groups unaffiliated with hospital systems in Nampa see Medicaid patients. Trial Tr. at 2290:14-17 (Richard Armstrong).

599. As a Saltzer physician, Steven Williams has never refused to see a Medicare or Medicaid patient or to provide surgical services to him or her. Nor has he ever refused to care for an indigent patient that was referred to him. Trial Tr. at 2484:24-2485:5 (Steven Williams).

3. New Entry And Expansion Will Not Counteract Or Deter The Acquisition's Anticompetitive Effects

600. The merger does not change the potential for entry or change the potential for filling capacity. Trial Tr. at 1362:20-25 (David Dranove).

601. Even if other market participants have the capacity to see more patients, this excess capacity would not counteract the anticompetitive effects of the acquisition. To the extent that additional capacity functions as a constraint, it does so both before and after the acquisition—the acquisition still increases the relative leverage of the merged St. Luke's/Saltzer. Trial Tr. at 3431:12-3432:16 (David Dranove).

602. Defendants have claimed that other providers may have the capacity to expand their operations. But, as Professor Dranove's diversion analysis demonstrated, St. Luke's and Saltzer are each other's closest substitutes. Trial Tr. at 1349:17-1354:15 (David Dranove). Although other providers may have additional capacity to see patients, this potential constraint on price existed before the Acquisition. By merging many patients' first and second most-preferred providers, the Acquisition significantly enhances St. Luke's relative negotiating leverage, even if those patients' third or fourth options have some additional capacity. Trial Tr. at 3431:24-25, 3432:1-18 (David Dranove).

a) Entry And Expansion Will Not Be Timely

603. For primary care physicians coming into a new market, the entry barriers are considerable. It is not as simple as hanging up a shingle and expecting patients to come. Trial Tr. at 1360:4-14 (David Dranove). Other entry barriers include leasing an office, hiring staff, and buying expensive equipment. Trial Tr. 1360:4-24 (David Dranove); *see also* TX1251 at SLHS000522529.

604. A physician must establish a reputation so he or she can get recommendations. A physician cannot get recommendations from other patients without any patients to begin with.

The physician needs to have to be integrated into a referral network. Trial Tr. at 1360:4-24 (David Dranove).

605. In 2012, SAMG had three family practice doctors start in Nampa, but they have had difficulty growing their practice and are roughly in the 25th percentile for productivity compared to national averages. Trial Tr. at 715:8-18 (Nancy Powell). SAMG is currently losing money on those Nampa doctors' practices. Trial Tr. at 715:19-20 (Nancy Powell).

606. One reason that SAMG family practice doctors have had a hard time ramping up their practice in Nampa is they compete against Saltzer, which has a very strong reputation in the community. Moreover, even St. Luke's Family Practice Group has been in the community longer than the SAMG doctors. Trial Tr. at 711:1-6, 715:21-716:4 (Nancy Powell).

b) Entry And Expansion Is Not Likely To Occur

607. There has been no *de novo* entry of PCPs into Nampa over the last several years. All of the physicians who have come into the market have come into established group practices. Trial Tr. at 1360:25-1361:4 (David Dranove); TX 1798. The unlikeliness of entry is confirmed by the fact that the PCP market shares in Nampa have changed little over time. Trial Tr. at 1361:5-10 (David Dranove).

608. Recruiting general internists has been difficult because there is a tendency among internal medicine physicians who finish their residencies either to go into a hospitalist program, which is just inpatient medicine, or to go on to various subspecialties like cardiology or pulmonology. Trial Tr. at 714:8-19 (Nancy Powell); Dkt. No. 364 (Roach Dep. Tr.) at 254:17-18, 254:20-21.

609. A 2012 Physician Demand assessment found that "there is a shortage of 90 primary care physicians in greater Treasure Valley market or about 8 primary care physicians per 100K population." TX 1592 at SLHS000040981; Dkt. No. 100 (St. Luke's Answer) at ¶ 57.

610. It's more difficult to recruit physicians to Nampa than it is to recruit to Boise because Boise is a more attractive community to most providers. Dkt. No. 363 (Reinhardt Dep. Tr.) at 47:15-20; Tr. 714:20-715:4 (Nancy Powell). And it is easier to recruit physicians to Meridian than Nampa. Trial Tr. at 3332:23-3333:1 (Thomas Patterson).

611. [redacted] Trial Tr. at 1179:5-19 (David Peterman). Younger doctors prefer to live and practice in Ada County. Trial Tr. at 1181:6-16 (David Peterman). [redacted] Trial Tr. at 1221:16-25 (David Peterman).

612. [redacted] Trial Tr. at 1222:20-1223:12 (David Peterman).

613. In 2013, SAMG has not had any success in recruiting family practice doctors to Nampa. Trial Tr. at 715:5-7 (Nancy Powell). In fact, SAMG has not had any success recruiting pediatricians to Nampa since Nancy Powell joined nearly two years ago. Trial Tr. at 713:18-714:2 (Nancy Powell). Likewise, SAMG has not been able to recruit general internists to Nampa during that same time period. Trial Tr. at 714:3-7 (Nancy Powell).

614. Saltzer also had problems recruiting new physicians. Dkt. No. 271 (Reiboldt Dep. Tr.) at 114:24-115:13. Before the acquisition, Saltzer had problems recruiting physicians because of lack of capital. Saltzer officials were "starting to see this as a trend and were fearful that this would be more so . . . going forward." Dkt. No. 271 (Reiboldt Dep. Tr.) at 114:24-115:6.

c) Entry And Expansion Will Not Be Sufficient To Deter Or Counteract The Harm That Will Result From The Acquisition

615. Saltzer's reputation in Nampa is much stronger than SAMG's. Saltzer has been in the Nampa community for 52 years. Trial Tr. at 705:22-706:4 (Nancy Powell). Even with that reputational advantage, it took new Saltzer family practice physicians about six-months to ramp up their practice to the point where they were getting close to their guarantee or exceeding it. Trial Tr. 716:5-11 (Nancy Powell).

616. Existing players have had a difficult time attracting patients because it is hard to get patients to leave their preferred providers. "Patients establish relationships with their doctors, especially in primary care, and do not want to leave them." Trial Tr. at 1361:22-1362:3 (David Dranove).

617. At Saltzer, the practice is full because of the reputation in the community, and everyone in the practice benefits from that kind of word-of-mouth marketing. Trial Tr. at 716:12-13, 716:21-717:9 (Nancy Powell).

618. Recruiting primary care doctors was easier at Saltzer than at SAMG because of the support they had within the group. Trial Tr. 717:10-18 (Nancy Powell).

619. Since the acquisition, Saint Al's has been unsuccessful in recruiting both pediatricians and general internal medicine physicians. Trial Tr. at 882:8-16 (Karl Keeler).

620. Karl Keeler testified that it would be "nearly impossible to "recruit enough primary care physicians to provide a contribution to the hospital comparable at all to what Saltzer has provided." Trial Tr. at 882:17-882:20 (Karl Keeler). "Primary Health has a couple clinics in Nampa, but other than that, from a primary care standpoint, there really isn't any other primary care, inclusive of internal medicine and pediatrics." Trial Tr. at 882:24-883:5 (Karl Keeler).

V. THE ACQUISITION SUBSTANTIALLY LESSENS COMPETITION IN OTHER MARKETS[1]

A. ADDITIONAL RELEVANT MARKETS

1. Pediatric Primary Care Physician Services

621. An additional relevant market in this case involves pediatric primary physician services. This represents a separate relevant market, because many consumers prefer to have their children's medical needs treated by a pediatrician. As a result, health care plans always include pediatricians in their networks, and a health care plan would be unsuccessful if it attempted to sell a product without pediatricians in the network. This means that there is no reasonable substitute for pediatricians in a health care plan's network. Trial Tr. at 1476:21–1477:4 (Deborah Haas-Wilson); TX 3000 at Slide 5; Trial Tr. at 1481:14–1482:12 (Deborah Haas-Wilson); TX 3000 at Slide 9.

622. Both economists agree that payer networks need pediatricians. *See* Trial Tr. at 3057:13–3057:22 (David Argue) (It would be difficult for a payer in the Treasure Valley to successfully sell a product without pediatricians in the network); Trial Tr. at 1482:6–12 (Deborah Haas-Wilson); TX 3000 at Slide 9 (Not a single network that Haas-Wilson examined in the Treasure Valley exists without pediatricians).

623. Professor Haas-Wilson's conclusions are also supported by substantial factual testimony. *See* Trial Tr. at 3333:5–14 (Thomas Patterson) (Important to offer a pediatric option separate from family medicine in Nampa because certain children "need a pediatric medical home" as opposed to a family physician.); Trial Tr. at 1235:1–10 (Blaine Petersen) (Never seen or put together a network without pediatricians "because many families, many individuals,

[1] The Federal Trade Commission and the State of Idaho do not join this section of Plaintiffs' Proposed Findings of Fact and Conclusions of Law.

request pediatricians be part of the network to care for their children"); Trial Tr. at 709:16–20 (Nancy Powell) (Saltzer perception that parents prefer children see a pediatrician if given the option); Trial Tr. at 1780:10–15 (Patricia Richards) (Pediatricians are in all of the networks offered by SelectHealth and she "can't imagine that [it] would" offer a network without pediatricians).

2. General Acute Care Inpatient Services

624. General acute care inpatient hospital services represent another relevant product market. This product market consists of hospital services requiring an overnight stay. Trial Tr. at 1477:5–12 (Deborah Haas-Wilson); TX 3000 at Slide 5.

625. This product market definition is uncontested by defendants.

3. Outpatient Surgical Facilities Markets

626. The outpatient surgical facilities markets encompass general surgery and neuro+orthopedic surgery "facility services, not the professional services provided by the physicians." Trial Tr. at 1477:13–20 (Deborah Haas-Wilson); TX 3000 at Slide 5. *See also* Trial Tr. at 1477:21–1478:1 (Deborah Haas-Wilson); TX 3000 at Slide 5.

627. These product markets are also not contested by defendants.

4. Relevant Geographic Market for Pediatric Physician Care

628. The relevant geographic market for pediatric physician care should be limited to Nampa because "physicians recognize that patients are interested in having close, convenient access to their pediatrician, that they don't want to travel far to get their pediatric primary care services." Trial Tr. at 1483:18–24 (Deborah Haas-Wilson); TX 3000 Slide 10.

629. Dr. Haas-Wilson's conclusion was supported by patient flow analyses, location of physician offices, deposition testimony from physicians, evidence from Saltzer and St. Luke's

documents, Trial Tr. at 1482:25–1484:4 (Deborah Haas-Wilson); TX 1686; TX 3000 at Slides 10 & 11. Dkt. No. 249 (Johnson Dep. Tr.) at 119:10–18; 119:20–120:1.

630. "[A]ny health insurer or an employer who is trying to develop a marketable health plan has to satisfy this 56 percent of the Nampa residents who want to receive the pediatric care in Nampa. So when they are designing their health plan and determining their provider network, they recognize that they need to have pediatricians located in Nampa as part of their provider network." Trial Tr. at 1484:5–15 (Deborah Haas-Wilson); TX 3000 at Slide 10.

631. Pediatric offices are located in multiple neighborhoods, Trial Tr. at 1483:5–17 (Deborah Haas-Wilson); TX 3000 at Slide 10, because "the physicians recognize that patients are interested in having close, convenient access to their pediatrician . . ." Trial Tr. at 1483:18–24 (Deborah Haas-Wilson); TX 3000 at Slide 10.

632. Dr. Patterson of Saltzer agreed that "it's important for pediatric patients to have care close to home." Trial Tr. at 3333:15–17 (Thomas Patterson). *See also* Trial Tr. at 3333:12–14 (Thomas Patterson) ("[I]t's important to offer a pediatric option to the residents in Nampa.").

633. The theoretical possibility that patients could travel based on price or other financial incentives does not change this conclusion. "There are no employers or payers willing to impose those sorts of financial incentives on their employees or enrollees. They're not willing to take the risk of angering or upsetting or disrupting their employees or enrollees by giving financial incentive to travel further to more distant providers." Trial Tr. at 1486:5–18 (Deborah Haas-Wilson); TX 1686; TX 3000 at Slide 11.

634. Alternative relevant geographic markets include Nampa and Caldwell, or Nampa, Caldwell and Meridian. Trial Tr. at 1484:16–1485:2 (Deborah Haas-Wilson); TX 1693; TX 1694; TX 1695; TX 3000 at Slide 12. Prof. Haas-Wilson's conclusions are not dependent on the

choice of geographic market. Whether the market is defined as Nampa alone, Nampa plus Meridian, Canyon County or Canyon County plus Meridian, the resulting HHIs exceed 3,000. Trial Tr. at 1484:16–1485:2 (Deborah Haas-Wilson); TX 1694; TX 1695; TX 3000 at Slide 12.

5. Relevant Geographic Market for Hospital and Surgical Facilities Markets

635. The relevant geographic market applicable to inpatient acute care hospital services and outpatient surgical facilities is comprised of Ada and Canyon counties. This is because "[p]atients tend to be willing to travel further distances to receive their hospital inpatient and their outpatient services than they are for primary care." Trial Tr. at 1478:2–11 (Deborah Haas-Wilson); TX 3000 at Slide 5.

636. Dr. Argue does not dispute that the relevant geographic market for the hospital and facilities product markets include Ada and Canyon counties. Trial Tr. at 2994:7–2994:16 (David Argue).

B. ANTICOMPETITIVE CONDUCT

1. Foreclosure

a) Definition and Economic Principles

637. "Foreclosure" involves "impeding a rival or rivals from access to a necessary input. And in this case, that necessary input is the patients. . . ." Trial Tr. at 1494:8–1494:15 (Deborah Haas-Wilson). "[T]hat foreclosure from the necessary input, or the patients, impedes rivals' abilities to compete on the merits to compete based on price and quality." Trial Tr. at 1494:8–15 (Deborah Haas-Wilson). "[T]hen you have decreased competition in the market, and consumers will be . . . worse off . . . because they will be facing higher prices." Trial Tr. at 1494:16–1495:3 (Deborah Haas-Wilson).

638. Acquisition of physician groups results in foreclosure because "if a hospital system acquires physicians' practices, those physicians become part of that health system, and at that point the incentives of those physicians are aligned with the incentives of the health system that has acquired them." Trial Tr. at 1495:20–1496:4 (Deborah Haas-Wilson). Dr. Haas-Wilson's opinion is supported by a statement by John Kee, Vice President, Network Operations of St. Luke's, that "[f]inancial integration ensures the alignment of our partners because they will be mutually invested in the arrangement." Trial Tr. at 1496:5–14 (Deborah Haas-Wilson).

639. This alignment of financial incentives does not depend on a specific contractual requirement regarding referrals. Trial Tr. at 1496:22–24 (Deborah Haas-Wilson).

b) Significance of Primary Care Physician Referrals

640. Prof. Haas-Wilson concluded that foreclosure is significant in this case because "physicians have a very large influence on where their patients go for the next level of care." Trial Tr. at 1495:4–1496:4; 1498:9–16 (Deborah Haas-Wilson); TX 3000 at Slide 22. "[T]he primary care providers are key to determining where patients receive their outpatient services, their ancillaries, and how they decide which hospital to use for their inpatient or outpatient services." Trial Tr. at 1478:19–1479:2 (Deborah Haas-Wilson); TX 1366 at SMG000033689; TX 3000 at Slide 6.

641. Prof. Haas-Wilson's conclusion was based on testimony from a number of St. Luke's physicians as well as her review of the health care literature. Trial Tr. at 1495:4–1496:4 (Deborah Haas-Wilson). Dr. Haas-Wilson referenced to, among other things, the deposition testimony from St. Luke's Clinic physicians, Dr. Robert Walker, Dr. Jon Schott, and Dr. Mark Rutherford, all of whom testified that their patients follow their recommendations on choices of hospitals and specialists. Trial Tr. at 1495:4–1496:4 (Deborah Haas-Wilson); TX 3000 at Slide 22.

642. Dr. Argue agreed that "many patients do not have a preference about where they are hospitalized and will just follow their physicians' recommendations." Trial Tr. at 3058:19–22 (David Argue).

643. The same conclusions were expressed by a number of Saltzer and St. Luke's personnel. Dr. Page (who served on Saltzer's Negotiating Committee) stated in a letter signed by 26 Saltzer physicians that providers "control the input to outpatient services, diagnostics, and referral to proceduralists who then use the hospital." TX 1366 at SMG000033689, SMG000033690. Dr. Kunz, the Chair of Saltzer's Executive Committee, agreed that "part of the value of primary care physicians to a hospital system is the access that those primary care physicians provide to their patient base for referrals." Trial Tr. at 3310:22–3311:5; 3378:15–18 (Harold Kunz).

644. Joni Stright of St. Luke's agreed that the value of a physician group is comprised of its "professional practice activity plus the hospital outpatient and inpatient activity it generates plus the primary care referrals it generates." Dkt. No. 320 (Stright Dep. Tr.) at 175:11–177:12; TX 1255 at 10.

645. Specialty physicians in Boise rely on primary care physicians across all market areas for referrals. TX 2528 at p. 16.

c) Evidence of Foreclosure

646. Prof. Haas-Wilson relied on at least eight different sources of testimony and documents for her conclusion that the Saltzer physicians, like other St. Luke's acquired physicians, were likely to cause their patients to utilize St. Luke's facilities after a Saltzer transaction, resulting in foreclosure. These sources included substantial testimony and documents from both Saltzer and St. Luke's as well as at least five different sources of data. Trial Tr. at 1498:17–25 (Deborah Haas-Wilson); TX 3000 at Slide 23.

647. Dr. Argue admits based on St. Luke's own data that "there is a direct relationship between the gain or loss of patients for physician services and the gain or loss of patients for hospitalization." Trial Tr. at 3058:23–3059:2 (David Argue).

(1) Expectations of Saltzer and St. Luke's Regarding Referrals to St. Luke's

648. Substantial documentary and testimonial evidence (set forth below) establishes that there is an expectation on the part of St. Luke's that the Saltzer physicians will cause their patients to utilize St. Luke's facilities after the acquisition. This expectation was recognized, and agreed to, by Saltzer from the beginning of negotiations with St. Luke's. *See supra* Section IV.B.4.

649. According to Max Reiboldt, the consultant to Saltzer Medical Group, St. Luke's, St. Luke's personnel told Saltzer that "once the new [St. Luke's Nampa] hospital is up, [St. Luke's] expect[s] that volume" that is currently being performed at Mercy (now Saint Alphonsus-Nampa) to be transferred to St. Luke's new hospital. Dkt. No. 271 (Reiboldt Dep. Tr.) at 123:8–124:6; TX 1144 at COKER-P-0000013-14. [redacted] Dkt. No. 271 (Max Reiboldt) at 97:4–97:23, 97:25–99:1.

650. [redacted] TX 1143 at SMG000033854. [redacted] TX 1143 at SMG000033850.

651. [redacted] Dkt. No. 271 (Reiboldt Dep. Tr.) at 97:4–23, 97:25–99:1; TX 1156 at COKER0011261.

652. [redacted] TX 1143 at SMG000033856. [redacted] Dkt. No. 271 (Reiboldt Dep. Tr.) at 90:14–91:11.

653. These conclusions are confirmed by St. Luke's and Saltzer personnel. Jeff Taylor, CFO of St. Luke's, expects Saltzer physicians to shift their referrals, testifying that "in the context of a plan over an – extended period of time" it is the "intention of St. Luke's management to . . . build a hospital in Nampa and staff it with Saltzer physicians." Dkt. No. 287 (Taylor Dep. Tr.) at 218:5–218:13. *See* Trial Tr. at 1638:1–20 (David Pate).

654. [redacted] TX 1155 at COKER0006581.

655. This expectation of referrals became an especially significant issue for the Saltzer surgeons. Chris Roth, St. Luke's Treasure Valley CEO, admitted that he told Dr. Williams of Saltzer that he "needed the surgeons to cover the new Nampa hospital" and that "St. Luke's expected that the surgeons commit to the new Nampa Facility." Trial Tr. at 2319:12-16;

2320:24-2321:3 (Chris Roth). He agreed that by "cover the hospital" he "meant perform the surgeries needed at the hospital." Trial Tr. at 2320:17-23 (Chris Roth).

656. In St. Luke's view, this commitment was inconsistent with practice at other hospitals, such as Treasure Valley Hospital. Roth told Dr. Williams and the other surgeons that "we have plans and we intend to build services in Nampa, inpatient services, surgical services. And as time passes, I predicted that it would be more difficult for them to commit and serve a growing facility and also Treasure Valley Hospital." Trial Tr. at 2322:6-2323:4 (Chris Roth).

657. John Kee of St. Luke's told Dr. Williams that exclusive referrals would be necessary from the Saltzer surgeons. Mr. Kee stated specifically, that "St. Luke's was spending a lot of money on [the surgery center]and that a half interest from us was not going to be good enough and was not going to keep it running." Mr. Kee said "that he needed all [Dr. Williams'] business." Trial Tr. at 2492:20- 2493:16 (Steven Williams).

658. [redacted] Pl. Ex. 1370 at SMG000279202. [redacted]

659. [redacted] TX 1384 at COKER0007737.

660. [redacted] Trial Tr. at 740:8-741:13 (Nancy Powell). TX 1384 at COKER 0007737.

661. St. Luke's was concerned that if the Saltzer surgeons that were invested in Treasure Valley "were not loyal to their hospital in Nampa, if they continued to do all the work at Treasure Valley", St. Luke's would not have enough volume for their new hospital. Dkt. No. 271 (Reiboldt Dep. Tr.) at 121:22-123:3, TX 1144 at COKER-P-0000013..

662. [redacted] Dkt. No. 271 (Reiboldt Dep. Tr.) at 136:7-138:5; TX 1160 at COKER0009508.

663. Most of the critical evidence on this issue arose during 2011, and the Saltzer transaction was not completed until late 2012. However, given the commencement of the Federal Trade Commission and Idaho Attorney General investigations at the beginning of 2012 (Trial Tr. at 2470:7-19 (John Kaiser)), it is not surprising that the most candid documents are to be found during 2011.

664. While the referral issue was addressed in documents less frequently after the government investigation began in 2012, the same views were reported orally. Former Saltzer surgeon Steven Williams testified that "Dr. Kaiser [President of Saltzer] . . . made the statement . . . that if the primary care doctors were getting their operative reports sent back to them from places such as Treasure Valley Hospital or Saint Alphonsus, that they needed to think long and

hard about that because that was not the direction that the majority of the group had decided that the group wanted to take." Trial Tr. at 2495:4-2496:21 (Steven Williams).

665. After the surgeons decided to leave Saltzer rather than accept St. Luke's offer, and as the closing of the transaction neared, St. Luke's anticipated that the Saltzer surgery referrals would migrate to St. Luke's. In a September 2012 email, Kathy Moore, Chief Operating Officer of St. Luke's Treasure Valley, stated that "If Saltzer spins off General and Ortho specialties" they would refer to "St. Luke's aligned docs." TX 1120. Dkt. No. 284 (Moore Dep. Tr.) at 94:12-95:4; 95:7-12; 95:14-96:1 . *See also* TX 1122.

666. The Professional Services Agreement with Saltzer includes an Exclusivity Provision at Section 2.2(a) that states "Saltzer and Saltzer physicians shall only provide Services and related administrative activities on behalf of St. Luke's." TX 24 AT CX0005-005. Chris Roth testified that exclusivity requires that doctors be "100 percent dedicated to St. Luke's" as defined in Section 2.2. Trial Tr. at 2319:6-11 (Chris Roth).

667. This documentary and testimonial evidence establishes that St. Luke's expects, and Saltzer intends, that Saltzer referrals will be shifted to St. Luke's at least at the time when St. Luke's opens its new hospital facility in Nampa. Statements at trial to the contrary by Saltzer witnesses are not credible in light of this clear pattern. See Findings, *supra.*

668. The testimony of Saltzer and St. Luke's witnesses regarding their lack of anticompetitive intent is also not credible in light of their efforts in testimony to distort the plain English meaning of the words in their ordinary course documents. For example, Dr. Page, a member of Saltzer's Negotiating Committee, claimed that "dominant" does not mean "dominate." Trial Tr. at 2864:19-2865:17 (Randell Page); TX 1366 at SMG00033689. Dr. Page also claimed that "control" means "input." Trial Tr. at 2865:18-2866:8 (Randell Page); TX 1366

at SMG000033689. Chris Roth, the CEO of St. Luke's Treasure Valley, claimed that "pressure" means to "engage" or "ask," or "work with." Trial Tr. at 2314:7-19 (Chris Roth); TX 1093 at SLHS000006605. These statements are not only themselves not credible, but they seriously weaken the credibility of the overall testimony of Saltzer's and St. Luke's key witnesses.

(2) Changes in Referrals from Saltzer

669. Despite the Court's December 2012 Order, many referrals by Saltzer physicians have already shifted to St. Luke's. Dr. Kunz testified that since Saltzer entered into its PSA with St. Luke's, his referrals to the St. Luke's Boise Surgical Group, St. Luke's orthopedic department and St. Luke's specialists generally have increased. Trial Tr. at 3378:19-25; 3379:1-3 (Harold Kunz).

670. Dr. Kunz admitted that he hasn't sent patients to Dr. Williams "in a while." Trial Tr. at 3379:7-9 (Harold Kunz). Prior to the St. Luke's acquisition, he referred more than 10 patients a year to Dr. Williams, because "it was good for [his] patients to refer to a surgeon who was highly skilled." Trial Tr. at 3381:24-3382:6 (Harold Kunz). Dr. Kaiser, Saltzer's President, acknowledged that referrals to former Saltzer surgeons are down substantially. Dkt. No. 323 (Kaiser Dep. Tr.) at 251:16-23.

671. Dr. Page of Saltzer acknowledged that his outpatient cases at Saint Al's are down to less than half what they were prior to the acquisition. He chose to go off the endoscopy call schedule at Saint Al's Nampa and, as a result, was doing less cases at Saint Al's Nampa. Dkt. No. 270 (Page Dep. Tr.) at 220:9-221:4

672. Dr. Williams' "Saltzer referrals became nonexistent" starting in September 2012, when he announced he was not participating in the St. Luke's acquisition. Trial Tr. at 2497:15-2498:5 (Steven Williams).

673. The Saltzer physicians who had not had privileges at St. Luke's have now obtained them as a result of the transaction. Dr. Djernes of Saltzer's Executive Committee first applied for privileges at St. Luke's after the agreement for Saltzer to be acquired by St. Luke's was reached. He did so in order to refer patients to St. Luke's facilities. Previously, he had done these procedures at Saint Alphonsus. Dkt. No. 269 (Djernes Dep. Tr.) at 54:16-55:2; 55:22-56:19.

674. Dr. Kunz first obtained admitting privileges at St. Luke's in 2013 in connection with entering into the transaction with St. Luke's. Trial Tr. at 3380:10-15 (Harold Kunz).

675. [redacted] Trial Tr. at 961:3-962:7 (Lannie Checketts).

(3) St. Luke's Clinic Physicians Refer to St. Luke's

676. This pattern has been exhibited by many other groups acquired by St. Luke's, including the so-called Mercy Physicians Group of primary care physicians in Nampa. These physicians had active staff privileges at Saint Alphonsus Nampa, but after joining St. Luke's they relinquished their privileges. Trial Tr. at 871:10-872:17 (Karl Keeler). An internal St. Luke's document reporting on a meeting with Dr. Crownson of the Mercy Physicians Group stated that: "The physicians first attempt to make a referral to St. Luke's providers." TX 1445 at SLHS001146556; Trial Tr. at 2211:14-2212:6 (Adebayo Crownson).

677. St. Luke's physicians limit their referrals to St. Luke's facilities even when Saint Alphonsus facilities are substantially more convenient. There are new urology, general surgery, ENT, and orthopedic St. Luke's physicians practicing in the Saltzer offices located in Saint Al's Nampa parking lot, but none of these physicians have sought privileges to practice at Saint Alphonsus Nampa. Trial Tr. at 875:25-876:12 (Karl Keeler).

678. This same pattern of referrals to St. Luke's facilities and specialists has been repeatedly admitted by a wide variety of St. Luke's physicians. Dr. Johnson of St. Luke's Mountain View Medical testified that unless a patient states a preference for a particular hospital, "I'll typically have them admitted at St. Luke's." Dkt. No. 249 (Johnson Dep. Tr.) at 73:16-24.

679. Prior to Boise Orthopedic Clinic's acquisition by St. Luke's, Dr. Walker of BOC performed approximately 20% of his cases at Treasure Valley Hospital. Dkt. No. 255 (Walker Dep. Tr.) at 74:2-6. Since the acquisition, Dr. Walker has performed no more than five cases at TVH. Dkt. No. 255 (Walker Dep. Tr.) at 9:16-19; 77:16-20. Dr. Walker could not recall performing any procedures at TVH since 2011. Dkt. No. 255 (Walker Dep. Tr.) at 78:6-9.

680. In 2010, the year that Boise Orthopedic Clinic was acquired by St. Luke's, its number of cases at Treasure Valley Hospital dropped from over 400 to 60. Trial Tr. at 1015:22-1016:6 (Nicholas Genna). And in 2011 through 2013, Boise Orthopedic Clinic surgeons have not performed any surgeries at Treasure Valley Hospital. Trial Tr. at 1016:25-1017:4. (Nicholas Genna).

681. Dr. Barresi of Boise Surgical Group estimated that, prior to the group's acquisition by St. Luke's, he performed 70 to 80 percent of both his inpatient and outpatient procedures at Saint Alphonsus. Dkt. No. 370 (Barresi Dep. Tr.) at 75:9-25. Since Dr. Barresi relinquished his privileges at Saint Alphonsus in May of 2012, he has not performed any surgeries at Saint Alphonsus. Dkt. No. 370 (Barresi Dep. Tr.) at 77:1-10, 77:12-14. Dr. Barresi now performs all of his inpatient and outpatient procedures at St. Luke's. Dkt. No. 370 (Barresi Dep. Tr.) at 77:18-24.

682. This change cannot be attributed to changes in Saint Alphonsus Medical Group ("SAMG") primary care referrals to Dr. Barresi. The patients for whom Dr. Barresi had

previously performed surgeries at Saint Alphonsus included patients that did not have a SAMG primary care physician, but were referred to him from St. Luke's Clinic physicians and other independent physicians. Dkt. No. 370 (Barresi Dep. Tr.) at 76:1-10; 76:11-25; 118:17-25; 119:21-25.

683. Dr. Priest of St. Luke's Idaho Cardiology Associates testified that after becoming employed by St. Luke's, he and his partners relinquished their privileges at Saint Alphonsus. Trial Tr. at 1827:16-22 (Marshall Priest).

684. Dr. Priest admitted that "prior to [his] employment at St. Luke's [he] referred 50 percent of [his] patients that needed pacemakers or defibrillators to Dr. Seale," one of his former partners. Trial Tr. at 1851:23-1852:3 (Marshall Priest). When ICA was acquired by St. Luke's, Dr. Seale was one of the four former ICA physicians who joined Saint Alphonsus instead. Trial Tr. at 1853:9-17 (Marshall Priest). Dr. Priest admitted that he thereafter "dropped using Dr. Seale even though [he] thought he was [his] go-to guy who did a good job on pacemakers and defibrillators." Trial Tr. at 1853:13 - 1854:1 (Marshall Priest).

685. Dr. Priest admitted that even without having privileges at Saint Alphonsus, he could still send outpatient cases to or have ancillary procedures performed at Saint Alphonsus. However, in 2010 and 2011, the overwhelming majority of his ancillary (outpatient) referrals were to St. Luke's. Trial Tr. at 1825:13-17; 1825:18-1826:1 (Marshall Priest).

686. Dr. Souza of St. Luke's Idaho Pulmonary Associates acknowledged that following the acquisition by St. Luke's in January of 2010, he "stopped seeing patients at Saint Alphonsus all together in May 2010." Dkt. No. 290 (Souza Dep. Tr.) at 79:24-80:5. Previously 50% of his work was at Saint Alphonsus. Trial Tr. at 2055:6-8 (James Souza). Dr. Souza has

not sent any patients to Saint Alphonsus for outpatient procedures since May of 2010. Dkt. No. 290 (Souza Dep. Tr.) at 89:23-90:4.

687. Dr. Souza testified that when making referrals to specialists, unless a patient states a specific preference, he refers them to a St. Luke's specialist. Dkt. No. 290 (Souza Dep. Tr.) at 100:3-100:14.

688. The changes in Idaho Pulmonary Associates' referrals after acquisition cannot be explained by a desire to reduce the burden of hospital call. Dr. Souza testified that prior to Idaho Pulmonary Associates' acquisition by St. Luke's, the fourteen physicians in the practice shared call at four different hospitals. After the acquisition, the ten physicians that went to St. Luke's share call at three different hospitals. Trial Tr. at 2091:22-2092:10 (James Souza). This is a minor change in burden.

689. Dr. Williams testified that he "received a lot of referrals from –from Dr. Crownson" when Dr. Crownson was part of the Mercy Medical Group at Saint Alphonsus." Trial Tr. at 2517:7-15 (Steven Williams). But in the last 12 months, Dr. Williams hasn't had a single referral from Dr. Crownson, who is now a St. Luke's Clinic primary care physician. Trial Tr. at 2485:6-21 (Steven Williams).

690. A sign at each St. Luke's Internal Medicine facility reads: "If you need emergency care … St. Luke's Internal Medicine doctors admit patients only to St. Luke's facilities." Dkt. No. 285 (Orr Dep. Tr.) at 112:3-9, 116:8-13, 116:18-22 – TX 1017.

(4) St. Luke's Expectations Regarding Referrals by St. Luke's Clinic Physicians

691. St. Luke's executives fully expect that the physicians in the groups they acquire will utilize St. Luke's facilities. Kathy Moore, also acknowledged that St. Luke's seeks to create revenue enhancement through acquisition and integration of new groups like Saltzer, which they

expect will result in "greater use of the hospital." Dkt. No. 284 (Moore Dep. Tr. at) 79:9-80:1; 80:3-4; 81:23-82:4; 83:3-6.

692. St. Luke's expected that, post-acquisition, physicians at Cardiovascular and Chest Surgical Associates, Boise Orthopedic Clinic and the Women's Clinic would "end up doing most of their work" at St. Luke's. Dkt. No. 289 (Fletcher Dep. Tr.) at 148:3-9; 149:19-149:24, TX 1138.

693. Gary Fletcher, St. Luke's COO, acknowledged that St. Luke's made plans "to provide sufficient capacity for all cases [of Intermountain Orthopaedics] to be performed at St. Luke's after the acquisition of the group. Dkt. No. 289 (Fletcher Dep. Tr.) at 155:1-7.

694. In an internal email, Gregory Orr, St. Luke's former Director of Physician Services, referenced "St. Luke's historical willingness to preferentially direct patients to St. Luke's affiliated practices rather than equally among all on med staff." TX 1014 at SLHS0000004621.

695. St. Luke's physicians are expected to refer to St. Luke's specialists and facilities even when they regard them as inferior. Dr. Bathina, Vice President of St. Luke's Idaho Cardiology Associates, stated in an email that "[i]t will be very disappointing to us doctors who work on the west side to have to refer to these guys [Saltzer], because they are now part of [Luke's], when we are fully aware that they offer a far inferior product to what our colleagues at IPA can provide." TX 1357 at 0000004617; Trial Tr. at 2087:2-2088:11; Dkt. No. 290 (James Souza Dep. Tr.) at 150:15-151:4; 155:4-13.

696. St. Luke's tried to cover up the evidence related to shifting of referrals. In an internal St. Luke's email, Kathy Moore, the COO of St. Luke's Treasure Valley, instructed Joni Stright to delete the portion of a document addressing the Boise Surgical acquisition which

stated: "Currently, the surgical volume is divided between St. Luke's and St. Alphonsus hospitals. It is anticipated that surgical volume will migrate to St. Luke's over time as additional outpatient surgical capacity at St. Luke's becomes available." TX 1116 at SLHS000091783 - 91785. Ms. Moore explained in the email: "We can talk to this but I don't think we want it in the document."

(5) St. Luke's Actions to Control Referrals by St. Luke's Clinic Physicians

697. St. Luke's has also taken specific steps to assure that referrals will remain within the system. St. Luke's Intermountain Orthopedics changed its order screens to "eliminate[_] the ability to easily choose from several imaging centers." TX 1094 at SLHS000104683.

698. The EPIC electronic medical records system causes "all referrals [to] auto default to internal referral [St. Luke's] type." TX 1257.

699. The "default lab" and default option for imaging for St. Luke's Clinic physicians are St. Luke's facilities. Dkt. No. 285 (Orr Dep. Tr.) at 123:20-125:5

(6) Analysis of Data

700. Dr. Haas-Wilson examined a broad range of data in addition to documents and testimony to support her conclusion that a Saltzer acquisition will result in substantial foreclosure. This included inpatient and outpatient data, payer and hospital data, and data concerning specialists and primary care physicians. Trial Tr. at 1498:17-25 (Deborah Haas-Wilson); TX 3000 at Slide 23.

701. Dr. Haas-Wilson's conclusions were supported by evidence that after five specialty practices were acquired by St. Luke's, "their business at Saint Alphonsus Boise dropped dramatically [and] the amount of business that they did at St. Luke's facilities increased dramatically." The declines, which occurred for both inpatient and outpatient business, were

often 90% or greater. Trial Tr. at, pp. 1501:17-22 (Deborah Haas-Wilson); TX 1668, 1705, 1741, 1853; TX 3000 at Slides 31-34; Trial Tr. at 1502:4-25; 1503:5-13 (Deborah Haas-Wilson).

702. The same loss of cases was experienced at Treasure Valley Hospital after surgical practices were acquired by St. Luke's. In fact, the decline was by 95-96%. Trial Tr. at 1503:14-21, 1503:24-1504:3 (Deborah Haas-Wilson); TX 1668; TX 3000 at Slides 34-35.

703. A similar pattern was seen in a more than 77% decline in imaging cases done at Saint Alphonsus Nampa by the "Mercy Group" physicians after they were acquired by St. Luke's. Trial Tr. at 1505:3-1505:20 (Deborah Haas-Wilson), TX 1669; TX 3000 at Slide 36.

704. Dr. Crownson's efforts to explain this pattern do not account for the extremely large decline. Saint Luke's imaging facility opened in June of 2012. Trial Tr. at 2218:25-2219:2 (Adebayo Crownson). Therefore, Dr. Crownson's testimony about patients choosing an imaging center based upon interfacing with St. Luke's medical records "wouldn't apply to data prior to June of 2012." Trial Tr. at 2219:3-5. Moreover, Dr. Crownson's statement that many patients without prompting ask which imaging center interfaces with their medical record is simply not credible. Trial Tr. at 2207:7-18; 2212:23-2214:2; 2214:22- 2216:14; 2216:25-2218:24 (Adebayo Crownson).

705. Dr. Crownson testified that "if a patient that lives in South Nampa, most of – most of the time they will probably prefer to go to Saint Alphonsus Nampa [for imaging]. If they live in North Nampa, they will probably prefer to go to North Nampa." Trial Tr. at 2217:7-20 (Adebayo Crownson). About 40% of the group's patients are in south Nampa. Trial Tr. at 2217:24-2218:2 (Adebayo Crownson). Dr. Crownson's offices are in South Nampa. Trial Tr. at 2218:3-2218:8 (Adebayo Crownson). In North Nampa, there is both a St. Luke's imaging facility and a Saint Alphonsus imaging facility. Trial Tr. at 2218:9-12 (Adebayo Crownson).

Therefore, patient location cannot explain the 77% drop in imaging cases at Saint Alphonsus Nampa after the St. Luke's acquisition of the Mercy Physicians Group.

706. Dr. Haas-Wilson conducted her data analysis in a number of different ways in order to account for possible alternative explanations for the results that she found. Trial Tr. at 1500:21-1505:15 (Deborah Haas-Wilson); TX 1668, 1669, 1705, 1741, 1853; TX 3000 at Slides 31-36. In particular:

a. St. Luke's economist suggested that changes in inpatient admissions after an acquisition could have resulted from a pattern of admissions by hospitalists. As a result, Dr. Haas-Wilson examined changes in both inpatient and outpatient cases. Outpatient cases are not handled by hospitalists. She found the same pattern in both cases. Trial Tr. at 1503:1-1504:3; 1505:3-1505:15; 1507:10-1507:16 (Deborah Haas-Wilson); TX 3000 at Slides 31-36, TX 1668, 1669, 1705, 1853.

b. When patients are admitted by specialists, those cases are not attributed to hospitalists. Trial Tr. at 3271:24-3272:2 (Lisa Ahern). Prof. Haas-Wilson's analyses of specialists' admissions. discussed above, cannot be explained by the use of hospitalists.

c. St. Luke's experts have suggested that an increase in cases at St. Luke's after an acquisition could result from "split billing," at St. Luke's facilities, which could cause two procedures to be recorded for some items. Dr. Haas-Wilson therefore examined not only increases in cases at St. Luke's, but also declines in cases at Saint Alphonsus. Trial Tr. at 1504:4-1505:20 (Deborah Haas-Wilson); TX 1668, 1669; TX 3000 at Slides 34-36.

d. St. Luke's experts and witnesses suggested that declines at Saint Alphonsus were due to shifts in referrals by SAMG primary care physicians. Dr. Haas-Wilson found declines in referrals occurred regardless of whether the patient had a SAMG or non-SAMG PCP. In fact, the decline was 96% for non-SAMG patients versus 97% for SAMG patients. Trial Tr. at 1506:19-1507: 16 (Deborah Haas-Wilson), TX 1673, 1674; TX 3000 at Slide 37, Trial Tr. at 1590:14-1592:7 (Deborah Haas-Wilson).

707. Dr. Argue admitted that the groups of the three St. Luke's physicians who testified at trial, Idaho Pulmonary Associates, Idaho Cardiovascular Associates, and Cardiovascular and Chest Surgical Associates "after the acquisitions saw their cases at Saint Al's

drop by more than 90% for those patients who had not seen a SAMG primary care doctor." Trial Tr. at 3059:6-15 (David Argue). Dr. Argue also conceded that it was "probably" true that these physicians' outpatient cases and specialty referrals declined by similar amounts. Trial Tr. at 3059:16-18 (David Argue). Therefore, this pattern cannot be explained by changes in SAMG referrals.

708. Dr. Haas-Wilson did not examine whether Saint Alphonsus was able to gain back lost business from past St. Luke's acquisitions, because that wasn't directly relevant to the question of what would happen if Saltzer was acquired. She did look at the likelihood that Saint Alphonsus Nampa could gain back lost Saltzer referrals if the acquisition went forward, and concluded that it was very unlikely that Saint Alphonsus would be able to recruit sufficient physicians to replace the losses from Saltzer. Trial Tr. at 1508:24-1510:6 (Deborah Haas-Wilson).

(7) PCP vs. Admission Analysis

709. The analyses of referrals by St. Luke's experts were flawed because, instead of examining the identity of the admitting physician, they examined hospital admissions for patients who had a particular primary care physician. Dr. Argue's analyses of referrals did not specifically identify the physician making the referral or the physician making the admission. Trial Tr. at 3060:1-6. Dr. Argue simply identified the primary care physician the patient had seen. Trial Tr. at 3060:7-10. Dr. Ahern took the same approach. Trial Tr. at 3169:19-3170:13; 3177:24-3178:3 (Lisa Ahern); TX 5123 at 5123.25.

710. This approach simply assumes, without evidence, that the hospital admission or referral is attributable to the patient's primary care physician. In many cases, instead, the admission or referral may be performed by a specialist. Trial Tr. at 1507:17-1508:23 (Deborah Haas-Wilson); TX 3000 at Slide 38.

711. This approach is particularly susceptible to error when examining the pattern of admissions or outpatient cases before and after an acquisition of a PCP group, because the PCP's referral to the specialist could have occurred before the acquisition, and the hospital admission or outpatient case ordered by the specialist after the acquisition. In that event, the analyses by St. Luke's experts would falsely attribute cases that occurred after a PCP group's acquisition to that PCP group. Trial Tr. at 1507:17-1508:23 (Deborah Haas-Wilson); TX 3000 at Slide 38; Trial Tr. at 3058;23-3063:1 (David Argue); Trial Tr. at 3266:17-3269:12 (Lisa Ahern); Trial Tr. at 3297-6-3301:17 (Lisa Ahern).

712. Dr. Argue did not even try to assess "even approximately" the frequency with which patients of primary care physicians whose practice were acquired by St. Luke's had hospital admissions after the acquisition that were "not attributable in any way to the actions of the primary care physician after the acquisition." Trial Tr. at 3061:10-16. This problem "is a function of the specific way" that Dr. Argue looked at the data. Trial Tr. at 3063:9-14 (David Argue).

713. Even under Dr. Argue's methodology, referrals by acquired primary care groups to St. Luke's specialists increased by more than 50% after the groups were acquired by St. Luke's. Trial Tr. at 3063:22-3064:2 (David Argue).

714. St. Luke's expert Ms. Ahern admitted that the PCP field at Saint Alphonsus Nampa does not mention referrals. Trial Tr. at 3266:24-3267:1 (Lisa Ahern). The PCP field "doesn't tell you whether any patient admission was caused in any way by the primary care physician who is shown in the field." Trial Tr. at 3268:3-8 (Lisa Ahern).

715. The primary care physician field at Saint Alphonsus Nampa is often incomplete. Trial Tr. at 975:11-19 (Lannie Checketts).

716. In contrast to Dr. Argue and Ms. Ahern, Dr. Haas-Wilson's analysis of pre and post-acquisition admissions utilized the admitting physician field. This field identified the doctor shown as responsible for the admission in the hospital's records. Trial Tr. at 3172:2-3173:5; 3268:9-15 (Lisa Ahern); TX 5123.25.

717. Prof. Haas-Wilson utilized the primary care physician field only when estimating the potential overall magnitude of Saltzer physicians' importance to Saint Alphonsus Nampa and Treasure Valley hospital. Trial Tr. at 1514:15-1516:23 (Deborah Haas-Wilson); TX 3000 at Slide 43, TX 1702. Prof. Haas-Wilson did not attempt to estimate the change in admissions due to acquisitions using the primary care physician field, because of the timing problems involved in estimating the effect of referrals that may have occurred before the acquisition leading to admissions after the acquisition. Trial Tr. at 1507:17-1508:23 (Deborah Haas-Wilson); TX 3000 at Slide 38.

718. In fact, the use of the admitting physician field, as Dr. Haas-Wilson did, may underestimate the admissions attributable to a primary care physician (since it will not include hospitalist cases), and therefore the effective amount of foreclosure. Trial Tr. at 3268:9-15 (Lisa Ahern). This is a more conservative approach.

(8) Ms. Ahern's Analysis

719. Ms. Ahern's data analysis was also contradicted by her own statements regarding her expectations of Saltzer referrals. While Ms. Ahern's calculations were intended to show that St. Luke's physicians' admissions at Saint Alphonsus did not decrease substantially after the physician groups' acquisitions by St. Luke's, her conclusions regarding physician behavior were directly to the contrary. Ms. Ahern stated that because Dr. Ballantyne's practice was acquired by St. Luke's "the presumption is that Dr. Ballantyne will no longer be performing all of his volume

any longer at Saint Alphonsus." Trial Tr. at 3258:13-20. She added that "his practice will change . . . by no longer being at Saint Alphonsus." Trial Tr. at 3259:2-5 (Lisa Ahern).

720. In fact, when asked whether "if this acquisition goes forward", Saltzer doctors will "typically have the patients admitted at St. Luke's" "if there is not a [patient] preference", Ms. Ahern could only say "I have no expectation of what Saltzer doctors will do at St. Luke's." Trial Tr. at 3260:23-3261:7 (Lisa Ahern).

721. Additionally, when asked "what St. Luke's expectations were as to where the Saltzer referrals would go after St. Luke's acquired Saltzer" Ms. Ahern said "I don't know what their expectations are, no." Trial Tr. at 3261:9-12 (Lisa Ahern).

722. Since Ms. Ahern was unwilling to reach any conclusions about to whom the Saltzer physicians will refer if this acquisition goes forward, her analysis of data pertaining to this question is of no weight. See Findings, *supra.*

723. Ms. Ahern has very little experience in the kinds of analyses she has performed in this case. She never previously provided a specific opinion to a client on physician referrals. Trial Tr. at 3262:8-10 (Lisa Ahern). Apart from this case, she never tried to perform any kind of calculation where she attributed referrals or admissions at a hospital to particular physicians or groups of physicians. *Id.* at 3262:22-3263:1 (Lisa Ahern). She has never prepared projections of hospital revenues from scratch. Trial Tr. at 3272:3-5 (Lisa Ahern).

724. Ms. Ahern addressed the cases handled by the Saltzer surgeons. But she has no view about the relationship between those cases and any loss of surgery cases performed by Saint Alphonsus Nampa due to the Saltzer transaction. Trial Tr. at 3265:16-3266:2. She admits that to the extent the ex-Saltzer surgeons gained referrals from SAMG doctors, those may have

been cases that would have gone to Saint Alphonsus Nampa in any event. Trial Tr. at 3266:3-6 (Lisa Ahern).

(9) Exclusivity Does Not Lead to Efficiencies

725. Exclusive control of referrals within a health system is not necessary to improve quality of care. Dr. Pate "believe[s] it's possible for physicians who are aligned with one hospital in the Treasure Valley to work closely on clinical issues with hospitals and physicians in the other system." Trial Tr. at 1688:17-21 (Dr. Pate).

726. Dr. Pate agreed that it is not "necessary for a physician to make referrals exclusively within one system or another in order to participate effectively in coordinated care and clinical integration." Trial Tr. at 1688:22 - 1689:14 (Dr. Pate).

727. Dr. Polk testified that he does not think that physician groups belonging to both the Saint Alphonsus Health Alliance and other networks will have difficulties achieving the quality goals of the Alliance, because if they are engaged "in doing clinical integration work with different networks, the metrics, the quality measures are going to be very similar. We're all using the NCQA HEDIS metrics." Trial Tr. at 3652:14-3653:6 (Robert Polk).

(10) Conclusion Regarding Foreclosure

728. Therefore, based upon the strong evidence of both St. Luke's and Saltzer's expectations regarding referrals of the Saltzer physicians after the Saltzer acquisition; admissions by St. Luke's physicians whose practices have been acquired St. Luke's; the practices within St. Luke's to steer referrals; and the data analyzed by Prof. Haas-Wilson, the Court finds that significant foreclosure of competition for the referrals of the Saltzer physicians is likely if the acquisition is not unwound. See Findings, *supra*.

C. THE ACQUISITION WILL HARM NETWORK COMPETITION

1. Importance of network competition

729. Competition between networks of providers is an important competitive activity in the Treasure Valley and in health care generally. Because patients need to access a wide range of providers, including hospitals, physicians in many specialties, outpatient centers, and ancillary facilities, a payer or employer will need to contract with providers in each of these categories to provide a full range of health care services. This can involve very substantial transaction costs if the payer or employer needs to separately make arrangements with each independent provider in each of these categories. Trial Tr. at 1486:19-1488:14 (Deborah Haas-Wilson); TX 3000 at Slides 14,15.

730. These transaction costs are substantially reduced through the formation of networks of providers, which can contract on behalf of a range of providers. This is especially important for employers, smaller payors and national payors without a substantial presence in Idaho, for whom these transaction costs will be greater than, for example, a very large payer like Blue Cross or Regence Blue Shield. Trial Tr. at 1487:18-1488:14 (Deborah Haas-Wilson); TX 3000 at Slides 13, 14.

731. Thus, networks provide an important, efficiency-enhancing competitive alternative, especially for self-insured employers, smaller payors and national payors. Any impediment to vigorous network competition will harm overall competition in the markets in which the networks provide services, including each of the relevant markets in this case. Trial Tr. at 1486:19-1488:14 (Deborah Haas-Wilson); TX 3000 at Slides 14, 15.

732. There are a number of networks competing in the Treasure Valley. These include Select Medical (the network anchored by St. Luke's and St. Luke's Clinic Physicians) (Trial Tr. at 1659:11 – 1660:1 (David Pate)); the Saint Alphonsus Health Alliance (the network anchored by Saint Alphonsus (Trial Tr. at 1237:11-15 (Blaine Petersen)) formerly Advantage Care

Network or ACN. (Trial Tr. at 1237:1-7 (Blaine Petersen)); the Micron Health Partner Network, put together by Imagine Health (Trial Tr. at 556:18-22 (Patrick Otte)); and IPN or the Idaho Physicians Network, a broad-based PPO network operating across Idaho (Trial Tr. at 459:17 – 19; 459:25 – 460:17 (Linda Duer)). Trial Tr. at 1548:24-1549:13 (Deborah Haas-Wilson). IPN (which represents many employers and national payors) serves more lives in Idaho than any payer except Blue Cross of Idaho. Trial Tr. at 460:15-461:13 (Linda Duer).

733. Provider networks will play an important role in St. Luke's strategy going forward. St. Luke's BrightPath network will provide medical services to Select Health. Trial Tr. at 1766;10-19 (Patricia Richards). St. Luke's is planning to further emphasize the role of its Select Medical network in its competitive and quality activities. Trial Tr. at 1660:2-17 (David Pate); TX 1658 at 1.

2. Importance of Saltzer to Network Competition

734. Professor Haas-Wilson concluded that Saltzer is critical to the competitiveness of any Treasure Valley network, based on the testimony of St. Luke's and payer witnesses, as well as the experience of Saint Alphonsus employees. Trial Tr. at 1489:18-21 (Deborah Haas-Wilson); TX 3000 at Slides 15-17. Her conclusion was based in part on the fact that Saint Alphonsus Nampa employees demanded that Saltzer be included in their network. Trial Tr. at 1547:18-1548:7 (Haas-Wilson Cross)

735. Many market participants, including representatives of IPN, Blue Cross, Regence, Saint Alphonsus and St. Luke's, share this conclusion. "There is no comparison" between the reputation of SAMG and Saltzer physicians. Trial Tr. at 466:18-467:1 (Linda Duer).

736. Linda Duer, Executive Director of Idaho Physicians Network, testified that she could not "successfully market a network to self-funded employers in Nampa that did not include Saltzer primary care physicians . . . [b]ecause Saltzer is the -- well, it was the largest

independent, multispecialty clinic in the state of Idaho. They are not only the largest, but they're a very prestigious group . . . and it's just a clinic that everybody goes to." Trial Tr. at 465:2-465:14 (Linda Duer).

737. Customers have told Linda Duer that they will not contract with IPN if Saltzer is not included in IPN's network. Trial Tr. at 486:14-20 (Linda Duer).

738. [redacted] Trial Tr. at 331:6-331:10 (Jeff Crouch). He further testified that "if SelectHealth had Saltzer and Blue Cross of Idaho did not have Saltzer in their respective networks," it would "give an advantage to St. Luke's." Trial Tr. at 317:21-318:1 (Jeff Crouch).

739. Greg Sonnenberg (formerly of Saint Alphonsus) testified that in connection with St. Luke's acquisition of Saltzer, "[a]ll the payers have asked about the status of Saltzer….meaning they have a concern as to whether or not Saltzer is in our network." Dkt. No. 373 (Sonnenberg Dep. Tr.) at 230:1-10. "If Saltzer is not part of the network", the Saint Alphonsus Health Alliance would "have a major hole in the Nampa service area" and the Alliance "will not be an attractive primary care network in the Nampa area without Saltzer." Trial Tr. at 1257:2-17 (Blaine Petersen).

740. [redacted] Trial Tr. at 1258:6-13 (Blaine Petersen).

741. [redacted] Trial Tr. at 1257:18-1258: 5 (Blaine Petersen).

742. Scott Clement of Regence is "not able to think of any" employers or health plans that have been able to sell products in the Nampa area without Saltzer in their network. Dkt. No. 252 (Clement Dep. Tr.) at 184:13-17.

743. Mr. Clement of Regence explained that "[t]he reasons that we made any departures from the statewide fee schedule for anybody, when it came right down to it, had to do with how not having somebody in the network might impact our ability to sell products, and that would be directly related, at least one dimension that we consider, and that would be the size of a group. … [t]here were customers for whom we knew, I knew, it was critical that Saltzer be part of the network." Dkt. No. 252 (Clement Dep. Tr.) at 156:5-18. These included Nampa School District and City of Nampa. Dkt. No. 252 (Clement Dep. Tr.) at 156:19-24.

744. Regence paid Saltzer more because "we weren't - wouldn't be able to field a competitive product if they weren't in it." Dkt. No. 252 (Clement Dep. Tr.) at 71:20-72:3.

745. [redacted] TX 1224 at SLHS001222471. [redacted] Dkt. No. 321 (Billings Dep. Tr.) at 96:16-97:11.

746. [redacted]

[redacted] Trial Tr. at 1491:6-22 (Deborah Haas-Wilson); TX 3000 at Slide 17.

747. Patricia Richards testified that "Select Health needs Saltzer in its provider network because [it] want[s] a robust provider network that would be attractive in the commercial market." Trial Tr. at 1763:4-21 (Patricia Richards).

3. St. Luke's Plans to Pull Doctors from Competing Networks

748. [redacted] Dkt. No. 321 (Billings Dep. Tr.) at 99:10 - 99:23; TX 1225 at SLHS000892455.

749. [redacted] Trial Tr. at 471:5-24 (Linda Duer); Dkt. No. 322 (Drake Dep. Tr.) at 8:6-8.

750. In February 2012, the St. Luke's Payor Contracting Committee approved a decision to "[e]xit the ACN agreement for all clinics by July 1, 2013." That approval has never been rescinded. Dkt. No. 322 (Drake Dep. Tr.) at 254:7-255:12; 255:14; TX 1207 at 2, TX 1208 at SLHS000656059.

751. [redacted]

[redacted] TX 1989 at SLHS001394172.

752. St. Luke's "inten[ded] to take out every group that [it] had acquired that was in the [Micron] high-performance network." Dkt. No. 322 (Drake Dep. Tr.) at 237:9 – 13. When asked by Randy Billings if he was "able to alert [Micron] regarding our intentions with St. Luke's few existing WISE relationships," Mr. Drake responded "[y]es . . . I told them we intended to terminate those agreements by June 30." Dkt. No. 322 (Drake Dep. Tr.) at 237:9-13; 234:5 - 235:3. TX 1204 at SLHS000031963.

753. A number of physician practices have left Advantage Care Network ("ACN") (the Micron PPO network) since being acquired by St. Luke's. Jackie Butterbaugh identified several examples in her testimony, including Boise Heart, who did not "stay in the PPO network after being acquired by St. Luke's, Dkt. No. 318 (Butterbaugh Dep. Tr.) at 43:10-43:19, and the Boise Surgical Group, which Imagine terminated from ACN after determining that the Boise Surgical physicians no longer held privileges at Saint Alphonsus. Since the Boise Surgical physicians no longer had privileges at Saint Alphonsus, "all of their services would be going to St. Luke's, "which is . . . out of network, and a . . . service concern for the Micron patients. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 50:25-52:2.

754. Although St. Luke's initially planned to "pull all of the St. Luke's acquired groups and St. Luke's Clinic physicians from ACN," and Mr. Drake "probably had a discussion" with Greg Sonnenberg of ACN about that plan, St. Luke's has not yet completed that step. Mr.

Drake testified that the FTC investigation was "probably a factor" in St. Luke's decision to not yet proceed with the plan. Dkt. No. 322 (Drake Dep. Tr.) at 241:5-8; 10-17; 244:7-10; 12-16.

755. "The concern in the long-term for Saltzer is that St. Luke's will drop Saltzer out of our ConnectedCare network and out of the Saint Al's Alliance Network and they'll only be available through the BrightPath Network and through Select Health." Trial Tr. at 427:21-428:10 (Jeff Crouch).

756. The acquisition of Saltzer threatens to severely reduce or eliminate network competition because access to vital Saltzer and St. Luke's physicians would only be possible through St. Luke's-supported networks, such as Select Medical or BrightPath. "[T]his will certainly harm the ability of IPN, the Saint Al's Health Alliance network, to compete with the St. Luke's network. The other rivals will look a lot less attractive to any employer or any payer when they decide which network to contract with." Trial Tr. at 1518:20-1519:5, 1519:23-1520:15 (Deborah Haas-Wilson), TX 1854 at 22; TX 3000 at Slide 47.

757. St. Luke's failed to present any testimony at trial from any of its executives responsible for its networks or managed care strategy.

4. St. Luke's Anticompetitive Actions Directed at Micron and Imagine Health

758. Events relating to Micron illustrate St. Luke's intent to avoid price competition and to prevent robust network competition, using its acquired physician groups as part of that strategy. See Findings, *infra.*

(1) St. Luke's and Saltzer's Concerns Regarding Competition

759. Both St. Luke's and Saltzer were concerned that the Micron/Imagine "biding model" would spread in the Treasure Valley and create more price competition.

760. Select Medical board minutes discussing the Micron strategy noted that: "Keep in mind with the growth of the Treasure Valley, Select will be seeing other companies likewise making their presence in Boise." TX 1165 at SLHS000243830. When asked whether the idea being discussed was whether other companies may come in and try to get deep discounts in exchange for preferential treatment on behalf of employers, Linda House of St. Luke's responded "I believe that's what was discussed." Dkt. No. 267 (House Dep. Tr.) at 77:10-25.

761. It "was obvious that" Wise and Imagine had a strategy to disrupt current levels of competition in the market, and "Linda House was against that." Dkt. No. 267 at 118:20-22; 118:24-119:2; 119:4-11. [redacted] TX 1229. See also Dkt. No. 321 (Billings Dep. Tr. at) 140:5-16.

762. [redacted] TX 2193 at SALTZER1661633. In testimony, Powell expressed concern regarding "giv[ing] the network any strength so that they would be able to take the network beyond outside of Micron." Trial Tr. at 759:13-760:14 (Nancy Powell).

763. An email sent by Ms. Powell to Randall Page, Exhibit 2193, expressed concern regarding "giving the network any teeth." When asked what this phrase meant, Ms. Powell testified that Saltzer "didn't want to give the network any strength so that they would be able to take the network beyond . . . Micron." Trial Tr. at 760:9-14 (Nancy Powell); TX 2193 at SALTZER161633.

(2) St. Luke's Efforts to Impede the Micron Network

764. [redacted] Trial Tr. at 565:5-16 (Patrick Otte).

765. Micron/Imagine also sought to include Saltzer in the preferred network. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 29:23-30:3. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 32:16-17. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 31:9-32:25.

766. Imagine later offered a better price to Saltzer (2% better than Blue Cross) to participate in the network, and Saltzer again declined. Trial Tr. at 748:15-24 (Nancy Powell). Dr. Page noted "pros [in joining Micron Network] are decent fee schedule . . . Cons are that we help legitimize a network and a process that may end up setting bad precedent for this area if it is successful." TX 32 at SMG000300733.

767. In 2011, Saltzer joined the ACN network and thereby became part of Micron's second tier network. Trial Tr. at 718:10-13, 749:23-750:1 (Nancy Powell).

768. After the bidding was complete for the high performance network, Micron/Imagine sought a national preferred provider organization or "PPO" to provide a second tier network. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 33:17-34:1. Imagine initially selected First Health—an existing PPO network with St. Luke's Boise hospital in its network—to be the PPO network for Micron. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 36:5-15.

769. St. Luke's issued a termination notice to First Health, and First Health withdrew its bid. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 36:5-37:4; Trial Tr. at 567:3-16 (Patrick Otte); TX 1167 at SLHS001045879, TX 1199 at SLHS000259990, TX 1200 at SLHS000606120.

770. Steve Drake admitted that St. Luke's was "working against Micron" in its efforts with First Health. Dkt. No. 322 (Drake Dep. Tr.) at 211:1-11. An internal St. Luke's document stated that "[a] very strong response is required to assure that WISE does not try to replicate this effort in conjunction with First Health for other larger employers." TX 1197 at SLHS000847691.

771. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 34:2-7.

772. [redacted] TX 1165 at SLHS000243831.

773. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 34:8-18.

774. St. Luke's was ultimately "unable to scuttle the [Micron] network." Dkt. No. 322 (Drake Dep. Tr.) at 207:2-3; 207:5-7.

775. ACN was eventually chosen as the core of the PPO tier of the Micron network in 2008. Trial Tr. at 567:17-568:9 (Patrick Otte); Dkt. No. 318 (Butterbaugh Dep. Tr.) at 40:1-18.

(3) St. Luke's Discussions with Micron

776. [redacted] Trial Tr. at 573:25-574:20, 575:4-17, 577:6-14, 578:14-580:23 (Patrick Otte).

[redacted]

777. A 2010 St. Luke's agenda for a meeting with Micron stated that "[w]e are not interested in discounting for volume [or] participating in the Wise network." This view was articulated to Micron at the time by Linda House of St. Luke's. Dkt. No. 267 (House Dep. Tr.) at 111:25-112:19; Dkt. No. 267 (House Dep. Tr. at) 118:4-19.

778. Even after the Micron program was successful, St. Luke's never came back to Imagine and asked to be considered for a bid, and still have not done so up to today. Dkt. No. 318 (Butterbaugh Dep. Tr.) at 41:8-22.

(4) St. Luke's Withdrawal of Physicians from the Micron Network

779. In 2012, St. Luke's pulled several acquired physician groups from the Micron network. Trial Tr. at 581:3-582:2, 582:8-583:18, 585:11-586:4 (Patrick Otte); TX 1005 at Imagine 000604. St. Luke's intended to pull every group that it had acquired from the high-performance network. Dkt. No. 322 (Drake Dep. Tr.) at 237:9-13.

780. [redacted] TX 1005 at IMAGINE000604.

781. Steven Drake admitted that it was his intention "to take out every group that [St. Luke's] had acquired that was in the [Micron] high-performance network." Dkt. No. 322 (Drake Dep. Tr.) at 237:9-237:13.

782. Drake admits that one message Micron could take from St. Luke's pulling out its physicians is that Micron "can't have [Luke's] physicians in [Micron's] high-performance network unless [Micron] do[es] a deal with [Luke's]. Dkt. No. 322 (Drake Dep. Tr.) at 238: 17 – 20; 238: 22 – 25.

783. Micron has had substantial success in shifting patients to their preferred providers in its high performance network. But this has not relieved Micron of problems resulting from the absence of St. Luke's and St. Luke's physicians from its network. Butterbaugh says there was "serious disruption" when Boise Orthopedic left the network. "Micron, by nature of their business, orthopedic is a big medical spend for them. … Boise Orthopedic provided that full scope, head to toe, for orthopedic services that they were able to cover." Dkt. No. 318 (Butterbaugh Dep. Tr.) at 135:10-23. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 58:7-23.

784. [redacted] Trial Tr. at 581:10-582: 2 (Patrick Otte). [redacted] Trial Tr. at 1254:14-1255:4 (Blaine Petersen).

(5) St. Luke's Continues to Refuse to Compete Vigorously on Price

785. [redacted]

[redacted] Trial Tr. at 584: 11 – 25 (Patrick Otte).

786. While St. Luke's has attempted to argue that what it opposes is fee for service discounts, Linda House doesn't know the way, if any, that agreeing to deep discounts for volume would interfere with St. Luke's clinical integration efforts. "I'm not sure I can answer that. . . . I don't know." Dkt. No. 267 (House Dep. Tr.) at 87:3-7; 87:9-18; 87:20-24.

787. Dr. Pate testified that "St. Luke's was not interested in any proposal to Micron that would have involved a cost-per-unit proposal that would have met Saint Al's prices." Trial Tr. at 1695:5-8 (David Pate). Yet, Dr. Pate told Micron President Mark Durcan in 2012 Luke's was not prepared to take on risk with Micron. Trial Tr. at 1695: 22-1696:14 (David Pate).

788. [redacted] Dkt. No. 321 (Billings Dep. Tr.) at 140:5 – 140:16. [redacted] Trial Tr. at 580:20-23 (Patrick Otte).

789. It appears that St. Luke's will nevertheless gain entry into the Micron network, as Mark Durcan, the President of Micron, told David Pate that he "very much wanted St. Luke's in its network" and "committed" to a relationship with St. Luke's. Trial Tr. at 1696:15-1696: 21 (David Pate).

790. [redacted]

[redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 137:7-8; 137:10-19.

(6) Failure to Expand Micron Network to Other Employers

791. [redacted] Dkt. No. 318 (Butterbaugh Dep. Tr.) at 57:8-58:6.

792. Despite discussing Micron's healthcare plans with several other firms in the Treasure Valley, Micron has only been able to lease the network to Wal-Mart. Trial Tr. at 588:2-16 (Patrick Otte). After five years, only one other employer (Walmart) and no Boise-area employers have joined the Micron network. Trial Tr. at 590:2-24 (Patrick Otte).

793. Patrick Otte, Micron's VP of Human Resources, believes Micron's lack of success in leasing to other firms stems from "an unwillingness to take on an institution. And, to a certain extent, that is how it is stated, that St. Luke's is an institution. You have to be willing to take that on." Trial Tr. at 590:14-24 (Patrick Otte).

5. Importance of Saltzer and St. Luke's Physicians to Saint Alphonsus Health Alliance

794. [redacted]

795. [redacted] Trial Tr. at

1239:5-7 (Blaine Petersen). [redacted] Trial Tr. at 1239:17-1241:2 (Blaine Petersen).

796. [redacted] (Trial Tr. at 1241:3-1242:21 (Blaine Petersen)).

797. Payors like Boise Schools and Idaho Power ultimately terminated arrangements to offer a network that did not include St. Luke's "because St. Luke's was…sort of a must have." Dkt. No. 397 (Jeffcoat Dep. Tr.) at 76:21-77:10.

798. [redacted] Trial Tr. at 1238:1-3; 1238:5-12 (Blaine Petersen).

799. [redacted] TX 2223 at p.4.

[redacted] *Id.* at p.35.

800. [redacted] Dkt. No. 363 (Reinhardt Dep. Tr.) at 81:4-10.

801. [redacted] Trial Tr. at 1242:22- 24; 1243:7-12 (Blaine Petersen). [redacted] Trial Tr. at 313:18-314:14 (Jeff Crouch). [redacted]

802. [redacted] Dkt. No. 373 (Sonnenberg Dep. Tr.) at 87:15-18, 87:21-88:6.

803. [redacted] Dkt. No. 373 (Sonnenberg Dep. Tr.) at 238:24-239:1.

804. [redacted]

[redacted] Dkt No. 373 (Sonnenberg Dep. Tr.) at 239:2-15.

805. [redacted] Dkt. No. 397 (Jeffcoat Dep. Tr.) at 90:19-21.

806. [redacted] TX 2222 at p. 128. [redacted]

807. [redacted] Dkt. No. 397 (Jeffcoat Dep. Tr.) at 74:6-13. [redacted] Dkt. No. 397 (Jeffcoat Dep. Tr.) at 74:6-74:25.

808. While Saint Alphonsus through its counsel has represented to the FTC that "health care reform and clinical advancement are inextricably linked to narrow networks," it also explained that as a result of the Saltzer transaction, "any clinically managed narrow network without St. Luke's will no longer be feasible in the Boise area. As a result, St. Luke's

acquisitions will prevent anyone but St. Luke's from competitively providing such a clinically managed network in the future." TX 2230.

6. Conclusion Regarding Network Competition

809. The Court finds that it is likely that network competition will likely be substantially diminished as a result of the acquisition of Saltzer. See Findings, *supra.*

D. THE ACQUISITION WILL HARM OVERALL COMPETITION IN THE ADDITIONAL RELEVANT MARKETS

1. Introduction

810. The acquisition of Saltzer is highly likely to harm competition in the inpatient services and outpatient hospital surgical facilities markets in multiple respects:

a. *Given the highly concentrated nature of these markets today, and St. Luke's dominant position, any greater competitive advantage to St. Luke's will increase that dominance and therefore further harm competition. Trial Tr. at 1510:11-1516:24 (Deborah Haas-Wilson); TX 3000 at Slides 39-43.*

b. *Saint Alphonsus and Treasure Valley Hospital represent St. Luke's only two significant rivals in these markets. The acquisition of Saltzer will significantly weaken these rivals, and will thereby significantly diminish the few competitive constraints on St. Luke's. For this reason, in the context of this case, significant harm to Saint Alphonsus and TVH constitutes harm to overall competition. Trial Tr. at 1518:15-19 (Deborah Haas-Wilson); TX 3000 at Slides 39, 45-46.*

c. *Given the importance of Saltzer to network competition and St. Luke's plans to pull Saltzer and its other physician groups from competing networks, the acquisition threatens to severely diminish, if not eliminate, the rival networks to Select Medical and BrightPath. Trial Tr. at 1518:20-1519:8; 1519:23-1520:15 (Deborah Haas-Wilson); TX 3000 at Slides 39, 47.*

d. *Given the high quality/low cost nature of the care provided by Treasure Valley Hospital, any reduction in competition by Treasure Valley Hospital will be especially harmful to overall competition and to consumers. Trial Tr. at 1520:16-1522:14; 1524:18-1525:10; 1525:15-1526:3 (Deborah Haas-Wilson); TX 3000 at Slides 39, 48-50.*

e. *The effects of the Saltzer transaction must be assessed in light of the series of prior acquisitions made by St. Luke's. The cumulative effect of these transactions will be significantly greater than the effect of the Saltzer acquisition in isolation. Trial Tr. at 1527:9-16 (Deborah Haas-Wilson); TX 3000 at Slides 39, 56.*

f. *If the Saltzer transaction is permitted, St. Luke's will proceed to make other transactions, including those that have been on hold, and have not yet been pursued because of this litigation. In particular, continuing acquisitions of primary care physicians by St. Luke's will put pressure on other specialty physicians to seek acquisition by St. Luke's to maintain their primary care referral bases. This will further increase St. Luke's dominance, and further diminish St. Luke's few remaining rivals in the hospital and outpatient surgical facilities markets. Trial Tr. at 1510:11-1511:1 (Deborah Haas-Wilson); TX 3000 at Slide 39. Trial Tr. at 1526:6-1527:16 (Deborah Haas-Wilson); TX 44 at SLHS000075066, 1777; TX 3000 at Slides 51-56.*

811. It is Dr. Argue's view that "for harm to competitors to rise to the level of harm to competition, the losses would have to be enough to diminish substantially the competitive constraint [that competitors] place on St. Luke's." Trial Tr. at 3058:12-18 (David Argue).

2. Harm to Competition in Relevant Pediatrics Primary Care Physicians Services Market

812. Post-merger concentration in pediatrics is extremely high, substantially above the 2500 level where market power is presumed, under a series of alternative market definitions:

a. Nampa: 8,282

b. Nampa+Meridian: 4,749

c. Canyon County: 5,168

d. Canyon County+Meridian: 3,997

Trial Tr. at 1484:16–1485:2; TX 1694, 1695, 3000 at Slide 12.

813. Saltzer pediatricians face virtually no competition in Nampa. Nancy Powell stated that "[t]he only other pediatrician I'm aware of in Nampa is Dr. Hammer and he has a small independent practice." Trial Tr. at 707:18-707:21 (Nancy Powell).

814. The combination of Saltzer and St. Luke's will diminish competition in pediatrics if the relevant geographic market is defined as including Meridian. Even if there is no reduction in competition in pediatrics, because St. Luke's has no pediatricians in Canyon County, a combination of Saltzer's dominance in general pediatric care with St. Luke's already dominant market position in general acute inpatient care services and surgical facility services will increase St. Luke's referral base in these markets and further enhance its dominant position in these markets. Moreover, St. Luke's ability to withhold Saltzer's pediatricians from other networks, will further harm competing networks. See Findings, *supra.*

3. High Concentration and St. Luke's Dominance in the Relevant Hospital and Outpatient Facilities Markets

815. Concentration levels in the hospital and outpatient facilities markets are quite high, substantially greater than the level at which market power is presumed:

a. General Inpatient Acute Care Admission: 4,715

b. Neuro+Ortho Surgery Outpatient Facilities Services: 3,878

c. General Surgery Outpatient Facilities Services 4140.

816. Trial Tr. at 1513:18-1514:4 (Deborah Haas-Wilson), TX 1695, 1696, 1697; TX 3000 at Slide 42. These concentration levels are not contested by defendants.

817. Prof. Haas-Wilson opined that "[b]ecause these markets are already so highly concentrated, even small changes in concentration could harm competition." Trial Tr. at 1566:19-1567:1 (Deborah Haas-Wilson).

818. The same conclusion applies when market shares are examined. St. Luke's has a "dominant share," 59.4% of the acute care hospital inpatient market. Trial Tr. at 1511:2-10 (Deborah Haas-Wilson), TX 1695; TX 3000 at Slide 40. *See also* TX 1082 at p. 8 (St. Luke's strategic document shows St. Luke's FY11 Treasure Valley market share as 59.7%). Moreover,

"there are very few rivals in this market for St. Luke's and only one, Saint Alphonsus, that has enough -- a high enough market share to really provide some competitive constraints on St. Luke's in the inpatient market." Trial Tr. at 1511:11-25 (Deborah Haas-Wilson), TX 1695; TX 3000 at Slide 40. "[H]arm to Saint Alphonsus, while just a particular competitor, will result in harm to competition because of the important role Saint Alphonsus is playing in terms of a competitive constraint on St. Luke's, the dominant hospital." Trial Tr. at 1512:1-11 (Deborah Haas-Wilson), TX 1695; TX 3000 at Slide 40.

819. [redacted] TX 2223 at p. 12. [redacted] *Id.* This is the time period during which St. Luke's has made a large series of physician acquisitions.

820. St. Luke's already has 54-56% shares in the relevant outpatient surgical facilities markets, with its largest rivals with substantially smaller shares. Trial Tr. at 1512:19-1513: 17 (Deborah Haas-Wilson) TX 1696, 1697; TX 3000 at Slide 41.

821. Harm to Saint Alphonsus and TVH, the only two significant rivals to St. Luke's in the outpatient surgical facilities markets, would diminish the competitive constraint on St. Luke's. Trial Tr. at, pp. 1513:7-17 (Deborah Haas-Wilson) TX 1696, 1697; TX 3000 at Slide 41.

822. Other rivals are not only very small, but are also not directly competitive. Chris Roth, CEO of St. Luke's Treasure Valley, stated that the relationship between St. Luke's and West Valley as "coopetition" and "used where when we need to partner in a way that is in the best interest of the community and the organizations . . . ." Dkt. No. 286 (Roth Dep. Tr.) at 32:3-

32:18. [redacted] TX 2087 at ALPH00430572. [redacted] *Id.*

823. Competition in the relevant surgical facilities markets has been reduced by St. Luke's purchase of independent surgery centers. There had been plans to build a large physician-owned surgical hospital, referred to as the Riverside Surgical Hospital, according to Nicholas Genna who had interviewed for a position as CEO of the organization that was planning on opening the hospital. Trial Tr. at 1003:21-24; 1005:9-1006:5 (Nicholas Genna). But the project did not move forward because St. Luke's purchased the rights to the project and the land upon which it was going to build. . . . Trial Tr. at 1003:21-1004:23; 1006:6-22 (Nicholas Genna). St. Luke's also bought the River Street Orthopedic Center. Trial Tr. at 1009:25-1010:21 (Nicholas Genna).

824. The perceptions of St. Luke's dominance are shared by numerous St. Luke's and Saltzer personnel. Dr. Souza chose to affiliate with St. Luke's in significant part because in his view "St. Luke's is better positioned to be the dominant player in the market for the foreseeable future." Trial Tr. at 2090:22-2091:2 (James Souza).

825. Steven Drake of St. Luke's admitted that St. Luke's has gained market share by acquiring physician groups since 2010, and "the potential exist[ed]" that Blue Cross' likely knowledge "that many of the most popular previously independent physician groups in the Treasure Valley were now part of St. Luke's clinic" would give St. Luke's a further advantage in negotiations. Dkt. No. 322 (Drake Dep. Tr.) at 145:16-23; 145:25-146:24; 147:1.

826. Dr. Page of Saltzer opined in a letter signed by 26 Saltzer physicians: "We are already linked in many ways to St. Luke's because we all know they are and will likely remain the dominant provider." TX 1366 at SMG 000033688.

827. [redacted] TX 1093 at SLHS0000006605.

828. [redacted] If St. Luke's dominance in these relevant markets increases, it is in a better position to further that objective and continue to reduce price competition. Trial Tr. at 1520:16-1521:5 (Deborah Haas-Wilson); Dkt. 321 (Amended Billings Tr.) at 104:3-17, Trial Tr. at 140:5-140:16, TX 1225 at SLHS000892455; TX 3000 Slide 48.

829. [redacted] TX 1216 at SLHS000153663.

830. St. Luke's has contended that it will reduce customer costs by reducing utilization rather than price. But its own consultants have concluded that there is little if any opportunity to reduce utilization in Idaho. Dkt. No. 286 (Roth Dep. Tr.) at 156:12-25; 157:20-23, 158:8-159:5, 164:18-24; TX 1057 at SLHS000920868; TX 1083 at SLHS000892216.

831. Linda Duer testified that Saint Al's had higher charges than St. Luke's, but this was based on 2010 and 2011 data. Trial Tr. at 493:9-13 (Linda Duer).

832. [redacted] Dkt. No. 373 (Sonnenberg Dep. Tr.) at 67:22-68:12, this was based on the resume that he had secretly provided to St. Luke's in order to convince them to hire him.

Trial Tr. at 3390:4-17 (Gregory Sonnenberg); TX 2064 at ALPH00287653. [redacted] Dkt. No. 373 (Sonnenberg Dep. Tr.) at 70:14-71:5. [redacted] Dkt. No. 373 (Sonnenberg Dep. Tr.) at 237:11-24, 238:3-4. [redacted] Dkt. No. 373 (Sonnenberg Dep. Tr.) at 236:14-237:10. [redacted] Dkt. No. 373 (Sonnenberg Dep. Tr.) at 238:11-17.

833. Greg Sonnenberg's deposition testimony should be given little or no weight. At the time of Greg Sonnenberg's deposition, he was engaged in job negotiations with St. Luke's. Trial Tr. at 3387:4-21; 3389:9-21 (Gregory Sonnenberg); TX 1617 at SLHS000133759, Trial Tr. at 3388:19-23 (Gregory Sonnenberg). He did not advise Saint Alphonsus that he was negotiating with St. Luke's. Trial Tr. at 3389:22-25 (Gregory Sonnenberg).

4. Harm to Treasure Valley Hospital Diminishes Overall Competition

a) Procompetitive Benefits from TVH and Treasure Valley Surgery Center

834. As Prof. Haas-Wilson explained, harm to a low price/high quality competitor like TVH raises anti-competitive concerns: "Across the board, for all four services, MRI, CT scans, colonoscopies, and hernia repairs, TVH's price is significantly lower than St. Luke's average insurance payment for these selected services. . . . Trial Tr. at 1524:18-1525:10 (Deborah Haas-Wilson); TX 1654 at TVH60385, 1682; TX 3000 at Slides 49, 50: "[H]arm to the low-price

competitor that's providing competitive constraint on St. Luke's will harm competition." Trial Tr. at 1525:15-1526:3 (Deborah Haas-Wilson); TX 1654 at TVH 60385, 1682; TX 3000 at Slides 49, 50.

835. There are many examples of these lower prices. An MRI at Treasure Valley is $622, compared to $1227 at St. Luke's. CT scans at TVH are $372, while they are $904 at St. Luke's. Colonoscopy at TVH is $675; at St. Luke's, $2250. Trial Tr. at 1032:15-1033:12 (Nicholas Genna). TVH's low cost of care compared to other hospitals is what "we're known for," and is used as a selling point when recruiting physicians. Trial Tr. at 998:12-18 (Nicholas Genna).

836. St. Luke's and its board member, Dr. Huntington, have noted the disparity between its prices for outpatient surgeries and the prices charged by independent facilities. TX 1055 at p. 7, TX 1054 at SLHS000709867.

837. TVH ranks first in the U.S. in the federal government's Center for Medicare and Medicaid Services Healthcompare.com rankings on quality outcomes. Trial Tr. at 1041:16-1042:10; 1042:21-1043:10. (Nicholas Genna) TX 1649.

838. The same benefits to competition would accrue from the newly opened Treasure Valley Surgery Center. [redacted] TX 2168 at ALPH00120747. [redacted] *Id.* at ALPH00120748.

839. [redacted] TX 2168 at ALPH00120753-4.

840. [redacted] TX 2168 at ALPH00120752 in Appendix A (ALPH00120761, *et seq*.).

841. [redacted] TX 2168 at ALPH00120754.

b) Likely Harm to TVH and Treasure Valley Surgery Center

842. Saltzer has been very important to TVH's competitiveness. Obtaining referrals from PCPs is a "primary way" that TVH gets "patients referred to them for surgery." Trial Tr. at 1027:14-19 (Nick Genna). Saltzer is "pretty much the biggest group in town that is independent and had been referring to surgeons that do work at Treasure Valley Hospital." Trial Tr. at 1026:22-1027:19 (Nicholas Genna).

843. 21% of Neuro+Ortho patients and 60% of general surgery patients who had an outpatient encounter at TVH had seen a Saltzer PCP in the previous year. Trial Tr. at 1517:25-1518:19 (Deborah Haas-Wilson) TX 1703, 1704; TX 3000 at Slides 45, 46. By TVH's count, Saltzer referrals represented more than 40% of the TVH surgeon case count, with the case count growing consistently from 2008 – 2011. Trial Tr. at 1023:23-1024:3 (Nicholas Genna).

844. [redacted]

[redacted]

[redacted]Trial Tr. at 1052:16-1053:1 (Nicholas Genna) "80 percent or greater" of Williams' overall cases originated with Saltzer PCPs from 2008 – July 2012. Trial Tr. at 2474:25- 2475:5 (Steven Williams).

845. 80 percent of the surgeries Dr. Williams performed at TVH came from Saltzer PCPs prior to the fall of 2012. Trial Tr. at 2481:1-4; Trial Tr. at 2485:23- 2486:3 (Steven Williams).

846. [redacted] (TX 1144 at COKER-P-0000011), [redacted] TX 1157 at COKER-P-0000054.

847. [redacted] Trial Tr. at 1047:8-1048:1 (Nicholas Genna). TX 3001, Demonstrative 3; TX 1655 1963, 1964.

848. [redacted] [redacted]Trial Tr. at 1112:6-1113:6 (Nick Genna), Trial Tr. at 2537:6-10 (Steven Williams). [redacted] TX 2168 at ALPH00120754. [redacted]

849. [redacted] Trial Tr. at 1092:16-1093:5 (Nicholas Genna).

850. [redacted] Trial Tr. at 1108:8-1109:13 (Nicholas Genna).

851. [redacted] Trial Tr. at 1059:19-1060:3 (Nicholas Genna).

852. Surgeons that TVH has tried to recruit in 2013 have expressed reticence to become associated with TVH in an atmosphere in which primary care physicians, who control referrals, are being employed by St. Luke's. Trial Tr. at 1063:18-1064:7 (Nicholas Genna)

853. [redacted] Trial Tr. at 1055:7-19 (Nicholas Genna).

854. This follows the effects of other St. Luke's transactions. As a result of St. Luke's purchase of the River Street Orthopedic Surgery Center, the orthopedic surgeons were prevented from making new investments in Treasure Valley Hospital, which "diminish[ed] the overall pool of available surgeons to attract to Treasure Valley Hospital." Trial Tr. at 1011:8-10; 1011:24-1012:7; 1012: 10-11 (Nicholas Genna).

5. Harm to Saint Alphonsus Nampa Diminishes Overall Competition

a) Importance of Saltzer to Saint Alphonsus Nampa

855. Saint Alphonsus Nampa is critically dependent on Saltzer. 47 % of patients admitted to Saint Al's Nampa saw a Saltzer primary care physician in the previous year. If Saint Al's Nampa were to lose even a fraction of this patient group as a result of the acquisition, it would be extremely damaging to Saint Al's ability to compete. Trial Tr. at 1514:15-24 (Deborah Haas-Wilson), TX 1702, TX 3000 at Slide 43.

856. 55% of Neuro+Ortho patients and 12% of general surgery patients who had an outpatient encounter at Saint Al's Nampa had seen a Saltzer PCP in the previous year. Trial Tr. at 1518:5-19 (Deborah Haas-Wilson) TX 1703, 1704; TX 3000 at Slides 45, 46.

857. St. Luke's own executives agree with this assessment. St. Luke's personnel told Saltzer's consultant that "Saint Al's Mercy will be imploding if they kick Saltzer out." Dkt. No. 271 (Reidboldt Dep. Tr.) at 117:22-118:9; TX 1144 at COKER-P-0000013.

858. The testimony from Saint Alphonsus personnel is equally strong. When the largest medical group "not only in the state but also in your city . . . that's in your parking lot" that decides to "go with your competitor," it becomes "extremely difficult to be successful." Trial Tr. at 856:24-857:1; 857:18-25 (Karl Keeler). No physician groups are close to Saltzer or SAMG in terms of importance to Saint Al's hospital. Trial Tr. at 871:3-871:9 (Karl Keeler).

859. Saltzer is a primary source of admissions and outpatient cases at Saint Al's Nampa, and one of the two most financially important physician groups to Saint Al's Nampa. Trial Tr. at 933:8-19 (Lannie Checketts).

860. The Saltzer pediatricians are critical to Saint Al's Nampa as they are the "only pediatricians in the market[] and they provide the inpatient care at the hospital . . . ." Trial Tr. at 870:7-870:12 (Karl Keeler). The Saltzer internal medicine physicians are the "only internal medicine [physicians] in Nampa." Trial Tr. at 870:13-870:19 (Karl Keeler).

861. [redacted] TX 2510 at ALPH00329835. [redacted] TX 2510 at ALPH00329860.

862. Lannie Checketts, Saint Alphonsus Nampa's CFO, estimates that "upwards of 20 percent" of "Saint Alphonsus Nampa's revenues . . . are attributable to Saltzer physicians," based on hospitalist cases and the identity of the admitting physician. Trial Tr. at 932:15-18; 934:4-9 (Lannie Checketts). Dr. Ahern assumes that the use of the admitting field will understate the cases in which the Saltzer physicians had a role. Trial Tr. at 3268:9-15 (Lisa Ahern).

b) Improvements by Saint Alphonsus Nampa

863. Saint Alphonsus Nampa has been substantially improved. As a result, it provides greater benefits to consumers and more competition for St. Luke's. For example, the facility has improved with new flooring and paint throughout the whole facility, improved heating and cooling, upgraded rooms, increased size on orthopedic floor and lab renovations. Trial Tr. at 858:1-858:21(Karl Keeler)

864. Saint Al's IT and medical equipment have been improved as well. "[Saint Al's] implemented a 100 percent electronic health record . . . made improvements to our wireless; [Saint Al's] has wireless throughout the facility" and "100 percent of our computers have been upgraded." In addition, Saint Al's has added telemetry "as opposed to just in [Saint Al's] ICU . . . throughout the facility." In relation to medical equipment, Saint Al's has "replaced [its]

endoscopy equipment", "updated CT", and "upgraded almost every piece of equipment in our radiology department . . . ." Trial Tr. at 858:22-859:17 (Karl Keeler).

865. Substantial quality improvements have included, for example, perinatal safety initiatives, including reducing elective deliveries before 39 weeks from "around 39 percent" to "less than 1 percent." Trial Tr. at 863:20- 864:4 (Karl Keeler).. Additionally, the hospital has adopted "new protocols" to combat catheter infection based on evidence-based care and "we've only had one in the last two years." Trial Tr. at 864:5-17 (Karl Keeler).

866. Since arriving at Saint Alphonsus Nampa, Karl Keeler has "made efforts to improve hospital-physician relationships" by meeting "with all the groups to talk about what the care was in the facility and what are the things we could do to make improvements." Trial Tr. at 866: 10-19 (Karl Keeler).

867. In order to "make the hospital more physician – friendly in the surgery area," Keeler and Saint Al's Nampa now allow orthopedic surgeons to "hop rooms so we could have two ORs ready so when one was done, the surgeon would go directly into the other and start the case…they didn't have to wait until that same OR was ready for them to do another surgery." Trial Tr. at 867: 8- 20 (Karl Keeler).

868. In an effort to "improve the information flow between the hospital and physicians," physicians at Saint Al's Nampa now make sure "everything [is] transcribed " in the emergency department so that the patient's primary care physician is "able to understand what happened while the patient was in the hospital and what the next course of treatment" is. This had been a complaint of Saltzer's before, but now PCPs "get exactly what happened in the emergency department and in a timely fashion." Trial Tr. at 867:21- 868:7 (Karl Keeler).

869. These improvements have resulted in positive feedback from Saltzer personnel; "Bill Savage had made a number of comments, as well as Dr. Patterson specifically came to my office and thanked me for making – Trinity Saint Al's making improvements to the facility." Trial Tr. at 868:8-17 (Karl Keeler).

870. While prior to its acquisition by Saint Alphonsus, Mercy Medical Center faced declining facilities and declining volume, Saint Alphonsus Nampa's revenues increased by more than 10% after the improvements instituted by Karl Keeler. Trial Tr. at 3264:7-13 (Lisa Ahern).

[redacted] TX 2082 at p. 21.

871. [redacted] Trial Tr. at 908:23-909:1 (Karl Keeler). [redacted] Trial Tr. at 876:19- 877:2; 909:2-7 (Karl Keeler).

872. [redacted] TX 2079 at p. ALPH00430304. [redacted] TX 2079 at ALPH00430314. [redacted] TX 2172 at ALPH00009738.

873. [redacted] TX 2172 at p. 1 (ALPH00009735). [redacted] TX 2172 at p. 31 (ALPH00009765). [redacted] TX 2172 at p. 4 (ALPH00009738); Trial Tr. at 885:1-887:7 (Karl Keeler).

874. If the Saltzer acquisition is not unwound, it will have a crippling effect on Saint Al's because "care starts in the primary care office, so not having any of those referrals to the organization will have, I think, a devastating effect on the hospital." Trial Tr. at 876:19-877:2 (Karl Keeler).

875. The employees, once hearing of the acquisition, reacted with "definitely panic, I think a little hysteria . . . ." Trial Tr. at 877:3-7 (Karl Keeler).

876. [redacted] Trial Tr. at 881:23-883:5 (Karl Keeler).

877. Although some of the former Saltzer surgeons now work for SAMG, this will not offset the harm from the Saltzer transaction as "[t]hey still rely on referrals from primary care for those physicians." Trial Tr. at 881:15-881:22 (Karl Keeler).

878. The analyses done by Saint Alphonsus of the surgeon's income were based on their professional activities, not their hospital activities. Trial Tr. at 982:25-983:10 (Lannie Checketts). The surgeons practice in Nampa and Boise, and therefore their activities do not necessarily benefit Saint Alphonsus Nampa. Trial Tr. at 983:11-16 (Lannie Checketts).

879. [redacted] Trial Tr. at 984:3-5 (Lannie Checketts).

c) Saint Alphonsus Nampa Projections

880. [redacted] Trial Tr. at 954:3-955:9 (Lannie Checketts); TX 1661, Demonstrative 4, Demonstrative 7.

881. Mr. Checketts' work was based upon his 28 years of experience working as CFO at Mercy Medical Center and then Saint Alphonsus Nampa, more than 100 different efforts at preparing projections, and an extensive process that involved more than 20 drafts and reviewed by a number of other executives at the hospital. Trial Tr. at 917:17 – 918:6; 921:2 – 922:5 (Lannie Checketts).

882. Mr. Checketts' projections were also based on his extensive experience in dealing with physicians and operations at Mercy Medical Center and Saint Alphonsus Nampa for more than 28 years. Trial Tr. at 917:17 – 918:6 (Lannie Checketts).

883. [redacted] TX 2085 at p. 13.

884. [redacted]

[redacted] TX 2161 at ALPH00020949. [redacted]

885. [redacted] Trial Tr. at 883:6–11, 885:11–886:21, 892:18–893:14 (Karl Keeler); Trial Tr. at 928:23–924:1 (Lannie Checketts); TX 2172 at ALPH00009735.

886. [redacted] Trial Tr. at 948:12–949:1 (Lannie Checketts). [redacted] Trial Tr. at 949: 2–5 (Lannie Checketts).

887. [redacted] Trial Tr. at 951:20–24 (Lannie Checketts). [redacted] Trial Tr. at 951:25–952:3 (Lannie Checketts). [redacted]

888. [redacted] Trial Tr. at 979:23–980:4 (Lannie Checketts).

889. [redacted] Trial Tr. at 960:4–14 (Lannie Checketts). [redacted] Trial Tr. at 879:14–880:11 (Karl Keeler). [redacted]

890. [redacted] Trial Tr. at 960:15– 961:2 (Lannie Checketts). [redacted] TX 5123-20.

891. Though his projections estimate a 100% loss of admissions in many areas, Checketts' conclusions are not dependent on literally losing one hundred percent of Saint Al's

Saltzer business. The problem would not go away if Saint Al's only lost 80% of that business, or 50%. Due to "the nature of fixed costs, the impact of that level of business going away would be very detrimental." Trial Tr. at 944:11–24 (Lannie Checketts). In the hospital business, because of fixed costs, the loss of incremental volumes has a disproportionate effect on the bottom line. Trial Tr. at 923:17–925:1 (Lannie Checketts).

d) Harm to Saint Alphonsus Nampa If Saltzer Acquisition Goes Forward

892. Saint Alphonsus has no good competitive response if it loses the Saltzer referrals. The hospital will be unable to recruit to Nampa sufficient physicians to offset the loss of cases from the very large Saltzer group. The hospital has been unable in recent years to recruit either pediatricians or internal medicine physicians, and the few family practice physicians it has recruited to Nampa have not been busy. Trial Tr. at 713:18–716:4 (Nancy Powell).

893. [redacted] Trial Tr. at 959:19–960:3 (Lannie Checketts).

6. Injury to Competition in Canyon County

894. Canyon County is an important growth area for both hospital systems. Trial Tr. at 1517:18–23 (Deborah Haas-Wilson); TX 1081, p. 2; TX 1086, p. 17; TX 3000 at Slide 44. Canyon County is one of the fastest growing counties in the nation. TX 2087 at ALPH00430554.

895. Internal St. Luke's documents confirm the importance of Canyon County to St. Luke's. The portion of the July 26, 2011 minutes of the Audit and Finance Committee relating to the "Treasure Valley Expansion" notes that "Mr. Taylor began the presentation by noting the

importance of St. Luke's presence not only in the Treasure Valley, but in Nampa and Fruitland as well. We have made decisions to make major expansions in downtown Boise, in Meridian and into Canyon County." TX 1086 at SLHS000037620.

896. St. Luke's has long considered Saltzer Medical Group the "key to our Canyon County development plans." TX 1619 at 2.

897. Chis Roth, CEO of St. Luke's Treasure Valley, testified that Saltzer is "the oldest multispecialty group practice in the area. They are highly regarded. They are very important in providing care to patients, not only in Canyon County, but Ada County as well. . . . they are established. They've got a good reputation, not only with patients but with the medical staff. So, yeah, they are -- they are a key partner." Dkt. No. 286 (Roth Dep. Tr.) at 172:8–23.

898. [redacted] TX 1153 at SMG000278640.

7. Harm to Network Competition

899. St. Luke's planned withdrawal of its providers from competing networks will likely significantly harm the ability of those networks to effectively compete with St. Luke's. This will especially be true if the Saltzer physicians are among those denied to competing networks. Such actions will seriously impede the ability of such networks to offer an alternative to the St. Luke's network to payors and employers. It will therefore substantially diminish the ability of St. Luke's rivals to provide a competitive constraint to St. Luke's. Trial Tr. at 1518:20-1519:5 (Deborah Haas-Wilson).

900. If network competition for St. Luke's is significantly diminished, this will also diminish competition in the provider markets encompassed by these networks, including adult

and pediatric primary care physician services, general acute inpatient care services and the relevant surgical facility services markets, among others. See Findings, *supra.*

8. Possible Future Changes in the Market

901. These conclusions do not change if the health care environment changes in the future. These effects on network competition will be present in a risk-based environment as much as a fee for service environment. Incentives for competition remain the same regardless of whether the payer contracts in question are risk-based or fee-for-service. Trial Tr. at 1521:6–24 (Deborah Haas-Wilson).

902. Nor does the Affordable Care Act change the analysis. "[T]he major impact of the Affordable Care Act is going to be that many more individuals actually have health insurance, and there will have to be new health plans that will be bought on these exchanges for all of these -- this new influx of individuals getting insurance. And certainly those insurers are going to need to contract with networks to have a provider network for their health plans. So increasing the number of insured individuals in no way diminishes the importance of network competition." Trial Tr. at 1521:25–1522:14 (Deborah Haas-Wilson).

903. These conclusions are not disputed by St. Luke's experts.

9. Sufficient Entry Will Not Occur

904. Entry into pediatric primary care would also be extremely difficult. Saint Alphonsus has attempted to recruit pediatricians to Nampa without any success. Trial Tr. at 870:7–19 (Karl Keeler); Trial Tr. at 713:18–714:7 (Nancy Powell).

905. Dr. Argue has not offered an opinion that entry into primary care in Nampa would be timely, likely or sufficient. He has contended only that competitors could expand their volume by utilizing their excess capacity. Trial Tr. at 2986:4–21 (David Argue). However, as Dr. Argue admits, the fact that SAMG primary care physicians in Nampa possess excess capacity

is an indication that these physicians are simply not busy. Trial Tr. at 3064:3–11 (David Argue). If, as Nancy Powell has explained, the SAMG physicians are unable to attract patients in light of the popularity and reputation of Saltzer, there is no reason to expect that they would be able to expand their business at the expense of Saltzer if a St. Luke's-acquired Saltzer acted in an anticompetitive manner. Trial Tr. at 715:12–716:13; 716:20–717:9 (Nancy Powell).

906. Sufficient, timely entry can in principle offset anticompetitive effects. See Proposed Findings, supra. However, Dr. Argue agrees that "to the extent one is concerned about foreclosure, you would need sufficient entry to take enough business from Saltzer . . . so that the worry about shifting referrals would no longer be a concern." Trial Tr. at 3064:16–21 (David Argue). Thus, in order for entry to be sufficient to eliminate anticompetitive concerns with regard to foreclosure, there would need to be sufficient entry or expansion to replace the business held by Saltzer's primary care physicians who make these referrals. Trial Tr. at 1509:9–1510:6 (Deborah Haas-Wilson). [redacted] Trial Tr. at 882:17–20 (Karl Keeler). The three primary care physicians that Saint Alphonsus has been able to recruit in Nampa since 2012 falls far short of what would be necessary for sufficient entry. Trial Tr. at 715:5–716:4 (Nancy Powell).

10. Future Anticompetitive Effects and Cumulative Effects of St. Luke's Acquisitions

907. The anticompetitive effects of the Saltzer transaction should be assessed not only in light of the Saltzer transaction in isolation, but in light of the series of transactions undertaken by St. Luke's, and the effect of a successful Saltzer transaction on future transactions and referral patterns. See Findings, *supra.*

908. Past acquisitions by St. Luke's include, among others, Idaho Cardiology Associates, Mountain View Medical, Orthopedic Surgery Center of Idaho, Idaho Pulmonary Associates, Boise Orthopedic Group, Boise Surgical Group and Cardiovascular Associates. Trial Tr. at 1826:20–24, 1827:9–15, 1848:1–4 (Marshall Priest); Trial Tr. at 1860:22–1861:1, 1861:2–8 (Mark Johnson); Dkt. No. 255 (Walker Dep. Tr.) at 8:5–15; 9:13–15; Dkt. No. 290 (James Souza Dep. Tr.) at 79:24–80:1; Trial Tr. at 2041:23–24 (James Souza); Dkt. No. 255 (Walker Dep. Tr.) at 9:16–19; Trial Tr. at 2350:7–11, 2365:5–7 (Scott Huerd); Dkt. No. 370 (Barresi Dep. Tr.) at 10:12–17, 13:17–19. [redacted] TX 2082 at p. 13. St. Luke's has over 400 primary care and specialty providers in its employed and PSA physician base. TX 2087 at ALPH00430573. These additional acquisitions involve in part physicians in various specialties, but ultimately affect referrals to hospitals and outpatient surgical facilities.

909. [redacted] Dkt. No. 320 (Stright Dep. Tr.) at 121:23–123:21. [redacted] Dkt. No. 320 (Stright Dep. Tr.) at 124:15–125:10.

910. A successful Saltzer transaction and the prospect of additional transactions will also put pressure on specialty physicians to either refer more cases to St. Luke's or to become acquired by St. Luke's in order to avoid losing referrals from St. Luke's growing complement of

primary care physicians. St. Luke's CEO Dr. Pate has stated in a published article that "when a specialist experiences a number of his or her referring physicians being hired by a hospital, this creates pressure for the specialist to consider employment with the hospital to preserve the referral base." TX 44 at SLHS000075066.

911. Dr. Baressi of the acquired St. Luke's Boise Surgical Group agreed that one factor affecting his group's decision to be acquired was that "a network of clinics that are affiliated . . . would certainly facilitate referrals." Dkt. No. 370 (Baressi Dep. Tr.) at 45:23–46:7, 46:9–13.

912. Professor Haas-Wilson also explained that acquisitions of primary care groups put pressure on independent specialists to join hospital systems because of the perception of a shrinking referral basis if they are outside of the system's employed physician network. This pressure leads to more acquisitions and shrinks the referral base even further, leading to further anticompetitive effects. Trial Tr. at 1526:6–1527:16 (Deborah Haas-Wilson); TX 44 at SLHS000075066, 1777; TX 3000 at Slides 51–56.

913. Dr. Argue did not dispute this conclusion.

914. If the Saltzer transaction is permitted, in light of this pattern, it is very likely that St. Luke's will successfully proceed with additional transactions, including the transactions that it has put on hold and other transactions which it has not pursued because of the pending litigation. See Findings, *supra*.

915. [redacted] TX 1105 at SLHS000581969. [redacted]

916. There is a significant risk that this outcome could result if St. Luke's acquisitions do not cease. See Findings, *supra.*

E. CONCLUSION REGARDING COMPETITIVE EFFECTS IN ADDITIONAL MARKETS

917. Based upon the dominant position of St. Luke's in the relevant hospital and surgical facilities market; the limited number of rivals remaining to St. Luke's; the importance to competition and consumers of the lower prices and high quality provided by Treasure Valley Hospital; the reliance by Saint Alphonsus and Treasure Valley Hospital on primary care referrals, including, especially Saltzer referrals; the importance to overall competition in the Treasure Valley of the growing population in Canyon County; the importance of Saltzer to the competitive viability of Treasure Valley provider networks; the threat to network competition posed by St. Luke's acquisition of Saltzer and its plans to pull its physicians out of competing networks; the cumulative effect of St. Luke's series of physician practice acquisitions, and the likely future effects on additional acquisitions of an approval of the Saltzer transaction; this Court finds it likely that if the Saltzer transaction goes forward, it is likely that overall competition will be significantly harmed in the pediatric primary care, general acute inpatient care, general surgical outpatient facilities and neuro+ortho surgical outpatient facilities markets. See Findings, *supra.*

VI. REMEDY

A. DIVESTITURE IS THE APPROPRIATE REMEDY FOR RESTORING COMPETITION

918. As noted above, prior to the Acquisition, Saltzer and St. Luke's were each other's closest competitors in the Nampa market for Adult PCP services. Trial Tr. 1351:13–1352:3 (David Dranove). In other words, Saltzer is viewed as the second-most-attractive option for St. Luke's patients if a St. Luke's PCP is unavailable to them, and vice-versa. *Id.* This finding in turn reinforces the finding that prior to the Acquisition, the best outside option for a health plan,

if it was negotiating with Saltzer, was St. Luke's, and vice versa. *Id.* 1353:21–1354:15 (David Dranove).

919. The Acquisition eliminates the benefits of competition between St. Luke's and Saltzer as each other's closest substitutes by taking away each health plan's best-outside option, or best alternative to a negotiated agreement ("BATNA"). Trial Tr. 1354:6–15 (David Dranove).

920. A complete divestiture of Saltzer by St. Luke's is required in order to restore the benefits of the competition eliminated by the Acquisition. Dkt. No. 98 (Gov't Pls.' Redacted Complaint) at ¶ 25.

921. In denying Saint Al's and Treasure Valley Hospital's motion for preliminary injunction, this Court relied on the fact "the gradual integration and the built-in unwinding process mean that the Court will have no difficulty in ordering an immediate and complete divestiture if that is the result compelled at trial." Dkt. No. 47 (Mem. Decision & Order Denying Mot. for Prelim. Inj'n) at 8.

B. DIVESTITURE IS STRAIGHTFORWARD BECAUSE SALTZER HAS NOT SIGNIFICANTLY INTEGRATED WITH ST. LUKE'S

922. At the December 14, 2012 preliminary injunction hearing, St. Luke's counsel represented to the Court that "[St. Luke's] will not oppose the divestiture – if ultimately this court . . . were to hold that this transaction is unlawful, we will not oppose divestiture on grounds that divestiture cannot be accomplished." Dkt. No. 49 (Tr. of Dec. 14, 2012 Prelim. Inj'n Proceedings) at 88:3–7.

923. On December 20, 2012, as a means of persuading the Government Plaintiffs not to challenge the Acquisition before it closed, St. Luke's represented both to the Federal Trade Commission and the Idaho Attorney General that St. Luke's would not argue that unwinding the

transaction would be either "costly" or "burdensome." TX 2625 (Dec. 20, 2012 Letter from J. Bierig to B. DeLange and S. Hirschfeld) at 1.

C. DEFENDANTS' "WEAKENED COMPETITOR" DEFENSE TO REMEDY IS MERITLESS

924. If the Acquisition were unwound, it is unlikely that Saltzer would "close its doors." Indeed, Saltzer's Dr. Kunz testified that he dismissed such ideas as doomsday scenarios and further noted that such notions were "overly dramatic." Trial Tr. at 3369:7–3371:3 (Harold Kunz).

925. Saltzer was profitable in fiscal year 2012. Trial Tr. at 3372:9–11 (Harold Kunz). In fact, Saltzer has been profitable every year since 1980, at least. Trial Tr. at 3372:12–14 (Harold Kunz). In Nancy Powell's view as the group's former CFO, Saltzer was financially successful. Trial Tr. at 705:13–21, 753:22–24 (Nancy Powell).

926. Saltzer's Dr. Djernes agrees that before the Acquisition, Saltzer was "a very strong and economically healthy group." Dkt. No. 269 (Djernes Dep. Tr.) at 32:14–24; TX 1155 at COKER0006581. Dr. Djernes recalls no discussion of Saltzer being in poor financial condition. Dkt. No. 269 (Djernes Dep. Tr.) at 95:14–19.

927. On November 20, 2012, Dr. John Kaiser sent an email to all Saltzer employees regarding the legal action by Saint Al's and TVH and the investigation by the Idaho Attorney General and the Federal Trade Commission. In it he wrote, "[f]or each of our employees I would like to emphasize that you will continue to have your jobs no matter what course these investigations and legal challenges take." Dkt. No. 323 (Kaiser Dep. Tr.) at 202:23–203:22; TX 1386 at SMG000288177.

928. [redacted] Trial Tr. at 3235:5–13 (Lisa Ahern).

1. Any Financial Difficulty Is Self-Inflicted and Likely Short-Lived

929. Saltzer knew that going ahead with the St. Luke's transaction would likely cause the surgeons to leave and knew those departures would have significant financial impact on its business, but decided to proceed with the transaction anyway. Trial Tr. at 3106:21–3110:24 (William Savage). As Mr. Savage testified: "The shareholders knew the consequences." Trial Tr. at 3110:17 (William Savage).

930. Lisa Ahern, a financial consultant retained by St. Luke's, opined that physicians remaining with an unwound Saltzer would experience a decrease in compensation [redacted]. Trial Tr. 3216:19–3217:6, 3221:12–18 (Lisa Ahern).

931. Ms. Ahern's opinion is limited, however, to the immediate impact on compensation in the first year following the unwind. She offered no opinions as to what might happen in the second or third year, for example. Trial Tr. 3280:7–13 (Lisa Ahern).

932. Ms. Ahern suggests that the decrease in physician salary would have occurred whether or not there was a St. Luke's affiliation. Trial Tr. 3218:4–18 (Lisa Ahern). But in contemplating a transaction with St. Luke's, Saltzer knew that it might cause the surgeons with an interest in the Treasure Valley Hospital to leave the practice, so Saltzer hired a consultant to study the financial impact on Saltzer if the surgeons left Saltzer. Trial Tr. at 3106:21–3108:1 (William Savage). And as Dr. Williams testified, the Saltzer surgeons would not have left the practice absent the merger. Trial Tr. at 2535:19–24 (Steven Williams).

2. Saltzer Will Be Able To Regroup with the Help Of A Goodwill "Breakup Fee"

933. The Saltzer physicians will keep the goodwill payment made to them by St. Luke's, if the transaction were undone. Trial Tr. at 3332:8–22 (Thomas Patterson).

934. If Saltzer were unwound, the management team would be able to regroup, replace the departed physicians, and remain together without dissolving. Trial Tr. at 757:16–24 (Nancy Powell).

935. Saltzer has had years before where five or six doctors left, and the remaining physicians were able to absorb the overhead costs until they could replace those physicians. Trial Tr. at 753:25–754:14 (Nancy Powell). To remedy such a situation, Saltzer would recruit new physicians, reduce overhead, and get the current physicians to work a little harder so that there would be more revenue. *Id.* at 754:15–22.

936. In the past, physicians did not leave Saltzer simply because they were upset about the additional overhead they would have to absorb. Trial Tr. at 754:23–755:1 (Nancy Powell).

937. Saltzer would not have difficulty recruiting surgeons to replace those who left because Saltzer has a strong primary care base to support the surgeons as a source of referrals. Trial Tr. at 753:2–14 (Nancy Powell).

938. Saltzer's Dr. Djernes agrees: if St. Luke's divests Saltzer, Saltzer will be able to cover the financial impact of the surgeons who left for Saint Al's by hiring additional orthopedic surgeons to replace them. Dkt. No. 269 (Djernes Dep. Tr.) at 58:1–11, 59:6–9, 59:24–61:6; TX 1538 at SALTZER177706.

939. Indeed, Saltzer has already been able to recruit Dr. Dahlke and a new ENT surgeon, Dr. Affleck. Trial Tr. at 3220:6–16, 3239:5–18 (Lisa Ahern).

940. Ms. Ahern's opinion on the competitiveness of Saltzer in the marketplace after the unwind is limited to the competitiveness of the physicians' compensation. Trial Tr. at 3281:24–3282:13 (Lisa Ahern).

941. If the Court unwinds the Acquisition, the PSA requires St. Luke's to loan money to Saltzer at fair market value, which Saltzer would then pay back—similar to a lease. TX 24 at SLHS000787884; Trial Tr. at 3101:4–8 (William Savage).

942. Ms. Ahern has no opinion on what the Court may order in terms of unwinding of the Acquisition of Saltzer by St. Luke's. Trial Tr. 3243:8–19, 3286:8–12 (Lisa Ahern). Nor does her opinion take into account what the Court might order to mitigate the impact of the decrease in compensation. *Id.* at 3286:13–20.

3. Saltzer Has Not Put Together a Contingency Plan In The Event Of A Break-Up

943. Despite Saltzer's claims that unwinding the Acquisition will be catastrophic, it has never come up with a strategy to plan for that contingency. Trial Tr. at 3102:2–22, 3104:2–6, 3105:2–6 (William Savage). In fact, even though the CEO of Saltzer admitted that Saltzer has "never substantively discussed a contingency plan" and "never hired consultants to consider it," he attempted to claim that it was "impossible to develop one." Trial Tr. at 3127:1–7 (William Savage).

944. Saltzer has done no formal evaluation of its financial condition if the Acquisition were undone. Trial Tr. at 3331:12–20 (Thomas Patterson).

945. Indeed, Defendants' financial expert, Ms. Ahern, does not have an opinion on whether Saltzer physicians would leave the area in the event of an unwinding. Trial Tr. at 3282:25–3283:15 (Lisa Ahern). And Ms. Ahern offered no opinion about how long it might take Saltzer to recruit additional physicians in the event of an unwind. Trial Tr. at 3281:11–23 (Lisa Ahern).

946. Ms. Ahern's calculations of the decrease in compensation assume that no additional physicians would be added to Saltzer after the unwind. Trial Tr. at 3280:14–18 (Lisa Ahern).

947. Ms. Ahern's opinion does not address the formulation of a physician recruiting plan by Saltzer. Trial Tr. at 3280:19–24 (Lisa Ahern).

948. Ms. Ahern does not offer an independent opinion on the success or failure of physician recruitment by Saltzer, or Saltzer's ability or inability to recruit. Trial Tr. at 3280:25–3281:10 (Lisa Ahern).

949. And Ms. Ahern is not offering an opinion regarding how long it would take Saltzer to recruit additional physicians. Trial Tr. at 3281:11–20 (Lisa Ahern).

950. Saltzer has no plans for what will be done if the Court orders divestiture. Trial Tr. at 3371:20–23 (Harold Kunz).

951. Another member of the Saltzer Executive Committee, Dr. Page, testified that although he was "curious" about what contingency plans Saltzer has in the event that the Court unwinds the transaction, he never inquired about such plans, and could not offer any reason why he failed to do so. Dkt. No. 270 (Page Dep. Tr.) at 233:23–234:12.

VII. WITNESS BACKGROUNDS

Name	Affiliation	Title	Citation
Lisa Ahern	St. Luke's Expert	Managing Director, Financial Advisory Services Department (AlixPartners, LLP)	Trial Tr. at 3145:8–20 (Lisa Ahern).
David Argue	St. Luke's Expert	Corporate Vice President and Principal (Economists Incorporated)	Trial Tr. at 2882:10–2883:4 (David Argue).
Richard Armstrong	State of Idaho	Director of the Department of Health and Welfare (State of Idaho)	Trial Tr. at 2258:10–21 (Richard Armstrong).

Name	Affiliation	Title	Citation
Dr. Robert Barresi	St. Luke's	Medical Site Manager (St. Luke's Clinic Boise Surgical Group)	Dkt. No. 370 (Barresi Dep. Tr.) at 10:12–17, 11:6–11.
Randy Billings	St. Luke's	Director of Payor Contracting (SLHS)	Trial Tr. at 226:8–9 (Jeff Crouch).
Dr. Steven Dunning Brown	Saint Al's	Vice President of (Saint Al's Health System), Chief Medical Officer and President (SAMG)	Dkt. No. 366 (Brown Dep. Tr.) at 16:21–17:3.
Jackie Butterbaugh	Imagine Health	Director of Contract Network Development and Network Management (Imagine Health)	Dkt. No. 318 (Butterbaugh Dep. Tr.) at 7:2–9, 7:17–19.
Ed Castledine	St. Luke's	Director of Business Development (SLHS)	TX 1277; TX 1281; Dkt. No. 262 (Castledine Dep. Tr.) at 12:23–13:13, 15:2–7, 74:1–11, 119:15–22.
Dr. Marc Chasin	St. Luke's	Chief Medical Information Officer, Interim Chief Information Officer (SLHS)	Trial Tr. at 2789:19–20 (Marc Chasin).
Lannie Checketts	Saint Al's	Chief Financial Officer (Saint Al's, Nampa)	Trial Tr. at 762:11–19 (Nancy Powell).
Scott Clement	Regence Blue Shield of Idaho	Former Vice President (Regence Blue Shield of Idaho)	Dkt. No. 252 (Clement Dep. Tr.) at 5:4–6, 11:8–10, 14:5–11.
Jeff Crouch	BCI	Vice President of Provider Contracting (BCI)	Trial Tr. at 181:9–13 (Jeff Crouch).
Dr. Adebayo Crownson	St. Luke's	Physician and Site Medical Director at (St. Luke's Family Medicine, Nampa)	Trial Tr. at 2190:23–2191:2, 2199:19–23, 2216:1–3, 2210:22–25 (Adebayo Crownson).
Dr. Andrew Curran	TVH	Orthopedic Surgeon, Physician Owner (TVH)	Trial Tr. at 1049:4–6, 1052:1–4 (Nicholas Genna).

Name	Affiliation	Title	Citation
William Deal	State of Idaho	Director of Insurance (State of Idaho)	Trial Tr. at 1796:16–17 (William Deal).
Dr. Michael Djernes	Saltzer	Neurologist and member of the Finance and Executive Committees (SMG)	Dkt. No. 269 (Djernes Dep.) at 7:13–7:25, 8:17–9:12.
Steven Drake	St. Luke's	Director of Payer Contracting (SLHS)	Dkt. No. 322 (Drake Dep.) at 8:3–11, 9:18–10:8.
Dr. David Dranove	Plaintiffs' Expert	Walter McNerney Distinguished Professor of Health Industry Management and the Director of the Health Enterprise Management Program (Kellogg School of Management, Northwestern University)	Trial Tr. at 1289:22–1290:11 (David Dranove).
Linda Duer	IPN	Executive Director (IPN)	Trial Tr. 459:13–24 (Linda Duer).
Dr. Alain Enthoven	St. Luke's Expert	Former Marriner Eccles Professor of Public and Private Management in the Graduate School of Business (Stanford University), Former Professor of Health Economics and Research in the (Medical School, Stanford University)	Trial Tr. at 2547:7–16 (Alain Enthoven).
Gary Fletcher	St. Luke's	Chief Operating Officer (SLHS)	Dkt. No. 289 (Fletcher Dep. Tr.) at 6:12–15, 6:21–23, 12:4–7.
Dr. Brian Fortuin	St. Luke's	Internist in Twin Falls (St. Luke's Clinic)	Trial Tr. at 2122:24–2123:7 (Brian Fortuin).
Nicholas Genna	TVH	Chief Executive Officer (TVH, Boise)	Trial Tr. at 987:7–11, 989:4–8 (Nicholas Genna).
Deborah Haas-Wilson	Plaintiffs' Expert	Professor of Economics (Smith College)	Trial Tr. at 1474:5–23 (Deborah Haas-Wilson).

Name	Affiliation	Title	Citation
Dr. Erik Heggland	SLRMC	Orthopedic Surgeon (SLRMC), Medical Director for the Orthopedic Hospitalist Service (SLRMC), Executive Medical Director (St. Luke's Ortho Neuro Management Services Organization)	Dkt. No. 291 (Heggland Dep. Tr.) at 5:12–15, 6:3–19.
Dr. Jeffrey Hessing	TVH	Orthopedic Surgeon, Physician Owner (TVH)	Dkt. No. 372 (Hessing Dep. Tr.) at 24:16–17, 29:8–18.
Linda House	St. Luke's	Systems Director of Employer Relations (SLHS)	Dkt. No. 267 (House Dep. Tr.) at 7:3–8:9, 11:22–12:5.
Dr. Steven Huerd	St. Luke's	Physician (CVA) (St Luke's Clinic)	Trial Tr. at 2349:20–23, 2350:9–14 (Steven Huerd).
Sally Jeffcoat	Saint Al's	President and Chief Executive Officer (Saint Al's)	Dkt. No. 397 (Jeffcoat Dep. Tr.) at 8:3–9.
Dr. Mark Johnson	St. Luke's	Physician and Division Director of Family Medicine in Treasure Valley (St. Luke's Clinic)	Dkt. No. 249 (Johnson Dep. Tr.) at 10:16–11:1; Trial Tr. at 1859:20–1860:1 (Mark Johnson).
Dr. John Kaiser	Saltzer	President (SMG)	Dkt. No. 268 (Kaiser Dep. Tr.) at 10:5–12, 12:14–24.
John Kee	St. Luke's	Vice President for Network Operations (SLHS)	Trial Tr. at 1879:7–18 (John Kee).
Karl Keeler	Saint Al's	President and Chief Executive Officer (SAMC, Nampa)	Trial Tr. at 850:18–19 (Karl Keeler).
Dr. Kenneth Kizer	Plaintiffs' Expert	Director for the Institute of Population Health Improvement (UC Davis), Distinguished Professor of Medicine and Nursing (UC Davis)	Trial Tr. at 3508:4–12 (Kenneth Kizer).

Name	Affiliation	Title	Citation
Dr. Harold Kunz	Saltzer	Physician and Chairman of the Finance Committee (SMG)	Trial Tr. at 3342:13–3343:19 (Harold Kunz).
Peter LaFleur	Consilium Group, LLC	Owner (Consilium Group, LLC)	Dkt. No. 288 (LaFleur Dep. Tr.) at 8:3–15.
Kathy Moore	St. Luke's	Chief Operating Officer (SLRMC)	Dkt. No. 284 (Moore) at 8:11–25.
Arthur "Skip" Oppenheimer	St. Luke's	CEO (Oppenheimer Companies), Board Member (SLHS)	Trial Tr. at 2756:2–2757:2 (Arthur Oppenheimer).
Gregory Orr	St. Luke's	Former Director of the Internal Medicine Group, Former Director of Surgical Practices (St. Luke's Clinic, Treasure Valley)	Dkt. No. 285 (Orr Dep. Tr.) at 9:24–10:16.
Patrick Otte	Micron	Vice President of Human Resources (Micron)	Trial Tr. at 544:4–7 (Patrick Otte).
Dr. Randell Page	Saltzer	Physician, Member of Executive Committee (SMG)	Trial Tr. at 2846:4–21 (Randell Page).
Dr. David Pate	St. Luke's	President and CEO (SLHS)	Trial Tr. at 1603:17–23 (David Pate).
Dr. Thomas Patterson	Saltzer	Pediatrician (SMG), Chairman of the Business Marketing Development Committee (SMG), serves on Executive Committee and Joint Operating Council (SMG)	Trial Tr. at 3309:8–13, 3310:22–3311:2, 3310:22–3311:2 (Thomas Patterson).
Dr. David Peterman	PHMG	President (PHMG)	Trial Tr. at 1125:1–5 (David Peterman).
Blaine Petersen	Saint Al's	System Chief Financial Officer (Saint Al's)	Trial Tr. at 921: 19–21 (Lannie Checketts).
Dr. Robert Polk	Saint Al's	Chief Quality Officer and Vice President for Patient Safety and Quality (Saint Al's)	Trial Tr. at 3610:21–24 (Robert Polk).

Name	Affiliation	Title	Citation
Nancy Powell	Saint Al's	Chief Administrative Officer (SAMG)	Trial Tr. at 698:21–25 (Nancy Powell).
Dr. Marshall Priest	St. Luke's	Cardiologist and Executive Medical Director for St. Luke's Heart (St. Luke's Clinic)	Trial Tr. at 1824:1–1825:24 (Marshall Priest).
James Reiboldt	Coker Group	President and CEO (Coker Group of Atlanta)	Dkt. No. 271 (Reiboldt Dep. Tr.) at 10:8–18.
Rodney Reider	Saint Al's	President (SARMC)	Dkt. No. 361 (Reider Dep. Tr.) at 15:15–17.
Thomas Reinhardt	Saint Al's	Former Assistant Vice President for Physician Network Development (Saint Alphonsus Health System)	Dkt. No. 363 (Reinhardt Dep. Tr.) at 9:13–17; 10:14-18.
Patricia Richards	SelectHealth	CEO and President (SelectHealth)	Trial Tr. at 1719:9–11, 1733:17–1734:9 (Patricia Richards).
Dr. Michael Roach	Saint Al's	Family Practice Physician (SAMG)	Dkt. No. 364 (Roach Dep. Tr.) at 18:2–9.
Christopher Roth	St. Luke's	Chief Executive Officer (SLRMC)	Dkt. No. 286 (Roth Dep. Tr.) at 7:25–8:3.
Bill Savage	Saltzer	Chief Executive Officer (SMG)	Dkt. No. 253 (Savage Dep. Tr.) at 11:23–12:2.
Dr. Jonathan Schott	St. Luke's	Medical Director (St. Luke's Eastern Oregon Medical Associates)	Dkt. No. 292 (Schott Dep. Tr.) at 5:6, 9:14–23.
Dr. Kurt Seppi	St. Luke's	Executive Medical Director (SLHS)	Dkt. No. 317 (Seppi Dep. Tr.) at 7:3–4.
Gregory Sonnenberg	Saint Al's	Director of Managed Care (Saint Al's)	Dkt. No. 365 (Sonnenberg Dep. Tr.) at 6:24–25, 13:14–22.

Name	Affiliation	Title	Citation
Dr. James Souza	St. Luke's	Vice President of Medical Affairs (St. Luke's Treasure Valley Hospital), Physician (SLIPA)	Dkt. No. 290 (Souza Dep. Tr.) at 10:15–11:4, 11:13–12:5; Trial Tr. at 2041:20–2042:6 (James Souza).
Joni Stright	St. Luke's	Administrator (St. Luke's Treasure Valley clinics)	Dkt. No. 320 (Amended Stright Tr.) at 9:3–8.
Dr. Geoffrey Swanson	St. Luke's	System Vice President of Clinical Integration (SLHS), President (Select Medical Network), Chair of the Board of Directors (BrightPath)	Dkt. No. 254 (Swanson Dep. Tr.) at 7:13–22; 12:20–14:2.
Jeffery Taylor	St. Luke's	Chief Financial Officer (SLHS)	Trial Tr. at 735:9–13 (Nancy Powell).
Dr. Robert Walker	St. Luke's	Medical Director of Surgical Services, Medical Director of Sports Medicine (St. Luke's Clinic)	Dkt. No. 255 (Walker Dep. Tr.) at 20:5–11.
Dr. Steven Williams	TVH	General Surgeon, Physician Owner (TVH)	Trial Tr. at 2471:20–24, 2478:6–24 (Steven Williams).

VIII. COMPANY BACKGROUNDS

Payer	Description	Citation
Blue Cross of Idaho ("BCI")	BCI, the largest payer in Idaho, covers over 400,000 lives. [redacted]. BCI utilizes a single fee schedule for all physicians in the state.	Trial Tr. at 227:21–228:4, 305:14–15 (Jeff Crouch); Trial Tr. at 1329:15–22 (David Dranove); Trial Tr. at 722:1–9 (Nancy Powell).

Payer	Description	Citation
BrightPath	BrightPath is the provider network for St. Luke's affiliation with SelectHealth. The BrightPath network includes independent physicians, and there are no limitations in St. Luke's agreement with SelectHealth on the participation of independents through the BrightPath network.	Trial Tr. at 1989:21–24, 1989:25–1990:2, 1990:9–1991:12 (John Kee).
Idaho Physicians Network ("IPN")	IPN is a broad PPO network with approximately 13,000 physicians, hospitals, and ancillary providers, covering approximately 236,000 lives in Idaho. The network serves national payors such as Aetna, Cigna, and United, as well as regional payors such as PacificSource. IPN also leases their network to self-funded employers.	Trial Tr. at 459:1–460:5, 460:15–17, 460:18–461:4, 464:7–15 (Linda Duer).
Imagine Health	Imagine Health is a Utah-based managed care company that develops and manages PPO networks as well as narrow networks of physicians and hospitals for self-funded employers. Imagine administers the WISE Network on behalf of Micron.	Dkt. No. 318 (Butterbaugh Dep. Tr.) at 7:10–15; Trial Tr. at 556:18–25 (Patrick Otte).
PacificSource	Pacific Source is a regional payer that owns approximately 60 percent of IPN and uses the IPN network for its customers. Approximately 3 percent of PacificSource's enrollees would have to travel out of their zip code if they wanted to remain in network.	Trial Tr. at 1329:13–1330:2 (David Dranove); Trial Tr. at 480:2–4 (Linda Duer).
Regence Blue Shield of Idaho	Regence Blue Shield is the second largest commercial insurer in the Ada and Canyon County markets.	Dkt. No. 365 (Sonnenberg Dep. Tr.) at 38:1–23; TX 1782 at Figure 11.
SelectHealth	SelectHealth is a Utah-based health plan that is a wholly owned subsidiary of Intermountain Healthcare. The plan's SelectHealth-St. Luke's product offerings became effective in early 2013.	Dkt. No. 34-23 (Declaration of Patricia Richards) at ¶ 3-9.

Provider	Description	Citation
Boise Orthopedic Clinic ("BOC")	BOC was a group of approximately 5 orthopedic surgeons, all of whom were on staff at TVH. After St. Luke's purchased the clinic in 2010, BOC went from being in Micron's PPO level to out-of-network.	Trial Tr. at 1013:6-14, 1015:22–24 (Nicholas Genna); Trial Tr. at 582:8–583:18 (Patrick Otte).
The Physician Center	The Physician Center, now owned by St. Luke's, is the largest PCP group in Twin Falls [redacted].	Trial Tr. at 241:3–12, 243:10–245:9, 246:9–247:18 (Jeff Crouch).
Primary Health Medical Group	PHMG is a primary care multispecialty group with 13 clinic locations, 30 physicians, and 26 mid-level employees. 11 of their 13 clinics combine urgent care facilities with a traditional, appointment-based family practice site. These 11 clinics are located in Boise, Meridian, Eagle, Nampa, and Caldwell.	Trial Tr. at 1123:4–1124:21 (David Peterman).
West Valley Medical Center	West Valley Medical Center is a hospital system located in Caldwell. The system has been involved in partnerships with St. Luke's aimed at improving aspects of their cardiac services.	Trial Tr. at 2254:2–2255:25 (Christopher Roth).

Other	Description	Citation
Boise Schools	Boise Schools is a local employer that developed a directed health plan using narrow a network; however, they have since discontinued their directed benefits program.	Trial Tr. at 71:2–20 (David Ettinger); Trial Tr. at 3054:3–6 (David Argue).
Idaho Power	Idaho Power is a local employer that developed a directed health plan using a narrow network. Under the plan, employees who used Saint Al's Regional Medical Center over another hospital received a $500 payment. However, they have since discontinued their directed benefits program.	Dkt. No. 252 (Clement Dep. Tr.) at 35:11–22, 36:21–37:1; Trial Tr. at 3054:3–6 (David Argue).

Other	Description	Citation
Micron Technology	Micron is a memory product manufacturer and one of the largest employers in Idaho, with approximately 6,000 employees in the Treasure Valley. In an effort to curb rising healthcare costs in 2008, Micron turned to Imagine Health and the Wise Network to create a network for its employees. Micron also has an onsite clinic—the Micron Family Health Center—which is a key provider of primary care services for employees.	Trial Tr. at 545:9–15, 545:16–17, 556:18–557:17, 559:4–22 (Patrick Otte); Dkt. No. 318 (Butterbaugh Dep. Tr.) at 41:8–22, 138:1–11.
Paul's Market	Paul's Market is a local employer that recently established a directed benefit program for its employees. [redacted]	Trial Tr. at 1240:2–11 (Blaine Petersen); Trial Tr. at 485:9–24 (Linda Duer).
Select Medical Network	The Select Medical Network is St. Luke's clinically integrated network. The network is part of BrightPath and includes independent physicians.	Trial Tr. at 1989:25–1990:2 (John Kee); Trial Tr. at 1659:11–24 (David Pate).

IX. PLAINTIFFS' PROPOSED CONCLUSIONS OF LAW

A. NATURE OF THE ACTION AND JURISDICTION

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

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

954. The Federal Trade Commission ("FTC") is an administrative agency of the U.S. Government established, organized, and existing pursuant to the FTC Act, 15 U.S.C. § 41, et seq. The FTC is vested with authority and responsibility for enforcing, inter alia, Section 7 of the Clayton Act, 15 U.S.C. § 18.

955. The State of Idaho is a sovereign state within the United States. The Attorney General, Lawrence G. Wasden, is the chief law enforcement officer of the State of Idaho, *see* Idaho Code § 67-1401, et seq., with the authority to bring this action on behalf of the State pursuant to Section 16 of the Clayton Act, 15 U.S.C. § 26, and Idaho Code § 48-108 of the Idaho Competition Act.

956. Defendant St. Luke's Health System, Ltd. ("St. Luke's"), including its relevant operating subsidiaries, is, and at all relevant times has been, engaged in activities in or affecting "commerce" as defined in Section 4 of the FTC Act, 15 U.S.C. § 44 (2006), and Section 1 of the Clayton Act, 15 U.S.C. § 12 (2006). Dkt. No. 100 (St. Luke's Answer) at ¶ 11. It has also engaged in "Idaho Commerce" as defined in Idaho Code § 48-103(1) of the Idaho Competition Act.

957. Defendant Saltzer Medical Group, P.A. ("Saltzer") is, and at all relevant times has been, engaged in activities in or affecting "commerce" as defined in Section 4 of the FTC Act,

15 U.S.C. § 44 (2006), and Section 1 of the Clayton Act, 15 U.S.C. § 12 (2006). It has also engaged in "Idaho Commerce" as defined in Idaho Code § 48-103(1) of the Idaho Competition Act.

958. St. Luke's and Saltzer, by virtue of their engagement in activities in or affecting "commerce" as defined in Section 1 of the Clayton Act, are subject to the FTC's jurisdiction to enforce Section 7 of the Clayton Act. 15 U.S.C. § 21 (2006) (vesting authority to enforce compliance with 15 U.S.C. § 18 in the FTC "where applicable to all other character of commerce"); *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1214–15 (11th Cir. 1991) (holding that 15 U.S.C. § 21 makes clear that the FTC's enforcement of Section 7 applies to asset acquisitions by nonprofit hospitals).

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

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

B. LEGAL STANDARD UNDER CLAYTON ACT SECTION 7 AND IDAHO CODE SECTION 48-106 OF THE IDAHO COMPETITION ACT

961. Section 7 of the Clayton Act, as amended, prohibits any acquisition "where in any line of commerce . . . the effect of such acquisition *may be* substantially to lessen competition, or tend to create a monopoly." 15 U.S.C. § 18 (emphasis added); *United States v. Pabst Brewing Co.*, 384 U.S. 546, 547 (1966).

962. "Congress used the words 'may be' . . . to indicate that its concern was with probabilities, not certainties" and to "arrest restraints of trade in their incipiency and before they develop into full-fledged restraints." *Brown Shoe Co., Inc. v. United States*, 370 U.S. 294, 323 n.39 (1962). All that is necessary under the law is that the merger create an appreciable danger of such consequences in the future. *Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1389 (7th Cir. 1986). A "fundamental purpose of amending § 7 was to arrest the trend toward concentration, the tendency to monopoly, before the consumer's alternatives disappeared through merger . . . ." *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 367 (1963).

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

964. "[M]ergers should not be permitted to create, enhance, or entrench market power or to facilitate its exercise." U.S. Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines* § 1 (2010) ("*Horizontal Merger Guidelines*").

965. St. Luke's acquisition of Saltzer constitutes an acquisition under Section 7 of the Clayton Act. *United States v. Columbia Pictures Corp.*, 189 F. Supp. 153, 182 (S.D.N.Y. 1960); *see also FTC v. Phoebe Putney Health Sys.*, 793 F. Supp. 2d 1356, 1363–65 (M.D. Ga. 2011),

rev'd on other grounds, ___ U.S. ___, 133 S. Ct. 1003 (2013); *Gerlinger v. Amazon.com, Inc.*, 311 F. Supp. 2d 838, 853-54 (N.D. Cal. 2004).

966. Courts use a burden-shifting framework to analyze whether an acquisition is likely to substantially lessen competition under Section 7 of the Clayton Act. *Olin Corp. v. FTC*, 986 F.2d 1295, 1305 (9th Cir. 1993); *California v. Am. Stores Co.*, 872 F.2d 837, 842 (9th Cir. 1989), *rev'd on other grounds*, 495 U.S. 271 (1990), *reinstated in relevant part*, 930 F.2d 776, 777 (9th Cir. 1991); *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 982–93 (D.C. Cir. 1990).

967. Plaintiffs establish a *prima facie* case of a Section 7 violation—and a presumption of illegality—by showing "that the acquisition at issue would produce a firm controlling an undue percentage share of the relevant market, and would result in a significant increase in the concentration of firms in that market." *Univ. Health*, 938 F.2d at 1218 (citations, brackets and quotation marks omitted); *see also Am. Stores*, 872 F.2d at 841; *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1279 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990). A showing of undue concentration in any relevant market is sufficient to meet Plaintiffs' *prima facie* burden. *FTC v. CCC Holdings*, 605 F. Supp. 2d 26, 45–46 (D.D.C. 2009).

968. Once Plaintiffs' *prima facie* case is established, the burden of production shifts to Defendants to rebut the presumption of illegality with evidence clearly showing that the market's concentration inaccurately predicts the likely competitive effects of the transaction. *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 631 (1974); *Am. Stores*, 872 F.2d at 842.

969. "The more compelling the prima facie case, the more evidence the defendant must present to rebut it successfully." *Heinz*, 246 F.3d at 725; *see also Baker Hughes*, 908 F.2d at 991; *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1094 (N.D. Ill. 2012).

970. The Supreme Court has rejected the position that an otherwise anticompetitive merger should be permitted merely because it may be motivated by beneficial goals:

> A merger is not saved from illegality under § 7 . . . "because, on some ultimate reckoning of social or economic debits and credits, it may be deemed beneficial. A value choice of such magnitude is beyond the ordinary limits of judicial competence, and in any event has been made for us already, by Congress when it enacted the amended § 7. . . . It therefore proscribed anticompetitive mergers, the benign and malignant alike, fully aware, we must assume, that some price might be paid."

Ford Motor Co. v. United States, 405 U.S. 562, 570 (1972) (quoting *Phila. Nat'l Bank*, 374 U.S. at 371).

971. If Defendants produce sufficient evidence to rebut the presumption of illegality, the burden of production shifts back to Plaintiffs, who retain the ultimate burden of persuasion. *Chicago Bridge & Iron Co., N.V. v. FTC*, 534 F.3d 410, 423 (5th Cir. 2008); *Heinz*, 246 F.3d at 715.

972. Like Section 7 of the Clayton Act, the Idaho Competition Act prohibits acquisitions that may substantially lessen competition. Idaho Code § 48-106. Because the provisions of the Idaho Competition Act "shall be construed in harmony with federal judicial interpretation of comparable federal antitrust statutes," the antitrust analysis under the Clayton Act applies equally to the Idaho Competition Act. Idaho Code §§ 48-102(3), 48-106.

C. THE RELEVANT MARKETS ARE CONCLUSIVELY ESTABLISHED

973. Courts frequently have relied on the analytical framework set forth in the *Horizontal Merger Guidelines* to assess how acquisitions affect competition. *See, e.g., United States v. Kinder*, 64 F.3d 757, 771 (2d Cir. 1995); *Univ. Health*, 938 F. 2d at 1211 n.12; *Heinz*, 246 F.3d at 716 n.9; *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1278, 1279–80 (N.D. Ill. 1989); *FTC v. ProMedica Health Sys., Inc.*, No. 11-CV-47, 2011 WL 1219281, at *12, 54 (N.D. Ohio Mar. 29, 2011).

1. Adult PCP Services is a Relevant Product Market

974. A relevant product market is one in which a hypothetical monopolist could profit from a small but significant non-transitory increase in price for a meaningful period of time ("SSNIP"). *Horizontal Merger Guidelines* § 4.1.1; *see also H & R Block*, 833 F. Supp. 2d 36 at 51–52; *ProMedica*, 2011 WL 1219281, at *54; *In re Evanston Nw. Healthcare*, No. 9315, 2007 WL 2286195, at *45 (FTC Aug. 6, 2007).

975. Defining a relevant product market generally focuses on "demand substitution factors, *i.e.*, on customers' ability and willingness to substitute away from one product to another in response to a price increase or . . . reduction in product quality or service." *Horizontal Merger Guidelines* § 4. To define a relevant product market, courts assess whether two products or services are substitutes for one another in the eyes of purchasers. *H & R Block*, 833 F. Supp. 2d at 50–51 (citations omitted).

976. Adult PCP services are physician services provided to commercially insured patients aged 18 and over by physicians practicing internal medicine, family practice, and general practice. *See HTI Health Servs., Inc., v. Quorum Health Group, Inc.*, 960 F. Supp. 1104, 1115–17 (S.D. Miss. 1997).

2. Nampa is a Relevant Geographic Market

977. To define a relevant geographic market, courts assess whether a hypothetical monopolist controlling *all* of the services in that market could profitably implement a SSNIP. *H & R Block*, 833 F. Supp. 2d at 51–52; *ProMedica*, 2011 WL 1219281, at *55.

978. "The hypothetical monopolist test requires that a hypothetical profit-maximizing firm that was the only present or future producer of the relevant product(s) located in the region would impose at least a SSNIP from at least one location, including at least one location of one

of the merging firms. . . . A single firm may operate in a number of different geographic markets, even for a single product." *Horizontal Merger Guidelines* § 4.2.1.

979. The boundaries of a relevant geographic market need not be defined with "scientific precision," *U.S. v. Conn. Nat'l Bank*, 418 U.S. 656, 669 (1974), or "by metes and bounds as a surveyor would lay off a plot of ground." *Pabst Brewing*, 384 U.S. at 549; *see also United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1285 (7th Cir. 1990) (Posner, J.) (choosing more reasonable among two "imperfect" market definitions).

980. Rather, as noted by the most recent district court to resolve a litigated healthcare merger, the relevant geographic market must "correspond to the commercial realities of the industry," *OSF Healthcare*, 852 F. Supp. 2d at 1076–77 (quoting *Brown Shoe*, 370 U.S. at 336); *accord RSR Corp. v. FTC*, 602 F.2d 1317, 1323 (9th Cir. 1979), and be "sufficiently defined so that the Court understands in which part of the country competition is threatened." *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 49 (D.D.C. 1998).

981. In recent years, courts have recognized that the healthcare industry is characterized by two-stage competition, where price competition involves negotiations between providers and health plans, and decisions by consumers are based primarily on non-price factors like convenience and reputation. *See, e.g., OSF Healthcare*, 852 F. Supp. 2d at 1083–85; *ProMedica*, 2011 WL 1219281, at *5–8. The analysis in some of the earlier healthcare antitrust cases fails to appreciate this significance of this market dynamic. *See, e.g., FTC v. Freeman Hospital*, 69 F.3d 260, 270 n.14 (8th Cir. 1995); *United States v. Mercy Health* Services, 902 F. Supp. 968, 980–81 (D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997); *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1049–50 (8th Cir. 1999).

982. The appropriate customers for defining the relevant markets in this case are therefore commercial health plans, rather than individual patients, because health plans are the entities that negotiate with providers to determine the price of healthcare services and the terms on which those services will be offered to health plan members. *ProMedica*, 2011 WL 1219281, at *5–6; *see also OSF Healthcare*, 852 F. Supp. 2d at 1083–84; *Evanston*, 2007 WL 2286195, at *5 ("Hospitals and patients rarely negotiate directly over the price of hospital services, and patients almost never pay directly the full cost of the hospital services that they receive.").

983. Courts in some older healthcare cases relied on patient flow analysis in the form of an "Elzinga-Hogarty" test. *See, e.g.*, *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1120–24 (N.D. Cal. 2001). But, the application of this type of patient flow analysis to healthcare services markets has been thoroughly discredited. One of the creators of the Elzinga-Hogarty test, Professor Kenneth Elzinga, testified in a recent hospital merger case that the test, which was developed in the coal and beer industries, was not appropriate for healthcare provider markets. *Evanston*, 2007 WL 2286195, at *63–66; *see also Steven Tenn*, "The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction," 18 *Int'l J. of the Econ. of Bus.* 65 (2010) (retrospective study of the hospital merger evaluated in *Sutter Health*, which concluded that "Summit's price increase was among the largest of any comparable hospital in California, indicating that this transaction may have been anticompetitive").

984. A relevant geographic market within which to analyze the competitive effects of the Acquisition is Nampa, Idaho. The antitrust analysis of the Acquisition would not materially change if the geographic market were much broader, encompassing Nampa, Caldwell, and Meridian.

D. THE ACQUISITION IS PRESUMPTIVELY UNLAWFUL BASED ON MARKET CONCENTRATION THRESHOLDS

985. A merger that allows a firm to control an "undue percentage" of a relevant market and that causes a "significant increase in . . . concentration" is "so *inherently likely to lessen competition substantially that it must be enjoined* in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects." *Phila. Nat'l Bank*, 374 U.S. at 363 (emphasis added); *accord American Stores Co.*, 872 F.2d at 842; *see also Rockford Mem'l*, 898 F.2d at 1285 ("The defendants' immense shares in a reasonably defined market create a presumption of illegality.").

986. Market concentration is measured using the Herfindahl-Hirschman Index ("HHI"), as adopted by the federal antitrust enforcement agencies. *Horizontal Merger Guidelines* § 5.3. Courts have adopted and used the HHI as a measure of market concentration. *See, e.g., Univ. Health Inc.*, 938 F.2d at 1211 n.12 (HHI is the "most prominent method" of measuring market concentration); *ProMedica*, 2011 WL 1219281, at *12, 56–57; *CCC Holdings*, 605 F. Supp. 2d at 37. Where an acquisition increases the HHI by over 200 points and results in a post-merger HHI exceeding 2,500 (which defines a highly-concentrated market), the acquisition is presumed likely to enhance market power and to be illegal. *United States v. H & R Block, Inc.*, 833 F. Supp. 36, 71–72 (D.D.C. 2011) (citations omitted).

987. The market shares and HHI levels in the relevant adult primary care services market far exceed levels found to be unlawful by the Supreme Court and other courts. In *Philadelphia National Bank*, the Supreme Court found that a combined market share of 30 percent, with many remaining competitors, violated the Clayton Act. *Phila. Nat'l Bank*, 374 U.S. at 364. In the last 25 years, courts have enjoined numerous mergers involving lower market shares and HHI levels than those produced by this Acquisition:

Case	Combined Share	Pre-Merger HHI	HHI Increase	Post-Merger HHI	Holding
Phila. Nat'l Bank (Supreme Court 1963)[2]	30%	N/A	N/A	N/A	Enjoined
Rockford Mem'l (N.D. Ill. 1989)[3]	68%	2789	2322	5111	Enjoined
Univ. Health Inc.[4] (11th Cir. 1991)	43%	2570	630	3200	Enjoined
Cardinal Health, Inc. (D.D.C. 1998)[5]	37%	1648	1431	3079	Enjoined
H&R Block, Inc. (D.D.C. 2011)[6]	28%	4291	400	4691	Enjoined
ProMedica (N.D. Ohio 2011)[7]	58%	3313	1078	4391	Enjoined
OSF Healthcare (N.D. Ill. 2012)[8]	59%	3353	2052	5406	Enjoined

988. The Acquisition is presumptively unlawful even though it does not eliminate *all* competition among healthcare providers in the relevant market. *See OSF Healthcare*, 852 F. Supp. 2d at 1083 ("[T]he continued existence of one competitor following the merger, even a strong competitor, does not necessarily reduce the probability that the proposed merger would substantially lessen competition in the future.").

989. Courts in recent cases have endorsed the two-stage model of competition in healthcare markets, noting that mergers among competing providers can enhance the merging

[2] *Phila. Nat'l Bank*, 374 U.S. at 364.

[3] *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1278, 1280–82 (N.D. Ill. 1989).

[4] *FTC v. Univ. Health Inc.*, 938 F. 2d 1206, 1211 n.12 (11th Cir. 1991).

[5] *FTC v. Cardinal Health*, 12 F. Supp. 2d 34, 53–54 (D.D.C. 1998).

[6] *U.S. v. H & R Block, Inc.*, 833 F. Supp. 2d 36, 72 (D.D.C. 2011).

[7] *ProMedica*, 2011 WL 1219821, at *12.

[8] *OSF Healthcare*, 852 F. Supp. 2d at 1079.

parties bargaining leverage with health plans by eliminating attractive alternative provider options. *See OSF Healthcare*, 852 F. Supp. 2d at 1083; *ProMedica*, 2011 WL 1219281, at *5–7.

990. "As a general rule, the merger of two closely substitutable [healthcare providers] will increase the combined system's bargaining leverage because the alternative . . . of not contracting becomes less attractive from the perspective of health plans." *OSF Healthcare*, 852 F. Supp. 2d at 1083 (quotations omitted); *see also ProMedica*, 2011 WL 1219281, at *7 ("A hospital's bargaining power with health plans also depends in part on the availability of alternatives that could serve as substitutes for the hospital in the eyes of the health plan's current and prospective members."); *In the Matter of ProMedica Health Sys., Inc.*, 2012 WL 1155392, at *36 (FTC 2012) ("Combining competitors for which consumers view the firms' products as significant substitutes may enable the merged firm profitably to increase prices. It reduces the value of an MCO's walk-away network and consequently reduces its bargaining leverage.").

991. In evaluating healthcare provider mergers, the presence of "large, sophisticated insurance companies" does not necessarily constrain the merged entity from exercising enhanced market power. *OSF Healthcare*, 852 F. Supp. 2d at 1083–85. As explained in the *Horizontal Merger Guidelines*, "the Agencies not presume that the presence of powerful buyers alone forestalls adverse competitive effects from the merger." *Horizontal Merger Guidelines* § 8. Rather, the antitrust analysis properly focuses on how a merger changes the relative leverage of the negotiating parties: "a merger that eliminates a supplier whose presence contributed significantly to a buyer's negotiating leverage will harm that buyer." *Id.* "Furthermore, even if some powerful buyers could protect themselves, the Agencies also consider whether market power can be exercised against other buyers." *Id.*

E. DEFENDANTS FAILED TO REBUT THE STRONG PRESUMPTION OF HARM TO COMPETITION

992. Proof that an acquisition will increase concentration in a relevant market establishes a *prima facie* case that a merger is anticompetitive. *Phila. Nat'l Bank*, 374 U.S. at 363; *Heinz*, 246 F.3d at 716; *Am. Stores*, 872 F.2d at 842.

993. The burden shifts to Defendants to rebut the *prima facie* case by attempting to show that market-share statistics do not accurately predict the effects on the market. *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 631 (1974); *Am. Stores*, 872 F.2d at 842; *Univ. Health.*, 938 F. 2d at 1218–19.

994. The stronger the *prima facie* case, the greater Defendants' burden on rebuttal. *Baker Hughes*, 908 F.2d at 991; *Heinz*, 246 F.3d at 725.

1. Defendants' Purported Efficiencies Are Not Verifiable or Merger-Specific, and Do Not Address the Harm to Competition

995. High market concentration levels "require proof of *extraordinary efficiencies*" to "ensure that those 'efficiencies' represent more than mere speculation and promises about post-merger behavior." *H & R Block*, 833 F. Supp. 2d at 89 (emphasis added); *see also OSF Healthcare*, 852 F. Supp. 2d at 1089; *Heinz.*, 246 F.3d at 720–22.

996. "No court . . . has found efficiencies sufficient to rescue an otherwise illegal merger." *ProMedica*, 2011 U.S. Dist. LEXIS 33434, at *154 (citing *Phila. Nat'l Bank*, 374 U.S. at 371); *see also Procter & Gamble*, 386 U.S. at 580 ("[P]ossible economies cannot be used as a defense to illegality. Congress was aware that some mergers which lessen competition may also result in economies, but it struck the balance in favor of protecting competition."); *RSR Corp. v. FTC*, 602 F.2d 1317, 1325 (9th Cir. 1979) ("RSR argues that the merger can be justified because it allows greater efficiency of operation. This argument has been rejected repeatedly."); *Heinz*, 246 F.3d at 720–21; *OSF Healthcare*, 852 F. Supp. 2d at 1089; *H & R Block*, 833 F. Supp. 2d at 89.

997. "[C]ourts only consider efficiencies that are verifiable and merger-specific, and it is incumbent upon the court to 'undertake a rigorous analysis of the kinds of efficiencies being urged by the parties in order to ensure that those efficiencies represent more than mere speculation and promises about post-merger behavior.'" *OSF Healthcare*, 852 F. Supp. 2d at 1088–89 (quoting *H & R Block*, 833 F. Supp. 2d at 89); *see also Univ. Health*, 938 F.2d at 1223 ("[A] defendant [cannot] overcome a presumption of illegality based solely on speculative, self-serving assertions.").

998. "[D]efendants must establish by clear and convincing evidence that the efficiencies provided by the merger produce a significant economic benefit to consumers, even in light of the possible anticompetitive effects of the merger." *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1289 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990).

999. As the court recently explained in *OSF Healthcare*, "'[t]he greater the potential adverse competitive effect of a merger, the greater must be the cognizable efficiencies,'" and "'[e]fficiencies almost never justify a merger to monopoly or near-monopoly.'" *OSF Healthcare*, 852 F. Supp. 2d at 1088 (quoting *Horizontal Merger Guidelines* § 10).

a) Defendants Efficiency Claims Are Not Verifiable

1000. Defendants must "verify by reasonable means the likelihood and magnitude of each asserted efficiency, how and when each would be achieved (and any costs of doing so), how each would enhance the merged firm's ability and incentive to compete, and why each would be merger-specific." *H & R Block*, 833 F. Supp. 2d at 89.

1001. Defendants cannot "overcome a presumption of illegality based solely on speculative, self-serving assertions." *Univ. Health*, 938 F.2d at 1223.

1002. Defendants must prove the Acquisition will result in "significant economies, and that these economies would benefit competition and, hence, consumers." *Id.*

1003. Efficiency claims "generated outside of the usual business planning process" are "viewed with skepticism." *ProMedica*, 2011 WL 1219281, at *40; *Horizontal Merger Guidelines* § 10. This skepticism is particularly important for efficiency claims developed after Defendants became aware that the transaction was under investigation. *See ProMedica*, 2011 WL 1219281, at *40–41 (discussing efficiencies report produced after "SLH leadership was aware that a transaction with PHS would generate an antitrust review").

1004. "Delayed benefits . . . are less proximate and more difficult to predict," and thus are entitled to little weight. *CCC Holdings*, 605 F. Supp. 2d at 73; *Horizontal Merger Guidelines* § 10.

1005. "While reliance on the estimation and judgment of experienced executives about costs may be perfectly sensible as a business matter, the lack of a verifiable method of factual analysis resulting in the cost estimates renders them not cognizable by the Court." *H & R Block*, 833 F. Supp. 2d at 91.

b) Defendants' Efficiency Claims Are Not Merger-Specific

1006. Efficiencies claimed by a defendant are not to be credited unless they are merger-specific, substantiated, and of such a magnitude that the transaction is not likely to be anticompetitive in any market. *Merger Guidelines* § 10.

1007. "A 'cognizable' efficiency claim must represent a type of cost saving that could not be achieved without the merger . . . ." *H & R Block*, 833 F. Supp. 2d at 89. Efficiencies that are "merger-specific" are those "that cannot be achieved by either company alone because, if they can, the merger's asserted benefits can be achieved without the concomitant loss of a competitor." *Heinz*, 246 F.3d at 721–22.

1008. "The *Merger Guidelines* 'credit only those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed

merger or another means having comparable anticompetitive effects. These are termed merger-specific efficiencies.'" *ProMedica*, 2011 WL 1219281, at *39 (quoting *Horizontal Merger Guidelines* § 10).

1009. As the court found in *ProMedica*, the types of efficiencies claimed by Defendants in this case can be accomplished through other means: "the savings achieved by an ACO can be shared via contractual relationships, joint ventures, and other methods besides mergers, joinders, or acquisitions." *ProMedica*, 2011 WL 1219281, at *41.

1010. Absent a showing of merger-specificity, Defendants' "desirable goals" such as improving clinical quality or access to care, are insufficient to rebut a compelling *prima facie* case of likely anticompetitive effects. *OSF Healthcare*, 852 F. Supp. 2d at 1094.

c) Defendants' Efficiency Claims Do Not Address the Harm to Competition

1011. Courts have rejected the claim that anticompetitive effects in one market can be offset by potential procompetitive benefits in another market. *Phila. Nat'l Bank*, 374 U.S. at 370–71; *RSR Corp.*, 602 F.2d at 1325; *Rockford Mem'l*, 717 F. Supp. at 1288–89.

1012. In *Rockford*, the claimed efficiencies, like those in this case, included the assertion that as a result of merger "the number, depth and quality of services . . . will improve," there, due to the alleged addition of tertiary services. 717 F. Supp. at 1288. The court acknowledged that "the improvement in services would have a positive impact for consumers of healthcare," but concluded that that was "not relevant for our purposes today." *Id*. The court noted that its "exclusive role is to evaluate the merger's effect on competition for the relevant market and no more." *Id.* As in this case, any effort to improve healthcare quality would not avoid competitive harm to consumers in the form of higher prices and fewer competitive choices.

1013. As the Supreme Court stated in *Philadelphia National Bank*, an anticompetitive merger is "not saved because, on some ultimate reckoning of social or economic debits and credits, it may be deemed beneficial. A value choice of such magnitude is beyond the ordinary limits of judicial competence and, and in any event, has been made for us already by Congress, when it enacted the amended Section 7." 374 U.S. at 371.

2. Entry and Expansion Will Not Counteract the Anticompetitive Effect of the Acquisition

1014. The mere possibility that a new provider may enter the market or an existing provider may be able to expand its operations is not sufficient to counteract the anticompetitive effect of the Acquisition. The *Horizontal Merger Guidelines* provide that entry must be "timely, likely, and sufficient in its magnitude, character, and scope to deter or counteract the competitive effects" of the proposed transaction. *Horizontal Merger Guidelines* § 9; *FTC v. Procter & Gamble*, 386 U.S. 568, 579–81 (1967).

1015. Defendants must show both that entry or expansion is *likely*—meaning both technically possible and economically sensible—and that it will *replace* the competition that existed prior to the merger. *See Cardinal Health*, 12 F. Supp. 2d at 56–58; *In re Chicago Bridge & Iron Co.*, 138 FTC 1024, 1071–72 (2005) (noting "new entrants and fringe firms" might not replace competition), *aff'd sub nom. Chicago Bridge & Iron Co. N.V. v. FTC*, 534 F.3d 410 (5th Cir. 2008).

1016. In assessing this evidence, the "history of entry into the relevant market is a central factor in assessing the likelihood of entry in the future." *Cardinal Health*, 12 F. Supp. 2d at 56; *see also Horizontal Merger Guidelines* § 9 ("Recent examples of entry, whether successful or unsuccessful, generally provide the starting point for identifying the elements of practical entry efforts."). Accordingly, evidence that firms have had limited success entering the market

or expanding their operations is relevant in assessing whether entry or expansion are likely to constrain the exercise of market power.

1017. "[F]or entry or expansion to be sufficient," to replace the competition lost through the merger of head-to-head competitors, "it must replace *at least the scale and strength* of one of the merging firms in order to replace the lost competition from the Acquisition." *ProMedica*, 2011 WL 1219281, at *34 (emphasis added).

1018. Numerous factors can serve as barriers to successful entry and expansion, including the strong market reputation enjoyed by the merging providers. *See Cardinal Health*, 12 F. Supp. 2d at 57 (noting that the "strength of reputation that the Defendants already have over these wholesalers serve as barriers to competitors as they attempt to grow significantly in size"); *Horizontal Merger Guidelines* § 9.3 (describing "reputational barriers to rapid expansion"). For this reason, the mere possibility of entry or expansion is not sufficient to counteract the anticompetitive effects of the Acquisition.

3. Defendants' Other Defenses Also Fail To Rebut the Strong Presumption of Illegality

a) Defendants' "Healthcare Reform" Defense is Contradicted by the Regulations Implementing the Affordable Care Act

1019. Defendants have suggested that federal healthcare policy generally, and the Affordable Care Act specifically, is somehow inconsistent with effective enforcement of the antitrust laws. Contrary to Defendants' claims, the Centers for Medicare & Medicaid Services (CMS) has explained that competition promotes the goals of federal health policy, and market power threatens to undermine these goals:

> [C]ompetition in the marketplace benefits Medicare and the Shared Savings Program because it promotes quality of care for Medicare beneficiaries and protects beneficiary access to care. Furthermore, competition benefits the Shared Savings Program by allowing the opportunity for the formation of two or more ACOs in an area. Competition among ACOs can accelerate advancements in

> quality and efficiency. *All of these benefits to Medicare patients would be reduced or eliminated if we were to allow ACOs to participate in the Shared Savings Program when their formation and participation would create market power.*

42 C.F.R. Part 424, 76 Fed. Reg. 67802, 67841 (Nov. 2, 2011) (emphasis added).

1020. Most notably, these regulations clarify that CMS "reject[s] the proposition that an entity under single control, that is an entity formed through a merger, would be more likely to achieve the three-part aim," *Id.* at 67843, *i.e.*, "(1) Better care . . . ; (2) better health . . . ; and (3) lower growth in expenditures," *Id.* at 67804.

1021. Furthermore, this argument ignores the well-established principle that "implied repeal" of the antitrust laws is not favored. As the Supreme Court stated in another healthcare case:

> The antitrust laws represent a fundamental national economic policy . . . . Implied antitrust immunity is not favored, and can be justified only by a convincing showing of clear repugnancy between the antitrust laws and the regulatory system. . . . Repeal is to be regarded as implied only if necessary to make the [subsequent law] work, and even then only to the minimum extent necessary. This is the guiding principle to reconciliation of the two statutory schemes.

Nat'l Gerimedical Hosp. & Gerontology Ctr. v. Blue Cross of Kan. City, 452 U.S. 378, 388–89 (1981) (quotations omitted).

1022. Courts in recent healthcare merger cases have properly rejected such a "healthcare reform" defense. *See OSF Healthcare*, 852 F. Supp. 2d at 1095 (rejecting "defendants' claim that the merger is essential to meet the challenges of healthcare reform"); *ProMedica*, 2011 WL 1219281, at *41–42 (concluding that healthcare reform measures do not justify the acquisition).

b) Defendants' "Board Member" Defense Has Been Rejected

1023. Defendants rely on *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1294 (W.D. Mich. 1996) for the proposition that St. Luke's not-for-profit tax status and community board members will constrain its anti-competitive behavior.

1024. Numerous courts have rejected this argument. *See, e.g.*, *Univ. Health*, 938 F.2d at 1213–14 (reversing denial of preliminary injunction and noting that "the district court's assumption that University Hospital, as a nonprofit entity, would not act anticompetitively was improper"); *Rockford Mem'l*, 898 F.2d at 1285 (rejecting argument that not-for-profit status removes competitive concerns) (citing *National Collegiate Athletic Ass'n v. Board of Regents*, 468 U.S. 85, 100 n.22 (1984)); *OSF Healthcare*, 852 F. Supp. 2d at 1081 (distinguishing *Butterworth* and noting that "the evidence in this case reflects that nonprofit hospitals do seek to maximize the reimbursement rates they receive").

F. THE APPROPRIATE REMEDY IS COMPLETE DIVESTITURE

1025. Where "the Government has successfully borne the considerable burden of establishing a violation of the law, all doubts as to the remedy are to be resolved in its favor." *United States v. E.I. duPont de Nemours, Inc.*, 366 U.S. 316, 334 (1961); *see also In re Polypore Int'l Inc.*, No. 9327, 2010 WL 9434806, at *257 (FTC Mar. 1, 2010).

1026. Divestiture is "the remedy best suited to redress the ills of an anticompetitive merger." *California v. Am. Stores Co.*, 495 U.S. 271, 285 (1990). "The very words of Section 7 [of the Clayton Act] suggest that an undoing of the acquisition is a natural remedy." *E.I. duPont*, 366 U.S. at 329. "Congress also made express its view that divestiture was the most suitable remedy in a suit for relief from a Section 7 violation." *Am. Stores*, 495 U.S. at 285. "[D]ivestiture has been called the most important of antitrust remedies" and "should always be in the forefront of a court's mind when a violation of § 7 has been found." *E.I. duPont*, 366 U.S. at 330–31.

1027. Structural remedies—specifically, complete divestitures—are generally the preferred and most appropriate method to restore the competition eliminated by violations of Section 7 of the Clayton Act. *See E.I. duPont*, 366 U.S. at 329–31; *Polypore*, 2010 WL 9434806, at *257; *Evanston*, 2007 WL 2286195, at *77. "Of the very few litigated §7 cases which have been reported, most decreed divestiture as a matter of course. Divestiture has been called the most important of antitrust remedies. It is simple, relatively easy to administer, and sure. It should always be in the forefront of a court's mind when a violation of Section 7 has been found." *Ash Grove Cement Co. v. FTC*, 577 F.2d 1368, 1380 (9th Cir. 1978).

1028. A remedy is "more likely to restore competition if the firms that engaged in pre-merger competition are not under common ownership." *Evanston*, 2007 WL 2286195, at *77. Moreover, there "are also usually greater long-term costs associated with monitoring the efficacy of a conduct remedy than with imposing a structural solution." *Id.*

1029. In his opening statement, counsel for St. Luke's cited a private merger case for the proposition that "divestiture should not be entered into without substantial evidence that the benefit outweighs the harm." Trial Tr. at 165:22–23 (Jack Bierig); *see Antoine L. Garabet, M.D., Inc. v. Autonomous Techs. Corp.*, 116 F. Supp. 2d 1159, 1171–72 (C.D. Cal. 2000). But, the Supreme Court has long recognized that divestiture is the most important remedy in government challenges under Clayton Act Section 7. *See Am. Stores*, 495 U.S. at 285; *Ford Motor Co. v. United States*, 405 U.S. 562, 573 (1972); *E.I. duPont*, 366 U.S. at 330–31.

1030. Moreover, the court in *Garabet* relied on Ninth Circuit precedent stating that "the costs and complexities of unwinding a merger may be considered in evaluating prejudice to the affected parties." *Garabet*, 116 F. Supp. 2d at 1173 (citing *Fed. Home Loan Bank Bd. v. Elliott*, 386 F.2d 42, 55 (9th Cir. 1968)). In this case, however, Defendants have represented to the

Court that they have held off on integrating Saltzer into St. Luke's and will not argue that "the transaction should not be unwound because doing so would be costly or burdensome." TX 2625.

1. Defendants' "Weakened Competitor" Argument is Unavailing

1031. Defendants have suggested that Saltzer would not be as viable of a competitor if it were divested from St. Luke's. Notably, Defendants have disclaimed a "failing firm" defense, *see* Trial Tr. at 2402:17–25, which has strict legal requirements that are not met here. *See Citizen Publ'g Co. v. United States*, 394 U.S. 131, 136–38 (1969) (requiring evidence that "the resources of one company were so depleted and the prospect of rehabilitation so remote that it faced the grave probability of a business failure" and that there was "not other prospective purchaser"). The *Horizontal Merger Guidelines* clarify that this defense is limited to the "extreme instance" of "imminent failure" by one of the merging firms, which would cause "the assets of that firm to exit the market." *Horizontal Merger Guidelines* § 11.

1032. Courts strongly disfavor the type of "weak company defense" that Defendants appear to be advancing in this case, because it "would expand the failing company doctrine, a defense which has strict limits." *FTC v. Warner Commc'ns, Inc.*, 742 F.2d 1156, 1164 (9th Cir. 1984) (internal quotations omitted); *see also Kaiser Aluminum & Chem. Corp v. FTC*, 652 F.2d 1324, 1338–41 (7th Cir. 1981); *ProMedica*, 2011 WL 1219281, at *57–58.

1033. In addition, the Supreme Court has squarely rejected the argument that an otherwise unlawful acquisition can be permitted if it has the "beneficial effect" of making the acquired entity a "more vigorous and effective competitor." *Ford Motor Co. v. United States*, 405 U.S. 562, 569–70 (1972).

1034. Furthermore, St. Luke's represented to this Court that it could easily order divestiture if the Court found after the merits trial that the Acquisition violated Section 7. Dkt. No. 49 (Tr. of Prelim. Inj'n Proceedings) at 87–88. Counsel stated that a preliminary injunction

would be unnecessary because "it would be quite possible to unscramble this egg if, after full factual development . . . and review, it were found to be unlawful." *Id.* at 87. "[I]f ultimately this court . . . were to hold that this transaction is unlawful," counsel continued, "we will not oppose divestiture on grounds that divestiture cannot be accomplished." *Id.* at 88.

1035. St. Luke's made similar representations to the FTC and the Attorney General, in a December 20, 2012 letter providing "written assurances regarding the ability of the Federal Trade Commission and the Idaho Attorney General's office to seek unwinding of the transaction . . . after it closes." TX 2625. In that letter, St. Luke's assured the government that "St. Luke's will not argue, in any subsequent challenge to the Saltzer transaction, that the transaction should not be unwound because doing so would be costly or burdensome." *Id.*

1036. Any financial hardship caused by Defendants decision to proceed with the transaction is self-inflicted, as Defendants knew that going forward with the transaction would lead to the departure of the Saltzer surgeons. The Court does not consider such self-inflicted wounds in fashioning the appropriate remedy. *See, e.g.*, *Davis v. Mineta*, 302 F.3d 1104, 1116 (10th Cir. 2002); *Sierra Club v. Army Corps. of Eng'rs*, 645 F.3d 978, 996–97 (8th Cir. 2011); *Pappan Enters., Inc. v. Hardee's Food Sys., Inc.*, 143 F.3d 800, 806 (3d Cir. 1998).

1037. Even if there were any merit to Defendants' weakened competitor argument, the Court's equitable powers give it discretion to fashion an appropriate remedy to restore competition. *See Ford Motor Co.*, 405 U.S. at 573 ("The District Court is clothed with large discretion to fit the decree to the special needs of the individual case") (quotation omitted); *see also Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410, 441–42 (5th Cir. 2008) (order requiring divestiture of more than the acquired assets was appropriate because it restored "two competitors

capable of competing on an equal footing" following an acquisition of a "previously viable and independent entity").

1038. Although the Stark Act, 42 U.S.C. § 1395nn, ordinarily limits the payments that a hospital may make to an independent physician, it does not apply to payments made pursuant to a court-ordered equitable remedy. *See Braun v. Promise Regional Medical Center-Hutcheson, Inc.*, No. 11-2180-RDR, 2011 WL 6304119, at *4–5 (D. Kan. Dec. 16, 2011) (holding that the Stark Act does not "limit the power of a court to issue equitable remedies"). Certainly, a court-ordered remedy would not in any way implicate the purpose of the Stark law, which is to prevent overutilization of services through payment for referrals. *See, e.g., United States ex rel. Kosenske v. Carlisle HMA, Inc.*, 554 F.3d 88, 95 (3d Cir. 2009); *Colo. Heart Institute, LLC v. Johnson*, 609 F. Supp. 2d 30, 32 (D.D.C. 2009).

2. Separate Contract Negotiating Teams Is Not an Appropriate Remedy

1039. Defendants also suggest the possibility that St. Luke's and Saltzer could negotiate separately with health plans, Trial Tr. at 167:25–168:6 (Jack Bierig), as the FTC ordered in a unique case involving the retrospective review of a consummated hospital merger. *See Evanston Nw. Healthcare Corp.*, 2007 WL 2286195, at *76–79.

1040. In *Evanston*, the Commission ordered the establishment of separate contract-negotiating teams only reluctantly and explicitly curtailed the future applicability of that remedy by highlighting the unique circumstances of that case. *Evanston*, 2007 WL 2286195, at *76–79. Specifically, seven years had elapsed between the consummation of the acquisition and the conclusion of the litigation, making divestiture "much more difficult, with a greater risk of unforeseen costs and failure." *Id.* at *79. A significant amount of integration and improvements had occurred since the merger and, thus, divestiture had the potential to reduce or eliminate benefits that had been achieved. *Id.* at *78–79. The Commission concluded that the rationale for

its unusual remedy "is likely to have little applicability to our consideration of the proper remedy in a future challenge to an unconsummated merger, including a hospital merger." *Id.* at *79. The Commission also stated:

> Nor will our reasoning here necessarily apply to consideration of the appropriate remedy in a future challenge to a consummated merger, including a consummated hospital merger. Divestiture is the preferred remedy for challenges to unlawful mergers, regardless of whether the challenge occurs before or after consummation.

Id.

1041. The unusual remedy ordered in *Evanston* is unlikely to prevent the competitive harm from this Acquisition. As explained by a highly respected group of academic economists, the remedy ordered in the *Evanston* case "is likely to be ineffective in curbing anticompetitive behavior." *In re Evanston Nw. Healthcare Corp.*, No. 9315, Brief Amicus Curiae of Economics Professors ¶ 4 (Oct. 16, 2007), *available at* http://www.ftc.gov/os/adjpro/d9315/071017econprofsamicusbrief.pdf. Even with separate negotiating teams, St. Luke's and Saltzer would share the same ultimate economic incentives, as these economists explained in the context of the *Evanston* case: "Suppose that one ENH hospital holds out for a high price and is excluded from a managed care network, its patients will just end up at the other ENH hospital. This will encourage each to drive prices higher. In economics parlance, prices will become 'strategic complements.'" *Id.* In addition, this type of remedy creates "hard to oversee opportunities for collusion." *Id.*

1042. Since *Evanston*, the Commission has rejected attempts to impose this unusual remedy. In *ProMedica*, for example, the merging hospitals proposed that maintaining two separate negotiating teams could prevent any anticompetitive effects while addressing concerns about the financial viability of one of the hospitals. The Commission disagreed, concluding

based on "well-established principles" that "divestiture is the most appropriate remedy . . . to restore competition." *In re ProMedica Health Sys., Inc.*, No. 9346, 2012 WL 1155392, at *48 (FTC June 25, 2012).

1043. The Commission also noted that a "Hold Separate Agreement" that had limited the integration of the two hospitals was intended to preserve the acquired hospital "as an independent and viable competitor, should the transaction be found illegal." *Id.* at *49. As in *ProMedica*, St. Luke's similar assurances to the government and the Court support divestiture as the most appropriate remedy.

1044. Counsel for St. Luke's also cited that the FTC's recently settled challenge to a consummated hospital merger in *In re Phoebe Putney Health System*. Trial Tr. 168:7–12 (Jack Bierig). But *Phoebe Putney* involved "highly unusual" circumstances, and the FTC made clear that "settlement of this case on the proposed terms are acceptable to the Commission *only under the unique circumstances presented here*." Analysis of Proposed Agreement Containing Consent Order to Aid Public Comment, *In re Phoebe Putney Health Sys., Inc.*, No. 9348 (2013), *available at* http://www.ftc.gov/os/adjpro/d9348/130822phoebeputneyanal.pdf.

1045. In this case, the circumstances do not support deviating from the preferred remedy to redress anticompetitive acquisitions under Section 7 of the Clayton Act: complete divestiture through unwinding of the Acquisition and rescission of the Professional Service Agreement.

3. The Attorney General is Entitled to Costs and Attorney's Fees

1046. In addition, the Office of the Idaho Attorney General is entitled to an award of reasonable costs and attorney's fees. Idaho Code Section 48-108(1)(d); 15 U.S.C. § 26.

X. HOSPITAL PLAINTIFFS' PROPOSED CONCLUSIONS OF LAW[9]

A. RELEVANT PRODUCT AND GEOGRAPHIC MARKETS

1047. The courts have consistently recognized that general acute-care services constitute a relevant product market. *See, e.g., FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1075–76 (N.D. Ill. 2012); *FTC v. ProMedica Health Sys.*, 2011 WL 1219281, at *54 (N.D. Ohio 2011) ("This is a 'cluster market' of services that courts consistently have found when analyzing hospital mergers.").

1048. It is also recognized that outpatient surgical facilities markets constitute a relevant product market. Analysis of Agreement Containing Consent Orders to Aid Public Comment, *In the Matter of Carilion Clinic* (FTC File No. 081-0259), http://www.ftc.gov/os/adjpro/d9338/091007carilionclinicanal.pdf.

1049. Patients will travel farther for (more serious and less frequent) hospital care than to see a primary care physicians, but the services are still generally provided locally. *See, e.g.*, *ProMedica*, 2011 WL 1219281, at *10 (defining the relevant geographic market as a single county); *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1077 (defining the relevant geographic market as the "30-minute drive-time radius from Rockford.").

B. COMPETITIVE EFFECTS

1050. There is a presumption that merged firms will self-deal with one another exclusively when possible. Areeda, *Antitrust Law* ¶ 1004b ("A subsidiary will in all probability deal only with its parent . . ."); *United States v. Columbia Steel Co.*, 334 U.S. 495, 523 (1948). Self-dealing forecloses competition because it prevents competitors from dealing with one of the

[9] The Federal Trade Commission and the State of Idaho do not join this section of Plaintiffs' Proposed Findings of Fact and Conclusions of Law.

merged firms. *See Brown Shoe*, 370 U.S. at 331–32. Courts generally presume the existence of foreclosure without further discussion. *See Ash Grove Cement Co. v. FTC*, 577 F.2d 1368 (9th Cir. 1978). *See also United States v. Bethlehem Steel Corp.*, 168 F. Supp. 576 (S.D.N.Y. 1959); *United States v. Kimberly-Clark*, 264 F. Supp. 439, 448 (N.D. Cal. 1967) ("It is not part of the Government's burden to show actual foreclosure; however, the evidence in this case goes beyond the statutory test . . . BMT's increasing purchases from K-C in a relatively short time establish the probability of future foreclosure."); *Harnischfeger Corp. v. Paccar Mach. Corp.*, 474 F. Supp. 1151, 1158 (E.D. Wis. 1979) (finding that, although the defendant manufacturer claimed it had "no intention of foreclosing" the plaintiff competitor, "[i]t is more likely than not that a manufacturer that owns a significant purchaser would prefer to utilize the advantages of having a captive market.").

1051. An assessment of competitive effects should involve the full range of conduct engaged in by defendants. *Orchard Supply Hardware LLC v. Home Depot USA, Inc.*, 2013 WL 5289011, at *8–9 (N.D. Cal. 2013) (*citing Twin City Sportservice, Inc. v. Charles O. Finley & Co.*, 676 F.2d 1291, 1302 (9th Cir. 1982)). *See also LePage's Inc. v. 3M*, 324 F.3d 141, 162 (3d Cir. 2003) (*citing City of Anaheim v. S. Cal. Edison Co.*, 955 F.2d 1373, 1376 (9th Cir. 1992)) ("[I]t would not be proper to focus on specific individual acts of an accused monopolist while refusing to consider their overall combined effect. . . . We are dealing with what has been called the 'synergistic effect' of the mixture of the elements."). There are multiple factors contributing to harm to overall competition under the facts of this case, including foreclosure, harm to network competition, the low price/high quality alternative provided by Treasure Valley Hospital and the existing dominant position of St. Luke's in the relevant hospital and surgical facilities markets.

1052. Antitrust concerns resulting from mergers and acquisitions are especially significant when engaged in by a dominant firm, and as part of a series of acquisitions. "[I]f concentration is already great, the importance of preventing even slight increases in concentration and so preserving the possibility of eventual deconcentration is correspondingly great." *United States v. Aluminum Co. of Am.*, 377 U.S. 271, 279 (1964); *see also Phila. Nat'l Bank*, 374 U.S. at 365 n.42. "[A] substantial lessening of competition [is] to be prohibited whether the acquiring corporation accomplish[es] these results by one immense gobble of another large producer or whether it set out to produce the same results by nibbling away at small producers." *Crown Zellerbach Corp. v. FTC*, 296 F.2d 800, 822 (9th Cir. 1961). This is the case because "Congress had to see to it that no dominant operator in any industry should be permitted to frustrate the purposes of the Act by absorbing its rivals bit by bit." *Id.* The Supreme Court has likewise determined that "the objective [of the Clayton Act] was to prevent accretions of power which "are individually so minute as to make it difficult to use the Sherman Act test against them." *United States v. Aluminum Co. of Am.*, 377 U.S. 271, 280 (1964) (citing S. Rep. No. 1775, 81st Cong., 2d Sess., p. 5; U. S. Code Congressional Service 1950, p. 4297). *See also United States v. Kimberly Clark Group*, 264 F. Supp. 439, 465 (N.D. Cal. 1967) ("Unless this acquisition is undone, K-C and its competitors will have a green light to proceed with further acquisitions").

1053. The same conclusion is supported by the *Horizontal Merger Guidelines*. Those guidelines provide that in a "highly concentrated" market, with an HHI above 2500, an increase in the HHI of 100 points "potentially raise[s] significant competitive concerns and often warrant[s] scrutiny." Such mergers resulting in an increase in the HHI of more than 200 points "will be presumed to be likely to enhance market power." *Horizontal Merger Guidelines* at

§ 5.3. In the general acute inpatient care market, with a current HHI of 4715, an increase in St. Luke's already dominant share by as little as 2 percentage points will increase the HHI by more than 100.

1054. Courts recognize harm to competition where a low price competitor is injured. *See H & R Block*, 833 F. Supp. 2d 36, 79 (D.D.C. 2011) (noting that proposed "merger would result in the elimination of a particularly aggressive competitor in a highly concentrated market, a factor which is certainly an important consideration when analyzing possible anticompetitive effects.") (quotation marks omitted); *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 146 (D.D.C. 2004).

1055. To succeed under Section 7 of the Clayton Act, the plaintiffs need only show that St. Luke's acquisition of Saltzer is a contributing cause of the cumulative harm that St. Luke's numerous acquisitions have brought upon Saint Alphonsus and competition in general in the relevant market. *See, e.g., Discover Fin. Servs. v. Visa U.S.A. Inc.*, 582 F. Supp. 2d 501, 504 (S.D.N.Y. 2008) ("To prove causation, an antitrust plaintiff must demonstrate that the unlawful conduct at issue … substantially contributed to its injury, even though other factors may have contributed significantly.") (Internal quotations omitted). *See also E.V. Prentice Mach. Co. v. Associated Plywood Mills, Inc.*, 252 F.2d 473, 479 (9th Cir. 1958) (noting that under the Clayton Act "a plaintiff may recover for loss to which a defendant's wrongful conduct substantially contributed, notwithstanding that other factors also contributed").

1056. While the antitrust laws are generally said to protect competition, not individual competitors, "[t]he oft-quoted chestnut distinguishing between protecting competition and protecting competitors has been misconstrued with some regularity by antitrust defendants. . . . Injury to competition necessarily entails injury to at least some competitors. Competition does

not exist in a vacuum; it consists of rivalry among competitors. Clearly, injury to competitors may be probative of harm to competition, although the weight to be attached to such evidence depends on its nature and on the nature of the challenged conduct." *Hasbrouck v. Texaco, Inc.*, 842 F.2d 1034, 1040 (9th Cir. 1987), *aff'd sub nom. Texaco, Inc. v. Hasbrouck*, 496 U.S. 543 (1990).

1057. The Supreme Court explained that a "refusal to compete with respect to the package of services offered to customers, no less than a refusal to compete with respect to the price term of any agreement, impairs the ability of the market to advance social welfare. . . ." *FTC v. Ind. Fed. of Dentists*, 476 U.S. 447, 459 (1986). To the extent that the acquisition enables St. Luke's to refuse to compete on quality with TVH or compete on price with TVH or Saint Al's, that harms competition.

C. ENTRY AS A DEFENSE

1058. For entry to be sufficient to offset the anticompetitive effects of a Saltzer acquisition in the relevant hospital and surgical facilities markets, see entry discussion, *supra*, it would have to provide new competition equal to that presented by Saltzer. Otherwise, shifts in Saltzer referrals and the loss of Saltzer to competing networks would still harm the few remaining competitive constraints to St. Luke's in these markets.

D. DIVESTITURE IS THE APPROPRIATE REMEDY IN FORECLOSURE CASES

1059. "Courts are required to . . . decree relief effective to redress the violations, whatever the adverse effect of such a decree on private interests." *United States v. E. I. duPont de Nemours and Co.*, 366 U.S. 316, 326 (1961). Only a complete divestiture of Saltzer will address the anticompetitive effects presented by this acquisition in the relevant hospital and surgical facilities markets. A complete divestiture is necessary in order to prevent the loss of

referrals from Saltzer and to assure that the Saltzer physicians are available to contract with competing networks.

1060. Courts have utilized divestiture to address the competitive issues raised by foreclosure. *E.I. duPont*, 336 U.S. at 329; *Ash Grove Cement Co. v. FTC*, 577 F.2d 1368, 1380 (9th Cir. 1978). The Court is not aware of any attempt to do so through a regulatory solution**.** A regulatory approach would not be practical to address the referral issue in this case. The record in this case makes clear how easily referring physicians can attempt to suggest alternatives to the conclusion that foreclosure exists. *See, e.g.*, testimony of Dr. Huerd (loss of SAMG referrals); Trial Tr. at 2359:18–2361:5 (Scott Huerd); Dr. Souza (needed to avoid burden of multiple call) Dkt. No. 290 (Souza Dep. Tr.) at 82:19–83:12. While these alternative arguments have been shown on this record to be false, they illustrate that any regulator would be faced with constant disputes as to whether shifts in referrals were due to foreclosure or some other reason.

1061. Similarly, a regulatory remedy could not assure that Saltzer would make independent, self-interested decisions as to whether to participate in networks which compete with the St. Luke's networks. Even if there was a separate Saltzer "negotiating team," as Defendants have suggested, as long as Saltzer ultimately was part of St. Luke's, it could be expected to act in St. Luke's interest. As the Supreme Court made clear in *Copperweld v. Independence Tube*, 467 U.S. 752, 769 (1984), "[t]he officers of a single firm are not separate economic actors pursuing separate economic interests." "[W]ith or without a formal 'agreement,' the subsidiary acts for the benefit of the parent, its sole shareholder." *Id.* at 771. If St. Luke's bottom line is benefited whether negotiating team "Saltzer" or negotiating team "St. Luke's" succeeds in getting more business, there is no incentive for a separate Saltzer negotiating team to vigorously compete.

1062. An order that prohibits future acquisitions is warranted when (as here) a pattern of acquisitions has been established. *See Luria Bros. & Co. v. FTC*, 389 F.2d 847, 865–66 (3d Cir. 1968) (*citing United States v. Crescent Amusement Co.*, 323 U.S. 173, 186 (1944) ("This type of provision is often the only practical remedy against continuation of illegal trade practices. … The pattern of past conduct is not easily forsaken.") *See also Abex Corp. v. FTC*, 420 F.2d 928, 933 (6th Cir. 1970) ("read[ing] the [Clayton Act] as authority for the remedy [of divestiture and a 10-year injunction against similar acquisitions] chosen by the [FTC].").

1063. The Private Plaintiffs as prevailing parties are entitled to recover their reasonable attorneys' fees. 15 U.S.C. § 26.

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