No. 12-3583

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

PROMEDICA HEALTH SYSTEM, INC.,
Petitioner,

v.

FEDERAL TRADE COMMISSION,
Respondent.

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

PUBLIC BRIEF FOR RESPONDENT FEDERAL TRADE COMMISSION

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GLOSSARY

For ease of reference, the following abbreviations and citation forms are used in this brief:

Op.	Commission's Opinion
ID	Initial Decision of the Administrative Law Judge
IDF	Initial Decision Finding of Fact
PX	Complaint Counsel Exhibit
RX	ProMedica Exhibit
JX	Joint Exhibit
Tr.	Transcript of Trial Testimony before the Administrative Law Judge
JA	Joint Appendix
Br.	Brief for Petitioner
*	In Camera Material

STATEMENT REGARDING ORAL ARGUMENT

The Federal Trade Commission ("FTC" or "Commission") agrees with the petitioner that oral argument would aid the Court's resolution of this case and, accordingly, requests that the Court hear oral argument in this case.

STATEMENT OF JURISDICTION

This is a petition to review a Final Order of the Commission, entered pursuant to Section 11(b) of the Clayton Act, 15 U.S.C. § 21(b), and Section 5(b) of the Federal Trade Commission Act ("FTC Act"), 15 U.S.C. § 45(b). This Court has jurisdiction to review the Order pursuant to 15 U.S.C. §§ 21(c) and 45(c).

STATEMENT OF THE ISSUES

1. Whether substantial evidence supports the Commission's findings that the acquisition is likely to substantially lessen competition in the markets for general acute-care inpatient hospital services and obstetrical inpatient services.

2. Whether the Commission's final divestiture order is within the bounds of its discretion.

STATEMENT OF THE CASE

A. Nature of the Case, Course of Proceedings, and Disposition Below

This is a petition to review a final divestiture order that the Commission issued following an administrative adjudication under Section 5 of the FTC Act, 15 U.S.C. § 45. It involves the consummated joinder (the "Joinder") of two hospital providers in Toledo, Ohio: ProMedica Health System, Inc. ("ProMedica"), a large hospital system that operates three area hospitals; and St. Luke's Hospital

("St. Luke's"), a formerly independent community hospital. The Joinder eliminates significant, beneficial competition for inpatient general acute-care ("GAC") services, reducing the number of competitors in Lucas County (which encompasses the Toledo area) from four to three. The Joinder also eliminates competition for inpatient obstetrical ("OB") services, reducing the number of competitors in Lucas County from three to two – a merger to duopoly.

The Joinder alters the alternative hospital network available to commercial health plans if they fail to reach an agreement with ProMedica. By decreasing the desirability of the health plans' walk-away network, the Joinder increases ProMedica's bargaining leverage. Exercise of this increased leverage gives ProMedica the ability to demand and obtain supra-competitive reimbursement rates – costs that will ultimately be borne by consumers and employers in Lucas County.

On May 25, 2010, ProMedica and St. Luke's entered into a Joinder Agreement, under which St. Luke's became part of ProMedica.[1] After Commission staff opened an investigation of the transaction, ProMedica entered into a Hold Separate Agreement that allowed the deal to close but restricted ProMedica's consolidation of its operations with those of St. Luke's. On January

[1] ProMedica became the sole corporate member or shareholder of St. Luke's. PX00058-009-12 (JA448-51). Consequently, for antitrust analysis of the transaction, ProMedica controls St. Luke's.

6, 2011, the Commission issued an administrative complaint against ProMedica, alleging that the Joinder threatened to substantially lessen competition for health care services in Lucas County – specifically, the markets for GAC inpatient hospital services sold to commercial health plans and inpatient OB services – in violation of Section 7 of the Clayton Act, 15 U.S.C. § 18.

The Commission, joined by the State of Ohio, also sought a preliminary injunction in the U.S. District Court for the Northern District of Ohio, seeking to maintain the viability of St. Luke's as an independent hospital and preserve the Commission's ability to order effective relief should the transaction ultimately be found unlawful. On March 29, 2011, after a two-day hearing and based on its review of the parties' evidence, the district court ruled in favor of the FTC and the State of Ohio and entered a preliminary injunction holding ProMedica to the terms of the Hold Separate Agreement pending completion of the FTC administrative proceedings and any appellate review. *FTC v. ProMedica Health Sys., Inc.*, No. 3:11 CV 47, 2011 WL 1219281 (N.D. Ohio March 29, 2011).

An Administrative Law Judge ("ALJ") presided over an evidentiary hearing that lasted over 30 days, producing a record that includes nearly 8,000 pages of trial testimony and over 2,600 exhibits. On December 5, 2011, the ALJ issued a 215-page Initial Decision, holding that the Joinder is likely to substantially lessen

competition in the market for GAC inpatient hospital services in Lucas County (but finding no separate OB market), in violation of Section 7 of the Clayton Act. As a remedy, the ALJ ordered ProMedica to divest St. Luke's.

ProMedica appealed the ALJ's decision to the Commission. Complaint Counsel appealed the ALJ's determination of the relevant product market. After full briefing and argument, and based on its *de novo* review of the record, the Commission affirmed the ALJ's decision that the Joinder violates Section 7 – but disagreed with the ALJ's ruling on the relevant product market – and issued a Final Order requiring divestiture of St. Luke's.[2]

B. Statement of Facts

1. The Hospital Providers

Even before it acquired St. Luke's, ProMedica regarded itself, and was regarded by others, as the dominant hospital system in Lucas County. IDF 604 (JA168); PX00270-025 (JA2654). ProMedica operated three general acute-care hospitals in Lucas County: The Toledo Hospital ("TTH"), the area's largest hospital; and two community hospitals, Flower Hospital and Bay Park Hospital. IDF 53-71 (JA109-110). ProMedica also owns and operates Paramount Health

[2] In a concurring opinion, Commissioner Rosch disagreed with certain aspects of the Commission opinion, but agreed with the Commission's ultimate conclusions on liability and remedy.

Care ("Paramount"), one of the largest commercial health plans in Lucas County. IDF 163 (JA118). At the time of the Joinder, ProMedica commanded the highest hospital commercial reimbursement rates in Lucas County; indeed, ProMedica's rates are among the highest in all of Ohio. IDF 524-25 (JA158).

Before the Joinder, St. Luke's was an independent, full-service community hospital. It is located in Maumee, an affluent suburban area in southwest Lucas County, considered to be a highly desirable location due to its growing population of employed, commercially insured patients. IDF 72-73, 472-74 (JA111, 152); Wakeman, Tr. 2477-81 (JA3187-91); Oostra, Tr. 6036-38 (JA3301-03). St. Luke's is the third-largest individual hospital in Lucas County based on commercial volume, IDF 462 (JA151), and is regarded as a low-cost, high-quality provider. IDF 758-64 (JA185); Pugliese, Tr. 1443-48, 1521-22 (JA3145-50, 3159-60); McGinty, Tr. 1190-92, 1205-06 (JA3130-34).

There are only two other hospital providers in Lucas County: Mercy Health Partners ("Mercy"), which operates three Toledo-area hospitals (St. Vincent, St. Anne, and St. Charles), IDF 79-81(JA111); and the University of Toledo Medical Center ("UTMC"), a state-supported research and teaching hospital that focuses on providing complex, highly-specialized treatments for higher acuity conditions

(tertiary and quaternary services), IDF 103-06 (JA113).[3] Neither UTMC nor Mercy St. Anne offers inpatient OB services, IDF 94-96, 110 (JA112-13), making ProMedica and St. Luke's the only OB providers in the western half of Lucas County. PX02148-070***** (JA1119); *see* PX00900 (JA2727).

A hospital's location within Lucas County is important because patients strongly prefer to stay close to home for inpatient GAC and OB services. IDF 283, 475 (JA129, 152); Shook, Tr. 942 (JA3129); Sandusky, Tr. 1305-06 (JA3136-37); Rupley, Tr. 1962 (JA3166); Randolph, Tr. 7101-7102***** (JA3320-21); Town, Tr. 3693-94 (JA3251-52); PX01917-008***** (JA2937). Location also matters because, although overall demographics indicate little growth in Toledo over the next few years, Lucas County suburbs (*e.g.*, Maumee, where St. Luke's is located) are growing. PX00159-005***** (JA2588) (ProMedica 2010 Environmental Assessment notes that "significant shifting of population away from central Toledo to surrounding communities presents both opportunities as well as threats. (St.

[3] Although the dividing line between the various levels of service is not precisely defined, generally speaking, primary services treat common conditions of mild to moderate severity (*e.g.*, minor surgery); secondary services are more complex and require some specialization and greater resources (*e.g.*, complex orthopedic surgery); tertiary services are more complex than secondary services, but less complex than quaternary services (*e.g.*, neurological intensive care); quaternary services are the most complex and require the most specialized equipment and expertise (*e.g.*, organ transplants). IDF 20-26 (JA106).

Luke's could be critically important.)").

2. MCO Contracts for Hospital Services

Privately-insured patients obtain health insurance coverage primarily through commercial health plans offered by managed care organizations ("MCOs"). IDF 44 (JA108).[4] MCOs contract with hospitals, physicians, and other health care providers to create provider networks that the MCOs then market to employers. The MCOs compete against one another to be selected by employers to offer health insurance to their employees. IDF 234, 237-38 (JA124). Because an MCO needs to offer an attractive network to win the business of employers and their employees, MCOs take into account the preferences of their current and potential members when designing hospital networks. PX02148-027***** (JA1076).

Reimbursement rates for hospital services are determined through bargaining between MCOs and hospital providers. IDF 509 (JA156). The MCO's goal is to assemble a provider network that will be attractive to its customers, at the lowest cost. IDF 277-79 (JA128). Although the network as a whole must provide the full range of services that MCO members will need, the MCO need not purchase the same bundle of services from each hospital provider – *e.g.*, a hospital

[4] MCOs marketing health insurance products to employers in Lucas County include Medical Mutual of Ohio ("MMO"), Anthem Blue Cross Clue Shield, Paramount, United Healthcare, FrontPath, Humana, and Aetna.

with a limited range of services but an attractive location may be an important component of a health plan's provider network. IDF 273-74 (JA128).

The rates and terms of these contracts are largely determined by the bargaining leverage of each party. IDF 554 (JA161). A hospital's bargaining leverage is based on the degree of difficulty an MCO would face in marketing its network without the hospital; it is therefore tied to the value the MCO's members place upon having access to that hospital provider. The more valued the hospital is by the MCO's members, the more bargaining power the hospital possesses. In turn, the MCO's bargaining leverage depends on the patient volume that the MCO can offer the hospital provider. The larger the MCO's membership, the more patient volume it can offer a hospital, and the more motivated the hospital provider is to reach an agreement with that MCO. PX02148-016-017***** (JA1065-66); Town, Tr. 3641-43, 3647-50 (JA3221-23, 3225-28).

Although, in the past, MCOs in Lucas County offered limited hospital networks, limited networks have become less acceptable to local employers and their employees; consequently, most MCOs now include all Lucas County hospitals in their networks. IDF 246, 256-57 (JA125-26).[5] Notably, no MCO has

[5] Nevertheless, MCOs may still have economic incentives to limit their networks, as doing so often enables them to obtain more favorable rates from the included providers, who stand to gain volume by virtue of others' exclusion.

offered a network in Lucas County consisting only of UTMC and Mercy, even when limited networks were more acceptable in the market than they are today. IDF 565 (JA163); Guerin-Calvert, Tr. 7893-95 (JA3330-32).

3. St. Luke's and ProMedica Were Significant Competitors.

Before the Joinder, ProMedica and St. Luke's competed vigorously to attract patients, particularly those who reside between ProMedica's hospitals and St. Luke's. IDF 464 (JA151). St. Luke's viewed ProMedica as its "most significant competitor." IDF 440 (JA148); Wakeman, Tr. 2511 (JA3195); Oostra, Tr. 6040 (JA3305). ProMedica likewise viewed ProMedica and St. Luke's as "[s]trong competitors." Oostra, Tr. 6038-6039 (JA3303-04). Recognizing the significant competition it faced from St. Luke's, ProMedica repeatedly sought to induce MCOs to exclude St. Luke's from their networks. For example, ProMedica's contract with Anthem offered discounted rates conditional on Anthem's agreement not to include St. Luke's in Anthem's provider network. JX00002A ¶18 (JA2579). ProMedica also opposed St. Luke's admission to Paramount's network because it recognized St. Luke's would draw patients away from ProMedica's hospitals. IDF 467-69 (JA151); Rupley, Tr. 1940-1941 (JA3163-64); Oostra, Tr. 6046-51

Accordingly, the prospect of exclusion remains an important part of the bargaining dynamic. IDF 268-69 (JA127).

(JA3306-11).[6]

St. Luke's understood that it was being targeted by ProMedica, reporting that "ProMedica desires the SLH geographic area, so they will continue to starve SLH through exclusive managed care contracts and owned physicians. They will do this until we sign up with them or are weakened." PX01127-001 (JA2808); *see* PX01152-001 (JA2825) (ProMedica "is continuing an aggressive strategy to take over St. Luke's or put us out of business"). When a new CEO joined St. Luke's in 2008, one of his particular goals was to gain volume from ProMedica in St. Luke's core and primary service areas. Wakeman, Tr. 2504-05 (JA3192-93).[7] ProMedica later reported that St. Luke's had picked up fully half of the market share that ProMedica lost in the first nine months of 2009. PX00159-012***** (JA2595). An acquisition of St. Luke's, ProMedica reported, "would 'recapture' a substantial portion of recent losses." *Id.* at 5.

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[6] ProMedica also evaluated opportunities to exclude St. Luke's from other MCO networks. PX00407-001***** (JA2722); Wachsman, Tr. 5215-5216***** (JA3299-3300).

[7] St. Luke's defines its core service area as the eight zip codes surrounding St. Luke's, where 55-60% of the admission base comes from. The primary service area is where approximately 80% of St. Luke's patients come from. Rupley, Tr. 1944-45 (JA3165-66).

4. St. Luke's Decision to Join the ProMedica System

In the years prior to the Joinder, St. Luke's, like many others during the recent recession, faced financial challenges. IDF 371-85; 785-86, 792-95, 799 (JA139-40, 187-89). To address these issues, St. Luke's hired a new CEO, Daniel Wakeman, who had previously engineered successful turnarounds of several other community hospitals. Wakeman, Tr. 2473-75 (JA3184-86). Mr. Wakeman developed a three-year strategic plan for St. Luke's that contained growth goals for patient volume and revenues. IDF 920 (JA202).

Mr. Wakeman's strategy delivered results: St. Luke's inpatient and outpatient net revenues increased in each calendar year from 2008 through 2010. ID 926-27 (JA203). St. Luke's operating losses declined and its operating margins improved, as patient volumes increased and expenses declined. IDF 948-54, 957-58 (JA206-07). By August 2010, St. Luke's was able to post a positive operating margin, which – Mr. Wakeman reported – though small, "confirms that we can run in the black if activity stays high. After much work, we have built our volume up to a point where we can produce an operating margin and keep our variable expenses under control." PX00170-001 (JA2620).

St. Luke's management pursued several options to address St. Luke's financial challenges, including attempting to renegotiate MCO contracts to obtain

more favorable reimbursement rates, IDF 540-49 (JA160-61); exploring the interest of out-of-market hospitals in acquiring St. Luke's, Wakeman, Tr. 2543-48 (JA3196-3201); and entering into discussions with ProMedica, Mercy, and UTMC, each of which was interested in an affiliation arrangement with St. Luke's, IDF 404 (JA144); Wakeman, Tr. 2551-55, 2558-59 (JA3204-10); PX01016-023-024 (JA2750-51). St. Luke's management felt that an affiliation with ProMedica "has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout." PX01030-020***** (JA2794); *see* IDF 598 (JA167); PX01125-002***** (JA2806) (noting the advantages of ProMedica's "incredible access to outstanding pricing on managed care agreements"). But St. Luke's management also recognized that an affiliation with ProMedica could "[h]arm the community by forcing higher hospital rates on them." Wakeman, Tr. 2700***** (JA3216); *see* PX01130-005***** (JA2815) (ProMedica affiliation "could stick it to employers, that is, to continue forcing high rates on employers and insurance companies"); PX01125-002***** (JA2806) (affiliation with ProMedica "may not be the best thing for the community in the long run. Sure would make life easier right now though."). Ultimately, despite these consequences, St. Luke's decided to become part of the ProMedica hospital system, entering into a Joinder Agreement that vests ProMedica with economic and decision-making control over St. Luke's.

IDF 434-35 (JA147-48); PX00058-016-018, 058 (JA455-57, 497).

C. The Commission's Decision and Order

The Commission affirmed the ALJ's decision that the Joinder is likely to substantially lessen competition for GAC inpatient hospital services sold to commercial health plans in Lucas County.[8] The Commission reached a different conclusion than the ALJ, however, about the boundaries of the GAC market, finding that it excludes tertiary services that St. Luke's does not perform, as well as inpatient OB services, which the Commission determined is a separate relevant product market. Op. 15-26 (JA40-51). The Commission made clear, however, that these differing views concerning the precise boundaries of the product market make no difference on the ultimate question of liability: Whichever definition is used, the Joinder significantly increases ProMedica's market share and market concentration, causing concentration levels to substantially exceed the thresholds that, under the federal antitrust agencies' Merger Guidelines[9] and the case law, warrant a presumption that the transaction is anticompetitive. Op. 26-27 (JA51-

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[8] ProMedica does not dispute that the relevant geographic market is Lucas County. Op. 26 (JA51).

[9] U.S. Dept. of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines (Aug. 19, 2010) ("Merger Guidelines"), available at http://www.ftc.gov/os/2010/08/100819hmg.pdf.

52).

The Commission found that the acquisition gave ProMedica a post-acquisition market share of 58.3% in the GAC market, as so defined, and increased HHIs by 1,078 points,[10] with a post-acquisition HHI of 4,391; and gave ProMedica an 80.5% market share in the OB inpatient services market, and increased HHIs in this market by 1,323 points, with a post-acqusition HHI of 6,854. Op. 26-27 (JA51-52); IDF 364, 368 (JA139); PX02148-143***** (JA1192). Under the Merger Guidelines, a post-acquisition HHI above 2,500 and HHI increase of more than 200 points "will be presumed to be likely to enhance market power," but "[t]he presumption may be rebutted by persuasive evidence showing that the merger is unlikely to enhance market power." Merger Guidelines § 5.3. As the Commission noted, ProMedica's expert did not calculate HHIs for the GAC market she defined, but conceded that the acquisition increased concentration in that market to levels deemed presumptively unlawful under the Merger Guidelines. Op. 27, n.32 (JA52); *see* Guerin-Calvert, Tr. 7730 (JA3329).

ProMedica sought to rebut this structural presumption by arguing that St. Luke's financial condition made market shares an inaccurate predictor of its future

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[10] The Merger Guidelines utilize the Herfindahl-Hirschman Index ("HHI") to measure market concentration. The HHI is calculated by summing the squares of the market shares of all firms in the market. Merger Guidelines § 5.3.

performance. The Commission carefully considered the evidence presented by ProMedica and found that the record did not support ProMedica's argument. Instead, the record showed that St. Luke's market share was growing, not declining, prior to the Joinder; it had made significant progress in improving its operational performance; it had sufficient resources to fund its existing capital needs; and it had options available to it other than an anticompetitive merger with ProMedica. Thus, the Commission concluded that ProMedica had failed to rebut the presumption. Op. 28-35 (JA53-60).

The Commission made it clear, however, that its decision was not based solely on a structural presumption. Instead, the Commission found that substantial additional evidence confirmed the likely competitive harm resulting from the Joinder, including testimony and documents from the merging parties acknowledging ProMedica's pre-Joinder market dominance and demonstrating that increased bargaining leverage resulting in higher reimbursement rates was an objective and expected result of the Joinder; testimony from MCOs that the Joinder will increase ProMedica's bargaining leverage and enable it to extract higher rates; and economic and statistical analyses showing that significant price increases are likely. *Id*. at 35-53 (JA60-78).

ProMedica did not advance any efficiency arguments before the

Commission.[11] Rather, ProMedica argued that MCOs and repositioning by competitors will prevent ProMedica from exercising market power. The Commission found both of these arguments unpersuasive and lacking in evidentiary support. Op. 53-56 (JA78-81).

Turning to the issue of remedy, the Commission noted that divestiture is generally the preferred remedy to restore the competition eliminated by a merger. Although ProMedica argued that more limited injunctive relief was appropriate, the Commission found otherwise. Accordingly, the Commission entered an order requiring the divestiture of St. Luke's. *Id*. at 56-59 (JA81-84).

STANDARD OF REVIEW

"The Commission's findings of fact are conclusive if supported by substantial evidence." *RealComp II, Ltd. v. FTC*, 635 F.3d 815, 823 (6th Cir. 2011); 15 U.S.C. § 45(c). "When we review the Commission's findings, we may not 'make [our] own appraisal of the testimony, picking and choosing for [ourselves] among uncertain and conflicting inferences.'" *Id*. (quoting *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447, 454 (1986)). Rather, "we uphold the

[11] The ALJ found that ProMedica had failed to demonstrate that the Joinder resulted in significant efficiencies benefitting consumers or that any such benefits were greater than the Joinder's substantial likely anticompetitive effects. ID 190-203 (JA286-99). ProMedica did not appeal this aspect of the ALJ's decision. Op. 4 n. 5 (JA29).

Commission's findings . . . 'if supported by such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.'" *Id*. (quoting *Indiana Fed'n*, 476 U.S. at 454) (internal quotation marks omitted); *accord In Re Detroit Auto Dealers Ass'n*, 955 F.2d 457, 461 (6th Cir. 1992).

Contrary to ProMedica's contention, this standard of review is not more exacting when the Commission and its ALJ disagree in some respect. *RealComp*, 635 F.3d at 823 ("[t]he substantial evidence standard is not modified in any way when the [agency] and its examiner disagree") (quoting *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 496 (1951)). This Court "defer[s] to the inferences that the [agency] derives from the evidence, not those of the ALJ." *Id*. (quoting *Vernadore v. Sec'y of Labor*, 141 F.3d 625, 630 (6th Cir. 1998)). ProMedica's argument is particularly inapt in this case, where the Commission's conclusions were based on the ALJ's own findings – indeed, the Commission and the ALJ reached the same conclusions on liability and remedy.

Review of the Commission's legal analysis and conclusions is *de novo*, "although even in considering such issues the courts are to give some deference to the Commission's informed judgment." *Indiana Fed'n*, 476 U.S. at 454; *accord RealComp*, 635 F.3d at 823; *Detroit Auto Dealers*, 955 F.2d at 461.

Remedial provisions are subject to an abuse of discretion standard because

"the Commission has wide discretion in its choice of a remedy deemed adequate to cope with the unlawful practices in this area of trade and commerce." *Jacob Siegel Co. v. FTC*, 327 U.S. 608, 611 (1946). The Commission is "the expert body to determine what remedy is necessary," and "the courts will not interfere except where the remedy selected has no reasonable relation to the unlawful practices found to exist." *FTC v. Nat'l Lead Co.*, 352 U.S. 419, 428 (1957) (quoting *Jacob Siegel*, 327 U.S. at 612-13).

SUMMARY OF THE ARGUMENT

In this appeal, ProMedica asks this Court to disregard the settled legal framework for analyzing Section 7 cases; to overlook the Commission's actual analysis and accept instead ProMedica's mischaracterizations of the Commission's decision; to ignore an extensive evidentiary record that unequivocally demonstrates the anticompetitive consequences of this Joinder; and to disregard (as ProMedica does) the competitive dynamics of this market. But ProMedica's arguments quickly give way upon scrutiny. By now, three tribunals – the district court, the ALJ, and the Commission – have evaluated this transaction (and ProMedica's arguments in defense of it); and three tribunals have determined that the Joinder likely causes substantial competitive harm. ProMedica fails to show otherwise here.

ProMedica's refusal to address the actual competitive dynamics of this market is evident in its challenge to Commission's definition of a GAC product market and a separate OB product market. The Commission's market definitions are supported not only by legal precedent and economic evidence in this case (including testimony by ProMedica's own economic expert), but also by other evidence (which ProMedica ignores) showing that tertiary and OB services are offered under different competitive conditions than other GAC services. As the Commission properly recognized, ProMedica's definition of an all-inclusive GAC product market, divorced as it is from market realities, merely serves to obfuscate an analysis of the competitive effects of the Joinder. (Part I.A.1.)

But even using ProMedica's GAC product market definition, the Joinder increases concentration to a level that, under the Merger Guidelines and established case law, is presumptively anticompetitive. ProMedica seeks to escape the import of these extremely high concentration levels by arguing that a presumption based on market structure is inapplicable in a unilateral effects case. Judicial precedent does not support ProMedica's proposition, however; nor does the economic commentary to which ProMedica cites. Moreover, contrary to what ProMedica argues, the Commission did not find liability based solely on a structural presumption, but instead found that substantial other evidence supported its

conclusions of competitive harm. (Part I.A.2.)

ProMedica likewise misrepresents the Commission's opinion in arguing that that the Commission refused to consider ProMedica's "weakened competitor" argument rebutting the structural presumption. In fact, the Commission carefully examined the evidence relating to this issue and found that the record did not support ProMedica's bleak portrayal of St. Luke's financial conditon. The Commission thus properly rejected ProMedica's argument on the merits. (Part I.A.3.)

Substantial other evidence in this case buttresses the structural presumption. St. Luke's own documents and testimony make it clear that one of the chief benefits expected from the Joinder was that it would give St. Luke's greater negotiating leverage with MCOs, resulting in higher rates for St. Luke's. ProMedica's arguments that this was pure speculation by St. Luke's and that St. Luke's could expect such rate increases without the Joinder are contravened by the record. Evidence of direct head-to-head competition between ProMedica and St. Luke's, eliminated by the Joinder, further bolsters the presumption of competitive harm. (Part. I.B.1.)

Testimony by the MCO witnesses also substantiates the Commission's findings of competitive harm. These witnesses explained in detail how the Joinder

has enhanced the bargaining leverage of St. Luke's and ProMedica, enabling them to command higher rates. Although ProMedica urges the Court to disregard this testimony as conjecture, this testimony was firmly grounded in the MCO witnesses' experience in assembling and marketing provider networks and negotiating reimbursement rates with hospitals. (Part I.B.2.)

Substantial evidence also demonstrates that ProMedica and St. Luke's were the most preferred hospitals for a significant number of consumers – *i.e.*, they were close substitutes, an important element of an unilateral effects analysis. Here ProMedica's attacks on this aspect of the Commission's analysis again disregard the nature of competition in this market. Thus, ProMedica's argument that unilateral effects arise only if the merging parties are viewed by the MCOs (rather than patients) as each other's next-best substitutes is wrong not only as a legal matter, but also because it ignores that MCOs are assembling networks of multiple providers that will be attractive to their customers; and patients' hospital preferences thus are central to this inquiry. (Part I.B.3.)

ProMedica's criticisms of the econometric analysis performed by Complaint Counsel's economic expert likewise do not withstand scrutiny. This analysis measured the increase in ProMedica's bargaining leverage with MCOs caused by the Joinder and predicted significantly higher prices for both St. Luke's and

ProMedica's legacy hospitals as a result of the Joinder. The results of this analysis are entirely consistent with the other evidence in this case. ProMedica's attacks on this analysis fails to demonstrate otherwise. Although the Commission indicated that it would have reached the same conclusion even without the econometric evidence, the Commission properly relied on this analysis as further support for its conclusion that the Joinder is likely to substantially lessen competition in the market for GAC and OB inpatient hospital services, in violation of Section 7. (Part I.B.4.)

Lastly, ProMedica fails to demonstrate that the Commission abused its discretion in ordering divestiture of St. Luke's. Contrary to ProMedica's contention, the Commission did not order divestiture out of a mistaken belief that the law *requires* divestiture, but instead ordered divestiture because the Commission determined (after considering ProMedica's arguments for a more limited conduct remedy) that divestiture was the most appropriate way to restore the competition eliminated by the Joinder. (Part II.)

ARGUMENT

I. THE COMMISSION PROPERLY FOUND THAT THE TRANSACTION IS ANTICOMPETITIVE.

Section 7 of the Clayton Act is "designed to arrest in its incipiency . . . the substantial lessening of competition from the acquisition by one corporation" of

the stock or assets of a competing corporation. *United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586, 589 (1957). Section 7 does not require certainty, but instead prohibits acquisitions that create a "reasonable probability of substantial anticompetitive effects." *United States v. Dairy Farmers of Am., Inc.*, 426 F.3d 850, 858 (6th Cir. 2005) (internal quotation marks omitted). Even in a consummated merger, the ultimate issue under Section 7 is whether anticompetitive effects are reasonably probable in the future, not whether such effects have occurred at the time of trial. *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 505-06 (1974).

A. The Joinder is Presumptively Illegal.

ProMedica does not dispute that, even using its definition of the relevant product market, the Joinder increases concentration in an already-highly concentrated market to levels that exceed the thresholds for presumptive illegality presented in the Mergers Guidelines and the case law. Instead, ProMedica argues that it was legal error for the Commission to apply a presumption of liability based on market structure in a case brought under a unilateral effects theory, and that the Commission further erred by disregarding evidence presented by ProMedica to rebut the presumption. ProMedica is wrong, both as to the law and in its characterization of the Commission's analysis. ProMedica also fails to show that

the Commission erred in defining the GAC and OB product markets – an issue that, in this particular case, makes no difference to the ultimate question of liability, but is important from the standpoint of analytical correctness.

1. The Commission correctly defined relevant product markets for GAC and OB inpatient hospital services.

The relevant product market can be defined by examining the reasonable interchangeability of use by consumers or the cross-elasticity of demand between the product itself and substitutes for it. *Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962). As this Court has explained, "reasonable interchangeability may be gauged by (1) the product uses, *i.e.*, whether the substitute products or services can perform the same function, and/or (2) consumer response (cross-elasticity); that is consumer sensitivity to price levels at which they elect substitutes for the defendant's product or service." *White & White, Inc. v. Am. Hosp. Supply Corp.*, 723 F.2d 495, 500 (6th Cir. 1983) (citing *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377 (1956)). The Court may rely on "practical indicia" of market boundaries, including industry or public recognition of the market, the product's particular characteristics and uses, unique production facilities, distinct customers, distinct prices, sensitivity to price changes, and specialized vendors. *Spirit Airlines, Inc. v. Nw. Airlines, Inc.*, 431 F.3d 917, 933 (6th Cir. 2005) (citing *Brown Shoe*, 370 U.S. at 325).

Both parties' economic experts agreed that each individual inpatient hospital service is potentially a distinct relevant product market because the individual services are not substitutes for one another (*i.e.*, appendectomies and knee surgery are not interchangeable). Town, Tr. 3666-67 (JA3240-41); Guerin-Calvert, Tr. 7634 (JA3321). The parties also agreed that, rather than analyzing each service line separately, it is appropriate to define a cluster market consisting of GAC inpatient hospital services. Complaint ¶12 (JA431); Answer ¶12 (JA2563). As the parties' Joint Stipulations of Law and Fact explain, "the cluster market is used 'as a matter of analytical convenience [because] there is no need to define separate markets for a large number of individual hospital services . . . when market shares and entry conditions are similar for each.' *Emigra Group v. Fragomen*, 612 F. Supp. 2d 330, 353 (S.D.N.Y. 2009) (citing Jonathan B. Baker, *Market Definition: An Analytical Overview*, 74 ANTITRUST L.J. 129, 157-59 (2007))." JX00002A ¶57 (JA2582).[12]

[12] ProMedica wrongly asserts that the Commission's own economists disagree with this approach to defining a cluster market. Br. 27. The debate between Baker and Vita, *et al.*, is about whether transactional complementarities can serve as an economic justification for cluster markets, not whether the "analytical convenience" rationale is justifiable. Indeed, the article to which ProMedica cites specifies that "conditions could easily arise that would justify enforcement actions based upon likely competitive harm in some subset of the traditional [GAC] hospital market." Michael G. Vita, *et al.*, *Economic Analysis of Health Care Antitrust*, 7 J. CONTEMP. HEALTH L. & POL'Y 73, 81 n.23 (1991).

The Commission reasonably adopted this approach, defining a GAC cluster market that, because it groups together only services with similar competitive conditions, excludes tertiary and OB services. Op. 18-26 (JA43-51). As the Commission noted, this approach is consistent with the GAC inpatient hospital service markets defined in prior hospital merger cases, which regularly exclude outpatient services from the cluster markets because the competitors for those services differ from the competitors for inpatient services. *See, e.g.*, *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290-91 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997);[13] *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990); *In re Evanston Nw. Healthcare Corp.*, 2007 WL 2286195, at *46-47 (FTC 2007). Notably, in the preliminary injunction proceeding in this matter, the district court defined a GAC cluster market that excludes tertiary services and found a separate OB product market. *ProMedica*, 2011 WL 1219281, at *9.

Ample evidence supports the Commission's product market definitions. In its Answer to the Complaint, ProMedica admitted that tertiary services are

[13] In *Butterworth*, the court found a separate relevant product market for primary care inpatient services in addition to the GAC inpatient services cluster because the primary care service lines were offered by a greater number of hospitals in competition with the merging hospitals. *Butterworth*, 946 F. Supp. at 1291.

excluded from the GAC inpatient market. Answer ¶13 (JA2563). St. Luke's provides few tertiary services. IDF 74 (JA111).[14] The Joinder thus is not likely to affect competition for tertiary services.[15] Indeed, the Commission found, and ample evidence shows, that inclusion of tertiary services in the GAC market might obscure the competitive effects analysis because patients are willing to travel farther for tertiary services, indicating that the geographic market for those services is broader and may include hospitals located outside of Lucas County. Gold, Tr. 212-13 (JA3092-93); Radzialowski, Tr. 633-34, 637-38 (JA3108-11); Sheridan, Tr. 6679 (JA3313).

With regard to OB services, examination of *Brown Shoe*'s "practical indicia" supports the Commission's finding that inpatient OB hospital services are a

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[14] Although St. Luke's provides a few services that might be considered tertiary, Professor Town properly excluded from the GAC cluster those services for which the geographic market is broader than Lucas County. Town, Tr. 3676-78, 3988 (JA3242-44, 3294); PX02148-136***** (JA1185).

[15] *See FTC v. CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 37 (D.D.C. 2009) ("the relevant product market identifies the product and services with which the defendants' products compete"); *Little Rock Cardiology Clinic v. Baptist Health*, 573 F. Supp. 2d 1125, 1140-41 (E.D. Ark. 2008) (finding that a firm cannot monopolize or create anticompetitive effects in a market where it does not participate); Merger Guidelines § 4.1 (explaining that the antitrust agencies begin market definition when a product of one merging firm competes with a product of the other merging firm); *cf. United States v. Mercy Health Servs.*, 902 F. Supp. 968, 976 (N.D. Iowa 1995) (parties agreed that the relevant product market was acute care inpatient services, limited "to those services for which Mercy and Finley currently compete for patients").

separate relevant product market. The record shows that the merging hospitals themselves track market shares for OB services separately from GAC inpatient services. IDF 314 (JA132); *see* PX01016-003***** (JA2730); PX00270-026 (JA2655). Significantly, in their negotiations of reimbursement rates, hospitals and MCOs often "carve-out" separate OB rates and rate structures apart from other GAC services. IDF 317 (JA133); Sheridan, Tr. 6662*****, 6683-84 (JA3312, 3314-15); Radzialowski, Tr. 752, 807-08***** (JA3126-28). This is precisely the type of evidence that this Court has identified as supporting a separate product market. *See Spirit Airlines*, 431 F.3d at 933-34 (holding that evidence that airlines viewed business and leisure travel as separate products and had different prices for business and leisure travel supported finding of separate market for leisure travel).

An OB services market also passes the Merger Guidelines' hypothetical monopolist test, which defines the product market by asking whether a hypothetical monopolist of the proposed product market could impose a small but significant and nontransitory increase in price and not lose an amount of its sales to alternative products that would make the price increase unprofitable. Merger Guidelines § 4.1.1. ProMedica's economic expert conceded as much, when she acknowledged that, if ProMedica achieved a monopoly over OB services, prices "could materially change." Guerin-Calvert, Tr. 7679-80 (JA3327-28).

Furthermore, OB services are offered under different competitive conditions than other services included in the GAC inpatient services cluster market. Because UTMC does not offer OB services, the Joinder of St. Luke's and ProMedica leaves only two competitors offering inpatient OB services, compared to three competitors offering GAC services. The availability of competitive alternatives for consumers of OB services therefore differs significantly from the alternatives available to consumers of services in the GAC cluster.

Under these circumstances, the Commission properly concluded that including OB services in the GAC inpatient services cluster market would not provide an accurate assessment of the Joinder's competitive effects. Indeed, in considering its affiliation options in the fall of 2009, St. Luke's recognized that – specifically with regard to OB services – an affiliation with ProMedica would present regulatory concerns and "may need to be carefully reviewed." PX01030-017***** (JA2791). St. Luke's was correct in that assessment.

Although ProMedica assails the Commission's approach to defining the GAC cluster market as an improper supply-side analysis, it is no such thing. Complaint Counsel's economic expert, Professor Robert Town, explained that this methodology is a demand-side analysis: it is based on the determination that each individual service line is a relevant product market based on demand-side

substitution. The grouping of those services into clusters based on similar competitive conditions merely serves to facilitate the analysis of the Joinder's competitive effects; it does not transform the Commission's product market analysis into a supply-side definition. Town, Tr. 3665-66 (JA3239-40).[16]

Furthermore, ProMedica's primary rationale for including tertiary and OB services in the GAC cluster market – its proposition that MCOs demand and contract for the "full range" of inpatient services "as a unit" when they negotiate with hospitals (Br. 24-25) – wholly ignores the commercial realities of this market. In fact, MCOs do *not* demand the full range of GAC services from each hospital provider or individual hospital in their network.[17] Rather, MCOs endeavor to put together a network of hospital providers that, in combination, will satisfy the

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[16] ProMedica's contention that Professor Town found the different competitive conditions for OB and other GAC services irrelevant in his analysis of the Joinder's competitive effects (Br. 30) is incorrect. Although Professor Town did not model predicted price increases separately for OB, he specifically addressed the impact that elimination of St. Luke's as an independent provider of OB services can be expected to have on MCOs' ability to market a network without the combined ProMedica-St. Luke's system. *See, e.g.*, Town, Tr. 3806-08***** (JA3264-66).

[17] For example, MCOs contract with and include UTMC and Mercy St. Anne in their hospital networks notwithstanding that those hospitals do not provide OB services. IDF 92, 110 (JA112-14). Similarly, MCOs contract with and include St. Luke's and the ProMedica and Mercy community hospitals in their networks even though those hospitals do not provide most tertiary services. IDF 63, 68, 74, 92, 100 (JA110-13).

demands of their insured members. IDF 273-74 (JA128). A central question in this case is what impact the elimination of St. Luke's as an independent provider of an important subset of GAC inpatient services will have on the marketablility of the MCOs' provider network if they failed to reach an agreement with the combined ProMedica-St. Luke's. ProMedica's insistence on treating all GAC services as a unit obfuscates this inquiry. Moreover, ProMedica's argument fails to account for the fact that, as part of the same contract negotiation, MCOs also contract for an array of hospital services in addition to GAC inpatient services (*e.g.*, outpatient services, inpatient psychiatric services, and inpatient long-term care) that ProMedica acknowledges are properly excluded from the GAC cluster market. Town, Tr. 3684-88 (JA3246-50); Guerin-Calvert, Tr. 7637-40 (JA3323-26). The fact that MCOs negotiate for these services in a single transaction may suggest a contracting efficiency but provides no rationale for including in the GAC cluster tertiary and OB services that are offered under different competitive conditions.

Nor is ProMedica's argument advanced by the cases it cites (Br. 27-28). In *United States v. Grinnell Corp.*, the Supreme Court found, *inter alia*, that there was "a single basic service – the protection of property through use of a central service station," "customers utilize different services [*i.e.*, burglar-alarm and fire-alarm

services] *in combination*," and for providers to "compete effectively, they must offer all or nearly all types of services." 384 U.S. 563, 572-73 (1966). None of these is true here. In *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1119-20 (N.D. Cal. 2001), the court did not rule that the GAC cluster was broader than services provided by the merging parties in competition with one another; instead, it ruled that the market included "niche" hospitals that offered a subset of GAC services in competition with the merging hospitals. In *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1211 n.11 (11th Cir. 1991), the court expressly chose not to analyze whether the market was broader than the overlap services and accepted the broader market merely "for ease of discussion." Lastly, in *Evanston*, counsel stipulated that tertiary services should be included in the GAC market, and the issue of including tertiary services in the GAC market was not considered by the Commission.[18] Thus, none of these cases helps ProMedica.

2. The Commission correctly applied a structural presumption of illegality.

Recognizing that a structural presumption of illegality applies regardless of which product market definition is used, ProMedica advances the novel argument

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[18] *See* Complaint Counsel's Answering and Cross-Appeal Brief, *In the Matter of Evanston Nw. Healthcare Corp.*, Docket No. 9315, at 37, available at http://www.ftc.gov/os/adjpro/d9315/060210ccattachmntpursuantrule.pdf.

that whether the presumption applies depends on the theory of competitive harm. ProMedica asks this Court to jettison half a century of judicial precedent and rule that, because this case was tried under a theory of unilateral effects, it was legal error for the Commission to apply a presumption of illegality based on market-concentration statistics. This argument does not withstand scrutiny.

Modern antitrust jurisprudence simply does not support ProMedica's argument. We are aware of no unilateral effects case (not even *Oracle*, relied on by ProMedica) that condones abandonment of the burden-shifting framework (applied by the Commission here, Op. 13-14, 27 (JA38-39, 52)) that courts have long applied in Section 7 cases: The government can establish a presumption of liability by "show[ing] that a merger would produce 'a firm controlling an undue percentage of the relevant market and [would] result[] in a significant increase in the concentration of firms in that market." *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 715 (D.C. Cir. 2001) (quoting *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 363 (1963)).[19] The burden then shifts to the defendant to rebut the

[19] As the Supreme Court has explained, "a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects." *Philadelphia Nat'l Bank*, 374 U.S. at 363.

presumption; if the defendant successfully rebuts the presumption, the burden shifts back to the government, which can bolster its *prima facie* case based on market structure with other evidence showing that anticompetitive effects are likely. *Id.*; *Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410, 423 (5th Cir. 2008); *Univ. Health*, 938 F.2d at 1218. The fact that this case involves a theory of unilateral effects does not render the Commission's application of this analytical framework, structural presumption included, legally erroneous.

Oracle does not support a different conclusion. The court there declined to apply a structural presumption because it rejected the government's relevant market definition, not because it deemed the structural presumption inapplicable in a unilateral effects case. *See United States v. Oracle Corp.*, 331 F. Supp. 2d. 1098, 1108 (N.D. Cal. 2004) ("plaintiffs have not proved that a post-merger Oracle would have sufficient market shares in the product and geographic markets, properly defined, to apply the burden shifting presumptions of *Philadelphia Nat'l Bank*"). Though ProMedica quotes the court as criticizing the Merger Guidelines' "reliance on particular market share concentrations" (Br. 36), the court was not referring to the HHI levels that the Merger Guidelines indicate "will be presumed to be likely to enhance market power," Merger Guidelines § 5.3, but to a separate

provision not at issue here.[20]

Furthermore, contrary to ProMedica's contention, there most assuredly is not a consensus that market concentration levels have no probative value in assessing the likelihood of competitive harm in a differentiated products unilateral effects context. The same commentators to whom ProMedica cites have written that:

> [M]arket concentration remains important in competitive effects analysis, and properly so. All else equal, greater market concentration makes both coordinated and unilateral effects more likely, and empirical studies show that in comparisons involving the same industry, higher concentration is associated with higher prices.

Jonathan B. Baker & Carl Shapiro, *Reinvigorating Horizontal Merger Enforcement*, in HOW THE CHICAGO SCHOOL OVERSHOT THE MARK 239 (Robert Pitofsky ed., 2009).[21] Indeed, one of the articles that ProMedica cites states:

> The combined shares of the merging firms, and the changes in the HHI can be useful and informative metrics in unilateral effects cases. . . . [H]igher shares in a properly defined relevant market do generally go along with elevated concern about unilateral price effects. . . .

Carl Shapiro, *The 2010 Horizontal Merger Guidelines: From Hedgehog to Fox in*

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[20] That provision applied a market share benchmark of 35% in analyzing unilateral effects. *See Oracle*, 331 F. Supp. 2d at 1222-23.

[21] Baker and Shapiro note that structural presumptions have important benefits: "They give guidance to firms seeking to stay within the law, and they give guidance to lower courts on how to apply the law when reviewing proposed deals. They also make merger law more easily administrable." Baker & Shapiro, *Reinvigorating Horizontal Merger Enforcement*, at 257.

Forty Years, 77 ANTITRUST L.J. 49, 69-70 (2010).

Moreover, Professor Town demonstrated that there is a close correlation between the market shares of hospital providers in Lucas County and their case-mix adjusted prices:[22] the higher the market share, the higher the prices. PX02148-039***** (JA1088).[23] This evidence linking pricing in Lucas County to market structure shows that the traditional structural analysis is indeed pertinent here.[24]

Lastly, ProMedica's argument that the Commission found liability "only because" it relied on a structural presumption (Br. 38), is demonstrably incorrect. The Commission made it clear that it did not consider statistics concerning market

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[22] Case-mix adjustment controls for variation in case-mix, severity, and patient demographics across hospitals and allows an apples-to-apples comparison of prices. Town, Tr. 3722-25***** (JA3253-56); PX02148-037, 103-05* (JA1086, 1152-54). MCOs utilize comparable case-mix adjustments in their analyses of hospital rates. Radzialowski, Tr. 687-88*****, 698-700***** (JA3114-18); Pugliese, Tr. 1512-14***** (JA3153-55); *see also* Wakeman, Tr. 3036-37 (JA3217-18).

[23] Although the correlation between market shares and price levels does not in itself rule out benign explanations for price differences, Professor Town examined and rejected the chief alternative explanations, finding no evidence that the observed price differences are caused by either quality or cost differences. PX02148-038***** (JA1087).

[24] The Commission cited this study as one piece of evidence supporting its conclusion that the Joinder likely will result in higher prices. Op. 41-42 (JA66-67). It did not, however, "rel[y] principally" on this aspect of Town's analysis, as ProMedica contends (Br. 52).

share and concentration to be "conclusive proof of competitive harm," Op. 27 (JA52), and proceeded to devote fully half of its Opinion to analyzing in great detail the other, non-structural evidence presented by the parties that supported, or potentially detracted from, a finding of competitive harm. Op. 28-56 (JA53-81). The Commission found that this evidence firmly buttressed the structural presumption and demonstrated that the Joinder is substantially likely to lessen competition.

3. The Commission considered and properly rejected ProMedica's "weakened competitor" argument.

Equally groundless is ProMedica's argument the Commission refused to consider ProMedica's evidence that St. Luke's was a "weakened competitor." Br. 40-41. In fact, the Commission carefully examined the evidence relating to this issue and found that it did not paint nearly so bleak a picture of St. Luke's financial condition and future competitive prospects as ProMedica claimed – that, while St. Luke's was experiencing some financial difficulties in the years prior to the Joinder, it had made significant improvements in its performance, and was growing prior to the Joinder. Op. 28-35 (JA53-60).

As the Commission explained, financial weakness arguments are strongly disfavored. "Financial weakness . . . is probably the weakest ground of all for justifying a merger," and it "certainly cannot be the primary justification of a

merger." *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1339, 1341 (7th Cir. 1981); *FTC v. Warner Commc'ns, Inc.*, 742 F.2d 1156, 1164 (9th Cir. 1984) (explaining that the financial weakness defense is disfavored because it "would expand the failing company doctrine, a defense which has strict limits"); *see also Univ. Health*, 938 F.2d at 1221 ("Since weak firms are not in grave danger of failure – if so, they would be failing, rather than weak, companies, and the analysis might differ . . . it is not certain that their weakness 'will cause a loss in market share beyond what has been suffered in the past, or that [such weakness] cannot be resolved through new financing or acquisition by other than a leading competitor.'") (quoting 4 Phillip E. Areeda & Donald F. Turner, ANTITRUST LAW ¶935b, at 140 (1980)).

The Commission found that, contrary to ProMedica's assertion that St. Luke's market share would decrease, St. Luke's market share was actually increasing – not declining – in the years before the Joinder. *See* PX00159-012* (JA2595); PX01235-003 (JA2888). St. Luke's achieved most of the growth goals in the strategic plan put in place by its new CEO, increasing St. Luke's "inpatient net revenue by more than $3.5 million per year on average" and its "outpatient net revenue by more than $5 million per year on average," and achieving a 40% market share in its core service area. IDF 924-25, 928 (JA203). As patient

volumes and patient care revenues improved, St. Luke's succeeded in getting its variable costs under control, and its operating margins consequently improved. IDF 949-54, 957-58 (JA206-07). The Commission found that, although St. Luke's did not achieve every financial goal in its strategic plan, it was making significant progress. *See* PX00170-001 (JA2620) (St. Luke's CEO reporting that St. Luke's "positive margin confirms that we can run in the black if activity stays high"); PX01582-003***** (JA2919) (St. Luke's Vice President for Patient Care Services writing in September 2010 that St. Luke's was "growing, not downsizing").

The Commission also found that, contrary to ProMedica's argument, St. Luke's had sufficient resources to fund its existing capital needs. *See* IDF 961, 966-69 (JA207-08); JX00002A ¶¶34-35 (JA2580). Additionally, St. Luke's had other options available to it: St. Luke's could have affiliated with an out-of-market hospital system,[25] which would not pose competitive issues, or with UTMC,[26]

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[25] *See* Wakeman, Tr. 2548-51 (JA3201-04) (St. Luke's held "general discussions" regarding a possible affiliation with other local community hospitals but did not pursue the arrangement after determining that it would have required complex, time-consuming negotiations).

[26] Prior to entering exclusive discussions with ProMedica St. Luke's was engaged in discussions with both Mercy and UTMC about possible affiliation arrangements. *See* p. 11, *supra*. In fact, St. Luke's and UTMC had drafted a Memorandum of Affiliation Terms in August 2009. PX02205 (JA3075). Up to the time when St. Luke's cut off these talks in late 2009 because of its decision to affiliate with ProMedica, both Mercy and UTMC remained interested in pursuing an affiliation with St. Luke's. Wakeman, Tr. 2552-55, 2559 (JA3205-08, 3210).

which would pose significantly fewer competitive concerns than a Joinder with ProMedica. Op. 34 (JA59).

In sum, the Commission considered each aspect of ProMedica's weakened-competitor argument and found its argument unpersuasive – not because the Commission mechanically adhered to a structural presumption of competitive harm, but because the evidence did not bear out ProMedica's characterization of St. Luke's circumstances.

B. Substantial Additional Evidence Supports the Commission's Conclusion that the Joinder is Likely to Lessen Competition.

The Commission did not rely only on a structural presumption of illegality, but found that ample other evidence demonstrated that the Joinder is likely to substantially lessen competition. ProMedica's response to this overwhelming evidence supporting liability is to label all of it unreliable and the Commission's reliance on it legal error. None of these arguments withstands scrutiny.

1. St. Luke's and ProMedica's own documents, testimony, and business conduct show that the Joinder will likely eliminate competition and increase rates.

St. Luke's own documents make it clear that one of the chief benefits expected from the Joinder was that St. Luke's would obtain the significantly higher rates that ProMedica's hospitals commanded. IDF 597-603 (JA167-68). An August 2009 St. Luke's planning document noted as one option "enter[ing] into an

affiliation/partnership with a local health system with the express purpose to raise reimbursement rates to the level of our competitors." PX01390-002* (JA2914). A subsequent presentation to St. Luke's Board of Directors by CEO Wakeman and other members of St. Luke's leadership team stated, "An SLH affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout." PX01030- 020***** (JA2794). As St. Luke's CEO testified, "ProMedica had a significant leverage on negotiations with some of the managed care companies," which would allow St. Luke's to obtain higher reimbursement rates, and that an affiliation with ProMedica could "[h]arm the community by forcing higher hospital rates on them." Wakeman, Tr. 2698-2700***** (JA3214-16). *See* PX01125-002***** (JA2806) (noting the advantages of ProMedica's "incredible access to outstanding pricing on managed care agreements"); PX01144-003 (JA2821) ("MCOs lose clout if St. Luke's is no longer independent"). Indeed, St. Luke's anticipated as much as $12 to $15 million in additional revenues from only three payors as a result of joining ProMedica. PX01231***** (JA2885).

In short, St. Luke's clearly anticipated that its rates would increase significantly because of the Joinder, and ProMedica's leverage with MCOs was a primary reason. Such evidence shedding light on the strategic objectives of the

merging parties can be highly probative of likely competitive effects. Merger Guidelines § 2.2.1 ("explicit or implicit evidence that the ability to [raise prices] motivated the merger, can be highly informative in evaluating the likely effects of a merger"); *see Graphic Prods. Distribs., Inc. v. Itek Corp.*, 717 F.2d 1560, 1573 (11th Cir. 1983) ("Evidence of intent is highly probative . . . 'because knowledge of intent may help the court to interpret facts and to predict consequences.'") (quoting *Chicago Bd. of Trade v. United States*, 246 U.S. 231, 238 (1918)).[27]

ProMedica argues that this was just speculation on St. Luke's part; that St. Luke's did not actually know what ProMedica's MCO contracts looked like or what rates ProMedica was receiving. Br. 57. But St. Luke's did not need to know the precise details of ProMedica's MCO contracts to understand that ProMedica was getting substantially higher rates than St. Luke's, *see* Wakeman, Tr. 2685-87* (JA3211-13) ("according to the aggregate information we were looking at . . . the ProMedica institutions had some of the better rates comparatively"), and that ProMedica, as the dominant system in Lucas County, exercised considerably more bargaining leverage with MCOs than standalone St. Luke's.

Also without merit is ProMedica's argument that, even if St. Luke's expected

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[27] *Accord Polypore Int'l, Inc. v. FTC*, 686 F.3d 1208, 1215 (11th Cir. 2012); *see also Heinz*, 246 F.3d at 717 ("Heinz's own documents recognize the wholesale competition and anticipate that the merger will end it.").

that its rates would increase as a result of the Joinder, St. Luke's pre-joinder rates likely would have risen anyway. This argument is belied by St. Luke's own assessment when it sought higher rates from MCOs before joining with ProMedica. St. Luke's approached MCOs with the argument that they could either pay St. Luke's the "little bit more" that it sought in order to sustain its position or pay later "at the other hospital system contractual rates." PX01018-009***** (JA2761). In other words, St. Luke's itself believed that the price increase from a potential merger would take reimbursement rates beyond a level it could expect to achieve on its own.

The structural case was also buttressed by numerous other admissions made by the merging parties in their testimony and documents. For example, ProMedica's CEO acknowledged that before the Joinder, the parties competed to attract patients and also competed to attract and retain physicians. IDF 464-65 (JA151). ProMedica's internal assessments viewed St. Luke's as a capable competitor that could take away patient volume. IDF 467-71, 1020 (JA151, 213). And St. Luke's CEO testified that after he came to St. Luke's in 2008, his goal was to regain volume from ProMedica in St. Luke's primary service area, IDF 441 (JA148), which, in fact, St. Luke's did, PX00159-012***** (JA2595). This is evidence of direct competition between ProMedica and St. Luke's, eliminated by the Joinder.

2. MCO evidence demonstrates that the Joinder will significantly increase ProMedica's bargaining leverage and likely increase rates.

The Commission's finding of competitive harm is also supported by the MCO witnesses, who testified that the Joinder has enhanced the bargaining leverage of St. Luke's and ProMedica, enabling them to command higher reimbursement rates. IDF 561-75, 583-96 (JA162-67). As Aetna's witness explained, because the Joinder gives ProMedica another hospital, more volume, and greater geographic coverage (the important southwest area of Lucas County), it will be considerably more difficult for Aetna to walk away from the ProMedica system post-Joinder if ProMedica demands higher rates. Radzialowski, Tr. 663-64, 712-14***** (JA3112-13, 3120-22). Similarly, the [redacted] witness testified that "ProMedica would find its bargaining power greater after the acquisition than before," explaining that it would be more difficult for [redacted] to serve its membership without both ProMedica and St. Luke's than without ProMedica's pre-Joinder hospitals. [redacted], Tr. 6687, 6698-6700***** (JA3316-18); *see also* [redacted], Tr. 1524-25***** (JA3161-62); McGinty, Tr. 1209 (JA3135); PX02073 at ¶15* (JA3072). The MCO witnesses testified that they expect that the Joinder will cause St. Luke's rates to rise to the level of ProMedica's other hospitals; some also expect that Joinder will cause rates for ProMedica's legacy hospitals to rise above pre-Joinder levels by virtue of the

additional bargaining leverage that ProMedica gains from the Joinder. PX01938-023***** (JA2994); McGinty, Tr. 1209 (JA3135); *see also* [redacted], Tr. 2262***** (JA3182); PX01944-013-014***** (JA3037-38); PX02377-001 (JA3082); PX02379-002 (JA3085).[28]

The MCO witnesses further testified that a network composed only of UTMC and Mercy – the only two remaining providers in Lucas County after the Joinder – would not be commercially viable. For example, the MMO witness testified that prior to the Joinder MMO could have marketed (and did market) an insurance product that excluded ProMedica's three hospitals (while including St. Luke's), but that post-Joinder it could not market a product that excluded both ProMedica and St. Luke's. Pirc, Tr. 2261-63***** (JA3181-83). Other MCO witnesses gave similar testimony. Radzialowski, Tr. 715-716***** (JA3125-26); Pugliese, Tr. 1477-78***** (JA3151-52); Sandusky, Tr. 1351***** (JA3138); *see also* Neal, Tr. 2112-13 (JA3168-69). Contrary to ProMedica's contention (Br. 56), this testimony is entirely

[28] An Aetna analysis of the impact of the initial change projected a [redacted] increase in rates to St. Luke's, accounting for differences of severity between ProMedica and St. Luke's. Radzialowski, Tr. 704* (JA3119). In fact, in early [redacted], Tr. 716-17***** (JA3124-25). An Anthem analysis calculated that an [redacted] to the rate levels at ProMedica's Flower and Bay Park hospitals would be [redacted], roughly between [redacted] and [redacted], Tr. 1517-19***** (JA3156-58); PX02380-001***** (JA3089).

consistent with the MCOs' history with narrow networks in Toledo. As ProMedica's own expert acknowledged, no MCO has offered a network composed only of UTMC and Mercy in at least the last ten years. Guerin-Calvert, Tr. 7893-95 (JA3330-32).

ProMedica argues, however, that the Commission is not entitled to rely on this testimony because it is based on conjecture. The Commission (and the ALJ) found otherwise. Op. 38-39 (JA63-64); ID 164-66 (JA260-62). As the Commission noted, the MCO witnesses testified that they rely on constant feedback from their sales and marketing teams regarding prospective enrollees' hospital coverage needs, as well as the analysis of various data sets, including utilization reports, claims data, Medicare cost reports, and hospital quality studies, in order to inform their assessments of which hospitals to include in their networks and what negotiating strategies to use with the hospitals. *See, e.g.*, Radzialowski, Tr. 582-83, 587-93, 600-04 (JA3094-107); Pugliese, Tr. 1420-25 (JA3139-44); Pirc, Tr. 2160-62, 2165-72 (JA3170-71, 3173-80). The MCOs' testimony thus was based on well-informed judgments, not conjecture.

Contrary to ProMedica's contention, neither *Arch Coal* nor *Tenet* supports a general rule that "customers lack expertise" to testify in such matters – and these cases most certainly do not support ProMedica's contention that customers must

conduct "empirical analyses of the market and prices post-joinder." Br. 55. In *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 145-46 (D.D.C. 2004), the court discounted customer testimony because it merely reflected a general "anxiety" about having one fewer supplier. In *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999), the court criticized reliance on MCO testimony that they could not resist price increases, where evidence showed the contrary. Here, by contrast, the MCO witnesses provided specific rationales as to why they expected the Joinder would increase ProMedica's bargaining leverage and enable it to raise prices; and this was consistent with other evidence in this case. It was thus entirely appropriate for the Commission, in the exercise of its judgment, to rely on this testimony as further evidence of the Joinder's likely competitive effects.

3. Substantial evidence demonstrates that ProMedica and St. Luke's were close substitutes.

As a result of the Joinder, the possible alternative network available to MCOs if they do not reach agreement with the combined ProMedica-St. Luke's has changed. Prior to the Joinder, MCOs that failed to reach agreement with ProMedica could form a network composed of Mercy, UTMC, and St. Luke's. MCOs that failed to reach agreement with St. Luke's could form a network composed of ProMedica, Mercy, and UTMC. Post-Joinder, the MCOs' walk-away network is limited to Mercy and UTMC. Without ProMedica, an MCO no longer can offer a

network that includes the first choice for the many patients who use ProMedica and St. Luke's. By decreasing the desirability of the MCOs' walk-away network, the Joinder increases ProMedica's bargaining leverage, which will enable ProMedica to command higher rates. Town, Tr. 3656-63 (JA3231-38); IDF 576-82 (JA164-65).

Unilateral effects evidence supports this conclusion. *See* Op. 41-49 (JA66-70). Under a unilateral effects theory, the merger of close substitutes leads to increased bargaining leverage and higher prices. Town, Tr. 3651-52, 3777-79***** (JA3229-30, 3243-45); PX02148-040-041***** (JA1089-90).[29] The record in this case leaves little doubt that, for patients who are the ultimate consumers of hospital services, St. Luke's was a close substitute for ProMedica's nearby hospitals and ProMedica was St. Luke's closest competitor. Because patients generally prefer to be treated at hospitals close to home, consumer preferences for specific hospitals will vary even within a geographic market. *See* p. 6, *supra*. Professor Town explained that market shares reflect consumer preferences, and comparing market shares within a smaller geographic area, such as within individual zip codes, will reveal the closeness of competition between specific hospitals. Town, Tr. 3646 (JA3224); PX02148-041-042***** (JA1090-91). The hospital with the second-highest

[29] As the Merger Guidelines explain, "Unilateral price effects are greater, the more the buyers of products sold by one merging firm consider products sold by the other merging firm to be their next choice." Merger Guidelines § 6.1.

market share in an area is likely to be the closest substitute for the hospital with the highest market share. *See* Wakeman, Tr. 2507 (JA3194).

Here, market shares show that St. Luke's and ProMedica were the most preferred hospitals for a significant number of consumers. Town, Tr. 3753-55***** (JA3257-59); PX02148-042***** (JA1090), in camera. St. Luke's and ProMedica have the highest market shares in southwest Lucas County, for both GAC and OB services. PX01235-003, 005 (JA2888, 2890); PX01016-003***** (JA2730). Professor Town's analysis of market shares in St. Luke's core service area confirms that ProMedica and St. Luke's have the first and second-largest market shares in a significant number of individual zip codes within Lucas County. PX02148-156-159***** (JA1205-08). Consumer preference surveys also confirm that ProMedica and St. Luke's are close competitors. PX01352-007 (JA2897); PX01169-015, 042 (JA2841, 2868).

Professor Town's diversion analysis, which used health plan claims data to quantify the degree of substitutability between pairs of hospitals, also demonstrated the closeness of the competition between ProMedica and St. Luke's.[30] IDF 453 (JA150). His analysis showed that ProMedica is St. Luke's closest competitor: for

[30] See Merger Guidelines § 6.1 ("Diversion ratios . . . can be very informative for assessing unilateral price effects, with higher diversion ratios indicating a greater likelihood of such effects.")

five of the six major health plans in Lucas County the highest share of those health plans' St. Luke's patients would go to a ProMedica hospital if St. Luke's were unavailable. This analysis also showed that St. Luke's is a significant substitute for ProMedica's legacy hospitals: for five of the six major health plans, St. Luke's was the next closest substitute for between [redacted] and [redacted] of ProMedica's patients. PX02148-046-047, 163***** (JA1095-96, 1212).

As the Commission found, this evidence demonstrated not only that ProMedica was St. Luke's closest competitor, but also that St. Luke's was ProMedica's closest substitute for a large number of customers, and thus supported a finding of unilateral effects. Op. 45-49 (JA70-74). ProMedica argues, however, that the Commission committed legal error because no MCO would turn to St. Luke's alone as a substitute for the three-hospital ProMedica system; instead, MCOs consider the Mercy hospital system to be ProMedica's closest substitute. According to ProMedica, unilateral effects arise only if the merging parties are each others' next-closest substitute for a majority of consumers. Br. 41-42. But ProMedica is wrong, both as a matter of law and economics.

As an initial matter, this argument wholly ignores that ProMedica is St. Luke's closest competitor and unquestionably an important part of the MCOs' walk-away network in negotiations with St. Luke's. Thus, the Joinder clearly gives

ProMedica greater bargaining leverage in negotiations with MCOs over St. Luke's rates, enabling it to demand higher rates for St. Luke's than pre-Joinder St. Luke's could achieve (as St. Luke's own documents assert, see pp. 40-41, *supra*). Town, Tr. 3660-63 (JA3235-38).

But the Joinder also enhances ProMedica's bargaining leverage with respect to its legacy hospitals, notwithstanding that St. Luke's alone would not be a replacement for the ProMedica system in an MCO's network. Town, Tr. 3657-59, 3784-85***** (JA3232-34). As the Merger Guidelines explain, "[a] merger may produce significant unilateral effects for a given product even though many more sales are diverted to products sold by non-merging firms than to products previously sold by the merger partner." Merger Guidelines§ 6.1. "Substantial unilateral price elevation post-merger," the Guidelines explain, "normally requires that a *significant fraction* of the customers purchasing that product view products formerly sold by the other merging firm as their next-best choice." *Id.* (emphasis added). There is no requirement that this "significant fraction . . . approach a majority." *Id.* A leading antitrust treatise agrees. *See* 4 Phillip E. Areeda & Herbert Hovenkamp, ANTITRUST LAW ¶914, at 77-80 (2009) (explaining that the merging parties need not be closest rivals for the merged firm to be able to increase price profitably and thereby cause unilateral anticompetitive effects); *United States*

v. H & R Block, 833 F. Supp. 2d 36, 83 (D.D.C. 2011) ("The fact that [a third party] may be the closest competitor for both [merging parties] also does not necessarily prevent a finding of unilateral effects for this merger.").[31]

Here, the MCOs are not making choices to switch from one hospital provider to what they might consider to be its "closest substitute" in the abstract; they are assembling networks of multiple providers that will satisfy the demands of their customers (employers and ultimate consumers). In this context, the Joinder enhances ProMedica's bargaining leverage, allowing it to sustain a unilateral price increase, because it removes from the MCOs' walk-away network a hospital, St. Luke's, preferred by a substantial number of patients within the market. Op. 48-49 (JA73-74).

ProMedica's argument that the Commission erred by analyzing substitution based on the preferences of patients rather than MCOs (Br. 43) ignores the nature of competition in this market. MCOs contract with hospitals because they have customers – employers and employees – who purchase their insurance products and use the services that hospitals offer. Accordingly, "an MCO's demand for hospital services is largely derived from an aggregation of the preferences of its employer

[31] ProMedica's attempt to dismiss as dicta the *H & R Block* court's analysis of unilateral effects does not deprive it of authoritative value.

and employee members." *Evanston*, 2007 WL 2286195, at *61; ID 156 (JA252). Patients' hospital preferences thus are central to an inquiry into the impact of the bargaining leverage a hospital has with an MCO. Here, "the record demonstrates that . . . St. Luke's and ProMedica were close substitutes for employers and MCO's members, and thus for the MCOs." ID 157-58 (JA253-54).

As Professor Town explained, the fact that the Mercy system is a closer substitute for the ProMedica system than St Luke's does not mean this merger has no anticompetitive effects; it just means that a merger between ProMedica and Mercy would be even more anticompetitive. Town, Tr. 3782***** (JA3260). Under ProMedica's reasoning, the only acquisition in a market that could conceivably substantially lessen competition is the hypothetical merger that would eliminate the most competition. This argument is patently wrong and should be rejected.

Failing these arguments, ProMedica asserts – citing a single e-mail – that it is really St. Luke's and UTMC that are each other's closest substitutes. Br. 46. Not only is this document unreliable (St. Luke's CEO admitted that he was unable to verify that information, Wakeman, Tr. 3049-50 (JA3219-20)), but also this contention is contrary to the great weight of the evidence just discussed. And though ProMedica seeks to raise doubts about the appropriateness of analyzing substitutability by examining localized competition (*e.g.*, in a hospital's core service

area), both St. Luke's and ProMedica themselves consider patients in this limited geographic area in their internal analyses of competition. PX01016-003***** (JA2730); PX00240-002***** (JA2628).

4. Professor Town's econometric analysis demonstrates that the Joinder increases ProMedica's bargaining leverage and will increase prices.

In addition to this evidence showing competitive harm, Professor Town conducted an econometric analysis quantifying the expected price impacts of the Joinder. His analysis quantifies the bargaining leverage of a hospital system by estimating the value that consumers place on having access to that hospital system, given the alternative hospitals available. This measure, labeled "Willingness-to-Pay" ("WTP") shows that the more desirable the hospital is to the MCO's enrollees, the higher the price an MCO is willing to pay to include a hospital in its network. Town, Tr. 3863-66 (JA3267-70); PX02148-105-107***** (JA1154-56), in camera. Professor Town found that the Joinder would cause an increase in bargaining leverage of the combined ProMedica and St. Luke's of almost 13.5%. Town, Tr. 3874-77 (JA3271-74); PX02148-165***** (JA1214). He then found that, given the relationship between prices and WTP in the pre-Joinder market, and controlling for other relevant factors, this increased bargaining leverage attributable to the elimination of competition between ProMedica and St. Luke's would likely result in

system-wide prices 16.2% higher than they would be absent the Joinder. Town, Tr. 3890-91 (JA3279-80); PX02148-108-110, 179-80***** (JA1157-59, 1228-29).[32]

ProMedica criticizes Professor Town's analysis on several fronts, but fails to cast meaningful doubt on its value. First, ProMedica questions whether an econometric analysis of this type can ever be used to support a finding of liability. Br. 58. But Professor Town's methodology has been peer-reviewed and has been applied to actual consummated mergers and found to be an accurate, if conservative, measure of price changes resulting from an acquisition. Town, Tr. 3888-90 (JA3277-79); PX1850 at 56***** (JA751).

ProMedica also argues that Professor Town's analysis is flawed because he did not analyze the precise product markets the Commission defined. As Professor Town explained, however, this analysis does not require a precisely defined product market, and that is one of its strengths. Town, Tr. 3801***** (JA3263). By definition, the analysis will identify the differences in competitive conditions across different lines of hospital services. Town, Tr. 4044-46 (JA3295-97).[33]

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[32] Allocating this aggregate price increase between ProMedica and St. Luke's shows an expected price increase of 38.38% for St. Luke's and 10.75% for ProMedica's legacy hospitals. Town, Tr. 3891-92 (JA3280-81).

[33] There is no need to replicate this analysis for OB services separately because the analysis explicitly accounts for the fact that OB patients cannot substitute to UTMC or Mercy St. Anne. Town, Tr. 3806-08***** (JA3264-66).

Next, ProMedica argues that Professor Town omitted certain variables that have been included in other regression analyses of hospital pricing. But the variables to which ProMedica refers are highly correlated with variables already included, while adding little explanatory power. Others are highly correlated with WTP (and prices), but there is no evidence that this correlation is indicative of a causal relationship. Town, Tr. 3898-3908 (JA3283-93); PX01850 at 64-69***** (JA759-64).[34] It is well known that adding variables in a regression model that are correlated with included variables without adding meaningful explanatory power, or are not causally related, can lead to highly unreliable estimated regression coefficients. PX01850 at 64 (JA759).[35] Professor Town's results are highly

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[34] For example, ProMedica's expert adds a variable for a hospital's discharges of Medicare patients on the rationale that hospitals may increase commercial prices to cost-shift and cover these patients, but the model, so revised, predicts that commercial prices would decrease as Medicare share increases, precisely the opposite of ProMedica's rationale for including the variable. Professor Town appropriately concluded that the high negative correlation between Medicare share and prices was not indicative of a causal relationship, and, therefore, excluded it from his analysis. Town, Tr. 3904-06 (JA3289-91); PX01850 at 66-68 (JA761-63).

[35] In *Realcomp*, this Court explained: "Regression analysis measures the effect of different factors, called independent or explanatory variables, on a particular outcome, called a dependent variable. The more that independent variables are correlated with one another – such as when two measures capture the same information – the less unique information they will each contribute to the prediction of the dependent variable. When predictors become more correlated, the estimate of individual regression coefficients becomes more unreliable. . . ." 635 F.3d at 834 n.13.

significant, both economically and statistically. Importantly, they are also highly consistent with the structural analysis, the documentary evidence, and MCO testimony.[36]

ProMedica's suggestion that these predicted price increases might not be attributable to the Joinder – because "hospital prices generally increase anyway" (Br. 61) – ignores that the price increases predicted by Professor Town's analysis arise from the change in bargaining leverage resulting from the Joinder. Town, Tr. 3892-93 (JA3281-82). In other words, by definition, the model predicts only price increases that are *caused* by the Joinder, not simply occurring after the Joinder. PX02148-058 (¶102) (JA1107).

ProMedica's final argument – that the Commission failed to identify precisely when the projected price increases would occur (Br. 63) – is spurious.[37] The Commission has no burden to project exactly when predicted price effects will

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[36] ProMedica also criticizes Professor Town for using an alternative model, replacing WTP with a measure known as the patient-weighted HHI. Using this model, Professor Town predicted that system-wide prices would be 10.1% higher than they would be absent the Joinder. PX02148-111* (JA1160). This is a more conservative estimate, but it remains highly significant. Moreover, as Professor Town testified, WTP is more consistent with the intuition derived from bargaining theory, and so it is the preferable approach. Town, Tr. 3881-82 (JA3275-76).

[37] ProMedica misrepresents Professor Town's testimony on this point. *See* Town, Tr. 4257 (JA3298) (the price increases he estimated likely "will occur closer to two years than to 20 years").

occur. Moreover, the Commission has no burden to even predict specific price increases. Indeed, the Commission indicated that, while the econometric analyses provided further confirmation for its conclusions about the Joinder's anticompetitive effects, it would have reached the same conclusions without them. Op. 49 (JA74).

* * *

In sum, substantial evidence supports the Commission's findings that the Joinder is likely to substantially lessen competition in the sale of GAC and OB inpatient hospital services.

II. THE COMMISSION'S FINAL ORDER OF DIVESTITURE IS PROPER AND SHOULD BE ENFORCED.

The purpose of relief in a Section 7 case is to restore competition lost through the unlawful acquisition. *Ford Motor Co. v. United States*, 405 U.S. 562, 573 n.8 (1972). Complete divestiture is generally the most appropriate way to restore competition. As the Supreme Court has observed:

> 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 § 7 has been found.

United States v. E.I. du Pont de Nemours & Co., 366 U.S. 316, 330-31 (1961) ("*DuPont*") (footnote omitted). The selection of a remedy – whether divestiture or

something else – is subject to the Commission's broad discretion. *Jacob Siegel* 327 U.S. at 611; *see Seeburg Corp. v. FTC*, 425 F.2d 124, 129 (6th Cir. 1970) ("[w]e have no question but that under the broad powers Congress has given the FTC . . . divestiture is an appropriate remedy"); *Chicago Bridge*, 534 F.3d at 440-42 (rejecting petitioner's argument that the Commission's divestiture order was "overbroad and punitive" and holding that Commission did not abuse its "wide discretion" in fashioning a divestiture remedy). "[O]nce the Government has successfully borne the considerable burden of establishing a violation of law, all doubts as to the remedy are to be resolved in its favor." *DuPont*, 366 U.S. at 334 (footnote omitted); *accord Dairy Farmers*, 426 F.3d at 859 n.1.

Given the clear difficulty of challenging the Commission's discretion to order divestiture when it finds that an acquisition violates Section 7, ProMedica comes up with a rather creative – but entirely specious – argument. It argues that the Commission misinterpreted the law as all but *requiring* divestiture – in other words, that the Commission somehow failed to comprehend that it has the discretion to select a remedy other than divestiture if it determines that such remedy will be effective at restoring competition. Br. 62. But ProMedica is wrong. The Commission ordered divestiture rather than ProMedica's suggested remedy because it concluded that divestiture is the best way to restore the competition eliminated by

the Joinder. Nowhere did the Commission state, or even suggest, that it thought ProMedica's proposed remedy would adequately restore competition, but felt its hands were tied by a legal standard that prohibits anything other than divestiture, except under the narrowest of circumstances. Op. 56-59 (JA81-84).

As the Commission noted, "[d]ivestiture is desirable because, in general, a remedy is more likely to restore competition if the firms that engage in pre-merger competition are not under common ownership," and there are "usually greater long term costs associated with monitoring the efficacy of a conduct remedy than with imposing a structural solution." Op. 57 (JA82) (quoting *Evanston*, 2007 WL 2286195, at *77). In *Evanston*, notwithstanding these concerns about the effectiveness and long-term costs of a conduct remedy, the Commission determined that a conduct remedy was more appropriate than divestiture, because the long time (seven years) that had elapsed and extensive integration that had occurred since the merger was consummated made divestiture "much more difficult, with a greater risk of unforeseen costs and failure" *Evanston*, 2007 WL 2286195, at *78. The Commission was also concerned that divestiture could reduce or eliminate significant public benefits from improvements made to the acquired hospital during that time. *Id.* By contrast, here, the Commission found that the circumstances did not warrant departing from the surer structural remedy of divestiture in favor of a

potentially less effective injunctive remedy. Among other things, the Hold Separate Agreement has limited the extent of St. Luke's integration into the ProMedica system. IDF 13 (JA105). ProMedica utterly fails to show that the Commission erred in its judgment.

Contrary to what ProMedica suggests, the ALJ's views about the cogency of ProMedica's arguments provide no reason to disturb the Commission's broad discretion to decide the issue of remedy; moreover, the ALJ also determined that divestiture was the better remedy. Additionally, though ProMedica touts the "independence" of St. Luke's Board as a reason to select its proposed remedy, there is no denying that St. Luke's interests are now aligned with those of ProMedica, making St. Luke's economic incentives in its negotiations with MCOs far different than they were when St. Luke's was truly independent. *See Dairy Farmers*, 426 F.3d at 862 (rejecting argument that firm cured any potential antitrust problems assigning its voting right in company to another firm, because "[t]his cure . . . ignores the fact that [the two firms] have closely aligned interests to maximize profits via anticompetitive behavior").

Furthermore, although ProMedica argues that divestiture would deprive St. Luke's and the community of the Joinder's "efficiencies and benefits" (Br. 65), ProMedica abandoned its claims of efficiencies in it appeal to the Commission.

Moreover, the Commission fully considered ProMedica's arguments that important benefits would be lost if divestiture were ordered, and found that the record simply did not support ProMedica. Op. 58-59 (JA83-84). For example, contrary to ProMedica's claim that, on its own, St. Luke's was not well positioned for healthcare reform, St. Luke's own assessment prior to the Joinder was that it was "uniquely positioned for a smooth transition to expected health care reform." PX01072-001 (JA2798).[38] As the Commission noted, ProMedica's claims of benefits that are premised on St. Luke's pre-Joinder financial difficulties are unlikely to present a concern if St. Luke's is divested to a third party acquirer with adequate financial resources. Even if the Joinder were merely unwound and St. Luke's restored as an independents hospital, the record does not support ProMedica's assessment of St. Luke's ability to address these financial challenges on its own. *See* pp. 10-11, 37-39, *supra*.

[38] The ALJ found that ProMedica had not demonstrated that ProMedica's capital contribution allowed St. Luke's to make improvements that it couldn't have made but for the Joinder. ID 193 (JA289). For example, the evidence shows that, prior to the Joinder, St. Luke's fully intended to begin implementing EMR in 2010 to meet "meaningful use" requirements and had budgeted $6 million for it in 2010, but stopped the process because of the Joinder. IDF 838-90, 997 (JA193-94, 211).

The Commission fully understood that it has the discretion to select a remedy other than divestiture if warranted by the particular facts of the case at hand. The Commission considered the merits of ProMedica's proposed remedy, but determined that divestiture of St. Luke's is the best way to restore competition eliminated by the Joinder. ProMedica has failed to show that the Commission abused its discretion in its selection of a remedy.

CONCLUSION

For the foregoing reasons, the petition for review should be denied and the Commission's Final Order affirmed and enforced.

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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitation set forth in Fed. R. App. 32 (a)(7)(B), in that it contains 13,981 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii) and 6 Cir. R. 32(b).

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MICHELE ARINGTON

CERTIFICATE OF SERVICE

I hereby certify that on November 14, 2012, I electronically filed with this Court the attached Sealed Brief for Respondent Federal Trade Commission using the CM/ECF system. I certify that all participants in the case are CM/ECF users and that service will be accomplished by the CM/ECF system.

s/ Michele Arington
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