Oral Argument Before the Federal Trade Commission
February 6, 2012

In the Matter of ProMedica Health System, Inc.

Docket No. 9346

Overview

*"A ProMedica … affiliation could still **stick it to employers**, that is, to continue forcing high rates on employers and insurance companies"*
(PX01130 at 5, Notes from St. Luke's DD Meetings, Phase II, *in camera*)

- ProMedica Health System
  - 11 hospitals in SE Michigan & NW Ohio, including three GAC hospitals in Lucas County, Ohio: The Toledo Hospital (TTH), Flower, Bay Park
  - Owns Paramount, one of the largest local commercial health plans
  - Largest employer of physicians in Lucas County
  - Total revenues of $1.6 billion in 2009
  - Self-described dominant health system in Toledo area
- St. Luke's Hospital
  - High-quality, independent, not-for-profit general acute-care hospital
  - Located in Maumee, Ohio (SW Lucas County)
  - 178 staffed beds

Judge Katz and Judge Chappell Agree on Major Aspects of CC's Case

- March 29, 2011 – Judge Katz (N.D. Ohio) issues preliminary injunction
- Dec. 5, 2011 – Judge Chappell holds Acquisition violated § 7; orders divestiture of St. Luke's
- Rulings consistent on all key aspects of this case:
  - Inpatient general acute-care services is a relevant service market
  - Geographic market is Lucas County, Ohio
  - ProMedica and St. Luke's were significant competitors prior to the Acquisition
  - Acquisition eliminated vigorous head-to-head competition
  - Acquisition results in extraordinarily high market concentration and presumption of illegality
  - Acquisition enables ProMedica to raise rates at St. Luke's and legacy hospitals
  - Post-Acquisition, no viable constraints on ProMedica's market power
  - ProMedica has not raised a viable defense, whether based on entry, efficiencies, or flailing firm/weakened competitor

CC's Appeal Limited to ALJ's Erroneous Product-Market Determinations

- Judge Katz properly excluded tertiary services from GAC cluster market and held that OB is a separate relevant market (*ProMedica*, FOF ¶ 69, COL ¶¶ 11, 13)
- ALJ defined a single market for "all" inpatient GAC services
  - Includes tertiary and OB services but excludes outpatient services and inpatient quaternary, rehabilitation, and other inpatient services (IDFF ¶¶ 299, 306; IDA at 145)
- Two errors in ALJ's Initial Decision
  - First, ALJ improperly included tertiary services in the inpatient GAC cluster market
  - Second, ALJ failed to recognize inpatient OB services as a distinct relevant market

Market Definition Begins with Overlaps

- A prerequisite to finding a relevant product market is an actual overlap in products the merging parties offer
  - Relevant market "identifies the product[s] and services with which the defendants' products compete" (*CCC Holdings*)
  - If the merging parties do not compete by providing overlapping, substitutable services, there can be no competitive harm (*Little Rock Cardiology v. Baptist Health*)
    - "[Defendant] does not compete in the cardiologists' services market; it has no market share and therefore no market power in the market for cardiologists' services. Therefore, the relevant product market cannot include both the services offered by [defendant] and the services offered by cardiologists." (*Id*. at *1146)
- Individual relevant markets are then defined around each set of overlapping services
  - "When a product sold by one merging firm (Product A) competes against one or more products sold by the other merging firm, the Agencies define a relevant product market around Product A" (*Merger Guidelines* § 4.1)

Demand Substitution Determines Products in Each Individual Market

- Hypothetical Monopolist Test used to identify set of products that are reasonably interchangeable (*Merger Guidelines* § 4.1.1)

- Can/will customers substitute away from one product to another in response to a small-but-significant price increase?
  - Yes: they are in same relevant market
  - No: they are not in same relevant market

- Health-plan members, not MCOs, are the relevant customers for demand-substitution analysis in a hospital case
  - True, MCOs contract for services
  - But *members* – the actual consumers – determine which hospitals' services are substitutable for their needs

MCOs Are Not Only Appropriate Customers for Analysis

- Overstating *Sutter* and misstating *University Health*, Respondent argues MCOs are the only relevant consumer (RAB at 13-14; RRB at 2-3) – **WRONG**
- *Sutter Health*, 130 F. Supp. 2d at 1129 (Resp.'s cite)
  - *Sutter* court focused on "the extent to which patients will seek acute inpatient services at hospitals outside of the proposed [geographic] market" if prices rose (emphasis added)
  - Court looked at MCOs as proxies for patients' behavior: to determine where patients will go, behavior of MCOs is "particularly important" (emphasis added)
  - *Sutter* court, like Respondent, also wholly misstates holding in *University Health*
- *University Health*, 938 F.2d at 1213 n.13 (Resp's and *Sutter's* cite)
  - Court did not hold that "true customers" of GAC services were MCOs – that was the defendant/appellee's argument
  - Court rejected that notion, stating: "insurance companies in this market … are not truly large buyers; rather, they are third-party payors acting on behalf of individuals, **the ultimate consumers**." (emphasis added)

Cluster Markets Used for Analytical Convenience in Hospital Cases

- Each individual hospital service could appropriately be analyzed as a distinct relevant market (Guerin-Calvert, Tr. 7633; Town, Tr. 3666-67)
  - No demand substitution among individual GAC services *from the perspective of patients*
    - *e.g.,* appendectomies and knee surgery not reasonably interchangeable
  - *In re Carilion Clinic* serves as case-in-point
    - Commission issued complaint alleging separate relevant markets for outpatient imaging and outpatient surgery, which exist within a broader cluster of outpatient services
- Clustering thus obviates the need for unwieldy competitive-effects analysis in hundreds of individual relevant markets (*Emigra Group; ProMedica;* JSLF ¶ 57)

Clustering Appropriate Only Where It Will Not Be Misleading

- Cluster markets are a practical tool – but only for services with similar competitive conditions, where result will not be misleading
  - 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*; JSLF ¶ 57)
  - Appropriate "solely for descriptive and analytic convenience in situations where it will not be misleading" (Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry)*
  - Should only include services having the same competitive conditions (Town, Tr. 3595, 3667-3668, 3672-3673)
  - "[I]n some cases it might be appropriate to ignore some services that are competitively irrelevant to evaluating the merger" (*In re Adventist* (1994))

Cluster-Market Composition

- Demand-substitution and competitive-effects analysis are the same for the vast majority of overlapping primary and secondary GAC services; appropriate, therefore, to cluster them
- But do demand-side factors for any services differ materially?
  - Are consumers willing to travel more or less for the services than others?
  - Does the universe of competitive substitutes differ?
  - Are competitive effects of the merger different for these services?
- If yes, then services should not be clustered with the others – would be *misleading to do so*

Tertiary Services Do Not Belong in the GAC Cluster

- St. Luke's provides few, if any, tertiary services (IDFF ¶ 74; Admissions ¶ 2), so overlaps are lacking
- Competitive conditions for tertiary services are markedly different
  - Patients willing to travel farther for these services
  - As such, tertiary market includes reasonably interchangeable substitutes from a different group of providers
  - Different competitive-effects analysis, merger impact
- Hospital cases exclude tertiary services from GAC cluster (*Butterworth* (6th Cir.); *Tenet*; *ProMedica*; *Long Island Jewish*; *Mercy Health Servs*.)
  - Cases where parties *agreed* to exclude tertiary services highly relevant because against the merging parties' interest to do so
- Exclusion of outpatient and quaternary – with which Respondent agrees – appropriate for same reasons

Respondent's Cluster-Market Cases Are Inapposite

- *Grinnell* (1966)
  - Nearly 50-year old case in the protective-services industry – not hospitals/healthcare
  - Defined broad cluster market because of commercial realities not applicable here
    - "[T]here is here a single basic service" and "customers utilize different services in combination"
    - Simply to "compete effectively, [providers] must offer all or nearly all types of services"
    - Plenty of cases define market around overlap products, rejecting broader cluster (*see, e.g.*, *H&R Block*, *Mrs. Smith's Pie*, *ProMedica*)
- *Sutter Health* (N.D. Cal 2001)
  - Tertiary included in GAC cluster based on finding similar services and resources across primary, secondary, and tertiary services – ALJ here found otherwise (IDFF ¶¶ 23, 26; IDA at 140) and Respondent argued that tertiary services require higher-cost resources (RPTRB at 37-39)
  - Holds market includes services offered by niche competitors "that compete with [the merging parties] in providing only part" of cluster – does not say relevant market includes non-overlap products
- *University Health* (11th Cir. 1991)
  - In footnote, appeals court merely said it did not "appear" that the district court intended to limit the relevant market to overlap services
  - Plaintiff and court agreed that whether relevant market is limited to overlaps or all GAC services "of no moment for our purposes"
  - Court treated inpatient GAC as the relevant market for "ease of discussion"

Respondent's Cluster-Market Cases Are Inapposite

- *Evanston* (FTC 2007)
  - Complaint excluded tertiary services from GAC cluster
  - Tertiary added to GAC cluster by stipulation and after CC's expert, "reviewing all the evidence," concluded tertiary should be in GAC cluster – not true here (*Evanston*, CC's Answering and Cross App. Br. at 37 n.37)
  - Commission did not focus on whether tertiary properly included in GAC cluster, only on whether to include outpatient services
- No precedent whatsoever for Respondent's theory that MCOs contracting for multiple services simultaneously requires their inclusion in same cluster market
  - *Evanston* specifically rejected the analysis that Respondent advocates
    - "Respondent argues incorrectly that complaint counsel's 'focus on MCOs as the consumer' warrants including hospital-based outpatient services in the market because MCOs simultaneously negotiate with hospitals for both inpatient and outpatient services." (*Evanston,* at *149)

OB Services Constitute a Distinct Relevant Market

- Practical indicia/commercial realities confirm
  - Distinct providers (obstetricians) and customers (pregnant mothers and their partners)
  - Hospitals – including ProMedica and St. Luke's – separately track OB shares (IDFF ¶ 314)
  - St. Luke's anticipated greater scrutiny in OB due to market concentration (PX01030 at 17, *in camera*)
  - Health-plan contracts have different negotiated rates and rate structures for OB (e.g., PX00365 at 030, *i/c*; PX02520 at 003-005, *i/c*)
- A hypothetical monopolist could profitably raise OB prices by a SSNIP (Guerin-Calvert, Tr. 7679-80)
- No other GAC services are reasonably interchangeable with OB services

OB Services Do Not Belong in the GAC Cluster

- Competitive conditions for OB differ significantly from those for other GAC services
  - Different “choice set” of providers available to consumers because UTMC and Mercy St. Anne do not offer OB
- Clustering OB with other services would lead to misleading results
  - Significantly different market shares in OB versus GAC cluster
  - Would substantially understate the Acquisition’s competitive harm as to OB services (**merger to duopoly**)

Respondent's Price-Discrimination Argument is a Red Herring

- *Merger Guidelines* § 4.1.4 has no bearing on OB product-market issue
  - Applies where a market is alleged for sales targeting a specific subset of customers within *an individual relevant product market*
    - HMG Example: glass containers sold to baby-food manufacturers, who will not substitute to other materials in response to a SSNIP
  - No claim here that a subset of OB customers may be targeted for price increases
  - Rather, *all* OB patients will be forced to pay higher rates due to the Acquisition

Acquisition Makes ProMedica Even More Dominant in Both Markets

- ProMedica was already dominant, lower-quality, and high-priced
  - "**Dominant** market share position" listed under "Strengths" (2007 SWOT Analysis, PX00319 at 1)
  - "ProMedica Health System has **market dominance** in the Toledo MSA." (2008 Standard & Poor's Credit Presentation, PX00270 at 25)
  - "As Healthcare evolves it is critical that ProMedica evolves to maintain its **competitive dominance** in the Region." (2009 Planning Pres., PX00221 at 2)
  - "**[L]eading market position** within the Toledo metropolitan area." "**[D]ominant** market share[s] in oncology, orthopedics and women's services." (2010 Credit and Capital Presentation, PX00320 at 3)
  - "[W]e continue to … see **subpar quality scores** when we look at published comparisons." (PX00153 at 1)
  - "[W]e hear from payors we are **among the most expensive in Ohio**" (PX00153 at 1)

Strong Presumption of Competitive Harm in Both Concentrated Markets

Cases Enjoining Merger/ Guidelines	Combined Share	HHI Increase	Post-Acq. HHI
Phil. Nat'l Bank (Supreme Court 1963)	30%	n/a	n/a
Bass Bros. Enter. (N.D. Ohio 1984)	29%	200-300	1900-2000
Univ. Health Inc. (11th Cir. 1991)	43%	630	3200
Evanston (F.T.C. 2007)	35-40%	384	2739
H&R Block (D.D.C. 2011)	28.4%	400	4691
Merger Guidelines § 5.3 (presumption of harm)	n/a	200	2500
ProMedica: General Acute Care	**58%**	**1078**	**4391**
ProMedica: Obstetrics	**81%**	**1323**	**6854**

Additional Evidence of Competitive Harm

- Additional evidence *strengthens* the presumption of competitive harm
  - Documents: Ordinary-course documents show close and vigorous competition and explicitly predict price increases
  - Testimony of all constituencies forecasts harm:
    - Health plans
    - Employers and Small Businesses
    - Hospitals
    - Physicians
    - ProMedica and St. Luke's executives
  - Econometric analysis

Respondent's Unilateral-Effects Approach is Flawed

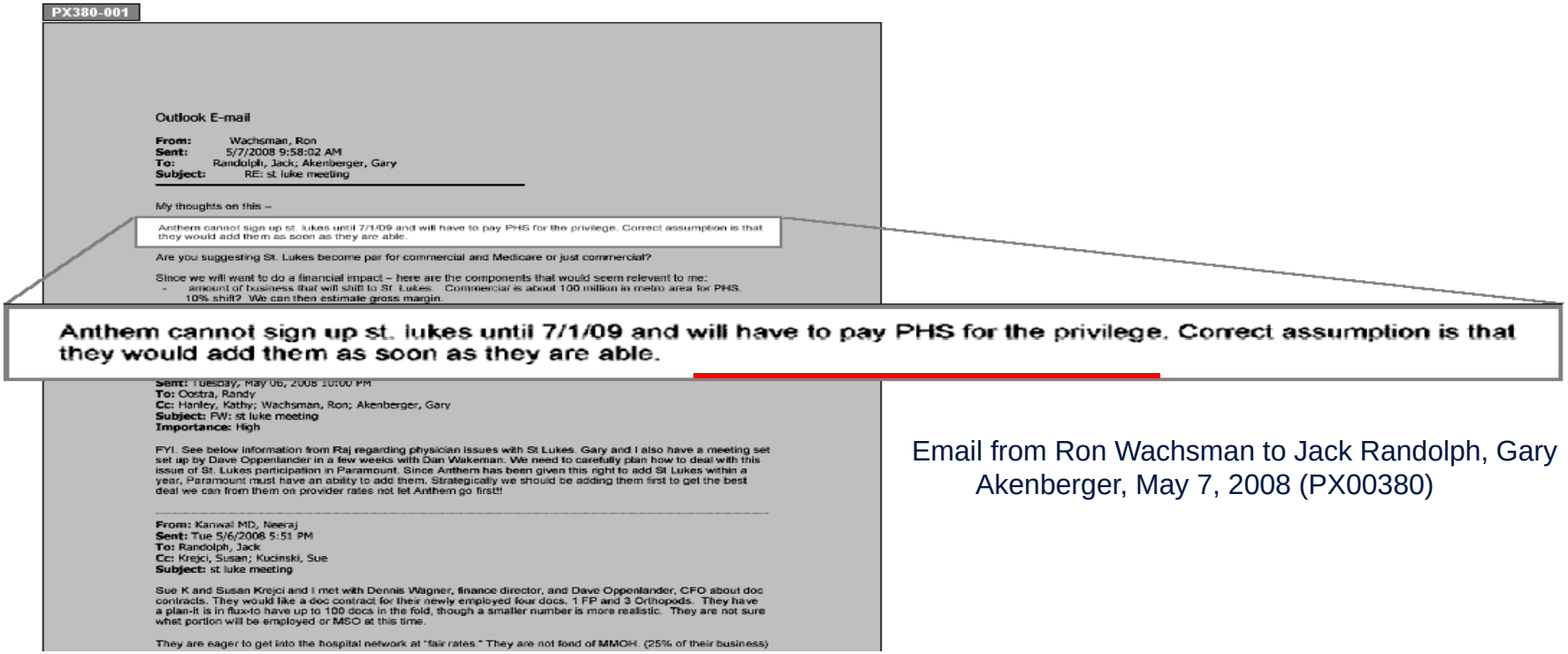
- Section 7 concerned with *substantial lessening of competition* – as is case here
- Argument that Mercy, not St. Luke's, is ProMedica's closest substitute is irrelevant
  - Just means a ProMedica-Mercy merger would be *even more* anticompetitive
- Case law, *Merger Guidelines*, and logic contradict notion that unilateral effects are only possible if St. Luke's is ProMedica's closest competitor or perfect substitute
  - *H&R Block* (125-26): "fact that Intuit may be the closest competitor for both HRB and TaxACT [ ] does not necessarily prevent a finding of unilateral effects"
  - *Evanston* (*160): "it is not necessary for the merged firms to be the closest substitutes for all customers, or even a majority of customers."
  - *HMG* § 6.1: "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."
  - Respondent's approach would favor/immunize acquisitions by dominant firms
  - Ignores fact that ProMedica is St. Luke's closest competitor
- Correct analysis is of substitution between <u>individual</u> hospitals in eyes of <u>patients</u> – <u>not</u> whether SLH and the ProMedica system are interchangeable in MCO networks
- **Bottom line**: Acquisition eliminates significant, close competition between St. Luke's and ProMedica

St. Luke's and ProMedica Were Close Substitutes, Vigorous Competitors

- **Professor Town's diversion analysis:**
  - ProMedica is St. Luke's closest substitute for members of five of the six major health plans and a significant substitute for the sixth (PX01850 Table 3, *in camera*; CCPFF ¶¶ 338-345)
  - St. Luke's is ProMedica's second-closest substitute (CCPFF ¶ 345)
- **Market-share statistics (ordinary-course and expert):**
  - "In metro Toledo, ProMedica's share of the inpatient market declined 1% through nine months of 2009, with St. Luke's hospital picking up half of that share." (PX00159 at 12, *in camera*)
  - ProMedica and St. Luke's have highest market shares in SW Lucas County in GAC and OB; Mercy and UTMC are not close behind for either GAC or OB (CCPFF ¶¶ 323-330)
- **Consumer surveys (SW Lucas County):**
  - St. Luke's and TTH most preferred, most direct competitors, and first hospitals to come to mind (CCPFF ¶¶ 335-337)
  - St. Luke's, TTH and Flower most preferred for OB (CCPFF ¶ 337)
- **Testimony:**
  - ProMedica was St. Luke's "most significant competitor" (Wakeman, Tr. 2511)
  - Mr. Oostra viewed ProMedica and St. Luke's as "strong competitors" (Oostra, Tr. 6038-39)
  - Mercy does not consider itself "in any way, shape or form a primary competitor" to St. Luke's. (Shook, Tr. 1038).

St. Luke's and ProMedica Were Close Substitutes, Vigorous Competitors

- ProMedica obtained contract that excluded St. Luke's from a major health-plan network; required health plan to pay increased rates at all ProMedica Lucas County hospitals for re-admitting St. Luke's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Outlook E-mail

From: Wachsman, Ron
Sent: 5/7/2008 9:58:02 AM
To: Randolph, Jack; Akenberger, Gary
Subject: RE: st luke meeting

My thoughts on this –

Anthem cannot sign up st. lukes until 7/1/09 and will have to pay PHS for the privilege. Correct assumption is that they would add them as soon as they are able.

Are you suggesting St. Lukes become par for commercial and Medicare or just commercial?

Since we will want to do a financial impact – here are the components that would seem relevant to me:
- amount of business that will shift to St. Lukes. Commercial is about 100 million in metro area for PHS. 10% shift? We can then estimate gross margin.

Anthem cannot sign up st. lukes until 7/1/09 and will have to pay PHS for the privilege. Correct assumption is that they would add them as soon as they are able.

Sent: Tuesday, May 06, 2008 10:00 PM
To: Oostra, Randy
Cc: Hanley, Kathy; Wachsman, Ron; Akenberger, Gary
Subject: FW: st luke meeting
Importance: High

FYI. See below information from Raj regarding physician issues with St Lukes. Gary and I also have a meeting set set up by Dave Oppenlander in a few weeks with Dan Wakeman. We need to carefully plan how to deal with this issue of St. Lukes participation in Paramount. Since Anthem has been given this right to add St Lukes within a year, Paramount must have an ability to add them. Strategically we should be adding them first to get the best deal we can from them on provider rates not let Anthem go first!!

From: Kanwal MD, Neeraj
Sent: Tue 5/6/2008 5:51 PM
To: Randolph, Jack
Cc: Krejci, Susan; Kucinski, Sue
Subject: st luke meeting

Sue K and Susan Krejci and I met with Dennis Wagner, finance director, and Dave Oppenlander, CFO about doc contracts. They would like a doc contract for their newly employed four docs. 1 FP and 3 Orthopods. They have a plan-it is in flux-to have up to 100 docs in the fold, though a smaller number is more realistic. They are not sure what portion will be employed or MSO at this time.

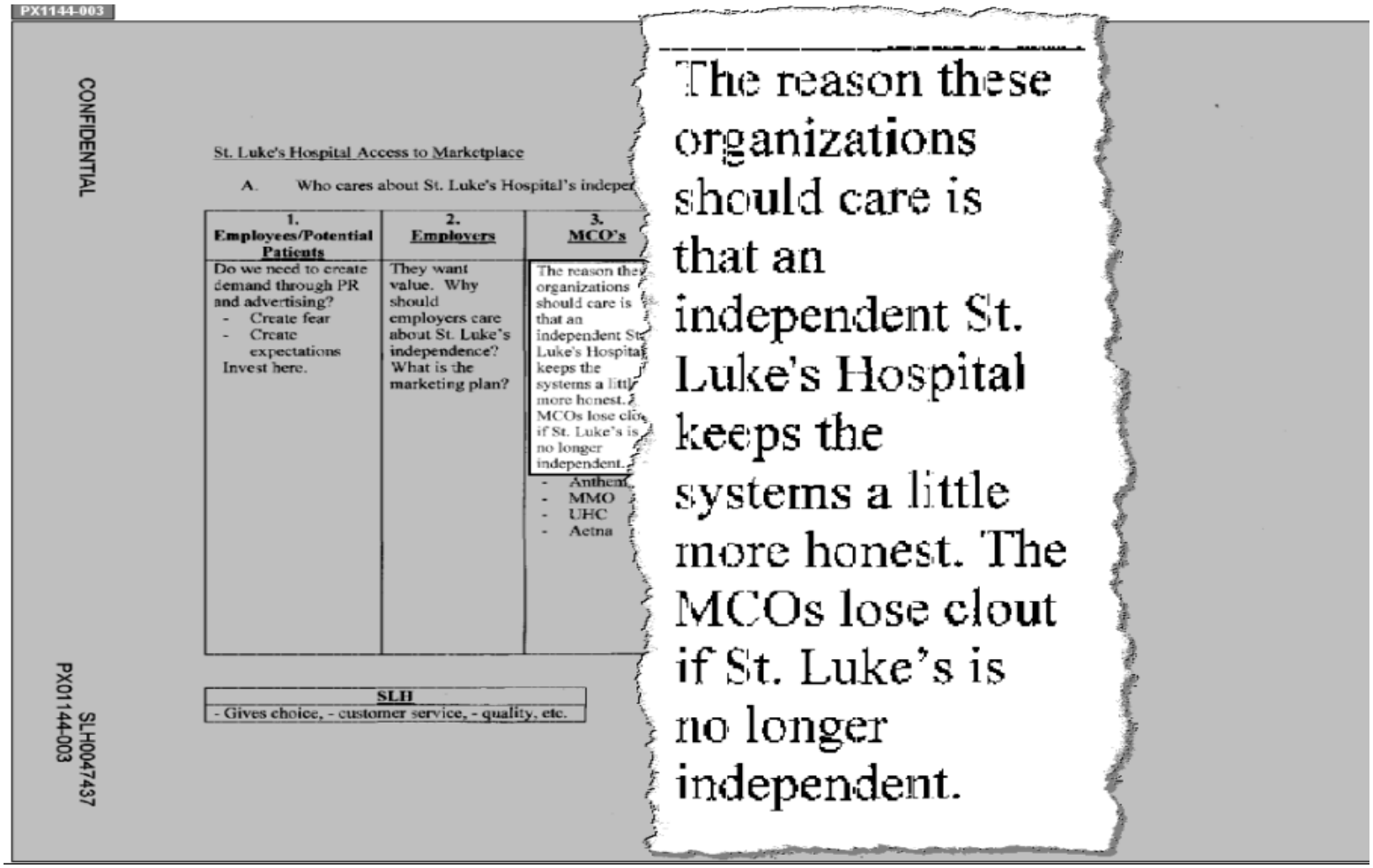
They are eager to get into the hospital network at "fair rates." They are not fond of MMOH. (25% of their business)

Email from Ron Wachsman to Jack Randolph, Gary Akenberger, May 7, 2008 (PX00380)

- PHS explored excluding SLH from other health-plan networks (e.g., PX02267 at 1, *i/c*)
- PHS refused to allow Paramount to add SLH to its network (Oostra, Tr. 6045-6046)

What Does the Acquisition Change?

- Pre-Acquisition, an independent St. Luke's was competitively significant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St. Luke's Hospital Access to Marketplace

A. Who cares about St. Luke's Hospital's indepe

1. Employees/Potential Patients	2. Employers	3. MCO's
Do we need to create demand through PR and advertising? - Create fear - Create expectations Invest here.	They want value. Why should employers care about St. Luke's independence? What is the marketing plan?	The reason the organizations should care is that an independent St Luke's Hospital keeps the systems a litt more honest. MCOs lose clo if St. Luke's is no longer independent. - Anthem - MMO - UHC - Aetna

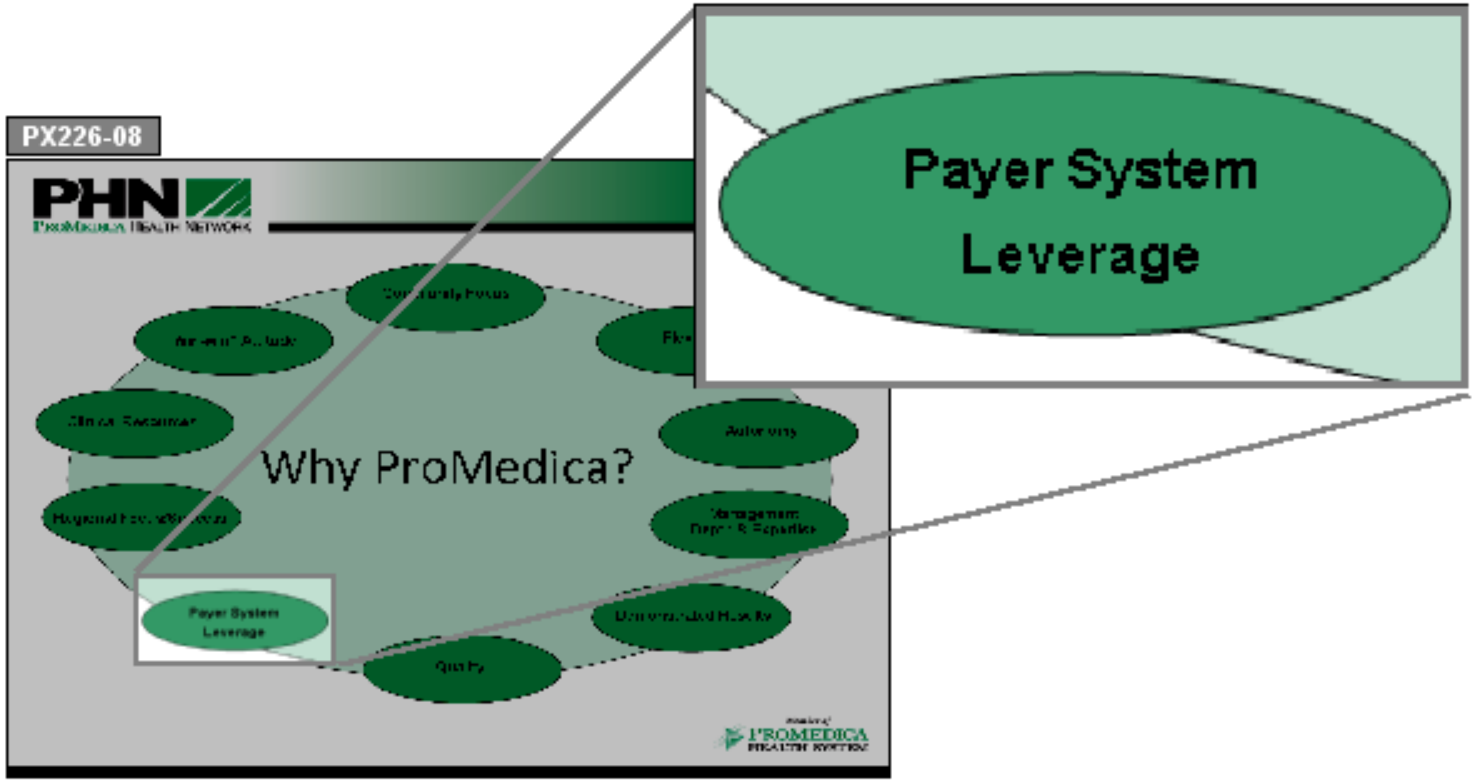
SLH
- Gives choice, - customer service, - quality, etc.

SLH0047437
PX01144-003

The reason these organizations should care is that an independent St. Luke's Hospital keeps the systems a little more honest. The MCOs lose clout if St. Luke's is no longer independent.

Acquisition Leads to Increased Leverage and Higher Rates

- ProMedica was aware of its bargaining leverage with health plans



Draft Presentation: ProMedica Health Network ProMedica Partnerships (late 2009/early 2010) (PX00226 at 8)

Acquisition Leads to Increased Leverage and Higher Rates

- St. Luke's viewed increased bargaining leverage and access to higher rates as principal benefits of Acquisition:

ProMedica:
- An SLH affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout.

Presentation to St. Luke's Board of Directors, 10/30/09 (PX01030 at 20, *i/c*)

Two things Promedica brings to the table are strong market/capital position, and incredible access to outstanding pricing on managed care agreements. Taking advantage of these strengths may not be the best thing for the community in the long run. Sure would make life much easier right now though.

Email from D. Wakeman to Board of Directors, 10/11/09 (PX01125 at 2, *in camera*)

Option 3: Affiliate with ProMedica. What do they bring?

Strong managed care contracts.

Presentation by D. Wakeman, 2009 (PX1018 at 14, *in camera*)

Acquisition Leads to Increased Leverage and Higher Rates

- The DD Phase II Team believed the community would be better served with a U.T. affiliation. A ProMedica or Mercy affiliation could still stick it to employers, that is, to continue forcing high rates on employers and insurance companies.

(DD Phase II Team Notes, PX01130 at 005, *in camera*)

prepared with a story to tell them. Ed was correct, we need to show them that we intend to merge with another system, and all the value we produce will diluted, as our payments skyrocket.
Dan

(D. Wakeman 8/20/09 Email, PX01229, *in camera*)

care contracts. Yes we asked MCO 1 for $[redacted], but if we go over to the dark green side....we may pick up as much as $[redacted] in additional MCO 1, MCO 2 and MCO 3 fees, and I'll bet their managed care guys know what type of carve outs need to be in place for the expensive implantable, especially with all their orthopedic and hearts.

(D. Wakeman 10/13/09 Email, PX01231, *in camera*)

Third-Party Health Plans in Agreement

Health Plan	ProMedica High-Priced Before Acquisition	Acquisition Increases ProMedica's Bargaining Leverage	Increased Bargaining Leverage Will Lead to Higher Rates	UTMC-Mercy Network Not Marketable or Viable Substitute
Health Plan A	✓	✓	✓	✓
Health Plan B	✓	✓	✓	✓
Health Plan C	✓	✓	✓	✓
Health Plan D	✓	✓	✓	✓
Health Plan E	✓	✓	✓	✓
Health Plan F	✓	✓	✓	✓

Criticisms of Customer Witnesses in *Oracle*, *Arch Coal*, and *Tenet* Not Applicable Here

- ALJ in best position to assess whether MCO testimony is credible and reliable – and ALJ found it to be both
- Health-plan witnesses provided detailed testimony, relying on decades of experience in healthcare, utilization data and pricing analyses, and familiarity with bargaining dynamics and provider-network marketability in Lucas County
  - Unlike in *Oracle*, where customer witnesses testified "with a kind of rote" (*Oracle*, 331 F. Supp. 2d at 1131)
  - Unlike in *Arch Coal*, where customers testified to little more than anxiety that fewer suppliers would lead to higher prices (*Arch Coal*, 329 F. Supp. 2d at 145-46)
  - Unlike in *Tenet*, where evidence contradicted health-plan claims regarding responses to price increases (*Tenet*, 186 F. 3d at 1054)

Health-Plan Testimony Is Credible, Reliable, and Consistent

- ProMedica cannot argue with the substance of health-plan testimony – only response is to attempt to attack witness credibility
- Whose witnesses are more likely to be biased:
  - Third parties with no ties to the FTC, who are putting their business relationships on the line?
  - Or ProMedica's executives and highly-paid consultants?
- Health-plan testimony is credible and reliable
  - Founded on decades of experience and ordinary-course business research, reporting, analysis
  - Consistent with pre-investigation ordinary-course documents and other documentary evidence
  - Consistent with one another
  - Backed by economic expert testimony and econometric evidence

Both Experts' Analyses Predict Post-Acquisition Price Increases

- Professor Town's merger-simulation model predicts inpatient reimbursement-rate increases:
  - 10.8% at ProMedica's pre-Acquisition Lucas County Hospitals
  - 38.4%- 56.2% at St. Luke's
- Respondent's expert predicts prices will increase, too:
  - 7.3% overall
  - 18% at St. Luke's and 5% at ProMedica's hospitals
- All predicted price increases are statistically significant at the 95% level

Resp.'s Criticism of Professor Town's Empirical Work Unfounded

- Prof. Town's pricing analysis consistent with party and third-party evidence and health plans' ordinary-course analysis of case-mix-adjusted prices
  - Criticism of "constructed" prices ignores need to compare apples-to-apples; Town's method accepted by academic literature, *ProMedica* decision, and *Evanston* case
  - Not a flaw that the model doesn't explain *how* prices change post-Acquisition – analysis shows ProMedica's pre-Acquisition dominance and high prices, correlation between market share and rates, and resulting harm if SLH rates raised to PHS rates
  - Not a flaw that the model does not explain *why* prices vary – not intended to do so; moreover, Town explained that "benign" cost/quality reasons do not explain price differential
- Town's merger-simulation model has been peered-reviewed
  - The fact that exact specifications used for this case were not peer-reviewed is a red herring
  - Literature finds Town's approach highly relevant to bargaining incentives and outcomes
  - Claim that model doesn't explain where patient would go is inaccurate: model and diversion analysis explain that (consistent with testimony and documents)
  - Wrong to claim that model does not accurately explain price changes – model isolates and identifies effect of Acquisition on prices holding all else constant
    - Guerin-Calvert's addition of variables correlated with model's variables is an obfuscating tactic rejected by the 6th Circuit (*Realcomp II,* 635 F. 3d 815, 834 n.13 (6th Cir. 2011))

Consumers Will Be Harmed by the Acquisition

- Self-insured employers, which pay their employees' healthcare claims, will directly feel the impact of higher rates
  - Approx. 70% of commercially insured employees are covered by self-insured plans
  - Approx. 50-66% of major MCOs' business is comprised of self-insured customers
- Health plans will be forced to pass along higher costs to fully-insured employers, families, and individuals
- Fully-insured employers will be forced to pass along higher costs to employees through higher deductibles, co-pays, other contributions
- Higher healthcare costs mean higher out-of-pocket costs for individuals and/or reduced access to healthcare services

No Viable Defenses: Mercy, UTMC Will Not Constrain ProMedica

	ProMedica (w. St. Luke's)	Mercy & UTMC (combined)	
GAC Market Share	58.3%	41.7%	ProMedica 40% higher
OB Market Share	80.47%	19.53%	ProMedica 312% higher
Inpatient OB At All Lucas County Hospitals	✓	✗	
Owns Integrated Health Plan	✓	✗	
GAC Market Share in St. Luke's Core Service Area	71.6%	25.3%	ProMedica 183% higher
OB Market Share in St. Luke's Core Service Area	86.6%	11.5%	ProMedica 653% higher
Willingness-To-Pay	12,346.19	8,942.86	ProMedica 38% higher

Source: PX02148 at 8, 143, 161, 165.

No Viable Defenses: Steering Will Not Constrain ProMedica

- Why hasn't anyone implemented steering before to defeat ProMedica's already-high prices?
- No health plan in past 20 years has offered Mercy-UTMC-only network (Guerin-Calvert, Tr. 7895; Randolph, Tr. 7065)
- Only witnesses on ProMedica's payroll testified in favor of this network
- Health-plan steering will not constrain ProMedica (IDA at 179-80)
  - Currently do not steer commercial members and have no plans to do so
  - Patients dislike steering; demand broad-access network
  - Hospitals with bargaining leverage (e.g., ProMedica) resist steering and contract for anti-steering provisions
    - ProMedica has anti-steering provision in contracts with two major health plans and negotiated anti-steering provision in SLH contract with {major health plan}
- Physician steering will not constrain ProMedica (IDA at 178-79)
  - All physicians testified they are unaware of hospital reimbursement rates
  - Ignores patient preferences (hospitals invest in marketing, surveys)
  - Physicians admit based on clinical need, not price
- Even if steering were possible, just introduces some price sensitivity (as exists in many industries) but would not fix the competitive harm

No Viable Defenses: Entry, Quasi-Entry, Efficiency Defenses Fail

- No viable entry defense: entry would not be timely, likely, sufficient
  - No evidence of entry; entry costly ($1M/bed) and takes years
- Quasi-entry defense fails (IDA at 177-78)
  - Mercy's physician-recruiting strategy has not achieved implementation goals or increased its I/P market share in SW Lucas County
  - Physician-recruiting strategy limited in scope and insufficient to replace competition lost by Acquisition: Physicians ≠ GAC hospital
- No viable efficiencies defense: speculative, not cognizable, insufficient (IDA at 192)
  - Neither of Respondent's experts conducted analysis; only CC's expert
  - Claimed benefits not merger-specific
    - "ProMedica admits that any St. Luke's affiliation with any potential partner, including UTMC, may have led to certain efficiencies" (Admissions ¶ 12; *see also* Admissions ¶ 11)
  - Efficiencies disputed by key employees; just "preliminary"; based on "gut feeling"; made for litigation (CCPFF ¶ 779 et seq.)

No Viable Defenses: "Flailing Firm" Defense is Weakest of All

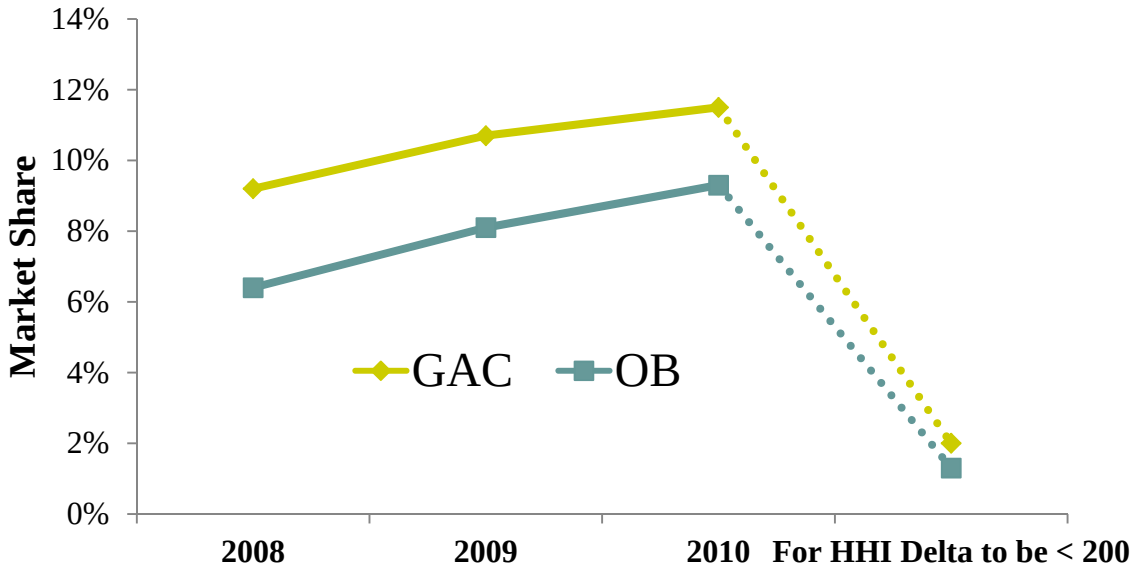
- "Financial weakness … is probably the weakest ground of all for justifying a merger . . .[It] certainly cannot be the primary justification of a merger." (*Kaiser Alum. & Chem. Corp.* (7th Cir. 1981))
- Courts strongly disfavor "a weak company defense" because it "would expand the failing company doctrine, a defense which has strict limits." *Warner Commc'ns* (9th Cir. 1984))
- Respondent must make a "substantial showing that the acquired firm's weakness, which cannot be resolved by any competitive means, would cause that firm's market share to reduce to a level that would undermine the government's *prima facie* case" (*Univ. Health* (11th Cir. 1991))
- "[F]inancial difficulties are relevant only where they indicate that market shares would decline in the future and by enough to bring the merger below the threshold of presumptive illegality" (*Arch Coal* (D.D.C. 2004))

What Would a "Flailing" St. Luke's Actually Look Like?

To fall below an HHI delta of 200 (eliminating presumption), St. Luke's pre-joinder share would have to:

- fall from **11.5% to 2.0% or lower** for GAC
- fall from **9.3% to 1.3% or lower** for OB

…BUT



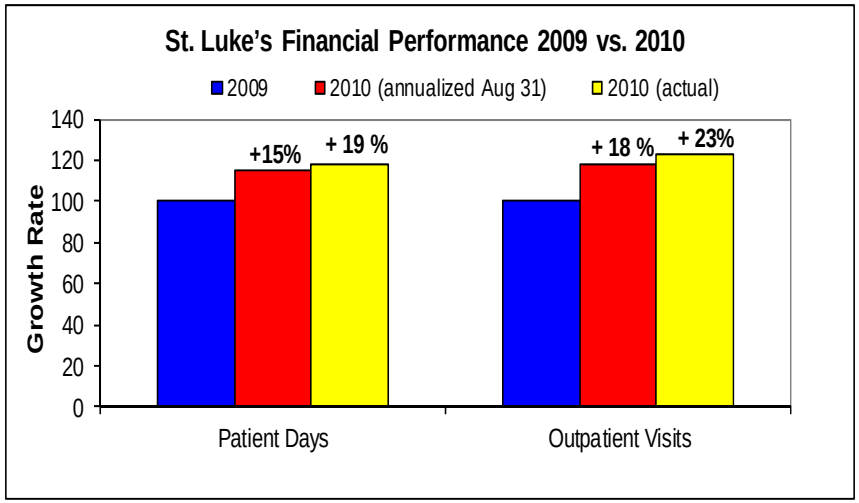
- SLH was **gaining** share prior to the Acquisition (PX00159 at 12, *in camera*; PX01235 at 3)
- Market share would not have collapsed
  - Respondent admits that St. Luke's was not a failing firm, so there was no "grave probability of a business failure" (JSLF ¶ 21; *US Steel Corp.* (6th Cir. 1970); *Merger Guidelines* § 11)
- Neither of Resp.'s **two** testifying experts projected market shares or financial performance absent Acquisition (*See* CCPFF ¶¶ 1174-1176, 1202-1204)

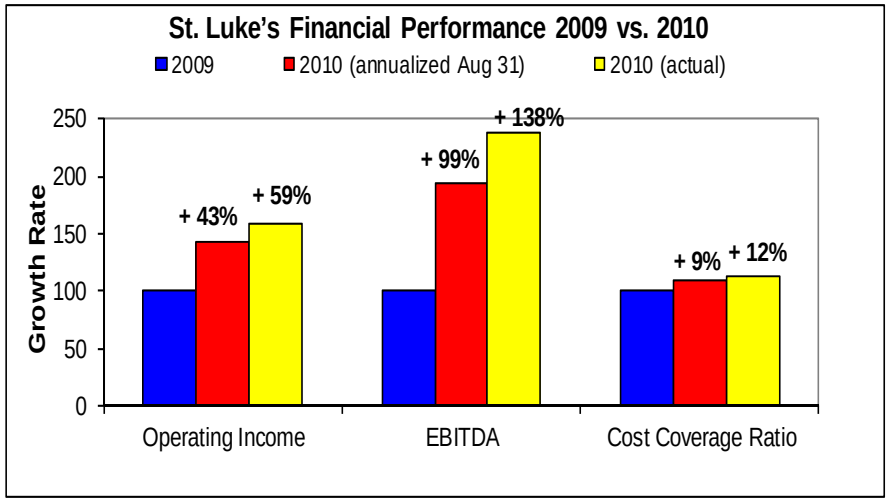
St. Luke's Finances Were *Improving*

St. Luke's was <u>growing</u> prior to the Acquisition

- Revenues – inpatient & outpatient
- Market share
- Inpatient admissions
- Outpatient visits
- Patient days
- Occupancy rate
- EBITDA
- Cost-coverage ratio
- Operating income and margin
- Operating cash flow margin
- Decreased expenses

Source: JSLF ¶¶ 27-32; Tr. 6591-92, 6603, PX01951 at t 64, *in camera*; CC's Answering Br. at 30-33





St. Luke's NOT Losing Money on Each Patient

Respondent's Appeal Brief:

Second, the ALJ ignores evidence that proves that St. Luke's will not achieve any "significant and sustained improvements" on its own. For example, Mr. Dagen's pro forma analysis that St. Luke's could improve profitability based upon volume growth was flawed. (RCCPF 962, *in camera*, 1082, *in camera*, 1083-1084, 1209, *in camera*, 1211, *in camera*, 1212.) In reality, St. Luke's lost money on average for each patient that it treated, and St. Luke's reduction in capital expenditures was unsustainable. (RPF 1643, *in camera*, 1763-1764, *in camera*, 1777, *in camera*, 1781, *in camera*; Den Uyl, Tr. 6423, 6468, *in camera*; Johnston, Tr. 5329). Moreover, dismissing St. Luke's debt obligations and looming capital requirements on the grounds that St. Luke's had enough cash to cover these costs ignores the reality that such a move would have worsened St. Luke's financial condition. (RPF 1641-1643, *in camera*; 2024, *in camera*, 2027-2028, *in camera*; Wakeman, Tr. 3009, *in camera*; ID 187). Nor could St. Luke's have borrowed money to cover these costs. (RPF 1644). Mr. Brick's conclusion that St. Luke's could have borrowed money at a reasonable interest rate lacks foundation because he did no independent analysis to support his opinions. (IDFOF 887; Brick, Tr. 3474, 3511-3557). Because St. Luke's lacked independent prospects for improvement, *Arch Coal* is directly on point.

Resp't Appeal Br. at 39

Respondent's Expert Witness:

Q. And in the first eight months of 2010 St. Luke's covered all direct and indirect costs and therefore was profitable on its treatment of MCO1 members; isn't that right?
A. Yes.
Q. And for the same time period, if we look at MCO2, St. Luke's in the first eight months of 2010 covered all direct and indirect costs and therefore was profitable on its treatment of MCO2 members; correct?
A. Well, it was barely profitable.
Q. It was a positive profit; right?
A. Right. The problem is, the commercial payers have to be very positive to make up for the government payers.
Q. For the first eight months of 2010 St. Luke's was also profitable on its treatment of MCO3 members, wasn't it?
A. Yes.
Q. And MCO4 members; right?
A. Yes.
Q. And MCO5 members; right?
A. Yes.

Den Uyl, Tr. 6597-6598, *i/c*

See also PX01062 at 3, *i/c* (citing profit from high activity levels); PX00157 at 12, *i/c* (stating that SLH's commercial reimbursement is {not below cost})

CEO's Last Words to the Board on Behalf of an Independent St. Luke's

PX170-001

ST. LUKE'S HOSPITAL
MAUMEE, OHIO

MEMORANDUM

Date: September 24, 2010

To: Board of Directors

From: Dan Wakeman
President/CEO

Subject: Monthly Report - August 2010

Inpatient, (up 7.5%) and outpatient, (up 6.1%), activity was running hot all month. While we still have capacity for outpatient, especially in the offsite centers, inpatient capacity is limited except for weekends. Details regarding service levels will be provided later in the report.

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

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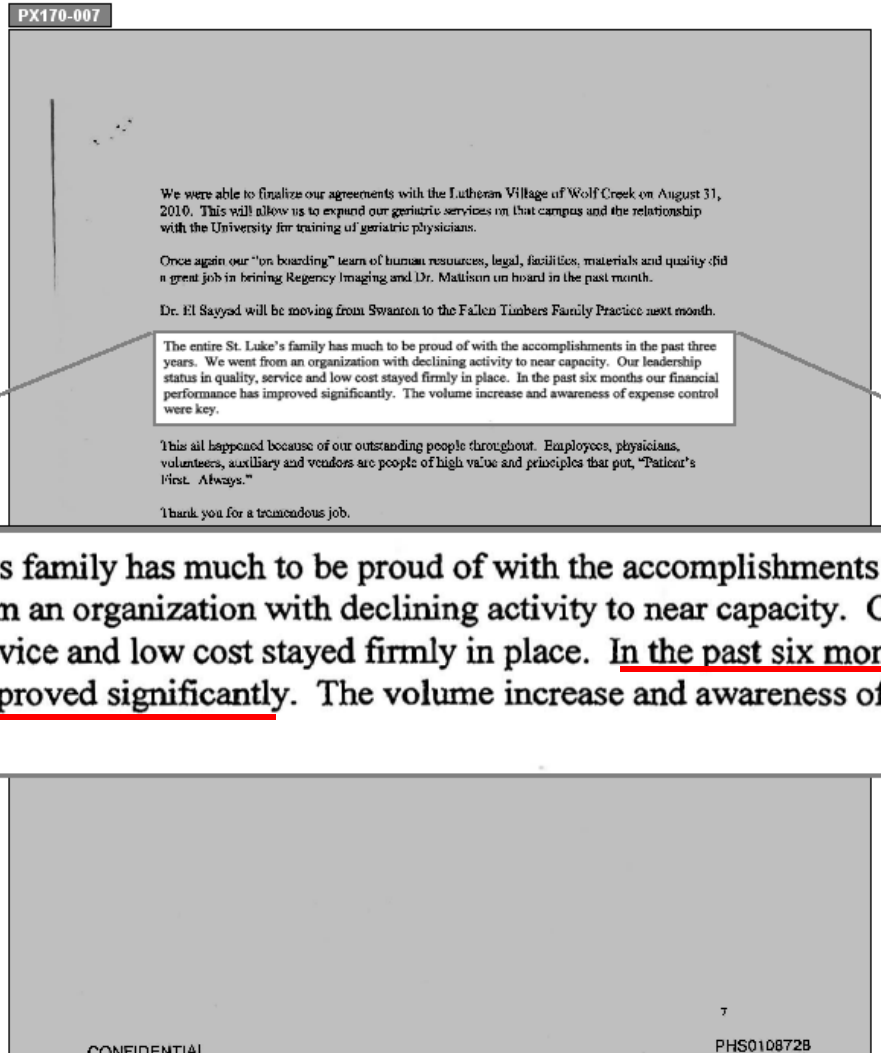
PX0170-001

CEO's Last Words to the Board on Behalf of an Independent St. Luke's


PX170-007

We were able to finalize our agreements with the Lutheran Village of Wolf Creek on August 31, 2010. This will allow us to expand our geriatric services on that campus and the relationship with the University for training of geriatric physicians.

Once again our "on boarding" team of human resources, legal, facilities, materials and quality did a great job in brining Regency Imaging and Dr. Mattison on board in the past month.

Dr. El Sayyed will be moving from Swanton to the Fallen Timbers Family Practice next month.

The entire St. Luke's family has much to be proud of with the accomplishments in the past three years. We went from an organization with declining activity to near capacity. Our leadership status in quality, service and low cost stayed firmly in place. In the past six months our financial performance has improved significantly. The volume increase and awareness of expense control were key.

This all happened because of our outstanding people throughout. Employees, physicians, volunteers, auxiliary and vendors are people of high value and principles that put, "Patient's First. Always."

Thank you for a tremendous job.

The entire St. Luke's family has much to be proud of with the accomplishments in the past three years. We went from an organization with declining activity to near capacity. Our leadership status in quality, service and low cost stayed firmly in place. In the past six months our financial performance has improved significantly. The volume increase and awareness of expense control were key.

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Divestiture Is the Appropriate Remedy

- Divestiture is the usual, proper remedy (*du Pont*, *Polypore*, *Evanston*)
  - Clayton Act § 11(b): the Commission "shall" order a divestiture of "the stock, or other share, capital, or assets, held" for violations of Section 7 (15 U.S.C. § 21(b))
  - "The very words of § 7 suggest that an undoing of the acquisition is a natural remedy." (*du Pont* (1961))
  - "[C]omplete divestiture provides the greatest likelihood that the asset package will restore competition and be sufficiently viable" to attract a buyer (*Polypore*)
  - Remedy "more likely to restore competition if the firms that engaged in pre-merger competition are not under common ownership" (*Evanston*)
- Divestiture is not overbroad, punitive as a factual and legal matter
  - St. Luke's can be divested to a third-party or spun-off (*see* Order IIA.1)
  - "Even remedies which 'entail harsh consequences' would be appropriate to ameliorate the harm to competition from an antitrust violation." (*Whole Foods* (D.C. Cir.))

Evanston Remedy Not Proper Here

- ALJ's comments regarding cogency of Respondent's argument and whether *Evanston* remedy would be effective here are dicta
- *Evanston* remedy ordered under highly unusual circumstances, only reluctantly, and explicitly limiting its future application
  - "Nor will our reasoning here necessarily apply to consideration of the appropriate remedy in a future challenge to a consummated merger, including a consummated hospital merger." (*Evanston*, at *250)
- This case is not *Evanston*

Evanston	*ProMedica*
7 years between closing and conclusion of litigation	Consummated ~17 months ago subject to Hold-Separate Agreement (HSA)
Extensive integration of hospitals	- HSA and PI order prevented (1) eliminating, transferring, or consolidating any St. Luke's clinical services, (2) terminating any SLH employees, (3) modifying or cancelling physicians' privileges at SLH, (4) terminating any contract between a health plan and SLH - No EMR implementation at SLH
Divestiture could eliminate benefits achieved	- HSA required ProMedica to maintain viability and competitiveness of St. Luke's - ALJ rejected virtually all of Resp.'s efficiency claims

For ProMedica To Be Right, Who Has To Be Wrong?

- All health plans
- Employers
- Physicians
- St. Luke's executives, Board members, Due-Diligence Team, and ordinary-course documents
- ProMedica executives and ordinary-course documents
- All experts
- Judge Katz
- Judge Chappell

ProMedica can win only in spite of evidence, not because of evidence