No. 14-35173

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

SAINT ALPHONSUS MEDICAL CENTER–NAMPA INC., SAINT ALPHONSUS HEALTH SYSTEM INC.; SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC.; TREASURE VALLEY HOSPITAL LIMITED PARTNERSHIP; FEDERAL TRADE COMMISSION; STATE OF IDAHO,

Plaintiffs-Appellees,

and

IDAHO STATESMAN PUBLISHING, LLC; THE ASSOCIATED PRESS; IDAHO PRESS CLUB; IDAHO PRESS-TRIBUNE LLC; LEE PUBLICATIONS INC.,

Intervenors,

v.

ST. LUKE'S HEALTH SYSTEM, LTD.; ST. LUKE'S REGIONAL MEDICAL CENTER, LTD.; SALTZER MEDICAL GROUP,

Defendants-Appellants.

Appeal from the United States District Court for the District of Idaho, Case Nos. 1:12-cv-00560-BLW (Lead Case) and 1:13-cv-00116-BLW, the Honorable B. Lynn Winmill, Presiding

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rules of Appellate Procedure 26.1 and 28(a)(1) and Circuit Rule 28-1, Defendants-Appellants St. Luke's Health System, Ltd., St. Luke's Regional Medical Center, Ltd., and Saltzer Medical Group, P.A. make the following disclosure:

St. Luke's Regional Medical Center, Ltd. is an Idaho nonprofit corporation, wholly owned by St. Luke's Health System, Ltd., an Idaho nonprofit corporation. St. Luke's Health System, Ltd. has no parent corporation. No publicly held corporation owns 10% or more of the stock in St. Luke's Regional Medical Center, Ltd. or St. Luke's Health System, Ltd.

Saltzer Medical Group, P.A. does not have a parent corporation, and no publicly held corporation owns 10% or more of its stock.

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JURISDICTIONAL STATEMENT

1. Plaintiffs Saint Alphonsus Medical Center, Nampa, Inc. and related entities ("Saint Alphonsus"), and Treasure Valley Hospital Limited Partnership ("TVH") (collectively, "private plaintiffs") sought an injunction against St. Luke's Health System, Ltd. and St. Luke's Regional Medical Center, Ltd. (collectively, "St. Luke's") under 15 U.S.C. §§ 1, 18, and Idaho Code Ann. §§ 48-104, 48-106, barring St. Luke's from affiliating with Saltzer Medical Group, P.A. ("Saltzer"). The district court had subject matter jurisdiction under 28 U.S.C. §§ 1331, 1337(a), and 1367.

Subsequently, plaintiffs Federal Trade Commission ("FTC") and State of Idaho (collectively, "government plaintiffs") sued St. Luke's and Saltzer under 15 U.S.C. § 18 and Idaho Code Ann. § 48-106. The district court had subject matter jurisdiction under 28 U.S.C. §§ 1331, 1337, 1345, and 1367. The two suits were consolidated. ER.130-131.[1]

2. Following a bench trial, the district court entered Findings of Fact and Conclusions of Law, ER.10-61, and final judgment, ER.1-2. This Court has jurisdiction under 28. U.S.C. § 1291.

[1] Citations to "ER." refer to defendants' Excerpts of Record.

3. The district court entered judgment on February 28, 2014. ER.2. Defendants filed a timely notice of appeal on March 4. ER.62-65; Fed. R. App. P. 4(a)(1)(B).

STATEMENT OF THE ISSUES

1. Did the court err in concluding that the government plaintiffs made a prima facie case that the challenged transaction was likely to cause substantial anticompetitive effects in a properly defined market where:

a. the court viewed the town of Nampa as the relevant geographic market even though the court did not consider whether Nampa residents had sufficient practicable alternatives outside of Nampa to defeat any anticompetitive price increase; and

b. the record contains no evidence of a likely anticompetitive price increase in the relevant market or any reasonable basis for predicting such an increase.

2. Did the court err in dismissing the substantial procompetitive benefits that it found would result from the transaction on the ground that the benefits were not "merger-specific" where:

a. the court failed to identify any means less restrictive of competition through which these same procompetitive benefits could be obtained; and

b. the court improperly placed the burden on defendants to prove that these benefits could not have been achieved in a manner less restrictive of competition.

3. Did the court abuse its discretion in requiring divestiture rather than imposing a conduct remedy where the court failed to consider that:

a. divestiture would likely not promote competition; and

b. divestiture would cause patients to lose the significant benefits of the transaction.

PERTINENT STATUTES

15 U.S.C. § 18 and Idaho Code Ann. § 48-106 are reproduced in the attached Addendum.

STATEMENT OF THE CASE

This appeal will determine whether the antitrust laws prevent integrated health systems in mid-size markets from financially affiliating with physician groups in order to improve the quality of healthcare and to move to a value-based rather than volume-based system of payment for services—in accord with federal policy as reflected in the Affordable Care Act. The appeal arises out of the affiliation between St. Luke's, an integrated healthcare delivery system centered in Boise, and Saltzer, an independent group of predominantly primary care physicians ("PCPs") in Nampa, a town of fewer than 85,000 residents in Canyon County,

Idaho, approximately 20 miles from Boise on Interstate 84. As the district court found, St. Luke's and Saltzer affiliated in order to improve the quality of healthcare in southern Idaho. They sought to promote the Triple Aim—better health, better care, and lower cost—by working together to provide integrated, value-based healthcare instead of the fragmented, fee-for-service care that is common in this country.

Before the affiliation, St. Luke's employed eight PCPs who treated adults in Nampa, and Saltzer employed sixteen. Despite Nampa's small size and proximity to Boise, the government plaintiffs contended that adult PCP services in Nampa constituted the relevant market for purposes of antitrust analysis, and that the fact that the affiliated entity would provide 80% of adult PCP services in Nampa rendered the transaction presumptively unlawful. They alleged that, by employing twenty-four adult PCPs in Nampa, St. Luke's would gain sufficient bargaining leverage to obtain supracompetitive payment rates from commercial third-party payers.

The district court ruled the transaction unlawful. Despite its finding that the affiliation would permit Saltzer and St. Luke's to offer a new and superior form of healthcare, the court ordered divestiture of Saltzer because, in its view, integrated care and the transition to value-based medicine could be achieved equally well by

other, unspecified means. The court declined to consider alternate remedies that would preserve the transaction's benefits for patients and the public.

I. Factual Background

A. The Parties

The government plaintiffs are the FTC and the State of Idaho. The private plaintiffs are Saint Alphonsus and TVH. Saint Alphonsus operates hospitals, outpatient clinics, and other healthcare facilities in the Treasure Valley of Idaho (the area roughly bounded by Ada and Canyon Counties, which include Boise and Nampa, respectively) and eastern Oregon. It owns the only hospital in Nampa. ER.13 ¶¶1-3. TVH is a physician-owned, for-profit hospital in Boise. *Id.* ¶8. Both private plaintiffs compete with St. Luke's.

St. Luke's is an integrated health system that operates hospitals in southern Idaho and eastern Oregon and employs or has entered into professional services agreements ("PSAs")[2] with some 500 physicians. ER.15 ¶12. St. Luke's did not employ any adult PCPs in Nampa until the fall of 2011. *Id.* ¶15. At that time, seven physicians affiliated with the Mercy Physicians Group joined St. Luke's after their previous employer, Saint Alphonsus, required a restrictive covenant in

[2] Physicians working under a PSA work exclusively on behalf of St. Luke's and are compensated by St. Luke's at the group level. St. Luke's is reimbursed by payers for the care they provide. For purposes of the antitrust analysis in this case, "a PSA arrangement creates a relationship functionally equivalent to employment." ER.15 n.1. Thus, defendants will, like the district court, refer here to PSA-based relationships and employment interchangeably. *Id.*

their employment agreements. *Id.* ¶16. St. Luke's later recruited one additional PCP, for a total of eight adult PCPs practicing in Nampa. ER.15-16 ¶¶14, 17.

In December 2012, St. Luke's and Saltzer entered into an affiliation through which St. Luke's acquired Saltzer's assets and the Saltzer physicians entered into a PSA with St. Luke's. ER.18 ¶¶31-32. Prior to the transaction, Saltzer was an independent group of forty-one physicians. ER.16 ¶18. Nineteen were adult PCPs, and another ten were pediatric PCPs. *Id.* ¶19. Thirty-four of the Saltzer physicians, including sixteen of the adult PCPs, practiced in Nampa. *Id.* When the affiliation was announced, seven surgeons—the physicians who brought in the most revenue at Saltzer—chose to leave the practice and did not join St. Luke's. ER.57 ¶¶55-56.

B. The Changing Healthcare Landscape

1. The Movement Toward Greater Integration

Our country is striving to control the rising costs of healthcare while reducing the incidence and severity of disease and improving quality of care for patients. It is widely recognized—and undisputed in this case—that the cost and quality of healthcare in the U.S. suffer because the system is dominated by fragmented care that is compensated on a fee-for-service basis. ER.38 ¶151; ER.39 ¶161. Each physician is typically paid based on the volume of care provided—not on the quality or value of that care, or on the successful

coordination of care with other healthcare providers. ER.40 ¶¶163-65. Likewise, health systems are most commonly reimbursed based on the volume of services the system provides.

With fragmented, fee-for-service care, "there is no reward for teamwork or enhancing the value of care for patients. If a botched hip replacement must be redone, both surgeries will be paid for under the [fee-for-service] system, providing no incentive to get it right the first time." *Id.* ¶165. Nor is there incentive to take on the enormous upfront costs of information technology infrastructure that increases the value of care—by, for example, facilitating teamwork among providers and enabling the collection and analysis of evidence to identify what forms of care are most effective. *See* ER.16-17 ¶¶23-24; ER.44 ¶191; ER.472, Tr.2588:22-2590:1 (A. Enthoven).

Consequently, as the court found:

> Among the experts, there is a rough consensus on a solution to the cost and quality concerns nationwide. They advocate moving away from our present fee-for-service health insurance reimbursement system that rewards providers, not for keeping their patients healthy, but for billing high volumes of expensive medical procedures. A far better system would focus on maintaining a patient's health and quality of life, rewarding successful patient outcomes and innovation, and encouraging less expensive means of providing critical medical care. Such a system would move the focus of health care back to the patient, where it belongs.

> In fact, there is a broad if slow movement to such a system. It will require a major shift away from our fragmented delivery system and toward a more integrated system….

ER.11.

Integrated, value-based care has several features. Foremost is alignment of incentives between providers and patients. For physicians, compensation based on value of care, rather than volume, incentivizes care that offers the greatest benefit at the lowest cost—including preventive care, education, and outreach that avoid the need for more costly interventions down the road. ER.41 ¶¶173-74. For health systems, aligned incentives mean that the health system accepts risk and accountability for patient care. This is most fully accomplished through a set "per patient per month" payment for all care, rather than payment for each service rendered, such that the system shares in the savings if patients' health is maintained at lower cost. ER.41-42 ¶¶172, 176-77. This type of arrangement is referred to as "value-based" care, "risk-based" care, or "capitation."

Integrated, value-based care likewise depends on sharing information, generally using an electronic health record through which physicians can coordinate care to reduce waste and can follow best practices. ER.43-44 ¶¶186-90. Integrated care also involves a culture of teamwork and shared responsibility: With aligned incentives, providers have no need to "hoard" patients in order to obtain fee-for-service compensation. Instead, a patient's care can be overseen by the

best-informed and lowest-cost provider—typically a PCP—with specialist physicians acting as consultants. ER.41 ¶¶170-71. And it both makes possible and incentivizes the use of information technology to gather and analyze evidence of what care provides the highest value, and then make that the systemwide standard of care.

As the district court explained, integrated, value-based care

> promotes innovation. For example, when the Duke Medical School identified an improved procedure for treating coronary bypass patients that resulted in lower cost and better results for patients, reimbursement based on a capitation system would ensure that the innovation increased the School's revenue while reimbursement based on [a fee-for-service] system would have the opposite effect (because the volume of services declined).

ER.42 ¶176; *see also* ER.41 ¶169 (noting that "'examples of fully-integrated delivery systems that exist today demonstrate that financial accountability for a population's health is a very effective motivator of innovative practices in prevention, chronic disease management and care for seriously ill patients'").

With incentives aligned toward value of care rather than volume of services, systems providing integrated care are compensated for successful efforts to promote the health of the overall population. Indeed, Congress in the Affordable Care Act has encouraged expanding the availability of shared-risk, integrated care by establishing accountable care organizations, which are "groups of providers of

services … [who] work together to manage and coordinate care" for Medicare beneficiaries, who are "accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to" them, and who "promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care." 42 U.S.C. § 1395jjj.

2. Healthcare in Idaho's Treasure Valley

Healthcare in Idaho's Treasure Valley has been marked by fragmentation and fee-for-service compensation. In past years, independent physician groups there sought to form loose collaborations—short of employing physicians—in attempts to better coordinate care. For instance, Saltzer previously sought to achieve more integrated care through loose collaboration with both the Mercy Medical Center (the former name of Saint Alphonsus–Nampa) and St. Luke's. But in each instance, the collaboration "did not get 'a whole lot of things accomplished,' and what limited success was achieved often took years to develop." ER.18 ¶29 (citation omitted); *see also* ER.17 ¶¶25-28. Undisputed evidence from other previously independent physician groups showed a similar lack of results from efforts short of direct affiliation. ER.429, Tr.1902:13-24, 1904:21-1905:16 (J. Kee); ER.443, 438, Tr.2109:18-23, 2049:12-21 (J. Souza).

St. Luke's has been working to bring integrated care to the Treasure Valley. As the district court found, "St. Luke's saw this major shift [toward integrated

care] coming some time ago. And they are to be complimented on their foresight and vision. They started purchasing independent physician groups to assemble a team committed to practicing integrated medicine in a system where compensation depended on patient outcomes." ER.11. St. Luke's began working to expand its capabilities—aiming to gain both the scale and breadth of service capacity necessary to become a fully integrated, fully capitated health system—by affiliating with various independent physicians who shared St. Luke's goals.

In addition to these efforts, St. Luke's has invested tens of millions of dollars—with much more committed—in technological infrastructure to support its efforts to provide integrated care. It has implemented Epic, an electronic health record that tracks a patient's history; that allows multiple providers to communicate and seamlessly coordinate the patient's care; and that allows patients to be more involved in their own care. ER.43-46 ¶¶186-98. St. Luke's has also invested some $15 million in developing its WhiteCloud data analytics tools. These tools use the data in St. Luke's Epic system to track the types of care St. Luke's physicians are providing, and to examine patient outcomes to determine which practices constitute the highest-value care. The WhiteCloud tools "put [the data] into a format that's actually usable for a physician to begin to modify behavior based on continuous feedback loops and actually seeing the results of

their work." ER.435, Tr.1939:22-1940:13 (J. Kee); ER.446, Tr.2134:4-11 (B. Fortuin).

St. Luke's has also begun the paradigm shift from fee-for-service compensation to value-based care. With the benefit of system-wide data regarding physician practices and patient outcomes, St. Luke's has undertaken to move its physicians to value-based compensation. *E.g.,* ER.432, Tr.1923:16-22 (J. Kee). St. Luke's is also working to have *its* reimbursement from payers become increasingly risk-based rather than volume-based. While St. Luke's has accepted risk in connection with Medicare products, *see, e.g.*, ER.379, Tr.398:11-399:9 (J. Crouch), risk-based contracts remain the exception for commercially insured patients. Thus, St. Luke's has worked to expand the availability of risk-based arrangements with commercial payers by partnering with Utah-based insurer SelectHealth, a subsidiary of Intermountain Healthcare, to bring a new, risk-based insurance product into the Idaho market. ER.476, Tr.2632:7-9 (A. Enthoven); ER.551, Tr.105:24-106:1(S. Drake Dep.); ER.420, Tr.1725:10-18; ER.423, Tr.1747:12-21 (P. Richards).

C. The Saltzer Transaction

1. Reasons for the Transaction

Like St. Luke's, Saltzer sought to participate in the transition to value-based, integrated care. For years before the affiliation, Saltzer recognized that

fragmented, fee-for-service care was not sustainable and that it would need to transition to an integrated, value-based model. However, it could not do so on its own. ER.16-17, 20 ¶¶22-23, 44. It recognized that it would need to upgrade its technological infrastructure to support such a model, but it could not afford to do that either. ER.17 ¶24. And its attempts at loose collaborations with larger systems had failed. ER.17-18 ¶¶25-29.

Accordingly, in 2009, Saltzer approached St. Luke's. ER.18 ¶30. As the district court found, "Saltzer's primary motivation for affiliating with St. Luke's was to provide the best possible health care to the community." ER.20 ¶41. Saltzer believed that affiliating with St. Luke's would allow it to provide value-based care (*i.e.*, capitation)—which it could not do on its own or through a looser collaboration. *Id.* ¶¶44-45. Moreover, an affiliation would bring St. Luke's greater resources to the population of Canyon County, allowing Saltzer to "increase access to medical care for the significant population of Medicaid and Medicare patients in Canyon County by enabling Saltzer to move away from providing fee-for-service care as an independent group, which required many Saltzer physicians to manage their patient populations to limit the number of Medicaid or uninsured patients they could accept." ER.20-21 ¶46. Saltzer further recognized that becoming tightly aligned would allow Saltzer physicians to share St. Luke's state-of-the-art information technology and work closely with specialists so that Saltzer doctors

could be "'involved in all aspects of care rather than being fragmented as part of an outside system that works in concert with the health system but not integrated with the health system.'" ER.20 ¶43.

St. Luke's saw an affiliation with Saltzer as a critical step toward its goal of transforming into an integrated system with the capacity to take on full risk for patient care. Prior to the transaction, St. Luke's had few employed physicians in Canyon County—no more than eight adult PCPs in Nampa—even though approximately 22 percent of its patients were traveling from Canyon County for care. ER.480, Tr.2766:19-2767:7 (A. Oppenheimer). Yet, to extend integrated care into Canyon County, St. Luke's concluded that it needed adequate coverage of physicians, and in particular, a nucleus of employed PCPs fully committed to integrated care. ER.529, 531, Tr.69:19-71:9, 113:25-114:25, 116:3-24 (G. Swanson Dep.). As the district court found, "[t]he Acquisition is an attempt by St. Luke's and Saltzer to improve the quality of medical care." ER.59 ¶71.

2. Terms of the Transaction

Effective December 31, 2012, St. Luke's affiliated with Saltzer. Under the parties' agreement, Saltzer agreed to operate the Saltzer clinic as an outpatient department of St. Luke's for an initial term of five years, *see* ER.18 ¶32; ER.561, 565-67 (Ex. 24) §§ 1.1(a), 3.1, and St. Luke's agreed to provide all nonphysician staff, equipment, and billing and administrative services, ER.567-69 (Ex. 24)

§§ 3.2, 3.3, 4.1. St. Luke's would be reimbursed for Saltzer's services under contracts that St. Luke's had entered into with payers. *See, e.g.*, ER.560 (Ex. 24).

3. Benefits of the Transaction

The affiliation has already begun to produce improvements in the care that Saltzer physicians have been able to provide to their patients. As a result of this litigation, Saltzer has not yet been brought onto the St. Luke's Epic system. However, Saltzer has begun contributing data to, and using data from, the WhiteCloud analytics tools—and that has already changed the Saltzer physicians' approach to care. ER.512-13, Tr.3359:1-3360:14 (T. Patterson); ER.465, Tr.2393:6-13 (J. Kaiser). For example, Dr. Thomas Patterson, a Saltzer pediatrician, explained that use of WhiteCloud had enabled him to improve his quality of care for diabetic patients because he could see, for the first time, which patients would benefit from further care. ER.513, Tr.3360:1-14 (T. Patterson). Saltzer physicians testified that they could not have afforded, and would not have obtained, access to WhiteCloud if the transaction had not occurred. ER.463, 467, Tr.2383:23-2384:10, 2399:24-2400:9 (J. Kaiser); *see also* ER.449, 452-53, Tr.2157:11-21, 2183:7-2184:11 (B. Fortuin).

Additionally, Saltzer has been able to take on all Medicaid, uninsured, and other low-pay (or no-pay) patients—efforts that Saltzer could not manage on its own. *See* ER.506, 508, 510, Tr.3312:22-3313:4, 3320:3-3321:2, 3329:9-3330:5

(T. Patterson); ER.502, Tr.3082:22-25 (W. Savage). Saltzer physicians no longer consider patients' insurance status when determining whether to accept a patient. ER.508, Tr.3321: 22-3323-25 (T. Patterson); *see also* ER.536, Tr.81:15-82:4 (M. Djernes Dep.); ER.467, Tr.2398:8-17 (J. Kaiser); ER.512, Tr.3358:11-25 (H. Kunz). In addition, Saltzer has been able to expand its community outreach efforts (with, for example, a diabetes education and management program) and thereby help to keep people well—an important development as St. Luke's transitions to value-based delivery of care. ER.508, Tr.3320:6-21, 3321:9-21 (T Patterson); ER.465, Tr.2392:8-21, 2393:14-24 (J. Kaiser).

II. This Litigation

A. The Claims

1. Government Plaintiffs' Claims

The government plaintiffs advanced a single theory: that the Saltzer transaction was a horizontal merger that would enable St. Luke's to exercise market power by raising prices above competitive levels. *E.g.*, ER.133 ¶1. They alleged that the relevant market was adult PCP services in the town of Nampa. ER.21-25 ¶¶48-73. The sole focus of the government plaintiffs' theory was the horizontal overlap between the sixteen Saltzer adult PCPs who practice in Nampa and the eight Nampa-based PCPs who had previously joined St. Luke's. ER.356, Tr.12:12-14 (FTC Opening Statement); ER.455, Tr.2194:10-23, 2195:8-20 (A. Crownson); ER.460, Tr.2310:2-4 (C. Roth). In effect, it is because—and only

because—St. Luke's previously employed eight PCPs in Nampa that the government plaintiffs contend the affiliation with Saltzer is unlawful.

2. Private Plaintiffs' Claims

The private plaintiffs early on acknowledged that, as St. Luke's competitors, they have no standing to challenge the Saltzer transaction on the ground that it will raise prices. *See* ER.69. Instead, they advanced a theory that the transaction would harm *them* so severely that it would ultimately harm *competition*. *See, e.g.*, ER.211 ¶2(c). They asserted that, by "controlling" a substantial number of adult PCPs in Nampa, St. Luke's would have the ability to cut off referrals from those PCPs. The court did not accept the private plaintiffs' claims; its ruling was predicated solely on the government plaintiffs' claim that the transaction would permit defendants to impose higher prices. ER.59 ¶¶64-65; ER.60 ¶¶72-74.

B. The District Court's Judgment

The district court ruled that St. Luke's affiliation with Saltzer violates Section 7 of the Clayton Act, 15 U.S.C. § 18, and the Idaho Competition Act, Idaho Code Ann. § 48-106. It ordered St. Luke's to divest itself of Saltzer's physicians and assets. ER.1. In the court's view, the "particular structure of the Acquisition—creating such a huge market share for the combined entity—creates a substantial risk of anticompetitive price increases." ER.60 ¶72.

1. Market Definition

The district court correctly noted that "[w]ith regard to the FTC action, there is no dispute that the relevant product market is Adult Primary Care Services sold to commercially insured patients." ER.21 ¶48. Accordingly, the court treated that as the relevant product market.[3]

As for geographic market, the court held that the government plaintiffs had proven that Nampa was the relevant market. The court noted that "68% of Nampa residents get their primary care from providers who are located in Nampa." ER.24 ¶65. The court then cited testimony from commercial insurer Blue Cross of Idaho ("Blue Cross") as well as the government plaintiffs' expert, Dr. Dranove, that "commercial health plans need to include Nampa PCPs in their networks to offer a competitive product." ER.23-24 ¶¶61, 69. Thus, in the court's view, "[g]iven this dynamic—that health plans must offer Nampa Adult PCP services to Nampa residents to effectively compete—Nampa PCPs could band together and successfully demand a 5 to 10% price increase (or reimbursement increase) from health plans." ER.25 ¶71.

The court did not address defendants' evidence that consumers could and would obtain PCP services outside of Nampa in the event of anticompetitive price

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[3] The court declined to reach other product markets that only the private plaintiffs had alleged. ER.59 ¶¶ 64-65.

increases—including undisputed evidence of a natural experiment that occurred when Micron, a major regional employer, put in place a tiered network structure that caused its employees to pay more to see Saltzer and St. Luke's PCPs. That development resulted in substantial numbers of Micron employees obtaining PCP services from providers outside of Nampa. *See infra*, p. 31-33.

2. Likely Anticompetitive Effects

Having accepted adult PCP services in Nampa as the relevant market, the district court observed that "St. Luke's and Saltzer account for nearly 80 percent of PCP services in Nampa." ER.26 ¶80. In light of this supposed market share, the court recited, "the Nampa market has a post-merger HHI of 6,219 and an increase in HHI of 1,607, both of which are well above the thresholds for a presumptively anticompetitive merger." *Id.* ¶81. The court said nothing more about price increases or other anticompetitive effects in the Nampa market for adult PCP services.

The court instead pointed to supposed evidence of anticompetitive effects outside of the defined market. Thus, the court concluded that "[i]t is likely that St[.] Luke's will exercise its enhanced bargaining leverage from the Acquisition to charge more [ancillary] services"—including "laboratory and diagnostic imaging, as well as therapy services and specialized facility services for colonoscopies and minor outpatient surgeries"— at higher rates than the Saltzer physicians had when

performing such services in their own offices. ER.32-33 ¶¶121, 124. After the Acquisition, the court concluded, Saltzer PCPs would refer patients to St. Luke's facilities for such ancillary services, and St. Luke's would exercise its leverage to bill for those services at higher "'hospital-based' rates." ER.33, 36 ¶¶125, 140. In this way, "[b]y increasing St. Luke's relative leverage, the Acquisition will likely lead to higher reimbursements from health plans." ER.34 ¶130.

3. Likely Procompetitive Benefits

As the court recognized, St. Luke's presented extensive evidence of procompetitive benefits that would result from the transaction. ER.37 ¶147. These included clinical integration of care, the ability of Saltzer physicians to treat all patients regardless of ability to pay, an increase in community outreach programs designed to keep the population healthy, and facilitation of a transition from fee-for-service to value-based care. The plaintiffs raised two principal challenges to St. Luke's showing: (1) the benefits from the transaction were speculative, and (2) any benefits that the transaction did produce could be achieved by other, less restrictive means.

The district court rejected the plaintiffs' first argument. As the court explained, "[t]he Acquisition was intended by St. Luke's and Saltzer primarily to improve patient outcomes. *The Court believes that it would have that effect if left*

intact." ER.12 (emphasis added). Indeed, the court stated that, but for the Clayton Act, "the best result might be to approve the Acquisition." ER.60 ¶76.

Nevertheless, the court found that St. Luke's had not "carried its burden of showing convincing proof of significant and merger-specific efficiencies arising as a result of the Acquisition." ER.56 ¶49. Specifically, although "St. Luke's believed that the best way to create the unified and committed team of physicians required to practice integrated medicine was to employ them," ER.56 ¶¶44-45, and although Saltzer's prior "attempts to coordinate care with other health systems under less-formal affiliations" had failed, ER.17 ¶25, the court disagreed with defendants' judgment. As the court explained, "physicians are committed to improving the quality of health care, and lowering its cost, whether they are employed or independent." ER.42 ¶180.

Because it concluded that the transaction's benefits could be achieved by other, less restrictive means, the court held that none of the transaction's benefits were "merger-specific." It therefore did not assess whether the transaction's procompetitive benefits outweighed its potential anticompetitive effects.

4. Remedy

The court asserted that divestiture is the presumptive remedy when the FTC has proven a violation of the Clayton Act. ER.56 ¶¶50-51. It therefore did not address the fact that divestiture would deprive consumers of the benefits of the

transaction, and it did not consider alternative remedies. Further, although it recognized that the departure of the seven surgeons would weaken a divested Saltzer's ability to compete effectively, the court declined to consider "Saltzer's weakness" in identifying the best remedy because, in its view, the loss of the seven surgeons was caused by the transaction. ER.57 ¶¶55-57.

SUMMARY OF ARGUMENT

The district court found that the transaction was designed to, and would, promote the goal of integrated healthcare. As the court put it, "[t]he Acquisition was intended by St. Luke's and Saltzer primarily to improve patient outcomes." ER.12. Moreover, the court concluded, the transaction was structured so as to maximize consumer benefits: "St. Luke's believed that the best way to create the unified and committed team of physicians required to practice integrated medicine was to employ [the Saltzer physicians]. St. Luke's followed this strategy to improve the quality of medical care." ER.56 ¶¶44-45. And the court stated that it believed the transaction "would have that effect if left intact." ER.12.

Thus, this case is not about two manufacturers engaging in a strictly horizontal merger and claiming efficiencies from the ability to consolidate their production facilities. *Compare, e.g.*, *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 721 (2001). Instead, this is a predominantly vertical affiliation between a regional health system and a group of physicians. It is, as the district court expressly found,

part of a broader mission to move healthcare in southern Idaho toward integrated care, and, if allowed to go forward, is likely to be a *successful* part of that mission.

Nonetheless, the court held the transaction unlawful based in part on its finding that adult PCP services in Nampa is the relevant market. The court failed, however, to assess whether Nampa consumers would have practicable alternative sources for adult PCP services in the event that Nampa PCPs raised prices above competitive levels, a particularly relevant inquiry since nearly one-third of Nampa residents already see adult PCPs elsewhere. It ignored evidence of a natural experiment in which Micron adopted a tiered network plan that caused Saltzer and St. Luke's PCPs to be marginally more expensive than providers outside of Nampa—and that resulted in Nampa consumers obtaining care outside that purported "market."

Notably, although the court found the relevant market to be the supposed Nampa market for adult PCP services, it did not find any evidence of anticompetitive price increases in that market. Rather, its finding of likely anticompetitive effects focused on supposed increased prices for *ancillary services*—not adult PCP services. Yet the court never assessed whether there exists a Nampa market for ancillary services, much less whether defendants have market power in any such market.

Having found a likelihood of anticompetitive effects, the court was then required to assess whether those effects were outweighed by the procompetitive effects that it acknowledged the transaction would produce. But the court did not do so. Instead, it simply dismissed the transaction's procompetitive effects, because it deemed them not "merger-specific." In particular, although it believed that procompetitive benefits would result directly from the transaction, it concluded that St. Luke's did not carry its "burden" to prove the absence of less restrictive alternatives—*i.e.*, the absence of means through which the same procompetitive benefits could be achieved with less market concentration.

In so ruling, the district court erred in two fundamental ways. First, it applied an incorrect definition of "merger-specific." It concluded that the mere possibility of achieving some form of integration someday by other means was enough to render the benefits not "merger-specific," without regard to the existence of any means available to the Saltzer physicians. And second, it imposed on defendants the burden of proving the *absence* of any such less restrictive alternatives—rather than requiring plaintiffs to prove both the existence and likely effectiveness of such alternatives.

Finally, the court ordered divestiture on grounds that divestiture is the presumptively appropriate remedy. However, it failed to consider the reasons why any such presumption is overcome here: First, the goal of divestiture—*i.e.*

reinjecting competition into the market—will not be served. Second, divestiture is inappropriate where the challenged transaction has significant procompetitive benefits that could be preserved through a less drastic remedy.

This Court has held that courts should "exercise extreme caution" before dissolving transactions that might promote consumer welfare—lest they achieve the opposite of the pro-consumer goals of the antitrust laws. *United States v. Syufy Enters.*, 903 F.2d 659, 663 (9th Cir. 1990). This case demonstrates the wisdom of the Court's admonition.

STANDARD OF REVIEW

This Court "review[s] the district court's conclusions of law following a bench trial *de novo* and its findings of fact for clear error." *Navajo Nation v. U.S. Forest Serv.*, 535 F.3d 1058, 1067 (9th Cir. 2008) (en banc). Federal Rule of Civil Procedure 52(a) "does not inhibit an appellate court's power to correct … a finding of fact that is predicated on a misunderstanding of the governing rule of law." *Thornburg v. Gingles*, 478 U.S. 30, 79 (1986) (internal quotation marks and citation omitted). "The district court's choice of remedies is reviewed for an abuse of discretion." *United States v. Alisal Water Corp.*, 431 F.3d 643, 654 (9th Cir. 2005).

ARGUMENT

To prevail under § 7 of the Clayton Act, a plaintiff must prove that the challenged transaction is likely, on balance, to cause substantial anticompetitive effects in a properly defined market.[4] *United States v. Penn-Olin Chem. Co.*, 378 U.S. 158, 171 (1964). Although § 7 is designed to "curb[] in their incipiency" anticompetitive trends, *Brown Shoe Co. v. United States*, 370 U.S. 294, 346 (1962), the statute deals with "probabilities" and not "ephemeral possibilities" of anticompetitive effects. *Id.* at 323; *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 982-83 (D.C. Cir. 1990).

If a plaintiff establishes a *prima facie* case that the challenged transaction is likely to result in anticompetitive effects, the burden shifts to defendants to rebut the presumption of illegality. *Baker Hughes*, 908 F.2d at 982-83. "[E]vidence on a variety of factors can rebut a prima facie case," *id.* at 984, including as relevant here, evidence that the transaction will lead to "integrated delivery" of care and, ultimately, "better medical care." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999); *Blue Cross v. Marshfield Clinic*, 65 F.3d 1406, 1412 (7th Cir. 1995). If defendants successfully rebut the *prima facie* case, the burden returns to the plaintiff to further prove anticompetitive effects. *Baker Hughes*, 908 F.2d at

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[4] The analysis is the same under federal and state law. *See* Idaho Code Ann. § 48-102.

983. Significantly, the burden of persuasion always remains on the plaintiff. *E.g.*, *United States v. Citizens & S. Nat'l Bank*, 422 U.S. 86, 120 (1975).

The court ultimately applies a "totality-of-the-circumstances" test and weighs all relevant factors to determine the transaction's overall effect on competition. *Baker Hughes*, 908 F.2d at 984. The court here relied on the concentration-focused analysis utilized in *United States v. Philadelphia National Bank*, 374 U.S. 321, 367 (1963), in determining that the government plaintiffs had established a prima facie case of anticompetitive harm. ER.51 ¶16; ER.53 ¶¶24-25; ER.60 ¶¶72-74. But subsequent decisions have questioned a narrow focus on market concentration, opining instead that "[e]vidence of market concentration simply provides a convenient *starting point* for a broader inquiry into future competitiveness." *Baker Hughes*, 908 F.2d at 984 (emphasis added), *id.* at 990 (*Philadelphia National Bank* has been "cut … back sharply" by later case law). As the Supreme Court has said, market concentration statistics alone are insufficient to win a case. *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 498 (1974). This is particularly so where, as here, a transaction involves significant procompetitive benefits.

I. THE COURT ERRED IN ASSESSING THE LIKELIHOOD OF ANTICOMPETITIVE EFFECTS.

A. The Plaintiffs Failed to Prove That Nampa Is a Relevant Geographic Market.

The threshold requirement for proving a § 7 claim is properly defining the relevant market. This is solely plaintiffs' burden. *United States v. Conn. Nat'l Bank*, 418 U.S. 656, 669 (1974); *R.C. Dick Geothermal Corp. v. Thermogenics, Inc.,* 890 F.2d 139, 143 (9th Cir. 1989). "Without a definition of the relevant market, it is impossible to determine market share." *Rebel Oil Co., Inc. v. Atl. Richfield Co.*, 51 F.3d 1421, 1434 (9th Cir. 1995). Failure to define the relevant market correctly is "fatal" to plaintiffs' claim. *Tenet*, 186 F.3d at 1053.

The district court concluded that the relevant market is adult PCP services in Nampa. ER.53 ¶23. It was undisputed that adult PCP services are a relevant *product* market. The parties disputed, however, whether Nampa is an appropriate *geographic* market.

"A geographic market is an area of effective competition where buyers can turn for alternate sources of supply." *Morgan, Strand, Wheeler & Biggs v. Radiology, Ltd.*, 924 F.2d 1484, 1490 (9th Cir. 1991) (citation, internal quotation marks, and ellipses omitted). The key question in determining the limits of the geographic market is whether a monopolist in the alleged market could profitably impose supracompetitive prices. Thus, if consumers can turn to alternate sources

of supply and defeat a supracompetitive price by causing the monopolist to experience a net loss of revenue, the alleged market is defined too narrowly. *See Rebel Oil*, 51 F.3d at 1434.

The district court held that plaintiffs proved that Nampa was a properly defined geographic market based on the following reasoning: The proper test "evaluates whether all the sellers in the proposed candidate market would be able to impose a small but significant, non-transitory increase in price (SSNIP), which is generally 5 to 10 percent, and still make a profit." ER.22 ¶53. However, healthcare consumers are not "direct purchasers" of PCP services; instead, consumers purchase health insurance, and insurers negotiate directly with PCPs. *Id.* ¶¶54-55. Accordingly, the district court said, the test "examines the likely response of insurers to a hypothetical demand by all the PCPs in a particular market for a significant non-transitory reimbursement rate hike." *Id.* ¶56.

To address that issue, the court focused on two facts. First, 68% of Nampa residents currently obtain primary care from providers located in Nampa. ER.24 ¶¶64-65. Second, insurers—in particular, Blue Cross—consider it important to offer primary care services near *all* of their insureds' homes in order to provide competitive plans. *See* ER.23 ¶¶60-61. The court concluded, "[b]ecause Nampa patients strongly prefer access to local PCPs, commercial health plans need to include Nampa PCPs in their networks to offer a competitive product. … Given

this dynamic—that health plans must offer Nampa Adult PCP services to Nampa residents to effectively compete—Nampa PCPs could band together and successfully demand a 5 to 10% price increase (or reimbursement increase) from health plans." ER.24-25 ¶¶69, 71.

Putting aside momentarily the fact that nearly one-third of Nampa residents already see adult PCPs outside of Nampa without any anticompetitive price increase, the court's reasoning is flawed: It considers only where consumers *currently* obtain healthcare, and how insurers *currently* market insurance plans—not how consumers would respond in the event of a supracompetitive price increase. *See Theme Promotions, Inc. v. News Am. Marketing FSI*, 546 F.3d 991, 1002 (9th Cir. 2008) (explaining that SSNIP analysis asks whether "a significant number of customers would respond to a SSNIP by purchasing" from outside the alleged market); *Tenet*, 186 F.3d at 1054 (reversing district court analysis that relied on "testimony of … market participants [on] current competitor perceptions and consumer habits"). Simply put, the district court considered the wrong question. This was legal error.

The "critical question" in assessing the limits of a geographic market is "where consumers of [the relevant service] could practicably turn for alternative services should the merger be consummated and prices become anticompetitive. *This evidence must address where consumers could practicably go, not … where*

they actually go." *Tenet*, 186 F.3d at 1052 (citations omitted; emphasis added); *see also FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995). In other words, while most Nampa consumers choosing among competitively priced options might prefer to obtain care in Nampa and prefer insurance plans that offer PCP services in Nampa, those facts do not speak to whether Nampa consumers *could and would obtain care* elsewhere if confronted with supracompetitive prices. The district court's analysis is silent on that key question.

Focusing on the role of insurers, as the district court did, does not obviate the need to examine consumers' practicable alternatives. The district court concluded that insurers would simply accept a 5 to 10% price increase from Nampa PCPs based on testimony that insurers could not "effectively compete" without including Nampa-based PCPs in their plan. ER.25 ¶71. But that finding focuses on *current* insurer perceptions of *current* consumer preferences, and does not assess how consumers and insurers would *change* their practices and preferences in the event of supracompetitive pricing. The district court's analysis thus "gives a static, rather than a dynamic, picture" of the market for PCP services in southern Idaho, *Freeman*, 69 F.3d at 269—a picture that is inadequate to support the court's conclusion that Nampa is a properly defined geographic market.[5]

[5] The evidence here demonstrated multiple ways that consumers could cause supracompetitive pricing by Nampa PCPs to be unprofitable *even if the district court were right* that insurers would initially agree to a 5 to 10% price increase.

The district court's static analysis is particularly problematic because it fails to consider evidence of how Nampa consumers *actually* responded when faced with a price increase for PCP services. A natural experiment occurred when Micron, a major regional employer, in 2008 switched from the Blue Cross PPO plan—in which Saint Alphonsus, St. Luke's, and Saltzer PCPs were all fully participating providers—to a new "narrow network" plan that offered financial incentives for Micron employees to use certain preferred providers. ER.386-87, 392, Tr.557:18-558:2, 594:14-595:2 (P. Otte); ER.607 (Ex. 2001). Saltzer PCPs were out of network, so Micron plan members incurred higher co-payments to see them. ER.386-87, Tr.557:25-558:1, 558:10-11, 561:3-4 (P. Otte).

After these price incentives were implemented, there was a dramatic shift of Micron employees in Nampa from more expensive Saltzer PCPs to preferred PCPs, notwithstanding the relatively small difference in price between the two. ER.619, 645 (Exs. 2241, 2536); ER.396-97, Tr.at 602:16-604:1, 604:17-607:17 (P.

For one, if the price increase resulted in an increase in patients' out-of-pocket costs—if patients were, *e.g.*, required to pay percentage co-pays that increased with Nampa PCP prices—that would cause patients to switch to non-Nampa PCPs. ER.490, Tr.2924:5-9 (D. Argue). For another, insurers or employers could create tiered network plans, in which Nampa PCPs were included, but in which enrollees were incentivized to use less expensive providers. ER.490, Tr.2924:14-21 (D. Argue). As defendants' expert testified, Nampa PCPs would likely see revenues drop sufficiently through these and other mechanisms that a price increase would be unprofitable. ER.490, Tr.2924:5-21 (D. Argue); *see also Tenet*, 186 F.3d at 1054 ("large, sophisticated third-party buyers can [and] do resist price increases"). Yet the district court simply failed to address that testimony.

Otte). In the first year of the Micron plan, 90 percent of the members switched to lower-priced preferred providers. ER.391, 397, Tr.579:20-25, 607:9-17 (P. Otte). And, most importantly, Micron employees switched from providers *in* Nampa to lower-priced providers *outside* of Nampa. ER.546, Tr.80:16-25 (J. Butterbaugh Dep.); ER.513, Tr.3362:23-3363:9 (H. Kunz); ER.495, Tr.2948:16-25 (D. Argue); ER.671 (Ex. 2577). This is hardly surprising given that a substantial number of Nampa residents work outside of Nampa.

The undisputed evidence of what happened when Micron effectively imposed a SSNIP for Nampa PCP services demonstrates, far more clearly than any economist's prognostication, how Nampa consumers would respond to anticompetitive price increases from Nampa PCPs: They would seek care outside of Nampa. *See, e.g., In re Se. Milk Antitrust Litig.*, 739 F.3d 262, 281 (6th Cir. 2014) ("[T]he hypothetical monopolist construct requires speculation about a buyer's likely reaction to a supplier's price increase. Quite obviously, the estimate should be informed by actual evidence when possible ….") (internal citation omitted). That evidence alone is sufficient to defeat any conclusion that Nampa is a properly defined geographic market. The court's failure to mention, let alone

consider, this highly relevant evidence was clear error.[6] *See, e.g.*, *Fisher v. Tucson Unified Sch. Dist.*, 652 F.3d 1131, 1136 & n.7 (9th Cir. 2011).

Instead of examining evidence on practicable alternatives available to Nampa consumers, the court placed undue reliance on testimony regarding Blue Cross's perceptions of current competitive conditions. *See Bathke v. Casey's Gen. Stores, Inc.*, 64 F.3d 340, 346-47 (8th Cir. 1995) ("[T]he problem with the evidence the plaintiffs submitted to establish the relevant geographic market is that it looks at the issue only from the perspective of [defendant's] rivals, not from the perspective of the consumer.").

Significantly, Blue Cross—the same insurer that provided evidence that no health plan could compete unless it included Nampa PCPs—also provided

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[6] Plaintiffs' expert argued that Micron's experience can be distinguished on various factual grounds. He opined that the price increase incurred to see Saltzer PCPs was too big as a matter of percentage to "draw any conclusion from the Micron experience for the SSNIP analysis." ER.405, Tr.1355:25-1356:18 (D. Dranove). However, the percentage increase was, in real dollars, very small—$1 or $2 per PCP visit. *See* ER.498, Tr.2963:11-20 (D. Argue). He also opined that Micron's experience was uninformative because Micron faced unique pressures to reduce costs. ER.405, Tr.1357:7-25 (D. Dranove). But that says nothing about consumers' response to Micron's narrow network—and it is wrong. Micron maintained its narrow network even when it became more financially sound; moreover, other employers in the area followed Micron's example. ER.487, Tr.2908:13-16 (D. Argue); ER.554, 557-58, Tr.39:3-18, 63:19-64:6, 65:10-14 (G. Sonnenberg Dep.); ER.544, Tr.20:7-11(J. Butterbaugh Dep.); ER.401, Tr.1239:12-16 (B. Petersen). In any event, the court did not deem the Micron evidence distinguishable; it failed entirely to address Micron because it focused exclusively on current consumer and insurer practices.

testimony that Saltzer alone, before its affiliation with St. Luke's, was a "'must have provider for Blue Cross in Nampa.'" ER.27 ¶84. In particular, Jeff Crouch, Blue Cross's vice president of provider contracting, testified that, before the affiliation, Blue Cross could not successfully market a health plan that excluded Saltzer physicians. *Id.* Yet Mr. Crouch conceded that although "Blue Cross views Saltzer as a must-have provider, Blue Cross has successfully resisted all attempts by Saltzer to negotiate physician fee amounts above [Blue Cross's] statewide fee schedule." ER.366, Tr.331:11-333:8 (J. Crouch). Thus, Blue Cross's own testimony confirms that Blue Cross's subjective impression of particular providers' "must have" status does not, in reality, mean that those "must have" providers have power in a relevant market.[7] The court's over-reliance on Blue Cross's testimony was error.

Finally, the proposition that Nampa is a geographic market cannot be reconciled with the fact that nearly one-third of Nampa residents *already* get adult PCP services outside of Nampa, even in the absence of any supracompetitive pricing. *See* ER.24 ¶65. Given that 32% of Nampa residents choose to leave that town *without* any anticompetitive price increase, the court committed reversible error in concluding that Nampa residents have insufficient practicable alternatives

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[7] Indeed, Mr. Crouch explained that under his understanding of the term, "*every* payor and *every* provider has some level of market power." ER.365, Tr.325:11-12 (J. Crouch) (emphasis added).

outside of Nampa. *See Tenet*, 186 F.3d at 1053 ("In adopting the FTC's position, the district court improperly discounted the fact that over twenty-two percent of people in the most important zip codes already use hospitals outside the FTC's proposed market.").

B. The Plaintiffs Failed to Prove Market Power or Likely Anticompetitive Effects in the Relevant Product Market.

1. The Court Did Not Find a Likelihood of Anticompetitive Price Increases for Adult PCP Services.

The plaintiffs' strategy was to name both a narrow geographic market and a narrow product market: adult PCP services sold to commercially insured patients in Nampa.[8] ER.21 ¶¶48-49. The effect of defining the relevant market so narrowly was to portray the transaction as creating a very large market share and high HHI figures, even though the absolute numbers—combining St. Luke's eight Nampa-based adult PCPs with Saltzer's sixteen—were small. This portrayal of the transaction proved essentially dispositive for the district court. *See* ER.60 ¶72 (holding transaction unlawful in light of its "particular structure … —creating such a huge market share for the combined entity").

When it came to identifying likely effects on competition, however, plaintiffs' strategy, and the court's findings, underwent a dramatic shift. Plaintiffs did not prove, and the court did not find, any likelihood of anticompetitive effects

[8] Although the private plaintiffs alleged additional product markets, the court expressly made no finding as to those markets. ER.58-59 ¶¶ 63-65.

in the narrowly defined Nampa market for adult PCP services. As for that market, the court rested solely on market concentration statistics. *See* ER.25-26 ¶¶74-82. *But see Gen. Dynamics*, 415 U.S. at 498 ("statistics concerning market share and concentration, while of great significance, [are] not conclusive indicators of anticompetitive effects"); Phillip E. Areeda & Herbert Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* ("Areeda") ¶932a (mergers should never "be conclusively determined to be unlawful on the basis of concentration data alone").

In fact, the undisputed evidence, unmentioned by the district court, showed that there was no likelihood of anticompetitive effects in any Nampa adult PCP services market. Significantly, the two largest commercial insurers in Idaho, Blue Cross and Regence, use statewide physician fee schedules that unilaterally set forth amounts that those payers will pay for physician services.[9] *See* ER.366, Tr.331:11-

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[9] The court's only discussion of PCP services at all related to negotiations between St. Luke's and Blue Cross years earlier as to PCP services in a geographically separate area—Twin Falls, Idaho. ER.32 ¶¶ 117-20. Such evidence is irrelevant to assessing the likelihood of anticompetitive effects in the supposed Nampa market. *See Daw Indus. Inc. v. Hanger Orthopedic Grp., Inc.*, No. 11-56858, 2014 WL 689722, at *1 (9th Cir. Feb. 24, 2014) (unreported) (evidence from outside the market "tell[s] us nothing of the relevant market"). Moreover, as the district court failed to note, those negotiations merely caused PCP services in Twin Falls to be reimbursed at Blue Cross's statewide level, instead of below that level. Plaintiffs acknowledged that there was no evidence that bringing Twin Falls PCPs' reimbursement up to the statewide level was anticompetitive. *See* ER.409-10, Tr.1383:19-23, 1386:3-6 (D. Dranove).

332:2 (J. Crouch); ER.525, Tr.42:24-43:3, 44:19-22 (S. Clement Dep.). Despite being what Blue Cross described as a "must have" provider, *see* ER.28 ¶89, St. Luke's has never been able to negotiate higher fees for physician services—including, since the transaction, for the services of Saltzer PCPs. ER.526, Tr.46:16-24 (S. Clement Dep.); ER.366-67, 374, 382, Tr.331:11-332:2, 333:4-8, 377:11-14, 414:20-22 (J. Crouch).

2. The Court's Findings as to Price Increases for Ancillary Services Are Analytically and Factually Unsupported.

Instead of finding a likelihood of anticompetitive effects in the narrow market alleged by plaintiffs, the district court concluded that the transaction carried "a substantial risk that the combined entity will use its dominant market share (1) to negotiate higher reimbursements with health plans, and (2) charge more services at the higher hospital billing rates." ER.60 ¶74; *accord* ER.53 ¶25, ER.34, 36 ¶¶130, 144. What the court meant by this was that the combined entity "could increase commercial reimbursements by insisting that health plans pay higher 'hospital-based' rates for routine ancillary services, such as X-rays and laboratory tests, even when those services are performed in the same physical location as before the Acquisition." ER.33 ¶123. In other words, the alleged anticompetitive effects that the district court anticipated were not price increases in the relevant market, but price increases for *ancillary services* through the designation of what were previously Saltzer facilities as St. Luke's "hospital-based" facilities.

Some payers, including most notably Medicare, offer higher reimbursement for ancillary services provided at "hospital-based" facilities than for such services provided in independent physicians' offices. *See* 42 C.F.R. § 413.65. For the Medicare program, the increase in reimbursement reflects the costs and obligations of complying with federal regulations applicable to hospital-based facilities—including, *inter alia*, accreditation standards ensuring quality and safety of services, federal requirements for handicapped accessibility and other nondiscrimination provisions, and the requirement that all patients be treated regardless of their ability to pay. 42 C.F.R. § 413.65(d), (g). If a hospital-based facility satisfies these regulatory requirements, it is permitted to use "provider-based billing," and is entitled to increased reimbursement from Medicare—without regard to market power. Some commercial insurers also agree to pay greater reimbursement for ancillary services provided at hospital-based facilities, but others do not.

The court here found that the transaction would permit defendants to negotiate for greater reimbursement from commercial insurers by causing ancillary services to be performed at "hospital-based" facilities and reimbursed at higher rates than if those ancillary services were performed in an independent Saltzer facility. ER.34 ¶¶129-30. Of course, the plaintiffs did not allege, and the district court did not find, the existence of a Nampa market for "ancillary services." *See*

ER.21 ¶¶48-49 (only product market at issue is adult PCP services); ER.21-25 ¶¶50-73 (only evidence as to geographic market related to adult PCP services). They likewise offered no evidence of defendants' market share in any market for ancillary services. Thus, the district court did not find that defendants had market power in any market for ancillary services.

That omission is significant. It is axiomatic that price increases in the absence of market power do not create any concern under the antitrust laws. *See, e.g.*, *Brooke Grp. Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 232 (1993); *Rebel Oil*, 51 F.3d at 1434. Prices rise for a multitude of reasons consistent with competition. Moreover, even if a firm increases prices above competitive levels, the increase will be defeated if the firm does not have market power, because consumers can obtain services from lower-priced competitors. Thus, absent a finding that expected price increases for ancillary services would result from an exercise of market power, the district court's finding as to ancillary services is meaningless. *Id.* ("Without market power," price increases "do not threaten consumer welfare.")

Instead of assessing defendants' market power in a Nampa market for ancillary services, the district court opined that the expected price increases for ancillary services were evidence of anticompetitive effects because they supposedly resulted from defendants' "enhanced bargaining leverage from the

Acquisition." ER.32 ¶121. In other words, because the affiliation increased defendants' "leverage" in negotiating with insurers, any subsequent price increases in the market for ancillary services constituted an anticompetitive effect. ER.32, 34 ¶¶121, 130. But this conclusion finds no support in the law.

Mergers do not violate the Clayton Act merely because they cause the merged firms to have increased "leverage." By definition, *every merger* necessarily increases the leverage of the merged firms. *See* Areeda ¶1144a (increased leverage is "inherent in a merger," and "its significance is doubtful"); *Broadcast Music, Inc. v. Columbia Broad. Sys., Inc.*, 441 U.S. 1, 23 (1979) ("Mergers among competitors eliminate competition … but they are not *per se* illegal, and many of them withstand attack under any existing antitrust standard."). Yet the district court here made no finding that would explain how the increased "leverage" that defendants obtained from this affiliation could have enabled them to impose supracompetitive prices in any ancillary services market.

This Court has repeatedly rejected such an analytically unsupported approach. *See Cost Mgmt. Servs., Inc. v. Wash. Natural Gas Co.*, 99 F.3d 937, 951 (9th Cir. 1996); *Alaska Airlines, Inc. v. United Airlines, Inc.*, 948 F.2d 536, 546-47 (9th Cir. 1991). In assessing monopolization claims under section 2 of the Sherman Act, the Court has considered what is necessary to establish that a defendant improperly "leveraged" monopoly in one market to bring about

anticompetitive effects in a separate market. In particular, the Court considered an argument that antitrust liability could be established by showing "only two rather loose elements: 1) there must be monopoly power in some market, and 2) such power must be exercise[d] … to the detriment of competition in another market." *Cost Mgmt. Servs.*, 99 F.3d at 951 (internal quotation marks and citation omitted).

This Court unequivocally rejected the notion that these "loose elements" could establish liability "*in the absence of a threat that the 'leveraged' market will be monopolized.*" *Id.* (internal quotation marks and citation omitted; emphasis in original). Here, the district court not only failed to assess whether defendants had market power in the relevant market (adult PCP services), but it equally failed to assess whether there was a threat of market power in any market for ancillary services. The district court's repeated references to "leverage," unsupported by these other crucial findings, cannot sustain its holding.[10] *See* Areeda ¶1710e ("The

[10] The court likewise did not find that defendants would or could engage in "tying"—*i.e.*, exploit any market power in the adult PCP services market to force consumers of adult PCP services also to purchase ancillary services from defendants. *Compare Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 12 (1984) (*overruled on other grounds by Ill. Tool Works Inc. v. Indep. Ink, Inc.*, 547 U.S. 28 (2006)). Nor did it find that plaintiffs had proved that ancillary services were part of a "cluster market" with adult PCP services. *Compare ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 2014 WL 1584835, at *5 (6th Cir. Apr. 22, 2014). The court relied solely on its finding of undefined "leverage"—nothing more.

pure ‘leverage’ theory, which assumed that all customers could be exploited even in the absence of foreclosure, never withstood careful analysis.”).

Moreover, the evidence does not support the conclusion that the transaction would result in anticompetitive price increases for ancillary services. Blue Cross and St. Luke’s entered into their most recent contract with knowledge that Saltzer would be affiliating with St. Luke’s and with Blue Cross well aware that services provided at Saltzer facilities would be compensated under St. Luke’s contract. ER.378, Tr.393:6-14 (J. Crouch). Yet the pricing negotiated in that contract was consistent with previous years. Plaintiffs presented no evidence that the negotiated prices were above competitive levels. *See* ER.500, Tr.2978:17-24 (D. Argue). Rather, Blue Cross successfully negotiated an express limit on any future price increases that might result from the transaction. ER.378, Tr.394:5-396-5 (J. Crouch). And it did so even though Blue Cross contended in this litigation that St. Luke’s and Saltzer were both “must have” providers. ER.27-28 ¶¶84, 89.[11]

[11] The district court cited Mr. Crouch’s testimony that “[a]fter the Acquisition, if St. Luke’s were to bill for these ancillary services at the higher ‘hospital-based’ rates, [Blue Cross] estimates that costs under its commercial contracts would increase by 30 to 35 percent.” ER.33 ¶ 125. However, as Mr. Crouch later clarified, under terms that Blue Cross had successfully negotiated, St. Luke’s *could not* obtain reimbursements from Blue Cross in that measure by moving Saltzer to hospital-based pricing. ER.378, Tr.394:5-396-5 (J. Crouch). Thus, Mr. Crouch’s 30 to 35% estimate was purely hypothetical.

It is no surprise that Blue Cross can impose this condition in its contract with St. Luke's. Blue Cross insures more than one-quarter of Idaho's entire population—and therefore has "leverage" in its own right to resist leverage that defendants might attempt to wield. ER.416, Tr.1646:18-20 (D. Pate) (testimony of St. Luke's CEO that "Blue Cross is so dominant that they are a must-have for us. We couldn't just walk away from their business."); *accord* ER.365, Tr.325:13-14, 326:2-6 (J. Crouch) (recognizing that Blue Cross "dominates the large group market in Idaho" and "has market power"). *See, e.g.*, *Baker Hughes*, 908 F.2d at 986 (concentration held not indicative of anticompetitive effects where market involved complex products sold to sophisticated consumers, not "trinkets sold to small consumers who may possess imperfect information and limited bargaining power"); *Syufy*, 903 F.2d at 670 (affirming judgment for antitrust defendant who "[w]hile successful, [was] in no position to put the squeeze on distributors"). The district court failed entirely to consider Blue Cross's countervailing leverage.

No other evidence supported the court's ruling. The court cited a report prepared for St. Luke's by an outside consultant, Peter LaFleur, purportedly "showing how office/outpatient visits could be billed for higher amounts if the visit was hospital-based rather than Saltzer-based." ER.33-34 ¶¶126-28.[12] Mr. LaFleur,

[12] What the district court referred to as "St. Luke's own analysis," ER.33 ¶¶ 126-27 (citing ER.588 (Ex. 1277)), was in fact the report prepared by Mr. LaFleur.

however, explained that the only changes in revenues that defendants could count on were related to increased payments *from Medicare* if St. Luke's complied with regulatory requirements for provider-basing. ER.540, Tr.332:3-13 (P. LaFleur Dep.). He made clear that defendants could *not* count on realizing similar changes in reimbursement from commercial insurers—a point the district court simply failed to note. ER.539-40, Tr.319:21-320:4, 320:6-14, 332:3-13 (P. LaFleur Dep.).

In any event, even if St. Luke's and Saltzer had intended to charge higher prices for ancillary services, or ancillary services in some combination with adult PCP services, that is irrelevant under the antitrust laws unless defendants had market power in *a relevant market*. *See, e.g.*, *Marshfield Clinic*, 65 F.3d at 1411-12 ("when dealing with a heterogeneous product or service, such as the full range of medical care, a reasonable finder of fact cannot infer monopoly power just from higher prices"). Yet the district court neither found nor even addressed market power in any market for ancillary services or in any market that included ancillary services. In short, the district court's conclusion that the transaction would lead to anticompetitive effects in the form of higher reimbursements for ancillary services is both analytically and factually unsound.

II. THE COURT ERRED IN DISREGARDING THE TRANSACTION'S PROCOMPETITIVE BENEFITS.

A. The Court Used an Improper Definition of "Merger-Specific" Efficiencies.

The court found that the challenged transaction was designed to, and would succeed in, promoting the procompetitive goal of integrated healthcare. As the court put it, "[t]he Acquisition was intended by St. Luke's and Saltzer primarily to improve patient outcomes." ER.12. Moreover, the court concluded, the transaction was intentionally structured to maximize consumer benefits: "St. Luke's believed that the best way to create the unified and committed team of physicians required to practice integrated medicine was to employ [the Saltzer physicians]. St. Luke's followed this strategy to improve the quality of medical care." ER.56 ¶¶44-45. The court recognized that Saltzer's prior efforts to achieve integrated care through looser affiliations had failed. ER.17-18 ¶¶25-29. It found, however, that this transaction would succeed at improving patient outcomes "if left intact." ER.12.

Nonetheless, the court never balanced these benefits against the likelihood of anticompetitive effects to determine whether the transaction was, on balance, procompetitive—as the law requires. Instead, it simply disregarded the benefits that it had found would result because it deemed them not "merger-specific." ER.56 ¶49.

The court reasoned as follows: "[P]hysicians are committed to improving the quality of health care, and lowering its cost, whether they are employed or independent." ER.42-43 ¶180. Any "committed team" of physicians, large or small, and whether employed by an integrated delivery system or not, can achieve integrated care. ER.43 ¶¶182, 184. Independent physicians also can obtain access to health information technology, whether or not they are affiliated with a larger health system. ER.46-47 ¶¶201-02, 205. Although a larger health system that employs physicians and that has invested in high-quality health information technology can achieve the benefits of integrated care, "it is not the only way. The same efficiencies have been demonstrated with groups of independent physicians." ER.56 ¶46.

This analysis is woefully incomplete. In short, the court's analysis rested almost exclusively on aspirational generalities about physicians—*i.e.*, that both independent and employed physicians have their patients' best interests at heart, and that both are capable of working in a "committed team." ER.42-43 ¶¶180, 185. Of course, since Hippocrates, physicians have been dedicated to their patients' best interests. And physicians have likewise always been capable of working in committed teams. Yet these facts have not been sufficient to bring integrated, value-based care to fruition in southern Idaho.

Significantly, the court made no effort to determine, on the evidence presented in this case, whether *the Saltzer physicians* could have achieved integrated care by some less restrictive means than the affiliation with St. Luke's. And the court did not address its own findings that the Saltzer physicians—despite years of efforts to move toward integrated, value-based care as an independent group—had been unable to do so. *See, e.g.*, ER.17 ¶24 ("Saltzer believed that it needed to upgrade its … health information technology … but could not afford to do so"); *id.* ¶25 ("Saltzer made attempts to coordinate care with other health systems under less-formal affiliations … [but n]one of those projects came to fruition"); ER.20 ¶44 ("Saltzer did not believe that by itself, it was big enough, or had sufficient financial reserves, to engage in capitation (or value-based billing)"). Indeed, the court's findings leave no doubt that, no matter how "committed" they were to improving the quality and cost of healthcare, the Saltzer physicians faced insuperable hurdles to doing so—hurdles that they overcame only through the challenged transaction.[13]

Significantly, the district court did not identify any specific way in which the Saltzer physicians could be expected to achieve integrated care following divestiture. Beyond general comments about the ability of any physician to be part

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[13] There was also evidence, unmentioned by the district court, that several other physician groups in southern Idaho who had attempted to move toward integrated care without joining a larger system were equally unsuccessful. *Supra*, p. 10.

of a "committed team," the court did not cite any *concrete*, existing example of a less restrictive alternative through which the Saltzer physicians could achieve the goal of providing integrated, value-based care in Nampa. Notably, Saltzer tried looser collaborations with nearby health systems—St. Luke's and the predecessor to Saint Alphonsus—and in both cases failed to achieve the desired results. ER.17-18 ¶¶25-29. And the court did not point to any other system or network that Saltzer could work with to coordinate care or take on risk.[14]

The omission undermines the court's entire analysis of less restrictive alternatives. *See* Areeda ¶1914c (explaining "the need that any inquiry into less restrictive alternatives not become unduly speculative, but must rest on alternatives that are either *quite obvious* or of *proven success*") (emphasis added). Even if it is theoretically possible that some physicians could achieve integrated care without joining a larger health system, that is irrelevant if *the Saltzer physicians* cannot do

[14] The closest the court came to describing a specific opportunity actually available to the Saltzer physicians was in pointing to St. Luke's plans for an "Affiliate Electronic Medical Record program," through which independent physicians would be able to gain access to St. Luke's Epic system. ER.46 ¶ 201. However, the district court ignored the fact that participating in the Affiliate EMR program—which is not even available yet—would require Saltzer to pay an upfront investment of approximately $800,000, in addition to costs associated with hardware, maintenance, and training, ER.484, Tr.2823:3-2824:4 (M. Chasin), which would likely be impossible, ER.463, Tr.2383:23-2384:10 (J. Kaiser). And even if Saltzer could gain access to St. Luke's information technology, that alone would not enable Saltzer physicians to, *inter alia*, coordinate care with other providers, take on risk for their patients' care, or accept patients without regard to insurance status.

so, as the evidence showed they could not. In other words, if *the Saltzer physicians* had no less restrictive means of achieving integrated care, then their ability to achieve integrated care through the challenged transaction is "merger-specific."

Because it did not address any specific alternatives available to Saltzer, the district court also did not consider the comparative advantages of the challenged transaction. For one thing, it failed entirely to assess whether Saltzer could achieve integrated care as *quickly* by other means as it will through the challenged transaction. Yet the FTC's Horizontal Merger Guidelines specify that if a merger allows for procompetitive benefits to be achieved more quickly, then "the timing advantage is a merger-specific efficiency." U.S. Dep't of Justice & FTC, *Horizontal Merger Guidelines* 30 n.13 (2010). The district court ignored this.

The court likewise failed to assess how the extent of procompetitive benefits achievable by other means compares to those that the challenged transaction will produce. For one, the court recognized that financially affiliating with St. Luke's allowed Saltzer to "increase access to medical care for the significant population of Medicaid and Medicare patients in Canyon County," whereas their independent practice had "required many Saltzer physicians to manage their patient populations to limit the number of Medicaid or uninsured patients they could accept." ER.20-21 ¶46. The court identified no way in which a divested Saltzer, once again

independent, could maintain the increased access for Medicaid and other low-pay or no-pay patients allowed by the transaction.

Similarly, the court stated that "[i]n Idaho, independent physician groups are using risk-based contracting successfully," apparently suggesting that Saltzer could as well. ER.43 ¶183 (citing ER.360, Tr.195:22-196:5 (J. Crouch)). But the testimony the court cited referred to a single network of independent physicians in a different region—a network unavailable to Saltzer.[15] Moreover, the court did not discuss whether or how Saltzer could take on *full* risk—that is, both upside and down side risk for patient outcomes. While smaller physician groups have taken on limited upside risk through "gain-sharing arrangements," the undisputed evidence showed that larger "scale" is necessary to assume both upside and downside risk. ER.379, Tr.397:23-398:4 (J. Crouch). This point, too, was ignored by the district court.

By focusing on generalities, rather than the facts of *this* transaction and healthcare in *this* region, the district court made, at bottom, a policy judgment that could have profound implications for the U.S. healthcare system. As the court found, there is currently "a broad if slow movement" toward integrated care.

[15] That network, the North Idaho Health Network, has lost one-third of its physician membership since the trial. *See* David Cole, *Idaho Physicians' Network Shrinks*, Coeur d'Alene Press (Feb. 27, 2014), *online at* http://www.idahostatesman.com/2014/02/27/3051913/kootenai-health-pulls-doctors.html.

ER.11. Healthcare is "in an experimental stage, where hospitals and other providers are examining different organizational models, trying to find the best fit." ER.59 ¶69. St. Luke's and Saltzer concluded that the challenged transaction, through which the Saltzer physicians become employees of a larger, integrated delivery system, is the best fit given the facts and circumstances of healthcare in southern Idaho. ER.56 ¶44.

The district court's reasoning, however, forecloses that conclusion—not only for St. Luke's, but for any health system operating in a mid-sized market like that in southern Idaho, where the scale necessary to form an integrated delivery system entails a substantial market share. Under the district court's reasoning, there is no case in which the benefits of integrated care could be deemed "merger-specific," for in all cases, there exists the same theoretical possibility that independent physicians could simply work together as a "committed team." *See* ER.43 ¶¶184-85.

Thus, if affirmed, the district court's judgment will foreclose a major avenue of innovation in healthcare in many mid-sized regional markets. Foreclosing innovation stands the antitrust laws on their head. *See Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979) (antitrust laws are "a consumer welfare prescription"); *SCFC ILC, Inc. v. Visa USA, Inc.*, 36 F.3d 958, 962 (10th Cir. 1994) (the "objective[] of antitrust regulation" is "to improve people's lives … [through]

economic efficiency … more efficient production methods … [and] through increased innovation") (citation omitted, ellipses in original). As this Court previously explained, "judicial intervention in a competitive situation can itself upset the balance of market forces, bringing about the very ills the antitrust laws were meant to prevent." *Syufy*, 903 F.2d at 663. The district court's decision here does just that.

Otherwise stated, the antitrust laws should not put a strait-jacket on how a health system should structure its relationship with physicians in moving to integrated, value-based care. Indeed, this case can be analogized to the Supreme Court's decision in *Broadcast Music*. There, copyright holders joined together to form organizations that would negotiate innovative blanket licenses to perform members' copyrighted works and to detect unauthorized uses of the works. 441 U.S. at 4-5. Although the blanket licenses "involve[d] 'price-fixing' in the literal sense," the Court held that they were not subject to the *per se* rule typically applied to price-fixing. *Id.* at 8, 20-21.

Instead, the Court recognized that in light of "the practical situation in the marketplace," issuing blanket licenses and detecting unauthorized use *required* coordinated action by "an organization of rather large size." *Id.* at 19 n.32, 20. The blanket licensing arrangement created a "whole" that was "truly greater than the sum of its parts; it is, to some extent, a different product," *id.* at 21-22. The

same is true of integrated, value-based care—which is "to some extent, a different product" from fragmented, fee-for-service care. *Cf. Marshfield Clinic*, 65 F.3d at 1412 ("Physicians practice in groups, in alliances, in networks, utilizing expensive equipment and support. Twelve physicians competing in a county would be competing to provide horse-and-buggy medicine. Only as part of a large and sophisticated medical enterprise … can they practice modern medicine…"). Just as the Supreme Court rejected uncritical adoption of the *per se* rule in *Broadcast Music*, this Court should reject the wooden, overly formalistic approach taken by the district court here.

B. The Court Improperly Required St. Luke's to Prove the Absence of Less Restrictive Alternatives.

The district court also erred in placing the burden to prove the absence of less restrictive alternatives on St. Luke's. Defendants rightfully bear the burden to show that procompetitive benefits are "merger specific," in the sense that these benefits result from the transaction. This showing fits within defendants' burden to establish that the plaintiffs' *prima facie* case of likely anticompetitive effects presents an inaccurate portrayal of overall competitive effects. *See supra*, p. 26. Here, the district court found that defendants had successfully carried the burden of showing that procompetitive benefits of improved patient outcomes would result from the transaction. ER.12.

A separate question is whether the same procompetitive benefits can be achieved through some other means that has less risk of anticompetitive effect—*i.e.*, a less restrictive alternative. The district court held that defendants also had, but did not carry, the burden to establish the absence of less restrictive alternatives. *See* ER.56 ¶¶46-49. That conclusion was an error of law.

Although this Court has not yet addressed the question of who holds the burden to prove the existence or absence of less restrictive alternatives in Clayton Act claims, it has addressed who holds the "closely related" burden to prove less restrictive alternatives for Sherman Act claims, which follow an analogous burden-shifting framework. *See* Areeda ¶973c4 n.16. And this Court has consistently held that the burden to prove less restrictive alternatives falls squarely on the plaintiff. *E.g.*, *Bhan v. NME Hosps., Inc.*, 929 F.2d 1404, 1413 (9th Cir. 1991) (if defendant establishes procompetitive benefits, plaintiff "must then try to show that any legitimate objectives can be achieved in a substantially less restrictive manner"); *Hairston v. Pac. 10 Conf.*, 101 F.3d 1315, 1319 (9th Cir. 1996) (same).

Placing this burden on plaintiff is consistent with the burden-shifting framework that applies to both Sherman and Clayton Act claims. As Areeda explains in discussing the Sherman Act, "[p]lacing a general burden of 'no less restrictive alternative' on the defendant effectively requires it to prove a negative potentially covering an infinite number of possibilities. By contrast, once the

plaintiff has suggested a particular alternative, the defendant has the more manageable obligation of showing its inadequacy." Areeda ¶1914c. Requiring a defendant to *disprove* an infinite number of theoretical possibilities—rather than requiring plaintiff to prove the existence of just one plausible alternative—in effect shifts the burden of persuasion as to the lawfulness of the conduct onto the defendant. That is an improper result. *See Baker Hughes*, 908 F.2d at 983 (rejecting analysis that would "shift[] the government's ultimate burden of persuasion to the defendant").

The district court, therefore, should not have required defendants to prove the absence of less restrictive alternatives. And that error was determinative here. Plaintiffs failed to identify any concrete, less restrictive alternative available to the Saltzer physicians. Plaintiffs' expert witness on this subject, Dr. Kenneth Kizer, explicitly conceded that it is, at most, uncertain whether an affiliation of physicians looser than that effectuated by the Saltzer transaction could produce the same benefits that the transaction does. ER.517-18, Tr.3584:14-3585:3 ("The jury is still out") (K. Kizer); ER.520-21, Tr.3596:17-3597:24 (statement of Dr. Kizer that he was "not asked to opine on the topic of what Saltzer could or should do if unwound so that it would be in a position to deliver integrated care") (K. Kizer). And the experience of such providers as Mayo Clinic, Kaiser-Permanente, and Marshfield Clinic demonstrate that, at a minimum, there is good reason to believe that tight

alignment with physicians produces greater benefits than looser ones. Regardless, had the court imposed on *plaintiffs* the burden to prove a less restrictive alternative, plaintiffs could not have met that burden.

III. THE COURT ABUSED ITS DISCRETION BY ORDERING DIVESTITURE WITHOUT ASSESSING THE LIKELY EFFECTS OF THAT ORDER ON COMPETITION AND CONSUMER WELFARE.

Having determined that the Saltzer transaction violated the Clayton Act, the district court was obligated to fashion a remedy that was "effective to redress the antitrust violation proved." *United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 323 (1961). It ordered divestiture, relying on cases indicating that divestiture is the presumptive remedy. ER.56 ¶¶50-51 (citing *California v. Am. Stores Co.*, 495 U.S. 271, 285 (1990); *Ash Grove Cement Co. v. FTC*, 577 F.2d 1368, 1380 (9th Cir. 1978)). The court failed, however, to consider the two key circumstances here that rebut that presumption—(1) that divestiture is unlikely to improve competitive conditions given the weakness of a divested Saltzer, and (2) that divestiture will deprive consumers of the procompetitive benefits that the court found will result from the transaction. *See Garabet v. Autonomous Techs. Corp.*, 116 F. Supp. 2d 1159, 1172 (C.D. Cal. 2000) ("[D]ivestiture … should not be entered into lightly or without substantial evidence that the benefit outweighs the harm. Its far-reaching effects put it at the least accessible end of a spectrum of injunctive relief.").

A. Divestiture Would Not Be an Effective Remedy.

The purpose of an antitrust remedy is to restore competition. Divestiture is therefore an appropriate remedy if it is "the most appropriate means for restoring competition." *FTC v. PepsiCo, Inc.*, 477 F.2d 24, 29 n. 8 (2d Cir. 1973); *see also Ginsburg v. InBev NV/SA*, 623 F.3d 1229, 1235 (8th Cir. 2010) ("Fashioning appropriate equitable antitrust relief requires that courts balance the benefit to competition against the hardship or competitive disadvantage the remedy may cause."). Indeed, as this Court recently explained, divestiture is a "drastic and rarely awarded remedy" that should not be awarded where it would "disserve the public interest." *Taleff v. Sw. Airlines Co.*, 554 F. App'x 598, 2014 WL 407449, at *1 (9th Cir. Feb. 4, 2014).

Here, divestiture will not restore competition. As the district court recognized, defendants submitted evidence "that an unwound Saltzer will be significantly and negatively affected due to the departure of seven surgeons from Saltzer to [Saint Alphonsus]." ER.57 ¶¶55-56. Notably, the court did not discredit that evidence. Instead, the court *dismissed* it on the ground that Saltzer's precarious financial state "was caused by the Acquisition," and thus could not be "raise[d] … as a reason to hold together the Acquisition." *Id.* ¶57. In other words, the Court gave no weight to what competition would actually look like in the Treasure Valley as a result of divestiture—*i.e.*, that Saltzer in its current form

might no longer exist as a competitor at all—on the ground that defendants were somehow estopped from arguing the point.

The court's decision to dismiss defendants' evidence of Saltzer's poor financial condition on this ground effectively treats divestiture as a form of punishment. Because the court disagreed with defendants' judgment that the transaction was procompetitive, it barred defendants from raising evidence relevant to determining whether divestiture would succeed in promoting competition. But punishment has no place in fashioning injunctive relief for a civil antitrust violation. *du Pont*, 366 U.S. at 326. Instead, it is the *actual* effect on competition that controls. *See Timken Roller Bearing Co. v. United States*, 341 U.S. 593, 602-03 (1951) (Reed, J., concurring) ("Since divestiture is a remedy to restore competition and not to punish those who restrain trade, it is not to be used indiscriminately, without regard to the type of violation or whether other effective methods, less harsh, are available.").

Where, as here, evidence demonstrates that the divested entity would be an ineffective competitor, divestiture is an ineffective, and therefore inappropriate, remedy. *Gen. Dynamics*, 415 U.S. at 507-08 (affirming denial of divestiture where merged company's "reserves position" was such that "even if it remained in the market, [it] did not have sufficient reserves to compete effectively"); *Mid-West Paper Prods. Co. v. Cont'l Grp., Inc.*, 596 F.2d 573, 587 (3d Cir. 1979)

(cautioning against "'overkill' recoveries, whose punitive impact may unduly cripple a defendant and lead to an overall deleterious effect upon competition"); *Nat'l Ass'n of Chain Drug Stores v. Express Scripts, Inc.*, Civ. A. No. 12-395, 2012 WL 1416843, at *3 (W.D. Pa. Apr. 25, 2012) (declining to order divestiture where the divested entity "would likely be unable to survive on its own, much less compete against" the divesting entity). The district court's failure to consider the evidence of Saltzer's ineffectiveness was an abuse of discretion. *See, e.g.*, *Lemoge v. United States*, 587 F.3d 1188, 1192-93 (9th Cir. 2009).

B. Divestiture Will Eliminate the Transaction's Procompetitive Benefits.

As discussed above, the district court expressly recognized that the Saltzer transaction will produce procompetitive benefits for consumers, including improving patient outcomes and increasing access to medical care for Medicaid and Medicare patients in Canyon County. ER.12, 20-21, ¶46. The court also observed that the expected anticompetitive effects of the transaction—namely a likelihood of price increases for ancillary services—were uncertain. *See* ER.60 ¶76.

The district court did not, however, weigh the adverse effects on consumers of preempting the transaction's procompetitive benefits through divestiture against the supposed beneficial effect of further reducing the likelihood of already uncertain anticompetitive harms. Indeed, it did not even address the question.

Instead, it relied solely on authorities in which *no procompetitive benefits* were shown to have resulted from the challenged transaction, so that—unlike here—no such benefits were lost through divestiture. *See Am. Stores*, 495 U.S. 271 (cited at ER.56 ¶50); *Ash Grove Cement*, 577 F.2d 1368 (cited at ER.56 ¶51); *In re ProMedica Health Sys., Inc.*, No. 9346, 2012 WL 155392 (FTC June 25, 2012) (cited at ER.58 ¶60).

The district court's failure to weigh the harms and benefits of divestiture was an abuse of discretion. Where the competitive harm from a transaction is uncertain, and procompetitive benefits will be lost if the transaction is unwound, divestiture is unwarranted. *See Ginsburg*, 623 F.3d at 1235 (holding that divestiture was unavailable where the proof of antitrust injury was "speculative," but "[b]y contrast, the hardship and competitive disadvantage resulting from forced divestiture would be both dramatic and certain"). In such circumstances, "the remedial equities balance overwhelmingly in favor of denying this remedy." *Id.* at 1236.

Here, the court had the opportunity to impose a remedy less drastic than divestiture that would have largely preserved the transaction's procompetitive benefits while eliminating the potential for anticompetitive effects. The court could have required Saltzer and St. Luke's to negotiate separately with health plans for fee-for-service contracts, so that both Saltzer and St. Luke's would be free to

enter independently into agreements with payers. By limiting such a remedy to fee-for-service contracts—not risk-based contracts—the court could have ensured that defendants would retain the panel of PCPs necessary to accept full risk under such contracts.

The court gave no reason for rejecting a conduct remedy here. It merely cited an administrative proceeding, *ProMedica*, in which the FTC had rejected a conduct remedy. ER.58 ¶¶60-62. The court did not explain why this case and *ProMedica* warrant similar remedies—and they do not. Most significantly, there was no evidence in *ProMedica* of procompetitive benefits that would be lost through divestiture. *See ProMedica*, 2014 WL 1584835, at *10 ("ProMedica did not even attempt to argue … that this merger would benefit consumers (as opposed to only the merging parties themselves) in any way."). Indeed, the Sixth Circuit deemed *ProMedica* "remarkable" in that regard. *Id.* *ProMedica* does not support the district court's remedy here.

CONCLUSION

For the foregoing reasons, this Court should reverse the judgment. In the alternative, the Court should vacate the judgment and remand for reconsideration in light of this Court's opinion.

Respectfully submitted,

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June 12, 2014

STATEMENT OF RELATED CASES

Defendants-Appellants St. Luke's Health System, Ltd., St. Luke's Regional Medical Center, Ltd., and Saltzer Medical Group, P.A. are aware of the following related cases pending in this court, which arises out of the same case in the district court: *The Associated Press v. USDC-IDB*, No. 13-73931 (9th Cir.).

CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 13,979 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface, 14-point Times New Roman, using Microsoft Word 2007.

June 12, 2014 s/ Jack R. Bierig________________

Jack R. Bierig

ADDENDUM

ADDENDUM

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15 U.S.C. § 18:

> No person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.
>
> No person shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of one or more persons engaged in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition, of such stocks or assets, or of the use of such stock by the voting or granting of proxies or otherwise, may be substantially to lessen competition, or to tend to create a monopoly.
>
> This section shall not apply to persons purchasing such stock solely for investment and not using the same by voting or otherwise to bring about, or in attempting to bring about, the substantial lessening of competition. Nor shall anything contained in this section prevent a corporation engaged in commerce or in any activity affecting commerce from causing the formation of subsidiary corporations for the actual carrying on of their immediate lawful business, or the natural and legitimate branches or extensions thereof, or from owning and holding all or a part of the stock of such subsidiary corporations, when the effect of such formation is not to substantially lessen competition.

Nor shall anything herein contained be construed to prohibit any common carrier subject to the laws to regulate commerce from aiding in the construction of branches or short lines so located as to become feeders to the main line of the company so aiding in such construction or from acquiring or owning all or any part of the stock of such branch lines, nor to prevent any such common carrier from acquiring and owning all or any part of the stock of a branch or short line constructed by an independent company where there is no substantial competition between the company owning the branch line so constructed and the company owning the main line acquiring the property or an interest therein, nor to prevent such common carrier from extending any of its lines through the medium of the acquisition of stock or otherwise of any other common carrier where there is no substantial competition between the company extending its lines and the company whose stock, property, or an interest therein is so acquired.

Nothing contained in this section shall be held to affect or impair any right heretofore legally acquired: Provided, That nothing in this section shall be held or construed to authorize or make lawful anything heretofore prohibited or made illegal by the antitrust laws, nor to exempt any person from the penal provisions thereof or the civil remedies therein provided.

Nothing contained in this section shall apply to transactions duly consummated pursuant to authority given by the Secretary of Transportation, Federal Power Commission, Surface Transportation Board, the Securities and Exchange Commission in the exercise of its jurisdiction under section 79j of this title, the United States Maritime Commission, or the Secretary of Agriculture under any statutory provision vesting such power in such Commission, Board, or Secretary.

Idaho Code Ann. § 48-106:

> (1) It is unlawful for a person to acquire, directly or indirectly, the whole or any part of the stock, share capital, or other equity interest or the whole or any part of the assets of, another person engaged in Idaho commerce, where the effect of such acquisition may be substantially to lessen competition or to tend to create a monopoly of any line of Idaho commerce.
>
> (2) This section shall not apply to persons purchasing the stock or other equity interest of another person solely for investment and not using those assets by voting or otherwise to bring about, or attempt to bring about, the substantial lessening of competition. Nothing contained in this section shall prevent a person engaged in Idaho commerce from causing the formation of subsidiary corporations or other business organizations, or from owning and holding all or a part of the stock or equity interest of such subsidiary corporations or other business organizations.

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on June 12, 2014.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

_s/Jack R. Bierig__________

Jack R. Bierig