ORIGINAL

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION

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

In the Matter of	**PUBLIC**
ProMedica Health System, Inc. **a corporation**	**Docket No. 9346**

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RECORD REFERENCES

Answer – Respondent ProMedica Health Sys., Inc.'s Answer to [Part III] Complaint

CCAB – Complaint Counsel's Appeal Brief

CCPFF – Complaint Counsel's Proposed Findings of Fact

CCPTB – Complaint Counsel's Post-Trial Brief

CCPTRB – Complaint Counsel's Post-Trial Reply Brief

Decl. – Declaration

ID – Initial Decision

IDA – Initial Decision Analysis

IDFF – Initial Decision Findings of Fact

IHT – Investigational Hearing Transcript

JSLF – Joint Stipulations of Law and Fact (JX00002A)

JX – Joint Exhibit

PX – Complaint Counsel Exhibit

RAB – Respondent's Appeal Brief

Resp't Admissions – Respondent ProMedica Health System, Inc.'s Response to Complain Counsel's Request for Admission

RPTB – Respondent ProMedica Health Sys., Inc.'s Pre-Trial Brief

RPTRB – Respondent ProMedica Health Sys., Inc.'s Post-Trial Reply Brief

RX – Respondent Exhibit

Tr. – Trial Transcript

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TABLE OF CASES AND AUTHORITIES

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INTRODUCTION

This a straightforward case with mostly undisputed – and indisputable – facts demonstrating that ProMedica's acquisition of St. Luke's ("Acquisition") is unlawful. There is no dispute that, prior to the Acquisition, ProMedica and St. Luke's were head-to-head competitors in general acute-care ("GAC") services and obstetrics ("OB") services. There is no dispute that one relevant market is inpatient GAC services. There is no dispute that Lucas County is the relevant geographic market. There is no dispute that the Acquisition reduced the number of GAC hospitals in Lucas County from four to three and the number of providers of inpatient OB service providers from three to two. There is no dispute that the Acquisition results in market shares far exceeding those held unlawful in *Philadelphia National Bank,* post-merger HHIs far exceeding the thresholds for a highly concentrated market, and that concentration levels lead easily to a presumption that the transaction is likely to enhance market power. It is indisputable that, pre-Acquisition, ProMedica took aim at St. Luke's by, among other things, excluding St. Luke's from its Paramount health plan and inducing another major health plan to exclude St. Luke's from its network for years, then required the health plan to "pay" ProMedica – that is, to raise ProMedica's reimbursement rates – "for the privilege" of adding St. Luke's back into its network. It is undisputable that, leading up to the Acquisition, St. Luke's took one half of the market share lost by ProMedica in the first nine months of 2009. It is indisputable that St. Luke's understood that an acquisition by ProMedica would give it significant negotiating clout with health plans and that St. Luke's expected to obtain higher reimbursement rates as a result of that increased leverage. In short, there is an overwhelming presumption that the Acquisition violates Section 7 of the Clayton Act, bolstered by reams of additional evidence.

Respondent fails to rebut that presumption. St. Luke's is indisputably not a failing firm. Respondent here concedes that St. Luke's is not even a "flailing firm." There is no dispute that St. Luke's inpatient revenue and patient volumes, outpatient revenue and patient volumes, EBITDA, and market share all increased in the period leading up to the Acquisition. Efficiency and entry/repositioning defenses, rejected by Judge Chappell, are relegated to subsidiary arguments in Respondent's Appeal Brief. No viable defenses remain.

Indeed, Respondent's Appeal Brief is not much more than a rehashing of the same unpersuasive and often baseless arguments that it has previously made and that two judges have resoundingly rejected. Space permitting, Complaint Counsel would respond to all of the inaccuracies, misstatements, omissions, red herrings, and errors in Respondent's Appeal Brief, but Rule 3.52's word limit for Answering Briefs prevents us from doing so. Rather, we focus here on Respondent's most egregious claims, demonstrating that none of its arguments even remotely changes the inevitable conclusion that the Acquisition is illegal.

ARGUMENT

I. THE ALJ'S CONCLUSION THAT THE ACQUISITION VIOLATES SECTION 7 IS FIRMLY SUPPORTED BY THE LAW AND THE EVIDENCE

The evidence, including Respondent's own documents and testimony, overwhelmingly shows that the Acquisition substantially lessens competition. Remarkably, Respondent's Appeal Brief leaves unaddressed and unrebutted some of the most fundamental and adverse evidence showing the Acquisition is anticompetitive.

For example, pre-Acquisition, ProMedica already had dominant GAC and OB market shares in Lucas County – approximately 47% and 71% respectively. IDFF ¶ 364; PX02148 (Town, Expert Report) at 143 (Ex. 6), *in camera*. ProMedica repeatedly touted its dominance, both internally and to third parties like Standard & Poor's. CCPFF ¶ 16 (citing, e.g., PX00270 at

025 (S&P Credit Presentation) ("ProMedica Health System has market dominance in the Toledo MSA")); *see also* CCAB at 9. Post-Acquisition, ProMedica becomes even more dominant, increasing its GAC market share to approximately 58% and its OB market share to 80.5%.

The Acquisition also results in massive increases in concentration in the already highly concentrated GAC and OB markets. IDFF ¶¶ 368-370; CCPFF ¶ 4. In the GAC market, concentration rises 1078 points to a post-Acquisition HHI of 4391. IDFF ¶ 368; *see also* IDFF at ¶ 369; IDA at 150-51. In the OB market, concentration increases 1323 points to a post-Acquisition HHI of 6854. PX02148 (Town, Expert Report) ¶ 61, 143 (Ex. 6), *in camera*. The Acquisition easily shatters the *Merger Guidelines* thresholds for acquisitions presumed likely to enhance market power. *Merger Guidelines* § 5.3. How does ProMedica respond to these facts about its dominance, market shares, and market concentration? Other than saying market shares and concentration levels do not end the competitive analysis, it responds with silence.[1]

The presumption of competitive harm is confirmed by a wide array of evidence, including party documents. Internal merger-related documents illustrate the parties' understanding that ProMedica would greatly enhance St. Luke's leverage with health plans and result in higher reimbursement rates. For example, ProMedica prepared a draft presentation for potential affiliation partners that asked and answered the question, "Why ProMedica? . . . Payer System Leverage." PX00226 at 008. St. Luke's documents – including board presentations, due diligence materials, and planning documents – reveal St. Luke's intention to avail itself of ProMedica's leverage with health plans in order to obtain higher rates. IDFF ¶¶ 597-600, 603 (citing, e.g., PX01030 at 020, *in camera* ("An SLH affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of

[1] ProMedica does dispute that OB is a separate relevant service market.

negotiating clout."); PX01125 at 002, *in camera* (ProMedica brings "incredible access to outstanding pricing on managed care agreements"); PX01231, *in camera* ("Yes we asked { } for { }, but if we go over to the dark green side [i.e., ProMedica] . . . we may pick up as much as { } in additional { } and Paramount fees"). ProMedica's explanation for these statements? None. Further silence.

Evidence of vigorous, head-to-head pre-Acquisition competition between ProMedica and St. Luke's bolsters the presumption of competitive harm. ProMedica repeatedly sought to induce health plans to exclude St. Luke's from their networks. CCPFF ¶¶ 365-80 (citing efforts to have St. Luke's excluded from { } and { } networks and evaluating the possibility of St. Luke's exclusion from { } and { } networks). ProMedica successfully procured a contract that excluded St. Luke's from { } network from 2005 until June 30, 2009. CCPFF ¶ 366. Even then, the contract required { } to increase ProMedica's rates at all of its Lucas County hospitals by { } if { } added St. Luke's to its network after June 30, 2009. CCPFF ¶ 427. This rate-penalty term was the "main deal breaker" for ProMedica in negotiations all along and required a "huge effort" involving the company's then-CEO to obtain. PX00295 at 001, *in camera*. The ProMedica executive in charge of health-plan contracting wrote that { } "will have to pay PHS for the privilege" of adding St. Luke's to its network. CCPFF ¶ 371. ProMedica's response to this evidence of direct, cut-throat pre-Acquisition competition with St. Luke's? Again, silence.

St. Luke's was well aware of this competitive bull's-eye on its back. PX01127 at 001 ("ProMedica desires the SLH geographic area, so they will continue to starve SLH through exclusive managed care contracts and owned physicians. They will do this until we sign up with them or are weakened[.]"); PX01152 at 001 (ProMedica is "continuing an aggressive strategy to

take over St. Luke's or put us out of business."). Yet St. Luke's maintained the ability to compete against the dominant ProMedica, even taking one-half of the share that ProMedica lost through the first nine months of 2009. CCPFF ¶ 356. In this appeal, ProMedica makes no attempt to explain how St. Luke's stole its market share even while St. Luke's was allegedly in financial distress. Still more silence.

The close and direct competition between ProMedica and St. Luke's is also apparent in party documents predicting ProMedica hospitals would lose { } of inpatient admissions and { } of dollars in revenues and profits annually if St. Luke's were admitted to Anthem's and Paramount's networks. IDFF ¶¶ 467-71; IDA at 154-55. Indeed, ProMedica estimated that it might lose up to ${ } in *margin* at { } alone if St. Luke's joined the Paramount network and lose another ${ } in margin upon St. Luke's readmission to Anthem's network. IDFF ¶¶ 469, 471. ProMedica's response? Silence.

Damning as these facts are, ProMedica tries to obscure them behind other, irrelevant facts and arguments. For example, Respondent's Appeal Brief alleges, without merit, that there are deficiencies in the testimony and evidence provided by Complaint Counsel's economic expert and MCO witnesses and that *any* deficiency, no matter how immaterial, is fatal to Complaint Counsel's *entire* case. There is no legal support for that proposition. Rather, the economic evidence and MCO testimony is consistent with – thus it confirms and reinforces – all the other evidence of the Acquisition's anticompetitive effects.

Notably, no witness who was not on ProMedica's payroll or serving as a paid consultant – i.e., not one objective third-party witness – testified in support of ProMedica's theory of the case. Not one testified that St. Luke's lacked competitive significance. On the contrary, MCOs stated that an independent St. Luke's was important to competition in Lucas County. PX02067

(Radzialowski (Aetna) Decl.) ¶ 21; PX02073 (McGinty (Humana) Decl.) ¶ 11; Pirc, Tr. 2234; *cf.* CCPFF ¶ 267. No third party testified – as ProMedica would have the Commission believe – that ProMedica would be constrained in its post-Acquisition pricing by health plans, the two remaining hospitals in Lucas County, or physician steering. Instead, all third parties who testified on the subject expect rates at St. Luke's, and potentially ProMedica's other Lucas County hospitals, to rise significantly. No third party testified that its concerns about the Acquisition would be ameliorated by the "*Evanston* remedy" Respondent proposes.

The only witnesses that testified in support of ProMedica's case were its own highly paid executives and consultants – and even they gave trial and deposition testimony that was consistent with, and even supportive of, several seminal aspects of Complaint Counsel's case. For example, with respect to the issue of whether OB services constitute a separate relevant service market, ProMedica's President of Acute Care admitted that Flower Hospital faces essentially *no competition* post-Acquisition. PX01904 (Steele, IHT) at 035, *in camera* (In OB, "Flower doesn't really have competition" now that St. Luke's has been acquired.). ProMedica's CEO testified that he viewed ProMedica and St. Luke's as "strong competitors." Oostra, Tr. 6038-6039. Respondent's economic expert admitted that, if Mercy discontinued OB services, leaving ProMedica an OB monopoly in Lucas County post-Acquisition – prices of OB services in Lucas County could increase. Guerin-Calvert, Tr. 7679-7680.

With respect to St. Luke's financial condition, St. Luke's CEO testified that St. Luke's independently had achieved important financial improvements prior to the Acquisition. *See, e.g.*, Wakeman, Tr. 2571-2572, 2593-2594; PX01920 (Wakeman, Dep.) at 010, *in camera.* ProMedica's CFO testified that, as of 2010, St. Luke's inpatient GAC admissions, outpatient visits, and patient days had increased significantly over prior periods. Hanley, Tr. 4699 (based

on annualizing results as of August 31, 2010), 4701-4702; PX02129 (Hanley, Decl. Ex. 1) at 002. According to trial testimony by the Chairman of St. Luke's Board of Directors, by August 2010 St. Luke's was a profitable, well-performing hospital nearing its capacity, and that financial indicators were "looking up." Black, Tr. 5684-5685, 5687. Respondent's financial expert testified that, in the six months before the Acquisition, St. Luke's financial performance improved and that its financial condition was, at the time of the Acquisition, sound and significantly improving. Den Uyl, Tr. 6562; PX01951 (Den Uyl, Dep.) at 249; *see also id.* at 213, 220-22.

The lone health plan that ProMedica called to testify at trial gave testimony abundantly supporting Complaint Counsel's case. *See, e.g.*, Sheridan, Tr. 6680-6681 (patients want broad networks with hospitals as close to home as possible); 6672-6673 (St. Luke's location serves a great need in Lucas County because no other hospitals are nearby); 6687 (it is harder for United to serve its membership without ProMedica now than it was before the Acquisition). Undermining ProMedica's claim that its hospitals' pricing is not unreasonable, United testified that { } rate with United "reflects an { } and that ProMedica's rates were { } than St. Luke's. Sheridan, Tr. 6654, 6658-6659, *in camera*. Contradicting ProMedica's claim that a Mercy-UTMC network is viable and would constrain ProMedica post-Acquisition, United testified that it { }, let alone ProMedica *and* St. Luke's. Sheridan, Tr. 6692-93, *in camera.* Moreover, like other Lucas County MCOs, United does not have any { }in place to steer patients to non-ProMedica hospitals, and has no plans to implement them in Lucas County. PX01939 (Sheridan, Dep.) at 006, 029, *in camera.*

Against this backdrop, ProMedica unsuccessfully asked Judge Chappell, and now asks the Commission, to *ignore* market share and HHI data, *ignore* all the evidence from third-party witnesses not paid by ProMedica, *ignore* all the party documents and testimony that supports Complaint Counsel's case and contradicts ProMedica's arguments, *and ignore* all the evidence put forth by Complaint Counsel's experts. ProMedica asks the Commission to credit and rely exclusively upon the self-serving testimony and declarations of ProMedica's highly-paid executives and consultants. No such departure from the evidence is warranted in this case.

In sum, Complaint Counsel has established a strong *prima facie* case that the Acquisition violates Section 7, reinforced by voluminous evidence that competition has been substantially lessened and that, as a result, rates at St. Luke's and ProMedica's other hospitals will increase significantly. IDA at 152, 169-73. Respondent bears the heavy burden of rebutting this strong case. IDA at 135. Its silence as to this evidence and feeble attempts at defenses have fallen short in two prior judicial proceedings, and fail yet again here.

A. St. Luke's and ProMedica Were Close Competitors and Close Substitutes

Contending in its Appeal Brief that the Acquisition does not substantially lessen competition or give rise to anticompetitive effects, ProMedica alleges three so-called errors in Judge Chappell's analysis. First, ProMedica states that, by basing his finding that ProMedica and St. Luke's are close substitutes on the perceptions of the "wrong" market participants – i.e., health-plan members rather than MCOs – Judge Chappell "turns unilateral effects theory on its head." RAB at 15. This argument reveals a fundamental misapprehension of law and fact on the part of ProMedica, and it should be rejected.

Undoubtedly, it is important to analyze MCO demand. Indeed, MCO-hospital contracting represents the first stage of competition where hospitals compete for inclusion in

health-plan networks. As such, the actions and views of MCOs are important to merger analysis – but not to the exclusion of employers and patients. MCOs contract with hospitals because they have customers – employers and individuals – who purchase their insurance products and use the services that hospitals offer. Thus, as the Commission recognized in *Evanston*, an "MCO's demand for hospital services is largely derived from an aggregation of the preferences of its employer and employee members." *In re Evanston Nw. Healthcare Corp.*, No. 9315, 2007 FTC LEXIS 210, at *195, 2007-2 Trade Cas. (CCH) ¶ 75,814 (Aug. 6, 2007). The evidence here shows that MCOs are essentially proxies for consumer demand for hospital services. *See, e.g.*, IDFF ¶¶ 276-282; CCPFF ¶ 136; PX02072 ({ }, Decl.) ¶ 12, *in camera.* Moreover, it is patients' desire for access to particular hospitals that drives MCOs relative willingness to submit to higher prices in negotiations, thereby giving hospitals more preferred by health-plan members more contracting leverage. Further, in the "second stage" of competition, in-network hospitals compete head-to-head to attract patients. Finally, it is important to consider on whose backs the anticompetitive harm of an acquisition falls. When hospital reimbursement rates rise, self-funded employers pay higher-cost claims on behalf of their employees directly and immediately; fully-insured employers' premiums rise; and insured individuals are forced to pay higher premiums, co-payments, deductibles, and other out-of-pocket costs. IDA at 173-74. When hospital quality falls, *patients* are harmed. Thus, MCOs *and* their customers – employers and patients – constitute relevant consumers.

Complaint Counsel has never argued that St. Luke's, as a stand-alone hospital, is the closest substitute for the entire ProMedica system in Lucas County, which consists of three hospitals, including a tertiary hospital – because that hardly matters. What matters, and what the evidence clearly demonstrates, is that St. Luke's is a close substitute for ProMedica such that a

substantial number of consumers would switch from ProMedica to St. Luke's if St. Luke's were not available, and vice versa.

Documents and data confirm the closeness of substitution between ProMedica and St. Luke's. First, market shares, which reflect consumer preferences, show that St. Luke's and ProMedica were the most preferred hospitals for a significant number of consumers in Lucas County as a whole. *See* PX02148 (Town Expert Report) ¶¶ 78-79, *in camera*; Town, Tr. 3753-3755, *in camera.*

Moreover, taking a more granular view, St. Luke's and ProMedica have the highest market shares in southwest Lucas County, where St. Luke's is located, for both GAC and OB services.[2] A St. Luke's analysis of market shares in the eight zip codes surrounding St. Luke's (its core service area or CSA) between 2007 and 2010 shows that St. Luke's and ProMedica consistently – and by far – have the two largest market shares for GAC services.[3] PX01235 at 003; *see also* PX01016 at 003, *in camera*; Rupley, Tr. 1978-1983, *in camera.* ProMedica and St. Luke's also have the two largest market shares for OB services in St. Luke's CSA, holding over 80% of the market. PX01235 at 005. An internal Mercy assessment found similar GAC market shares in southwest Lucas County: St. Luke's { }%; ProMedica { }%; UTMC and Mercy lag far behind with { }% and { }%, respectively. PX02290 at 002-003, *in camera*; Shook, Tr. 934-935, 980-981, 1012-1013, *in camera.* And Complaint Counsel's economic expert, Professor Town, found that St. Luke's and ProMedica have, by far, the largest GAC market shares in St. Luke's CSA: ProMedica { }%; St. Luke's { }%, Mercy { }%, and UTMC { }%.

[2] Comparing market shares within individual zip codes or in southwest Lucas County reveals the closeness of competition between specific hospitals. The hospital with the second-highest market share in an area is likely to be the closest substitute for the hospital with the highest market share. PX02148 (Town Expert Report) ¶¶ 77-78, *in camera*; *see* Wakeman, Tr. 2507.

[3] St. Luke's defines its core service area as the eight zip codes surrounding St. Luke's, where 55-60 percent of the admission base comes from. Rupley, Tr. 1944; PX01418 at 005, *in camera*; PX01077 at 008. The primary service area is where approximately 80 percent of St. Luke's patients come from. Rupley, Tr. 1949; PX01077 at 008.

Town, Tr. 3764, *in camera*; PX02148 (Town Expert Report) at 161 (Exhibit 11), *in camera*. For OB services in St. Luke's CSA, Professor Town's shares are ProMedica { }%, St. Luke's { }%, and Mercy { }%. Town, Tr. 3764-3765, *in camera*; PX02148 (Town Expert Report) at 161 (Exhibit 11), *in camera*.[4]

Consumer preference surveys commissioned by St. Luke's in 2006 and 2008 provide additional evidence that ProMedica and St. Luke's are close competitors.[5] Most notably, 42% of the 2008 survey respondents identified TTH as St. Luke's "*most direct competitor*," and another 8% identified Flower. PX01169 at 042; Rupley, Tr. 1958-1959. The surveys also found that St. Luke's and TTH were the two most preferred hospitals for GAC and OB services in St. Luke's primary service area by wide margins. PX01352 at 007; PX01077 at 013; Wakeman, Tr. 2521-2523; Rupley, Tr. 1958-1959. In 2008, 76 percent of patients in St. Luke's CSA preferred either St. Luke's or a ProMedica hospital. PX01169 at 015; Rupley, Tr. 1954-1956.

Professor Town's diversion analysis[6] for all six major health plans in Lucas County concludes that for the members of five of the six plans, ProMedica is St. Luke's next-best substitute, Town, Tr. 3775-3777, *in camera*; PX02148 (Town Expert Report) at ¶ 88, 163 (Exhibit 12), *in camera*,[7] while St. Luke's is ProMedica's second-closest substitute. CCPFF

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[4] Professor Town also found that ProMedica and St. Luke's have the first- and second-largest market shares in a significant number of individual zip codes within Lucas County. PX02148 (Town Expert Report) at 155-159 (Exhibit 10), *in camera*; *see also* RX-71A (Guerin-Calvert Expert Report) at 000165, *in camera* (in "Top 10 Zips," ProMedica and St. Luke's have #1 and #2 market shares).

[5] Respondent claims the ALJ erred in giving weight to consumer surveys to support the conclusion that ProMedica and St. Luke's are close substitutes. RAB at 17. The documents at issue are consumer market research studies conducted by outside consultants for St. Luke's in the ordinary course of business. *See* PX01352 at 007 (referring to 2006 consumer market research findings); PX01169 and PX01077 (2008 market report/study for St. Luke's); Rupley, Tr. 1905. St. Luke's was involved in developing the question and sampling methodology. Rupley, Tr. 1947. The survey findings were presented to the St. Luke's Board of Directors, management, the senior leadership team, and medical staff. *See* PX01352 at 001; Rupley, Tr. 1947, 1950.

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

[7] Respondent's claim that Professor Town "examined only five of six MCOs in Lucas County, omitting MMO" (RAB at 17), is demonstrably false. *See, e.g.*, PX01850 at 20 (showing diversions for all six health plans, including

¶ 345. Although Mercy is ProMedica's closest substitute under the diversion analysis, the salient fact for competitive-effects analysis of this Acquisition is that a significant percentage of patients would go to St. Luke's if ProMedica were not available. *See, e.g.*, CCPFF ¶ 342 ({ }% of { }-insured patients would have gone to St. Luke's if ProMedica were not available).

Complaint Counsel does not deny that Mercy is, in all likelihood, the ProMedica system's closest substitute. But this is not a crucial factor in the analysis of ProMedica's acquisition of St. Luke's. Rather, the closeness of competition between St. Luke's and ProMedica is what matters. That Mercy is ProMedica's closest substitute only shows that a merger between ProMedica and Mercy may be *even more anticompetitive* than ProMedica's acquisition of St. Luke's – it does not undermine the fact that this Acquisition substantially lessened competition. CCPFF ¶ 317-18.

Indeed, recent case law concludes that even if the merging parties are not each other's closest competitors, and even if a third party is the closest competitor to *each* of the merging parties, that does not prevent a finding of unilateral effects. *United States v. H&R Block, Inc.*, No. 11-00948, 2011 U.S. Dist. LEXIS 130219, at *125-26; 2011-2 Trade Cas. (CCH) ¶ 77,678 (D.D.C. 2011) (citing, *inter alia*, AREEDA & HOVENKAMP, ¶ 914, 77-80); *Evanston*, 2007 FTC LEXIS 210, at *160 ("Notably, it is not necessary for the merged firms to be the closest substitutes for all customers, or even a majority of customers.") (internal citation omitted); *Merger Guidelines* § 6.1 (a "merger may produce significant unilateral effects for a given product even though many more sales are diverted to products sold by non-merging firms than to

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MMO). The fact that ProMedica was not the next-best substitute for St. Luke's for MMO members likely reflects that MMO was, until recently, aligned with Mercy and did not have ProMedica in its network. PX02148 (Town Expert Report) at ¶ 88, *in camera*. Thus, Respondent's call to invalidate Professor Town's diversion analysis is baseless. Respondent also tries to discredit the diversion analysis by suggesting that courts "discount" expert testimony when the data and predictions cannot be confirmed by the evidence. RAB at 15-16. As is apparent, the diversion analysis is entirely consistent with the foregoing evidence showing that ProMedica and St. Luke's were close competitors.

products previously sold by the merger partner."); *FTC and DOJ Commentary on the Horizontal Merger Guidelines*, at 28 (Mar. 2006) (a "merger may produce significant unilateral effects even though a non-merging product is the 'closest' substitute for every merging product . . .").[8]

Respondent's preoccupation with competition between Mercy and ProMedica also ignores the equally important "other side of the coin": *ProMedica* undoubtedly was St. Luke's closest competitor and acted as a significant competitive constraint upon it prior to the Acquisition. The major MCOs are unanimous in the view that ProMedica was St. Luke's closest competitor. *See* PX02072 ({ }) ¶ 6, in camera; PX02067 ({ }) ¶ 9, in camera; PX01914 ({ }) at 56-58, in camera. Professor Town concluded that ProMedica was St. Luke's closest competitor for GAC and OB services. CCPFF ¶ 317. The CEOs of ProMedica and St. Luke's testified that, before the Acquisition, St. Luke's viewed ProMedica as its "most significant competitor." Wakeman, Tr. 2511, 2523-2527; Oostra, Tr. 6040. Mr. Oostra also viewed ProMedica and St. Luke's as "strong competitors." Oostra, Tr. 6038-6039.

Respondent appears to argue that, while ProMedica and St. Luke's are not interchangeable components of a health-plan network, a "network including Mercy and other providers ... was, and remains, viable," RAB at 15 – the implication being that health plans can resist a post-Acquisition price increase by substituting Mercy for ProMedica in their networks. It is undisputed, however, that no health plan in at least the last 10 to 20 years has offered a network comprised of only Mercy and UTMC, while they have offered a seemingly limitless menu of other network compositions. JSLF ¶ 9; Resp't Admissions ¶ 14; Guerin-Calvert, Tr. 7893-95. Further, the third-party health plans testified without a single exception that {

[8] Available at www.ftc.gov/os/2006/03/CommentaryontheHorizontalMergerGuidelinesMarch2006.pdf.

}. *See* Pirc, Tr. 2313, 2261-2262, *in camera*; Radzialowski, Tr. 716, *in camera*; Pugliese, Tr. 1478, *in camera*, 1577-1578; Sandusky, Tr. 1351, *in camera*; McGinty, Tr. 1200-1201; Sheridan, Tr. 6692-6694, *in camera*. Lucas County employers agreed that a Mercy and UTMC-only network would not be appealing to their employees. Neal, Tr. 2113; Buehrer, Tr. 3068, 3091. In short, Respondent's claim that this unprecedented network is viable is unsupported by *any* evidence and is contradicted by *all* the evidence.[9]

In a last-ditch effort, ProMedica cites a St. Luke's "patient shift analysis" allegedly showing that UTMC was the primary beneficiary of its lost patient volumes when it was nonparticipating with Paramount and Anthem. RAB at 19. Unfortunately for ProMedica, this analysis is unreliable and contradicted by other evidence. First, St. Luke's CEO, Mr. Wakeman, admitted that he has not verified these "industry reports" to support a correlation between St. Luke's admission to Paramount, a drop in UTMC's share, and an increase in St. Luke's share. Wakeman, Tr. 3049-50. Mr. Wakeman also testified that there has been a shift in baby deliveries from TTH to St. Luke's. Wakeman, Tr. 3051. Second, pre-litigation analysis shows that ProMedica expected greatly reduced admissions, revenues, and margins as a result of St. Luke's readmission to Paramount. IDFF ¶¶ 467-71; IDA at 154-55. Finally, none of this, even if true and correlated, disproves that St. Luke's and ProMedica were close pre-merger competitors; it only shows that UTMC is in the competitive mix as well.

B. The ALJ Appropriately Considered and Relied Upon Professor Town's Analysis

[9] Even if a Mercy-UTMC network were to some extent viable, that would not eliminate the competitive harm. The mere fact that *some* competition remains post-acquisition does not mean that an acquisition is not anticompetitive.

Respondent's second allegation is that Judge Chappell inappropriately relied on Professor Town's pricing analysis and merger-simulation model, which Respondent claims are "fatally" flawed.[10] Once again, Respondent's claims do not withstand scrutiny. Professor Town's analysis and model are based on the relevant evidence, sound economic principles and methods, and confirm what St. Luke's, ProMedica, and the health plans know and expect: the Acquisition will lead to substantially higher rates for health plans, employers, and Lucas County residents.

1. Pricing Analysis Is Reliable and Probative

Professor Town examined case-mix adjusted prices, finding ProMedica's prices are { }% higher than St. Luke's rates, as a volume-weighted average. PX02148 (Town Expert Report) at ¶ 92, *in camera*. This result is consistent with evidence from MCOs indicating that ProMedica was much higher priced than St. Luke's. Radzialowski, Tr. 684, *in camera*; Pugliese, Tr. 1484-1485, 1513, 1656-1657, *in camera*; Pirc, Tr. 2238, *in camera*; Sandusky, Tr. 1340-1342, *in camera*; PX02296 at 001, *in camera;* Sheridan, Tr. 6658-6659, *in camera* ({ } reimbursement rate "reflects an { }..."). It is also consistent with the parties' own view. *See, e.g.*, PX01125 at 002, *in camera* (ProMedica would bring St. Luke's "incredible access to outstanding pricing on managed care agreements"). Indeed, ProMedica's CEO, Mr. Oostra, wrote in 2009 that "we hear from payors we are the most expensive in [O]hio." PX00153 at 001.

Respondent's criticisms of Professor Town's pricing analysis are meritless. For example, Respondent's claim that Professor Town's analysis is flawed because it "constructs" prices "for patients at hospitals where they never actually received care" fundamentally misunderstands the

[10] Even if the Commission found any flaws in Professor Town's analysis, that would go to the weight given to his analysis; it would not, as Respondent suggests, doom his entire analysis or Complaint Counsel's entire case. *See H&R Block*, 2011 U.S. Dist. LEXIS 130219, at *88.

analysis. Because average prices can vary widely across hospitals, depending on the severity of the cases that each hospital actually treats, an "apples-to-apples" price comparison requires controlling for differences in hospitals' case-mix. The most effective way to adjust for case-mix is to compute prices for each hospital based on a common patient population, which, by definition, means prices are computed for a hypothetical, apples-to-apples patient population. PX02148 (Town Expert Report) at 104 (App. ¶ 14), *in camera.* This method is utilized by MCOs in the ordinary course of business, and it is the standard methodology accepted by the academic literature, the federal district court in this matter, and the Commission in *Evanston.* PX02148 (Town Expert Report) at 104 (App. ¶ 14 & n.7), *in camera.*

The claim that the pricing analysis is flawed because it does not explain *how* prices may change post-Acquisition (RAB at 21) misunderstands the value of the analysis. The vast differential in pre-Acquisition pricing between ProMedica and St. Luke's demonstrates ProMedica's dominance and leverage with health plans to extract higher rates, even before the Acquisition. PX02148 (Town Expert Report) at ¶ 70, *in camera.* Moreover, the analysis shows that pricing is highly correlated to market shares – that is, the higher a hospital's market shares, the higher its prices. PX02148 (Town Expert Report) at ¶ 71, *in camera.* Finally, the analysis confirms that, if ProMedica raises St. Luke's rates to those of its other Lucas County hospitals, as MCOs expect and St. Luke's expected, this will be a significant price increase for consumers.

Respondent's claim that the analysis is flawed because it cannot explain *why* prices vary across hospitals and whether they vary for competitively benign reasons (RAB at 23) is also misguided. The pricing analysis is not intended to explain the reason for such variation, so its failure to do so is no flaw. True, case-mix adjusted prices may differ by hospital because of market power or other factors such as cost or quality. But Respondent has presented no

evidence – nor is there evidence in the record – that cost or quality differences at Lucas County hospitals explain the observed price differences here. PX01850 (Town Expert Rebuttal Report) ¶¶ 46, 89, *in camera.* Thus, ProMedica's significant market power no doubt largely explains the prices differences; this is consistent with the MCO testimony and ordinary course party documents. PX01850 (Town Expert Rebuttal Report) ¶ 89, *in camera.*

Respondent feebly responds by pointing to a few instances in which a ProMedica hospital is not the most expensive in Lucas County for a given MCO. Complaint Counsel does not claim, however, that ProMedica's prices are the highest for every service, in every contract, with every health plan – and Section 7 has no such requirement. The key point is that, on average, ProMedica's prices are much higher than any of its competitors on a case-mix adjusted basis.

2. Merger Simulation Model is Reliable and Probative

Respondent's attacks on Professor Town's merger-simulation analysis are also baseless and do not disturb the reliability and probative value of his conclusions, especially in light of its consistency with abundant other evidence of competitive harm. For one, Respondent admits that Professor Town's merger-simulation framework has appeared in the peer-reviewed academic literature. RAB at 24. Yet Respondent faults the model here because the particular specification Professor Town employed had not been peer reviewed. RAB at 24. This is a red herring. Professor Town did not use the exact same model specification as in the academic literature because this relevant dataset is unique and requires appropriate tailoring for the case under analysis. PX01850 (Town Expert Rebuttal Report) ¶ 103 & n.161, *in camera.* Importantly, the peer-reviewed academic literature has found the approach used in Professor Town's merger-simulation analysis to be highly relevant for examining hospital/MCO bargaining outcomes. PX01850 (Town Expert Rebuttal Report) ¶ 91 & n.148, *in camera*; *see also* IDFF ¶¶ 633-634.

combination of hospitals but none has ever had a Mercy-UTMC network in at least 20 years, and none believes it is viable.[20] IDFF ¶¶ 565-66

Respondent criticizes the ALJ for ignoring health plans' own leverage in his analysis, but the purpose of the competitive-effects analysis is to measure the *change* in bargaining leverage as a result of the Acquisition. Town, Tr. 3641-42, 3652-52 3656-58. The evidence shows that ProMedica's acquisition of St. Luke's increased its bargaining leverage, allowing it to obtain significantly higher prices than it could have absent the Acquisition. Town, Tr. 3656-58. The merger does nothing to increase the leverage of health plans – indeed, it has the opposite effect. Moreover, health-plans leverage has existed for some time, yet ProMedica still maintained high rates, large market shares, and self-described dominance. The Acquisition increases ProMedica's leverage while the MCOs' remains unchanged, thus giving rise to the anticompetitive effects at issue.[21]

Respondent claims the ALJ inappropriately discounted evidence of pre- and post-Acquisition contract rates, which purportedly shows that ProMedica has not and cannot exercise market power. To accept Respondent's argument, the Commission must place inordinate weight on contracts that ProMedica negotiated for St. Luke's while the antitrust investigation was ongoing, litigation was pending in two forums, and the Hold-Separate Agreement was in place. But it is well-settled that the probative value of post-Acquisition is "extremely limited" precisely because Respondent can "refrain[] from aggressive or anticompetitive behavior when [an antitrust] suit [is] threatened or pending," and then point to their post-Acquisition behavior as evidence. *Chicago Bridge & Iron Co. N.V. v. FTC*, 534 F.3d 410, 434-35 (5th Cir. 2008) (citing

[20] Again, there is no evidence that, even if a Mercy-UTMC network were feasible, this would eliminate the competitive harm.

[21] Notably, Professor Town's willingness-to-pay model controls for the bargaining leverage of the health plans. Town, Tr. 3798-3799, 3884-3885, *in camera.*

and quoting *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 504-05 (1974)). As such, post-Acquisition evidence that *could arguably* be subject to manipulation has little or no probative value. *Chicago Bridge*, 534 F.3d 410 at 435; *see also Hospital Corp. of Am. v. FTC*, 807 F.2d 1381, 1384 (7th Cir. 1986) (Posner, J.).

Finally, unable to make out a legitimate entry defense, Respondent clings to Mercy's { } as a kind of quasi-entry/repositioning claim. Far from being timely, likely, and sufficient, { } has failed to meet its { } goals in 2010 and 2011. { }, *in camera*. { } has not { }. { }, *in camera*. And { } has not seen any measurable change in its { } as a result of the { }. { }, *in camera*. Even if successful, such modest steps ({ }) – which would have taken place without the merger – do not nearly replicate the competition lost by the Acquisition.[22]

II. PROMEDICA'S MERITLESS "FINANCIAL-WEAKNESS" DEFENSE

ProMedica's second fundamental – yet similarly misplaced – argument on appeal is that Judge Chappell, having stated that St. Luke's future independent viability beyond the next few years was "by no means certain," should have concluded the Acquisition was lawful. RAB at 37 et seq. Prior to the Acquisition, St. Luke's was a significant, effective competitor to ProMedica and other Lucas County hospitals. CCPTB at 41-48. Although St. Luke's faced financial challenges during the recent recession, leading up to the Acquisition St. Luke's was *growing* and

[22] Respondent is misguided in relying on *Baker Hughes* to argue that the "threat of entry" is sufficient. RAB at 36. Courts and treatises have rejected the lax standards that led the *Baker Hughes* court to accept a "threat of entry" argument. *See Chicago Bridge*, 534 F.3d at 430 n.10.

Moreover, Professor Town's results here are consistent with the peer-reviewed literature on the effect of hospital consolidation on prices. PX02148 (Town Expert Report) at 111, *in camera.*

Respondent's claim that Professor Town's merger-simulation model cannot "accurately predict" the hospital that patients would choose if their first choice hospital became unavailable or more expensive is false. The merger-simulation model and the diversion analysis estimate substitution patterns using the same mechanism – a mechanism widely accepted by a large body of academic literature examining competition in differentiated products markets. PX01850 (Town Expert Rebuttal Report) ¶¶ 94-95 & n.153, *in camera.* The model's prediction is also consistent with testimony and documents, noted *supra*, demonstrating the extent of close competition and substitution between ProMedica and St. Luke's.

Respondent's claim that Professor Town's merger-simulation model "cannot distinguish between joinder and non-joinder related reasons that explain price" is also incorrect. The merger simulation estimates the causal relationship between the value added, from the perspective of consumers, by each hospital to the MCO's provider network and case-mix adjusted prices. IDA at 170; PX02148 (Town Expert Report) at 101, 108, *in camera.* This added value is defined as the *Willingness-to-Pay (WTP)* for that hospital system. IDFF ¶ 613. The model then predicts a change in prices that results from the elimination of competition by the Acquisition, *holding all other factors constant.* IDA at 170; PX02148 (Town Expert Report) at 102, *in camera.* Therefore, the merger-simulation model specifically isolates and identifies the effect of the Acquisition on prices. PX01850 (Town Expert Rebuttal Report) ¶ 75, *in camera*; PX02148 (Town Expert Report) ¶ 102, *in camera.*

Respondent's expert attempted to dilute the predicted price difference through the addition of five "competitively benign" variables to Professor Town's merger-simulation model,

which is a clever tactic well known among econometricians. This tactic involves adding variables that are correlated with variables already included in the model and that measure no additional causal relationships.[11] Not one of Ms. Guerin-Calvert's five added "benign variables" uncovers a causal relationship that was unaccounted for in Professor Town's model. PX01850 (Town Expert Rebuttal Report) ¶¶ 102-104, *in camera*. Thus, this claim should be disregarded and these variables excluded.

Notably, even running the model with these five variables produces an estimated price increase of 7.3% across all of ProMedica's hospitals (predicting an 18% increase at St. Luke's and a 5% increase at ProMedica's legacy hospitals) that is statistically significant at conventional levels.[12] IDA at 170; CCPFF ¶¶ 1185, 1197.

Respondent's claim that "the *undisputed* evidence showed St. Luke's pre-joinder prices were below competitive levels" (RAB at 28) (emphasis added) – in order to argue that a subsequent price increase would not necessarily be anticompetitive – is wholly inaccurate. St. Luke's rates were lower than those of other hospitals in Lucas County but Complaint Counsel has repeatedly dispelled the notion that St. Luke's pre-Acquisition prices were below some fictitious "competitive level." *See, e.g.*, CCPTB at 25 et seq. In fact, courts generally rely on current prices as the presumptively "competitive price" in antitrust cases. *CF Indus., Inc. v. Surface Transp. Bd.*, 255 F.3d 816, 824 (D.C. Cir. 2001); *see also United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 142-43 (E.D.N.Y. 1997); IIA Phillip Areeda & Herbert Hovenkamp, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR

[11] Adding variable that are correlated with other explanatory variables but are not causally related to the prices has the same effect as reducing the sample size. This can significantly reduce the precision and reliability of estimated effects.

[12] The estimated effect of *WTP* on price is just shy of the threshold for significance. While the conventional level of statistical significance is found at 95% confidence levels – an arbitrary threshold – the estimated effect of *WTP* here has a 94.54% confidence level.

APPLICATION, ¶ 537b (3d ed. 2010).[13]

But even if it could be proved that St. Luke's prices were "sub-competitive" and would have increased absent the Acquisition, this would be irrelevant. By definition, price changes in the "but-for" world are independent of the extent to which the Acquisition will reduce competition. Rather, the predicted price increase resulting from the elimination of competition between ProMedica and St. Luke's would be expected to accrue in addition to any but-for price changes. Professor Town's merger simulation addresses the relevant question by predicting price changes *caused* by the Acquisition, not merely occurring after the Acquisition.[14]

Respondent's claim that Complaint Counsel did not show that ProMedica can *profitably* raise price (RAB at 29 n.6) is bizarre. Professor Town's merger-simulation model predicts a price increase of 16.2% due solely to the elimination of competition between ProMedica and St. Luke's. IDFF ¶¶ 614, 625; IDA at 170. Because the model holds all other factors constant, this price increase would be, by definition, profitable.

Finally, Respondent's assertion that Professor Town's merger-simulation model lacks a temporal component, while true, is irrelevant and constitutes no flaw. Indeed, other, well-established empirical tools, such as HHIs, do not have a temporal element.

C. ALJ Gave Appropriate Weight to MCO Testimony

The third error alleged by ProMedica is Judge Chappell's reliance on purportedly "biased, unsubstantiated, and speculative MCO testimony." Here, MCO testimony was properly admitted into evidence and, having found it to be relevant, material, reliable, and probative, the

[13] Indeed, no court has ever held that, although a price increase resulting from a merger will be significant, the merger will not violate § 7 because the increase is "reasonable" or "fair."

[14] Professor Town also predicted price effects caused by the Acquisition under the assumption of higher St. Luke's "but for" prices and nonetheless found a likely significant price increase, which the ALJ acknowledged. IDFF ¶ 629; IDA at 170 n.22.

ALJ was unquestionably justified in considering it as one type of evidence supporting the Initial Decision.

1. MCO Testimony Is Reliable and Probative

Respondent's claim that MCOs' testimony is unsubstantiated, biased, and speculative (and its reliance on *Oracle*, *Tenet*, and *Arch Coal*) proved hollow the first time (*see* CCPTRP at 20-24), and it remains meritless today. In short, in *Oracle,* the court observed that customer witnesses testified "with a kind of rote," and in *Arch Coal*, the court found customers' testimony constituted general anxiety about having one less supplier but did not persuasively indicate that post-merger coordination was more likely. *United States v. Oracle Corp.,* 331 F. Supp. 2d 1098, 1131 (N.D. Cal. 2004); *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 145-46 (D.D.C. 2004). By contrast, the MCO witnesses here gave detailed testimony about their specific concerns and the basis for those concerns, relying on reviews of utilization data and pricing analyses, decades of first-hand experience negotiating with health plans and evaluating provider networks, and bargaining dynamics and provider-network marketability in Lucas County as the foundation for their concerns about the Acquisition. IDA at 164-65; *see generally* CCPFF at ¶¶ 1306-1361 Pugliese, Tr. 1506-1508, *in camera*; Radzialowski, Tr. 635, 704, 712-713, *in camera*; Sandusky, Tr. 1351, *in camera*; Sheridan, Tr. 6691-6693, *in camera.* In *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999), the court discredited MCO testimony that they would not resist price increases where the evidence showed that they could and it was in their economic self-interest to do so. Here, the evidence shows that health plans cannot defeat a price increase by steering or any other means. IDFF ¶¶ 698-720; IDA at 164. Indeed, St. Luke's apparently came to that conclusion before the Acquisition. *See* PX01130 at 005.

The MCOs' testimony here is consistent with and reinforces the other evidence put forth by Complaint Counsel, showing that the Acquisition substantially lessens competition and gives ProMedica and St. Luke's greater leverage to raise rates. For example, consistent with evidence from St. Luke's, health plans expect that, post-Acquisition, ProMedica will raise St. Luke's prices to the levels paid to ProMedica's other community hospitals in Lucas County (Flower and Bay Park). Pugliese, Tr. 1507-1508, 1517, *in camera*; Radzialowski, Tr. 842-43, *in camera*; PX02148 (Town Expert Report) at ¶ 101 n.183, *in camera*; Black, Tr. 5718, *in camera*; Wakeman, Tr. 2653-2654, 2686.[15] On the other hand, no third-party or even Respondent witness expect rates at St. Luke's to hold steady or decrease post-Acquisition.

Respondent's assertion that the Commission should disregard the MCOs' testimony that a Mercy-UTMC network is not viable because they did not conduct formal studies of patients' travel preferences or willingness to travel is spurious. That patients prefer to stay close to home for basic general acute care and choose health-plan products with local hospitals in-network is well understood and has been noted consistently in prior hospital cases. *See, e.g., Long Island Jewish*, 983 F. Supp. at 141 ("there is evidence that in general, patients prefer to receive health care treatment relatively close to their homes"); *In re Evanston Nw. Healthcare Corp.*, No. 9315, 2005 FTC LEXIS 146, at *284 (Oct. 20, 2005) (Init. Dec.) ("the evidence establishes that people select managed care plans that include a local hospital – that is, a hospital that is close geographically and in travel time . . ."). The evidence that patients prefer local GAC care was stated unanimously by all health plans, including ProMedica's Paramount. IDFF ¶ 475; IDA at 158, 161; CCPFF ¶ 216-21; Randolph, Tr. 7101-7102, *in camera*.

[15] This represents a staggering rate increase. *See* PX02380; *in camera*.

Likewise, there was no need for MCOs to conduct a made-for-litigation study of patients' willingness to accept a narrow Mercy-UTMC network because the answer was obviously no. Radzialowski, Tr. 715-16, *in camera*. Witnesses relied on their experience and the information they regularly received from their sales departments as the foundation for their testimony. IDA at 164-65. In the ordinary course of business, health plans evaluate which network configurations would be marketable and attractive at which prices. IDA at 164-65. Most telling is that not once in the past twenty years or more has a health plan considered in the ordinary course that a Mercy-UTMC network is viable enough to offer to customers. Indeed, given that { } was not successful marketing a Mercy-UTMC-St. Luke's network, it simply strains credulity to think that a Mercy-UTMC network would suddenly become viable.

Finally, there is no proof – or even manifest indication – of bias. The MCO witnesses are independent third parties who, unlike ProMedica's witnesses, received no paycheck from the party calling them to testify at trial. The MCOs must continue to deal with ProMedica and St. Luke's regardless of how this case turns out; they have no reason to give false, misleading, or biased testimony against them. The notion that they are biased because they are competitors of Paramount is nonsense – their testimony related to the Acquisition would impact ProMedica's hospital business, not the Paramount business.[16] When asked, MCOs testified under oath that they had no axe to grind with ProMedica and were merely giving testimony pursuant to Complaint Counsel's subpoena. Radzialowski, Tr. 611-12; Sandusky, Tr. 1299-1300; Pugliese, Tr. 1427-29; Pirc, Tr. 2162-64.[17]

[16] Moreover, it is employers and employees who would ultimately bear the brunt of higher healthcare costs rather than health plans. IDFF ¶¶ 651-63; IDA at 173-74.

[17] Notably, if the Acquisition were going to result in some cost savings, the MCOs, as savvy businesspeople and as "agents" for their customers, would have testified to such savings at trial and supported the transaction.

2. Respondent, Not the ALJ, Ignores "Real World Evidence"

Respondent's claim that Judge Chappell ignored "real-world evidence" that prices cannot be increased beyond Respondent's perceived "competitive levels" (RAB at 32-37) is belied by the real-world evidence that Respondent conveniently ignores.

First, a wealth of evidence contradicts Respondent's suggestion that hospital location and distance from patients is unimportant. Previously cited evidence shows that patients generally prefer to (and do) receive basic GAC services close to home. *See supra* at 22-23. The undisputed fact that St. Luke's and other hospitals have their highest market shares in the area immediately around them illustrates that dynamic. PX02148 (Town Expert Report) at 155-59 (Ex. 10), *in camera.*

Second, Respondent claims that excess capacity at Mercy and UTMC enables health plans to constrain ProMedica post-Acquisition because health plans can steer patients to Mercy and UTMC. Not true. Excess capacity in Lucas County is not a recent development, yet ProMedica has sustained the highest prices for years. PX02148 (Town Expert Report) at 147 (Ex. 8), *in camera.* Moreover, the evidence indicates that UTMC does not, in fact, have excess capacity. Gold, Tr. 225-26. With respect to steering, it defies logic that health plans had an effective tool at their disposal to prevent ProMedica from obtaining high prices yet have chosen not to use it. Indeed, St. Luke's has been the lowest-priced hospital in Lucas County for years with excess capacity; if health plans could steer to low-priced hospitals with excess capacity, St. Luke's would have benefitted long ago, but did not. In fact, health plans testified that they have no way to steer patients and, in any event, patients dislike steering and hospitals resist it. IDFF

¶¶ 699-719; *see supra* at 21.[18] Perhaps most notably, ProMedica has used its leverage to insist on anti-steering provisions in its contracts with {

}. IDFF ¶ 719. Thus, Respondent's excess-capacity and steering claims are meritless.[19]

Third, Respondent claims that ProMedica will be constrained by physicians who have privileges at multiple hospitals in Lucas County and can steer patients away from ProMedica. Again, physician privileges are not a new phenomenon, yet ProMedica has not been price constrained. Moreover, widespread and increasing physician employment by hospitals in Lucas County – in particular by ProMedica – further limits the ability of physicians to steer patients. Town, Tr. 3819-3820, *in camera*; PX01850 (Town Rebuttal Expert Report) ¶ 16, *in camera*; *see* IDFF ¶¶ 688-89. Un aware of hospital rates, physicians make admission decisions based on medical need, not price, so they have no basis and no incentive to steer patients to lower-priced hospitals. IDFF ¶¶ 690, 692-97. Not one witness or ordinary-course document from Respondent shows that physicians steer patients to specific hospitals based on the cost to the employer or health plan.

Respondent yet again asserts that "history" shows that a limited network – meaning a Mercy-UTMC network – is viable. But merely asserting this as "fact" does not make it true. On the contrary, history shows that health plans have had networks consisting of every other

[18] Moreover, other than hospitals, which give their employees incentive to use their employers' hospitals, only one employer out of the thousands in Lucas County is running a pilot program involving 100 employees, and that employer has received complaints about the program. IDFF ¶¶ 708-14.

[19] Even if steering were feasible, this would not eliminate the competitive harm. This would still be a four-to-three GAC merger, a three-to-two OB merger, market shares and concentration would still be incredibly high, and prices would still increase substantially. Steering would introduce some price sensitivity but, in itself, does not render a merger competitively benign. Many mergers occur in markets where there is price sensitivity, yet are competitively harmful. PX01850 (Town Expert Rebuttal Report) ¶ 19, *in camera*; Town, Tr. 3813-14, *in camera*.

its financial condition was *improving*. *See generally*, CCPFF ¶¶ 898-988. Any "uncertainty" over its financial prospects *years from now* does not excuse this patently anticompetitive Acquisition. Indeed, even after affording too much credence to Respondent's claims about St. Luke's allegedly dire financial condition,[23] the ALJ still concluded that St. Luke's financial condition did not serve as a viable defense. IDA at 190. The law and the evidence here fully support that conclusion.

ProMedica concedes that St. Luke's was not a failing firm, as defined in applicable Supreme Court precedent and the *Merger Guidelines*. JSLF ¶ 21; Resp't Admissions ¶ 42. Despite all appearances to the contrary, ProMedica also states that it has never asserted a flailing-firm defense. RAB at 38. Though refusing to call it a flailing-firm defense,[24] ProMedica argues that St. Luke's alleged financial weakness "undermines any market analysis that assumes St. Luke's will continue to operate at pre-joinder levels into the foreseeable future." RAB at 38. Respondent thus attempts to avoid the heavy burdens of a flailing-firm defense, yet seek its benefits through the "back door."

As the Initial Decision states, defending an otherwise anticompetitive transaction on the basis of one merging party's financial condition is "strongly disfavored" (IDA at 182) because it impermissibly "would expand the failing company doctrine, a defense which has strict limits." *FTC v. Warner Commc'ns, Inc.*, 742 F.2d 1156, 1164 (9th Cir. 1984) (internal quotations omitted). A weak-company defense requires the defendant to show that the firm's financial condition is so compromised that current market shares overstate its future competitive

[23] Viewed as a whole and in context, St. Luke's financial condition was much better than one might be led to believe from reading the Initial Decision, and several specific aspects of St. Luke's financial condition (e.g., pension fund obligations, bond rating, etc.) had little or no bearing on its competitiveness or viability. *See generally*, CCPTB at 89-106; CCPTRB at 36-45; CCFF at ¶¶ 898-1085.

[24] This is the first time that ProMedica has objected to characterizing its defense as a flailing-firm defense.

significance. *See Gen. Dynamics*, 415 U.S. at 506-08; *Arch Coal*, 329 F. Supp. 2d at 153. But "[f]inancial weakness . . . is probably the weakest ground of all for justifying a merger [and it] certainly *cannot be the primary justification* of a merger." *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1339, 1341 (7th Cir. 1981) (emphasis added); *see also Warner Commc'ns Inc.*, 742 F.2d at 1164-65; *Arch Coal*, 329 F. Supp. 2d at 154. Moreover, the "weakness of the acquired firm is only relevant if the defendant demonstrates that this weakness undermines the predictive value of the government's market share statistics." *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1221 (11th Cir. 1991); *Arch Coal*, 329 F. Supp. 2d at 154. In other words, "financial difficulties 'are relevant only where they indicate that market shares would decline in the future and by enough to bring the merger below the threshold of presumptive illegality.'" *Arch Coal*, 329 F. Supp. 2d at 154 (citing 4 AREEDA, ANTITRUST LAW ¶ 963(a)(3), at 13).

Here, Respondent must show that St. Luke's market share would drop from 11.5% to 2% or less in the GAC market and from 9.3% to 1.3% or less in the OB market. In its Appeal Brief, Respondent claims that "St. Luke's market share will decrease" (RAB at 38), but it does not substantiate this or say by how much. Indeed, not one ordinary-course document states that St. Luke's will experience such a massive market-share decline.

One critical fact is fatal to ProMedica's entire financial-weakness defense. Prior to the Acquisition, St. Luke's was *gaining* market share – apparently at ProMedica's expense. *See, e.g.*, PX00159 at 012, *in camera* (showing SLH's metro Toledo acute care market share increased in 2008 and through the third quarter of 2009); PX01235 at 003 (showing SLH's GAC market share increased from 2007 through 2009 and OB share increased since 2008. Even assuming that St. Luke's garnered all of the inpatient GAC market share that was lost by hospitals other than ProMedica from 2008 to 2009, St. Luke's still took 0.6 percent of

ProMedica's inpatient market share in that same period).[25] An annual "environmental assessment" prepared for ProMedica's Board of Directors states that St. Luke's picked up half the 1% acute care market share that ProMedica lost through nine months of 2009. PX00159 at 012, *in camera*.[26] Rather than showing St. Luke's losing its competitive edge, this shows ProMedica's desire to nip this surging competitive threat in the bud: "Market share continued to wane in 2009. Adding St. Luke's [i.e., through acquisition] would 'recapture' a substantial portion of recent losses." PX00159 at 005, *in camera*; *see also* Oostra, Tr. 6177-6178, *in camera*.

Notably, St. Luke's 2009 market-share gains occurred at the very time when its financial metrics – including operating income, operating margin, EBITDA, EBITDA margin, operating cash flow, and (for OhioCare, SLH's parent) operating cash flow minus capital expenditures – suggest that St. Luke's was at it "weakest" point financially. IDFF ¶¶ 786, 794, 799. Thus, St. Luke's market shares likely understate, rather than overstate, its future competitiveness.

Furthermore, leading up to the Acquisition, St. Luke's financial condition was improving. *See, e.g.,* Den Uyl, Tr. 6562, 6593-6594, *in camera*; Dagen, Tr. 3187; PX02147 (Dagen Expert Report) at ¶¶ 49-55; Wakeman, Tr. 2594, 2597. Indeed, Respondent admits that St. Luke's achieved several specific financial improvements during this period. JSLF ¶¶ 27-32, 36.

St. Luke's financial improvement is largely attributable to a "Three-Year Plan" by Mr. Wakeman in June 2008, including strategic pillars for "Growth" and "Finance/Corporate." PX01026 at 001; JSLF ¶ 39. These pillars each included several goals for turning St. Luke's finances around, including, for example, increasing inpatient and outpatient net revenues and

[25] First quarter 2010 market shares are missing data for TTH and Toledo Children's Hospital so they will understate ProMedica's market share and may overstate St. Luke's and/or other competitors' market shares.

[26] One percent of ProMedica's 2009 gross revenue represents tens of millions of dollars. CCPFF ¶ 356.

growing St. Luke's market share to 40% within its core service area. PX01026 at 001-002; RX-56 (Den Uyl Expert Report) at ¶ 50, *in camera*. The Three-Year Plan led to concrete financial improvements. The ALJ concluded that "St. Luke's financial performance, as of the date of the Joinder, improved over its performance in 2008 and 2009." IDFF ¶ 949. Specifically, the ALJ found that St. Luke's financial condition was relatively strong and/or improving in several respects:

- By August 31, 2010, the month before the consummation of the Acquisition, St. Luke's had achieved its goal of obtaining more than a 40% market share in its core service area. IDFF ¶ 928.

- St. Luke's inpatient and outpatient net revenues increased in each calendar year from 2008 through 2010. IDFF ¶ 926-27. By August 31, 2010, St. Luke's had achieved its goal of increasing inpatient net revenue by more than $3.5 million per year on average and increasing outpatient net revenue by more than $5 million per year on average. IDFF ¶ 924-25.

- St. Luke's had $65 million in cash and investments as of August 31, 2010. IDFF ¶ 866; *see also* IDFF ¶ 862. Thus, St. Luke's had enough cash and investments to pay off *all* of its outstanding debt. IDFF ¶ 919.

- According to Moody's, St. Luke's had a "very low debt position," "very strong" cash-to-debt coverage, "adequate" liquidity measures, and a "relatively favorable payor mix." IDFF ¶ 881.

- St. Luke's level of bonds outstanding was fairly low – less than $11 million in total bond debt as of August 31, 2010. *See* IDFF ¶¶ 916, 918. St. Luke's cash-to-debt coverage ratio of 412% was four times higher than the average for all Moody's-rated hospitals. IDFF ¶ 882.

- Other than during the financial trough of 2009, St. Luke's had positive EBITDA and EBITDA margin from 2007 through August 31, 2010. IDFF ¶ 794.

- St. Luke's operating margin, operating cash flow margin (i.e., EBITDA margin), and operating income in the first eight months of 2010 improved compared to calendar year 2009. IDFF ¶ 950-51, 953. Over the same period, St. Luke's losses decreased. IDFF ¶ 952.

- As of August 31, 2010, St. Luke's had increased revenues, decreased expenses, and earned a positive operating margin. IDFF ¶¶ 790-91, 957-58.

- St. Luke's overall occupancy rate in the 12 months prior to the Acquisition increased by approximately { }%. IDFF ¶ 930.

- As of the Acquisition – a little more than two years into the Three-Year Plan – St. Luke's had achieved four of its five pillars (goals) set forth in its Three-Year Plan. *See* IDFF ¶ 931; *see also* PX01326 at 001 (Wakeman: "guess that growth thing worked . . . we did a great job in 4 of the 5 pillars."). St. Luke's also achieved three of the four specific goals under the "Growth" pillar. IDFF ¶ 932.

- In August 2010, St. Luke's activity exceeded its Operating Financial Plan and the prior year's activity. IDFF ¶ 948.

- Had it wanted or needed to access the credit markets, St. Luke's financial condition did not prevent it from borrowing money at a reasonable interest rate. IDFF ¶ 888; IDA at 187.

Additionally, the evidence in the record shows that, prior to the Acquisition, St. Luke's patient volume increased significantly. CCPFF ¶¶ 945-963; IDFF ¶ 930. Although Respondent yet again claims that St. Luke's lost money on average for each patient it treated, RAB at 39, this is false. Mr. Wakeman's own report to the St. Luke's Board of Directors states that higher patient volume led to higher profits at St. Luke's: "[A] positive margin confirms that we can run in the black *if activity stays high.* After much work, we have built our *volume* up to a point where we can produce an operating margin . . ." PX00170 at 001 (emphasis added); see also PX01062 at 003 (citing a profit from operations in August due to high activity levels). A ProMedica analysis verifies that St. Luke's was not losing money on its commercially insured patients: "Managed care plans are reimbursing St. Luke's at about { }% of Medicare which is { }." PX00157 at 012, *in camera.*

Respondent's own words confirm this financial improvement. According to the Chairman of St. Luke's Board of Directors, St. Luke's was a profitable and well-performing hospital nearing its capacity by August 2010. Black, Tr. 5687. He testified that St. Luke's financial indicators were "looking up" in August 2010. Black, Tr. 5684-5685. St. Luke's Vice

President for Patient Care Services wrote in August 2010 that St. Luke's was "growing, not downsizing." PX01582 at 003, *in camera*. Respondent's own financial expert testified that, in the six months leading up to the Acquisition, St. Luke's financial performance had improved. Den Uyl, Tr. 6562. ProMedica's CFO testified that St. Luke's has experienced a positive trend in patient revenues since 2008. Hanley, Tr. 4701-4702.

On September 24, 2010, St. Luke's CEO sent his regular monthly report to the Board of Directors, which contained the very last assessment of St. Luke's performance as an independent hospital, for example:

- "The entire St. Luke's family has much to be proud of with the accomplishments in the past three years. We went from an organization with declining activity to near capacity. Our leadership status in quality, service and low cost stayed firmly in place. In the past six months our financial performance has improved significantly. The volume increase and awareness of expense control were key."
- "Inpatient, (up 7.5%) and outpatient, (up 6.1%), activity was running hot all month . . ."
- "[A] positive margin confirms that we can run in the black if activity stays high."
- "Even with our increased activity, the patient satisfaction scores improved . . . ."
- "If there was one pillar we attained a high level of success in our strategic plan in the past two years, it would be growth."

PX00170 at 001, 004, 006, 007. These are the hallmarks of a resurgent hospital, not a flailing firm.

Rather than prove that St. Luke's financial condition renders *undisputed* market shares unreliable, as the case law requires (*see supra* at II), Respondent merely argues that the ALJ should have accepted its defense because of the vague potential for an uncertain financial future. RAB at 37, 38. As a practical matter, the long-term future viability of *all* businesses, large and small, is arguably uncertain (see Bear Stearns, Lehman Brothers). That St. Luke's recently experienced financial challenges, like virtually every other business, is not surprising in the

context of the recent recession. But more importantly, as explained above, the applicable legal authority requires much more than showing mere financial *uncertainty in the long run* to defend an otherwise patently anticompetitive transaction. Respondent must make a "*substantial showing* that the acquired firm's weakness, *which cannot be resolved by any competitive means*, would cause that firm's market share to reduce to a level that would undermine the government's *prima facie* case." *Univ. Health*, 938 F.2d at 1221 (emphasis added). Respondent fails to make this showing.

Respondent's claim that St. Luke's location in Lucas County "will become less competitively significant" is wholly unsubstantiated and contradicted by the evidence. Mr. Wakeman testified that St. Luke's is "in an optimal or better part of the community in the sense of growth and economic potential." Wakeman, Tr. 2481; *see also* 2477-80. Three witnesses, including Mr. Oostra and Mr. Wakeman, testified that the area around St. Luke's is one of the few places around Toledo that is growing, with an increasing population and new construction starts. Oostra, Tr. 6038; Wakeman, Tr. 2477; Sandusky, Tr. 1306; *see also* PX01906 (Oostra IH) at 81. Health plans repeatedly testified that geographic coverage in southwest Lucas County, where St. Luke's is located, is important for their networks. Pirc, Tr. 2195-2196; Radzialowski, Tr. 712-714, *in camera*; Pugliese, Tr. 1442-1443, 1459; Sandusky, Tr. 1306-1307; Sheridan, Tr. 6672-6673, 6680-6681. ProMedica's – and Mercy's, for that matter – deep-seated interest in acquiring St. Luke's shows that southwest Lucas County is strategically important, and Respondent's Appeal Brief says as much: "For ProMedica, the joinder provided an opportunity to expand its services in southwest Lucas County . . ." RAB at 1. ProMedica's desire to expand in southwest Lucas County – coupled with the millions of dollars that ProMedica has been

spending in litigation to retain St. Luke's – belies the claim that St. Luke's location will become less competitively significant.

Respondent makes the meritless argument that the ALJ's finding of an uncertain future at St. Luke's is akin to that in *Arch Coal*. As explained in more detail in Complaint Counsel's Post-Trial Reply Brief (at 37-40), the facts in *Arch Coal* are highly distinguishable from those here. In short, the industry dynamics and the unsalvageable financial condition of the flailing firm in *Arch Coal*, which include declining coal reserves, differ vastly from the conditions in this case.[27]

Respondent criticizes the ALJ for "dismissing St. Luke's debt obligations," but proper context shows this debt was immaterial. Prior to signing the Joinder Agreement, St. Luke's debt primarily consisted of { }. *See* PX02146 (Brick, Expert Report) at ¶ 13. As of the Acquisition, St. Luke's owed less than $11 million in *total* outstanding debt (including bond debt) and held at least $65 million in cash and investments. JSLF ¶¶ 33-34. In other words, St. Luke's had enough cash and investments on hand to easily pay off all of its outstanding debt. JSLF ¶ 24; Resp't Admissions at ¶ 48.[28]

Respondent decries "looming capital requirements" and claims that "St. Luke's reduction in capital expenditures was unsustainable" (RAB at 39). Yet Respondent points to no evidence that reductions in capital expenditures would, in fact, continue indefinitely. As a supposedly flailing firm cutting capital expenditures, St. Luke's spent at least $7 million on capital expenditures in calendar year 2009 and $14 million in 2008. JSLF ¶ 43; PX01006 at 007; PX01951 (Den Uyl

[27] This case is also distinguishable in almost every respect from the other case Respondent cites, *United States v. Int'l Harvester Co.*, 564 F.2d 769 (7th Cir. 1977). See CCPTRB at 40, n.24.

[28] For a hospital of St. Luke's size, its debt load was low. PX01920 (Wakeman, Dep.) at 107, *in camera*; RX-56 (Den Uyl Expert Report) at ¶ 48, *in camera*; Gordon, Tr. 6858, *in camera*; PX01204 at 011, *in camera* (describing the bond payments as "a car payment" and not a risk to St. Luke's because "we have [] enough cash to completely defease these.").

Dep. at 269) at 069, *in camera*. This is roughly the same as St. Luke's historical average. *See* RPTB at 94. Moreover, St. Luke's purported capital freeze "melted down quickly" as it continued to make capital investments in "big ticket" items and equipment. Wakeman, Tr. 2575; PX01920 (Wakeman, Dep.) at 007-008, *in camera*; PX01361 at 001 ("its [sic] not really a freeze, more like a delay"); PX00397 at 023-025; PX02147 (Dagen Expert Report) at ¶ 63. St. Luke's was the only hospital in Toledo that did not lay off employees during the recession. Wakeman, Tr. 2572. Any reduction in capital expenditures during an economic downturn is nothing more than prudent financial management.[29]

ProMedica's claim that St. Luke's could not have borrowed money to cover its debt and capital-expense costs disintegrates under scrutiny. This claim is entirely based on Mr. Den Uyl's response to a question at trial stating that St. Luke's "didn't really have the wherewithal to borrow money." But Mr. Den Uyl did not analyze, and had no expert opinion on, whether St. Luke's could have borrowed money as a stand-alone entity. CCPFF ¶ 1021. By contrast, Complaint Counsel's bond expert, Mr. Brick, performed an analysis of this issue and concluded that St. Luke's could have borrowed money, as had many other hospitals with the same credit rating from Moody's. PX02146 (Brick, Expert Report) at ¶¶ 9-10.[30]

Finally, Respondent's claim that St. Luke's would have had to cut services absent the Acquisition is contradicted by the evidence. At trial, St. Luke's Chairman of the Board testified that the Board decided not to cut services and that such cuts were not a "major topic of

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[29] ProMedica itself (and Mercy) froze non-emergency capital expenses until 2009. PX00409 at 013, *in camera*; Oostra, Tr. 6125; PX01906 (Oostra, Dep.) at 018, 021, *in camera* ("we pulled back { } that we had").

[30] Respondent's claim that Mr. Brick's conclusion "lacks foundation because he did no independent analysis to support his conclusion" (RAB at 39) is false. Mr. Brick was the only expert to analyze and opine on St. Luke's ability to access the debt markets. *See* CCPFF ¶ 1021. He based his opinion on a review of the relevant evidence and conducted independent analysis. *See* Brick, Tr. 3429-31, PX02146 (Brick, Expert Report) at ¶¶ 1-5, 8. That Mr. Brick did not prepare a brand-new analysis of "the characteristics of the region or service area in which St. Luke's competes" and instead relied on materials prepared by Moody's (Brick, Tr. 3511 et seq.) is unremarkable and irrelevant.

discussion" because the Board disliked that idea. IDFF ¶ 401. Additional evidence, consistent with Mr. Black's testimony, shows that St. Luke's considered service cuts in October 2009 (PX01018 at 008), but the Board abandoned that idea by December 2009 and did not consider it again while evaluating its other options going forward (*see* PX01016; PX01457 at 004-005). The claim that St. Luke's only choices were to cut services or join with another hospital both ignores a third option that St. Luke's specifically considered – pushing health plans for higher rates (PX01018 at 009)[31] – and fails to acknowledge that, even if joining another hospital was necessary, St. Luke's could have affiliated with a partner other than ProMedica (PX01018 at 015-017).

Regardless, three final points bear mention with respect to service cuts: (1) St. Luke's could have been profitable without cutting services and employees (PX02147 (Dagen, Expert Report) at ¶¶ 65-76); (2) the claim that St. Luke's would have cut services absent the Acquisition is undermined by ProMedica's plan to cut – outright or by transfer to ProMedica hospitals – services and staff from St. Luke's (PX01918 (Oostra, Dep.) at 98, 100-101, 106; PX00396 at 002-003, 006, 008-010; PX00020 at 011, 015, 017; RAB at 1 ("For ProMedica, the joinder provided an opportunity to ... 'reposition' its resources and services across four hospitals . . .")); and (3) unlike St. Luke's, ProMedica actually cut services to the community that it previously offered Toledo residents during the economic downturn (Oostra, Tr. 6126; PX01906 (Oostra, Dep.) at 066, *in camera*). ProMedica cannot have it both ways.[32]

[31] St. Luke's had a plan to obtain modest rate increases on its own through better negotiations with health plans, emphasizing St. Luke's low cost and high quality and the benefit to employers of having an independent St. Luke's. PX01018 at 009.

[32] ProMedica's complaint that the "ALJ cites no evidence to suggest that St. Luke's could have continued independently and maintained all of its services" improperly seeks to shift the evidentiary burden of the flailing-firm defense away from ProMedica.

III. REMEDY

A. Divestiture Is the Proper Remedy

Contrary to Respondent's arguments on appeal, Judge Chappell properly held that the appropriate remedy for ProMedica's violation of Section 7 was the divestiture of St. Luke's. The law and facts clearly support that conclusion, and there is no basis to impose here the unusual remedy issued in the highly distinct *Evanston* case.

Section 11(b) of the Clayton Act states that, upon finding a person has violated Section 7 of the Clayton Act, the Commission shall "issue and cause to be served upon such person an order requiring such person to cease and desist from such violations, *and divest itself of the stock, or other share capital, or assets, held* or rid itself of the directors chosen contrary to the provisions of" Section 7. 15 U.S.C. § 21(b) (emphasis added). The Commission still has broad discretion to select an appropriate remedy for antitrust violations. *Jacob Siegel Co. v. FTC*, 327 U.S. 608, 611-13 (1946); *Chicago Bridge*, 534 F.3d at 441; *In re Polypore Int'l, Inc.*, No. 9327, 2010 FTC LEXIS 97, at *100, 2010-2 Trade Cas. (CCH) ¶ 77,267 (Dec. 13, 2010) (Comm'n Dec.). Yet, where "the Government has successfully borne the considerable burden of establishing a violation of the law, all doubts as to the remedy are to be resolved in its favor." *United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 334 (1961); *see also Polypore*, 2010 FTC LEXIS 97, at *100.

Structural remedies – specifically, complete divestitures – are generally the preferred and most appropriate method to restore the competition eliminated by Section 7 violations. *See E.I. du Pont*, 366 U.S. at 329-31; *Polypore*, 2010 FTC LEXIS 97, at *99-100; *Evanston*, 2007 FTC LEXIS 210, at *245. Divestitures are preferred because "complete divestiture provides the greatest likelihood that the asset package will restore competition and be sufficiently viable to readily attract an acceptable buyer." *Polypore*, 2010 FTC LEXIS 97, at *100. A remedy is

"more likely to restore competition if the firms that engaged in pre-merger competition are not under common ownership." *Evanston*, 2007 FTC LEXIS 210, at *245. Moreover, there "are also usually greater long-term costs associated with monitoring the efficacy of a conduct remedy than with imposing a structure solution." *Id.* at *245-46.

B. Respondent's Plea for an "*Evanston* Remedy" Is Meritless and Should Be Rejected

Respondent argues that (1) the ALJ could have, and therefore should have, ordered an "*Evanston* remedy," and (2) that the divestiture order is overbroad because it provides for St. Luke's sale to a third-party rather than returning St. Luke's a stand-alone hospital. Neither argument has merit. Moreover, statements in the Initial Decision regarding the cogency of Respondent's argument (which differs from the argument's ultimate persuasiveness) and whether an *Evanston* remedy could work are nothing more than dicta and carry no legal weight. The Acquisition presents no unique circumstances that would warrant departure from the usual and preferred remedy of divestiture. Respondent presents no evidence that divestiture will be unusually difficult or impossible.

In *Evanston*, the Commission ordered the establishment of separate contract-negotiating teams only reluctantly and explicitly curtailed the future applicability of that remedy by highlighting the unique circumstances of that case. *Evanston*, 2007 FTC LEXIS 210, at *246-49. Specifically, a "long time" (seven years) had elapsed between the consummation of the acquisition and the conclusion of the litigation, making divestiture "much more difficult, with a greater risk of unforeseen costs and failure." *Id.* at *246. A significant amount of integration and improvements had occurred since the merger and, thus, divestiture could reduce or eliminate benefits that had been achieved. *Id.* at *246-47. The Commission concluded that the rationale for its unusual remedy "is likely to have little applicability to our consideration of the proper

remedy in a future challenge to an unconsummated merger, including a hospital merger." *Id.* at *249. The Commission also stated:

> Nor will our reasoning here necessarily apply to consideration of the appropriate remedy in a future challenge to a consummated merger, including a consummated hospital merger. Divestiture is the preferred remedy for challenges to unlawful mergers, regardless of whether the challenge occurs before or after consummation. *Id.* at *250.

The relevant facts here bear no resemblance to *Evanston*. ProMedica acquired St. Luke's subject to a Hold-Separate Agreement ("HSA") with FTC staff that specifically limited ProMedica's ability to integrate and operate St. Luke's. Specifically, among other things, the HSA prevented: (1) ProMedica's termination of St. Luke's health-plan contracts (while allowing health plans the option to extend their contracts with St. Luke's past the termination date, if a new agreement was not reached); (2) the elimination, transfer, or consolidation of any clinical service at St. Luke's; and (3) the termination of employees at St. Luke's without cause. PX00069 at ¶¶ 1-5. Indeed, in order to fully preserve the effectiveness of a divestiture remedy, Complaint Counsel sought and won a federal-court mandated hold-separate order.

The basis for Respondent's claim that an *Evanston* remedy is appropriate is incredibly thin. For legal support, Respondent scrapes together self-serving quotes from cases that are more than three and four decades old. *See* RAB at 41-43. None of these cases, however valid they remain, change the ultimate standard, set out by the Supreme Court and recent Commission decisions, that divestiture is the most appropriate remedy for Section 7 violations. *See E.I. du Pont*, 366 U.S. at 329; *Polypore*, 2010 FTC LEXIS 97, at *99-100; *Evanston*, 2007 FTC LEXIS 210, at *245. Indeed, most of the cases that Respondent cites for support – *Ekco Products*, *Fruehauf*, and *Diamond Alkali* (RAB at 41-42) – acknowledge that divestiture is the normal remedy. *In re Ekco Prods. Co.*, No. 8122, 65 F.T.C. 1163, 1964 FTC LEXIS 115, at *127 (June

30, 1964); *In re Fruehauf Corp.*, No. 8972, 90 F.T.C. 891, 1977 FTC LEXIS 9, at *3 n.1 (Dec. 21, 1977); *In re Diamond Alkali, Co.*, No. 8572, 72 F.T.C. 700, 742, 1967 FTC LEXIS 44, at *88 (Oct. 2, 1967).

Respondent employs a clever maneuver: having failed to put forth a viable efficiencies defense, it now claims that efficiency-destroying divestiture justifies an *Evanston* remedy. Although Respondent claims that "due regard should be given to the preservation of substantial efficiencies or important benefits to the consumers in the choice of an appropriate remedy," the Initial Decision rejected virtually all of Respondent's efficiency claims. IDA at 203 ("Overall, Respondent has not demonstrated that the Joinder has resulted in 'significant economies'"); *see also generally, id.* at 190-203. Any purported community benefits are unsubstantiated. Indeed, Respondent did not call a single community witness to testify at trial about the ostensible benefits of the Acquisition.

Evidence in the record also discredits Respondent's claim that St. Luke's could not meet "meaningful use" requirements to implement electronic medical records ("EMR"). RAB at 43. In fact, St. Luke's had sufficient funds to implement EMR and, prior to the Acquisition, had intended to do so in time to qualify for federal subsidies. CCPFF ¶¶ 1079-80. Respondent's own financial expert testified that, absent the Acquisition, St. Luke's "fully intended" to implement EMR starting in 2010. CCPFF ¶ 1081.

The evidence also dismantles Respondent's made-for-litigation claim that St. Luke's "was not well-positioned for healthcare reform without significant capital assistance." RAB at 43. Pre-Acquisition and pre-litigation, St. Luke's specifically stated that it was "uniquely positioned for a smooth transition to expected health care reform. The hospital already focuses on quality and cost – key components of reform." CCPFF ¶ 885. Pre-Acquisition, Mr.

Wakeman believed that St. Luke's was in a better position than other organizations in the Toledo community to get its cost structure in line with the expectations of health reform. CCPFF ¶ 885.

We need not delve into the details of the terms of Respondent's proposed order. Suffice it to say that there are several ambiguities and problems in it, and it would be a compliance morass.

C. Divestiture Order Is Not Overbroad or Punitive

Finally, Respondent's concern that the divestiture order is overbroad because it authorizes the sale of St. Luke's rather than requires St. Luke's to be "restored to independence" is meritless. The ALJ's order provides that St. Luke's must be divested to another entity, but that entity could be the previously-independent St. Luke's organization. *See* ID Order at 216 (Order I.D; II.A.1). In any case, the Commission has "wide latitude for judgments and the courts will not interfere *except where the remedy selected has no reasonable relation to the unlawful practices found to exist.*" *Chicago Bridge*, 534 F.3d at 441 (emphasis added). This is not such a case.

The two cases Respondent cites in which remedial order provisions were modified – *North Texas Specialty Physicians* and *The Raymond Lee Organization* – are distinguishable and inapposite. Neither is merger case, so the validity of a divestiture order was not at issue. Moreover, in *North Texas Specialty Physicians*, the appeals court upheld the entire order, except for one sub-provision that was "overly broad and internally inconsistent" because it could have required the respondent to affirmatively "messenger contracts or become a party to contracts ... regardless of the potential risks" and because the court found the prohibition on dealing with or refusing to deal with any payer contradictory. *North Tex. Specialty Physicians v. FTC*, 528 F.3d 346, 371 (5th Cir. 2008). *The Raymond Lee* case is even more readily distinguished. There, the

ALJ's order prohibited an "idea promotions company" from making certain misrepresentation and required it to make certain affirmative disclosures to potential customers. *In re The Raymond Lee Org., Inc.*, 92 F.T.C. 489, 1978 FTC LEXIS 124, at *226-31 (Init. Dec.). Fundamentally, the Commission approved the nature of the ALJ's remedy – prohibition of misrepresentations and disclosure requirements. *Raymond Lee*, 92 F.T.C. 489, 1978 FTC LEXIS 124, at *337-54 (Nov. 1, 1978) (Comm'n Dec.). The Commission revised very specific misrepresentations and disclosure provisions because Constitutional rights were implicated. *Raymond Lee*, 1978 FTC LEXIS 124, at *336. No such First Amendment rights are at issue here.

For the foregoing reasons, Complaint Counsel respectfully requests that the Commission affirm the ALJ's Initial Decision, subject to the corrections requested in Complaint Counsel's contemporaneous cross-appeal on product market issues.

Respectfully submitted,

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I also certify that on January 19, 2012, I delivered *via* electronic mail and hand delivery a copy of the foregoing document to:

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CERTIFICATE FOR ELECTRONIC FILING

I certify that the electronic copy sent to the Secretary of the Commission is a true and correct copy of the paper original and that I possess a paper original of the signed document that is available for review by the parties and the adjudicator.

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