

No. 14-762

In the Supreme Court of the United States

PROMEDICA HEALTH SYSTEM, INC., PETITIONER

v.

FEDERAL TRADE COMMISSION

*ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT*

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether a “cluster market,” defined to include health-care services sold under similar competitive conditions, must include services that are negotiated for separately and are offered by a set of service-providers that is different from the providers of other services in the cluster.

2. Whether, in a market that exhibits a strong correlation between higher market share and higher prices, a merger’s tendency to concentrate market share in a single firm can create a presumption that the merger will have anticompetitive effects.

3. Whether evidence of a merger target’s increasing market share and improving financial performance is relevant to a claim that the merger target is a “weakened competitor.”

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statement.....	2
Argument.....	14
Conclusion.....	29

TABLE OF AUTHORITIES

Cases:

<i>Brown Shoe Co. v. United States</i> , 370 U.S. 294 (1962).....	14
<i>Chicago Bridge & Iron Co. v. Federal Trade Comm’n</i> , 534 F.3d 410 (5th Cir. 2008)	23
<i>Federal Trade Comm’n v. H.J. Heinz Co.</i> , 246 F.3d 708 (D.C. Cir. 2001)	23
<i>Federal Trade Comm’n v. University Health, Inc.</i> , 938 F.2d 1206 (11th Cir. 1991)	20
<i>Green Country Food Market, Inc. v. Bottling Grp., LLC</i> , 371 F.3d 1275 (10th Cir. 2004)	19
<i>Image Technical Servs., Inc. v. Eastman Kodak Co.</i> , 125 F.3d 1195 (9th Cir. 1997), cert. denied, 53 U.S. 1094 (1998)	16, 19
<i>Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke’s Health Sys., Ltd.</i> , 778 F.3d 775 (9th Cir. 2015)	24
<i>United States v. Grinnell Corp.</i> , 384 U.S. 563 (1966)	18, 19
<i>United States v. Philadelphia Nat’l Bank</i> , 374 U.S. 321 (1963)	22
<i>United States v. Rockford Mem’l Corp.</i> , 898 F.2d 1278 (7th Cir.), cert. denied, 498 U.S. 920 (1990)	19

Statute:

Clayton Act, 15 U.S.C. 18 (§ 7)	5, 21
---------------------------------------	-------

IV

Miscellaneous:	Page
2B Phillip E. Areeda et al., <i>Antitrust Law</i> (4th ed. 2014)	17, 19
Jonathan B. Baker & Carl Shapiro, <i>Reinvigorating Horizontal Merger Enforcement</i> (2007), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=991588&download=yes	23
Greg Koonsman, CFA, Senior Partner, VMG Health, <i>Analyzing the Health System Market: Mergers, Acquisitions, and Joint Ventures</i> (Oct. 24, 2013), http://www.vmghealth.com/Downloads/BeckerASCKoonsman2013.pdf	22
Carl Shapiro, <i>The 2010 Horizontal Merger Guidelines: From Hedgehog to Fox in Forty Years</i> , 77 <i>Antitrust L.J.</i> 49 (2010).....	23, 26
United States Dep't of Justice & Fed. Trade Comm'n:	
<i>Commentary on the Horizontal Merger Guidelines</i> (Mar. 2006), https://www.ftc.gov/sites/default/files/attachments/merger-review/commentaryonthehorizontalmergerguidelinesmarch2006.pdf	27
<i>Horizontal Merger Guidelines</i> (Aug. 19, 2010), http://www.ftc.gov/os/2010/08/100819hmg.pdf	7, 11

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-29a) is reported at 749 F.3d 559. The opinion and order of the Federal Trade Commission (Pet. App. 30a-206a) are not yet reported but are available at 2012 WL 1155392 and 2012 WL 2450574. The opinion of the Administrative Law Judge (Pet. App. 207a-622a) is reported at 152 F.T.C. 708. The opinion of the district court granting a preliminary injunction is not published in the *Federal Supplement* but is available at 2011 WL 1219281.

JURISDICTION

The judgment of the court of appeals was entered on April 22, 2014. A petition for rehearing was denied on July 24, 2014 (Pet. App. 623a-624a). On September 26, 2014, Justice Kagan extended the time within which to file a petition for a writ of certiorari to and

including December 22, 2014, and the petition was filed on that date. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. a. Reimbursement rates (*i.e.*, prices) for hospital services are established through negotiations between hospitals and the insurers that offer commercial health plans (known as managed care organizations or MCOs). The rates are determined by the bargaining leverage of each party. Pet. App. 5a, 42a, 104a-106a. To attract members (*i.e.*, patients who use hospital services), an MCO must assemble a hospital network that offers the full range of services. *Id.* at 5a, 40a, 43a. However, MCOs need not—and often do not—purchase the same bundle of services from each hospital. For instance, a hospital with a limited range of services but an attractive location may be an important component of a health plan’s provider network. *Id.* at 5a, 17a-18a, 43a.

A hospital’s bargaining leverage is based on the degree of difficulty that the MCO would face in marketing its provider network without the hospital in its network—the MCO’s so-called “walk away” option. If a hospital demands rates above the MCO’s walk-away price-point, the MCO will attempt to assemble a network without that hospital. A hospital that becomes so dominant in a particular market, that an MCO cannot walk away from the hospital and still offer a viable competitive network can command monopoly rates. Pet. App. 5a-6a, 105a-106a.

b. This case involves the merger of two hospital providers in the Toledo, Ohio area, petitioner ProMedica Health System, Inc., and St. Luke’s Hospital (St. Luke’s). Pet. App. 4a, 6a, 30a-31a. Petition-

er operates three general acute care (GAC) hospitals in Lucas County, where Toledo is located. St. Luke's is an independent, full-service community hospital. There are only two other hospital providers in Lucas County: Mercy Health Partners (Mercy), which operates three area hospitals; and the University of Toledo Medical Center (UTMC), a state-supported research and teaching hospital that focuses on complex, specialized treatments for higher-acuity conditions (known as tertiary and quaternary services).¹ *Id.* at 44a-47a, 240a, 311a.

Even before it acquired St. Luke's, which is the area's third-largest provider, petitioner was the largest hospital system and commanded the highest commercial reimbursement rates in Lucas County. *Pet. App.* 22a, 44a-45a. Indeed, petitioner's rates are among the highest in the State. *Id.* at 106a, 324a-325a. MCOs that failed to reach agreement with petitioner, however, could successfully market a network composed of Mercy, UTMC, and St. Luke's. Since 2000, no MCO has offered a network in Lucas County without including either petitioner or St. Luke's. *Id.* at 6a, 108a, 123a, 332a.

Before the merger, petitioner and St. Luke's competed vigorously to attract patients, particularly those residing in the affluent southwest sector of Lucas

¹ Generally speaking, primary services treat common conditions of mild to moderate severity; secondary services are more complex and require some specialization and greater resources (*e.g.*, complex orthopedic surgery); tertiary services are more complex than secondary services, but less complex than quaternary services (*e.g.*, neurological intensive care); quaternary services are the most complex and require the most-specialized equipment and expertise (*e.g.*, organ transplants). *Pet. App.* 43a.

County. Pet. App. 6a, 123a-125a. St. Luke's viewed petitioner as its "most significant competitor." *Id.* at 118a. Petitioner likewise viewed St. Luke's as a "strong competitor." *Id.* at 6a (brackets omitted). Indeed, petitioner offered to discount its rates by 2.5%, amounting to millions of dollars, for MCOs that excluded St. Luke's from their networks. *Id.* at 6a-7a, 93a n.33.

St. Luke's faced financial challenges during the economic recession that occurred in the years leading up to the merger. Pet. App. 49a. St. Luke's Chief Executive Officer, Daniel Wakeman, responded with a three-year strategic plan to reduce costs, increase revenues, and regain patient volume, including from petitioner. *Id.* at 49a-50a. Even before the three-year plan was complete, St. Luke's fortunes began to improve. By August 2010, it had increased inpatient volumes, inpatient revenues, inpatient market share, outpatient volumes, and outpatient revenues. *Id.* at 50a. It had also posted a small but positive operating margin, which Wakeman cited as "confirm[ing] that we can run in the black if activity stays high." *Id.* at 50a-51a (citation omitted).

During this time, St. Luke's entered into affiliation discussions with petitioner, Mercy, and UTMC. Pet. App. 51a-52a. St. Luke's management felt that an affiliation with petitioner "would have a lot of negotiating clout" and "has the greatest potential for higher hospital rates." *Id.* at 54a (citation omitted). But St. Luke's management also recognized that an affiliation with petitioner could "harm the community by forcing higher hospital rates on them." *Ibid.* (citation omitted).

Ultimately, St. Luke's decided to become part of petitioner's system. In May 2010, petitioner and St. Luke's entered into a Joinder Agreement.² Pet. App. 33a, 55a. After the Federal Trade Commission (Commission) opened an investigation of the transaction, petitioner entered into a Hold Separate Agreement with the Commission that allowed the deal to close but restricted petitioner's consolidation of its operations with those of St. Luke's. *Id.* at 33a-34a.

2. In January 2011, the Commission issued an administrative complaint against petitioner, alleging that its acquisition of St. Luke's threatened to substantially lessen competition for inpatient GAC hospital services and for inpatient obstetrical (OB) services sold to commercial health plans in Lucas County, in violation of Section 7 of the Clayton Act, 15 U.S.C. 18. Pet. App. 34a-35a. To preserve its ability to order effective relief if the transaction was ultimately found to be unlawful, the Commission, joined by the State of Ohio, filed a separate complaint in federal district court in Toledo, seeking a preliminary injunction that would extend the Hold Separate Agreement pending the outcome of the Commission's administrative proceedings. *Ibid.* The district court found that the merger would likely lessen competition substantially for inpatient GAC services and for inpatient OB services, and it granted the injunction. *Id.* at 35a.

After a full administrative trial that lasted more than 30 days and produced more than 8000 pages of trial testimony and 2600 exhibits, Pet. App. 9a, an

² Petitioner became the sole corporate member or shareholder of St. Luke's. For antitrust analysis of the transaction, petitioner therefore controls St. Luke's. Pet. App. 33a.

administrative law judge concluded that the merger was unlawful. *Id.* at 207a-622a.

3. On de novo review, the Commission affirmed the determination that the merger was likely to lessen substantially competition in the markets for inpatient GAC services and inpatient OB services sold to commercial health plans in Lucas County. Pet. App. 30a-153a. The anticipated result, the Commission found, would be “higher health care costs for patients, employers, and employees in the Toledo area.” *Id.* at 31a.

a. In defining the relevant product market, the Commission agreed with the parties that inpatient GAC hospital services were properly viewed as a “cluster market.” Pet. App. 61a. Under the “administrative-convenience” theory, separate relevant products for sale (including services) may be clustered together—and thus aggregated for analytical purposes—if the products are sold under sufficiently similar competitive conditions. *Id.* at 12a-13a, 63a-64a. That approach works, however, only if the clustered products face similar market conditions. A “cluster that mixes services with different geographic markets, or that groups together services for which the merger leaves different numbers of remaining rivals or has a different competitive impact, could easily confuse the competitive analysis.” *Id.* at 72a; see *id.* at 64a-65a, 68a-69a.

The Commission concluded that primary and secondary health services, excluding inpatient OB services, could appropriately be clustered. Pet. App. 60a-84a. Tertiary services were excluded from the cluster because St. Luke’s does not provide tertiary services, and because patients are willing to travel farther for

tertiary services, making the geographic market for those services broader than Lucas County. *Id.* at 76a-77a.³ OB services were excluded from the cluster because such services “are offered under different competitive conditions than those applicable to the other services included” in the cluster. *Id.* at 81a. For instance, whereas all four Toledo-area hospital systems provide other primary and secondary services, UTMC does not offer OB services. *Ibid.* OB services also receive special “reimbursement rate carve-outs,” meaning that the rates and rate structures (*e.g.*, per diem or case rates) are negotiated separately from other services. *Id.* at 82a. The Commission therefore concluded that OB services “constitute a separate relevant product market,” requiring separate analysis. *Id.* at 79a.

Next, for each product market, the Commission assessed market concentration, widely considered a “useful indicator of likely competitive effects of a merger.” U.S. Dep’t of Justice & Fed. Trade Comm’n, *Horizontal Merger Guidelines* § 5.3, at 18 (Aug. 19, 2010) (*Merger Guidelines*)⁴; Pet. App. 666a. To do so, the Commission employed the Herfindahl-Hirschman Index (HHI), which “ranges from 10,000 (in the case of a pure monopoly) to a number approaching zero (in the case of an atomistic market).” Pet. App. 667a & n.9.⁵ Under the *Merger Guidelines*, a post-acquisition HHI of more than 2500 paired with an HHI increase

³ The parties agreed that the relevant geographic market for primary and secondary services is Lucas County. Pet. App. 84a.

⁴ See <http://www.ftc.gov/os/2010/08/100819hmg.pdf>, and portions reprinted at Pet. App. 636a-687a.

⁵ The HHI is calculated by summing the squares of the market shares of all firms in the market. Pet. App. 667a & n.9.

of more than 200 points “will be presumed to be likely to enhance market power.” *Id.* at 669a.

The Commission found that the merger at issue here produced HHI numbers that were “more than sufficient” to indicate likely anticompetitive effects. Pet. App. 85a. The merger would give petitioner 58.3% of the GAC market, increasing the market’s HHI by 1078 points and resulting in a post-acquisition HHI of 4391. *Ibid.* In the OB market, the merger would give petitioner an 80.5% market share, increasing the HHI by 1323 points and producing a post-acquisition HHI of 6854. *Ibid.* Although it evaluated inpatient OB services separately from other services—in accordance with its relevant-market definition—the Commission noted that the HHI numbers would have indicated “presumptive illegality” under the *Merger Guidelines* “regardless of which market definition [wa]s used.” *Id.* at 84a; see *id.* at 85a (“[Petitioner] does not dispute this.”); *id.* at 86a n.32 (petitioner’s expert “conceded that, even under her relevant market definition, the acquisition increased concentration levels in an already highly concentrated market to levels deemed presumptively anticompetitive under the” *Merger Guidelines*).

The Commission did not rely solely on a structural presumption arising from its market-share analysis. Instead, substantial additional evidence confirmed that the merger would likely have anticompetitive effects. That evidence included evidence of petitioner’s pre-merger market dominance, Pet. App. 106a; evidence that petitioner was St. Luke’s closest competitor, and that St. Luke’s was petitioner’s closest competitor for a significant fraction of Lucas County patients, *id.* at 118a-119a, 123a-125a, 129a-131a; evi-

dence that the merger's objective and expected outcome were increased bargaining leverage, resulting in higher reimbursement rates, *id.* at 111a-112a, 118a, 121a; testimony from MCOs that the merger would increase petitioner's bargaining leverage and enable it to extract higher rates, *id.* at 107a-108a, 112a-113a, 122a-123a; and economic and statistical analyses showing that anticompetitive price increases would likely ensue, *id.* at 113a-120a, 132a-137a. The record before the Commission showed that those anticompetitive effects would, "if anything, be even more severe in the OB services market." *Id.* at 137a; see *id.* at 137a-140a.

In response to that evidence, petitioner did not argue that the merger would create "procompetitive benefits [or] efficiencies." Pet. App. 38a n.5. Instead, it sought to defend the transaction by arguing that the weak financial condition of St. Luke's made market share an inaccurate predictor of its future performance. *Id.* at 89a, 92a-96a, 99a. The Commission found, however, that the record did not paint nearly so bleak a picture of that hospital's financial condition and competitive prospects. Instead, the record showed that St. Luke's had been gaining market share before the merger (at the expense of petitioner), *id.* at 89a-90a; that St. Luke's had made significant progress in improving its operational performance, *id.* at 90a-95a; that it had sufficient resources to fund its existing capital needs, *id.* at 95a-96a; and that it had options available to it other than an anticompetitive merger with petitioner, *id.* at 96a-101a.

Having found the merger unlawful, the Commission entered an order requiring petitioner to divest St. Luke's. Pet. App. 164a-206a.

b. In a concurring opinion, Commissioner Rosch stated that he would have defined the relevant cluster market to include tertiary and OB services. Pet. App. 154a-156a. He noted, however, that the merger's increase in HHI would be "more than sufficient to trigger [a] presumption of liability * * * even using [petitioner's] proposed market definition." *Id.* at 158a. He also agreed with the Commission's conclusions on liability and remedy. *Id.* at 154a.

4. The court of appeals affirmed. Pet. App. 1a-29a. The court found no merit in petitioner's assertions of factual and legal error, concluding that the Commission's analysis was "comprehensive, carefully reasoned, and supported by substantial evidence in the record." *Id.* at 29a.

With regard to the definition of the relevant product markets, the court of appeals found that the Commission had appropriately used an "administrative convenience" approach to cluster together hundreds of individual hospital services for its analysis of the merger's competitive effects. Pet. App. 11a-18a. The court found "[s]ubstantial evidence" to support the Commission's decision to aggregate primary and secondary services (excluding OB services), because the "competitive conditions" of those markets were sufficiently similar. *Id.* at 13a. The court further held that the Commission had properly excluded tertiary services from the cluster in light of the different characteristics (in terms of geographic scope and market share) of those services. *Id.* at 14a-15a. The court also sustained the Commission's treatment of OB services, "whose competitive conditions differ in at least two respects from those for other services," as a distinct market. *Id.* at 14a. The court explained

that the respective market shares of OB service-providers differ, and that only a limited number of hospitals offer *any* OB services. *Ibid.*

For several reasons, the court of appeals rejected petitioner’s contention that the product market should instead be defined according to a “transactional-complements” or “package-deal” theory. Pet. App. 16a. Petitioner argued that tertiary and OB services should be included under this theory “because MCOs typically bargain for all of a hospital’s services in a single negotiation.” *Id.* at 17a. The court found that argument to be at odds with the evidence. The court explained that “the record makes plain that the MCOs do not demand from each hospital a package of services that includes tertiary and OB,” and it found no evidence that MCOs are “willing to pay a premium to have all of those services delivered * * * in a single package.” *Ibid.*

The court of appeals similarly rejected petitioner’s argument that the established burden-shifting framework for analyzing mergers—under which a substantial increase in market concentration may create a rebuttable presumption of competitive harm—was inapplicable here because the case was tried under a theory of “unilateral effects.” Pet. App. 18a-24a. The unilateral-effects theory “holds that ‘the elimination of competition between two firms that results from their merger may alone constitute a substantial lessening of competition.’” *Id.* at 20a (brackets omitted) (quoting *Merger Guidelines* § 6, at 20); see *id.* at 669a. Petitioner did not dispute the theory’s validity as a general matter. Instead, petitioner argued that decreased competition would not result from “market concentration *per se*,” but rather would depend on

“the extent to which consumers regard [petitioner] as their next-best choice after St. Luke’s.” *Id.* at 21a-22a.

The court of appeals determined that application of a rebuttable presumption was warranted here for two reasons. First, the record showed that, “in this market, the higher a provider’s market share, the higher its prices.” Pet. App. 22a. The court explained that

[petitioner’s] prices—already among the highest in the State—are explained by *bargaining power*.
 * * * Here, the record makes clear that a network which does not include a hospital provider that services almost half the county’s patients in one relevant market, and more than 70% of the county’s patients in another relevant market, would be unattractive to a huge swath of potential members. Thus, the Commission had every reason to conclude that, as [petitioner’s] dominance in the relevant markets increases, so does the need for MCOs to include [petitioner] in their networks—and thus so too does [petitioner’s] leverage in demanding higher rates.

Id. at 22a-23a.

Second, the court of appeals noted the “exceptional” HHI numbers themselves, which “are in every respect multiples of the numbers necessary for the presumption of illegality.” Pet. App. 23a. The court observed, moreover, that petitioner’s large market share even before the merger “makes it extremely likely, as [a] matter of simple mathematics, that a ‘significant fraction’ of St. Luke’s patients viewed [petitioner] as a close substitute for services in the relevant markets.” *Ibid.* Because the “ultimate inquiry” is whether the

merger is likely to enhance market power, the court concluded that, taken together, these factors

strongly suggest that this merger would enhance [petitioner's] market power even more, to levels rarely tolerated in antitrust law. In the context of this record, therefore, the HHI data speak to our "ultimate inquiry" as directly as an analysis of substitutability would.

Id. at 24a (citation omitted). Accordingly, "[i]n the context of this record," the court held that "[t]he Commission was correct to presume the merger substantially anticompetitive." *Ibid.*

The court of appeals also agreed with the Commission that the structural presumption was supported by a wide range of direct evidence of anticompetitive effect, including the parties' own statements and documents and the testimony of the MCOs. Pet. App. 25a-27a. The court found "meritless" petitioner's assertion that MCOs considered Mercy to be a closer substitute than St. Luke's. *Id.* at 27a. The court explained that this assertion ignored the merging parties' own statements and other evidence showing substantial direct competition between petitioner and St. Luke's. *Ibid.*

Finally, the court of appeals rejected as factually unsupported petitioner's argument that St. Luke's was in such dire financial straits that it was not a meaningful competitive constraint on petitioner. Pet. App. 28a. The court explained that "[t]he record demonstrates that St. Luke's market share was increasing prior to the merger, that St. Luke's had sufficient cash reserves to pay all of its obligations and meet its capital needs without any additional borrowing; and

that, according to St. Luke’s CEO, ‘we can run in the black if activity stays high.’” *Ibid.* (citation omitted).

ARGUMENT

1. Petitioner argues (Pet. 15-23) that the court of appeals erred in applying the “administrative-convenience” approach to create a cluster market for inpatient GAC services and a separate product market for inpatient OB services. The Sixth Circuit’s analysis is correct and does not conflict with any decision of this Court or of another court of appeals.

a. The court of appeals correctly applied the administrative-convenience methodology for defining cluster markets. As petitioner observes (Pet. 17-18), different products may be grouped together for purposes of analyzing a merger’s anticompetitive effects if competitive conditions for those products are substantially similar. See, e.g., *Brown Shoe Co. v. United States*, 370 U.S. 294, 327-328 (1962) (analyzing together different ages and sexes within children’s shoes, because “whether considered separately or together, the picture of this merger is the same”). Grouping together products that are sold under *different* competitive conditions, however, would “obfuscate[] the competitive consequences of the transaction” and “confuse the competitive analysis.” Pet. App. 72a.

Petitioner acknowledges that the competitive conditions for OB services differ significantly from the GAC services included in the GAC cluster. Pet. 20; see Pet. App. 81a (“OB services are offered under different competitive conditions than those applicable to the other services included in the GAC inpatient hospital services cluster market.”). As the court of appeals noted, petitioner’s pre-merger market share for OB services was “more than half-again greater”

than its market share for other GAC services. *Id.* at 14a. The merger would also have left only two providers of OB services in Lucas County, compared with three providers of other primary and secondary GAC services. *Ibid.* Accordingly, the court properly upheld the Commission’s decision to analyze OB services as a separate relevant market.

Petitioner contends (Pet. 21) that the “only permissible approach to clustering here” was to group OB services along with other primary and secondary GAC services, because MCOs negotiate for a hospital’s primary and secondary services as a “package deal.” Petitioner alludes (without citation) to “unrebutted evidence showing that the relevant consumers in this market (i.e., MCOs), treated a collection of primary and secondary services, including inpatient OB services, as a single product during negotiations.” Pet. 19 (emphasis omitted). In petitioner’s view, the Commission and the court erred by failing to “respect the ‘package deal’ of services” that comprised all primary and secondary inpatient services, including OB services. Pet. 21.

That argument is inconsistent with substantial record evidence about how MCOs in Lucas County actually make their purchasing decisions. As the Commission explained, “the rationale on which [petitioner’s] cluster is based—[namely,] the cluster is the full range of inpatient services that MCOs demand when they negotiate with hospitals—is contradicted by the observation of actual services demanded by MCOs from each hospital or hospital provider.” Pet. App. 72a. The evidence at trial showed, *inter alia*:

- MCOs do not purchase the same bundle of services from each hospital provider and often

build a complete provider network using a combination of services from different hospitals. *Id.* at 17a, 71a.

- “[T]he merging hospitals track OB services market shares separately from [other] GAC inpatient services.” *Id.* at 80a.
- “MCO/hospital negotiations consider individual terms that fall within the resulting contract and permit modifications to those individual contractual terms.” *Id.* at 73a.
- “[C]ontracts between MCOs and hospitals may contain ‘carve-outs’ that price one hospital service differently from other hospital services.” *Ibid.* (citation omitted).
- Specifically, “case rates and per diem rates for OB services” have historically been negotiated separately. *Id.* at 82a.
- OB services receive “reimbursement rate carve-outs.” *Ibid.*
- Aetna, which contracts with all Lucas County hospitals, *id.* at 48a, “specifically negotiates rates for maternity care.” *Id.* at 82a.

The Commission accordingly found, *id.* at 71a-83a, and the court of appeals agreed, *id.* at 17a-18a, that OB services warrant separate analysis based on the actual market conditions under which contracts for those services are negotiated.

Petitioner also argues that package-deal treatment is required where “the product package is significantly different from, and appeals to buyers on a different basis from, the individual products considered separately.” Pet. 17 (quoting *Image Technical Servs., Inc.*

v. *Eastman Kodak Co.*, 125 F.3d 1195, 1205 (9th Cir. 1997), cert. denied, 523 U.S. 1094 (1998)). The court of appeals *agreed* with that proposition, stating that if “MCOs are willing to pay a premium to have a package of services * * * delivered by a single provider,” then “the relevant market is the market for the package as a whole.” Pet. App. 17a; see 2B Phillip E. Areeda et al., *Antitrust Law* ¶ 565c, at 433 (4th ed. 2014) (*Antitrust Law*) (package-deal approach may be appropriate where “most customers would be willing to pay monopoly prices for the convenience of receiving [that] grouping of products”).

The court of appeals rejected petitioner’s argument for package-deal treatment here, not because it disagreed with petitioner’s articulation of the governing legal standard, but because it found “no evidence that MCOs are willing to pay a premium to have all of those services delivered * * * in a single package.” Pet. App. 17a. Rather, although MCOs must offer a full range of services to their members, “MCOs do not need to obtain all of those services from a single provider” and “do not demand from each hospital a package of services” that includes OB services. *Id.* at 17a-18a. The court thus did not, as petitioner contends, “declin[e] to use demand-focused clustering.” Pet. 20. Instead, it determined that the evidence regarding MCOs’ purchasing decisions did not support petitioner’s package-deal approach to defining the cluster.

Petitioner’s argument also proves too much, because petitioner concedes that *some* components of the negotiation “package” are appropriately excluded from the cluster. Petitioner admitted below that outpatient services, which are often negotiated as a group

with inpatient services, are properly excluded from the GAC market “because they have different competitive conditions than inpatient services.” Pet. App. 276a; see *id.* at 275a-276a (citing petitioner’s expert). Petitioner has also abandoned its attempt to include tertiary services in the cluster. *Id.* at 14a-15a, 17a-18a. Petitioner offers no reason why it is acceptable to exclude some services that are part of the supposed negotiation package (outpatient services and tertiary services) but not others (OB services).

b. Petitioner asserts (Pet. 20) that the court of appeals’ analysis of the GAC cluster market is “in tension, if not outright conflict,” with this Court’s decision in *United States v. Grinnell Corp.*, 384 U.S. 563 (1966). In *Grinnell*, the trial court defined a market of protective services (*e.g.*, burglar alarm, fire alarm) that were operated by a central alarm station connected through a single telephone line. *Id.* at 571-572. This Court explained that the protective services were appropriately combined “in a single market” because “there is here a single basic service—the protection of property through use of a central service station.” *Id.* at 572. The Court emphasized that customers used the various protective services “in combination,” and that, for providers to “compete effectively, they must offer all or nearly all types of services.” *Id.* at 572-573; see *id.* at 574 (many customers would “be unwilling to consider anything but central station protection”).

The decision below is fully consistent with *Grinnell*. Even if *Grinnell* is read as a decision about a cluster market—rather than a single market for monitoring by a central alarm station⁶—it shows only

⁶ As a leading treatise observes, “the adopted grouping [in *Grinnell*] was not ‘clustering’ at all, but the simple provision of

that grouping is appropriate where products are demanded and used by consumers “in combination.” 384 U.S. at 573. The Court did not suggest that clustering is required where, as here, the factual record is to the contrary. Indeed, the real lesson of *Grinnell* is that product-clustering is permissible only insofar as “that combination reflects commercial realities.” *Id.* at 572. Here, the record firmly supports the rejection of petitioner’s package-deal approach, which does not reflect how patients use hospital services and “is contradicted by the observation of actual services demanded by MCOs.” Pet. App. 72a; see *United States v. Rockford Mem’l Corp.*, 898 F.2d 1278, 1284 (7th Cir.) (declining to cluster different hospital services whose “prices are not linked,” and noting that “services are not in the same product market merely because they have a common provider”), cert. denied, 498 U.S. 920 (1990).

For the same reason, petitioner is wrong in asserting (Pet. 17, 19-20) that the court of appeals’ approach to defining a cluster market conflicts with decisions of the Ninth and Tenth Circuits. Those decisions indicate that a package-deal approach is required “only when the ‘cluster’ is *itself* an object of consumer demand.” *Green Country Food Market, Inc. v. Bottling Grp., LLC*, 371 F.3d 1275, 1284 (10th Cir. 2004); see *Image Technical Servs.*, 125 F.3d at 1205 (package-deal approach is appropriate “where the product package is significantly different from, and appeals to buyers on a different basis from, the individual products considered separately”) (citation omitted). Here, there is “no evidence that MCOs are willing to pay a

remote protective services and alarm connections through a single telephone line, with a single operator monitoring the various alarms.” *Antitrust Law* ¶ 565c, at 435.

premium to have all [GAC] services delivered * * * in a single package.” Pet. App. 17a.

Petitioner’s reliance (Pet. 21) on *Federal Trade Commission v. University Health, Inc.*, 938 F.2d 1206 (11th Cir. 1991), is also misplaced. There, the court stated that the contours of the relevant health-care market “would be of no moment for our purposes,” and it accepted a broader market definition merely “[f]or ease of discussion.” *Id.* at 1211 n.11. The court did not agree with petitioner’s view that a package-deal approach is “the only permissible approach to clustering” in health-care cases like this one. Pet. 21.

The Commission acknowledged that petitioner’s package-deal approach might “be appropriate under different factual circumstances.” Pet. App. 76a n.23. But “market definition is a fact-specific exercise,” and the Commission determined that the package-deal approach would “not produce a meaningful relevant product market in which to assess competitive effects *in this case.*” *Ibid.* (emphasis added). The court of appeals made a similar fact-specific determination. *Id.* at 17a-18a. Petitioner’s challenge to those assessments of the record evidence presents no legal issue of broad importance warranting this Court’s review.

c. In any event, this case would be a poor vehicle for addressing petitioner’s challenge to the cluster-market methodology used by the Commission and the court below because resolution of this issue would “not make a difference” to the outcome here. Pet. App. 62a. The Commission noted that the merger’s HHI numbers would have indicated “presumptive illegality” under the *Merger Guidelines* “regardless of which market definition [wa]s used.” *Id.* at 84a; see *id.* at 85a (“[Petitioner] does not dispute this.”). Commis-

sioner Rosch’s concurrence, which agreed with petitioner’s market definition, similarly recognized that the merger’s increase in HHI would be “more than sufficient to trigger [a] presumption of liability * * * even using [petitioner’s] proposed market definition.” *Id.* at 158a. And petitioner’s own expert conceded that, “even under her relevant market definition,” the merger would “increase[] concentration in an already highly concentrated market to levels deemed presumptively anticompetitive” under the *Merger Guidelines*. *Id.* at 86a n.32.

For similar reasons, petitioner is wrong to suggest that the decision below would improperly permit the Commission to “find a single hospital service” with a high merging-party market share, “out of the scores of services typically included in the GAC-services cluster,” and then “rely on that single service to create a strong presumption of anticompetitive harm.” Pet. 22. To be sure, a merger that eliminates competition for a hospital service might indeed warrant a presumption of anticompetitive harm, consistent with the Clayton Act’s prohibition of mergers that substantially lessen competition “in *any* line of commerce.” 15 U.S.C. 18 (emphasis added). But that is not relevant here, because the merger at issue would produce HHI levels in *both* the general GAC services market *and* the OB-only market that are “multiples of the numbers necessary for the presumption of illegality.” Pet. App. 23a. Petitioner’s “‘gerrymandering’ concerns,” Pet. 22 (quoting Pet. App. 156a), are therefore misplaced.⁷

⁷ Petitioner is likewise wrong in asserting that the approach taken by the Commission and the Sixth Circuit here “threatens drastic and effectively outcome-determinative impact on countless hos-

2. Petitioner argues (Pet. 23-29) that the court of appeals erred in adopting a structural presumption of competitive harm based on market-share statistics. Because this case was tried under a theory of unilateral anticompetitive effects, in which “substitutes act as price constraints on one another,” petitioner argues that “*substitutability*, not *market share*,” was the relevant consideration. Pet. 24. The court of appeals correctly determined that market share was relevant to the competitive-effects analysis. The Court’s approach does not conflict with any other judicial decision, with leading antitrust commentators, or with the *Merger Guidelines*.

a. In *United States v. Philadelphia National Bank*, 374 U.S. 321 (1963), this Court explained that “a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market, is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects.” *Id.* at 363; see *ibid.* (presumption of illegality appropriate for “mergers whose size makes them inherently suspect in light of Congress’ design in § 7 to prevent undue concentration”). Accordingly, a merger that would result in a substantially concentrated market may give rise to “a ‘presumption’ that the merger will

pital mergers.” Pet. 36. From 2002 to 2012, the Commission challenged six hospital mergers out of 970 total hospital transactions—a rate of less than one percent. See Greg Koonsman, CFA, Senior Partner, VMG Health, *Analyzing the Health System Market: Mergers, Acquisitions, and Joint Ventures* 24 (Oct. 24, 2013), http://www.vmghealth.com/Downloads/BeckerASC_Koonsman2013.pdf.

substantially lessen competition.” *Federal Trade Comm’n v. H.J. Heinz Co.*, 246 F.3d 708, 715 (D.C. Cir. 2001). The burden then shifts to the defendant to rebut the presumption, and the government may bolster its *prima facie* case with other evidence that anticompetitive effects are likely. *Ibid.*

Contrary to petitioner’s contention, market shares and concentration are relevant to this analysis, including in a unilateral-effects case. The same commentators on whom petitioner relies (Pet. 26-27) explain that

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

Jonathan B. Baker & Carl Shapiro, *Reinvigorating Horizontal Merger Enforcement* 5 (2007)⁸; see Carl Shapiro, *The 2010 Horizontal Merger Guidelines: From Hedgehog to Fox in Forty Years*, 77 *Antitrust L.J.* 49, 69-70 (2010) (*2010 Horizontal Merger Guidelines*) (“The combined shares of the merging firms, and the change in the HHI, can be useful and informative metrics in unilateral effects cases.”). Consistent with that understanding, courts routinely look at market-share and concentration statistics when determining whether a presumption of anticompetitive effects applies. See, e.g., *Chicago Bridge & Iron Co. v. Federal Trade Comm’n*, 534 F.3d 410, 423-424 (5th Cir.

⁸ See http://papers.ssrn.com/sol3/papers.cfm?abstract_id=991588&download=yes.

2008). The Ninth Circuit recently applied that burden-shifting framework—including its structural presumption—in a health-care merger case based on a theory of unilateral anticompetitive effects. See *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke’s Health Sys., Ltd.*, 778 F.3d 775, 786 (2015) (“these HHI numbers are well above the thresholds for a presumptively anticompetitive merger”) (citation and quotation marks omitted).

Petitioner correctly observes (Pet. 24) that the potential anticompetitive effect of a merger depends in part on whether customers view the merging entities as substitutes for each other. But the record shows that such was the case here. Petitioner alludes (without citation) to “unrebutted evidence that the relevant consumers (MCOs) did not consider [petitioner] and St. Luke’s to be close substitutes.” Pet. 26. In fact, the record includes voluminous evidence that they were fierce competitors, including:

- Evidence that “St. Luke’s was the next best substitute for a substantial and important fraction of [petitioner’s] patients” due to “St. Luke’s advantageous location in [affluent] southwest Lucas County.” Pet. App. 124a.
- Petitioner’s own records reflecting its view that “St. Luke’s was capable of taking significant patient volume from [petitioner].” *Ibid.*
- Petitioner’s own estimate that hundreds of “commercial inpatient admissions * * * would be diverted” to St. Luke’s if St. Luke’s were added to Paramount, an MCO owned by petitioner. *Ibid.*; see *id.* at 48a.

- Petitioner’s estimate that St. Luke’s readmission to Anthem, a large MCO, would cost petitioner \$2.5 million annually. *Id.* at 124a; see *id.* at 47a.
- Petitioner’s contract with Anthem, which “explicitly offered discounted rates conditional on Anthem’s agreement not to include St. Luke’s in Anthem’s provider network.” *Id.* at 124a.
- Evidence of “particularly intense competition within St. Luke’s core service area.” *Id.* at 125a.
- Testimony from Aetna, an MCO, that a merger with St. Luke’s would make “walking away from [petitioner] substantially” harder. *Id.* at 107a; see *id.* at 48a.
- Testimony from MCOs that any attempt to build a network “composed only of UTMC and Mercy * * * would not be commercially viable.” *Id.* at 107a.
- Expert analysis, “[b]ased on claims data obtained from MCOs,” showing that “[petitioner] is St. Luke’s closest substitute” in terms of “diversion rates.” *Id.* at 118a-119a; see *id.* at 119a (“next-best substitute” for “five of the six major health plans in Lucas County”).

The trial thus produced ample evidence that “St. Luke’s and [petitioner] were close substitutes for employers and MCO’s members, and thus for the MCOs.” *Id.* at 129a (citation omitted); see *id.* at 130a (“St. Luke’s is [petitioner’s] closest substitute for a large and important number of Lucas County patients.”).

The court of appeals, moreover, did not reflexively apply a presumption of anticompetitive effect based solely on market-share and concentration statistics. Instead, it emphasized two “exceptional” (Pet. App. 22a) aspects of *this* case in particular that make such statistics a good predictor of likely anticompetitive effect. First, the market exhibits “a strong correlation between [petitioner’s] prices—*i.e.*, its ability to impose unilateral price increases—and its market share.” *Ibid.*; see *id.* at 22a-23a, 116a-117a. Accordingly, there is “every reason to conclude that, as [petitioner’s] dominance in the relevant markets increases, so * * * [will] [petitioner’s] leverage in demanding higher rates.” *Id.* at 23a.

Second, the court of appeals noted the “exceptional” (Pet. App. 23a) degree to which this merger would concentrate market share in a single firm. The merger’s HHI levels—both the increase caused by the merger and the resulting HHI—are “in every respect multiples of the numbers necessary for the presumption of illegality.” *Ibid.* In combination, these two aspects of this case indicate that the merger “would enhance [petitioner’s] market power to levels rarely tolerated in antitrust law.” *Id.* at 24a. Petitioner does not refute either component of the court’s context-specific analysis.

b. Contrary to petitioner’s contention (Pet. 25-26), there is no “tension” (Pet. 27) between the decision below and the *Merger Guidelines*. Although the *Merger Guidelines* “embrace multiple methods” for predicting the effects of a merger, “this certainly does *not* mean they reject the use of market concentration to predict competitive effects.” *2010 Horizontal Merger Guidelines* 56. Petitioner quotes the 2006 Comm-

tary on the *Merger Guidelines* as stating that “market share *may be unimportant* under a unilateral effects theory.” Pet. 28 (citation omitted).⁹ This statement, however, acknowledges that the relevance of market share is a fact-dependent inquiry. Here, the record contains substantial evidence that market share matters in *this* market, including econometric analysis that quantified the relationship between the merger’s increase in market share and the expected price impact. See Pet. App. 113a-119a.

c. This case would be a poor vehicle for exploring the role of market share in predicting a merger’s anticompetitive effect. Both the Commission and the court of appeals found substantial evidence above and beyond market share itself that confirmed the likelihood of competitive harm. See Pet. App. 102a-147a; *id.* at 25a-27a. That evidence included statements from the parties indicating their expectation that the merger would facilitate “significantly higher reimbursement rates,” *id.* at 112a; testimony from MCOs “that the Joinder likely will allow [petitioner] to command higher rates,” *id.* at 122a; and economic evidence “that price increases are likely at [petitioner] as a result of the Joinder,” *id.* at 132a. See pp. 8-9, 13, *supra*. There is consequently no reason to suppose that the Commission or the court of appeals would have reached a different outcome if they had not applied a structural presumption based on market share.

⁹ In fact, the Commentary refers to “market concentration,” not market share. See U.S. Dep’t of Justice & Fed. Trade Comm’n, *Commentary on the Horizontal Merger Guidelines* 16 (Mar. 2006), <https://www.ftc.gov/sites/default/files/attachments/merger-review/commentaryonthehorizontalmergerguidelinesmarch2006.pdf>.

3. Petitioner contends (Pet. 29-35) that the court of appeals failed to give meaningful consideration to its argument that St. Luke's was a weakened competitor. Petitioner states that the court adopted a "per se market-share-based approach to financial-weakness," under which "a party cannot rely on the defense unless it can show that the financial weakness would cause the firm's market share to reduce to a level that would undermine the government's prima facie case." Pet. 34 (citation and quotation marks omitted). Petitioner asserts that this per se approach led the court to "g[i]ve the defense the back of its hand" rather than "meaningfully engag[ing] with the issue." *Ibid.*

Far from treating petitioner's argument dismissively, the court of appeals relied on substantial record evidence showing

that St. Luke's market share was increasing prior to the merger; that St. Luke's had sufficient cash reserves to pay all of its obligations and meet its capital needs without any additional borrowing; and that, according to St. Luke's CEO, "we can run in the black if activity stays high."

Pet. App. 28a (citation omitted). Those findings echoed similar conclusions drawn by the Commission, which noted the "significant progress" St. Luke's had made in implementing its strategic plan, *id.* at 90a; improvements in "St. Luke's cost coverage ratios" and "other aspects of its financial performance," *id.* at 94a; and other indicators of the hospital's improving financial prospects, *id.* at 89a-90a. The significant evidentiary analyses performed by the Commission and the court below belie petitioner's contention that its weakened-competitor argument was "rejected * * * out of hand." Pet. 34.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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