more than thirty days confirms that eliminating a substantial competitor from two highly concentrated markets will substantially lessen competition. That record includes testimony and documents from the merging parties acknowledging ProMedica's pre-Joinder market dominance and demonstrating that increased bargaining leverage resulting in higher reimbursement rates was an objective and expected result of the Joinder; testimony from numerous health plans that the Joinder will enable ProMedica to extract higher rates; and economic and statistical analyses showing that significant price increases are likely.

Following the administrative hearing, Chief Administrative Law Judge D. Michael Chappell issued an Initial Decision in which he he

rather than to negotiate new contracts with ProMedica. IDF 13. The Joinder Agreement was consummated on August 31, 2010. Answer ¶ 2.

On January 6, 2011, the Commission issued an administrative Complaint against ProMedica. The Complaint alleged that the Joinder threatens to substantially lessen competition

The ALJ found Respondent's defenses unpersuasive. First, he concluded that the evidence did not support Respondent's claims that excess hospital bed capacity in Toledo, repositioning by competitors, and steering patients away from high-priced hospitals by doctors, employers, or health plans would constrain post-Joinder price increases. ID 7, 80-86, 176-79. Second, he found that the procompetitive benefits and efficiencies Respondent asserted were not merger-specific, did not represent significant economies that would benefit competition, or were insufficient to outweigh the Joinder's likely anticompetitive effects. ID 7, 114-31, 192-204. Third, with respect to Respondent's claim that St. Luke's was financially weak and a limited competitor, the ALJ found that "St. Luke's clearly was struggling financially prior to the Joinder and faced significant financial challenges to remaining independent in the future." ID 190. At the same time, the ALJ determined that prior to the Joinder "St. Luke's [had] succeeded in significantly raising its patient volume and market share," and "was still competing in the market." ID 189. On balance, he ruled, Respondent's weakened competitor justification should be rejected. ID 189; *see* ID 91-112, 180-90.

Having found liability, the ALJ ordered divestiture of St. Luke's to a Commission-approved buyer. ID 204-11. He rejected Respondent's proposal to allow the Joinder to stand under terms requiring separate and independent negotiating teams for the pre-joinder ProMedica hospitals (the "legacy hospitals") and St. Luke's. Judge Chappell determined that extensive integration of St. Luke's into the ProMedica hospital system had not yet occurred and that unwinding the Joinder would be unlikely to involve substantial costs. He held that Respondent had failed to demonstrate that this case presents unusual circumstances sufficient to overcome the presumption that divestiture is the appropriate remedy. ID 7.

III. <u>STANDARD OF REVIEW</u>

Pursuant to 16 C.F.R. § 3.54, the Commission reviews the ALJ's findings of fact and conclusions of law *de novo*, considering "such parts of the record as are cited or as may be necessary to resolve the issues presented." The Commission may "exercise all powers which it could have exercised if it had made the initial decision."[4] *Id.* We adopt the ALJ's findings of fact to the extent that those findings are not inconsistent with this opinion.[5]

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[4] The *de novo* standard of review is required by the Administrative Procedure Act, 5 U.S.C. § 557(b), and the FTC Act, 15 U.S.C. § 45(b), (c), and applies to both findings of fact and inferences drawn from those facts. *See Realcomp II, Ltd.*, No. 9320, 2009 WL 6936319 at *16 n.11 (FTC 2009), *aff'd*, *Realcomp II, Ltd. v. FTC*, 635 F.3d 815 (6th Cir. 2011).

[5] Respondent's appeal does not dispute the ALJ's findings and conclusions on the lack of procompetitive benefits and efficiencies from the Joinder; therefore, our Opinion does not address the issue other than to adopt the ALJ's findings.

MCOs seek to offer marketable plans to employers in terms of cost, geographical coverage, quality, and breadth of services, while at the same time staying competitive by, among other things, obtaining favorable rates from hospitals and other providers. IDF 278. They seek to offer within the network a complete complement of GAC inpatient services, from relatively simple primary and secondary services through more advanced services, including tertiary services. IDF 274. One important factor an MCO considers in creating its network is how broad to make it. On the one hand, narrower hospital networks, *i.e.*, networks that exclude certain hospitals in the market, drive more patient volume to the in-network hospitals. This, in turn, increases the network's value to those in-network hospitals and generally allows the MCO to obtain lower rates from those hospitals. IDF 269. On the other hand, the MCO's customers (employers, directly, and their employees, indirectly) generally favor broad networks that do not restrict their choice of providers. IDF 276. Thus, MCOs have to balance their customers'

associated with narrower networks to be more important. IDF 256-57. Generally, employers seek to satisfy the health-care coverage preferences of their employees, while keeping costs low. IDF 260.

4. The Bargaining Process for Reimbursement Rates

Reimbursement rates for hospital services are determined through the bargaining process between MCOs and hospitals. IDF 509. Although negotiations between hospitals and MCOs cover a variety of contractual terms (IDF 512), reimbursement rates and the contractual terms that affect rates are particularly important. IDF 513.

Both the parties and the MCOs acknowledged that higher hospital reimbursement rates are passed on to employers and often to their employees. IDF 596, 599, 655-63. Thus, the MCOs would not themselves absorb the higher rates; the higher rates would be passed on to the community-at-large.

C. Types of Hospital Services

Hospitals typically provide both inpatient services (those services requiring admission to the hospital for 24 hours or more) and outpatient services (which do not require an overnight stay). IDF 19. Within the category of inpatient services, different hospitals may provide different types of services along a continuum of care, ranging from primary services, which treat common conditions of mild to moderate severity, to quaternary services, such as organ transplants, which are the most complex and require the most specialized equipment and expertise. IDF 20-23, 25. Tertiary services include services such as neurological intensive care that are more complex than secondary services such as orthopedic surgery, but less complex than quaternary services. IDF 22-23. Hospitals that provide tertiary services also typically provide primary and secondary services, IDF 24, but many hospitals that provide primary and secondary services do not provide more complex tertiary services.[7] Thus, MCOs, in structuring their networks to attract employers and their employees, strive to enter into contracts with one or more hospitals that will give their covered enrollees access to various levels of care.

D. The Merging Parties

1. ProMedica

ProMedica is a non-profit, integrated health care system headquartered in Toledo, Ohio. IDF 1. It operates 11 hospitals in Ohio and southeast Michigan. IDF 3. It also owns and operates Paramount Health Care, which is one of the largest MCOs in Lucas County, Ohio. IDF 163. In 2009, ProMedica generated revenues of approximately $1.6 billion. Answer ¶ 8.

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[7] The dividing line between various levels of services is not, however, precisely defined. IDF 26.

Prior to the Joinder, ProMedica operated three general acute-care hospitals in Lucas County.[8] The largest is The Toledo Hospital ("TTH"), which is located in downtown Toledo, and has between 700 and 800 licensed beds, 550 of which are staffed. IDF 55. It offers all basic acute care services, ranging from general medical-surgical to orthopedics and OB services, as well as tertiary care services. IDF 56-57. It is also one of only two Lucas County hospitals that offers more complex Level III OB services. IDF 58. TTH is the single largest general acute-care hospital in Lucas County.

In addition to TTH, ProMedica operates two smaller community hospitals in Lucas County. Flower Hospital is located in Sylvania, Ohio, in the northwest Toledo area, and has about 300 licensed beds, 250 of which are staffed. IDF 61, 65. Bay Park Hospital is located in Oregon, Ohio, in the eastern Toledo area, and has about 86 licensed beds. IDF 70-71. Both Bay Park and Flower offer OB services, but neither offers any tertiary services. IDF 63-64, 68-69.

ProMedica regards itself as the dominant hospital system in Lucas County, and that assessment is shared by others. PX00270 at 025; PX00319 at 001; PX00221 at 002. It is also among the most expensive hospital systems in Ohio, IDF 525; at the same time, however, some of its quality scores are "subpar." PX00153 at 001.

2. St. Luke's Hospital

Before the Joinder, St. Luke's was an independent not-for-profit community hospital. St. Luke's was a wholly owned subsidiary of OhioCare Health System, Inc., along with several other subsidiaries, including St. Luke's Hospital Foundation, Care Enterprises, Inc., Physician Advantage MSO, and OhioCare Physicians, LLC. IDF 10.

St. Luke's is located in Maumee, Ohio, a suburban area in southwest Lucas County. IDF 72. St. Luke's provides a broad range of outpatient and inpatient services, including Level 1 OB services, and limited oncology, neurosurgery and pediatric services. IDF 73, 75. St. Luke's was reputed to be a low-cost, high-quality provider. *See, e.g.*, Pugliese, Tr. 1443-48, 1521-22; McGinty, Tr. 1190-92, 1205-06. It has about 178 staffed beds. IDF 77.

E. Other Hospitals in Lucas County

In addition to the ProMedica hospitals and St. Luke's, there are four other hospitals in Lucas County. Three are owned and operated by the same hospital system, Mercy, which, in turn, is part of the Catholic Health Partners health care system headquartered in Cincinnati, Ohio. IDF 79; Shook, Tr. 887-90. The remaining hospital is UTMC, which is part of the University of Toledo and an instrumentality of the State of Ohio. IDF 103.

1. The Mercy System Hospitals

The Mercy system hospitals in Lucas County are Mercy St. Vincent, Mercy St. Anne, and Mercy St. Charles. IDF 81. St. Vincent is a large tertiary hospital with 568 registered beds, 445

[8] ProMedica also operates a specialty hospital, Children's Hospital, located on The Toledo Hospital's campus. IDF 53.

of which are staffed. IDF 82-83. In addition to basic acute care services, it also offers a variety of tertiary services, including a large cardiology center, and is the only Lucas County hospital other than TTH that offers Level III inpatient OB services. IDF 82, 84. St. Vincent is located in downtown Toledo. IDF 87.

Both St. Anne and St. Charles are smaller general medical-surgical hospitals. IDF 92, 99. St. Anne has 128 registered beds, 96 of which are staffed (IDF 93); St. Charles is somewhat larger with 350 registered beds, but fewer than 150 are staffed (IDF 101). Neither hospital offers any tertiary services. IDF 92, 100. St. Anne discontinued providing OB services in 2008 because of insufficient demand, IDF 94-95; St. Charles does offer OB services, including Level II services. IDF 99. St. Anne is located in west Toledo; St. Charles is located in Oregon, Ohio, just east of Toledo. IDF 92, 98.

2. UTMC

percent. IDF 930. However, St. Luke's overall cost coverage ratio remained below one, meaning that St. Luke's was not generating sufficient reimbursements to cover its costs across all payors. IDF 944, 947. St. Luke's management identified the primary source of St. Luke's financial problem as "extremely low reimbursement rates from third party payors." IDF 388, *quoting* PX01390 at 0002, ¶ 6, *in camera*.

St. Luke's financial position improved in 2010. IDF 949. Its operating losses declined and its operating margins improved, as patient volumes increased and expenses declined. IDF 950-54, 957-58. By August 2010 – the month the Joinder was consummated – St. Luke's was able to post a positive operating margin. IDF 948. In his monthly report for August 2010, CEO Wakeman reported that "[t]he high activity produced a positive operating margin of $7,000 on $36.7 million in gross revenue. It is not impressive, but it is better than a loss. This positive margin confirms that we can run in the black if activity stays high. After much work, we have built our volume up to a point where we can produce an operating margin and keep our variable expenses under control." *Id., quoting* PX00170 at 001.

H. St. Luke's Decision to Affiliate with ProMedica

St. Luke's management pursued a number of options to address its financial condition. These included instituting various cost-cutting measures, IDF 800-03; exploring the interest of several out-of-market hospitals in acquiring St. Luke's, Wakeman, Tr. 2544-45; PX1016 at 024; entering discussions with ProMedica, Mercy, and UTMC about possible affiliation arrangements, IDF 404; and attempting to renegotiate MCO contracts to obtain more favorable reimbursement rates. IDF 541-45, 547-49.

In August 2009, Mr. Wakeman, in a document entitled "Options for St. Luke's – St. Luke's is now at a crossroads," presented three options to the Board: (i) "Remain independent. Surgically remove all financially losing services/programs until accepted margin is realized"; (ii) "Push the payors to . . . raise SLH reimbursement rates to an acceptable margin"; or (iii) merge with one of the other in-market hospitals. IDF 390, 393-95; PX01018 at 008, 009, 014-017, *in camera*. With respect to the first option, management noted that it would entail cutting "bone and muscle," not just fat, and would require that St. Luke's "cut major services and programs (downsizing), not just rightsizing." PX01018 at 008, *in camera*.

With respect to the second option, management noted that "St. Luke's is being grossly underpaid." IDF 391, *quoting* PX1018 at 003, *in camera.* It cautioned, however, that "[m]any payors [are] not in a good position to raise rates" and that "[i]f the payors raise our rates, competitor systems will react by offering discounts to lock out St. Luke's again." PX1018 at 009, *in camera*.

The final option involved a merger with Mercy, UTMC, or ProMedica. IDF 395. St. Luke's management believed that affiliating with ProMedica had several potential advantages, including ProMedica's strong managed care contracts, a "huge" cash in

The Board rejected the possibility of service cuts, and began to focus on the affiliation options. IDF 401; Black, Tr. 5703-04. In an October 30, 2009 update on affiliation options, St. Luke's management detailed the advantages and disadvantages of affiliating with each of the in-

that an affiliation with ProMedica could, in the short term, "harm the community by forcing higher hospital rates on them." IDF 598, *quoting* Wakeman, Tr. 2700, *in camera*.

J. The Joinder Agreement

Under the Joinder Agreement, ProMedica committed to "maintain[ing] St. Luke's using its current name and identity and at its current location for a minimum of ten (10) years . . . as a fully operational acute care hospital providing the following services: emergency room, ambulatory surgery, inpatient surgery, obstetrics, inpatient nursing and a CLIA certified laboratory." IDF 428, *quoting* PX00058 at 023, 045-046. ProMedica promised to pay $5 million at closing and to provide an additional $30 million in equal annual installments over a three-year period to fund various capital projects at St. Luke's, including converting semi-private rooms to private rooms, updating St. Luke's IT systems, constructing an outpatient lobby, renovating the heart center, moving administrative services, expanding surgical areas, and increasing the private postpartum and infant nursery. IDF 429-30, PX00058 at 021, 056. The Agreement also enabled St. Luke's to become a participating provider in the Paramount network, from which it previously had been excluded. IDF 432, PX00058 at 022-023. In return, ProMedica received the power to appoint two members of St. Luke's Board and to approve St. Luke's Board nominees, as well as certain important reserve powers, including the right to approve St. Luke's budgets and to appoint or remove St. Luke's management. IDF 434-35, PX00058 at 016-018.

V. LEGAL FRAMEWORK

Section 7 of the Clayton Act prohibits the acquisition of assets "where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. § 18. Section 7 prohibits acquisitions that create a reasonable probability of anticompetitive effects. "Congress used the phrase '*may be* substantially to lessen competition' to indicate that its concern was with probabilities, not certainties." *FTC* v. *H.J. Heinz Co.*, 246 F.3d 708, 713 (D.C. Cir. 2001), *quoting Brown Shoe Co.* v. *United States*, 370 U.S. 294, 323 (1962). "Thus, to establish a violation of Section 7, the FTC need not show that the challenged merger or acquisition *will* lessen competition, but only that the loss of competition is a 'sufficiently probable and imminent' result of the merger or acquisition." *FTC* v. *CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 35 (D.D.C. 2009), *quoting United States* v. *Marine Bancorp., Inc.*, 418 U.S. 602, 623 (1974).

Merger enforcement is therefore concerned with preventing the unlawful acquisition, maintenance, and exercise of market power. 2010 Horizontal Merger Guidelines § 1. Mergers that enhance market power can enable the merged firm to profitably alter its marketplace decisions to the detriment of consumers, for example, by raising prices, cutting output, or reducing product quality or variety. Mergers that enhance market power can also diminish incentives for innovation.

Courts have traditionally analyzed Section 7 claims under a burden-shifting framework. *See, e.g., Heinz*, 246 F.3d at 715; *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 982-83

In this case, the parties agree that there is a relevant product market for GAC inpatient hospital services sold to commercial health plans.[14] Complaint ¶¶ 12-13; Answer ¶ 12 (ProMedica "admits that general acute-care inpatient hospital services sold to commercial health

The first step in Complaint Counsel's cluster market approach is to identify the individual inpatient hospital services (*e.g.*, knee surgery, appendectomy) for which there is an overlap in services provided by ProMedica and St. Luke's. *See* CCRB 2. Each individual inpatient hospital service is potentially a self-standing, relevant product market under the 2010 Horizontal Merger Guidelines because the individual services are not clinical substitutes for one another. CCAppB 22.

Complaint Counsel then collect into a cluster all of the individual relevant service markets that have similar competitive conditions – here, a common group of hospital providers. This is done merely for the convenience of analysis: as long as the competitive conditions for each individual product are alike, only a single analysis of competitive effects is necessary. Complaint Counsel argue that this approach, "allows the analysis to be done efficiently, without creating inconsistent or distorted results, precisely because GAC inpatient hospital services are offered under similar market conditions, by the same market participants, and within the same geographic market." CCAppB 22.

Applying this approach, Complaint Counsel define a cluster market consisting of the group of GAC inpatient hospital services (i) for which there is an overlap between ProMedica and St. Luke's *and* (ii) that are provided by all four Lucas County hospital competitors. Because St. Luke's generally does not provide tertiary services,[17] there is no tertiary overlap with ProMedica, and Complaint Counsel do not place these services into the GAC inpatient services market. Complaint Counsel also argue that because patients are willing to travel greater distances for tertiary and quaternary services, the set of available hospitals may be broader than for primary and secondary services. For this reason too, tertiary services would not be aggregated into the cluster that corresponds to Toledo hospitals. Similarly, because UTMC does not provide OB services, the competitive conditions (*i.e.*, the number of competing suppliers) differ from those for GAC inpatient services. Consequently, Complaint Counsel exclude OB services from their GAC inpatient hospital services cluster market and, instead, analyze OB services separately.

In contrast, Respondent proposes an approach to defining the GAC inpatient hospital services market cluster based on the idea of transactional complements – the bundle of complementary inpatient hospital services for which MCOs demand access for their commercially insured patients and for which MCOs generally negotiate and contract as a package. RAnsB 3-4. According to Respondent, a cluster based on transactional complements covers the full range of inpatient hospital services available to commercially insured patients that MCOs negotiate for as a package. It includes both tertiary and OB services because both are demanded by MCOs when they contract with hospitals.

The ALJ adopted Respondent's transactional complements approach. ID 140 (explaining that "MCOs demand, and contract for, a broad array of inpatient hospital services together . . . on

contract for a broad array of primary, secondary, and tertiary inpatient services from hospitals together in a single negotiated transaction." ID 142-43; IDF 304. He found that limiting "the market to only those services that both St. Luke's and ProMedica actually provide is not what MCOs demand or contract to purchase." ID at 143. The ALJ similarly determined that inpatient OB services are included in the GAC inpatient hospital services market. ID 144 (explaining that "to carve out individual hospital se

Joinder's effect in hundreds of relevant product markets.[18] JSLF ¶ 57 ("the cluster market is used 'as a matter of analytical convenience [because] there is no need to define separate markets for a large number of individual hospital services . . . when market shares and entry conditions are similar for each,'" quoting *Emigra Group v. Fragomen*, 612 F. Supp. 2d 330, 353 (S.D.N.Y. 2009)); *see also* Commentary on the Horizontal Merger Guidelines (2006) at 8-9 ("when the analysis is identical across products or geographic areas that could each be defined as separate relevant markets using the smallest market principle, the Agencies may elect to employ a broader market definition that encompasses many products or geographic areas to avoid redundancy in

competition from other financial institutions. 374 U.S. at 356-57. In short, the competitive conditions faced by commercial banks was the same for each of the products or services in the cluster. Similarly, in *United States v. Grinnell Corp.*, 384 U.S. 563 (1966), the Court found a cluster of central station services in which the dominant firm with a 73 percent market share faced 38 competitors; whether the remaining 27 percent of the market in each service (*i.e.*, fire alarm, waterflow alarm) was provided by 24 or 38 competitors, the competitive conditions were the same. *Id.* at 572-73 n.6.

An approach that groups product markets with competitive overlaps when competitive conditions are similar is consistent with the GAC inpatient hospital service markets defined in prior hospital merger cases. Thus, courts and adjudicators regularly exclude outpatient services from the cluster markets because the competitors for those services differ from the competitors for inpatient services.

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.[21]

Worse, we find that treating all of the services within the contract in a single analysis of competitive effects likely obfuscates the competitive consequences of the transaction. Indeed, 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 unless great care were taken to separately analyze different aspects of the transaction's competitive effects. *See* Thomas L. Greaney, *Chicago's Procrustean Bed: Applying Antitrust Law in Health Care,* 71 Antitrust L. J. 857, 882-84 (2004).

In particular, when the prices of individual services within the cluster may be the subject of negotiation, treating all services in a single competitive analysis does not account for the relevant economic factors – the availability of substitutes – that would affect those individual prices. *See Rockford Mem'l Corp.*, 898 F.2d at 1284 (explaining that the price of an individual hospital service depends on the availability of substitutes for that service, and the prices are not linked to the prices of services that are not substitutes or complements). The record demonstrates that MCO/hospital negotiations consider individual terms that fall within the resulting contract and permit modifications to those individual contractual terms. *See* IDF 317 (explaining that contracts between MCOs and hospitals may contain "carve-outs" that price one hospital service differently from other hospital services); Randolph, Tr. 6953-56, 6960, *in camera*; Pirc, Tr. 2287; Radzialowski, Tr. 753. When each negotiating party may exert its bargaining power based on the availability of substitutes for a particular service and the number of substitutes differs for particular services, a cluster market that fails to account for such differences does not properly facilitate the analysis of competitive effects.

Respondent's approach has not been followed in prior cases. Respondent claims that the cluster is the entire group of services that a customer demands. Yet, in *Philadelphia National Bank*, where the Court defined a "commercial banking" cluster that it understood to include services as diverse as checking accounts and trust administration, 374 U.S. at 356, individual customers would hardly be expected to frequently purchase the entire group of services in a single transaction. In *Grinnell*, the Court found that Grinnell held majority control over three principal protective service suppliers: Holmes, which provided only burglary services; AFA, which supplied only fire protection services; and ADT, which provided both. 384 U.S. at 566. Certainly, customers who bought from Holmes or AFA were not demanding and negotiating for the entire group of central station protective services in a single transaction.[22]

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[21] Respondent notes that the contracts between hospitals and MCOs include prices for services that are not provided by the hospital. RAnsB 5. In light of MCOs' willingness to satisfy their networks' needs through a combination of hospital providers, we would not expect the listing of prices for unprovided services to be a meaningful determinant of the scope of the market relevant for assessing competitive effects on services that are provided.

[22] Although the Court suggested that customers often purchased

Respondent's proposed approach to defining the cluster has previously been rejected by the FTC. In *Evanston*, the Commission rejected the analogous claim that the relevant product market included hospital-based outpatient services "because MCOs purchase both inpatient and outpatient services from hospitals." *Evanston*, 2007 WL 2286195 at *46-47. Indeed, earlier in that proceeding Administrative Law Judge Stephen J. McGuire explained:

> Respondent argues that the relevant product market should be determined by using a demand-side analysis, which looks at the products sold by each merging firm, and that where a customer purchases several services together, it is those services taken as a whole that constitute the relevant product market. . . . [T]he Court of Appeals for the Seventh Circuit has explicitly rejected an approach that defined the relevant product market as *all* the services provided by the merging parties and demanded by customers. . . . The reasoning of the Seventh Circuit in *Rockford Memorial* applies with equal force here.

Evanston Nw. Healthcare Corp., No. 9315, Initial Decision at 134 (Oct. 21, 2005), http://www.ftc.gov/os/adjpro/d9315/051020initialdecision.pdf, *aff'd*, 2007 WL 2286195 at 46-47 (FTC Aug. 6, 2007) (citing *Rockford Mem'l*, 898 F.2d at 1284).

Similarly, in this case, Judge Chappell found that the single hospital contract was not a basis to include outpatient services in the relevant product market even though those services are part of the single negotiation between an MCO and a hospital. *Compare* IDF 307, 308 (explaining that outpatient services are not part of the relevant product market) *with* ID 172-73 (explaining that complex negotiations and single contracts between MCOs and hospitals cover outpatient as well as inpatient services); *see also, e.g.*, *Butterworth Health*, 946 F. Supp. at 1290-91.

Thus, based on the facts of this case and this industry, and, consistent with precedent, we reject Respondent's approach to defining a cluster market.[23]

3. Defining the Relevant Markets

We now address the specific issues raised by Complaint Counsel's appeal. First, we conclude that tertiary services are not part of the GAC inpatient hospital services market in this case. Importantly, in its Answer to the Complaint, Respondent admitted that tertiary services are excluded from the GAC inpatient market. Answer ¶ 13. A party is bound by the admissions in

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transactional complements. *See Grinnell*, 384 U.S. at 573 (observing that customers utilized in combination different services provided from a single office).

[23] We do not conclude that Respondent's approach could not be appropriate under different factual circumstances. After all, market definition is a fact-specific exercise. We conclude only that a cluster market based on the scope of what MCOs demand and negotiate in single transactions with hospitals does not produce a meaningful relevant product market in which to assess competitive effects in this case.

its answer. *Gibbs ex rel. estate of Gibbs v. Cigna Group*, 440 F.3d 571, 578 (2d Cir. 2006); *Mahtui v. Bohrell*, 219 F.2d 642, 643 (9th Cir. 1955). The admissions in an answer help to focus the issues in the litigation; Complaint Counsel, the ALJ, and the Commission should be able to rely on those admissions. We will not allow a Respondent to admit things in its Answer and, post-discovery, change its position.

Even if Respondent were not bound by its Answer, we would exclude tertiary services from the relevant GAC inpatient hospital services market in this case. St. Luke's generally does not provide tertiary services. *See* JSLF ¶ 6; ID 140. Absent an overlap or potential overlap involving a given service line, there is no substantial lessening of competition, and, thus, no need to include the service in the relevant product market.[24] Moreover, inclusion of tertiary services could obscure the analysis of competitive effects. Because patients are likely willing to travel farther for more complex treatments, IDF 283, the geographic market for tertiary services could be larger than that for primary and secondary services. If so, the number of competitors that could constrain price increases for those tertiary services could be higher (although it would have little impact on prices for primary and secondary services), and an analysis limited to hospital providers in Lucas County might be inappropriate.[25] Under an analysis that takes care to group together only relevant service markets with similar competitive conditions, tertiary services should not be aggregated into the cluster for GAC inpatient hospital services.

Judge Chappell notes that prior hospital merger cases have been inconsistent regarding whether tertiary services are included in a GAC inpatient hospital services market. ID 141-42 (citing *Butterworth,* 946 F. Supp. at 1291 and *United States v. Long Island Jewish Med. Center,* 983 F. Supp. at 137, 140, as examples where tertiary services were excluded from the GAC inpatient hospital services market). This is not surprising because defining a relevant product market in any particular case is a fact-specific question. However, we disagree with the ALJ's description of the Commission's treatment of the market in *Evanston*. Although the complaint in *Evanston* excluded tertiary services from the alleged relevant product market, at trial counsel for both sides agreed that, based on the particular facts of that case, tertiary services should be part of the GAC inpatient hospital services market. *See* Compl. Counsel's Answering and Cross-Appeal Brief, *In the Matter of Evanston Northwestern Healthcare Corp.*, Docket No. 9315 at 37,

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[24] *See CCC Holdings*, 605 F. Supp. 2d at 37 ("the relevant product market identifies the product and services with which the defendants' products compete"); *Little Rock Cardiology Clinic v. Baptist Health*, 573 F. Supp. 2d 1125, 1140-41 (E.D. Ark. 2008) (finding that a firm cannot monopolize or create anticompetitive effects in a market where it does not participate); 2010 Horizontal Merger Guidelines § 4.1 (explaining that the antitrust Agencies begin market definition when a product of one merging firm competes with a product of the other merging firm); *cf. United States v. Mercy Health Servs.*, 902 F. Supp. 968, 976 (N.D. Iowa 1995) (explaining that parties agreed that the relevant product market was acute care inpatient services, limited "to those services for which Mercy and Finley currently compete for patients").

[25] Typically, a respondent seeks to expand the relevant product market to increase the number of competitors. Here, however, Respondent seeks to include tertiary services in the GAC inpatient market, but does not argue that there are additional competitors. Granting Complaint Counsel's appeal on this issue does not affect the number of competitors.

available at: http://www.ftc.gov/os/adjpro/d9315/060210ccattachmntpursuantrule.pdf. Thus, the issue of whether to include tertiary services in the relevant product market was not raised on appeal. Not surprisingly, the Commission decision included tertiary services in the GAC inpatient hospital services market without any analysis of the issue and focused instead on the disagreement between the parties over whether outpatient services should be included in the GAC hospital services market. *Evanston,* 2007 FTC LEXIS 210, at *146-151. The Commission is faced with a different situation here, and our decision to exclude tertiary services from the relevant GAC inpatient hospital services product market is based on the particular facts of this case.[26] Similarly, *FTC v. University Health Inc.*, 938 F.2d 1206 (11th Cir. 1991), is not inconsistent with our analysis. The Court of Appeals for the Eleventh Circuit expressly chose not to analyze whether the market was broader than the overlap services. It explained that determining the precise bounds of the relevant product market "would be of no moment for [its] purposes," and accepted the broader market merely "for ease of discussion." *Id.* at 1211 n.11.

Second, we conclude that inpatient OB services are not in the GAC inpatient hospital services cluster market but rather constitute a separate relevant product market. As with many of the individual inpatient hospital services grouped together in the GAC cluster market, OB services warrant delineation as a relevant product market under standard principles of analysis. No other services are interchangeable with OB services. IDF 313; Resp. to Compl. Counsel's Req. for Admiss. at 6. An OB services market passes the 2010 Horizontal Merger Guidelines test: a hypothetical monopolist could profitably impose a small but significant and non-transitory increase in price. 2010 Horizontal Merger Guidelines § 4.1.1. Respondent's economic expert conceded as much. Guerin-Calvert, Tr. 7679-80 (acknowledging that prices "could materially change" if ProMedica achieved a monopoly over OB services). Moreover, examination of "practical indicia," which cour5987eiTw[(see21.772uld be of rkeo)Tvidualteour59ble wcth ilth I wc

The OB services market satisfies the hypothetical monopolist test in its own right – there is no need to look within it for a subset of customers who could be harmed by price discrimination. Respondent's reliance on Section 4.1.4 of the 2010 Ho

FTC that there is a separate relevant product market for primary care inpatient hospital services in addition to the GAC inpatient hospital services market, based on the existence of a differing group of suppliers for those services).[27]

In any event, the outcome of this case is the same whether or not OB services are included in the GAC inpatient hospital services market.

B. Relevant Geographic Market

The ALJ found that the relevant geographic market for GAC inpatient hospital services is Lucas County, Ohio,[28] ID 145-46, and we agree. Moreover, there is agreement between the parties that the relevant geographic market for the GAC inpatient hospital services market is Lucas County, Ohio. Complaint ¶ 16; Resp. to Compl. Counsel's Req. for Admiss. 7; Tr. 7683 (Guerin-Calvert).

Similarly, we also conclude that the relevant geographic market for OB inpatient hospital services is Lucas County. *See* Town, Tr. 3593-94. The ALJ determined that for the "GAC inpatient services market, which includes OB services," the proper geographic market is Lucas County. ID 145. If patients do not travel beyond Lucas County for GAC inpatient hospital services such as scheduled diagnoses and surgeries, patients are even less likely to travel outside Lucas County for delivery of a baby. *See* Sheridan, Tr. 6682; *cf*. Town, Tr. 3632 (stating, "if you have an acute condition . . . time matters"), 3694-95 (finding average patient travel time for OB

that would undermine the government's prima facie case." *Univ. Health*, 936 F.2d at 1221; *see also FTC* v. *Warner Commc'ns, Inc*., 742 F.2d 1156, 1164 (9th Cir. 1984) (explaining that the financial weakness defense is disfavored because it "would expand the failing company doctrine, a defense which has strict limits").

Here, the record shows that St. Luke's was experiencing some financial difficulties in the years prior to the Joinder, and the ALJ so found. ID 182-87; IDF 784-919. However, it is also clear that St. Luke's, under Mr. Wakeman's leadership, was making significant improvements in its performance, and was *growing* prior to the Joinder. Thus, although Respondent asserts that St. Luke's market share will decrease, RAppB 38, it does not point to any evidence to substantiate that assertion. In fact, St. Luke's market share was increasing – not declining – in the years before the Joinder; indeed, some of St. Luke's gains were at ProMedica's expense. *See* PX00159 at 005, 012 *in camera*; PX01235 at 003.

St. Luke's improved performance reflected its implementation of a strategic plan shortly after Mr. Wakeman was hired as St. Luke's CEO in February 2008. IDF 920. St. Luke's achieved most of the growth goals set out in that plan, increasing its "inpatient net revenue by more than $3.5 million per year on average" and its "outpatient net revenue by more than $5 million per year on average" (IDF 924-25), and achieving a 40 percent market share in its core service area. IDF 928. Its overa

> The high activity produced a positive operating margin of $7000 on $36.7 million in gross revenue. It is not impressive, but it is better than a loss. *This positive margin confirms that we can run in the black if activity stays high. After much work, we have built our volume up to a point where we can produce an operating margin and keep our variable expenses under control.*

PX000170, at 001, 006-007 (emphasis added). Summarizing what St. Luke's had accomplished, CEO Wakeman concluded:

> 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.

Id. at 007. Other evidence likewise points to significant improvements in St. Luke's financial performance in the months prior to the Joinder. *See* Black, Tr. 5684-85 (St. Luke's Board of Directors Chairman testifying that St. Luke's financials were "looking up" in August 2010); PX01582, at 003, *in camera* (St. Luke's Vice President for Patient Care Services writing in September 2010 that St. Luke's was "growing, not downsizing").

Respondent does not deny that these improvements occurred. JSLF ¶¶ 27-36; Uyl Tr., 6562 (Respondent's expert testifying that St. Luke

suggests that St. Luke's was moving toward, not away from, a sustainable path.[33] *See* PX00171 at 001 (St. Luke's CEO Wakeman concluding, based on the results through the time of the Joinder, that St. Luke's "can run in the black if activity stays high").

Respondent's argument that "St. Luke's lost money, on average, for each patient that walked through its door" and that this undermined any showing that St. Luke's was "rebounding" in the months before the Joinder, RRB 20, is likewise unpersuasive. While the record shows that St. Luke's payments from all payors – MCOs, self-pay, and government – were too low to cover its costs, IDF 373, 377, St. Luke's cost coverage ratios, like other aspects of its financial performance, were improving significantly in the months before the Joinder.[34] Moreover, we are not persuaded that St. Luke's would not have been able to negotiate more favorable rates with the MCOs – especially with MMO, which accounted for a significant portion of St. Luke's commercially-insured patient volume, but whose reimbursement rates were significantly below St. Luke's costs.[35] The representative testified that

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[33] The increase in patient volumes and revenues for St. Luke's resulted largely from its successful physician recruiting efforts and its renewed participation in the Anthem network in July 2009. IDF 957. In 2005 ProMedica had persuaded Anthem to exclude St. Luke's from its network in return for greater rate discounts at ProMedica hospitals. *See* Wakeman, Tr. 2528-32, 3030-31. However, in July 2009 Anthem readmitted St. Luke's to its network, and Anthem-insured patients once again could receive care at St. Luke's. *Id.* at 2530-31. There is no reason to believe that St. Luke's will not continue to be able to participate in the Anthem network in the future. As to the recruiting of physicians, St. Luke's already had achieved what was necessary. *See* PX000170 at 001 ("we have built our volume up to a point where we can produce an operating margin"). Respondent offers no reason why, having achieved this recruiting success, the resulting volume and revenue benefits would be "non-recurring."

[34] St. Luke's overall cost coverage ratio for all payors was 0.91 for 2007, 0.90 for 2008, 0.86 for 2009 and 0.94 for the first eight months of 2010. IDF 373. However, there were significant disparities between the cost coverage ratios for different payors. St. Luke's cost coverage ratios for Medicare and Medicaid, which represented about 51 percent of St. Luke's revenues, were very low. IDF 375. According to one witness,

Sheridan, Tr. 6647-48, *in camera* (testifying that

. Among the MCOs, only MMO and United had below-cost reimbursement rates for St. Luke's in 2009, and in 2010 only MMO did. IDF 376. Negotiating a more favorable contract with only one large payor – MMO – would have gone a long way toward solving St. Luke's financial problems.

[35] In 1995, under its prior CEO, St. Luke's had negotiated a long-term contract with MMO, which saddled St. Luke's with low rates that were insufficient to meet its costs of care. IDF 540; Black, Tr. 5580-81; Pirc, Tr. 2345-46, *in camera* (St. Luke's had similar loss for Medicare and MMO patients). According to Mr. Black, St. Luke's Chairman of the Board, St. Luke's financial problems came to light after the prior CEO retired. Black, Tr. 5560-62.

[36] } Accordingly, we cannot conclude that St. Luke's would not have been able to negotiate rates sufficient to cover its costs if it had not decided instead to pursue the Joinder with ProMedica.

Respondent's argument that St. Luke's would not be able to fund capital projects and meet its other obligations also is unpersuasive. The record shows that at the time of the Joinder St. Luke's had enough cash reserves to fund its existing capital needs and to meet its financial obligations; that it had a low debt load; and that it could borrow at reasonable rates if it chose to do so.[38] While it is true that St. Luke's had been dipping into its cash reserves to fund its operating losses and capital improvements in the years before the Joinder, and that it could not continue to do so indefinitely, we cannot assume, based on the record before us, that St. Luke's could not have funded needed capital improvements in the future, especially in view of its significantly improved operating performance in 2010.

We likewise are unpersuaded by Respondent's argument that, in the absence of an affiliation, St. Luke's necessarily would have had to implement deep service cuts, and that this would have led to St. Luke's decline within, and even possible disappearance from, the Lucas County market. As the case law discussed above establishes, to prevail Respondent must show not only that the acquired firm's financial difficulties would result in a decline in its market share in the future, but also that those declines would be enough to bring the merger below the threshold of presumptive illegality. That means that St. Luke's market share of the GAC inpatient hospital services market would have to decline from 11.5 percent to 2.1 percent or less and that its share of the OB services market would have to decline from 9.3 percent to 1.4 percent or less. *See* CCAnsB 29. Respondent does not dispute either the legal standard or the underlying calculations. Rather Respondent argues that we should assume that, in the absence of the Joinder, St. Luke's would have had to implement deep service cuts and that such service cuts would result in a continuing deterioration in St. Luke's position sufficient to meet any required thresholds. RRB 19-21.

This we decline to do. In support of its argument on service cuts, Respondent relies primarily on one document, PX01018, *in camera,* an August 2009 presentation by Mr. Wakeman to the St. Luke's Board of Directors. That document identifies and discusses three options to

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[36] , Tr. 2229-36, *in camera*. The record shows that *Id.* at 2354-55. *Id.* at 2356; IDF 541-45. *see* IDF 546-49, the proposed deal with MMO did not proceed further. Instead, St. Luke's pursued an affiliation with ProMedica.

[37] Tr. 2353, *in camera.*

[38] ID 187. As of the date of the Joinder, St. Luke's owed less than $11 million in total outstanding debt, and held at least $65 million in cash and investments. JSLF ¶¶ 34-35.

southwest sector. *See, e.g.*, Pirc, Tr. 2195-96; Pugliese, Tr. 1442-43. Elsewhere in its briefs, Respondent recognizes that "[f]or ProMedica, the joinder provided an opportunity to expand its services in southwest Lucas County." RAppB 1. Respondent has failed to demonstrate that St. Luke's location will become competitively less significant, and one of its own rationales for acquiring St. Luke's belies its argument.

For all of these reasons, Respondent has not shown that St. Luke's financial condition so reduces its competitive significance as to undermine Complaint Counsel's *prima facie* case. Further, Respondent has not shown that there were no other competitive means by which St. Luke's could have addressed its financial difficulties. *See Univ. Health*, 938 F.2d at 1221 (requiring that "defendant 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." (Emphasis added)).

The record shows that the primary source of St. Luke's financial weakness was its low reimbursement rates. ID 186, IDF 372-77. In light of St. Luke's reputation as a high-quality provider and its advantage of being the only hospital in the growing and more affluent sector of Lucas County, *see* IDF 472-74, it is likely that St. Luke's would have succeeded in negotiating more favorable reimbursement rates had it remained independent, especially since St. Luke's had identified negotiation of higher reimbursement rates as a major goal. Respondent concedes this. *See* RRB 15 ("it would be ridiculous

In sum, Respondent's "weakened competitor" showing falls far short of what the courts have demanded. Comparison to *Arch Coal*, 329 F. Supp. 2d 109, is telling. *Arch Coal* involved the acquisition of one coal company, Triton, by another, Arch Coal. There, as here, the defendant argued that the acquiree was a weak competitor and that its competitive significance was overstated. *Id.* at 153-57. The *Arch Coal* court concluded that the FTC's claims of Triton's competitive significance were in fact "far overstated." *Id.* at 157. The facts of *Arch Coal*, however, bear no resemblance to those here. For example, in *Arch Coal,* the presumption of competitive harm was weak (*id.* at 129, noting that "HHI increases are far below those typical of antitrust challenges brought by the FTC and DOJ" and that "the FTC's prima facie case is not strong"); here, in contrast, the presumption is very strong, and the evidence required to rebut the statistical case is accordingly greater. *Id.*, *quoting Baker Hughes*, 908 F.2d at 991 ("[t]he more compelling the prima facie case, the more evidence the defendant must present to rebut it successfully"). Whereas in *Arch Coal*, there were no prospects for improvement, 329 F.Supp. 2d at 157, St. Luke's was improving its financial performance, and its market share was increasing, not declining. Whereas in *Arch Coal* prospects for finding an alternative buyer were "dim," *id.* at 156, here that is far from clear.[42] In short, this is not one of those "rare cases," *Univ. Health*, 938 F.2d at 1221, where Respondent has met its burden of showing that financial weakness rebuts the presumption of illegality based on the government's structural case.

IX. <u>SUBSTANTIAL RECORD EVIDENCE BUTTRESSES THE STRUCTURAL CASE</u>

The evidence of market structure discussed above establishes a strong presumption that the Joinder will substantially lessen competition. Respondent has failed to present a showing of financial weakness sufficient to rebut that presumption. Nor, as discussed below, does Respondent provide evidence that entry or repositioning by competitors would be timely, likely or sufficient to deter or counteract the Joinder's likely anticompetitive effects or that other actions by market participants would be likely to constrain an exercise of market power.

Complaint Counsel, however, have not rested their case on market structure alone. They have gone on to present substantial evidence of likely competitive harm that buttresses their structural showing. This evidence includes documents, testimony, and business conduct of the merging parties that demonstrates their understanding that the Joinder will enhance market power. It includes a demonstration that the Joinder will increase the bargaining leverage of the

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combined ProMedica/St. Luke's hospital system by detracting from the alternatives available to MCOs in negotiations with the combined system, and, consequently, can be expected to generate unilateral anticompetitive effects in the form of higher prices at both St. Luke's and the ProMedica legacy hospitals.[43] In addition, Complaint Counsel present econometric analysis quantifying the price impacts. This additional analysis – while unnecessary, particularly in light of the strength of Complaint Counsel's *prima facie* case – is nonetheless helpful because it is tailored to the unique competitive dynamics of hospital markets, stemming from the bargaining between hospitals and MCOs over

When the merger reduces the value of the alternatives available if the MCO fails to reach an agreement with the first provider, it reduces the desirability of the MCO's walk-away network. *Id*. at 3652.

The rates that emerge from a negotiation will be a function of the parties' bargaining leverage. *Id*. at 3641. If a merger increases the hospital provider's bargaining leverage by increasing the MCO's loss from failing to reach an agreement with the provider, the MCO will be willing to pay more to have that hospital provider in its network.[45] Generally speaking, an increase in the hospital provider's bargaining leverage translates to an increase in its reimbursement rates. *Id*. at 3649-50. IDF 293-94.

B. MCO Evidence Demonstrates That the Joinder Will Significantly Increase ProMedica's Bargaining Leverage

Even before the Joinder, ProMedica, as the dominant hospital system in Lucas County, had significant bargaining levera

(McGinty, Decl.), *in camera.* Similarly, the [redacted] witness testified that "ProMedica would find its bargaining power greater after the acquisition than before," explaining that it would be more difficult for [redacted] to serve its membership without ProMedica and St. Luke's than without ProMedica's pre-Joinder hospital network in Lucas County. IDF 574, [redacted] Tr. 6687, 6698-6700, *in camera.*

The MCO witnesses also testified that a network composed only of UTMC and Mercy – the only two remaining providers in Lucas County after the Joinder – would not be commercially viable. Thus, the MMO witness testified that prior to the Joinder MMO could have marketed (and in fact did market) an insurance product that excluded ProMedica's three Lucas County hospitals (while including St. Luke's), but that post-Joinder it could not market a product that excluded both ProMedica and St. Luke's. Pirc, Tr. 2261-63, *in camera*. Other MCO witnesses likewise testified that a network composed only of UTMC and Mercy would not be commercially viable. IDF 566-68; Radzialowski, Tr. 715-716, *in camera*; Pugliese, Tr. 1477-78; Sandusky, Tr. 1351, *in camera*. This is consistent with observed marketing patterns: as Respondent' s own expert acknowledged, no MCO has marketed a network composed only of UTMC and Mercy in at least the last ten years. Guerin-Calvert, Tr. 7895; IDF 565.

Respondent, however, urges us to disregard all the MCO testimony on the grounds that it is "[u]nsubstantiated, [b]iased, and [s]peculative." RAppB 30; RRB 14. In particular, Respondent contends that, because the MCOs "did not perform *any* analyses to support their beliefs about their ability to sell narrower networks or send their insureds to other hospitals in the event of a post-joinder price increase," their testimony "is speculative and unsupported by any analysis." RAppB 30-31; RRB 14.

We disagree. The mere fact that the MCOs had not performed tailor-made studies geared to litigation is no reason to discredit their testimony. The ALJ determined that "the MCOs used general market knowledge, feedback from the field, and/or claims utilization data to determine the attractiveness and marketability of their offerings and provided explanations to support their beliefs." ID 165 (citation omitted). The MCO witness testimony was based directly on years of relevant experience in designing and marketing networks in Lucas County. The MCO witnesses testified at length about how they rely on constant feedback from their sales and marketing teams regarding prospective enrollees' hospital coverage needs, as well as the analysis of various data sets, including utilization reports, claims data, Medicare cost reports, and hospital quality studies, in order to inform their assessments of which hospitals to include in their networks and what negotiating strategies to use with the hospitals. *See, e.g.*, Radzialowski, Tr. 582-83, 587-93, 600-04; Pirc, Tr. 2160-62, 2165-72; Pugliese, Tr. 1420-27.

The precedents relied on by Respondent in urging us to disregard the MCO testimony are clearly distinguishable. Thus, in *United States* v. *Oracle Corp*., 331 F. Supp. 2d 1098, 1131 (N.D. Cal. 2004), the court noted that the customer witnesses testified with a "kind of rote," offering "speculation" unsupported by "credible and convincing testimony" but "little or no" testimony about what they "would or could do or not do to avoid a price increase"; in *FTC* v. *Arch Coal*, 329 F. Supp. 2d 109, 145-46 (D.D.C. 2004), the court found that customer testimony simply reflected general "anxiety" about having one fewer supplier but provided no persuasive reason for finding post-merger coordination more likely; and in *FTC* v. *Tenet Health Care Corp*.,

186 F.3d 1045, 1054 (8th Cir. 1999), the court discredited MCO testimony that the MCOs could not resist price increases where the evidence showed that they could and that it was in their interest to do so. Here the MCO witnesses gave detailed testimony on why they believed that the Joinder would increase ProMedica's bargaining leverage and why they would not be able to resist rate increases sought by ProMedica in the future. We see no reason to discredit their testimony as a buttress to Complaint Counsel's structural case.

We likewise reject Respondent's contention that the "MCOs have an inherent bias against ProMedica" because "ProMedica owns Paramount, against which MCOs compete for members," and "have an interest in continuing to extract low, often below-cost rates from St. Luke's." RRB 16; RAppB 31. Respondent has offered no proof of bias, and the MCO witnesses testified under oath that they were appearing pursuant to subpoena, and that they had good business relationships with ProMedica and every incentive to maintain those relationships. Radzialowski, Tr. 611-12; Sandusky, Tr. 1299-1300; Pugliese, Tr. 1427-29; Pirc, Tr. 2162-64. In short, we have no reason to believe that the MCO witnesses gave false, misleading, or biased testimony against ProMedica, St. Luke's or the Joinder, or that any of the MCO testimony should be disregarded on that ground.

C. The Evidence Demonstrates that Prices Will Likely Increase at St. Luke's as a Result of the Joinder

The unilateral effects evidence is consistent with the presumption that the Joinder is likely to result in higher prices at St. Luke's. Testimony from St. Luke's officials, contemporaneous St. Luke's documents, MCO testimony, and economic evidence all confirm the presumption.

1. St. Luke's Anticipated that the Joinder Would Raise its Rates

St. Luke's own documents make it clear that one of the chief benefits expected from the Joinder was obtaining the significantly higher rates that the ProMedica hospitals were able to command. An August 10, 2009 St. Luke's planning document noted as one option "enter[ing] into an affiliation/partnership with a local health system with the express purpose to raise reimbursement rates to the level of our competitors." PX1390 at 002, *in camera*. A presentation made the following month to St. Luke's Board of Directors by CEO Wakeman and other members of St. Luke's leadership team states, "An SLH affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout." PX1030 at 020, *in camera*; IDF 598. As St. Luke's CEO testified, "ProMedica had a significant leverage on negotiations with some of the managed care companies," which would allow St. Luke's to obtain higher reimbursement rates, so that an affiliation with ProMedica could, in the short term, "[h]arm the community by forcing higher hospital rates on them." Wakeman, Tr. 2698-2700, *in camera*. Other St. Luke's documents likewise establish that among the chief advantages of affiliating with ProMedica was the ability to increase St. Luke's reimbursement rates. *See* PX01125 at 002, *in camera* (noting the advantages of ProMedica's "incredible access to outstanding pricing on managed care

rates would increase after the Joinder and that St. Luke's thought that it would get more from affiliating with ProMedica than with other possible partners. *See* RRB 15; Oral Arg. Tr. at 37 (Marx).

Likewise, both Mr. Wakeman and Mr. Black, St. Luke's Chairman of the Board, testified to the hope or expectation that an affiliation with ProMedica would allow St. Luke's to obtain the significantly higher reimbursement rates that the ProMedica hospitals were able to command. Wakeman, Tr. 2685-86, 2700-01, *in camera*; Black Tr. 5714-15, 5718, *in camera*. Indeed, another St. Luke's document indicates that St. Luke's anticipated as much as $12 to $15 million in additional revenues from only three payors – MMO, Anthem, and Paramount – as a result of joining ProMedica. PX01231, *in camera*; IDF 603. In short, St. Luke's clearly anticipated that its rates would increase as a result of the Joinder, and ProMedica's superior negotiating clout with the MCOs was among the primary reasons St. Luke's joined the ProMedica system.

2. MCOs Expect that the Joinder Will Raise St. Luke's Rates

Numerous MCO representatives similarly testified that they expect St. Luke's rates to rise as a result of the Joinder. Thus, Aetna expected that its post-Joinder rates for St. Luke's initially will rise to the level of Aetna's rates for ProMedica, and that all ProMedica rates will then rise above pre-Joinder levels based on the additional leverage gained from the Joinder. PX01938 at 023 (Radzialowski, Dep. at 88-89), *in camera.* An Aetna analysis of the impact of the initial change projected a [redacted] increase in rates to St. Luke's, accounting for differences of severity between ProMedica and St. Luke's. IDF 591; Radzialowski, Tr. 704, *in camera.* [redacted]: in early [redacted] Tr. 717, *in camera.*

Similarly, Humana believed that the Joinder would enable ProMedica to leverage rates for St. Luke's as well as for the ProMedica legacy hospitals. IDF 594. [redacted] expected rates at St. Luke's to rise because post-Joinder ProMedica would have greater bargaining power than pre-Joinder St. Luke's. IDF 595. MMO expected that after the Joinder, ProMedica could seek "extraordinary" rates because of the lessening of competition. IDF 587-88. And [redacted] expected rates at St. Luke's, which were [redacted] than the rates paid to ProMedica's community hospitals, to rise to the higher ProMedica rates. [redacted] Tr. 1506, 1517, *in camera.* An [redacted] analysis calculated that [redacted] to the rate levels at ProMedica's Flower and Bay Park hospitals would be [redacted] roughly between [redacted] and [redacted], Tr. 1517-19, *in camera*; PX02380, *in camera.*

over inclusion in MCO networks . . ."). Combining competitors for which consumers view the firms' products as significant substitutes may enable the merged firm profitably to increase prices. It reduces the value of an MCO's walk-away network and consequently reduces its bargaining leverage. The extent of direct competition between the merging parties is the key: "Unilateral price effects are greater, the more the buyers of products sold by one merging firm consider products sold by the other merging firm to be their next choice." 2010 Horizontal Merger Guidelines § 6.1.

other MCOs was 56 percent higher than its revenue from MMO,[54] PX01850 at 017, *in camera.* Respondent asks us to consider a minority, and ignore the majority, of St. Luke's patients. Finally, Respondent's analysis of MMO is based on 2009 data, when ProMedica had just become an in-network hospital at MMO in 2008. MMO's enrollees would be expected to modify their hospital choice and admission decisions over time in response to the availability of a broader network. ID 159 n.19; PX02148 at 047, *in camera*; PX01850 at 017-018, *in camera*. The data supports this explanation. From 2008 to 2010, diversion rates for MMO enrollees from St. Luke's to ProMedica increased each year following ProMedica's admission to MMO, and the increased patient diversion to ProMedica precisely corresponded to decreased diversion of St. Luke's patients to Mercy. *See id.* at 017-019, *in camera*. Over time, as patients continue to adjust to the in-network availability of ProMedica, ProMedica is becoming a more significant alternative to St. Luke's among MMO enrollees, and Mercy's role is diminishing.

Finally, Respondent contends that any price increases at St. Luke's would merely raise St. Luke's low rates to competitive levels and therefore would not cause competitive harm. Post-Joinder, absent action by the Commission, St. Luke's reimbursement rates can be expected to rise to the level that will be charged by ProMedica's community hospitals post-Joinder. This will likely result in a price increase that encompasses, and exceeds, ProMedica's pre-Joinder price levels, since the combined hospital system will have even greater leverage than ProMedica had pre-Joinder. Respondent's claim would thus require that we find that ProMedica's pre-Joinder hospital reimbursement rates did not reflect its substantial pre-existing market power. *See* PX02148 at 036-040, *in camera*. We would also have to conclude that (i) the rates at Mercy and UTMC, which are also substantially below ProMedica's rates, *see id.* at 145, *in camera* (case-mix adjusted prices); Pirc, Tr. 2238-2242, *in camera*, are also substantially below competitive levels; and (ii) rates at the vast majority of Ohio hospitals are all below competitive levels. *See* Oostra, Tr. 5996 (Anthem informed ProMedica that its rates were among the highest in the state); PX00153 at 001. We would also have to ignore St. Luke's own market assessment when it sought higher rates from MCOs before joining with ProMedica. St. Luke's approached MCOs with the argument that they could either pay St. Luke's the "little bit more" that it sought in order to sustain its position or pay later "at the other hospital system contractual rates."[55] In other words, St. Luke's believed, and thought MCOs would credibly accept, that the price increase from a potential merger would take reimbursement rates beyond a competitive level. For all these reasons, we are not persuaded that a price increase at St. Luke's to the price levels that will be charged by ProMedica's community hospitals would merely raise St. Luke's reimbursement rates to competitive levels.

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[54] Revenues were calculated from St. Luke's discharge data for the year prior to the Joinder, third quarter 2009 through second quarter 2010. PX01850 at 017, *in camera*.

[55] *See* PX01018 at 009, *in camera* ("Push the payors. Provide compelling argument to raise SLH reimbursement rates to an acceptable margin; In essence, the message would be pay us now (a little bit more) or pay us later (at the other hospital system contractual rates).").

D. Evidence Demonstrates that, as a Result of the Joinder, Price Increases at ProMedica are Likely

1. MCOs Expect that the Joinder Will Likely Raise ProMedica's Rates

A number of MCO representatives testified that the Joinder likely will allow ProMedica to command higher rates at its legacy hospitals as well as at St. Luke's. Thus, an Aetna witness testified that additional leverage from the Joinder would give ProMedica the ability to raise reimbursement rates – as a first step, ProMedica will increase Aetna's rates to St. Luke's to the level of Aetna's rates to ProMedica, and, as a second step, it will use the additional leverage "to raise all of ProMedica's rates." Radzialowski, Tr. 712-13, *in camera*; PX01938 at 023 (Radzialowski, Dep. at 88-89, *in camera*). Similarly, a Humana representative testified that, prior to the Joinder, Humana had used its nego

admissions at ProMedica hospitals would be diverted from ProMedica to St. Luke's in the first year if St. Luke's were added to Paramount's network. IDF 468; *cf*. IDF 470 (finding that St. Luke's also expected to gain patients from ProMedica if St. Luke's were readmitted to Paramount). Similarly, ProMedica estimated that St. Luke's readmission to Anthem's network would cost ProMedica $2.5 million in gross margin annually. IDF 471; PX00333 at 002, *in camera.* In exchange for its loss of exclusivity with Anthem, ProMedica insisted that Anthem pay [redacted] higher rates at [redacted] when St. Luke's was added to Anthem's network in 2009. PX00231 at 015, *in camera*; Pugliese, Tr. 1497-98, *in camera*. This followed a four-year period in which ProMedica's contract with Anthem explicitly offered discounted rates conditional on Anthem's agreement not to include St. Luke's in Anthem's provider network, JSLF ¶ 18, a further indication that ProMedica believed St. Luke's would have taken patients from ProMedica.

Both parties' documents depict particularly intense competition within St. Luke's core service area. *See, e.g.*, PX01418 at 005, *in camera* (St. Luke's cost and revenue presentation showing that within its core service area, St. Luke's had the largest market share for GAC services and ProMedica had the second largest share); PX00333 at 002, *in camera* (showing ProMedica's expectation that Flower Hospital would lose patient volume within St. Luke's core service area if St. Luke's became a participating provider in the Anthem network). Similarly, analysis of market shares by zip codes shows that ProMedica and St. Luke's are the most important hospitals for patients in southwest Lucas County. *See* PX02148 at 042-044, 161, *in camera* (showing that St. Luke's and ProMedica have the highest market shares among patients located in the geographic area in southwest Toledo surrounding St. Luke's); Town, Tr. 3645-46, 3753-54, *in camera* (explaining that market shares reflect patient preferences).[56]

Professor Town's diversion analysis confirms that St. Luke's is a significant substitute for ProMedica's legacy hospitals. The analysis examined patient-level hospital claims data obtained from MCOs to predict to which other hospitals a specific hospital's patients would go if that hospital were not available. PX02148 at 047, *in camera*; IDF 453. The analysis shows that for five payors – [redacted] – St. Luke's was the next closest substitute for between [redacted] percent and [redacted] percent of ProMedica's patients. PX02148 at 046-047 *in camera*; PX01850 at 018-019, *in camera*. For each of the MCOs analyzed, St. Luke's was the preferred alternative for the second largest number of ProMedica patients; only three-hospital system Mercy would draw a larger number if ProMedica were unavailable. *Id.*

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[56] IDF 450-52. Respondent argues that we should not consider this limited geographic area because it is smaller than the relevant geographic market defined in this case. RRB 3-4. However, MCOs, as well as St. Luke's and ProMedica, focus on this area in the ordinary course of business. MCOs consistently testified about the importance of their ability to meet members' demand for hospital coverage in this area. IDF 477-81. In addition, both St. Luke's and ProMedica consider patients in this limited geographic area in their internal analyses of competition. *See, e.g.*, PX01418 at 005, *in camera*; PX00333 at 002, *in camera*. Our focus on this part of Lucas County appropriately parallels the focus of MCOs and the merging parties. *See generally* Concurring Opinion of Commission J. Thomas Rosch, *In the Matter of Evanston Northwestern Healthcare Corp.,* Docket No. 9315.

Consequently, our conclusion that St. Luke's is ProMedica's closest substitute for a large and important number of Lucas County patients supports a finding of a unilateral anticompetitive effect.[59] The cost to most MCOs of failing to reach an agreement with ProMedica has been increased by removing from their walk-away network the hospital most preferred by percent of their enrollees, too much to just dismiss as insignificant. Added to the substantial MCO testimony, the teachings of bargaining theory, the parties' business behavior and their contemporaneous, ordinary-course-of-business documents, all showing close head-to-head competition, we find ample basis to conclude that the Joinder is indeed likely to raise reimbursement rates at ProMedic

Respondent argues that adding five variables would reduce the price effect of the

E. The Evidence Demonstrates that Prices Will Likely Increase for OB Services as a Result of the Joinder

The anticompetitive effects of the Joinder will, if anything, be even more severe in the OB services market than in the overall GAC market. Before the Joinder, there were three competing hospital providers of inpatient OB services. Now there remain only two – ProMedica and Mercy. Thus, the Joinder is a merger to duopoly in the Lucas County market for inpatient OB services.[61]

Moreover, for OB services, Mercy – now ProMedica's only remaining competition – is relatively weak in comparison with ProMedica. Post-Joinder Mercy has only a 19.5 percent market share of the OB inpatient services market in Lucas County; ProMedica has 80.5 percent. PX02148 at 143, *in camera* (Ex. 6) (Town Expert Report). In St. Luke's core service area, ProMedica's strength is even more pronounced – its share is about 87 percent. *Id.* at 161 (Ex. 11). Beyond the mere share statistics, one of the three Mercy hospitals, St. Anne, no longer provides any OB services[62] and the remaining two Mercy hospitals, as Catholic facilities, cannot offer a full complement of inpatient OB services. Shook, Tr. 1065-66. Accordingly, ProMedica, as a result of the Joinder, is now the *only* hospital provider in Lucas County that is able to offer a full complement of OB services.

The Joinder would eliminate head-to-head competition between ProMedica and St. Luke's for inpatient OB services. St. Luke's understood that it was a desirable alternative for some ProMedica OB patients. *See* Rupley, Tr. 2010, *in camera* (St. Luke's Marketing and Planning Director testifying that St. Luke's believed that if it were readmitted to Paramount it would gain OB patients currently utilizing ProMedica's TTH). Indeed, St. Luke's was ProMedica's closest competitor with respect to OB services in St. Luke's core service area. Town, Tr. at 3760-61, *in camera*; PX01077 at 013 (2008 patient preference survey showing that the top three preferences for patients in St. Luke's core service area for OB services were St. Luke's and ProMedica's TTH and Flower). Similarly, for many OB patients in southwest Lucas County, ProMedica was the closest substitute for St. Luke's. *See* Rupley, Tr. 1946 (testifying, based on patient origin data, that if patients in St. Luke's primary service area do not go to St. Luke's, they are most likely to go to TTH); Wakeman, Tr. 2511 (testifying that ProMedica was St. Luke's most significant competitor in OB services in St. Luke's core service area). Thus, the Joinder removed a significant rival to ProMedica in the OB inpatient services market.

As the MCO witnesses made clear, OB services are an essential component for their networks, and the hospital's location is especially important for OB services because OB patients

UTMC and Mercy – the only rivals remaining after the Joinder – to be commercially viable.[63] *See supra* at Section IX.B. This evidence likewise undermines Respondent's contentions that excess capacity and overlapping physician admitting privileges enable MCOs to exclude ProMedica from their networks and thereby defeat any supracompetitive price increase.

The record also fails to support the proposition that, without excluding ProMedica from their networks, MCOs can defeat price increases by ProMedica through "steering" – that is, by providing financial incentives to health plan members and physicians to use lower-cost hospitals. The evidence shows that MCOs have not employed steering in the past to discipline Lucas County hospital prices, including ProMedica's already-high prices. IDF 702, 704-05, 715-17.[64] MCOs testified that patients dislike steering and hospitals resist it. IDF 699-700. Significantly, ProMedica has used its leverage in the past to obtain anti-steering provisions in its contracts with the health plans in Lucas County along with ProMedica's own MCO, Paramount. IDF 718-19. Now that ProMedica has greater leverage in negotiations with MCOs as a result of the Joinder, it is even more likely to be able to obtain such contractual provisions to protect itself against steering in the future.

Additionally, we find no merit to Respondent's argument that contracts negotiated by ProMedica on behalf of St. Luke's after the Joinder demonstrate that the Joinder is not likely to result in supracompetitive prices. It is settled law that such post-acquisition evidence is of limited probative value because "violators could stave off such [Section 7] actions merely by refraining from aggressive or anticompetitive behavior when such a suit was threatened or pending." *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 504-05 (1974), *see Chicago Bridge & Iron Co.* v. *FTC* &

determinative – post-acquisition evidence "is deemed of limited value whenever such evidence *could arguably* be subject to manipulation." *Chicago Bridge*, 534 F.3d at 435 (emphasis in original). Such is the case here. Moreover, all post-Joinder rates here have been negotiated while the Hold Separate Agreement was in place. That agreement permits an MCO to continue its existing contract beyond expiration, rather than negotiating a new contract with new rates. *See* PX00069. Thus, the Hold Separate Agreement constrains ProMedica's bargaining leverage, with the result that the post-Joinder contracts do not reflect the full market power that ProMedica will be able to exercise as a result of the Joinder.

2. Repositioning By Competitors

Respondent also argues that repositioning by competitors will constrain post-Joinder price increases. RAppB 36-37. The 2010 Horizontal Merger Guidelines note that "[i]n some cases, non-merging firms may be able to reposition their products to offer close substitutes for the products offered by the merging firms" and thereby "deter or counteract what otherwise would be significant anticompetitive unilateral effects from a differentiated products merger." 2010 Horizontal Merger Guidelines § 6.1. Repositioning is evaluated like entry. *Id.* Thus, Respondent must show that the purported repositioning will be timely, likely, and sufficient to constrain prices post-Joinder. 2010 Horizontal Merger Guidelines §§ 6.1, 9; *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 55 (D.D.C. 1998). Respondent's burden is to produce evidence sufficient to show that the likelihood of entry "reaches a threshold ranging from 'reasonable probability' to 'certainty.'" *Chicago Bridge*, 534 F.3d at 430 n.10.

As evidence of repositioning, Respondent points to Mercy's so-called "Southwest Strategy," a program to increase Mercy's presence in southwest Lucas County by recruiting primary care physicians there and constructing a new outpatient facility to provide diagnostic and therapeutic services. *See* IDF 747-48. Respondent contends that Mercy's Southwest Strategy will put approximately 30 percent of St. Luke's billed charges at risk of loss to Mercy, which has enough excess capacity to serve all of St. Luke's commercially-insured patients, and that this risk of loss will deter any anticompetitive price increase. RAppB 37.[65] The ALJ found Respondent's argument unpersuasive, concluding that the evidence did not show that such repositioning is likely to replace the competition lost by the Joinder or would be either timely or sufficient. ID 177-78.

We likewise find that the record does not support Respondent's argument. Notably, Mercy's Southwest Strategy does not include any plan to build an inpatient facility or offer any inpatient services. IDF 750. Rather, Mercy's Southwest Strategy purportedly will provide competition for inpatient services by generating referrals to Mercy's existing hospitals. IDF 753. At the time of the hearing, however, the prospects for this program were very much in question. Mercy did not meet its 2010 physician recruitment goals for southwest Lucas County, had not succeeded in recruiting any physicians in furtherance of its 2011 goals, and faced diminishing

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[65] Respondent also makes passing reference to UTMC's facility renovations and "outreach activity," RAppB at 37 n.8, but makes no effort to show that these undertakings will constrain ProMedica's post-Joinder prices (and certainly not with regard to OB services, which UTMC does not provide).

after the Commission's remedy in *Evanston*, cures any anticompetitive effects of the Joinder while addressing concerns about St. Luke's viability as an independent hospital. Respondent also argues that an order that requires ProMedica to divest St. Luke's to an acquirer, instead of allowing the parties simply to unwind the Joinder, goes beyond restoring competition to its pre-Joinder state and is, therefore, overbroad and punitive. RAppB 40-45.

The purpose of relief in a Section 7 case is to restore competition lost through the unlawful acquisition. *Ford Motor Co. v. Unites States*, 405 U.S. 562, 573 n.8 (1972); *United States v. E.I du Pont de Nemours & Co.*, 353 U.S. 586, 607 (1957). Structural remedies are preferred in such cases. *See United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 329 (1961) (calling divestiture "a natural remedy" when a merger violates the antitrust laws). As we explained in *Evanston*, "[d]ivestiture is desirable because, in general, a remedy is more likely to restore competition if the firms that engage in pre-merger competition are not under common ownership," and there are "usually greater long term costs associated with monitoring the efficacy of a conduct remedy than with imposing a structural solution." *Evanston*, 2007 WL 2286195 at *77. The manner and scope of divestiture are subject to the Commission's broad discretion. *See Jacob Siegel Co. v. FTC*, 327 U.S. 608, 611-13 (1946); *Chicago Bridge*, 534 F.3d at 440-42.

In accordance with these well-established principles, we conclude that divestiture is the most appropriate remedy to restore the competition eliminated by the Joinder. Unlike *Evanston*, this case does not present special circumstances that warrant a departure from the preferred structural remedy. In that case, the lengthy amount of time – seven years – that had elapsed since the merger, during which the acquired hospital had been fully integrated into the larger hospital system, led the Commission to conclude that divestiture would be a "complex, lengthy, and expensive process," *Evanston*, 2007 WL 2286195 at *79, and "much more difficult, with a greater risk of unforeseen costs and failure," *id.* at *78. The Commission was also concerned that divestiture could reduce or eliminate significant public benefits from improvements made to the acquired hospital during that time. *Id.* The Commission specified that its reasoning for an injunctive remedy in that case would not necessarily apply in a future challenge to a consummated merger, including a consummated hospital merger, and that, "where it is relatively clear that the unwinding of a hospital merger would be unlikely toefficacy0Tc0Tw(B8)]Tge01anst[12 001 Tc-.000