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# UNITED STATES COURT OF APPEALS

## FOR THE SIXTH CIRCUIT

PROMEDICA HEALTH SYSTEM, INC.,
Petitioner,

v.

FEDERAL TRADE COMMISSION,
Respondent.

No. 12-3583

On Petition for Review of a Final Order of the
Federal Trade Commission
No. 9346.

Argued: March 7, 2013

Decided and Filed: April 22, 2014

Before: KETHLEDGE, WHITE, and STRANCH, Circuit Judges.

## COUNSEL

ARGUED: Douglas R. Cole, ORGAN COLE + STOCK LLP, Columbus, Ohio, for Petitioner.
Michele Arington, FEDERAL TRADE COMMISSI

OPINION

KETHLEDGE, Circuit Judge. This is an antitrust case involving a proposed merger between two of the four hospital systems in Lucas County, Ohio. The parties to the merger were ProMedica, by far the county's dominant hospital provider, and St. Luke's, an independent community hospital. The two merged in August 2010, leaving ProMedica with a market share above 50% in one relevant product market (for so-called primary and secondary services) and above 80% in another (for obstetrical services). Five months later, the Federal Trade Commission challenged the merger under § 7 of the Clayton Act, 15 U.S.C. § 18. After

radiology services, and most kinds of inpatient obstetrical (OB) services. "Secondary services," such as hip replacements and bariatric surgery, require the hospital to have more specialized resources. "Tertiary services," such as brain surgery and treatments for severe burns, require even more specialized resources. And "quaternary services," such as major organ transplants, require the most specialized resources of all.

Different hospitals offer different levels of these services. There are four hospital providers in Lucas County. The most dominant is ProMedica, with 46.8% of the GAC market in Lucas County in 2009. ProMedica operates three hospitals in the county, which together provide primary (including OB), secondary, and tertiary services. The county's second-largest provider is Mercy Health Partners, with 28.7% of the GAC market in 2009. Mercy likewise operates three hospitals in the county, which together provide primary (including OB), secondary, and tertiary services. The University of Toledo Medical Center (UTMC) is the county's third-largest provider, with 13% of the GAC market. UTMC operates a single teaching and research hospital, just south of downtown Toledo, and focuses on tertiary and quaternary services. It does not offer OB services. The remaining provider is St. Luke's Hospital, which before the merger was an independent, not-for-profit hospital with 11.5% of the GAC market. St. Luke's offers primary (including OB) and secondary services, and is located in southwest Lucas County.

B.

With respect to privately insured patients, hospital providers do not all receive the same rates for the same services. Far from it: each hospital negotiates its rates with private insurers (known as Managed Care Organizations, or MCOs); and the rates themselves are determined by each party's bargaining power.

The parties' bargaining power depends on a variety of factors. An MCO's bargaining power depends primarily on the number of patients it can offer a hospital provider. Hospitals need patients like stores need customers; and hence the greater the number of patients that an MCO can offer a provider, the greater the MCO's leverage in negotiating the hospital's rates. But MCOs compete with each other just as hospitals do. And to attract patients, an MCO's health-care plan must offer a comprehensive range of services—primary, secondary, tertiary, and quaternary—within a geographic range that patients are willing to travel for each of those

services. (The range is greater for some services than others.) These criteria in turn create leverage for hospitals to raise rates: to the extent patients view a hospital's services as desirable or even essential—say, because of the hospital's location or its reputation for quality—the hospital's bargaining power increases.

But another important criterion for a plan's competitiveness is its cost. Thus, if a hospital demands rates above a certain level—the so-called "walk-away" point—the MCO will try to assemble a network without that provider. For example, rather than include all four hospital providers in its network, the MCO might include only three. If a provider becomes so dominant in a particular market that no MCO can walk away from it and remain competitive, however, then that provider can demand—and more to the point receive—monopoly rates (*i.e.*, prices significantly higher than what the MCOs would pay in a competitive market).

Here, before the merger, MCOs in Lucas County had sometimes offered networks that included all four hospital providers, but sometimes offered networks that included only three. From 2001 until 2008, for example, Lucas County's largest MCO, Medical Mutual of Ohio, successfully marketed a network of Mercy, UTMC, and St. Luke's. Since 2000, however, no MCO has offered a network that did not include either ProMedica or St. Luke's—the parties to the merger here.

C.

The likely reason MCOs have historically found it necessary to include either ProMedica or St. Luke's in their networks is that those providers are dominant in southwest Lucas County, where St. Luke's is located. In that part of the county—relatively affluent, and with a high

higher—perhaps much higher—than it is for the single hospital. Here, the record bears out that conclusion: ProMedica's rates before the merger were among the highest in the State, while St. Luke's rates did not even cover its cost of patient care. That was true even though St. Luke's quality ratings on the whole were better than ProMedica's.

As a result, St. Luke's struggled in the years before the merger, losing more than $25 million between 2007 and 2009. To improve matters, St. Luke's hired Daniel Wakeman, a hospital-turnaround specialist, as its CEO. Wakeman implemented a three-year plan to reduce costs, increase revenues, and regain patient volume from ProMedica. Eventually St. Luke's fortunes began to improve: by August 2010, St. Luke's was out of the red (albeit barely), and Wakeman reported that "this positive margin confirms that we can run in the black if activity stays high."

By then, however, St. Luke's was contemplating other options. In August 2009, Wakeman presented three options to St. Luke's Board. The first was for St. Luke's to "[r]emain independent" by "cut[ting] major services" until an "accepted margin is realized." The second was for St. Luke's to "[p]ush the [MCOs] . . . to raise St. Luke's reimbursement rates to an acceptable margin." Under this option, Wakeman noted, "the message [to] MCOs] would be [to] pay us now (a little bit more) or pay us later (at the other hospital system contractual rates)." The third option was for St. Luke's to join one of the three other providers in Lucas County—ProMedica, Mercy, or UTMC.

Of all these options, Wakeman believed that a merger with ProMedica "ha[d] the greatest potential for higher hospital rates.[2] A ProMedica-[St. Luke's] partnership would have a lot of negotiating clout." Wakeman also recognized, however, that an affiliation with ProMedica could "[h]arm the community by forcing higher hospital rates on them."

Three months later, Wakeman recommended to St. Luke's Board that it pursue a merger with ProMedica. The Board accepted the recommendation the same day. Six months later, on May 25, 2010, ProMedica and St. Luke's signed a merger agreement.

D.

In July 2010—less than two

This petition followed.

II.

We review the Commission's legal conclusions de novo, and its factual findings under the substantial-evidence standard. 15 U.S.C. § 21(c);

and if so, whether and to what extent purchasers are willing to substitute one for the other." F.T.C. v. Arch Coal, Inc., 329 F. Supp. 2d 109, 119 (D.D.C. 2004) (quotations omitted).

By this measure, each individual medical procedure could give rise to a separate market: "[i]f you need your hip replaced, you can't decide to have chemotherapy instead." United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1284 (7th Cir. 1990). But nobody advocates that we analyze the effects of this merger upon hundreds if not thousands of markets for individual procedures; instead, the parties agree that we should "cluster" these markets somehow. The parties disagree, however, on the principles that should govern which services are clustered and which are not.

Two theories of clustering are pertinent here. The first—which the FTC advocates and the Commission adopted—is the "administrative-convenience" theory. (A better name might be the "similar-conditions" theory.) This theory holds, in essence, that there is no need to perform separate antitrust analyses for separate product markets when competitive conditions are similar for each. See Emigra Group v. Fragomen, 612 F. Supp. 2d 330, 353 (S.D.N.Y. 2009). In Brown Shoe, for example, the Supreme Court analyzed together the markets for men's, women's, and children's shoes, because the competitive conditions for each of them were similar. 370 U.S. at 327-28.

The competitive conditions for hospital services include the barriers to entry for a particular service—e.g., how difficult it might be for a new competitor to buy the equipment and sign up the professionals necessary to offer the service—as well as the hospitals' respective market shares for the service and the geographic market for the service. See Jonathan B. Baker, The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry, Law & Contemp. Probs., Spring 1988, at 93, 138; United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 142-43 (E.D.N.Y. 1997). If these conditions are similar for a range of services, then the antitrust analysis should be similar for each of them. Long Island, 983 F.Supp. at 142-43. Thus, if the competitive conditions for, say, secondary inpatient procedures are all reasonably similar, then we can cluster those services when analyzing a merger's competitive effects.

Here, the Commission applied this theory to cluster both primary services (but excluding OB, for reasons discussed below) and secondary services for purposes of analyzing the merger's competitive effects. Substantial evidence supports that demarcation. The respective market shares for each of Lucas County's four hospital systems (ProMedica, Mercy, UTMC, St. Luke's) are similar across the range of primary and secondary services. A hospital's market share for shoulder surgery, for example, is similar to its market share for knee replacements. Barriers to entry are likewise similar across primary and secondary services. So are the services' respective geographic markets. Thus, the competitive conditions across the markets for primary and secondary services are similar enough to justify clustering those markets when analyzing the merger's competitive effects. *See Emigra Group*, 612 F. Supp. 2d at 353.

But the same is not true for OB services, whose competitive conditions differ in at least two respects from those for other services. First, before the merger, ProMedica's market share for OB services (71.2%) was more than half-again greater than its market share for primary and secondary services (46.8%). And the merger would drive ProMedica's share for OB services even higher, to 80.5%—no small number in this area of the law. Second, and relatedly, before the merger there were only three hospital systems that provided OB services in Lucas County (ProMedica, Mercy, St. Luke's) rather than four; after the merger, there would be only two. (One might also suspect that the geographic market for OB services is smaller than it is for other primary services—one can drive only so far when the baby is on the way—but the record is not clear on that point.) The Commission therefore flagged OB as a separate relevant market for purposes of analyzing the merger's competitive effects. For the reasons just stated, substantial evidence supports that decision.

Finally, the Commission excluded tertiary services from its analysis of the merger's competitive effects. The competitive conditions for tertiary services differ from those for primary and secondary services, in part because patients are willing to travel farther for tertiary services (*e.g.*, a liver transplant) than they are for primary or secondary services (*e.g.*, hernia surgery). Indeed, UTMC's representative testified that, "[f]or the tertiary . . . services, we compete with . . . institutions such as the University of Michigan, the Cleveland Clinic, University Hospital in Cleveland, and the Ohio State University." The geographic market for tertiary services is therefore larger than the geographic market for primary and secondary

services. Moreover, the hospitals' respective market shares for these services are different than their respective shares for primary or secondary services; St. Luke's market share for tertiary services, for example, is nearly zero. Thus, the competitive conditions for tertiary services differ from those for primary and secondary services.

receiving certain products as a package, then the relevant market for those products is the market for the package as a whole. 2B Areeda, Antitrust Law

ProMedica responds that this sort of analysis—measuring HHI to apply a presumption of illegality—applies only in "coordinated-effects" cases, rather than in "unilateral-effects" ones. And the FTC admittedly challenges the merger only on unilateral-effects grounds here. The two theories are different: the idea behind coordinated effects is that, "where rivals are few, firms will be able to coordinate their behavior, either by overt collusion or implicit understanding in order to restrict output and achieve profits above competitive levels." H&R Block, 833 F. Supp.2d at 77. A simple example might be parallel pricing by two gas stations located across the street from each other in a remote small town. Unilateral-effects theory, on the other hand, holds that "[t]he elimination of competition between two firms that results from their merger may alone constitute a substantial lessening of competition." Merger Guidelines § 6 at 20. The most obvious example of this phenomenon is a "merger to monopoly"—where a market has only two firms, which then merge into one—but unilateral effects "are by no means limited to that case." Id. The Guidelines also distinguish between unilateral effects for "homogeneous products" and for "differentiated products." Homogeneous products are indistinguishable from each other—oil, corn, coal—whereas differentiated products are similar enough to compete in a relevant market, but different enough that some

"[u]nilateral 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." *Id.*

For a merger to raise concerns about unilateral effects, however, not every consumer in the relevant market must regard the products of the merging firms as her top two choices. Instead, "[s]ubstantial unilateral price elevation post-merger for a product sold by one of the merging firms normally requires that a significant fraction of the customers purchasing that product view products formerly sold by the other merging firm as their next-best choice." *Id.* at 20-21. That "significant fraction," moreover, "need not approach a majority." *Id.* at 21.

But none of this, in ProMedica's view, has much to do with market concentration *per se*. Thus, what the Commission should have focused on, ProMedica says, is the extent to which consumers regard ProMedica as their next-best choice after St. Luke's, or vice-versa. And ProMedica therefore argues that the Commission was wrong to presume the merger illegal based upon HHI data alone.

The argument is one to be taken seriously. The Guidelines themselves state that "[a]gencies rely much more on the value of diverted sales [*i.e.*, in rough terms, the extent to which the products of the merging firms are close substitutes] than on the level of HHI for diagnosing unilateral price effects in markets with differentiated products." *Id.* But this case is exceptional in two respects. First, even without conducting a substitutability analysis, the record already shows a strong correlation between ProMedica's prices—*i.e.*, its ability to impose unilateral price increases—and its market share. Before the merger, ProMedica's share of the GAC market was 46.8%, followed by Mercy with 28.7%, UTMC with 13%, and St. Luke's with 11.5%. And ProMedica's prices were on average 32% higher than Mercy's, 51% higher than UTMC's, and 74% higher than St. Luke's. Thus, in this market, the higher a provider's market share, the higher its prices. In ProMedica's case, that fact is not explained by the quality of ProMedica's services or by its underlying costs. Instead, ProMedica's prices—already among the highest in the State—are explained by bargaining power. As the Commission explained: "the hospital provider's bargaining leverage will depend upon how the MCO would fare if its network did not include the hospital provider (and therefore became less attractive to potential members who prefer that provider's services)." Op. 36. 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 ProMedica's dominance in the relevant markets increases, so does the need for MCOs to include ProMedica in their networks—and thus so too does ProMedica's leverage in demanding higher rates.

The second respect in which this case is exceptional is simply the HHI numbers themselves. Even in unilateral-effects cases, at some point the Commission is entitled to take seriously the alarm sounded by a merger's HHI data. And here the numbers are in every respect multiples of the numbers necessary for the presumption of illegality. Before the merger, ProMedica already held dominant market shares in the relevant markets, which were themselves already highly concentrated. The merger would drive those numbers even higher—ProMedica's share of the OB market would top 80%—which makes it extremely likely, as matter of simple mathematics, that a "significant fraction" of St. Luke's patients viewed ProMedica as a close substitute for services in the relevant markets. On this record, the Commission was entitled to put significant weight upon the market-concentration data standing alone.

These two aspects of this case—the strong correlation between market share and price, and the degree to which this merger would further concentrate markets that are already highly concentrated—converge in a manner that fully supports the Commission's application of a presumption of illegality. What ProMedica overlooks is that the "ultimate inquiry in merger analysis" is not substitutability, but "'whether the merger is likely to create or enhance market power or facilitate its exercise.'" Carl Shapiro, The 2010 Horizontal Merger Guidelines: From Hedgehog to Fox in Forty Years, 77 Antitrust L.J. 49, 57 (2010) (emphasis added) (quoting U.S. Dep't of Justice & Fed. Trade Comm'n, Commentary on the Horizontal Merger Guidelines (2006)). Here, as shown above, the correlation between market share and price reflects a correlation between market share and market power; and the HHI data strongly suggest that this merger would enhance ProMedica'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. The Commission was correct to presume the merger substantially anticompetitive.

C.

The remaining question is whether ProMedica has rebutted that presumption. ProMedica argues on several grounds that it has; but more remarkable is what ProMedica does not argue.

prices: its CEO stated that a merger with ProMedica "has the greatest potential for higher hospital rates" and would bring "a lot of negotiating clout." The parties' own statements, therefore, tend to confirm the presumption rather than rebut it.

The same is true of testimony from the MCO witnesses. Those witnesses testified that a network comprising only Mercy and UTMC—the only other providers who would remain after the merger—would not be commercially viable because it would leave them with a "hole" in the suburbs of southwest Lucas County. (That no MCO has offered such a network during the past decade corroborates the point.) Consequently,

ProMedica and St. Luke's—was disfavored because "there are usually greater long term costs associated with monitoring the efficacy of a conduct remedy than with imposing a structural solution." And the Commission found no circumstances warranting such a remedy here. We have no basis to dispute any of those findings. The Commission did not abuse its discretion in choosing divestiture as a remedy.

* * *

The Commission's analysis of this merger was comprehensive, carefully reasoned, and supported by substantial evidence in the record. The petition is denied.

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FEDERAL TRADE COMMISSION,
Respondent.

Before: KETHLEDGE, WHITE, and STRANCH, Circuit Judges.

**JUDGMENT**

On Petition for Review of a Final Order of
the Federal Trade Commission.

This matter came before the court upon ProMedica Health System, Inc.'s petition for review of an order of the Federal Trade Commission.

UPON FULL REVIEW of the record and the briefs and arguments of counsel,

IT IS ORDERED that the petition for review is DENIED.

**ENTERED BY ORDER OF THE COURT**

Deborah S. Hunt, Clerk