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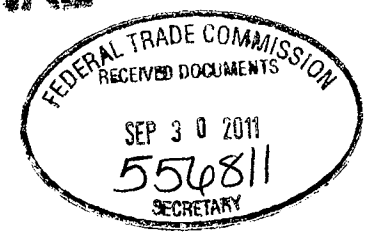

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

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

COMPLAINT COUNSEL'S POST-TRIAL REPLY BRIEF

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I. INTRODUCTION

Complaint Counsel's *prima facie* case demonstrates that the Acquisition triggers an overwhelming presumption of competitive harm based on market shares and market concentration in two relevant markets, then explains the precise mechanism by which the Acquisition has eliminated competition and will lead to higher prices. Each factual and analytical assertion is supported by testimony from numerous, credible market participants, including hospitals, health plans, and employers, and further relies on accomplished experts and an econometric analysis predicting significant price increases. Long before ProMedica witnesses began meeting with attorneys to hone and prepare their testimony for trial, their own words, recorded in internal documents, spoke directly and unambiguously about the implications of the Acquisition. Payments will "skyrocket." Health plans will "lose clout if St. Luke's is no longer independent." The Acquisition "may not be the best thing for the community in the long run." It could "increase prices/costs to the community" and "stick it to employers." Indeed, even ProMedica's own economic expert expects that prices at St. Luke's will increase significantly.

Respondent fails to rebut this mountain of evidence by relying on scraps of half-formulated and unsubstantiated defenses and only biased witnesses. St. Luke's is not a failing firm. It is not even a flailing firm. Entry is demonstrably unlikely and would be insufficient. The efficiencies have been shown to be speculative, at best, and certainly not merger-specific. In every case, Respondent's evidence falls far short of what the law requires to rebut the strong *prima facie* case and additional evidence that Complaint Counsel has presented. And in many instances, the only evidence that Respondent can marshal is derived from its own employees and highly-paid consultants.

Perhaps recognizing this, Respondent embarks on a strategy of blurring lines, muddying

waters, and kicking up dust. Respondent suggests that there are significant disputes where there are none – for example, by suggesting that Complaint Counsel's market shares are fatally flawed when, in fact, even accepting Respondent's claims would have no impact on the conclusion that the Acquisition substantially lessens competition. Respondent raises a flurry of irrelevant arguments about the closeness of competition between other market participants that have no bearing on the loss of competition between St. Luke's and ProMedica. And Respondent attempts to avoid the burden of production *it bears* to put forth a defense by attacking the sufficiency of *Complaint Counsel's* evidence rebutting Respondent's defenses.

Moreover, Complaint Counsel has already anticipated and addressed nearly all of Respondent's arguments. If the "Government's *prima facie* case anticipates and addresses the respondent's rebuttal evidence, as in this case, the *prima facie* case is very compelling and significantly strengthened." *Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410, 426 (5th Cir. 2008). Where the *prima facie* case is strengthened, "the respondent's burden of production on rebuttal is also heightened." *Id*. (citing *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 991 D.C. Cir. 1990).

In short, Complaint Counsel has conclusively established the significant harm that the Acquisition will cause consumers in Lucas County. Respondent's attempts to discredit and obscure the clear meaning of the evidence fail. As such, the Acquisition should be found illegal and a divestiture remedy should be ordered.

II. RELEVANT MARKETS ARE WELL-DEFINED AND SUPPORTED BY THE FACTS AND CASE LAW

A. Respondent Agrees that Inpatient GAC Constitutes a Relevant Service Market

In its Post-Trial Brief, Respondent agrees with Complaint Counsel that inpatient general acute-care services constitute a relevant service market. (Resp't ProMedica Health Sys., Inc.'s

Post-Tr. Br. at 45 [*hereinafter* Resp. Post-Tr. Br.]; Joint Stipulations of Law and Fact, JX00002A ¶ 3). Indeed, this market definition is conclusively supported by case law, a *Mergers Guidelines* analysis, and the evidence submitted in this case. (Complaint Counsel's Post-Tr. Br. at 6-15; Complaint Counsel's Proposed Findings of Fact ¶¶ 189-198 [*hereinafter* CC Post-Tr. Br. and CCPFF]).[1]

B. Inpatient Obstetrics Services Constitute a Relevant Service Market

The conclusion that OB is a separate relevant service market is firmly supported by case law, a *Merger Guidelines* analysis, *Brown Shoe*'s practical indicia, and the evidence put forth by Complaint Counsel. (CC Post-Tr. Br. at 16-21; CCPFF ¶¶ 199-207). Respondent's Post-Trial Brief did nothing to unsettle that conclusion.

Respondent's claim that there is "no legal support for carving inpatient OB services out of the cluster market of general acute inpatient services" (Resp. Post-Tr. Br. at 45) is false.[2] For one, the Northern District of Ohio, in the related preliminary-injunction proceeding here, specifically held that OB constitutes a relevant service market, separate from GAC services. *FTC v. ProMedica Health Sys., Inc*., 2011 U.S. Dist. LEXIS 33434, at *147-49; 2011-1 Trade Cas. (CCH) ¶ 77,395 (N.D. Ohio 2011). Additionally, another federal court, affirmed by the Sixth Circuit, previously found two relevant service markets in a single hospital merger: one for

[1] Respondent does quibble with the exact contours of the GAC market in its market share and concentration discussion (*see* Resp. Post-Tr. Br. at 50-53) but, as discussed *infra*, those quibbles, and any difference regarding whether certain services are included in the GAC cluster market, have no effect on the competitive-effects analysis or conclusion. Notably, even courts adopting the GAC market have differed in the details of its application, based on the facts of the case. *See, e.g, FTC v. Butterworth Health Corp*., 946 F. Supp. 1285, 1291 (W.D. Mich. 1996), *aff'd*, 1997 U.S. App. LEXIS 17422, 1997-2 Trade Cas. (CCH) ¶ 71,863 (6th Cir. 1997) (two market definitions, each with different market participants and geographic markets)*; United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121 (E.D.N.Y. 1997) (analyzing tertiary services as separate market)*; FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 (8th Cir. 1999) (excluding tertiary services from GAC market)*; California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001) (including tertiary services where both parties offered them).

[2] Respondent also misleadingly says that this Court has "no reason to abandon that *precedent* in this case." (Resp. Post-Tr. Br. at 45 (emphasis added)). Respondent cites to no case where a plaintiff claimed OB was a relevant service market and no case where a court held that inpatient OB was *not* a relevant service market – because there is none.

inpatient GAC services and a second for primary care inpatient hospital services. *FTC v. Butterworth Health Corp*., 946 F. Supp. 1285, 1291 (W.D. Mich. 1996), *aff'd*, 1997 U.S. App. LEXIS 17422, 1997-2 Trade Cas. (CCH) ¶ 71,863 (6th Cir. 1997); *see also United States v. Rockford Mem'l Hosp.,* 898 F.2d 1278, 1284 (7th Cir. 1990) (Posner, J.). Similarly, Respondent overlooks non-merger antitrust cases where courts defined markets more narrowly than GAC services (i.e., by service-line) because it was appropriate given the market facts. *See Morgenstern v. Wilson*, 29 F.3d 1291, 1296 (8th Cir. 1994); *Defiance Hosp. v. Fauster-Cameron, Inc.*, 344 F. Supp. 2d 1097, 1109 (N.D. Ohio 2004); *Little Rock Cardiology Clinic v. Baptist Health*, 573 F. Supp. 2d 1125, 1140-41 (E.D. Ark. 2008).

Respondent's other arguments against an OB market also fail. Respondent argues that OB should not be a separate market because hospital-health plan negotiations "cover the full range of services that a MCO's members may need, including inpatient OB services." (Resp. Post-Tr. Br. at 46). That is true – negotiations extend beyond just the services in the GAC and OB markets. Indeed, those negotiations and the resulting contracts also cover outpatient, psychiatric, and substance-abuse services. (*See, e.g.,* PX00365 at 030, 033-035 (inpatient and outpatient rates in { } contract with { }), *in camera*; PX02520 at 003-005, 009-012, *in camera* (2011 rate schedule for { } contains inpatient, psychiatric, detoxification, and outpatient rates)). These are all services, however, that Respondent admits are *not* included in the GAC market. (Response to RFA at ¶ 3; Answer at ¶ 13; Guerin-Calvert, Tr. 7195-7196). Therefore, the scope of negotiations is not dispositive, or even relevant, to market definition.

Respondent also makes the claim that "[n]o MCOs testified that they negotiate separate rates for OB, but instead testified that they negotiate for the full scope of inpatient services."

(Resp. Post-Tr. Br. at 46). Again, the scope of negotiation is not dispositive or relevant, but the claim that "[n]o MCOs testified that they negotiate separate rates for OB" is wholly incorrect. United, which Respondent called as a witness, specifically testified that OB rates could be a point of negotiation between a hospital and United, and that OB rates were in fact an explicit subject of negotiation in their 2010 negotiations with ProMedica. (Sheridan, Tr. 6684-6685). Aetna also testified that OB rates are negotiated. (Radzialowski, Tr. 752). Moreover, hospital-health plan contracts, which are negotiated, demonstrate that OB rates and rate structures often differ from other inpatient GAC services. (*See, e.g.*, PX00365 at 030, *in camera*; PX00366 at 030, *in camera*; PX02520 at 003-005, *in camera*; PX00363 at 019, 022; PX00364 at 019, 022; PX01262 at 004, 027). Respondent points only to a single health plan, { }, that has a contract with ProMedica that does not *currently*[3] "carve out" OB rates from GAC rates. This does not undermine the conclusion that OB is a separate market. In fact, this strengthens the conclusion that OB is a separate market because it illustrates that health plans and hospitals negotiate over the structure of OB rates – i.e., whether to have a separate OB rate or to include it in the base rate for GAC – in addition to the OB rate methodology (e.g., case rate or per diem) and the OB rate itself.

C. Lucas County Is the Relevant Geographic Market for GAC and OB

Respondent agrees with Complaint Counsel that Lucas County is the relevant geographic market. (Resp. Post-Tr. Br. at 47). In its Post-Trial Brief, Respondent puts forth no arguments that the relevant geographic market for OB is any different (i.e., broader) than Lucas County. Indeed, the proposition that the OB geographic market is broader than the GAC market is belied by the record and simple common sense – it is implausible that a woman in labor would be

[3] Anthem testified that nothing, other than mutually agreeing to terms, prevents { }. (Pugliese, Tr. 1668, *in camera*).

willing to travel farther than someone with a scheduled elective surgery. The case law, a *Merger Guidelines* analysis, and voluminous evidence consisting of data, documents, and testimony confirm that Lucas County is the relevant geographic market for both relevant service markets. (*See* CC Post-Tr. Br. at 21-28; CCPFF ¶¶ 208-272).

III. VOLUMINOUS EVIDENCE DEMONSTRATES LIKELY ANTICOMPETITIVE EFFECTS

In contrast to Respondent's arguments, many of which are not substantiated and some of which are spurious, Complaint Counsel has put forth voluminous evidence of the Acquisition's likely anticompetitive effects. This evidence demonstrates that the Acquisition substantially lessens competition.

A. Market Shares and Concentration Establish Overwhelming Presumption of Illegality

The law is clear: "a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market, is *so inherently likely to lessen competition substantially that it must be enjoined* in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects." *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 363 (1963) (emphasis added; internal citations omitted); *see also United States v. Citizens & S. Nat'l Bank*, 422 U.S. 86, 120-121 (1975); *Chicago Bridge*, 534 F.3d at 423; *United States v. Dairy Farmers of Am.,* 426 F.3d 850*,* 858 (6th Cir. 2005); *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 716 (D.C. Cir. 2001) ("Sufficiently large HHI figures establish the FTC's *prima facie* case that a merger is anti-competitive."); *FTC v. Butterworth Health Corp*., 946 F. Supp. 1285, 1294 (W.D. Mich. 1996), *aff'd*, 1997 U.S. App. LEXIS 17422, 1997-2 Trade Cas. (CCH) ¶ 71,863 (6th Cir. 1997) ("A transaction resulting in a high concentration of market power and creating, enhancing, or facilitating a potential that such

market power could be exercised in anticompetitive ways is presumptively unlawful.") (internal citations omitted). Thus, "[m]arket share and concentration statistics can establish a presumption of harm and *shift the burden of proof to Defendants* to demonstrate that the presumption does not accurately reflect a merger's likely effects on competition in the relevant market(s)." *FTC v. CCC Holdings, Inc*., 605 F. Supp. 2d 26, 44 (D.D.C. 2009) (emphasis added) (citing *United States v. Baker Hughes*, 731 F. Supp. 3, 11-12 (D.D.C. 1990)).

One of the most glaring omissions from Respondent's Post-Trial Brief is *any* post-Acquisition market shares or HHIs, even ones that Respondent suggests are more accurate. This is not surprising. Because Respondent cannot avoid the relevant service and geographic markets established here, Respondent cannot avoid the market shares and HHIs established in this case, which create – by a wide margin – an overwhelming presumption that the Acquisition violates Section 7 in two relevant markets.

To distract the Court from the overwhelming presumption created by the market shares and HHIs, Respondent resorts to a multi-prong effort to muddy the waters – but to no avail. First, Respondent makes much ado about market shares and HHI calculations not ending this Court's analysis. (Resp. Post-Tr. Br. at 48-49). Complaint Counsel agrees. So Respondent's suggestion that Complaint Counsel is "rely[ing]" or "solely relying" on market shares to analyze competitive effects is simply false. Indeed, as the Court will note, Complaint Counsel's briefs and findings of fact provide voluminous additional evidence beyond market structure and concentration levels, including third-party testimony and documents, expert analysis, and substantial evidence from Respondent's own documents and testimony. This evidence bolsters the presumption of anticompetitive effects that are so apparent in the market shares and

concentration data.[4]

Respondent's reliance on *United States v. Oracle*, 331 F. Supp. 2d 1098, 1171-1172 (N.D. Cal. 2004) for the proposition that the Court should disregard the market shares calculated by Complaint Counsel is highly misleading. In *Oracle*, the court wholly rejected the plaintiff's proposed market definition and thus was left with no means of calculating market shares or HHIs. *Oracle*, 331 F. Supp. 2d at 1161, 1165 (noting that the court cannot "furnish its own statistics"). Here, Respondent agrees with Complaint Counsel that GAC is a relevant service market and that Lucas County is the relevant geographic market, and the evidence fully supports the OB service market. So, unlike in *Oracle,* the Court is not in the position of having to "furnish its own statistics" regarding market concentration. And the Acquisition is shown to be presumptively unlawful regardless of how the market is defined.

Respondent also makes the spurious allegation that Complaint Counsel and its economic expert have "manipulated" market definition and market shares to "artificially inflate St. Luke's share" and importance. (Resp. Post-Tr. Br. at 49-50). This is patently false. Complaint Counsel bases its market-share calculations on Ohio Hospital Association data, which market participants regularly use (Wakeman, Tr. 2766-2767; Korducki, Tr. 468-469; Beck, Tr. 386-387), and on properly-defined relevant service and geographic markets. In fact, Complaint Counsel's market shares are consistent with – in some cases even *lower than* – the market shares seen in Respondent's own ordinary-course documents:

[4] Market share "statistics provide a graphic picture of the immediate impact of a merger, and, as such, also provide a meaningful base upon which to build conclusions of the probable effects of the merger." *Brown Shoe Co., Inc. v. United States*, 370 U.S. 294, 343 n.70 (1962).

Source	Post-Acquisition GAC Market Share (Basis, Period, Area)	Post-Acquisition OB Market Share (Basis, Period, Area)
Complaint Counsel/ Professor Town (PX02148 at 143 (Exhibit 6) (Town Expert Report), *in camera*)	58.3% (patient days, 7/09-3/10, Lucas County)	80.5% (patient days, 7/09-3/10, Lucas County)
ProMedica 2008 Presentation to Standard & Poor's (PX00270 at 025-026)	55% (discharges, 2006, Toledo MSA)	69.5% (discharges for Women's Services, 2006, Toledo MSA)
St. Luke's Board Meeting Affiliation Update, Dec. 15, 2009 (PX01016 at 003, *in camera*)	67%* (discharges, 2008, SLH Core Service Area)	78%* (discharges, 2008, SLH Core Service Area)
St. Luke's Market Report, Nov. 18, 2008 (PX01077 at 006)	50.3%* (discharges, 2007, SLH Primary Service Area)	63.8%* (discharges, 2007, SLH Primary Service Area)
Market Share in the Toledo Area 1997-1Q 2010 (PSA) (PX01236 at 002, 054)	53.6% (discharges, 2009, SLH 80% Primary Service Area)	70.6% (discharges, 2009, SLH 80% Primary Service Area)
Market Share in the Toledo Area 1997-1Q 2010 (CSA) (PX01235 at 003, 005)	68.4% (discharges, 2009, SLH Core Service Area)	85% (discharges, 2009, SLH Core Service Area)

* Includes only St. Luke's, TTH, and Flower (i.e., does not include Bay Park's market share), so Respondent's post-Acquisition market share is understated by these figures.

Additionally, as the Court can see from Complaint Counsel's Post-Trial Brief, Complaint Counsel also presented market shares and concentration statistics based on Respondent's prior claims about the relevant service market, geographic market, and fringe competitors. It makes no difference: the Acquisition still leads to undue market concentration and an overwhelming presumption of harm regardless of how the boundaries of the relevant markets are defined. (*See* CC Post-Tr. Br. at 34-36 and accompanying Tables). Specifically, this Court could:

- **Analyze market shares and HHIs based on the broader service and geographic markets proposed by Respondent's economic expert and add the University of Michigan Medical Center and the Cleveland Clinic as fringe**

competitors ⇒ ***Overwhelming presumption stands*:** As a result of the Acquisition, Respondent commands a 43% market share, concentration increases by 560 points, and the resulting HHI is 2855 – all of which exceed the thresholds in *Philadelphia National Bank* and the *Merger Guidelines*. (*See* CC Post-Tr. Br., Appendix, Tables 6 and 7).

- **Analyze market shares and HHIs based on beds-in-use data prepared by Respondent's economic expert and add WCH, FCHC, Fremont Memorial Hospital, and H.B. Magruder Memorial as fringe competitors ⇒**

  Overwhelming presumption stands: As a result of the Acquisition, Respondent commands a 47.8% market share, concentration increases by 662 points, and the resulting HHI is 3413 – all of which exceed the thresholds in *Philadelphia National Bank* and the *Merger Guidelines*. (*See* CC Post-Tr. Br., Appendix, Table 8).

- **Expand the geographic market to include Wood and Fulton counties ⇒**

  Overwhelming presumption stands: As a result of the Acquisition, Respondent commands a 55.8% GAC market share and a 75.3% OB market share, concentration increases by 989 points in GAC and 1157 points in OB, and the resulting HHI is 4037 in GAC and 6020 in OB – all of which exceed the thresholds in *Philadelphia National Bank* and the *Merger Guidelines*. (*See* CC Post-Tr. Br., Appendix, Tables 4 and 5).

- **Analyze market shares and HHIs in Lucas County based on all inpatient DRGs, even those that Respondent's expert excluded from her relevant service market definition and those that St. Luke's does not even offer ⇒**

  Overwhelming presumption stands: As a result of the Acquisition, Respondent commands a 56.3% market share in GAC, an 80.5% market share in OB, or a 58.7% market share in a combined GAC-OB market; concentration increases by 823 points in GAC, 1289 points in OB, or 867 points in a combined GAC-OB market; and the resulting HHI is 4246 in GAC, 6855 in OB, or 4424 in a combined GAC-OB market – all of which exceed the thresholds in *Philadelphia*

National Bank and the *Merger Guidelines*. (OHA Data; based on commercial patient days (7/09 – 3/10) including all MDCs/DRGs).

Complaint Counsel did not – and had no need to – manipulate market shares because under all scenarios the Acquisition is presumptively illegal. It is not a close call.

Complaint Counsel and Professor's Town's market definitions are correct and analytically appropriate. Respondent, however, claims that Professor Town manipulated market shares by "limiting" his analysis (1) to services that both ProMedica and St. Luke's provide and (2) by filtering DRGs in which St. Luke's had less than three discharges in a year. (Resp. Post-Tr. Br. at 50). First, Professor Town properly analyzed those services that *both* St. Luke's and ProMedica provide because, by definition, it is only in those overlapping services that the Acquisition eliminates competition. (*See* CC Post-Tr. Br. at 11-15).

Second, Professor Town's filtering of the DRGs in which St. Luke's had two, one, or zero discharges eliminates errors and distortions in the data. (PX02148 at 023 (¶ 40 n.53) (Town Expert Report), *in camera*). For example, the filter eliminates errors where a hospital mistakenly uses a DRG code even though it does not offer that particular service. Moreover, the three-admission filter does not meaningfully affect the analysis. Even with the filter, the analysis still captures 347 DRGs, which represent about 90% of the commercial admissions for ProMedica and St. Luke's. (PX02148 at 023 (¶ 40 n.53) (Town Expert Report), *in camera*). Ultimately, changing the filter to add in (or delete) additional DRGs does not materially change the analysis or Professor Town's conclusion that the Acquisition is anticompetitive. (PX02148 at 023 (¶ 40 n.53) (Town Expert Report), *in camera*).[5]

[5] Notably, Respondent's economic expert used filters in her analysis, and she did not criticize Professor Town's use of filters anywhere in her expert reports for the related federal-court proceedings. (RX-71(A) at 158-159 (Guerin-Calvert Expert Report), *in camera*; Guerin-Calvert, Tr. 7660-7661; *see* PX02122 (Guerin-Calvert, Decl.); PX02136 (Guerin-Calvert, Supplemental Decl.)).

B. Respondent's Arguments Misunderstand the Relevance of the Evidence Regarding the Close Competition Between St. Luke's and ProMedica

Although Respondent would have the Court believe that Complaint Counsel has relied solely on market shares and market concentration to prove its case, this is far from true. Complaint Counsel has thoroughly substantiated the mechanism of competitive harm caused by the Acquisition, based on the bargaining dynamics between health plans and hospitals. The evidence supports Complaint Counsel's case at every turn: by the health-plan and employer witnesses, by ProMedica and St. Luke's witnesses, by ordinary-course documents, by expert testimony, and by econometric analysis.

In short, for many patients, St. Luke's and one of ProMedica's legacy hospitals are the top two choices (i.e., close substitutes) for GAC and OB services. (CC Post-Tr. Br. at 38-41; CCPFF ¶¶ 315-345). Consequently, before the Acquisition, health plans needed to contract with *either* ProMedica *or* St. Luke's in order to meet those customers' needs. (CC Post-Tr. Br. at 36-37). After the Acquisition, St. Luke's is no longer available as an alternative if a health plan fails to reach an agreement with ProMedica. (CC Post-Tr. Br. at 36-37). Now, health plans that fail to reach agreement with ProMedica (including St. Luke's) must offer an unattractive and less marketable provider network that fails to include the top two hospital choices for a significant number of patients. (CC Post-Tr. Br. at 36-37). As a result, ProMedica has significantly increased its bargaining leverage with health plans and will obtain much higher prices. (CC Post-Tr. Br. at 36-37). This mechanism of harm comports with unilateral effects analysis, which is premised on the notion that the merger of close substitutes in differentiated markets leads to competitive harm.[6] (*Merger Guidelines* § 6.1; Town, Tr. 3778-3779, *in camera*).

[6] Respondent's argument that Complaint Counsel has not provided evidence of anticompetitive effects in the OB market is patently false. The competitive effects analysis described here, and the supporting evidence confirming ProMedica's significant increase in leverage, applies equally to the OB and GAC markets. (*See* Town, Tr. 4454-

Respondent turns unilateral effects analysis on its head and argues that there is no anticompetitive harm because (1) St. Luke's is not a close substitute to *health plans* for the ProMedica system *as a whole*; and (2) ProMedica and Mercy are each other's closest substitutes. Both arguments widely miss the mark.

First, Complaint Counsel does not dispute that St. Luke's, as a single hospital, likely could not adequately replace ProMedica's three legacy hospitals in a Lucas County provider network. (*See* Resp. Post-Tr. Br. at 59-60.) But ProMedica gains nothing by pointing out this obvious fact.[7] The relevant inquiry is whether St. Luke's is a close substitute in the eyes of health plans' *members* with any *one* of ProMedica's hospitals; this is what affects ProMedica's bargaining leverage. (Town, Tr. 3864-3865). Complaint Counsel has presented ample evidence, including Professor Town's diversion analysis and his willingness-to-pay analysis, showing that St. Luke's and ProMedica hospitals were, in fact, close substitutes in precisely that respect. (CC Post-Tr. Br. at 38-41; CCPFF ¶¶ 315-345). To ask – as Respondent would have this Court do – whether St. Luke's is a close substitute for the *entire* ProMedica system would lead to perverse results, essentially permitting (and perhaps encouraging) a hospital to acquire a close competitor if the acquirer already owns numerous other hospitals in the area. Indeed, the evidence demonstrates that no hospital system in Lucas County is interchangeable with ProMedica and so, under Respondent's test, ProMedica could conceivably acquire every hospital in Lucas County without violating the Clayton Act. Essentially, Respondent's argument amounts to a "dominant hospital" exception to the antitrust laws.

4456 (explaining that bargaining analysis applies equally to OB market)). Furthermore, Complaint Counsel has provided additional evidence specifically pertaining to the close competition between ProMedica and St. Luke's in the OB market. (*See, e.g.,* CCPFF ¶¶ 314, 324-325, 337, 364, 432, 435, 482-483, 507-508, 701-702). Finally, Professor Town's merger simulation predicting significant price increases applies to both the GAC and OB markets. (Town, Tr. 4468-4469).

[7] Respondent's argument suggests that any merger between differently-sized hospitals or hospital systems would be immune from antitrust scrutiny because they would not be perfectly interchangeable in provider networks.

Second, it is also irrelevant that ProMedica and Mercy may be each other's closest substitutes, whether as systems or as individual hospitals. (*See* Resp. Post-Tr. Br. at 58-61). Closer substitution between Mercy and ProMedica signifies only that a merger between them may be even *more* anticompetitive than the Acquisition. (Town, Tr. 3777-3778, *in camera*). This does not undermine the conclusion that St. Luke's and ProMedica are also close substitutes.[8] Nor does it detract from the fact that ProMedica was larger and more dominant than Mercy even before the Acquisition or that Mercy could not have replaced ProMedica in health plans' networks without a significant loss in value to health plans and their members. (*See* CC Post-Tr. Br. at 66-68; CCPFF ¶¶ 478-502; *see also* PX02148 at 165 (Exhibit 13) (Town Expert Report), *in camera* (consumers place 22 percent more value on having in-network access to ProMedica than to Mercy)). Respondent's reliance on competition from Mercy alone as a constraint on ProMedica's exercise of market power also fails – the law does not require that a merger eliminate *all* competition in order to be found illegal, nor does it immunize mergers where *any* modicum of competition still remains in the marketplace.

Respondent's argument that Lucas County residents can drive to more-distant hospitals within Lucas County is equally beside the point. Respondent argues that for residents living in St. Luke's core service area the drive time to "an alternative hospital" is not materially different than the drive time to St. Luke's; that a large proportion of St. Luke's patients bypassed a closer hospital; and that many patients residing in the zip codes around St. Luke's go to an alternative hospital for treatment. (Resp. Post-Tr. Br. at 54, 62). In this flurry of arguments, Respondent glosses over the fact that the vast majority of the residents who are going to "an alternative hospital" to St. Luke's are going to a *ProMedica hospital,* either Flower or TTH, or would do so

[8] In fact, the diversion analysis conducted by Professor Town shows that, while Mercy and ProMedica are each other's closest substitute, ProMedica is St. Luke's closest substitute and St. Luke's is ProMedica's second-closest substitute. (PX01850 at 020 (Table 3) (Town Rebuttal Report), *in camera*).

if St. Luke's were not available. (CC Post-Tr. Br. at 38-41; CCPFF ¶¶ 315-345). Thus, as a result of the Acquisition, both St. Luke's *and* these patients' next-best or next-closest alternatives are owned by ProMedica, which is the very source of the competitive harm. And none of ProMedica's arguments undermine the conclusion that, all else equal, patients prefer to be treated in hospitals close to home, as even Jack Randolph, head of Paramount, testified. (Randolph, Tr. 7102, *in camera*).[9] Moreover, Respondent's own Proposed Findings of Fact state that the need to drive to a more distant Lucas County hospital may have real, adverse health consequences. (RPFF ¶ 1748 ("Emergency room diversions pose a risk to patients having true emergencies like heart attacks since traveling to a more distant hospital can have an effect on patient outcomes."); *see also* CCPFF ¶ 639).

As such, the evidence demonstrating the close competition between St. Luke's and ProMedica – especially in southwest Lucas County – is appropriate and highly relevant to the competitive-effects analysis. Even if patients *could* switch to more distant hospitals within Lucas County, health plans wanting to successfully market their products must fulfill the *preference* of customers not to travel too far and, specifically, the *preference* of customers in southwest Lucas County to go to either St. Luke's, Flower, or TTH. (*See* CC Post-Tr. Br. at 54-55, 69-70). ProMedica ignores the relevance of this evidence to the bargaining dynamics and instead suggests, incorrectly, that the focus on southwest Lucas County is designed to inflate St. Luke's competitive significance (which, in any case, is well-established by other evidence) and that the focus on customer preference is somehow improper. (Resp. Post-Tr. Br. at 53, 74; *see also* CC Post-Tr. Br. at 41-43 (discussing St. Luke's competitive significance)). ProMedica is

[9] Furthermore, the data relied upon by Ms. Guerin-Calvert necessarily includes patients seeking tertiary care services, for which patients are willing to travel further; services that St. Luke's does not provide; and Paramount patients, for whom St. Luke's was out-of-network.

muddying the waters in a failed effort to discredit the powerful evidence of the close competition between ProMedica and St. Luke's.

C. The Complexity of Contract Negotiations Has No Bearing on ProMedica's Ability to Exercise Market Power in the GAC and OB Markets

Contrary to Respondent's claims, the complexity and breadth of the negotiations between health plans and hospitals does not prevent Respondent from exercising its increased market power in the GAC and OB markets, nor prevent a well-constructed econometric analysis from measuring the effects of that market power. As an initial matter, it is both intuitively obvious and clearly established by the evidence that, despite the many important contract terms that are negotiated, reimbursement rates are the most critical. (*See, e.g.*, Wachsman, Tr. 5139-5140, *in camera*; Sandusky, Tr. 1318-1319, *in camera*; Radzialowski, Tr. 660; Pugliese, Tr. 1514, *in camera*; Sheridan, Tr. 6703, *in camera*; *cf.* Pirc, Tr. 2292 (rates are the primary cost that is factored into members' insurance premiums)). Moreover, health plans consistently compare rates among hospital providers and rely on these comparisons to craft business strategies; the multitude of contract terms does not render this exercise useless. (*See, e.g.,* Pirc, Tr. 2227-2229, *in camera*; Pugliese, Tr. 1506-1508, *in camera*; Radzialowski, Tr. 704, *in camera*).

Ultimately, the complexity and scope of contract negotiations merely give ProMedica more avenues in which to exercise the market power it has gained in the GAC and OB markets. (*See* Town, Tr. 3884-3885, 3918-3920). For example, ProMedica may choose to exercise its market power in GAC and OB by demanding higher rates for those specific services in negotiations. (CC Post-Tr. Br. at 58). Alternatively, ProMedica might demand a more favorable rate methodology, negotiate other favorable contract provisions, or demand higher rates for other services.

Respondent's argument about contract negotiations is flatly inconsistent with claims it makes elsewhere. For example, Respondent argues that Complaint Counsel's analysis is flawed because outpatient services and GAC services, among other things, are contracted for together. (Resp. Post-Tr. Br. at 55-56). But ten pages earlier, Respondent argues that outpatient services do not belong in a GAC market for the exact opposite reason: because inpatient and outpatient services are contracted for separately. (Resp. Post-Tr. Br. at 45). Respondent also criticizes Complaint Counsel for focusing only on GAC services in the contract negotiations but then *also* criticizes Professor Town's merger simulation model for *not* focusing only on GAC services. (Resp. Post-Tr. Br. at 63). It is precisely because – as Respondent so strenuously argues – a variety of services are negotiated together that Professor Town's merger simulation analyzes ProMedica's market power in GAC but then examines the price effects beyond the GAC market. (Town, Tr. 4291 ("[T]he structural analysis is focused on the set of overlapping services. Here, I want to have the possibility that price effects may manifest elsewhere.")). Indeed, Respondent's analytical approach would create an impossible Catch-22 for antitrust authorities: Respondent argues that the GAC market is the only appropriate product market in which to analyze competitive effects in hospital mergers (Resp. Post-Trial Br. at 44-47), but that any analysis of competitive effects in a GAC market alone is flawed because contract negotiations are complex and include non-GAC services. (Resp. Post-Tr. Br. at 55-58). This amounts to the view that although hospital mergers may be anticompetitive, there is no way to prove it.

D. Complaint Counsel's Case is Supported By Credible Testimony From Many Market Participants While Respondent Relies Heavily on Biased Witnesses

1. Third-Party Health Plans and Employers Offered Credible, Consistent Testimony at Trial

Because the testimony of health plans and employers consistently contradicts Respondent's assertions on key factual issues, Respondent argues that this testimony –

essentially all testimony provided by anyone other than Respondent's pre-Acquisition employees or hired experts – must be rejected in its entirety. This position is as incorrect as it is extreme.

Respondent principally relies on three antitrust cases in which the court disregarded customer testimony, either because it was "rote," because it was conclusory, or because it did not stand up to patently contradictory evidence. (*See* Resp. Post-Tr. Br. at 72; *Oracle,* 331 F. Supp. 2d at 1131-32 (observing customer witnesses testified "with a kind of rote"); *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 145-46 (D.D.C. 2004) (noting customers testified to little more than anxiety that fewer suppliers would lead to higher prices); *FTC v. Tenet Health Care Corp.*, 186 F. 3d 1045, 1054 (8th Cir. 1999) (holding testimony that health plans would not resist price increases suspect where evidence showed that they could and it was in their economic self-interest to do so)).[10] Here, the health-plan and employer testimony, documentary evidence, and econometric evidence offered by Complaint Counsel are mutually reinforcing and consistently reach the same conclusions on multiple aspects of Complaint Counsel's case-in-chief.

Indeed, in *Oracle*, the court explicitly noted that "[i]f backed by credible and convincing testimony [about what customers could or could not do to avoid a price increase] or testimony presented by economic experts, customer testimony . . . can put a human perspective . . . on the injury to competition that plaintiffs allege." *Oracle*, 331 F. Supp. 2d at 1131. The health-plan and employer witnesses who testified at trial explained why they could not constrain

[10] Specifically, in *Tenet*, the court was skeptical of the health plans' testimony that they *would* not steer their members to other hospitals to defeat a rate increase in light of the evidence establishing that they *could* do so. *Tenet*, 186 F.3d at 1054 ("the evidence shows that . . . buyers can and do resist price increases."). In fact, the parties had stipulated that the health plans at issue had "a very significant, if not determinative, effect on patients' selection of hospitals." *FTC v. Tenet Health Care Corp.*, 17 F. Supp. 2d 937, 940 (E.D. Mo. 1998). As such, the health plans' testimony contradicted their obvious economic self-interest to steer patients. *Tenet*, 186 F. 3d at 1054. Respondent wrongly tries to shoehorn those holdings into this case without any of the underlying evidence. Here, the evidence has shown that health plans *cannot* steer patients to defeat a price increase, even if it were in their interest to do so. (*See* CC Post-Tr. Br. at 70-75).

unreasonable rate requests by ProMedica post-Acquisition.[11] (*See, e.g.*, Pirc, Tr. 2261-2263, *in camera* (explaining that before the Acquisition MMO {

}); Radzialowski, Tr. 712-713, *in camera* (describing that Aetna's {

}); Sandusky, Tr. 1351, *in camera* (explaining that FrontPath {

}); Neal, Tr. 2111 (explaining Chrysler's reliance on ProMedica and St. Luke's based on analysis of healthcare spend in Lucas County)).

Whereas the customer witnesses in *Oracle* testified "with a kind of rote," and the customer witnesses in *Arch Coal* made only simple and conclusory statements, the health plan witnesses at trial relied on reviews of utilization data and pricing analyses, decades of experience negotiating with health plans and evaluating provider networks, and their understanding of bargaining dynamics and provider-network marketability in Lucas County as the foundation for their concerns about the Acquisition. (*See generally* CCPFF at ¶¶ 1306-1361 (Witness Backgrounds); *see e.g.,* Pugliese, Tr. 1506-1508, *in camera* (describing pricing analysis conducted by Anthem in response to Acquisition); Radzialowski, Tr. 635, 704, 712-713, *in camera* (describing bargaining dynamics, utilization statistics, and pricing analysis conducted by Aetna in response to Acquisition); Sandusky, Tr. 1351, *in camera* (describing utilization

[11] Respondent suggests that the health-plan testimony lacks credibility simply because three of the health-plan witnesses could not provide precise answers on the stand to a "pop quiz" administered by Respondent's counsel regarding specific utilization statistics. (*See* Resp. Post-Tr. Br. at 53.) Of the three witnesses, Mr. Pirc provided his best estimate without having the data in front of him (Pirc, Tr. 2302, *in camera*), and Mr. Radzialowski stated that the numbers are available in reports, but he did not have those reports on the stand with him. (Radzialowski, Tr. 738). Respondent refers to a third witness, Mr. Pugliese, but the citation provided contains no testimony on point. (*See* Resp. Post-Tr. Br. at 53 (citing Pugliese, Tr. 1447)).

statistics for Lucas County); Sheridan, Tr. 6691-6693, *in camera* (describing historical experience with limited network in Lucas County)). The testimony has other indicia of reliability. For example, Anthem expressed its concerns about the Acquisition in ordinary-course documents that pre-date its first contact with the FTC. (*See, e.g.*, PX02377 at 001; PX02379 at 001). Mr. Pirc of MMO did not meet or speak with Complaint Counsel before testifying, (Pirc, Tr. 2162-2163), and yet his testimony was entirely consistent with that of the other health plan and employer witnesses, even in the details, regarding key aspects of Complaint Counsel's case. And, of course, all of the fact-witness testimony is backed by economic-expert testimony, including the econometric and diversion analyses that were lacking in *Oracle*. 331 F. Supp. 2d at 1172.

Meanwhile, the only purportedly "contrary evidence" that Respondent has put forth on key factual issues testified to by health-plan witnesses is derived from Respondent's executives or its highly-paid consultants.[12] And for many factual assertions that, if credible, should have been elicited from the lay witnesses, Respondent instead relies entirely on its economic expert. For example, for the claim that travel time will not deter patients from switching hospitals, Respondent relies solely on Ms. Guerin-Calvert and does not point to a single health plan or other fact witness for corroboration. (*See* RPFF ¶¶ 1210-1218). Similarly, Respondent relies solely on Ms. Guerin-Calvert for assertions regarding demographic and economic trends in

[12] The only witnesses called by Respondent who are not affiliated with Respondent or a paid consultant were Bruce Gordon, formerly of AMBAC, who testified regarding St. Luke's bond debt, and Gina Sheridan of United, who agreed with Complaint Counsel on many key aspects of its case. (*See* CCPFF at ¶¶ 1422-1503 (Witness Backgrounds); *see, e.g.,* Sheridan, Tr. 6683 (OB rates are separately negotiated); 6680-6681 (patients want broad networks with hospitals as close to home as possible); 6654, 6659, *in camera* (ProMedica had { }); 6672-6673 (St. Luke's location serves a need in Lucas County because no other hospitals are nearby); 6687 (it will be harder for United to serve its membership without ProMedica than it was before the Acquisition), etc.).

Toledo and their significance to hospitals and health plans. (*See* RPFF ¶¶ 1219-1248, 1316-1319).

Respondent's insistence that witnesses be judged by what they do rather than what they say on the stand, while reasonable, only backfires on Respondent. (*See* Resp. Post-Tr. Br. at 53 (citing *Oracle*, 331 F. Supp. 2d at 1167)). The testimony of the health-plan and employer witnesses is entirely consistent with their actions in the marketplace. For example, health-plan witnesses testified that St. Luke's is a significant competitor in Lucas County; indeed, Anthem {

} (Wachsman, Tr. 5206, *in camera*; Pugliese, Tr. 1481, 1484-1485, *in camera*), and MMO {

}. (PX01944 at 017 (Pirc, Dep. at 62), *in camera*). Health-plan witnesses also testified that a UTMC-Mercy network is not viable; indeed, no health plan has ever offered such a network in Lucas County. (*See* CC Post-Tr. Br. at 68). And health-plan witnesses testified that customers prefer broad access and open networks; indeed, all Lucas County commercial health plans switched to open networks by 2010, leaving only Paramount as a narrow-network provider. (Radzialowski, Tr. 741-742).

In contrast, the actions of Respondent's witnesses often undermine the claims made on the stand. For example, despite numerous documents showing that St. Luke's wanted to affiliate with ProMedica for "incredible access to outstanding pricing," Respondent's witnesses testified that St. Luke's actually chose ProMedica for local governance and cultural fit. (*Compare* PX01125 at 002 *with* Wakeman, Tr. 2961, *in camera*). Despite having attempted to either acquire St. Luke's or put it out of business for many years, Respondent's witnesses testified that

a desire to "help" St. Luke's motivated ProMedica to enter into the Acquisition. (*Compare* PX01127 at 001 *with* Oostra, Tr. 5876-5877, *in camera*). Despite building Bay Park in eastern Lucas County and purchasing land in southwest Lucas County specifically to attract patients in those locations, Respondent's witnesses testified that Lucas County is small enough that hospital location does not matter. (*Compare* Oostra, Tr. 5804-5805 and PX01152, *in camera*, *with* Wachsman, Tr. 5131-5132, *in camera*).

2. Respondent's Argument That It Will Not Be Able to Raise Prices to Supracompetitive Levels is Analytically Flawed and Factually Unsupported

In an attempt to prove that the Acquisition has not allowed it to raise St. Luke's rates above competitive levels, Respondent argues, first, that the "competitive level" before the Acquisition is represented by rates that St. Luke's never actually charged and, further, that those hypothetical rates are equivalent to the rates that ProMedica actually did negotiate for St. Luke's after the Acquisition. (*See* Resp. Post-Tr. Br. at 85-90). Thus, according to Respondent, there has been no change in prices and no change in market power.[13]

There are a myriad of problems with this argument. First, as explained in Complaint Counsel's Post-Trial Brief, the rates that St. Luke's requested but *failed to achieve* in negotiations with MMO cannot tell us what rates would have been "but-for-the-Acquisition." (CC Post-Tr. Br. at 56-57). Nor is it clear why Respondent and Ms. Guerin-Calvert rely on the

[13] Respondent makes the puzzling claim that Complaint Counsel is required to prove that pre-Acquisition rates were anticompetitive. (Resp. Post-Tr. Br. at 85, citing *Oracle*, 331 F. Supp. 2d at 1170). It is not clear why this would be true and the *Oracle* citation Respondent provided is not illuminating. Regardless, Complaint Counsel has in fact demonstrated ProMedica's dominance and market power even before the Acquisition, including that ProMedica's prices were the highest in Lucas County, which cannot be explained by competitively-benign factors such as cost or quality. (*See* CC Post-Tr. Br. at 51-52; PX01850 at 057-059 (¶¶ 89-90) (Town Rebuttal Report), *in camera*). Professor Town's willingness-to-pay model also properly accounts for the pre-Acquisition bargaining power of the hospitals. (PX01850 at 059 (¶ 94) (Town Rebuttal Report), *in camera*).

larger increase that St. Luke's *requested* from as the "but-for" price rather than the modest increase of that was *actually* achieved from before the Acquisition.[14] (*See* Guerin-Calvert, Tr. 7872-7873, *in camera*). It *is* clear that, using actual pre- and post-Acquisition prices at St. Luke's under the test devised by Respondent' s expert, ProMedica was able to negotiate significant rate increases, notwithstanding the Hold Separate Agreement and two pending antitrust lawsuits against the merger.

Respondent's argument is also legally unsound: courts generally rely on current prices as the presumptively "competitive price" in antitrust cases. (IIA Phillip Areeda & Herbert Hovenkamp, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION, ¶ 537b (3d ed. 2010); *CF Indus. v. Surface Transp. Bd.*, 255 F.3d 816, 824 (D.C. Cir. 2001); *see also U.S. v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 142-43 (E.D.N.Y. 1997) (generally assuming current prices represent competitive levels)). To accept ProMedica's argument, the Court would have to find that St. Luke's mutually-agreed and freely-contracted rates were unreasonable and that some other hypothetical rate is the actual "competitive" price. But courts recognize that they are ill-equipped to delve too far into such determinations.[15] *Pac. Bell Tel. Co. v. Linkline Communs., Inc*., 129 S.Ct. 1109, 1121 (2009); *United States v. Addyston Pipe & Steel Co*., 85 F. 271, 283-84 (6th Cir. 1898) (Taft, J.) (inquiring into the reasonableness of prices is to "set sail on a sea of doubt."), *aff'd*, 175 U.S. 211 (1899); *see also ProMedica*, 2011 U.S. Dist. LEXIS 33434, at *158 ("The Court declines Defendant's invitation to delve into whether St. Luke's current prices are 'subcompetitive' or otherwise unreasonable in some

[14] The negotiation also demonstrates that St. Luke's was capable of negotiating for rates that would enable it to cover its costs.

[15] Of course, it is appropriate for St. Luke's to negotiate aggressively to obtain higher rates, if it chooses. But that does not mean that St. Luke's pre-Acquisition, freely-negotiated (though perhaps poorly-negotiated) rates are not at competitive levels. *See ProMedica*, 2011 U.S. Dist. LEXIS 33434, at *158.

way.").

Furthermore, to accept Respondent's argument, the Court would also have to improperly place enormous weight on post-Acquisition evidence, i.e., the contracts that ProMedica negotiated for St. Luke's while the investigation was ongoing, litigation was pending in two forums, and the Hold Separate Agreement was in place. (*See United States v. Gen. Dynamics*, 415 U.S. 486, 504-505 (1974); Resp. Post-Tr. Br. at 85-90; RX-71(A) at 53-56 (¶¶ 97-103) (Guerin-Calvert Expert Report), *in camera*)). The standard is extremely strict: post-acquisition evidence that is even *arguably* subject to manipulation is entitled to little or no weight. *Chicago Bridge*, 534 F.3d at 435.

Respondent takes the incredible position that it could not have manipulated the post-Acquisition negotiations in which it was a key participant. (Resp. Post-Tr. Br. at 85). It is irrelevant that another party was also involved in the negotiations. In *Hospital Corporation of America v. FTC*, the appellate court upheld the Commission's decision to entirely disregard post-acquisition evidence where the defendant had merely "reacted with unaccustomed mildness" to a contract termination initiated by a third-party.[16] 807 F.2d 1381, 1383-1384 (7th Cir. 1986) (Posner, J.). Here, ProMedica easily could – and likely did – negotiate less aggressively under the spotlight of the investigation and litigation, knowing that the contract negotiations would be used as evidence. (*See* Radzialowski, Tr. 831-832, *in camera*). Surely, a health plan would not complain if ProMedica decided not to exercise its full market power now due to the litigation spotlight.

[16] The two cases cited by Respondent, in which courts held that post-acquisition evidence was entitled to some weight, involved evidence that clearly could not have been manipulated by the defendant. *See Lektro-Vend Corp. v. The Vendo Co.*, 660 F. 2d 255, 276 (7th Cir. 1981) (relying on precipitous decline in defendant's post-acquisition market share); *United States v. Archer-Daniels-Midland Co.*, 781 F. Supp. 1400, 1423 (S.D. Iowa 1991) (relying on post-acquisition industry-wide trends).

Furthermore, the post-Acquisition rates negotiated by ProMedica for St. Luke's were also distorted by the existence of the Hold Separate Agreement, which temporarily constrains ProMedica's market power by giving health plans the right to maintain their existing contracts rather than renegotiate. (*See* CC Post-Tr. Br. at 57; PX01850 at 49-50 (¶ 76) (Town Rebuttal Report), *in camera*). Consequently, Respondent's "evidence" based on post-Acquisition contracts – which, in any case, represent substantial price increases – deserves no weight.

IV. RESPONDENT'S DEFENSES LACK LEGAL FOUNDATION AND FACTUAL SUPPORT[17]

Once Complaint Counsel establishes a *prima facie* case that the Acquisition is illegal, the burden shifts to Respondent to rebut the presumption of illegality by producing sufficient evidence to show that Complaint Counsel's case inaccurately predicts the likely competitive effects of the transaction. *United States v. Marine Bancorporation*, 418 U.S. 602, 631 (1974); *Chicago Bridge*, 534 F.3d at 423; *FTC v. Univ. Health Inc.,* 938 F.2d 1206, 1218-19 (11th Cir. 1991); *Polypore*, 2010 FTC LEXIS 97, at *26. The stronger the *prima facie* case, the greater the Respondent's burden of production on rebuttal. *In re Polypore Int'l, Inc.*, No. 9327, 2010 FTC LEXIS 97, at *26 (Dec. 13, 2010) (Comm'n Dec.) (citing *Heinz*, 246 F.3d at 725; *Baker Hughes*, 908 F.2d at 991). Respondent fails to meet its burden.

A. Market Participants Cannot Constrain ProMedica From Raising Rates

1. Respondent's Inability to Substantiate Claims About the Viability of a Mercy-UTMC Network is Fatal to Its Defense

Respondent persists in arguing that health plans can simply walk away from an anticompetitive rate demand by ProMedica and offer a provider network of Mercy and UTMC

[17] ProMedica's defenses were largely anticipated and addressed in Complaint Counsel's Post-Trial Brief. (*See* CC Post-Tr. Br. at 64-104.) This section of Complaint Counsel's reply brief will focus on specific issues raised in Respondent's brief and flaws in the cited evidence.

with no consequences for their businesses. Indeed, ProMedica *must* prove this to be true or else concede that the Acquisition has substantially increased its bargaining leverage and its ability to achieve higher rates. But ProMedica's attempt to find any credible support in the record falls woefully short.

All six third-party health-plan witnesses testified that a network of Mercy and UTMC would be unviable or unmarketable. (*See generally* CC Post-Tr. Br. at 69). Even Scott Shook, a longtime Mercy employee and the lone fact witness that Respondent cites to, merely testified that a Mercy-UTMC network would be and followed up by saying that it (*See* RPFF ¶ 1251; Shook, Tr. 1132, *in camera*).

Having no affirmative evidence, Respondent attempts to minimize the health-plan testimony as "unsubstantiated customer apprehensions" and also points to the past history of narrower networks in Lucas County. But the testimony of the health plans is substantiated by the very same history of narrow networks that Respondent otherwise relies on: no health plan has *ever offered a Mercy-UTMC network*, even in the time period (unlike today) when narrow networks were considered acceptable. Witnesses testified that they did not formally study its viability precisely *because* a UTMC-Mercy network is considered unmarketable on its face.[18] (*See generally* CC Post-Tr. Br. at 69).

Furthermore, Respondent's claim that "network breadth does not translate into any significant competitive advantage" in Lucas County utterly lacks substantiation and is countered by considerable evidence, including from Respondent's own witnesses and documents. (Resp. Post-Tr. Br. at 82; *cf.* CCPFF at ¶¶ 105-106, 349-351; Oostra, Tr. 6047-48 (explaining that Mr.

[18] The fact that United "replaced" ProMedica with Mercy in its network in 2005 is irrelevant because United also was contracted with St. Luke's at the time. (Resp. Post-Tr. Br. at 25; Sheridan, Tr. 6621). No health plan has ever walked away from ProMedica without having St. Luke's in its network.

Randolph felt that Paramount would "be at a competitive disadvantage" and "wouldn't be able to compete" with a narrower network than Anthem); PX00425 at 001, *in camera* (adding St. Luke's would "certainly open up opportunities for membership growth at Paramount.")). Respondent – which elsewhere takes pains to emphasize the sophistication of the health plans as customers – would have the Court believe that every single health plan in Lucas County, including its own, has fundamentally misunderstood how to grow its business. As proof, Respondent claims that health plans in Lucas County that offered broad networks when others offered narrow networks experienced no significant growth in membership. (Resp. Post-Tr. Br. at 31-32). But the evidence offered in support of this claim disintegrates under the slightest scrutiny. Respondent points to: United, which unsurprisingly was unable to grow its membership in Lucas County *without ProMedica*, the dominant hospital system; Aetna, which *did* consider it an "advantage" when it offered a broader network than Anthem and MMO offered in a short two-year window, but did not grow business because of "internal pricing issues"; and Humana, which *did* in fact experience "passive growth" when it offered a broader network than Anthem and MMO offered.[19] (*See* Resp. Post-Tr. Br. at 82; Sheridan, Tr. 6621-6622; Radzialowski, Tr. 741-742; McGinty, Tr. 1198-1199).

Finally, Respondent claims that Paramount is an example of a limited network that has been "tremendously successful" but cites to no evidence indicating that Paramount's network is considered successful, tremendously or otherwise, by anyone. (*See* Resp. Post-Tr. Br. at 83). To the contrary, in 2008, Mr. Randolph strongly advocated within ProMedica that St. Luke's be added to Paramount's network to improve the marketability of its network and its competitive position but was overruled by ProMedica executives concerned about "cannibalization" by St.

[19] Respondent also cites to an erroneous proposed finding stating that Aetna has not experienced any shift in market share in early 2011. (*See* RPFF at ¶ 393). In the cited testimony, Mr. Radzialowski was referring to *hospital* market share and not Aetna's market share. (*See* Radzialowski, Tr. 645-646).

Luke's. (Randolph, Tr. 7079-7080; PX00405 at 001; Oostra, Tr. 6045-6046, 6053; PX01233 at 005, *in camera*). And to the extent that Paramount has competed as the only limited network in Lucas County, it can do so because Paramount gets uniquely advantageous pricing from ProMedica that is not available to the other health plans. (Randolph, Tr. 7071).

2. It is Irrelevant That Health Plans Also Have Sources of Bargaining Leverage

Respondent makes the uncontroversial point that an appropriate competitive-effects analysis should take account of the countervailing bargaining leverage of the health plans. (Resp. Post-Tr. Br. at 58). But ProMedica goes a step too far and, citing to no evidence, claims that health plans are more important to ProMedica than ProMedica is to the health plans.[20] As an initial matter, this is demonstrably not true in the case of Aetna, for which ProMedica accounts than vice versa, and United, which intended to { }. (PX01917 at 019 (Radzialowski, Dep. at 71-72), *in camera*; Sheridan, Tr. 6693, *in camera*). In any case, Complaint Counsel has never argued that health plans do not also have bargaining leverage and indeed has specifically cited evidence demonstrating that they do, based primarily on the size of their membership. (CCPFF ¶¶ 139-141, 161-162). But the purpose of the competitive-effects analysis is to measure the *change* in the *merging firms'* bargaining leverage as a result of the Acquisition. (Town, Tr. 3641-3642; 3656-3658). The evidence shows that ProMedica's Acquisition of St. Luke's increased its bargaining leverage relative to the pre-

[20] Respondent's citation to *Oracle* and *Tenet* to suggest courts have held that the power and sophistication of buyers will necessarily mitigate anticompetitive effects is highly misleading. In *Oracle*, the court was summarizing (without adopting) the testimony of an economic expert who claimed that a unilateral effects theory did not apply to the market at issue because he believed it *only* applied to markets with unsophisticated buyers. *Oracle*, 331 F. Supp. 2d at 1171. ProMedica's own expert has made no such claim. In *Tenet*, as explained *supra,* note 10, the appellate court held that, based on the evidence, health plans were sophisticated enough that they would steer members to resist price increases given clear evidence of their ability to do so effectively. *Tenet*, 186 F.3d at 1054. That is not the case here. (CC Post-Tr. Br. at 70-74).

Acquisition period, allowing it to obtain significantly higher prices than it could have absent the Acquisition. (Town, Tr. 3656-3658). The health plans' leverage has existed for some time, even in the face of ProMedica's high rates, large market shares, and self-described dominance; nothing about the Acquisition increases their leverage or makes them more likely to ensure competitive rates. Notably, Professor Town's willingness-to-pay model controls for the bargaining leverage of the health plans. (Town, Tr. 3798-3799, 3884-3885, *in camera*,).

3. Market Participants Cannot Defeat a Price Increase Based on Bed Capacity and Steering

Respondent continues to claim that excess bed capacity enables market participants to discipline any rate increases. (Resp. Post-Tr. Br. at 76). As explained in Complaint Counsel's Post-Trial Brief, the record reflects that Toledo is not an outlier in terms of bed capacity. (CC Post-Tr. Br. at 65). More to the point, Respondent does not explain why – if there is excess bed capacity in Lucas County – Mercy, UTMC, and health plans have not *already* used this excess bed capacity to defeat ProMedica's *already-high prices*. Excess capacity is not a recent development, yet ProMedica has sustained the highest prices in Lucas County in the face of the very same excess capacity that Respondent now claims will prevent it from exercising market power. (PX02148 at 147 (Ex. 8) (Town Expert Report), *in camera*). It defies logic that health plans had an effective tool at their disposal to prevent ProMedica from obtaining high prices yet chose not to use it. This confirms that Respondent's claims are unfounded.

Respondent's claims that health plans can steer patients to UTMC and Mercy to defeat a rate increase are baseless for the same reason. (*See also* CC Post-Tr. Br. at 70-74; *see also* CC Post-Tr. Br. at 74-78). If health plans and employers were able to implement steering programs to defeat ProMedica's high prices, they surely would have done so already. They have not: the record reflects no history of steering by health plans in Lucas County, no intent by health plans

to implement steering programs (other than one tiny and unpopular pilot program), and evidence of "hard- steering" programs at only two of the thousands of employers in the county.[21] (CC Post-Tr. Br. at 72-73).

4. Demographic Trends Have No Bearing On the Conclusion That The Acquisition Is Anticompetitive

Respondent argues that a decline in demand from commercially-insured patients will put downward pressure on prices. (Resp. Post-Tr. Br. at 77-78). Respondent ignores that healthcare reform will decrease the number of individuals without health insurance and increase the number of hospital patients covered by private insurance. (PX02148 at 009 (¶ 12) (Town Expert Report), *in camera*). And southwest Lucas County, which already has a high proportion of commercial patients, is growing. (Wakeman, Tr. 2479-2481; Oostra, Tr. 6036-6038; Nolan, Tr. 6287, *in camera*). In addition, the evidence flatly contradicts that there is intense (or intensifying) price competition in Lucas County, in light of ProMedica's ability as the dominant provider to easily maintain much higher prices than its competitors. (PX02148 at 147 (Ex. 8) (Town Expert Report), *in camera*). Finally, the assertion that hospitals need access to health plans' members for revenue is nothing more than a restatement of the fact that health plans, like hospitals, have sources of leverage in contract negotiations. (*See supra* at 28).

B. ProMedica and St. Luke's Purportedly Benevolent Motivations For the Acquisition Are Legally Irrelevant and Contradicted by the Evidence

Respondent goes to great length to argue that St. Luke's chose to affiliate with ProMedica primarily because it valued local governance and cultural fit, and that ProMedica was

[21] It is important to note that steering programs, even if feasible and effective, would still not mitigate the anticompetitive effects of the Acquisition. Steering programs merely introduce price sensitivity into the marketplace by making the ultimate consumers (patients) pay costs that are more directly related to the cost of care. But this does not change the fact that the Acquisition eliminates significant competition between two formerly-close competitors, nor that this is a 4-3 merger in GAC and a 3-2 merger in OB, and therefore causes significant competitive harm. Thus, even if a highly successful steering program was implemented in Lucas County, that would not change the conclusion that the Acquisition substantially lessens competition.

motivated by a desire to help St. Luke's. (Resp. Post-Tr. Br. at 33-37). These claims are legally irrelevant and contradicted in several key respects by the documentary evidence.

First, the evidence overwhelmingly demonstrates that St. Luke's primary motivation in deciding to affiliate was the desire for higher reimbursement rates and that it chose ProMedica specifically for its "incredible access to outstanding pricing on managed care agreements." (PX01125 at 002, *in camera;* Wakeman, Tr. 2685-2686, *in camera*; *see* PX01932 at 015 (Bazeley, Dep. at 55-56, *in camera* (testifying that decision to affiliate driven by hope that a merger would allow higher reimbursement rates)). St. Luke's executives were well aware that the local health system with the best rates and strongest leverage was ProMedica. (Wakeman, Tr. 2681-2682, *in camera*, Rupley, Tr. 1998, *in camera*). Again and again, "negotiating clout" and "strong managed care contracts" are described in St. Luke's documents as the attributes that ProMedica brought to the table. (PX01018 at 014, *in camera* ("What does [ProMedica] bring? Strong managed care contracts."); PX01030 at 020, *in camera* ("An SLH affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout."); PX01125 at 002, *in camera* ("Two things ProMedica brings to the table are strong market/capital position and incredible access to outstanding pricing on managed care agreements."). Meanwhile, St. Luke's abandoned advanced affiliation talks with UTMC – despite the belief of its leadership that a UTMC affiliation "is in the best interests of the community" – out of concern that UTMC did not have "enough managed care clout" or high enough reimbursement rates.[22] (*See* PX01030 at 020, *in camera*; PX01018 at 017, *in camera*; PX01130 at 004, *in camera*).

[22] Respondent also argues that St. Luke's rejected Mercy and chose ProMedica because it wanted local governance. But this overlooks that St. Luke's also wanted a high-quality partner, which Mercy was and ProMedica was not. (Wakeman, Tr. 2560 (testifying that in late 2009 he believed Mercy was more focused on quality than ProMedica), 2961 (testifying that Board was focused on quality as a factor)). ProMedica's claim that St. Luke's did not want to

Second, ProMedica's history of trying either to buy St. Luke's or put it out of business makes it difficult to credit ProMedica's newfound altruism. (*See* CCPFF ¶¶ 387-398). A St. Luke's competitor assessment observed that "ProMedica desires the SLH geographic area, so they will continue to starve SLH . . . until we sign up with them or are weakened[.]" (PX01127 at 001; *see also* PX01152 at 001 (ProMedica is "continuing an aggressive strategy to take over St. Luke's or put us out of business."); PX00344 (email from former ProMedica CEO, Alan Brass, asking "[w]hat issues can be raised thru [sic] managed care" to retaliate against a St. Luke's effort to institute a cardiology program)). Mr. Oostra admitted that ProMedica has wanted to buy St. Luke's for at least fifteen years. (Oostra, Tr. 6117). Documents also reflect fears at St. Luke's that ProMedica would retaliate if St. Luke's chose a different affiliation partner and suspicions that ProMedica was threatening other potential St. Luke's partners. (CCPFF ¶¶ 395-398). These are not the hallmarks of a benevolent rescuer.

Regardless of the credibility of these claims, they are also irrelevant as a matter of law. Intent is not an element of a Section 7 claim. 15 U.S.C. § 18 (2006). There is also no exception to the antitrust laws for a desire for "local governance" or "cultural fit." The dispositive fact is that the Acquisition eliminates important competition between ProMedica and St. Luke's, enhancing their bargaining leverage and leading to higher rates in the marketplace.

C. Respondent Cannot Meet the Strict Requirements of an Entry Defense

The record is utterly lacking in evidence that would allow Respondent to meet the strict requirements of a valid entry defense. (*See* CC Post-Tr. Br. at 84-87). Undoubtedly aware of this, Respondent does not assert entry as a defense, which would put the evidentiary burden of

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be subject to a "common branding strategy" with Mercy is also odd given that St. Luke's has already been rebranded as "ProMedica St. Luke's" since the Acquisition. (*See*, *e.g.,* http://promedica.olhblogspace.com/2011/07/what%E2%80%99s-in-a-name/ (describing ProMedica plans to rename its hospitals and change signage to reflect ProMedica ownership); http://www.lenconnect.com/news/x828706049/Bixby-Herrick-get-name-changes (noting St. Luke's name change)).

production on Respondent. *Chicago Bridge*, 534 F.3d at 430, n.10 (noting that defendant's "burden of production must provide evidence that the likelihood of entry reaches a threshold ranging from 'reasonable probability' to 'certainty.'"). Instead, ProMedica dresses up a weak entry defense as an attack on the sufficiency of Complaint Counsel's evidence. (Resp. Post-Tr. Br. at 75-76). Respondent's repeated attempts to blur the lines of carefully-articulated legal defenses in antitrust cases – and avoid the burdens of production that go with them – should be rejected.

In any case, Respondent's reliance on Mercy's {

} and on "outreach activity" and "renovations" by UTMC – to the extent they are even relevant – falls far short of the scale and significance that the case law requires. (*See* CC Post-Tr. Br. at 86-87; *Polypore,* 2010 FTC LEXIS 97, at *86; *Merger Guidelines* at § 9.3.) Respondent is misguided in relying on *Baker Hughes* to argue that the "threat of entry" is sufficient. (*See* Resp. Post-Tr. Br. at 80, *citing Baker Hughes*, 908 F.2d at 988). Courts and treatises have rejected the lax standards that led the *Baker Hughes* court to accept a "threat of entry" argument. *See Chicago Bridge*, 534 F. 3d at 430 n.10 ("*Baker Hughes'* conclusion that a mere threat of entry is sufficient to constrain anti-competitive effects has been criticized, and we will not adopt it here.") (citing cases and treatises). Finally, Respondent offers no evidence or explanation indicating the means by which the "threat of entry" would constrain ProMedica's bargaining leverage with health plans.

D. Respondent Fails to Present a Viable Flailing-Firm Defense

The flailing-firm defense requires a "*substantial showing* that the acquired firm's weakness, *which cannot be resolved by any competitive means*, would cause that firm's market share to reduce to a level that would undermine the government's *prima facie* case." *Univ.*

Health, 938 F.2d at 1221 (emphasis added). Respondent's claim that St. Luke's competitive significance would be diminished by its financial condition is contradicted by the facts and undermined by the very same case law it cites.[23] Respondent primarily relies on *Arch Coal*, which is clearly distinguishable and actually undercuts Respondent's argument. Critically, the facts demonstrate that St. Luke's financial condition was improving, not worsening. (*See* CC Post-Tr. Br. at 89-93; CCPFF at ¶¶ 901-920, 964-988).

1. *Arch Coal* Only Underscores That Respondent Has Failed to Prove a Flailing-Firm Defense

Respondent's reliance on *Arch Coal* only highlights its failure to establish a valid flailing-firm defense. *Arch Coal* stated that "a presumption of illegality *based on market concentration alone* can be rebutted if *defendants can prove* that the acquired firm's current market shares overstate its future competitive significance due to its weak financial condition." 329 F. Supp. 2d at 153 (emphasis added; internal quotations and citations omitted). But the "more compelling the *prima facie* case, the more evidence the defendant must present to rebut it successfully." *Arch Coal*, 329 F. Supp. 2d at 129 (quoting *Baker Hughes*, 908 F.2d at 991). As the *Arch Coal* court emphasized, the "*weakness of the acquired firm is only relevant if the defendant demonstrates that this weakness undermines the predictive value of the government's market share statistics*." 329 F. Supp. 2d at 154 (emphasis in original) (internal citations omitted). "Thus, financial difficulties 'are relevant only where they indicate that market shares would decline in the future and by enough to bring the merger below the threshold of

[23] Remarkably, for the first time, Respondent suggests that St. Luke's would fail within three to four years. (Resp. Post-Tr. Br. at 1). But Respondent previously admitted that St. Luke's was not a "failing firm" (Resp. Response to RFA ¶ 42), which means that St. Luke's did *not* "face[] the grave probability of a business failure." *United States v. Greater Buffalo Press*, 402 U.S. 549, 555 (1971); *United States Steel Corp. v. FTC,* 426 F.2d 592, 608 & n.38 (6th Cir. 1970); *Merger Guidelines* § 11. Further, St. Luke's CEO, Mr. Wakeman, testified that St. Luke's could have continued to operate no less than { . (PX01920 at 037-038 (Wakeman, Dep. at 141-143), *in camera*; s*ee also* PX01920 at 037-040 (Wakeman, Dep. at 141-143, 145-146, 150-151, *in camera*; PX01918 at 013 (Oostra, Dep. at 45, *in camera*; PX02147 at 006, 026-027 (¶¶ 12, 49) (Dagen Expert Report)).

presumptive illegality.'" *Arch Coal*, 329 F. Supp. 2d at 154 (citing 4 Areeda, et al., ANTITRUST LAW ¶ 963(a)(3), at 13); *see also Univ. Health*, 938 F.2d at 1221.

Here, Complaint Counsel's case is patently not "based on market concentration alone" and Respondent fails to provide evidence that "genuinely undercuts" the evidence put forth by Complaint Counsel. *Arch Coal*, 329 F. Supp. 2d at 153-54. To show that St. Luke's financial condition would cause its market share to decline "below the threshold of presumptive illegality," Respondent would have had to show that St. Luke's market share was going to imminently plummet from 11.5% to 2% or less in GAC, and from 9.3% to 1.3% or less in OB. Respondent has not, and cannot, show this to be the case. The stubborn fact is that St. Luke's market share was *increasing* before the Acquisition. (*See, e.g.*, PX01235 at 003, 005; PX01236 at 002, 054; PX00159 at 012, *in camera*).

The facts in *Arch Coal*, moreover, are very distinct from the facts here. For example, the flailing firm in *Arch Coal* was a coal-mining company that faced depleting coal reserves and no prospects for recovery. 329 F. Supp. 2d at 127. In this case, St. Luke's financial condition does not depend on a finite natural resource. In *Arch Coal*, the court ruled that the transaction did *not* reduce the number of competitors in the market (five), "only modestly" increased concentration, and "just barely" raised competitive concerns. 329 F. Supp. 2d at 115, 124, 128-29, 158 ("this case is not one in which the post-merger increase in HHI produces an overwhelming statistical case for the likely creation or enhancement of anticompetitive market power."). Here, the Acquisition reduces the number of GAC competitors from four to three and the number of OB competitors from three to two, there are enormous increases in concentration, and *there is* an overwhelming statistical case that the Acquisition enhances market power. (CC Post-Tr. Br. at 30-36; CCPFF ¶¶ 306-309).

Moreover, the unsalvageable financial condition of the flailing firm in *Arch Coal* was significantly different than St. Luke's. For example, in *Arch Coal*, the court noted that "depletion at a mining company directly reduces its future earnings capacity." 329 F. Supp. 2d at 155. In this case, the area around St. Luke's is growing in patients, not declining. (*See, e.g.,* Wakeman, Tr. 2477, 2481 (SLH is "in an optimal or better part of the community in the sense of growth and economic potential"); Oostra, Tr. 6037-6038 ("growing part of the city, so a good location.")). In *Arch Coal*, the flailing firm had consistently lost money since its inception. 329 F. Supp. 2d at 155. Here, St. Luke's had positive EBITDA in every year except two since 2000, including in 2010. (PX02147 at 010 (¶ 21 & Table 1) (Dagen Expert Report)). St. Luke's operating cash flow margin improved from negative 2.5 percent in 2009 to *positive* 3.8 percent as of August 31, 2010. (PX02129 at 002 (Ex. 1) (Hanley Decl.); Hanley, Tr. 4702-4703; *see also* Wakeman, Tr. 2594-2595; Den Uyl, Tr. 6479; RX-56 at 6-7 (Tables 1, 3) (Den Uyl Expert Report), *in camera*). In *Arch Coal*, the flailing firm could not obtain bank financing and did not have even the "CCC" rating from Moody's needed to access the junk-bond markets for financing. 329 F. Supp. 2d at 156. Here, St. Luke's pre-Acquisition "Baa2" credit rating was investment grade and would have allowed St. Luke's to access the debt markets at a reasonable rate of interest, although its substantial cash reserves obviated the need to raise capital. (Brick, Tr. 3480-3490; PX02146 at 005-006 (¶¶ 9-10) (Brick Expert Report)).

Additionally, in *Arch Coal*, "the prospects for identifying and securing another buyer [were] dim," even after the flailing firm had hired an investment-banking firm that "engaged in a comprehensive search for a buyer" for three years and "contacted [] every potential purchaser worldwide." 329 F. Supp. 2d at 156-57. Here, St. Luke's unilaterally turned its back on at least two willing alternatives to ProMedica – UTMC and Mercy. (Joint Stipulations of Law and Fact,

JX00002A ¶ 51; Gold, Tr. 230-231, 244; Wakeman, Tr. 2551-2552, 2559; *see* Shook, Tr. 1003-1004, *in camera*; PX01030 at 011, *in camera*; CCPFF ¶¶ 1086-1109). St. Luke's did not hire an investment-banking firm to conduct a search for affiliation partners or hire a consultant to explore the benefits of an affiliation with potential partners. (Wakeman, Tr. 2545-2546, 2549-2550; PX01909 at 052 (Dewey, IHT at 204), *in camera*). And St. Luke's search for other partners was *not* comprehensive, it was cursory. (*See* PX01909 at 054, 056 (Dewey, IHT at 209, 219-220), *in camera*; Wakeman, Tr. 2541-2559; PX01911 at 049-051 (Wakeman, IHT at 192-198), *in camera*).[24]

2. Service-Line Cuts Were Not Seriously Considered or Necessary

Respondent, out of desperation, claims that St. Luke's would have had to cut major services and employees due to its financial condition, unless it joined ProMedica. This is baseless for several reasons. Although St. Luke's briefly considered service cuts as one of five options in August 2009, a year before the Acquisition was consummated, the option was quickly and decisively rejected. (PX01018 at 008-017, *in camera*; Black, Tr. 5703-5704; PX02136 at

[24] Respondent also cites *United States v. International Harvester Company*, 564 F.2d 769 (7th Cir. 1977) in its flailing-firm arguments. The case is distinguishable in almost every respect but we highlight three. First, in *International Harvester*, the flailing firm had "weak financial reserves"; its financial condition was "far worse" than any other firm in the *entire industry*; and it could no longer obtain credit through borrowing or stock offerings. 564 F.2d at 773, 775-76. Here, St. Luke's had $65 million in cash and investments prior to the Acquisition. (Joint Stipulations of Law and Fact, JX00002A ¶ 34). Respondent has not shown (and cannot show) St. Luke's financial position is "far worse" than all other hospitals in the entire industry. Finally, St. Luke's did not need or intend to borrow money for the foreseeable future (PX02147 at 18 (¶ 35) (Dagen Expert Report); Hanley, Tr. 4706-4707); St. Luke's did not attempt to issue new bond debt any time from 2009 through to the time of the Acquisition (Joint Stipulations of Law and Fact, JX00002A ¶¶ 37-38); and even if St. Luke's had intended to borrow money, its bond rating would not have prevented it from accessing the debt markets. (Brick, Tr. 3480-3490; PX02146 at 005-006 (¶¶ 9-10) (Brick Expert Report)). Respondent also cites *General Dynamics*, 415 U.S. 486, which (like *Arch Coal*) is similarly distinguishable. *General Dynamics* involved a flailing firm dependent on declining reserves of a natural resource, coal, in the context of sweeping changes in the industry following World War II that significantly reduced coal's competitiveness with other energy sources. 415 U.S. at 498-499. No such dramatic drop is afoot in the hospital industry. In *General Dynamics*, the flailing firm was tenth in the market in terms of reserve holdings, it held less than 1% of market reserves, and its reserves had already been depleted significantly and much of the rest was already committed under long-term contracts with no possibility of acquiring more reserves. 415 U.S. at 502-03. No such stark conditions face St. Luke's. Notably, the *General Dynamics* court warned that a flailing-firm defense was a "lesser of two evils" approach. 415 U.S. at 507.

062-063 (¶¶ 80-85) (Guerin-Calvert, Decl. in Prelim. Inj. Proceeding), *in camera*); PX01911 at 049, 058 (Wakeman, IHT at 190, 227-228), *in camera*; PX01909 at 048 (Dewey, IHT 187-188), *in camera*). St. Luke's promptly rejected the idea precisely because it would have affected St. Luke's mission of serving the community, so it never became a major topic of discussion. (PX02102 at ¶ 22 (Wakeman, Decl.); Black, Tr. 5703-5704).

There is no evidence that St. Luke's ever again re-visited the issue after August 2009. Before St. Luke's entered into exclusive discussions with ProMedica, St. Luke's executives made several subsequent presentations to the Board evaluating potential options for the future, such as remaining independent or pursuing a joint venture or affiliation with UTMC or Mercy – but no presentation ever again mentions cutting service lines as an option. (PX01030 (October 2009 presentation); PX01016, *in camera* (December 2009 presentation); PX01457 at 004-005, *in camera* (December 2009 Board minutes); *see also* CCPFF ¶¶ 1058-1062). Indeed, such cuts would have been unnecessary because St. Luke's financial condition was improving leading up to the Acquisition. (*See, e.g.,* Den Uyl, Tr. 6562, 6593-6594, *in camera*; RX-56 at 11 (¶ 30) (Den Uyl Expert Report), *in camera*; Dagen, Tr. 3187; PX02147 at 026-030 (¶¶ 49-55) (Dagen Expert Report); Wakeman, Tr. 2594, 2597).[25]

Additionally, Respondent's claim is undermined by this fact: from the outset, ProMedica planned to cut outright, or by transfer to other ProMedica hospitals, services and staff from St. Luke's. (PX01918 at 027, 029 (Oostra, Dep. at 98, 100-101, 106), *in camera*; PX00396 at 002-003, 006, 008-010, *in camera*; PX00020 at 011, 015, 017, *in camera*).[26] Even in its Post-Trial Brief, Respondent says one "benefit" of the Acquisition is to enable it to "optimize services" –

[25] Indeed, St. Luke's could have been profitable without cutting services or employees. (PX02147 at 036-042 (¶¶ 65-76) (Dagen, Expert Report)).

[26] Notably, while St. Luke's did not cut services or staff during the recent economic downturn, ProMedica did. (PX01918 at 014-015 (Oostra, Dep. at 48-50), *in camera*; Johnston, Tr. 5443-5444).

i.e., transfer and cut services at St. Luke's pursuant to Navigant's recommendations. (Resp. Post-Tr. Br. at 103; PX00479, *in camera*).

Finally, even assuming that St. Luke's needed an affiliation to avoid service cuts and layoffs, that does not immunize *this Acquisition* by ProMedica from violating Section 7 because St. Luke's could have affiliated with another partner, such as UTMC, to avoid eliminating services and staff with far less anticompetitive impact than ProMedica's acquisition creates. (*See* CCPFF ¶¶ 1086-1109).

3. Financial Metrics Show That St. Luke's Financial Condition Was Improving

Respondent also tries to point to a few isolated metrics to show that St. Luke's was flailing (Resp. Post-Tr. Br. at 92-93), but to no avail. Key metrics show that St. Luke's competitiveness and financial condition were improving. Again, prior to the Acquisition, St. Luke's was gaining market share. (PX01235 at 003, 005; PX00159 at 005, 012, *in camera*). Prior to the Acquisition, St. Luke's revenues, patient volume, occupancy, profitability, access to health plans, number of employed physicians, cash reserves, and other metrics all increased. (CC Post-Tr. Br. at 89-93; CCPFF ¶¶ 898-981).[27] Similarly, Respondent's arguments about St. Luke's credit rating, technical bond default, and pension plan funding levels are all decisively rebutted by the facts. (*See* CC Post-Tr. Br. at 93-97; CCPFF ¶¶ 993-1043).

4. St. Luke's Was Making Significant Capital Investments

Respondent's claims about St. Luke's ability to make capital investments also fall short on facts and persuasiveness. Even as a supposedly flailing firm, St. Luke's spent "at least $7 million of capital expenditures in calendar year 2009" and $14 million on capital expenditures in 2008. (Joint Stipulations of Law and Fact, JX00002A ¶ 43; PX01006 at 007; PX01951 at 069

[27] Respondent's Post-Trial Brief (at 92) says "losses that St. Luke's experienced . . . were not sustainable, because it could not draw down its reserves indefinitely," but Respondent has not proved, and cannot prove, that St. Luke's losses *would have* continued absent the Acquisition.

(Den Uyl Dep. at 269), *in camera*). This is roughly the same as St. Luke's historical average. (*See* Resp. Post-Tr. Br. at 94).

Respondent also points to St. Luke's "average age of plant," but as recently as April 2010, Mr. Wakeman believed that St. Luke's capital spending had enabled it to keep its plant and grounds in great condition. (Wakeman, Tr. 2615-2616; PX01279 at 002). While throwing stones from its glass house, Respondent fails to mention examples of ProMedica's own aging plant and outdated facilities.[28]

Respondent also says it is "doubtful" that St. Luke's could have converted to private hospital rooms absent the Acquisition. (Resp. Post-Tr. Br. at 94-95). But the truth is that St. Luke's projected that private room conversions would cost just $1.8 million and, as of August 31, 2010, St. Luke's held at least $65 million in cash and investments, from which it could fund bed conversions. (CCPFF ¶¶ 1078-1079, 1083; Joint Stipulations of Law and Fact, JX00002A ¶ 34). Moreover, merely having "doubts" about St. Luke's ability to fund the conversion does not suffice to fulfill Respondent's obligation to prove, with compelling evidence, that St. Luke's was a flailing firm. Even assuming that St. Luke's needed a partner to fund the conversion, that partner did not have to be ProMedica.

Finally, Respondent fails to point out its own lack of private beds. TTH's OB ward does not have all private rooms, and ProMedica's 2009 Executive Committee Retreat materials state that Flower Hospital "has the fewest number of private rooms in the metro area." (Marlowe, Tr.

[28] ProMedica's 2009 Executive Committee Retreat materials state that "[s]everal buildings on the { } campus are very old and master planning for future growth and replacement must be considered. . . . { } could have a better competitive advantage by planning for future growth and replacing aging facilities." (PX00214 at 161, *in camera* (emphasis added)). The same materials also state, with respect to { }, "Due to no sprinkler system or firewalls and limited truss roofing supports in the primary structure (1950s former grocery store), potential risk for rapid fire spread and roof collapse in case of fire . . . Core structure does not meet ADA or current electrical, plumbing or fire safety requirements. . . . Historic JCAHO, ODH and PHS Facilities and Infection Control Department concerns will remain unaddressed . . . Continued flooding of partial basement which also does not meet ADA requirements." (PX00214 at 165, *in camera* (emphasis added)).

2409-2410; Read, Tr. 5280; PX00214 at 180, *in camera*). In fact, Respondent's own consultant, Navigant, found that there are "significant shortages of private rooms in the [ProMedica] system" with the exception of Bay Park. (Nolan, Tr. 6287, *in camera*; PX01946 at 021 (Nolan, Dep. at 75); PX00479 at 008 ("most of the PHS metro facilities appear to have a combination of issues related to private bed availability"), *in camera*).

5. St. Luke's Was Positioned to Implement EMR and Meet Healthcare Reform Requirements Absent the Acquisition

Respondent also claims that St. Luke's "would have difficulty" implementing an electronic medical records ("EMR") system. (Resp. Post-Tr. Br. at 95). But the claim is simply not accurate. St. Luke's had the financial resources necessary to implement an EMR system. (PX01281 at 012; Black, Tr. 5701-5702; PX02147 at 015 (¶ 29) (Dagen Expert Report); PX01933 at 039 (Oppenlander, Dep. at 147-148), *in camera*; PX01908 at 055 (Deacon, IHT at 213), *in camera;* PX01503 at 001, *in camera*). Notwithstanding Respondent's impressive efforts to split hairs by saying St. Luke's had only "budgeted" $6 million to implement EMR but had not "allocated" the funds due to a supposed capital freeze,[29] the evidence shows that St. Luke's intended to begin implementing an EMR system at the start of 2010, but delayed these plans due to the Acquisition. (PX01933 at 038-039 (Oppenlander, Dep. at 144-148), *in camera*; PX01928 at 021, 023, 030 (Perron, Dep. at 75-76, 84-85, 113), *in camera*; PX01908 at 055 (Deacon, IHT at 213), *in camera*; *see also* Den Uyl, Tr. 6575-6576, *in camera*). And, again, even assuming this claim is true, merely saying St. Luke's "would have difficulty" with EMR is not compelling proof of St. Luke's inability to compete in the future.

[29] Again, St. Luke's made at least $21 million in capital expenditures over 2008 and 2009. (Joint Stipulations of Law and Fact, JX00002A ¶ 43; PX01006 at 007; PX01951 at 069 (Den Uyl Dep. at 269), *in camera*). The purported capital freeze "melted down quickly" as St. Luke's continued to make capital investments in "big ticket" items and equipment. (Wakeman, Tr. 2575; PX01920 at 007-008 (Wakeman, Dep. at 18-22), *in camera*; PX01361 at 001 ("its [sic] not really a freeze, more like a delay"); PX00397 at 023-025; PX02147 at 035 (¶ 63) (Dagen Expert Report)).

Finally, in direct contradiction to St. Luke's own ordinary-course assessment, Respondent offers the made-for-litigation claim that St. Luke's was poorly positioned to meet the "changing healthcare environment." (Resp. Post-Tr. Br. at 96-97).[30] Prior to the Acquisition and this litigation, however, St. Luke's stated that it was "*uniquely positioned for a smooth transition* to expected health care reform" because St. Luke's "already focuses on quality and cost – key components of reform." (PX01072 at 001 (emphasis added); Wakeman, Tr. 2620-2621). In fact, prior to the Acquisition, Mr. Wakeman believed that St. Luke's was in a better position than other organizations in the Toledo community to get its cost structure in line with the expectations of health reform. (*See* PX01408 at 001; Wakeman, Tr. 2845-2847).

In sum, Respondent does not come close to proving or making a substantial showing that St. Luke's weakness, which cannot be resolved by any competitive means, would cause St. Luke's market share to reduce so much as to undermine Complaint Counsel's *prima facie* case.

E. Purported Procompetitive Benefits and Efficiencies Are Woefully Inadequate

To make out a valid efficiencies defense, Respondent must prove the Acquisition results in "*significant* economies and that these economies ultimately would *benefit competition and, hence, consumers*." *Univ. Health*, 938 F.2d at 1223 (emphasis added); *see also Butterworth*, 946 F. Supp. at 1300. Respondent's "proof of *extraordinary efficiencies*" must be "more than mere speculation and promises about post-merger behavior." *Heinz*, 246 F.3d at 720-21 (emphasis added); *see also Univ. Health*, 938 F.2d at 1223 ("defendant [cannot] overcome a presumption of illegality based solely on speculative, self-serving assertions"); *FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1089 (D.D.C. 1997). Under the *Merger Guidelines*, efficiencies must be merger-specific,

[30] Notably, as a key component of its argument, Respondent relies on a *draft* Mercy document prepared just one month after St. Luke's spurned Mercy to sign a Joinder Agreement with ProMedica. This document's evaluation of St. Luke's can be dismissed as not much more than "sour grapes."

substantiated, and of such a character and magnitude that the transaction is not likely to be anticompetitive. *Merger Guidelines* § 10.

By antitrust standards, Respondent's purportedly procompetitive benefits from the Acquisition are woefully inadequate. Neither of Respondent's experts even conducted an efficiencies analysis.[31] (Guerin-Calvert, Tr. 7580; PX01925 at 012-013 (Guerin-Calvert, Dep. at 41-42); Den Uyl, Tr. 6515-6516). The purported efficiencies are not only *not* merger-specific, they are also vague and speculative. These alleged benefits and efficiencies do not come anywhere close to justifying this anticompetitive transaction.

1. Claimed Capital Investments Are Not Cognizable Efficiencies

Respondent claims that one benefit of the Acquisition is capital investment in St. Luke's. (Resp. Post-Tr. Br. at 98-99). Basically, Respondent is claiming that the consideration paid for the Acquisition of St. Luke's is an efficiency because that consideration is being used for St. Luke's capital projects. This argument leads to the perverse result that hospitals with the deepest pockets – often the most dominant hospitals charging the highest prices – have *carte blanche* to acquire competing hospitals, regardless of the anticompetitive harm that results. Even if that was a cognizable efficiency in theory, it is not cognizable in fact because it is not merger-specific. Any other well-capitalized acquirer of St. Luke's could have achieved that same "efficiency."

Respondent's claim that ProMedica has "facilitated the process" of St. Luke's implementation of EMR by providing employees to help St. Luke's is also meritless as an efficiency claim. Respondent provides no evidence that this "facilitation" is in any way proprietary and, thus, merger-specific, and it provides no indication of the value of this facilitation "net of costs … incurred in achieving th[e] efficienc[y]." *Merger Guidelines* § 10.

[31] The only person who opined on Respondent's efficiency claims is Complaint Counsel's financial and efficiencies expert, who concluded that most of Respondent's claims were not cognizable. (*See generally*, PX02147 at 004-005, 047-084 (¶¶ 9-10, 80-164) (Dagen Expert Report)).

2. Access to Paramount Is Not a Cognizable Efficiency

Respondent's claim that giving St. Luke's access to Paramount is a procompetitive benefit of the Acquisition is astounding and meritless. (Resp. Post-Tr. Br. at 99-100). ProMedica could have allowed Paramount to add St. Luke's to its network at any time, absent the Acquisition, but refused to do so. Indeed, Mr. Wakeman personally made serious attempts to have St. Luke's rejoin Paramount's network but was unsuccessful. (Rupley, Tr. 1940-1941). ProMedica – including Mr. Oostra himself – prioritized what was best for ProMedica over Paramount because St. Luke's admission into Paramount would have hurt patient volume at ProMedica's Lucas County hospitals. (Oostra, Tr. 6045-6046; Randolph, Tr. 7076-7077; Rupley, Tr. 1941; PX00405 at 001; PX01233 at 005, *in camera*). If ProMedica really wanted to help St. Luke's or, alternatively, facilitate Lucas County patients' access to St. Luke's, it could have readmitted St. Luke's to Paramount a long time ago, before this litigation. As such, Respondent's claim deserves no consideration.

3. Purported Benefits to St. Luke's Bond Debt and Credit Rating Do Not Justify an Anticompetitive Acquisition

Respondent's argument that the Acquisition helped St. Luke's with its bond debt and credit rating is dismantled by Complaint Counsel's Post-Trial Brief and its own admissions. (CC Post-Tr. Br. at 94-97; CCPFF at ¶¶ 1013-1043). Respondent admitted that as of the time of the Acquisition, St. Luke's "had enough cash and investments on its financial statement to pay off *all* of its outstanding debt." (Joint Stipulations of Law and Fact, JX00002A ¶ 24 (emphasis added)). Moreover, St. Luke's bond debt was not large; St. Luke's had never missed a bond payment or been late in making payment; and St. Luke's had come into compliance with the debt-coverage ratio by the time of the Acquisition. (CC Post-Tr. Br. at 94-96; CCPFF at ¶¶ 1032-1043; Joint Stipulations of Law and Fact, JX00002A ¶¶ 22-23).

St. Luke's credit rating was not an impediment for St. Luke's because it did not need or intend to borrow money for the foreseeable future; St. Luke's credit rating was still investment grade so it could have accessed the credit markets if it needed to; and St. Luke's improving financial condition may well have led to a higher credit rating in the future. (CC Post-Tr. Br. at 96-97; CCPFF at ¶¶ 1013-1031). Indeed, the best Respondent can say in its brief is that St. Luke's ability to borrow "had been in doubt." (Resp. Post-Tr. Br. at 100). That is far from definitive proof that St. Luke's would not have been able to borrow money. This alleged benefit is speculative at best.

4. Claims Regarding Defined Benefit Pension Plan Are Vague

Another of Respondent's vague claims is that St. Luke's had defined benefit pension funding issues in the past and Respondent has "plans" to fix it. (Resp. Post-Tr. Br. at 100).[32] As explained in Complaint Counsel's Post-Trial Brief, St. Luke's pension-plan funding has rebounded significantly, no payments to pensioners were ever missed, and St. Luke's had already taken steps to mitigate its pension-plan exposure to financial-market downturns prior to the Acquisition. Notably, even ProMedica could not keep its own pension plan 100% funded during the economic downturn – it was underfunded in 2008 by $84.8 million and in 2009 by $65.3 million, compared to underfunding at St. Luke's of $50.5 million and $34.2 million in the same years. (CC Post-Tr. Br. at 93-94; CCPFF at ¶¶ 993-1012).

5. Insurance and Back-Office Expense Savings Are Not Cognizable Efficiencies

Respondent's effort to stitch together an efficiencies defense next turns to cost reductions for insurance and "backroom services." (Resp. Post-Tr. Br. at 101). To be cognizable, such efficiencies must be merger-specific and substantiated. *Merger Guidelines* § 10. They are

[32] Notably, there is no mention of when this will happen and no guarantee that this plan will be executed.

neither. Respondent identifies no evidence that any such costs savings could be achieved only by St. Luke's joining ProMedica. In fact, Respondent admitted that "*any* St. Luke's affiliation with *any* potential partner, including UTMC, may have led to certain efficiencies[.]" (Response to RFA at ¶ 12 (emphasis added)). Indeed, Dr. Gold of UTMC specifically testified that efficiencies could have been achieved "[o]n many different levels [including] back-of-the-house functions: finance, information technology, human resources services, and many others that are typically used to run hospitals." (Gold, Tr. 245-246; PX01407 at 001 (UTMC affiliation "would provide just as much [expense reduction] as the two systems [Mercy and ProMedica].")).

Moreover, Respondent does not identify by how much "St. Luke's has been able to reduce expenses through consolidation of non-clinical backroom services," nor does it identify whether any costs were required to achieve the consolidation to determine if there was even a net savings. Thus, these efficiency claims fail.

6. Purported Community Benefits Are Unsubstantiated, Insufficient, and Meritless

Respondent also tries to spin a defense out of tenuous threads of purported community benefits. These claims do not withstand the slightest scrutiny. Most glaringly, Respondent overlooks the evidence demonstrating that St. Luke's executives and Board members were concerned that the Acquisition would *harm* the community. A presentation to the Board specifically considering the "impact on community" expected to result from the Acquisition concluded only that "[a]n affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout." (PX01030 at 020, *in camera* (stating that an affiliation with UTMC is "in the best interests of the community" and the impact of affiliating with Mercy is "difficult to gauge."). Mr. Wakeman wrote that the Acquisition by ProMedica "might not be the best thing for the community" and testified that he

had been concerned that the Acquisition would "[h]arm the community by forcing higher hospital rates on [health plans]." (PX01125 at 002, *in camera*; Wakeman, Tr. 2698-2700, *in camera*; *see also* PX01378 at 001 (describing ProMedica in 2008 as the organization that has "taken the greatest resources from the community.")).

Respondent's claim that the Acquisition enables it to "assess community needs" lacks credibility. ProMedica presumably does not need an acquisition to focus its attention on the community. Furthermore, Respondent's claim that the Acquisition enables it to {

} is simply another way of saying that it may eliminate services from one hospital and transfer them to another hospital. (*See* Resp. Post-Tr. Br. at 101). Indeed, Respondent admits as much in its brief. (Resp. Post-Tr. Br. at 103). Moreover, achieving any purported benefit is highly speculative. Respondent bases its claim on Navigant's recommendations, which ProMedica has no obligation to follow or implement. Indeed, Respondent states only that ProMedica "*may*" transfer certain services from St. Luke's to TTH and that "ProMedica has *the potential* to reconfigure healthcare services." (Resp. Post-Tr. Br. at 102-103 (emphasis added)). And to the extent any benefits might theoretically accrue to the community, St. Luke's did not need to affiliate with ProMedica to achieve them.

Respondent also claims that it needs to acquire "St. Luke's to achieve a critical mass of patients in some service lines . . . [so] it can reposition services to achieve an optimal distribution of services across the market." (Resp. Post-Tr. Br. at 103). Put differently, rather than compete with St. Luke's for additional patients – by improving quality and service and lowering prices – ProMedica prefers to enhance its market share and dominant position through the Acquisition and then transfer services around its system to achieve some nebulous "optimal distribution."

That is simply not a legitimate antitrust defense – it is an anticompetitive admission that embodies a desire to eliminate competition, not enhance it.

Respondent then makes the incredible claim that "St. Luke's could not have achieved integration benefits without the joinder because {

}." (Resp. Post-Tr. Br. at 103).

Respondent's only support for this claim is its own response to a Civil Investigative Demand. (Resp. Post-Tr. Br. at 103 (citing RPFF ¶ 2128, which cites RX-1856, *in camera*)). The claim is simply not true. The evidence makes clear that UTMC and Mercy were still interested in affiliating with St. Luke's when St. Luke's terminated discussions with them and that such affiliations would have brought significant efficiencies, of the types claimed to result from the Acquisition. (CCPFF ¶¶ 1094, 1102, 1107-1109; PX01406 at 001 (benefits to UTMC partnership are "endless"); PX01407 at 001 (UTMC affiliation "would provide just as much [expense reduction] as the two systems [Mercy and ProMedica]."); *see also generally* CCPFF ¶¶ 1088-1109).

Respondent's claim that the Acquisition "gives St. Luke's access to ProMedica's comprehensive quality programs and technologies" is undermined by the criticisms that ProMedica's own Medical Director leveled against ProMedica's approach to quality: "has not kept pace"; "we are behind today"; "corporate quality suffered"; "we are stuck with an out of date approach"; and "very few people . . . can fully explain the PHS approach to quality much less feel compelled to follow it." (PX00527 at 001-002). ProMedica's CEO called its quality "subpar" and ProMedica struggled on quality measures. (PX00153 at 001; *see* CC Post-Tr. Br. at 61-63; CCPFF ¶¶ 669-691). Meanwhile, St. Luke's quality was superior to ProMedica's.

(CCPFF ¶¶ 669-682, 693-702). In short, Respondent's claims about improving St. Luke's quality are simply not credible.

Finally, the notion that St. Luke's has access to eICU and smart pump "technologies *only* because of the joinder" is entirely unsubstantiated. (*See* Resp. Post-Tr. Br. at 104 (emphasis added)). That claim is also undermined by Ms. Guerin-Calvert's acknowledgment at trial that she did not know whether St. Luke's could have implemented eICU with UTMC and that there is nothing proprietary about smart pumps technology. (Guerin-Calvert, Tr. 7918-7920).

7. Additional, Future Efficiencies Are Not Credible or Cognizable

In its Post-Trial Brief, Respondent resurrects certain previously-discarded "efficiency" claims. (Resp. Post-Tr. Br. at 105-106). Respondent bases its claims on the work done by Compass Lexecon, but Respondent's economic expert, also from Compass Lexecon, did not even once cite the efficiencies presentation of her colleagues in any of her three Part III and federal-proceeding expert reports. (*See* RX 71(A) (Guerin-Calvert Expert Report), *in camera*; PX02122 (Guerin-Calvert Decl. in Prelim. Inj. Proceeding); PX02136 (Guerin-Calvert Supplemental Decl. in Prelim. Inj. Proceeding), *in camera*). Some of Respondent's key personnel had little or no involvement in developing many of the claimed efficiencies; in some instances, St. Luke's executives actually dispute the claimed efficiencies. (*See* Hanley, Tr. 4728-4729, *in camera*; Johnston, Tr. 5428-5429; PX01915 at 045, 051-052, 054 (Wagner, IHT at 173, 198-200, 202-204, 209), *in camera*; PX01908 at 050-052 (Deacon, IHT at 191-194), *in camera*; *see also* PX01905 at 050 (Wachsman, IHT at 194-195), *in camera*; *see also* PX02147 at 054, 067-069, 072 (¶¶ 99, 125-128, 133 n. 229) (Dagen Expert Report)). The Compass Lexecon efficiencies are unsubstantiated, vague, and speculative. (PX00020 at 003, *in camera*; Oostra, Tr. 6145; PX01906 at 074, 076 (Oostra, IHT at 291, 299), *in camera*; Hanley, Tr. 4727-4728, *in*

camera; PX01903 at 054 (Hanley, IHT at 206-207), *in camera*; PX01906 at 075 (Oostra, IHT at 294), *in camera*; *see generally* PX02147 at 043-081 (¶¶ 80-159) (Dagen Expert Report)). One document indicates that the size of efficiencies and time in which to achieve them was deliberately revised upward in anticipation of the FTC's likely reaction. (PX01136 at 001, *in camera*).

The claimed efficiencies themselves are not cognizable. Respondent claims { } in capital avoidance savings and related operating-cost savings of { }. (Resp. Post-Tr. Br. at 105). These purported efficiencies are due to ProMedica not building a new hospital in Arrowhead and new bed tower at Flower. (PX00020 at 004, *in camera*). To the extent that such capital investments would benefit the community, these capital-avoidance claims are not efficiencies at all, but rather constitute anticompetitive harm resulting from the Acquisition. (Town, Tr. 3928-3929; PX02148 at 094 (¶ 172) (Town Expert Report), *in camera*). Regardless, these are not cognizable efficiencies because there is no evidence that ProMedica actually intended to proceed with the projects. ProMedica has owned the Arrowhead land for a decade but has not started building any such hospital or even discussed the plan with architects for three or four years or the City of Maumee for a number of years. (Oostra, Tr. 6117-6119; *see also* CCPFF ¶¶ 803-808). Similarly, there is no evidence that ProMedica intended to go forward with plans to build a bed tower at Flower. The last time the bed tower appeared on any ProMedica budget approved by the ProMedica board was more than four years ago. (CCPFF ¶¶ 809-815).

Respondent's reference to having established a steering committee after the Acquisition (and in the middle of litigation) to develop additional efficiencies, which has identified more efficiencies than was originally projected, is self-serving and not reliable. *Hospital Corp. of Am.*,

807 F.2d at 1384 ("Post-acquisition evidence that is subject to manipulation by the party seeking to use it is entitled to little or no weight."). Other than the bald statement that Respondent has identified more than { } in efficiencies, there is no evidence to substantiate this claim and there is no indication that Respondent has netted out the costs required to achieve such efficiencies or whether these are even the same efficiencies previously claimed. In short, this is a bare allegation, not sufficient proof of cognizable efficiencies.

8. "Other Benefits" Are Meritless and Unsubstantiated

Finally, Respondent puts forth a last-ditch, mish-mash of efficiency claims from post-Acquisition developments, which are also "subject to manipulation by the party seeking to use [them]" and are thus "entitled to little or no weight." *Hospital Corp. of Am.*, 807 F.2d at 1384. Respondent first points to lifting a salary freeze to give 2 percent pay raises to St. Luke's employees and financial "thank you's" ranging from $25 to $200. (Resp. Post-Tr. Br. at 46, 106; RPFF ¶¶ 2259-2260). Putting aside whether a one-time $25 payment is a cognizable merger benefit, the fact remains that, even assuming a salary freeze, St. Luke's – unlike ProMedica – did *not* lay off any employees from 2008 to 2010; it actually hired employees from 2009 to 2010. (Wakeman, Tr. 2572, 2843-2844; PX01274 at 001, *in camera*; Joint Stipulations of Law and Fact, JX00002A ¶¶ 44-45; PX01384 at 003, *in camera*; PX01386 at 003, *in camera*). And it was ProMedica that increased the amount that employees were required to contribute to their healthcare benefits. (Oostra, Tr. 6124; Johnston, Tr. 5443-5444). Respondent is hard-pressed to claim that the community is better off as a result of the 2 percent pay increase and $25 checks, at the expense of laid-off employees and higher healthcare cost for its employees.

Respondent also points to St. Luke's employees' improved morale and the Maumee community's "increased confidence" and support for the Acquisition. (Resp. Post-Tr. Br. at 40,

106). But if morale at St. Luke's has increased, the evidence suggests that this is attributed to St. Luke's rebound under Mr. Wakeman, and not the Acquisition. In Mr. Wakeman's last memo to the Board on behalf of an independent St. Luke's, he makes clear that St. Luke's turnaround, incredible achievements, and commitment to its values gave "the entire St. Luke's family [] much to be proud of." (PX00170 at 007). Moreover, Respondent's claim is wholly based on unsubstantiated, self-serving testimony by a single employee of Respondent who "thinks" employees have increased confidence. (Johnston, Tr. 5373).

Similarly, Respondent's claim of community support is substantiated by its own self-serving response to a Civil Investigative Demand, in which Respondent cites to support from two entities and unnamed physicians, employees, employers, and community stakeholders. (Resp. Post-Tr. Br. at 106; RPFF ¶ 2257; RX-1855 at 29, *in camera*). Notably, Respondent did not call on *any* employers or community stakeholders as witnesses at trial to validate their support of the Acquisition. In contrast, Complaint Counsel presented the testimony of seven third-party community witnesses, including physicians, employers, and employee representatives.

In sum, Respondent's claims of purported efficiencies and procompetitive benefits are not cognizable to the extent they are even substantiated or constitute efficiencies at all. They clearly are not sufficient to overcome the overwhelming evidence of anticompetitive effects caused by the Acquisition. (CC Post-Tr. Br. at 78-83; CCPFF ¶¶ 779-895).

V. CONCLUSION

ProMedica's acquisition of St. Luke's substantially lessens competition in two relevant markets, in clear violation of Section 7. Respondent has not rebutted the presumption of competitive harm or proved any valid defenses to either violation. As such, a remedy requiring Respondent to divest St. Luke's is the necessary and appropriate remedy.

Respectfully submitted,

s/ Matthew J. Reilly

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CERTIFICATE OF SERVICE

I hereby certify that on September 30, 2011, I filed the foregoing document electronically using the FTC's E-Filing System, which will send notification of such filing to:

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

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