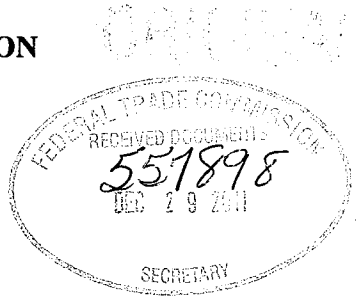
Public

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION



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

In the Matter of	)	
PROMEDICA HEALTH SYSTEM, INC.	)	Docket No. 9346
a corporation.	)	**PUBLIC**

RESPONDENT'S APPEAL BRIEF

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TABLE OF CASES AND AUTHORITIES

Cases

Statutes

Other Authorities

Rules

TABLE OF ABBREVIATIONS

The following abbreviations and citation forms are used in this Appeal Brief:

CCPF	Complaint Counsel's Proposed Findings of Fact
CCBR	Complaint Counsel's Post-Trial Brief
CCRBR	Complaint Counsel's Post-Trial Reply Brief
ID	Initial Decision
IDFOF	Findings of Fact in Initial Decision
PX	Complaint Counsel's Exhibit
RPF	Respondent's Proposed Findings of Fact
RBR	Respondent's Post-Trial Brief
RRBR	Respondent's Post-Trial Reply Brief
RCCPF	Respondent's Replies to Complaint Counsel's Proposed Findings of Fact
RX	Respondent's Exhibit

STATEMENT OF THE CASE

I. Introduction

Financially weakened from significant operational losses incurred during 2007-2009, burdened with reimbursement rates that did not cover the cost of treating its largest commercial payors' insureds, having deferred needed capital investment in its infrastructure and technology required by healthcare reform, and having explored potential collaborations with several healthcare systems, St. Luke's Hospital ("St. Luke's") chose to join ProMedica Health System, Inc. ("ProMedica") one of the two multi-hospital systems in Toledo, Ohio. For St. Luke's, the joinder offered long-term financial stability and the assurance that it would continue to be a locally-controlled community hospital. For ProMedica, the joinder provided an opportunity to expand its services in southwest Lucas County and "reposition" its resources and services across four hospitals to treat its patients more efficiently and cost-effectively, thereby reducing its total healthcare cost.

Nevertheless, Complaint Counsel challenged ProMedica's joinder with St. Luke's, focusing on the reduction in the number of independent providers of general acute care inpatient hospital services in Toledo from four to three. But, Complaint Counsel ignore the fact that the Toledo area's demographics and regional economy could no longer support four healthcare systems offering mostly the same services, when the two largest are multi-hospital systems offering a full range of primary, secondary, and tertiary services, the third is a state-owned academic medical center, and the smallest is a local community hospital (St. Luke's).

The Administrative Law Judge ("ALJ") properly acknowledged that calculating market shares and concentration levels is the beginning, not the end of the competitive analysis. He agreed that the "structure, history and probable future" of the market must be examined to

determine whether market shares are indicative of likely anticompetitive effects. And he correctly articulated the benchmark for measuring post-joinder prices — "there must be 'the reasonable probability' of a substantial impairment of competition by an increase in prices above competitive levels to render a merger illegal under § 7."

But the ALJ erred in his evaluation of the evidence and its application to the law in concluding that the joinder violated Clayton Act Section 7. His decision fails to reflect the changed competitive dynamic of the marketplace in which ProMedica and St. Luke's contract to provide healthcare services (not just general acute care inpatient hospital services) to large and powerful managed care organizations. Therefore, the Federal Trade Commission ("Commission") should reverse the Initial Decision and dismiss the complaint.

II. Statement of the Facts

A. The Parties

This case involves the joinder of ProMedica and St. Luke's, both located in Lucas County, Ohio. ProMedica is a nonprofit, integrated healthcare delivery system in northwestern Ohio and southeastern Michigan, consisting of hospitals, a physician group, and an insurance company. (IDFOF 1-2). ProMedica has a total of eleven hospitals, four of which are located in Lucas County: The Toledo Hospital ("TTH"), Toledo Children's Hospital, Flower Hospital ("Flower"), and Bay Park Community Hospital ("Bay Park"). (IDFOF 3, 53). ProMedica owns a health insurance plan, Paramount Healthcare, that provides health insurance to local employers and members. (IDFOF 163-167). ProMedica also employs approximately 330 physicians. (RPF 93). St. Luke's is an independent community hospital in Maumee, Ohio in southwest Lucas County. (IDFOF 6). St. Luke's also employs physicians. (RPF 133). St. Luke's joined ProMedica on August 31, 2010. (Answer at ¶ 2, IDFOF 11).

B. Competitor Hospitals

Mercy Health Partners ("Mercy") is a not-for-profit hospital system that is part of Catholic Health Partners ("CHP"), which has hospitals in five states and is headquartered in Cincinnati, Ohio. (IDFOF 79). Mercy operates six hospitals in CHP's northern region, three of which are located in Lucas County: St. Vincent Medical Center ("St. Vincent"), St. Anne Hospital ("St. Anne"), and St. Charles Hospital ("St. Charles"). (IDFOF 79, 81). Mercy's Lucas County hospitals line up "literally side by side" with ProMedica's Lucas County hospitals. (RPF 144). Mercy employs about 125 to 130 physicians in the Toledo area. (RPF 173).

Another competitor, the University of Toledo Medical Center ("UTMC"), is an academic medical center that is part of the University of Toledo, an instrumentality of the State of Ohio. (IDFOF 103, 105). UTMC employs about 175 physicians. (RPF 194).

C. Competitive Landscape

Excess inpatient bed capacity exists in Lucas County. (IDFOF 665, 668, 670, 671). Mercy and UTMC both acknowledge that excess capacity exists to treat additional inpatients in Lucas County. (RPF 659, 662, 668).

Lucas County is served by both independent and hospital employed physicians. Most physicians have privileges at multiple, competing hospitals in Lucas County. (RPF 674, 676, 677).

D. Managed Care Organizations

Managed care organizations ("MCOs") are commercial health plans that assemble provider networks and offer insurance products to employers. (IDFOF 115). MCOs operating in Lucas County include Medical Mutual of Ohio ("MMO"), Anthem, Paramount, United, Aetna, CIGNA, FrontPath, and others. (IDFOF 114).

MMO has approximately 1.4 million covered lives in Ohio, and is the largest health plan in Lucas County with approximately 100,000 covered lives. (IDFOF 132). MMO currently has all of the Lucas County hospitals in its network, but until 2008, ProMedica's hospitals did not participate in the MMO network. (IDFOF 135, 136).

Anthem is the largest health benefits company in the United States with over 33.3 million insured members in its health plans. (IDFOF 140, 141). Anthem is one of the top MCOs in Lucas County, with approximately 30,000 commercially-insured members. (IDFOF 147). Anthem currently has all of the Lucas County hospitals in its network, but until 2008, Mercy did not participate. (IDFOF 156, 158).

Paramount has approximately 85,000 to 90,000 covered lives in its commercially-insured products. (IDFOF 168). Paramount has a closed or limited network of hospitals in which the Mercy hospitals do not participate. (IDFOF 172).

FrontPath, a business coalition for health, does business in northwest Ohio, southeast Michigan, and northeast Indiana. (IDFOF 183, 184). FrontPath has always maintained an open-access platform that includes all Lucas County hospitals in its network. (IDFOF 191).

United's provider network includes all hospitals in Lucas County, but did not always. (IDFOF 204-207). ProMedica participated with United through 2005, whereupon Mercy became a participating provider as of January 1, 2006. (IDFOF 205, 206). ProMedica rejoined United's network in the fall of 2010. (IDFOF 205). .}

(IDFOF 207, *in camera*).

Aetna is a national, for-profit, publicly-traded health insurer. (IDFOF 209). Aetna has contracted with all hospitals in Lucas County since 2006. (IDFOF 222). Before 2006, Aetna did not contract with UTMC. (IDFOF 223).

Humana is another large, publicly-traded, national healthcare company that offers a diverse range of products and services. (IDFOF 226). Humana currently includes all Lucas County hospitals in its commercial PPO network. (IDFOF 233).

E. The Relevant Markets

The relevant product market in which to analyze the joinder is general acute care inpatient hospital ("GAC") services, including tertiary services and inpatient obstetrical services, sold to commercial health plans. (ID 139-145). The relevant geographic market in which to analyze the joinder is Lucas County, Ohio. (ID 145-146).

F. Factors Patients Consider when Choosing a Hospital

Patients consider a variety of factors when choosing a hospital for GAC services, including whether their physician has admitting privileges there, their physician's preferences, insurance coverage, hospital quality, and location. (IDFOF 243). Patients prefer private rooms, which have become the industry standard. (IDFOF 816).

G. Lucas County Demographics

The population in the greater Toledo area is stagnant to declining, aging, and not forecast to grow. (IDFOF 737). An aging population means the percentage of hospital patients covered by Medicare will increase. (IDFOF 740). Medicare and Medicaid reimbursements do not cover the costs of providing GAC services to those patients. (RPF 250). Moreover, Toledo has high unemployment, contributing to the decline in commercially insured patients. (IDFOF 741).

H. ProMedica and Mercy Are Each Other's Closest Substitutes

Complaint Counsel's case, and the Initial Decision, are premised on the claim that St. Luke's and ProMedica are each other's closest competitors. However, the evidence undeniably shows that { } view ProMedica and Mercy, the other multi-hospital system that mirrors ProMedica in number of hospitals,

services, and locations, as each other's closest or next-best competitor. (IDFOF 439, *in camera*, 440, 442, *in camera*, 444, 445, *in camera*, 446, *in camera*, 448, RPF 1109, 1110, *in camera*, 1111). Indeed, both Respondent's and Complaint Counsel's experts testified that ProMedica and Mercy are each other's closest substitutes, (RPF 1111, 1116-1117), a conclusion confirmed by a diversion analysis of patients from ProMedica or St. Luke's to other hospitals, which shows that

} (RPF 1138, *in camera*).

I. Complaint Counsel's Economic Evidence

1. Professor Town's Price Analysis

Complaint Counsel's economic expert, Professor Robert J. Town, presented two analyses that figure prominently in the Initial Decision. In the first, a price analysis, Professor Town "constructed" a comparison of pre-joinder hospital prices in Lucas County, which he asserted showed that ProMedica had the highest shares and the highest prices among Lucas County hospitals. (PX02148 at 037, *in camera*). The Initial Decision, however, did not address, let alone dispose of, the many foundational errors that Respondent's expert, Margaret Guerin-Calvert, identified in Professor Town's analysis. For example, Professor Town constructed his case-mix-adjusted prices by assuming each Lucas County hospital treated the same patient population; that is, he computed prices for patients at hospitals where the patients were not actually treated. (Town, Tr. 4168-4170, 4187-4188).

Moreover, Professor Town's case-mix-adjusted price estimations do not explain why prices across Lucas County hospitals differ. Because GAC services are differentiated products, factors like cost, quality, incorrect estimates of the increase in inflation or cost escalation, and the time period for which a contract is negotiated, can all cause one hospital's prices to differ from another hospital's. (Town, Tr. 4157-4161; Guerin-Calvert, Tr. 7266, 7474). Professor Town

agreed that prices for a hospital's services may differ across MCOs for several competitively-benign reasons, such as cost or quality. (Town, Tr. 4191). But his case-mix-adjusted price estimations do not control for the sources of price differences, like differences in hospitals' costs of care, and thus cannot distinguish between competitively-benign reasons and market-power-based reasons for higher prices. (Town, Tr. 4103, 4165-4166, 4168; Guerin-Calvert, Tr. 7467). As Professor Town conceded, price differences alone are not sufficient to infer the exercise of market power. (Town, Tr. 4151-4152, 4155; PX02148 at 145, *in camera*).

Professor Town's price analysis aggregates ProMedica's rates across all of its MCOs and hospitals; that is, it aggregates contracts with different reimbursement rates, different time periods and other different terms. (Guerin-Calvert, Tr. 7252-7256). When analyzed at a disaggregated level, by hospital and by MCO, Professor Town's estimated prices show that ProMedica's prices are not higher than all other hospitals in Lucas County. (Guerin-Calvert, Tr. 7480).

Evidence of actual market prices also contradicts Professor Town's price analysis. For example,

}, (Radzialowski, Tr. 684, *in camera*; PX02148 at 145, *in camera*), even though

} (Town Tr. 4183, 4185-4186). {

}

(Radzialowski, Tr. 684, *in camera*; RX-129 at 000001, *in camera*, PX02148 at 145, *in camera*), while Professor Town's case-mix-adjusted price calculations result in Mercy's prices being higher. (Town, Tr. 4181-4182). St. Luke's documents show that Lucas County hospital reimbursement rates are linked to their costs of care, not market share. (PX01016 at 009, *in*

camera). For example, a board presentation from St. Luke's shows that {

.} (PX01016 at 009, *in camera*). The document also shows that, on a disaggregated basis, {

,} further contradicting Professor Town. (PX01016 at 009, *in camera*).

2. Professor Town's Merger Simulation Model

Professor Town's second analysis is his merger simulation model that tries to predict the joinder's price effect. (Guerin-Calvert, Tr. 7485). Step one of Professor Town's merger simulation model identifies the price differences among hospitals, without explaining them. (Town, Tr. 4203-4205). Step two measures bargaining power as "willingness-to-pay" at a system level. (Town, Tr. 4206). Step three then estimates the relationship between willingness-to-pay and price. (Town, Tr. 4206). Steps four and five attempt to estimate the magnitude of the joinder's likely price effect, given the relationship estimated in step three. (Town, Tr. 4206).

Professor Town merger simulation model estimates that the joinder will lead to a 16.2 percent price effect. (Guerin-Calvert, Tr. 7495-7496). He then allocates this 16.2 percent price effect between ProMedica and St. Luke's and compares St. Luke's portion of the overall 16.2 percent price effect to its existing pre-joinder prices, arriving at a 38.38 percent price effect for St. Luke's and a 10.75 percent price effect for ProMedica. (Guerin-Calvert, Tr. 7496-7497). The final piece of Professor Town's merger simulation model takes the residual, or the unexplained portion, from his regression and adds that to St. Luke's purported 38.38 percent price effect to arrive at his predicted 56 percent price effect at St. Luke's. (Guerin-Calvert, Tr. 7497-7498).

It is undisputed that Professor Town's merger simulation model does not predict a specific price effect for either St. Luke's or ProMedica's legacy hospitals; rather it generates a single aggregate price effect for a ProMedica that contains St. Luke's. (Town, Tr. 4297-4298).

{

.} (Guerin-Calvert, Tr. 7375, *in camera*). In other words, Professor Town did not calculate his diversion ratios based upon a price increase at St. Luke's or at ProMedica that would reveal a patient's second choice hospital. (Town Tr. 4301-4302). Nor did he validate his allocated price effect between St. Luke's and ProMedica. (Town, Tr. 4307). Finally, Professor Town's merger simulation model cannot predict *when* ProMedica will be able to raise St. Luke's rates, only that it would allegedly occur over time. (Town, Tr. 4256).

J. St. Luke's Could Not Achieve Sufficient Improvements on Its Own To Obviate the Need for Service Cuts or To Remain Viable Beyond the Next Few Years

When it joined with ProMedica, St. Luke's was struggling financially. Despite experiencing revenue increases between 2008 and August 31, 2010, St. Luke's and its parent continued to experience large losses. (IDFOF 785-786). The conclusion of Complaint Counsel's financial expert, Mr. H. Gabriel Dagen, that these increased revenues could drive improved operating financial performance ignored the facts that,{

.} (RCCPF 1082, *in camera*). In reality, on average St. Luke's lost money for each patient that it treated and could not sustain its reduced capital expenditures over time. (IDFOF 944-946, 808-809, 977). Nor could St. Luke's ignore its mounting debt and delayed capital requirements. (IDFOF 805-809,

812, 845, 856-861, 893-900, 902-913, 977). Using St. Luke's dwindling cash reserves to cover its debt and capital requirements would only have worsened its financial condition. (IDFOF 864-865, 912-913; ID 187). St. Luke's weak financial condition led its management to conclude that {

} (RPF 1963-1965, *in camera*, 1966, 1969, *in camera*.) Indeed, St. Luke's CEO, Dan Wakeman, believed St. Luke's could only improve its situation by *either* affiliating with a partner *or* making aggressive service cuts. (RPF 1974; IDFOF 936-940).

III. Summary of the Argument

While the ALJ cites the appropriate legal standards for evaluating this case, he fails to apply them correctly to the facts adduced at trial. For example, the ALJ cited *In re Evanston Northwestern Healthcare Corp.*, No. 9315, 2007 FTC LEXIS 210, at *158-9 (Aug. 6, 2007) (*ENH*), for the proposition that merged firms may be able to raise prices unilaterally if "customers accounting for a 'significant share of sales' view the merging parties as their first and second choices," (ID 159), yet cites no evidence that a significant share of MCOs – the only relevant customers for the merger analysis here – actually view ProMedica and St. Luke's as their first and second choices, making anticompetitive effects unlikely.

The ALJ instead relies on patient preferences. But, even if that was the relevant inquiry, the ALJ further erred by relying on Professor Town's diversion analysis to conclude that ProMedica and St. Luke's are close substitutes (ID 158-159), when that analysis, in fact, shows that Mercy is ProMedica's closest substitute for all six major MCOs. (PX01850 at 020). The ALJ also erroneously relied on faulty consumer preference surveys. (ID 161-162). Not only do

the surveys speak only to current consumer perceptions and habits, making them legally irrelevant, they also are factually questionable and do not constitute the type of "reliable, probative, and substantive" evidence needed to support an Initial Decision. Finally, the ALJ ignored real world evidence of substantial patient volume and revenue shifts between Mercy and ProMedica, and St. Luke's own discharge data analysis that confirm St. Luke's and ProMedica are not close substitutes.

In addition to the flaws in the ALJ's conclusions on substitutability, the ALJ erred in his determination that the joinder will likely result in a substantial lessening of competition by misconstruing and relying on flawed expert testimony. Both components of Professor Town's economic analysis, his price analysis and his merger simulation model, are fatally flawed and cannot justify liability. Professor Town's price analysis is irrelevant and misleading, because it focuses on *pre-joinder* prices and does not explain *why* prices may differ. (PX02148 at 037 (¶68), *in camera*; Town, Tr. 3722-3725, *in camera*, 4155; Guerin-Calvert, Tr. 7469-7471). Further, Professor Town's price analysis confuses correlation with causation by inferring that ProMedica's purportedly high share *causes* the higher prices he "constructed." (PX02148 at 034 (¶68), *in camera*). Nor can Professor Town's merger simulation model, which tries to predict what the joinder's price effect would be to MCOs, survive scrutiny. When corrected for just some of its many flaws, the merger simulation model either predicts a price effect from the joinder not statistically different from *zero* or a price *decrease*. (RX-71(A) at 000081 (Table 9), *in camera*).

The ALJ also erred in relying on speculative opinion MCO testimony regarding ProMedica's ability to raise prices following the joinder (ID 164), while overlooking the impact of excess capacity on the market for healthcare services in Lucas County. Similarly, the ALJ

improperly ignored the facts that limited networks have thrived for much of the past decade in Toledo, and that broad networks have not profited at the expense of these limited networks, suggesting that a hospital's threat to leave an MCO network does not create significant leverage. (IDFOF 180, 224, RPF 803-808). Further, the ALJ incorrectly ignored evidence of the MCOs' countervailing bargaining leverage and erroneously discounted factual evidence of the insignificance of St. Luke's in a network. (ID 160-162). Lastly, the ALJ erred by discounting evidence of pre- and post-joinder contracting and implying Respondent must show that entry or repositioning has already occurred (ID 178), even though the evidence shows that competitor repositioning is timely, likely and sufficient. (IDFOF 747-751, *in camera*, RPF 1178, *in camera*).

The ALJ's rejection of what he characterized as ProMedica's "weakened competitor defense" and his conclusion that St. Luke's financial weakness does not undermine the predictive value of Complaint Counsel's market share statistics because "the evidence does not demonstrate that St. Luke's financial condition would render it competitively insignificant in the future" (ID 152) are inconsistent and incorrect. (*See* ID 214, ¶ 19). St. Luke's financial weakness undermines any analysis of market dynamics that assumes St. Luke's will continue to operate into the foreseeable future or operate at its pre-joinder level.

Lastly, the ALJ's rejection of Respondent's proposed remedy – that the parties maintain separate negotiating teams for the ProMedica legacy hospitals and St. Luke's – because he could not match this case with the specific facts of *ENH* lacks legal support. A remedy other than divestiture is particularly appropriate in this case, and the ALJ's overbroad and punitive order prohibits ProMedica and St. Luke's from unwinding the joinder in a manner that "restore[s] competition to the state of health it might be expected to enjoy *but for the acquisition.*" *In re*

Diamond Alkali Co., No. 8572, 1967 FTC LEXIS 44, at *84 (Oct. 2, 1967) (emphasis added); *see also In re B.F. Goodrich Co.*, No. 9159, 1988 FTC LEXIS 16, at *138 (Mar. 15, 1988).

SPECIFICATION OF QUESTIONS INTENDED TO BE URGED

I. Whether the ALJ erred in finding that the ProMedica/St. Luke's joinder will likely result in a substantial lessening of competition, when the ALJ: (i) considered the wrong customers when analyzing unilateral effects, (ii) accepted flawed expert testimony, and (iii) relied on biased and unsupported testimony from MCOs who compete with ProMedica's MCO affiliate.

II. Whether the ALJ erred in determining that the ProMedica/St. Luke's joinder will likely result in a substantial lessening of competition notwithstanding his conclusion that "St. Luke's was struggling financially prior to the [j]oinder and its future viability as an independent hospital . . . is by no means certain." (ID 214, ¶ 19).

III. Whether the ALJ erred in ordering a divestiture to remedy the purported substantial lessening of competition that will result from the ProMedica/St. Luke's joinder where he concluded that an alternative remedy would likely "restore ProMedica's bargaining power to its pre-[j]oinder state, preserve St. Luke's as a competitive constraint, and secure St. Luke's financial viability, to the benefit of consumers." (ID 215, ¶ 26).

COMMISSION STANDARD OF REVIEW

The Commission's standard of review is *de novo*. FTC Rule 3.54(a); *In re TransUnion Corp.*, No. 9255, 2000 FTC LEXIS 23 (Feb. 10, 2000). The Initial Decision and ALJ's findings must be supported by a "preponderance of the evidence" that is "reliable, probative, and substantial." *In re Chi. Bridge & Iron Co.*, No. 9300, 2005 FTC LEXIS 215, at *3 n.4 (Jan. 6, 2005); FTC Rule 3.51(c)(1); 5 U.S.C. §556(d) (2011).

ARGUMENT

I. The ALJ Erred in Finding that the ProMedica/St. Luke's Joinder Will Likely Result in a Substantial Lessening of Competition, when the Evidence Shows ProMedica and St. Luke's Are Not Close Substitutes, Complaint Counsel's Economic Evidence Is Fatally Flawed, and MCO Testimony Is Unsupported and Biased

A. The Evidence Shows that MCOs, the Customers at Issue, Do Not View ProMedica and St. Luke's as Close Substitutes

The ALJ cites *ENH* for the proposition that merged firms may be able to raise prices unilaterally if "customers accounting for a 'significant share of sales' view the merging parties as

their first and second choices." (ID 159). Here, the parties and the ALJ all agreed that MCOs are the "consumers" of GAC services for purposes of the merger analysis. (ID 140). The ALJ correctly relied on the actions of MCOs and how they contract with hospitals to conclude that the relevant market was all GAC services, including tertiary and inpatient obstetrical services. (ID 142) ("Therefore, it is important to look for what the consumer – *here the MCOs* – want or contract for."); *see also FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1213 n.13 (11th Cir. 1991) (holding true customers of acute inpatient services were third party payers). Yet, the ALJ does not cite to any evidence that a significant share of the relevant customers, MCOs, view ProMedica and St. Luke's as their first and second choices. Rather, having concluded that the MCOs are the relevant customers, the ALJ erred by inexplicably focusing on the purported views *of employers and patients* in making his determination regarding substitutability. (ID 157-158). Moreover, he did so despite conceding that Complaint Counsel's attempt to analyze substitutability from the perspective of patients "appears somewhat inconsistent with the allegation in the Complaint that a relevant product market is GAC inpatient hospital services 'sold to *commercial health plans*' and the position of Complaint Counsel's economic expert that '[t]he competitive analysis properly focuses upon the Acquisition's impact on the *hospital-MCO* bargaining process.'" (ID 155) (emphasis added).

No MCO testified that it considers St. Luke's to be the "next best substitute" for ProMedica for purposes of its Lucas County hospital networks. Rather, {

.} (IDFOF 439, *in camera*, RPF 1110, *in camera*, 1113). Indeed, MCOs do not even view ProMedica and St. Luke's as reasonably interchangeable; no MCO could substitute St. Luke's for ProMedica in its network. (IDFOF 448, 449). Before the joinder, faced with an anticompetitive price increase, no MCO

would have dropped ProMedica from its network in exchange for St. Luke's. (ID 157). Similarly, no MCO would have dropped Mercy in exchange for St. Luke's. But MCOs can and have successfully marketed networks with only one of the two main systems. (RPF 709-715). That is, a network including Mercy and other providers (excluding ProMedica), or a network including ProMedica and other providers (excluding Mercy) was, and remains, viable. Until 2008, although Anthem did not have Mercy in its network and MMO did not have ProMedica in its network, (RPF 712-714, IDFOF 158), both remained competitive and serviced their members with narrow network configurations. (RPF 719-720, 727-728). When United and ProMedica could not agree on a new contract in 2005, United substituted Mercy for ProMedica in its network. (IDFOF 205, 206).[1] Unsurprisingly, Complaint Counsel's economic expert conceded that Mercy was and is ProMedica's closest substitute. (RPF 1116).

The ALJ's mistaken deference to employers' and patients' preferences over MCO's actions matters greatly because the question of whether the merging parties are close substitutes is "central" to determining whether anticompetitive unilateral effects will result, which is Complaint Counsel's theory of the case. United States Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines*, § 6.1 (Aug. 2010). By basing his finding that ProMedica and St. Luke's are close substitutes on the perceptions of the wrong market participants (ID 157-158), the ALJ turns unilateral effects theory on its head. Here, the evidence is undisputed that MCOs – the proper customers – do not view ProMedica and St. Luke's as substitutes, making anticompetitive effects unlikely.

Furthermore, even if it had been appropriate for the ALJ to rely on patient preferences, the ALJ incorrectly relied on Professor Town's diversion analysis as reflecting those preferences.

[1] The MCOs' views are confirmed by the testimony of ProMedica and Mercy executives who identified each other as their respective closest competitors. (IDFOF 437-440).

(ID 158-159). Courts routinely discount expert testimony when, as here, "the data and predictions cannot reasonably be confirmed by the evidence." *FTC v. CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 70-72 (D.D.C. 2009); *see also FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 n.13 (8th Cir. 1999) ("When an expert opinion is not supported by sufficient facts to validate it in the eyes of the law, . . . it cannot support a decision."). In discussing Professor Town's diversion analysis, the ALJ focuses on diversion from St. Luke's to ProMedica. (ID 159). He ignores, however, Professor Town's estimates showing that Mercy is ProMedica's closest substitute for *all six major MCOs*.[2] (PX01850 at 020). Thus, the empirical diversion analysis's conclusions are entirely consistent with the testimony of the MCOs – ProMedica and Mercy are each other's closest substitutes. (IDFOF 461).

Professor Town's conclusions are also rebutted by a diversion analysis of 2009 data conducted by Ms. Guerin-Calvert, which predicts that if ProMedica were unavailable, {

s},

contrary to what one would expect if ProMedica and St. Luke's really were close substitutes.[3] (RPF 1129, *in camera*). Indeed, for MMO's network in 2010, the diversion rate from ProMedica to Mercy or UTMC is twice the diversion from ProMedica to St. Luke's. (RPF 1134). Similarly, if St. Luke's were unavailable, the diversion rate from {

.} (RPF 1128, *in camera*; RX-71(A) at 000028, *in camera*). The results are similar {

.} (RPF 1130, *in camera*). For example, for {

[2] The Initial Decision also incorrectly states that Professor Town's diversion analysis shows that for FrontPath, St. Luke's is ProMedica's closest substitute. (IDFOF 459). In fact, Professor Town's analysis shows that for FrontPath, Mercy is ProMedica's closest substitute. (PX01850 at 020, *in camera*).

[3] MMO represents the largest MCO Lucas County, and is the largest MCO for both ProMedica and St. Luke's. (RPF 263, 1128-1129, *in camera*).

.} (RPF 1132, *in camera*).

Therefore, patients would seek care from Mercy or UTMC, not St. Luke's, if ProMedica were unavailable. Professor Town reached a different conclusion, but only by examining only five of the six MCOs in Lucas County, omitting MMO. (CCBR 40-41). His omission of MMO was critical because MMO alone {

.} (RX-71(A) at 000191-000193, *in camera*).

Professor Town's failure to consider MMO invalidates any reliance on his diversion analysis because the flawed results do not constitute the type of "reliable, probative, and substantial evidence" needed to support an initial decision.

The ALJ's reliance on consumer preference surveys to support his conclusion that ProMedica and St. Luke's are close substitutes (ID 161-162) also represents legal error, because they speak only to current consumer perceptions and habits and do not address consumers' action in response to a price increase. *Tenet*, 186 F.3d at 1054; *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 145-46 (D.D.C. 2004) (noting that many cases and antitrust authorities "do not accord great weight to the subjective views of customers in the market," and customer concern "is little more than a truism of economics: a decrease in the number of suppliers *may* lead to a decrease in the level of competition in the market.") (emphasis added); *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1131 (N.D. Cal. 2004) ("the issue is not what solutions the customers would like or prefer," the issue is where these customers *would* go in the event of an anticompetitive price increase.). For these reasons, the consumer preference surveys are legally irrelevant to determining whether the joinder will likely result in a substantial lessening of competition.

Even if legally relevant, the surveys are factually questionable and are not the type of "reliable, probative, and substantial evidence" needed to support an initial decision. Professor Town interpreted the St. Luke's survey results to conclude that patients residing in St. Luke's "core service area" prefer St. Luke's and ProMedica for inpatient services. (IDFOF 498). The ALJ subsequently relied on the surveys to find that "for patients located near St. Luke's, St. Luke's and a ProMedica hospital were the most preferred." (ID 161, IDFOF 450- 452). The ALJ's reliance is misplaced, because these survey results were never validated and are not representative of the entire geographic market, Lucas County, Ohio. (ID 145-146). When asked how the survey was conducted, Professor Town admitted that he "was not privy to the survey specifically and how it was conducted," and was unaware of whether the survey company had statistically validated their results. (Town, Tr. 4087-4089). Complaint Counsel presented no evidence to the contrary.

Even if properly validated, the surveys did not ask respondents about their responses to price increases and, therefore, do not support the ALJ's conclusion on customer preference. *United States v. Oracle Corp.*, 331 F. Supp. 2d at 1131. Instead, the surveys asked respondents which hospitals came to mind, what hospitals they preferred, and what hospitals respondents – who were lay persons, not MCOs – felt were St. Luke's "most direct competitors." (PX01352 at 007; PX01077 at 009-010, 011-014; PX01169 at 006-007, 042).

Additionally, two documents Complaint Counsel highlight appear to refer to the same survey conducted between September 3-13, 2008 that canvassed 400 households in only six-eight zip codes that accounted for between 56-60 percent of St. Luke's inpatient discharges.[4] (*Compare* PX01077 at 007 *with* PX01169 at 003). Those surveys may reflect the preferences of

[4] The other document Complaint Counsel cite, PX01352, only contains a single-slide summary of a 2006 survey that does not discuss how many households were contacted. (PX01352 at 007).

residents in St. Luke's "core service area" who do not even participate in the relevant market, either because they did not utilize GAC services or are not insured by MCOs.[5] Also, the 400 households surveyed compares unfavorably to the over 16,000 inpatient discharges from all hospitals that come from St. Luke's "core service area" in a year. (PX01077 at 005).

The ALJ also erred by ignoring real world evidence that confirms Mercy and ProMedica are each other's closest substitutes. For example, when {

,} a substantial shift of volumes and revenues from { }

occurred, but no meaningful change occurred at St. Luke's. (RPF 1135, *in camera*). Therefore, the ALJ's dismissal of MMO's experience, based on his theory that the diversion analysis results for MMO are skewed because ProMedica only recently joined MMO's network (ID 159 n.19), should be rejected. In fact, ProMedica had participated in MMO's network for two years when the analysis was completed. (IDFOF 136).

Finally, St. Luke's ordinary course patient shift analysis confirms that St. Luke's and ProMedica are not close substitutes. Specifically, St. Luke's analyzed patient discharge data from 2000-2007 and concluded that UTMC, not ProMedica, gained most of the patient volume that St. Luke's lost when it did not participate in the Paramount and Anthem networks. (RX-2162 at 000001). Furthermore, when the joinder closed, St. Luke's re-joined Paramount's network, and St. Luke's believes that most of its new Paramount inpatient volume has come at { }, not ProMedica's. (Wakeman, Tr. 3025, *in camera*). Indeed, monthly industry reports show UTMC's *actual* admissions have decreased while ProMedica's *actual* admissions have either increased or remained stable. (Wakeman, Tr. 3025, *in camera*; 3045-3046, 3049-3051). In other words, what has transpired in the marketplace since the joinder

[5] One of the two survey documents shows only 181 respondents answered affirmatively when asked whether *anyone* in their household had stayed overnight in a hospital at all within the last two years. (PX01169 at 027).

undercuts a fundamental predicate for Complaint Counsel's unilateral effects theory. And, {

} (RPF 1139, *in camera*).

B. The ALJ Misconstrued and Relied on Flawed Expert Testimony

The FTC's Rules and the Administrative Procedures Act require that an initial decision "shall be based on a consideration of the whole record relevant to the issues decided and shall be supported by reliable and probative evidence." FTC Rule 3.51(c)(1); 5 U.S.C. § 556(d). The Initial Decision does not meet that standard because it relies on the testimony and economic modeling of Complaint Counsel's expert, despite fundamental flaws in Professor Town's analysis. The ALJ's error compels reversal pursuant to bedrock principles of administrative law. *McCain v. Director, OWCP*, No. 01-4074, 2003 U.S. App. LEXIS 4195, at *41 (6th Cir. Mar. 6, 2003) (reversing United States Department of Labor Benefits Board decision affirming ALJ decision where the ALJ failed to consider all the evidence, and finding that his decision to discredit certain testimony was not supported by substantial evidence); *see also Peabody Coal Co. v. Director, OWCP*, No. 99-2261, 2000 U.S. App. LEXIS 17496, at *3-4 (4th Cir. July 20, 2000) (expert opinion ALJ relied upon did not qualify as "reliable, probative, and substantial" evidence and, therefore, did not meet the preponderance of evidence standard); *U.S. Steel Mining Co. v. Director, OWCP*, 187 F.3d 384, 386 (4th Cir. 1999) (reversing ALJ decision when it was not supported by reliable, probative, and substantial evidence because the ALJ "failed to perform the important gatekeeping function of qualifying evidence under the Administrative Procedure Act before relying upon it.").

The evidence establishes that Professor Town's price analysis and merger simulation model are fatally flawed and cannot serve as the "reliable, probative, and substantial" evidence needed to support an Initial Decision. This is because, as the Supreme Court has cautioned, "when indisputable record facts contradict or otherwise render the [expert's] opinion unreasonable, it cannot support a jury's verdict." *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 242 (1993); *see also Tenet*, 186 F.3d at 1054 n.13; *CCC Holdings*, 605 F. Supp. 2d at 70-72. Neither of Professor Town's analyses withstands scrutiny.

Professor Town's analysis of ProMedica's *pre*-joinder prices is legally irrelevant, misleading, and counter to the facts adduced at trial. Professor Town attempted to "construct" case-mix adjusted prices, controlling for variation in case-mix, severity, and patient demographics. (PX02148 at 037 (¶68), *in camera*; Town, Tr. 3722-3725, *in camera*). However, Professor Town computed his case-mix adjusted prices by assuming each hospital in Lucas County treated the same patient population; that is, his model computes alleged "prices" for patients at hospitals where they never actually received care. (Town, Tr. 4168-4170, 4187-4188). He then concluded that ProMedica had the highest prices, Mercy had the second-highest, UTMC had the third-highest, and St. Luke's had the lowest prices. (PX02148 at 039 (¶71), 147 (Ex. 8), *in camera*).

Professor Town's analysis of ProMedica's *pre*-joinder prices is legally irrelevant because merger analysis is concerned with "determining whether the merger would enhance market power, not whether market power currently exists." *Oracle*, 331 F. Supp. 2d at 1121. Professor Town "constructed" average hospital to MCO prices based on data for only 2010. (PX02148 at 145 (Ex. 7), *in camera*). But Professor Town's price analysis makes no predictions about how prices may change *post*-joinder, which is the relevant inquiry. *Oracle*, 331 F. Supp. 2d at 1121;

see also United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 136 (E.D.N.Y. 1997) ("To determine whether there is a reasonable probability of a substantial lessening of competition, the courts have focused on whether the transaction has the 'potential for creating, enhancing, or facilitating the exercise of market power – the ability of one or more firms to raise prices above competitive levels for a significant period of time.'"). Because Professor Town's price analysis does not answer the only relevant question, the Commission should disregard it.

Even if Professor Town's price analysis were relevant, it is misleading. More specifically, it does not explain *why* prices at different hospitals may differ even when treating hypothetically identical patients. (Town, Tr. 4155; Guerin-Calvert, Tr. 7469-7471). This is particularly important because both parties' experts agree that competitively-benign factors (and not market power) such as differences in hospitals' costs, quality, mis-estimation of inflation or cost escalation in the hospitals' contracts with MCOs, and the time period for which a contract runs, may explain differences between hospitals' prices. (Town, Tr. 4157-4161; Guerin-Calvert, Tr. 7266, 7474). However, Professor Town's price analysis failed to include key variables, like hospitals' costs of providing care, to account for alternative explanations for why hospitals' prices differ. Simply put, he cannot eliminate the possibility that benign factors account for price differences. (Town, Tr. 4103, 4165-4166, 4168, 4191; Guerin-Calvert, Tr. 7252-7256, 7467). Therefore, inferring, as Professor Town does, that the purportedly high pre-joinder prices he constructed for ProMedica *result* from its high pre-joinder share confuses correlation with causation. (PX02148 at 034 (¶68), *in camera*). Unsurprisingly, courts have rejected that simplistic thinking by holding that "when dealing with a heterogeneous product or service, such as the full range of medical care, a reasonable finder of fact cannot infer monopoly power just from higher prices," a conclusion that even Professor Town acknowledges and accepts.

Compare Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic, 65 F.3d 1406, 1411-12 (7th Cir. 1995) *with* (Town, Tr. 4151-4152, 4155).

Professor Town's price analysis is also misleading because it aggregates ProMedica's prices across all hospital-MCO contracts when different hospital-MCO contracts contain different reimbursement rates, different lengths, and other different provisions. (Guerin-Calvert, Tr. 7252-7256). When Professor Town's results are disaggregated by hospital and by MCO, ProMedica is not always the highest priced. (Guerin-Calvert, Tr. 7480). For example, Professor Town's analysis shows that, for Aetna, Mercy St. Vincent has higher case-mix adjusted prices than any other hospital. (Town, Tr. 4177). Likewise, for Anthem, each of Mercy's hospitals' case-mix adjusted prices are higher than those for TTH and about the same as for Bay Park. (Town, Tr. 4177-4178; Guerin-Calvert, Tr. 7483). For FrontPath, Mercy St. Anne's case-mix adjusted price is higher than TTH's, Mercy St. Vincent's, UTMC's, and Flower's. (Town, Tr. 4180). Professor Town's price analysis does *not* show that ProMedica has the highest shares and the highest prices when properly viewed through the lens of each hospital's bilateral negotiations with MCOs. Given his failure to disaggregate the pricing information, Professor Town's price analysis cannot support a finding of liability. *Brooke Group*, 509 U.S. at 242; *Tenet*, 186 F.3d at 1054 n.13.

The results of Professor Town's price analysis also conflict with the facts adduced at trial, further undermining its reliability and probative value. For example, {

.} (Town, Tr. 4183, 4187-4188). But {

.} (Radzialowski, Tr. 684, *in camera*; PX02148 at 145, *in camera*).

Likewise, ordinary course documents from St. Luke's reveal that hospital reimbursement rates follow costs, so it is not surprising that they show {

.} (PX01016 at 009, *in camera*). That same document also shows that {

.} (PX01016 at 009, *in camera*). Given the divergence between Professor Town's price analysis and the actual evidence, his analysis does not constitute "reliable, probative, and substantial" evidence needed to support a verdict.

Professor Town's novel merger simulation model, which tries to predict what the joinder's price effect would be to MCOs (Guerin-Calvert, Tr. 7485), is also fatally flawed and cannot support a ruling that the joinder violates Clayton Act Section 7. To start, the ALJ erred in finding that the "willingness-to-pay" model has been "peer-reviewed and published in two prestigious economics journals." (IDFOF 633). While the *framework* of Professor Town's willingness-to-pay and merger simulation models may have appeared in journals, Professor Town admits that his particular specification of the model and the variables he uses here have not appeared in *any* peer-reviewed academic literature. (Town, Tr. 3469, 4247). Professor Town likewise concedes that his merger simulation model has not been accepted in any other hospital merger case (Town, Tr. 3969), and that economic literature has criticized the equation or specification he uses in the merger simulation willingness-to-pay model for generating restrictive substitution patterns (Town, Tr. 4236); this is cause for particular concern when Complaint Counsel's case is premised on ProMedica's and St. Luke's purported closeness of substitution. Also, neither Professor Town nor Ms. Guerin-Calvert is aware of any peer-reviewed studies that

validate the accuracy of the merger simulation model Professor Town uses to predict price effects. (Town, Tr. 4288-4289; Guerin-Calvert, Tr. 7511-7512). To the contrary, merger simulation models have generally been shown to yield imprecise predictions compared to what studies have revealed about actual post-merger prices. (Guerin-Calvert, Tr. 7511-7512). For these reasons alone, the Commission must decline to adopt Professor Town's novel and untested merger simulation model. *Tenet*, 186 F.3d at 1054 n.13.

Besides being novel and untested, Professor Town's merger simulation model is deeply flawed. For example, Professor Town's model cannot accurately predict which hospital patients would choose if their first choice hospital became unavailable or more expensive. (Town, Tr. 4240-4242). This shortcoming robs his model of any value because, as the *Horizontal Merger Guidelines* state, "[t]he extent of direct competition between the products sold by the merging parties is *central* to the evaluation of unilateral price effects," and "[u]nilateral price effects are greater, the more the buyers of products sold by one merging firm consider products sold by the other merging firm to be their next choice." *Horizontal Merger Guidelines*, §6.1 (Aug. 2010) (emphasis added). The merger simulation model, therefore, fails to address a core component of unilateral effects analysis, and the Commission should reject it accordingly.

The Commission must also reject the conclusions that Professor Town draws from his merger simulation model because it does not distinguish between joinder and non-joinder related reasons that explain price. (Guerin-Calvert, Tr. 7501-7502). In other words, the merger simulation model cannot explain whether a predicted price effect results from competitively-benign reasons or from the allegedly unlawful transaction. Courts have rejected economic models in antitrust cases when they cannot distinguish between lawful and unlawful conduct. *Concord Boat Corp. v. Brunswick Corp.*, 207 F. 3d 1039, 1057 (8th Cir. 2000) (reversing denial

of motion for judgment as a matter of law when economic model could not distinguish between lawful and unlawful conduct arising from defendant's acquisitions and discounting practices).

Here, Professor Town's merger simulation model's failure to explain whether ProMedica's purportedly higher prices result from market power or some other competitively-benign reason, like cost or quality, compels a similar result. Professor Town acknowledges the need to control appropriately for the intrinsic value associated with each hospital (i.e., the extent to which patients like a hospital for its quality, reputation, location and services), which is reflected in patient preference for a hospital (Town, Tr. 4280-4283; PX01850 at 062, *in camera*), because he agrees that the joinder does not affect that valuation. (Town, Tr. 4281-4282). Therefore, to predict the joinder-related price effect, Professor Town agrees that one must isolate (1) the substitution or diversion effect on price from (2) the effect of the intrinsic value on price by holding the characteristics of individual hospitals fixed. (Town, Tr. 4282).

Professor Town's merger simulation model, through its system willingness-to-pay variable, attempts to capture the intrinsic value of member hospitals and their membership in a system (i.e., the diversion or substitution between a system's hospitals). (Town, Tr. 4280-4281). But the results of his merger simulation model are subject to misinterpretation because the system willingness-to-pay variable captures many things that go to the intrinsic value of the hospital, including competitively-benign qualities. (Guerin-Calvert, Tr. 7502). Specifically, Professor Town's merger simulation model does not control for case mix index, assets per bed, percent Medicare reimbursements, percent Medicaid reimbursement and hospital-level willingness-to-pay, all of which can affect the intrinsic value associated with a hospital, are competitively-benign, and are variables identified in economic literature and are ones that other economists, including some employed by the FTC, have included in past hospital merger

analyses. (Town, Tr. 4283-4284; Guerin-Calvert, Tr. 7499-7550; RX-71(A) at 000077-000079, *in camera*). The case mix index variable accounts for a hospital's patient population distribution. Hospitals with a greater case mix index have different staffing, different attributes and possibly different reputations, all of which affect prices. (Guerin-Calvert, Tr. 7513-7514). The assets per bed variable measures a hospital's equipment and facilities that explain prices. (Guerin-Calvert, Tr. 7514-7515). The percent of Medicaid and Medicare discharges variables explain that the larger the proportion of Medicaid and Medicare patients a hospital has, the more it may have shortfalls it needs to cover with its MCO contracts, which may also explain prices. (Guerin-Calvert, Tr. 7515-7516). The hospital average willingness-to-pay per person variable accounts for differences between specific hospitals, rather than aggregating the willingness-to-pay at a system level. (Guerin-Calvert, Tr. 7516-7517). When these five competitively-benign variables are properly included in Professor Town's model, they fully explain the reason for the price differences he predicted. (Guerin-Calvert, Tr. 7501).

Adding these variables to Professor Town's merger simulation model reduces his 16.2 percent volume-weighted average calculated price effect to a 7.3 percent calculated price effect, but the coefficient on the system willingness-to-pay variable that generated the 7.3 percent effect is *not statistically significant*, meaning no confidence exists that the predicted price effect from the joinder is any different from *zero*. (Guerin-Calvert, Tr. 7525-7526; RX-71(A) at 000081, *in camera*).

Notwithstanding this result, the ALJ mistakenly relied on Ms. Guerin-Calvert's analysis as corroborating Professor Town's predicted price effect from the joinder. *Compare* (IDFOF 626; ID 170) ("When Respondent's expert . . . added several variables to Professor Town's model, even those additions resulted in a projected price increase of 7.3 percent") *with* (Guerin-

Calvert, Tr. 7525-7526) ("Q. And just so I'm sure we're understanding RX2154 correctly, are you – is your model – the model that you're using which adds the additional five variables, explanatory variables to Professor Town's model, is that predicting a 7.3 percent price effect? A. No, it is not."). The ALJ also failed to note that adding these five variables to Professor Town's alternate merger simulation regression, which he based on market shares, yields a predicted price effect of *-3.3* percent, (RX-71(A) at 000081 (Table 9), *in camera*) – that is, including the five additional variables predicts that the joinder will result in a price *decrease*. These widely varying results, which turn solely on the small changes of which variables to include, eviscerate the results of Professor Town's merger simulation model and establish that it is not the "reliable, probative, and substantive" evidence needed to support an Initial Decision. Moreover, by failing to include competitively-benign variables that can explain price differences, Professor Town's model does not "incorporate all aspects of the economic reality of the [relevant] market," and cannot distinguish between competitively-benign and potentially anticompetitive reasons for the differences, all of which means that the Commission must reject it. *Concord Boat*, 207 F.3d at 1056-57 (citing *Virgin Atl. Airways Ltd. v. British Airways PLC*, 69 F. Supp. 2d 571, 579 (S.D.N.Y. 1999) (*aff'd*, 257 F.3d 256 (2d Cir. 2001) ("an expert's opinion is not a substitute for a plaintiff's obligation to provide evidence of facts that support the applicability of the expert's opinion to the case.")).

Professor Town's merger simulation model also suffers from another fatal flaw – the method used to allocate the price increase between St. Luke's and ProMedica. As the ALJ noted, the undisputed evidence showed St. Luke's pre-joinder prices were below competitive levels. (ID 169). Thus, any price increase at St. Luke's would not necessarily be anticompetitive. (ID 169). The ALJ, however, did not address that issue, solely because he

concluded that the joinder "enables ProMedica to raise rates at not only St. Luke's, but throughout the ProMedica hospital system," a conclusion that rests exclusively on Professor Town's prediction that the joinder will enable ProMedica to raise rates at its legacy hospitals by 10.8 percent.[6] (ID 169-170). The problem with that analysis, however, is Professor Town's predicted price effect for ProMedica's legacy hospitals rests exclusively on his unsupported allocation of the predicted aggregated price effect for the entire ProMedica system, including St. Luke's. Essentially, Professor Town's model does not predict a price effect specific to St. Luke's or to ProMedica's legacy hospitals; rather it predicts a single aggregated price effect for the entire ProMedica system, including St. Luke's. (Town, Tr. 4297-4298). {

.} (Guerin-Calvert, Tr. 7375, *in camera*).

Moreover, no peer-reviewed literature exists that validates Professor Town's outcome determinative allocation method. (Town, Tr. 4307). In sum, Professor Town's use of faulty diversion ratios that cannot predict patient choices when faced with an increase in price, coupled with his failure to validate his allocation of the price effect, means that his predicted price effect for ProMedica's legacy hospitals cannot support a finding of liability. *Tenet*, 186 F.3d at 1054, n.13.

Finally, the ALJ erred by accepting Professor Town's predicted price impact for still another reason – the merger simulation model contains no temporal element. Professor Town's model says nothing about when or over what period of time ProMedica might be able to raise

[6] Complaint Counsel have also failed to show, as they must, that ProMedica can *profitably* increase prices post-joinder. (ID 166) (citing *Long Island Jewish*, 983 F. Supp. at 142). Professor Town failed to link ProMedica's predicted 10.8 percent price increase to profitability. Indeed, Complaint Counsel presented no evidence of whether ProMedica could profitably increase prices.

rates, only that it would occur some time. (Town, Tr. 4256, 4257) ("Q. But that price increase could occur within two years or it could occur with 20 years. You don't know when it's going to happen, do you? A. I think it will be closer to two year than to 20 years."). Professor Town's inability to address temporal issues merely highlights how speculative and unreliable his merger simulation model is, and shows why the Commission should not rely on the model to prohibit the transaction.

C. The ALJ Wrongly Relied on Unsubstantiated, Biased, and Speculative MCO Testimony

1. MCOs' Testimony that the Joinder Enables ProMedica To Raise Prices Is Unsupported

The ALJ erred in relying on speculative MCO opinion testimony regarding ProMedica's ability to raise prices following the joinder. (ID 168). Courts have discredited similar testimony as inherently suspect and lacking evidentiary support. *See Tenet*, 186 F.3d at 1054 (stating that MCOs' testimony that they would unhesitatingly accept a price increase was contrary to their economic interests and, therefore, suspect); *see also Oracle*, 331 F. Supp. 2d at 1131 (stating that "unsubstantiated customer apprehensions do not substitute for hard evidence"); *Arch Coal*, 329 F. Supp. 2d at 145-46.

Here, MCOs' testimony that the joinder will lead to higher prices from ProMedica and St. Luke's and that they lack any means to resist them (ID 164, 168) is speculative, particularly because MCOs did not analyze whether they could defeat a price increase by crafting narrower networks. (RBR 73). The ALJ's statement that MCOs "used general market knowledge, feedback from the field, and/or claims utilization data to determine the attractiveness and marketability of their offerings," (ID 165), is belied by the MCOs' testimony that they did not perform *any* analyses to support their beliefs about their ability to sell narrower networks or send their insureds to other hospitals in the event of a post-joinder price increase. For example, when

asked about MMO's ability to offer a network that does not include ProMedica and St. Luke's, MMOs' representative prefaced his response by emphasizing that {

.} (Pirc, Tr. 2262, *in camera*). When pressed to explain why such a network would not be viable, he retreated into a claim that {

.} (Pirc, Tr. 2262, *in camera*). Yet, the MMO representative acknowledged that MMO has *never* conducted any study of member travel preferences, or any studies of members' willingness to travel. (RPF 1264-1265, 1266, *in camera*). Similarly, Anthem, United and Aetna have not conducted any studies to analyze patients' willingness to travel for general acute care inpatient services in Lucas County. (RPF 1261-1262, 1267, 1269-1271). Therefore, MCO testimony regarding the marketability of a limited network is speculative and unsupported by any analysis.

Further, the cited MCO analyses refer only to the hypothetical possibility of ProMedica raising *St. Luke's* prices.[7] (ID 168). They do not analyze whether the joinder will enable ProMedica to raise rates at its legacy hospitals, which is what the ALJ concluded would harm competition. (ID 169-170). Therefore, the MCO testimony does not address whether the joinder will enable ProMedica to profitably increase prices above competitive levels for a prolonged period, the proper test for whether the joinder will likely substantially reduce competition. *See Tenet*, 186 F.3d at 1051; *Long Island Jewish*, 983 F. Supp. at 142.

Finally, the ALJ ignored the fact that MCOs' testimony is biased and self-serving. The MCOs are not just customers of ProMedica, but also its competitors, by virtue of ProMedica's ownership of Paramount. Also, the MCOs had extracted below market, and in some cases *below-cost*, rates from St. Luke's. (ID 169; RPF 1788-1791, *in camera*, 1793; RCCPF 423(a)).

[7] These analyses only compared existing rates at St. Luke's to existing rates at ProMedica's legacy hospitals and calculated the difference. They failed to consider how cost structure, quality, and other characteristics of St. Luke's may affect rate negotiations.

This further taints the MCOs' opposition to the joinder, because as the ALJ found, "St. Luke's likely would have increased rates regardless of the Joinder." (ID 169).

2. The ALJ Ignored Real World Evidence that Shows Price Increases above Competitive Levels Will Not Occur as a Result of the Joinder

The facts developed in this case contradict MCOs' testimony, because they support the viability of a properly-priced network comprised of UTMC and Mercy to constrain any potential post-joinder supracompetitive price increases. First, the evidence shows that distance from a hospital is not the determinant factor for patients in Lucas County. (RPF 218-243, 1210-1218). This belies MCO testimony regarding the need for an inpatient hospital in southwest Toledo. As local residents have indicated and expert study has confirmed, travel times in Lucas County are minimal and patients regularly travel past their closest hospital to receive care elsewhere. (RPF 218-243, 442, 1210-1218). The ALJ also acknowledged that patients rank other factors like availability of services, access to physicians, and alignment of insurance ahead of geographic location. (IDFOF 330). In addition, Mercy and ProMedica have successfully competed for patients throughout Lucas County without having an inpatient facility in southwest Toledo. Likewise, Paramount succeeded while offering a network without an inpatient facility in southwest Toledo. Further, competitor hospitals have testified that they believe they can successfully compete in the future without having an inpatient hospital in southwest Toledo. (PX01940 (Shook, Dep. at 45), *in camera*). Finally, for those patients for whom distance is important, the ALJ overlooked the fact that UTMC is located only six miles away from St. Luke's. (RPF 1140).

Second, the ALJ acknowledged that excess capacity exists, (IDFOF 670-671), and that low occupancy rates indicate that hospitals can treat additional patients. (IDFOF 677). However, he failed to realize that excess capacity gives MCOs increased bargaining leverage

because they do not need to have every hospital in their network when just a few have enough beds for all of their members. (RPF 1316). This, and the hospitals' need to attract commercially-insured patients, allows MCOs to press hospitals to maintain their rates at competitive levels or threaten to exclude them from their networks.

Third, while the ALJ acknowledged that physicians hold privileges at multiple hospitals in Lucas County, he failed to understand the importance of this fact. (IDFOF 685). The evidence reflects that even hospital-employed physicians maintain privileges at and regularly admit patients to competing hospitals. (RPF 686, 693, 756-757). This gives physicians the flexibility to direct patients to in-network hospitals for treatment to minimize their patients' expenses. (IDFOF 691; RPF 682).

The combination of patient willingness to travel, excess capacity, and flexible physician privileges allows physicians to send their patients to different hospitals, if needed for insurance reasons, without disrupting patient care and, thereby, constrains any market power ProMedica might gain from the joinder. (RPF 683). This, in turn, allows MCOs to credibly threaten to shift large volumes of patients away from ProMedica in the event of any post-joinder supracompetitive price increases. Indeed, courts have accepted evidence showing physician privileges can facilitate patient switching that will constrain hospitals' ability to raise prices in rejecting merger challenges. *See California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1132 (N.D. Cal. 2001) (concluding widespread physician privileges at competing hospitals countered MCO testimony that patients would not switch hospitals in the event of a price increase); *see also Tenet*, 186 F.3d at 1054 (finding MCO testimony that they would be forced to accept a price increase because patients insist upon going to the hospital closest to their home was "suspect").

The evidence refutes the ALJ's finding that MCOs will be unable to easily send their customers to other hospitals in the event of an anticompetitive price increase following the joinder.

Next, the ALJ erred by ignoring the undisputed fact that limited hospital networks have thrived in Toledo, even as broad networks have been unable to grow at their expense. (RPF 709-717, 779-781, 800-808). This factual evidence is more persuasive than the unsubstantiated testimony of the MCOs. *See Oracle*, 331 F. Supp. 2d at 1167 (holding that what customers do is more persuasive than what they say). For example, MMO successfully marketed a network that did not include ProMedica (RPF 719-721), and Anthem successfully marketed a network that did not include Mercy or St. Luke's. (RPF 725-728). During this time, United substituted ProMedica for Mercy. (RPF 359). Even as many of these MCOs transitioned to broad networks in the past few years, none has witnessed a significant change in its membership levels. (RPF 363, 392-393, 416). Further, Paramount has and continues successfully to operate a closed provider network. (RPF 716, 779-784). For years, Paramount succeeded with a network consisting of ProMedica and UTMC (with no physical presence in southwest Toledo other than UTMC). (RPF 313-314, 316, 319). MCOs' behavior indicates that St. Luke's was not a must-have in-network hospital in Lucas County and it will be possible to have a successful network without St. Luke's in the future. Moreover, the joinder will not change this because St. Luke's offers no services that the remaining competitors' hospitals do not offer, and because Mercy and UTMC have sufficient excess capacity to serve *all* of St. Luke's commercially-insured patients. (RPF 1149-1150, 1151-1152, *in camera*). The ALJ erred, therefore, by ignoring the history of narrow hospital networks when concluding that a network of Mercy and UTMC would not be marketable (ID 163-166).

Additionally, the ALJ incorrectly ignored evidence of the MCOs' countervailing bargaining leverage. As the court noted in *Tenet*, "large, sophisticated third-party buyers can and do resist price increases." 186 F.3d at 1054. Here, the evidence shows that all parties in every negotiation have bargaining leverage, and leverage alone does not automatically lead to anticompetitive effects. (RPF 1320-1321). Indeed, MCOs have obtained lower rates from hospitals by threatening to enter into exclusive agreements with competing hospitals. (IDFOF 268). { }, for instance, negotiated a lower rate from } by excluding { }, while { } negotiated a lower rate from { } by excluding }. (RPF 734, 735-736, *in camera*, 737, 740-741, *in camera*). MCOs have obtained most favored nations ("MFN") clauses from ProMedica, { }, and St. Luke's. (RPF 601, 602, *in camera*, 758, *in camera*). MFN clauses epitomize MCOs' buyer power because they ensure MCOs receive the hospital's lowest prices. (RPF 597). In fact, St. Luke's was unable to obtain rate increases from { } and { } due to the existence of MFN clauses in its contracts with those MCOs. (RPF 1830, *in camera*, RPF 1846, *in camera*). Finally, MCOs are particularly powerful in Toledo, where the number of commercially-insured patients is decreasing, forcing hospitals to compete more vigorously for ever-fewer potentially profitable patients. (IDFOF 739-741). The evidence establishes that MCOs are powerful third-parties well positioned to resist any post-joinder anticompetitive price increases.

The ALJ further erred by discounting evidence of pre- and post-joinder contracting. Post-acquisition evidence favorable to a defendant can be an important predictor of competitive effects. *See Lektro-Vend Corp. v. Vendo Co.*, 660 F.2d 255, 276 (7th Cir. 1981). The ALJ misconstrued the law and ignored critical facts regarding the post-joinder negotiations. Post-acquisition evidence should be discounted only if it is subject to manipulation; that has not been

shown here. First, some MCOs chose to enter into new contracts with ProMedica on behalf of St. Luke's, the life-spans of which extend well past the likely duration of this litigation. That means that ProMedica will be subject to the prices it has negotiated for years. (RPF 1382, *in camera*; RX-333 at 000017-000018, *in camera*). Second, the actual prices negotiated reveal a lack of manipulation. The evidence reflects that St. Luke's post-joinder prices are comparable to prices that St. Luke's would have received had it stayed independent. (RPF 1872-1876, *in camera*, 1385, *in camera*). In fact, the prices ProMedica achieved for St. Luke's are, in some cases, *less* than what St. Luke's negotiated for itself prior to the joinder. *Compare* (RPF 1872-1876, *in camera*) *with* (RPF 1385, *in camera*). In circumstances like these, the actual evidence of competitive effects should be given substantial weight.

Finally, the ALJ erred by implying that Respondent had to show that entry or repositioning was already occurring (ID 176-178), and by ignoring precedent stating that even perceived entry or expansion can constrain a possible anticompetitive price increase. *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 988, 989 n.8 (D.C. Cir. 1990) (holding that even "the threat of entry can stimulate competition in a concentrated market, regardless of whether entry ever occurs."). Specifically, the ALJ erred by finding {

,} is

insufficient to counter any anticompetitive effects. (IDFOF 747-748). The evidence shows, however, that Mercy's plans are timely, likely and sufficient repositioning. *See Horizontal Merger Guidelines*, § 9. The ALJ omitted the crucial fact that {

,} making its plans timely and

likely. (RPF 1176-1178, *in camera*). For example, after the joinder, {

.} (RPF 1180, *in camera*). St. Luke's understood this to be in direct response to the joinder. (RPF 1181, *in camera*). Further, { } has already { .} (Shook, Tr. 983, *in camera*). More importantly, { } is sufficient to counter post-joinder supracompetitive price increases. Respondent's expert found that St. Luke's is vulnerable to losing commercially-insured patients to Mercy because of the substantial overlap between Mercy's physicians and St. Luke's. (RPF 708, *in camera*). Respondent's expert also testified that { } will put approximately { } of St. Luke's billed charges at risk of going to { .} (Guerin-Calvert, Tr. 7390-7392, *in camera*). Mercy stated its intent to remain competitive following the joinder, explaining that "Mercy is continuing our plans to develop a strong and growing primary care base ... specifically in the southwest market" and "Mercy will continue to compete in the market." (RX-695-000001).

The ALJ, thus, erred in ignoring substantial real-world evidence that competitors will counter any post-joinder anticompetitive price increase.[8] Taken together, this evidence shows that the joinder will not likely result in anticompetitive harm.

II. The Joinder Is Unlikely To Result in a Substantial Lessening of Competition because St. Luke's "Future Viability as an Independent Hospital . . . Is by No Means Certain."

The ALJ's conclusion that "St. Luke's was struggling financially prior to the Joinder and its future viability as an independent hospital, beyond the next few years, is by no means certain" should have led him to conclude that the joinder would not result in substantial anticompetitive

[8] The ALJ similarly erred in ignoring evidence that UTMC, which has completed a number of renovations, expanded its facilities, and engaged in outreach activity, is also repositioning itself to be a stronger competitor in the future. (RPF 1190, 1193).

effects. (*See* ID 214, ¶ 19). Instead, the ALJ "rejected" what he characterized as ProMedica's "weakened competitor defense" (*id.*) and concluded that St. Luke's financial weakness does not undermine the predictive value of Complaint Counsel's market share statistics because "the evidence does not demonstrate that St. Luke's financial condition would render it competitively insignificant in the future." (ID 152). This is internally inconsistent and incorrect.

ProMedica has never asserted a flailing firm defense. Rather, ProMedica's position is that St. Luke's financial weakness undermines any market analysis that assumes St. Luke's will continue to operate at pre-joinder levels into the foreseeable future. *See United States v. Int'l Harvester Co.*, 564 F.2d 769, 773-76 (7th Cir. 1977) (stating that evidence of a company's "weakness as a competitor" informs a market analysis even where the defendants did not rely on the failing-company doctrine); *Arch Coal*, 329 F. Supp. 2d at 155-57 (stating a company's "weak competitive status remains relevant to . . . whether substantial anticompetitive effects are likely from the transactions" even if it does not support a full defense). If, as the ALJ correctly concluded, it is uncertain whether St. Luke's could sustain itself as an independent hospital beyond the next few years, it is likely that the market will naturally reduce St. Luke's competitive significance. Not only will St. Luke's market share decrease, but its location in Lucas County will become less competitively significant, and MCOs either will not have the option of including St. Luke's in their networks or St. Luke's will become even less attractive to MCOs.

The ALJ distinguishes *Arch Coal* by concluding that St. Luke's financial condition would not render it "competitively insignificant in the future" (ID 152) and because St. Luke's was still competing in the market. (ID 189). The facts and the ALJ's own findings do not support this conclusion. First, the ALJ's determination that St. Luke's viability beyond the next few years is

unclear without "significant and sustained improvements in St. Luke's financial conditions" (ID 190) should have resolved this issue. In *Arch Coal*, the court concluded that the acquired entity "may still continue to operate, but [] may become less and less of an active competitor" in the relevant market. 329 F. Supp. 2d at 155. That is no different from the ALJ's conclusion that although St. Luke's is competing in the market now, its viability beyond the next few years is uncertain. (ID 189, 208-209).

Second, the ALJ ignores evidence that proves that St. Luke's will not achieve any "significant and sustained improvements" on its own. For example, Mr. Dagen's pro forma analysis that St. Luke's could improve profitability based upon volume growth was flawed. (RCCPF 962, *in camera*, 1082, *in camera*, 1083-1084, 1209, *in camera*, 1211, *in camera*, 1212.) In reality, St. Luke's lost money on average for each patient that it treated, and St. Luke's reduction in capital expenditures was unsustainable. (RPF 1643, *in camera*, 1763-1764, *in camera*, 1777, *in camera*, 1781, *in camera*; Den Uyl, Tr. 6423, 6468, *in camera*; Johnston, Tr. 5329). Moreover, dismissing St. Luke's debt obligations and looming capital requirements on the grounds that St. Luke's had enough cash to cover these costs ignores the reality that such a move would have worsened St. Luke's financial condition. (RPF 1641-1643, *in camera*; 2024, *in camera*, 2027-2028, *in camera*; Wakeman, Tr. 3009, *in camera*; ID 187). Nor could St. Luke's have borrowed money to cover these costs. (RPF 1644). Mr. Brick's conclusion that St. Luke's could have borrowed money at a reasonable interest rate lacks foundation because he did no independent analysis to support his opinions. (IDFOF 887; Brick, Tr. 3474, 3511-3557). Because St. Luke's lacked independent prospects for improvement, *Arch Coal* is directly on point.

Finally, the ALJ fails to analyze how the market will react to a St. Luke's that only offers some of its pre-joinder services because the ALJ inaccurately concludes that St. Luke's could compete without cutting services absent the joinder. (ID 188 n.24). The only support the ALJ cites for this conclusion is a board member's testimony, who stated cutting service lines would have diminished St. Luke's ability to serve the community and that those cuts were not a major topic of discussion because the idea was distasteful to the board. (ID 188 n.24; Black, Tr. 5703-5704.) This testimony does not undermine St. Luke's management's conclusion that {

.} (RPF 1963-1965, *in camera*, 1966, 1969, *in camera.*) Indeed, Mr. Wakeman believed St. Luke's could only improve its situation by *either* choosing a joinder partner *or* making aggressive service cuts. (RPF 1974). The ALJ cites no evidence to suggest that St. Luke's could have continued independently *and* maintained all of its services. Thus, the Commission should reject the flawed competitive analyses of Complaint Counsel, its expert, and the ALJ because they fail to account for the fact that St. Luke's, at a minimum, would have had to cut services or, more likely, would have disappeared from the market altogether absent the joinder. This reduction in St. Luke's competitive significance going forward undercuts any suggestion that the joinder will result in a substantial lessening of competition.

III. An Alternative Remedy Exists that Will Restore Competition and Maintain St. Luke's as a Viable Community Hospital More Effectively than the ALJ's Overbroad and Punitive Divestiture Order

Even if the Commission concludes that the joinder violates Section 7, it should reject the ALJ's order and adopt ProMedica's, which requires the parties to maintain separate negotiating teams for the ProMedica legacy hospitals and St. Luke's. The ALJ's rejection of this proposed remedy because he could not shoehorn this case into the framework of *ENH* lacks legal support.

The Commission has broad equitable remedies at its disposal to cure any purported illegal conduct and is not limited to ordering divestiture. A remedy other than divestiture is appropriate because the ALJ concluded that ProMedica's remedy would nullify ProMedica's alleged post-joinder bargaining power and benefit consumers. (ID 207). Instead of adopting this remedy, the ALJ issued an overbroad order that prohibits ProMedica and St. Luke's from unwinding the joinder. (*See* ID 222).

A. The ALJ Had Discretion To Order ProMedica and St. Luke's To Negotiate MCO Contracts Separately

The question the Commission must ask in crafting a remedy is: "What kind of order, within the broad range of an equity court's remedial powers, would, in the particular circumstances, be most effective to 'cure the ill effects of the illegal conduct, and assure the public freedom from its continuance?'" *In re Ekco Prods. Co.*, No. 8122, 1964 FTC LEXIS 115, at *122 (June 30, 1964) (citation omitted); *see also In re Diamond Alkali Co.*, 1967 FTC LEXIS 44, at *87, 89-90 (stating the "primary focus of inquiry as to remedy is whether the relief adequately redresses the economic injury arising out of the violation").

Divestiture is only one answer to this question, and it is not an "automatic sanction, mechanically invoked in merger cases." *In re Retail Credit Co.*, No. 8920, 1978 FTC LEXIS 246, at *260 (July 7, 1978); *see also Diamond Alkali*, 1967 FTC LEXIS 44, at *86, 89-90 (stating the Commission is not "interested in adopting a purely formalistic remedy" and "[t]he immediate question which arises is whether restoration of competition can be achieved at all and whether it requires divestiture or might be accomplished without it"). A conclusion that the acquired entity is not viable absent the joinder counsels against divestiture. *See In re Fruehauf Corp.*, No. 8972, 1977 FTC LEXIS 9, at *3 n.1 (Dec. 21, 1977) (respondent had to demonstrate the sufficiency of a remedy other than divesture after considering complaint counsel's argument

that "a presumption should favor total divestiture in merger cases, because the acquired entity is more likely to prove viable upon divestiture (*having proven viable before its acquisition*) than some arbitrarily created sub-entity with no prior market history") (emphasis added). In addition, where equally effective remedies other than divestiture are available, "due regard should be given to the preservation of substantial efficiencies or important benefits to the consumer in the choice of an appropriate remedy." *Retail Credit*, 1978 FTC LEXIS 246, at *260-61, 341.

The ALJ found ProMedica's argument that its proposed remedy would both remedy any anticompetitive effects of the joinder and benefit consumers "cogent." (ID 207). Specifically, the ALJ found that ProMedica's proposed remedy "would restore ProMedica's bargaining power to its pre-Joinder state and preserve St. Luke's as a competitive constraint" and "preserve St. Luke's viability, to the benefit of consumers." (ID 207). ProMedica proved that its proposed remedy would cure any anticompetitive effects of the joinder while simultaneously retaining its community benefits. This is all the law requires. *Ekco*, 1964 FTC LEXIS 115, at *122; *Diamond Alkali*, 1967 FTC LEXIS 44, at *86, 87, 89-90; *Retail Credit*, 1978 FTC LEXIS 246, at *260-61, 341; (ID 205-06).

The ALJ denied ProMedica's proposed order, however, because the joinder lacked the extensive integration found in *ENH*. (ID 208). The fact that this case is not identical to *ENH* is not grounds to ignore that ProMedica's proposed remedy cures any anticompetitive effects of the joinder.

Furthermore, unique circumstances exist here that warrant this conduct remedy, even if the facts are not identical to those in *ENH*. The ALJ acknowledged the *ENH* decision's statement that divestiture is appropriate when the unwinding of a hospital merger "would be

unlikely to involve substantial costs" and "all else being equal." But here, unwinding the joinder would result in substantial costs to the community and all else is not equal.

As the ALJ correctly determined, St. Luke's viability beyond the next few years is uncertain at best (ID 208-209), which makes this case even more appropriate for alternative relief than was the case in *ENH*. In *ENH*, the Commission deemed the acquired hospital "essentially sound." *ENH*, 2007 FTC LEXIS 210, at *218. Here, however, the ALJ detailed St. Luke's financial condition prior to the joinder as "considerably weaker" than the acquired hospital in *ENH*. (ID 190 n.25). The community will suffer substantial costs if the Commission orders divestiture because it will likely lose St. Luke's as a full-fledged competitor. (ID 208-209). Furthermore, the parties will have to unwind the consolidation of inpatient rehabilitation services at Flower, which reduced St. Luke's ER diversions virtually to zero and opened space for St. Luke's to convert former inpatient rehabilitation beds to private beds. (IDFOF 1058-62). St. Luke's is also unlikely to meet "meaningful use" requirements if the Commission orders ProMedica to divest St. Luke's. The balance of the evidence from St. Luke's and ProMedica's management and healthcare experts demonstrates that St. Luke's was not well-positioned for healthcare reform without significant capital assistance. (RPF 926-927, 1634, 1687, 1727, *in camera*, 1732, *in camera*, 1733, 1737, 1961). Thus, unwinding the joinder presents unique costs that were not present in *ENH*.

The fact that the joinder is not factually identical to the merger in *ENH* is not grounds to reject ProMedica's proposed remedy. As the ALJ concluded, this remedy will cure any purported anticompetitive effects of the joinder while preserving St. Luke's as a viable competitor for the benefit of the community. The Commission should affirm this conclusion and enter ProMedica's proposed order.

B. The ALJ's Remedy Is Overbroad and Punitive because It Forecloses the Option of Unwinding the Joinder

Even if the Commission rejects ProMedica's proposed order, it should not enter the ALJ's order because it is overbroad and punitive. In the event of a section 7 violation, the Commission must fashion a remedy that "restore[s] competition to the state of health it might be expected to enjoy *but for the acquisition*." *Diamond Alkali*, 1967 FTC LEXIS 44, at *84 (emphasis added); *see also In re B.F. Goodrich Co.*, 1988 FTC LEXIS 16, at *138 ("In section 7 cases, the principal purpose of relief 'is to restore competition to the state in which it existed prior to, and would have continued to exist *but for, the illegal merger*.'") (emphasis added). Remedies that go beyond this and impose restrictions that are unnecessary to eliminate effects of a merger are punitive and overbroad. *In re The Raymond Lee Org.*, No. 9045, 1978 FTC LEXIS 124, at *227-28, *337-53 (Nov. 1, 1978) (eliminating provisions of a proposed order that were overbroad and unnecessary to remedy the abuse and stating that the order "must not be punitive, but must assure correction of those practices found to be unlawful and prevent their reoccurrence in the future."); *N. Tex. Specialty Physicians v. FTC*, 528 F.3d 346, 371 (5th Cir. 2008) (remanding the proceeding to the FTC after holding portions of its remedy were overly broad and internally inconsistent).

Although the ALJ identified this standard (ID 211), his order goes beyond restoring competition to its pre-joinder state and is, therefore, overbroad and punitive. The ALJ ordered ProMedica to divest St. Luke's to a willing buyer instead of allowing the parties to unwind the joinder because he concluded that St. Luke's viability beyond the immediate few years was uncertain. (ID 208-09). ProMedica agrees that St. Luke's is unlikely to sustain itself as an independent hospital absent the joinder and that the public benefits with St. Luke's in the community – this is partly why the parties entered into the joinder. (RPF 911, *in camera*, 937, *in*

camera, 942, *in camera*, 1974). But the Commission is not authorized to create the competitive dynamic that it wished had existed pre-joinder; the Commission can only institute a remedy curing any anticompetitive effects of the joinder.

Assuring St. Luke's viability does not fall within this mandate. An order prohibiting the dissolution is appropriate where the acquiring party has used a merger to reduce the acquired party's ability to compete. Under that scenario, unwinding the deal would not remedy the anticompetitive conduct. That did not occur here. St. Luke's financial woes existed prior to the joinder, and ProMedica did not cause or exacerbate them since the joinder. Even Complaint Counsel has stated its approval for allowing ProMedica to spin off St. Luke's as an independent hospital. (Closing Argument, Tr. 85-86). As to this point, the Commission should defer to Complaint Counsel. *See United States v. E. I. Du Pont de Nemours & Co.*, 366 U.S. 316, 334 (1961). The ALJ's order requiring ProMedica to divest St. Luke's to ensure St. Luke's financial viability overreaches. Thus, the order is overbroad and punitive and should be revised to allow the parties to unwind the joinder.

CONCLUSION

The record evidence shows that the ProMedica/St. Luke's joinder will not likely result in a substantial lessening of competition. ProMedica and St. Luke's are not close substitutes, Complaint Counsel's economic evidence is fatally flawed, and the MCOs' testimony is unsupported and biased. Moreover, as the ALJ acknowledged, St. Luke's independent future viability was uncertain at best, which would decrease its competitive significance going forward. Accordingly, Respondent urges the Commission to reverse the Initial Decision and dismiss the Complaint with prejudice. In the alternative, Respondent urges the Commission to adopt a conduct remedy that would eliminate any possibility of anticompetitive effects while still securing for Lucas County's residents the benefits of a financially-viable St. Luke's Hospital.

This the 29th of December, 2011.

D. Marx

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UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION

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

In the Matter of	)	
PROMEDICA HEALTH SYSTEM, INC.	)	Docket No. 9346
a corporation.	)	**NON-PUBLIC**

PROPOSED ORDER

Upon consideration of the briefs submitted by Respondent and Complaint Counsel, the arguments of counsel for the parties before this Commission in Open Session, and the record in this matter:

I.

IT IS ORDERED that, as used in this Order, the following definitions apply:

A. "Commission" means Federal Trade Commission.

B. "Contract Administration" means the act or acts associated with compliance with and implementation of final contract terms, such as payment monitoring, communication of Payor medical and administrative policies, utilization management, liaison to the business office, annual updates, and organizing managed care-related budget information.

C. "Contract Management System" means a software application or other system that houses contract rates and is utilized for patient billing and modeling Pre-existing Contract rates and/or proposed rates.

D. "Corporate Managed Care Department" means the department that will be responsible for Contract Administration for ProMedica Hospitals and St. Luke's.

E. "Final Offer Arbitration" means a manner of arbitration whereby each party in a disputed matter submits its best and final offer to an arbitrator who is then required to choose what he or she believes is the best offer (sometimes referred to as "baseball style arbitration").

F. "Hospital" means any human medical care facility licensed as a hospital in the state in which the facility is located.

G. "Hospital Services" means all inpatient hospital services, which include a broad cluster of medical, surgical, diagnostic, treatment, and all other services that are included as part of an admission of a patient to an inpatient bed within the ProMedica Hospitals or St. Luke's, and all outpatient services that are related to the use of that Hospital.

H. "Joinder" means the 2010 joinder of ProMedica with St. Luke's.

I. "Managed Care Contract" means a contract or agreement for Hospital Services between ProMedica and a Payor, including but not limited to rates, definitions, terms, conditions, policies, and pricing methodology (*e.g.*, per diem, discount rate, and case rate).

J. "Managed Care Contracting Information" means information concerning Managed Care Contracts and negotiations with a specific Payor for Hospital Services; provided, however, that "Managed Care Contracting Information" shall not include: (i) information that is in the public domain or that falls in the public domain through no violation of this Order or breach of any confidentiality or nondisclosure agreement with respect to such information by Respondent; (ii) information that becomes known to ProMedica from a third party that has disclosed that information legitimately; (iii) information that is required by law to be publicly disclosed; or (iv) aggregate information concerning the financial condition of ProMedica.

K. "Operate" means to own, lease, manage or otherwise control or direct the operations of a Hospital, directly or indirectly.

L. "Ownership Interest" means any and all rights, present or contingent, of Respondent to hold any voting or nonvoting stock, share capital, equity or other interests or beneficial ownership in an entity.

M. "Payor" means any Person that pays, or arranges for payment, for all or any part of any Hospital Services for itself or for any other Person. Payor includes any Person that develops, leases, or sells access to networks of Hospitals. The term does not include government payors for public health insurance programs, such as Medicare and Medicaid.

N. "Person" means any individual, partnership, joint venture, firm, corporation, association, trust, unincorporated organization, joint venture, or other business or government entity, and any subsidiaries, divisions, groups or affiliates thereof.

O. "Pre-existing Contract" means a Managed Care Contract between a Payor and ProMedica that is in effect on the date this Order becomes final.

P. "ProMedica" or "Respondent" means ProMedica Health System, its directors, officers, employees, agents, representatives, successors, and assigns; its joint ventures, subsidiaries, divisions, groups and affiliates controlled by ProMedica Health System, and the respective directors, officers, employees, agents, representatives, successors, and assigns of each.

Q. "ProMedica Hospitals" means The Toledo Hospital, Toledo Children's Hospital, Flower Hospital, and Bay Park Community Hospital, the hospitals owned by ProMedica and located in Lucas County in Toledo, Ohio.

R. "ProMedica Negotiating Team" means the team responsible for negotiating a Managed Care Contract for Hospital Services for ProMedica Hospitals.

S. "St. Luke's" means St. Luke's Hospital, owned by ProMedica, located at 5901 Monclova Road, Maumee, Ohio.

T. "St. Luke's Negotiating Team" means the team responsible for negotiating a Managed Care Contract for Hospital Services for St. Luke's.

II.

IT IS FURTHER ORDERED that Respondent shall

A. Negotiate Managed Care Contracts for Hospital Services for St. Luke's separately and independently from Managed Care Contracts for Hospital Services for ProMedica Hospitals, and vice versa;

B. Not make any Managed Care Contract for Hospital Services for ProMedica Hospitals contingent on entering into a Managed Care Contract for Hospital Services for St. Luke's, or vice versa;

C. Not make the availability of any price or term included in a Managed Care Contract for Hospital Services for ProMedica Hospitals contingent on entering into or agreeing to any particular price or term included in a Managed Care Contract for Hospital Services at St. Luke's, or vice-versa; and

D. At the request of the Payor, submit any disputes as to prices and/or terms arising out of the separate and independent negotiations required by Paragraphs II.A.- C. of this Order:

1. first to mediation under the Commercial Mediation Rules of the American Arbitration Association ("AAA"), and, if the dispute cannot be settled by mediation, at the request of the Payor to a single arbitrator, mutually agreed upon by ProMedica and the Payor, who shall conduct binding arbitration in accordance with the Commercial Arbitration Rules of the

AAA at a location mutually agreed upon by ProMedica and the Payor, in order to determine fair and reasonable prices and/or terms assuming competition between the hospitals as would exist but for the Joinder;

2. the arbitration shall be conducted as Final Offer Arbitration, unless ProMedica and the Payor agree to an alternative manner of arbitration;

3. costs of the arbitration (other than attorneys fees, which shall be borne by the party that incurs them) shall be borne by the loser if Final Offer Arbitration; if a manner other than Final Offer Arbitration or if the parties settle the matter prior to issuance of the final decision by the arbitrator, the arbitrator shall assess costs, unless the parties agree as to the allocation of costs;

4. *provided, however*, that neither the mediator nor the arbitrator shall have any responsibility or authority to resolve issues concerning any violation or possible violation of this Order; the Commission retains jurisdiction over these issues.

Provided further, however, that nothing in this Paragraph shall prohibit Respondent from negotiating a Managed Care Contract with a particular Payor for Hospital Services for both St. Luke's and ProMedica Hospitals jointly, if that Payor elects to negotiate jointly for all Hospitals rather than to negotiate separate Managed Care Contracts.

III.

IT IS FURTHER ORDERED that

A. No later than thirty (30) days after this Order becomes final, Respondent shall establish and thereafter maintain the ProMedica Negotiating Team and the St. Luke's Negotiating Team, which teams shall operate independent of each other and negotiate Managed Care Contracts separately and in competition with each other and other Hospitals.

B. The St. Luke's Negotiating Team shall be exclusively responsible for negotiating Managed Care Contracts for Hospital Services for St. Luke's when separate contracts are negotiated pursuant to Paragraph II. of this Order.

C. The ProMedica Negotiating Team shall be exclusively responsible for negotiating Managed Care Contracts for Hospital Services for ProMedica Hospitals when separate contracts are negotiated pursuant to Paragraph II. of this Order.

D. At the request of a specific Payor, ProMedica shall be permitted to negotiate a Managed Care Contract for Hospital Services jointly for ProMedica Hospitals and St. Luke's for that specific Payor for that specific Managed Care Contract; *provided, however*, that neither the St. Luke's Negotiating Team nor the ProMedica Negotiating Team shall be involved in the joint negotiations.

IV.

IT IS FURTHER ORDERED that

A. Respondent shall maintain Managed Care Contracting Information with respect to ProMedica Hospitals separate and confidential from Managed Care Contracting Information with respect to St. Luke's.

B. Managed Care Contracting Information with respect to ProMedica Hospitals shall not, directly or indirectly, be transmitted to or received by the St. Luke's Negotiating Team, and Managed Care Contracting Information with respect to St. Luke's shall not, directly or indirectly, be transmitted to or received by the ProMedica Negotiating Team, except as otherwise provided in this Order.

C. No later than thirty (30) days after this Order becomes final, Respondent shall implement procedures and protections to ensure that Managed Care Contracting Information for ProMedica Hospitals, on the one hand, and St. Luke's, on the other, is maintained separate and confidential, including but not limited to:

1. establishing a firewall-type mechanism that prevents the ProMedica Negotiating Team from requesting, receiving, sharing, or otherwise obtaining any Managed Care Contracting Information with respect to St. Luke's, and prevents the St. Luke's Negotiating Team from requesting, receiving, sharing, or otherwise obtaining any Managed Care Contracting Information with respect to ProMedica Hospitals;

2. establishing a Contract Management System for the St. Luke's Negotiating Team that is separate or clearly-partitioned from the Contract Management System for the ProMedica Negotiating Team to ensure the confidentiality of Managed Care Contracting Information; and

3. causing each of Respondent's employees with access to Managed Care Contracting Information to maintain the confidentiality required by the terms and conditions of this Order, including but not limited to:

    a. requiring each employee to sign a statement that the individual will comply with these terms;

    b. maintaining complete records of all such statements at Respondent's headquarters; and

    c. providing an officer's certification to the Commission stating that such statements have been signed and are being complied with by all relevant employees.

D. Nothing in this Order shall prevent the St. Luke's Negotiating Team from requesting, receiving, sharing, using or otherwise obtaining Managed Care Contracting Information with respect to Hospital Services for St. Luke's.

E. Nothing in this Order shall prevent the St. Luke's Negotiating Team from requesting, receiving, sharing, using or otherwise obtaining non-Managed Care Contracting Information relating to any ProMedica Hospital or the entire ProMedica system, including, but not limited to, information related to costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead.

F. Nothing in this Order shall prevent the ProMedica Negotiating Team from requesting, receiving, sharing, using, or otherwise obtaining Managed Care Contracting Information with respect to Hospital Services for ProMedica Hospitals.

G. Nothing in this Order shall prevent the ProMedica Negotiating Team from requesting, receiving, sharing or otherwise obtaining non-Managed Care Contracting Information relating to any Hospital in the ProMedica system or the entire ProMedica system, including, but not limited to, information related to costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead.

H. If a Payor elects to negotiate and contract jointly for Hospital Services for St. Luke's and ProMedica Hospitals, nothing in this Order shall prohibit ProMedica from requesting or obtaining Managed Care Contracting Information with respect to Hospital Services for ProMedica Hospitals and St. Luke's for that particular Payor or from using that Managed Care Contracting Information for that particular Payor with respect to the joint negotiations and contracting for that particular Managed Care Contract.

I. Nothing in this Order shall prevent the Corporate Managed Care Department from requesting Managed Care Contracting Information from the ProMedica Negotiating Team or the St. Luke's Negotiating Team, *provided, however*, that

1. the Managed Care Contracting Information that is requested and obtained is used solely for the purpose of Contract Administration, and

2. the Corporate Managed Care Department is prohibited from providing, sharing, or otherwise making available Managed Care Contracting Information:

   a. from the St. Luke's Negotiating Team to or with the ProMedica Negotiating Team; or

   b. from the ProMedica Negotiating Team to or with the St. Luke's Negotiating Team.

V.

IT IS FURTHER ORDERED that, no later than ten (10) days after being contacted by a Payor to negotiate a Managed Care Contract, Respondent shall notify said Payor

of its rights under this Order by sending a copy of this Order to the Chief Executive Officer, the General Counsel, and the network manager of the Payor by first class mail or e-mail, with return receipt requested. Respondent shall maintain complete records of all such notifications and return receipts at Respondent's headquarters and shall include in reports filed to the Commission an officer's certification to the Commission stating that such notification requirement has been implemented and is being complied with.

VI.

IT IS FURTHER ORDERED that Respondent shall,

A. Within ten (10) days after this Order becomes final, and every sixty (60) days thereafter until submission of the first annual report required by Paragraph VI.B. of this Order, submit a verified written report to the Commission setting forth in detail

1. the manner and form in which it will comply with Paragraphs II. and III. of this Order, including but not limited to the composition, structure, and intended operation of the ProMedica Negotiating Team and the St. Luke's Negotiating Team, including but not limited to who will comprise the teams, where they will be located, who will supervise the teams, who will approve the Managed Care Contracts, what instructions the team members will receive, how the team members will be compensated, what other responsibilities the team members will have, and other details necessary for the Commission to evaluate Respondent's compliance with this Order; and

2. the manner and form in which Respondent will comply with Paragraph IV. of this Order.

B. One (1) year from the date this Order becomes final, annually for the next nineteen (19) years on the anniversary date this Order becomes final, and at such other times as the Commission may require, submit a verified written report to the Commission setting forth in detail the manner and form in which it has complied and is complying with the Order. In each such verified written report, include, among other things that are required from time to time, the following:

1. a full description of the efforts being made to comply with each Paragraph of the Order, including all internal memoranda and all reports and recommendations concerning compliance with the requirements of this Order;

2. notification of all requests for mediation and/or arbitration and a full description of the mediation and/or arbitration, including but not limited to identification of the arbitrator and the location of the arbitration, a full description of the status and results of mediation, a full description of the status of the arbitration and, if resolved, of the resolution of each arbitration; and

3. the identity of each member of the ProMedica Negotiating Team, the St. Luke's Negotiating Team, and the Corporate Managed Care Department.

C. Within sixty (60) days after the date this Order becomes final, and every sixty (60) days thereafter until Respondent has fully complied with Paragraph VIII.A., and has obtained the signed statements of all of Respondent's employees described in Paragraph IV.C.3. and who are employed by the Respondent as of the date this Order becomes final, submit a verified written report to the Commission setting forth in detail the manner and form in which it has complied and is complying with the Order.

VII.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this Order, and subject to any legally recognized privilege, and upon written request and five (5) days notice to the Respondent made to its headquarters address, Respondent shall, without restraint or interference, permit any duly authorized representative of the Commission:

A. Access, during business office hours of the Respondent and in the presence of counsel, to all facilities and access to inspect and copy all books, ledgers, accounts, correspondence, memoranda, calendars, and all other records and documents in its possession, or under its control, relating to any matter contained in this Order, which copying services shall be provided by Respondent at the request of the authorized representative(s) of the Commission and at the expense of the Respondent; and

B. To interview officers, directors, or employees of the Respondent, who may have counsel present, regarding such matters.

VIII.

IT IS FURTHER ORDERED that Respondent shall

A. Within thirty (30) days after the date this Order becomes final, send by first class mail, return receipt requested, a copy of this Order to each officer and director of ProMedica; and

B. Within ten (10) days of appointment of any new officer or director of ProMedica, send by first class mail, return receipt requested, a copy of this Order to such officer or director.

IX.

IT IS FURTHER ORDERED that, Respondent shall notify the Commission at least thirty (30) days prior to (1) any proposed dissolution of Respondent in Lucas County, Ohio; (2) any proposed acquisition, merger, or consolidation of Respondent in Lucas County, Ohio; or (3) any other change in Respondent in Lucas County, Ohio including, but not limited to,

assignment or creation or dissolution of subsidiaries, if such change might affect compliance obligations arising out of this Order.

X.

IT IS FURTHER ORDERED that this Order shall terminate twenty (20) years from the date on which this Order becomes final.

Dated: _____

_____
The Commission

CERTIFICATE OF SERVICE

I, Christine Devlin, hereby certify that I served a true and correct copy of the foregoing Respondent's Appeal Brief, Public Version, upon the following individuals by hand on December 29, 2011.

Donald S. Clark
Secretary
Federal Trade Commission
600 Pennsylvania Avenue, NW, Room 172
Washington, DC 20580

The Honorable D. Michael Chappell
Administrative Law Judge
Federal Trade Commission
600 Pennsylvania Avenue, N.W.
Washington, D.C. 20580

I, Christine Devlin, hereby certify that I served a true and correct copy of the foregoing Respondent's Appeal Brief, Public Version, upon the following individuals by electronic mail on December 29, 2011:

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C. Devlin

Christine Devlin