In the Matter of
ProMedica Health System, Inc.
Docket No. 9346

Concurring Opinion of Commissioner J. Thomas Rosch

I concur with the Commission's decision finding that ProMedica Health System's acquisition of St. Luke's Hospital violates Section 7 of the Clayton Act. I also concur with the Commission's conclusion that the appropriate remedy for this violation is divestiture of St. Luke's. I write separately because (1) I would have affirmed the ALJ's finding that the general acute care inpatient services product market includes tertiary services, (2) I would have affirmed the ALJ's rejection of a separate market for inpatient obstetrical services, and (3) I would not have relied on any "willingness to pay" econometric models to establish liability, as the ALJ did.

I.

As to the first issue, the parties agreed, consistent with Commission and judicial precedent, that the relevant product market in this case consisted of general acute care (GAC) inpatient services sold to managed care organizations (MCOs). (Complaint ¶ 12; Answer ¶ 12; IDF 299, 306; *Evanston Nw. Healthcare Corp.*, 2007 FTC LEXIS 210, at *146-151 (2007) (citing six hospital merger decisions).) The Commission has previously concluded that an inpatient GAC market includes tertiary services. In *Evanston*, the Commission defined the relevant product market to include all of the inpatient services provided by Evanston Northwestern Hospital, which offered primary, secondary, and tertiary care services, and Highland Park Hospital, which offered *only* primary and secondary services. *Id.* at *23-24. The ALJ's relevant product market definition thus accords with the prior teaching of the courts and of this Commission, and there was no need for the Commission to revisit this issue.[1]

II.

As to the second issue, I would have also affirmed the ALJ's conclusion that there is not a separate market for inpatient obstetrical services. These services are already reflected in the inpatient GAC cluster market. Defining a separate market for obstetrical services would therefore be redundant.[2] Furthermore, neither Complaint Counsel nor the majority can point to

[1] The majority does not dispute that in *Evanston*, the Commission concluded that the relevant product market included tertiary care services even though only the acquiring hospital offered those services. The majority just asserts that the Commission did not need to reach that conclusion because the issue was not raised in the briefs. In fact, Jonathan Baker, on whom the majority relies, says that such a market definition may be supported simply by "convenience," even where there are "substantial" differences in market shares across services in the cluster market. Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 L. & Contemp. Probs. 93, 137-38 & n.212 (1988).

[2] The majority takes issue with the notion that inclusion of OB services with other inpatient services is redundant. But the majority acknowledges that whether OB services are included with other inpatient services makes no difference to the outcome of this case. The majority

any judicial precedent for defining a obstetrical services market separate from an overall inpatient GAC market.[3]

In sum, insofar as the Commission would reverse the ALJ as to the role of tertiary and obstetrical services in the relevant market, the Commission would not only depart from the case law, but also risk accusations of "gerrymandering" the relevant product market so as to make it more susceptible to a structural presumption of liability.

III.

As to the third issue, Complaint Counsel and their economist Dr. Town proffered a study linking hospital concentration to prices in the relevant geographic market (IDF 605-11), an MCO "willingness-to-pay" econometric model (IDF 612-34), and a diversion analysis purporting to show that ProMedica was the closest substitute for St. Luke's patients (IDF 453-61). Respondent and its economist, Ms. Guerin-Calvert, disputed Dr. Town's "willingness to pay" model and adjusted its specifications in an attempt to correct some of its alleged flaws.[4] (RX 71(A).) Thus, there ended up being two competing econometric "willingness to pay" models. As a result, the parties presented competing, and very different, predictions respecting MCOs' "willingness to pay."

A.

Insofar as the Commission relies on Dr. Town's study linking concentration to prices, it supports a "structural" theory of Section 7 liability. *See United States v. Baker Hughes Inc*., 908 F.2d 981 (1990). The traditional way of challenging a merger is to demonstrate that the merger is reasonably likely to lessen competition or create a monopoly by further concentrating an already concentrated market. If the change in concentration resulting from the merger is sufficiently high, this "structural" theory creates a presumption of liability. That presumption stands unless it is rebutted. *See United States v. Philadelphia Nat'l Bank*, 374 U.S. 321 (1963); *United States v. Baker Hughes Inc*., 908 F.2d 981 (1990). In this case, the pre-transaction and

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simply asserts that it would be more "transparent" to treat OB services as a separate market and cites to *Butterworth* as precedent for a separate OB market. However, neither the district court nor the Sixth Circuit (which, incidentally, did not affirm or even address the district court's conclusions regarding the relevant market) in that case held that a separate OB market could be carved out. *See FTC v. Butterworth Health Corp*., 946 F. Supp. 1285, 1290-91 (W.D. Mich. 1996), *aff'd*, 1997-2 Trade Cas. (CCH) ¶ 71,863 (6th Cir. 1997).

[3] If, as the majority says, getting the relevant market right is "important from the standpoint of analytical precision and guidance for future cases," it matters whether OB Services are a separate market. That is precisely why avoiding "gerrymandering" is important.

[4] Ms. Guerin-Calvert's modifications to Dr. Town's "willingness to pay" econometric model do not constitute a waiver of arguments challenging the propriety of the model. As counsel for Respondent explained, Ms. Guerin-Calvert's modifications to Dr. Town's model were only submitted to rebut his model, and Ms. Guerin-Calvert continued to insist that Dr. Town's model was fatally flawed. (Oral Arg. Tr. 27.)

post-transaction HHIs and the increase in the same are more than sufficient to trigger the presumption of liability established by the Supreme Court. *See Philadelphia Nat'l Bank*, 374 U.S. at 363-67. The ALJ found that even using Respondent's proposed market definition, the pre-merger HHIs meet the Merger Guidelines' presumption of a highly concentrated market (IDF 368-69) and that "the Joinder significantly increases concentration in the already highly concentrated Lucas County GAC inpatient service market" (IDF 370).

Moreover, the majority correctly concluded that Respondent had failed to produce evidence that St Luke's was in such bad shape that its market shares would be diluted enough in the future to fall below the level of presumptive illegality. *United States v. Gen. Dynamics Corp.*, 415 U.S. 486 (1974). For example, St. Luke's CEO informed his Board in August 2010—one month prior to the closing of the Joinder Agreement—that the hospital had "high activity" compared to the prior year and "produced a positive operating margin." (IDF 790-91, 948.) He also acknowledged that by the time of the Joinder, St. Luke's had achieved 4 of the 5 "pillars" set forth in its Three-Year Plan. (IDF 931; *see also* IDF 920-41.) Among other things, St. Luke's increased inpatient and outpatient net revenue, increased its occupancy rate, and increased its market share in its core service area. (IDF 924-28.) A variety of other financial metrics also improved in the two years leading up to the Joinder Agreements. (IDF 950-54.) Finally, ProMedica's documents and testimony contradict its assertion that, absent the Joinder, it would need to build a costly new hospital at its Arrowhead property and a new tower at its Flower Hospital. (IDF 1122, 1124, 1126, 1127.)

The structural case—and indeed, the anticompetitive effects of this change in structure—was also buttressed by numerous admissions made by the merging parties in their testimony and documents. For example, ProMedica's CEO acknowledged that before the Joinder, the parties competed to attract patients and also competed to attract and retain physicians. (IDF 464-65.) ProMedica's internal assessments viewed St. Luke's as a capable competitor that could take away patient volume. (IDF 467-71, 1020.) St. Luke's CEO testified that after he came to St. Luke's in 2008, his goal was to regain volume from ProMedica in St. Luke's primary service area. (IDF 441.)

St. Luke's also acknowledged that it entered into the Affiliation Agreement with ProMedica in part based on its expectation of higher reimbursement rates from managed care organizations (MCOs). (IDF 396, 421, 597-603.) A presentation from St. Luke's CEO to the Board of Directors stated that an "affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-[St. Luke's] partnership would have a lot of negotiating clout." (IDF 598.) The same presentation noted that an affiliation with ProMedica could "[h]arm the community by forcing higher hospital rates on them." (IDF 598.) Other merger planning documents noted St. Luke's belief that a ProMedica affiliation would allow it to "force[] high rates on employers and insurance companies" and lead to "outstanding pricing on managed care agreements." (IDF 599-600.)

B.

First, the "willingness to pay" model is not an appropriate basis on which to find that the transaction will result in unilateral effects.[5] The fundamental premise of the unilateral effects theory of liability has long been that customers accounting for a "significant share of sales" in the market must view the merging parties as each other's closest substitutes. *See* 1992 Merger Guidelines § 2.21 ("Substantial unilateral price elevation in a market for differentiated products requires that there be a significant share of sales in the market accounted for by consumers who regard the products of the merging firms as their first and second choices . . . ."); 2010 Merger Guidelines § 6.1; *United States v. H&R Block*, 2011 U.S. Dist. LEXIS 130219 (D.D.C. 2011) (unilateral effects in differentiated product market requires that "the products controlled by the *merging* firms must be close substitutes, *i.e.*, a substantial number of the customers of one firm would turn to the other in response to a price increase" (quoting *CCC Holdings Inc.*, 605 F. Supp. 2d 26, 68 (D.D.C. 2009), and *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1117-18 (N.D. Cal. 2004)); *Evanston*, 2007 FTC LEXIS 210, at *158 ("A merger between firms in a differentiated product market can enable the merged firm to raise prices unilaterally if customers accounting for 'a significant share of sales' view the merging parties as their first and second choices for a particular need."). In *Evanston*, the Commission explained that this principle applied to "bargaining markets" like hospital markets. *Evanston*, 2007 FTC LEXIS 210, at *167 ("In a bargaining market, a merger may allow the merged firm to exercise market power against a subset of customers who view the merging parties as their first and second choices . . . .").

This fundamental premise does not exist in this case. Each and every one of the six MCOs who testified admitted that *Mercy*, not St. Luke's, was *ProMedica's* next best substitute. (IDF 442-449; *see also* IDF 437.) Complaint Counsel do not seriously dispute this. (Complaint Counsel Answering Brief at 12 ("Complaint Counsel does not deny that Mercy is, in all likelihood, the ProMedica system's closest substitute.")) The ALJ also found that "from the perspective of the MCOs when constructing a marketable network, the Mercy hospital system is the closest substitute to the ProMedica hospital system." (ID at 157; *see also* ID at 159 ("MCOs, when constructing a network, viewed the hospital systems of ProMedica and Mercy to be each other's closest substitute . . . ."))

As stated above, in *Evanston* the Commission indicated that "willingness to pay" econometric models could apply in "bargaining" markets. But the Commission warned that "[t]he potential for a merger in a bargaining market to have disparate effects on different customers" was significantly different in such markets than it was in a "single-price market."

[5] The majority asserts that asymmetric unilateral effects – where only one party is the other's closest competitor – are "not at all uncommon particularly in markets involving competitors of varied size." But the majority has failed to cite a single case where a "willingness to pay" study was considered probative in a "bargaining" market like this one. Indeed, the majority ignores the teaching of *Evanston* that such a model "potentially creates sticky and unsettled issues for merger analysis [in such a market], most significantly, determining the percentage of the merged firm's revenues that must come from customers who are harmed by the merger for the transaction to violate Section 7." 2007 FTC LEXIS 210, at *167. Additionally, the majority ignores the other prudential reasons for eschewing such a study.

See Evanston, 2007 FTC LEXIS 210, at *167. The Commission went on to warn that that "potentially creates sticky and unsettled issues for merger analysis, most significantly, determining the percentage of the merged firm's revenues that must come from customers who are harmed by the merger for the transaction to violate Section 7." *Id.*

C.

Second, the Commission should not needlessly resolve all of the thorny issues that surround the "willingness to pay" models or saddle an appellate court with those issues either. Those issues begin with the reliability of the models themselves. They are a form of "simulation" study. Critics have charged that such studies always predict a price increase if there is any degree of substitution between the merging parties' products. *See* Statement of Commissioner J. Thomas Rosch on the Release of the 2010 Horizontal Merger Guidelines at 3-4 (Aug. 19, 2010). And even the Commission has stated that such studies are not "conclusive" in themselves. *See* 2010 Guidelines § 6.1. For another thing, it is not easy to choose between Dr. Town's model and the modifications that Ms. Guerin Calvert made to that model. Dr. Town's model in its original form and as modified predict very different levels of price increase and degrees of statistical significance. But these issues need not be resolved.

D.

Third and finally, the Commission has tried to persuade staff of the virtues of "telling a story" predominantly out of the mouths of the parties and their documents. This is how the top-flight plaintiff's lawyers try their cases. We have much to learn from them. The Commission should be reluctant to focus attention instead on economic models especially when the Commission has devoted so much time and effort to insisting that staff focus on the real world as contrasted with the theoretical world. *See generally* Vaughn R. Walker, *Merger Trials: Looking for the Third Dimension*, 5 Competition Policy Int'l 35 (2009) (observing that if economic evidence is to be persuasive, it must be communicated in a way that a generalist can understand it and must be consistent with other evidence).