

UNITED STATES OF AMERICA  
BEFORE THE FEDERAL TRADE COMMISSION

ORIGINAL

In the Matter of )  
 )  
PROMEDICA HEALTH SYSTEM, INC. )  
 )  
a corporation. )  
 )

Docket No. 9346  
PUBLIC



RESPONDENT PROMEDICA HEALTH SYSTEM, INC.'S,

POST-TRIAL BRIEF

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## I. INTRODUCTION

In this case the Federal Trade Commission (“FTC”) seeks to unwind the joinder, consummated over one year ago, of St. Luke’s Hospital (“St. Luke’s”), a financially-distressed, standalone community hospital, and ProMedica Health System (“ProMedica”), a multi-hospital system, both located in Toledo, Ohio.<sup>1</sup> The joinder already has and will continue to benefit St. Luke’s and the community these not-for-profit entities serve. If the Court orders ProMedica to divest St. Luke’s, those benefits will be lost and, the evidence shows that St. Luke’s is likely to fail within the next three to four years, which will leave consumers of healthcare services in Toledo worse, not better, off.

The FTC’s complaint (“the Complaint”) alleges that the joinder may substantially lessen competition in two relevant markets, general acute-care inpatient services and inpatient obstetrical (“OB”) services. To remedy these perceived but speculative injuries, Complaint Counsel seek a divestiture, despite their failure to present evidence that proves anticompetitive effects have occurred in the year since the joinder or are reasonably likely to occur, and their reliance on a novel, untested and fatally flawed “merger simulation” model that does not reflect actual competitive dynamics. To prevail on a Clayton Act Section 7 claim, the law requires more, especially when the market facts rebut any “presumption” of anticompetitive effects based simply on market share calculation, as they do here. Accordingly, the Court should dismiss the Complaint.

To prevail on its Section 7 claim, Complaint Counsel must show, by a preponderance of the evidence, that the joinder of St. Luke’s and ProMedica is reasonably likely to result in a

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<sup>1</sup> ProMedica and St. Luke’s have structured their affiliation as a “joinder,” whereby St. Luke’s joins ProMedica’s system through a member substitution transaction, but remains a separate entity with an independent board. (RPF 908). Citations to Respondent’s Proposed Findings of Fact are abbreviated as “RPF.”

substantial lessening of competition by enabling ProMedica to raise rates to managed-care organizations (“MCOs”), commercial health insurance companies who purchase services from hospitals on behalf of their members, above competitive levels for a prolonged period. *United States v. Penn-Olin Chem. Co.*, 378 U.S. 158, 171 (1964); *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1051 (8th Cir. 1999); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 142 (E.D.N.Y. 1997). Complaint Counsel have failed to meet their burden because their competitive effects analysis ignores undisputed facts relating to competition among the hospitals competing in the Toledo market.

To determine whether anticompetitive effects will result from the joinder, the Court must examine the “structure, history, and probable future” of the hospital services market in the greater Toledo area. *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 498 (1974). Here, careful review of the extensive record developed through eight weeks of trial reveals how Complaint Counsel failed to prove that its joinder with St. Luke’s will enable ProMedica to raise rates above competitive levels for a prolonged period of time. For example, it is undisputed that Complaint Counsel’s economic expert, Professor Robert J. Town, did not analyze the effects of the joinder in the same relevant markets as those alleged in the Complaint. (RPF 1486-1514). Instead, Professor Town applied techniques never before used in a hospital merger case to gerrymander the scope of services to examine *his* relevant markets, which differ substantially from general acute-care inpatient hospital services, which is the market the FTC, the Department of Justice and the federal courts have analyzed in “all modern hospital merger cases.” *Compare* (RPF 1486-1514) *with In re Evanston Nw. Healthcare Corp.*, No. 9315, 2007 FTC LEXIS 210, at \*148 (F.T.C. Aug. 6, 2007) (citing *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995)); *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1211-12 (11th Cir. 1991); *United States v. Rockford*

*Mem'l Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 138-40 (E.D.N.Y. 1997); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290-91 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997)). The result of Professor Town's manipulations is to inflate artificially St. Luke's competitive significance and to fail to analyze properly the competitive effects that will result from the joinder.

In addition, Complaint Counsel and their economic expert focus myopically on rates for general acute-care inpatient services and inpatient OB services when it is undisputed that MCOs and hospitals do not negotiate prices for those services separately or in a vacuum. Instead, the evidence shows that MCOs and hospitals negotiate holistically over the total reimbursement at stake for all services that MCOs demand from hospitals, including inpatient, outpatient, physician, diagnostic, and other services. (RPF 585-587, 1070-1082, 1083, *in camera*). Unsurprisingly, MCOs and hospitals negotiate across this entire bundle of services, trading increases in inpatient rates for decreases in the rates for other services, for example. (RPF 585-587, 1070-1082, 1083, *in camera*). Other factors are relevant to the complex set of rates MCOs and hospitals or health systems negotiate, including the hospital's cost of providing the services, the quality of care it delivers, and a myriad of other compensation and non-compensation factors. (RPF 585-587, 1084-1090, 1091-1093, *in camera*, 1094-1095, 1096, *in camera*). However, Professor Town's novel and flawed economic model that purports to predict the price increase that will result from this joinder fails to capture any of these real world influences on MCO and hospital rates. (RPF 1097-1104). And, correcting Professor Town's model for even some of these deficiencies reveals a price effect on general acute care inpatient services that may not differ from *zero*. (RPF 1564-1580). Moreover, those few corrections to Professor Town's model that generate a zero price effect are those that economists *employed by the FTC* have

previously identified in peer-reviewed economic literature as important to consider when attempting to model the effects of a hospital merger. (RPF 1581). Remarkably, Professor Town provided no separate estimate of the joinder's purported price effect for his inpatient OB services market (though he admitted that he had data available to estimate it). (RPF 1610-1611). Thus, the economic evidence that Complaint Counsel have advanced does not prove with the "reasonable probability" required that the joinder will harm competition in either of its alleged markets. *Tenet Health Care*, 186 F.3d at 1051 ("Section 7 deals in probabilities, not ephemeral possibilities.").

Complaint Counsel premise their theory of harm on unilateral effects; that is, that the joinder will provide ProMedica itself the ability to raise prices above competitive levels for a prolonged period of time. Compl. ¶¶ 23-33. But this unilateral effects theory depends on the closeness of competition between the two merging parties. United States Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines*, § 6.1 (2010). In Toledo, however, it is undisputed that {

} view

ProMedica and Mercy Health Partners ("Mercy"), another multi-hospital system in the area that mirrors ProMedica in number of hospitals, services, and locations, as each other's closest or next-best competitor. (RPF 1106-1107, *in camera*, 1108-1109, 1110, *in camera*, 1111, 1112, *in camera*, 1113-1118, 1119, *in camera*, 1120-1122, 1123, *in camera*, 1124). {

} views ProMedica and St. Luke's as each other's closest competitor. (RPF 1106-1107, *in camera*, 1108-1109, 1110, *in camera*, 1111, 1112, *in camera*, 1113-1118, 1119, *in camera*, 1120-1122, 1123, *in camera*, 1124).

In addition, the record reveals the existence of other, significant and undisputed market facts that undermine and refute Complaint Counsel's theory of harm. For example, substantial

excess hospital capacity exists in the Toledo area. (RPF 1237-1244). The significance of this substantial excess capacity cannot be understated, because it historically enabled MCOs successfully to exclude hospitals, including ProMedica and St. Luke's, from their hospital networks and still serve their members. (RPF 709-728). Prospectively, the joinder of St. Luke's and ProMedica will not eliminate this opportunity, and the continued existence of excess hospital capacity, coupled with a declining economic environment that makes Toledo a no- or low-growth region, will motivate the hospitals in Toledo to compete aggressively to participate in MCO networks and to garner patient referrals. The record also revealed that doctors in the Toledo area commonly hold admitting privileges and practice at multiple competing hospitals. (RPF 1204-1205). This means that patients can switch hospitals without changing doctors, if they prefer to use another hospital or if their MCO either creates an incentive to do so or requires it to receive benefits. The record further revealed that employers have already taken steps to provide their employees with financial incentives to use certain hospitals over others. (RPF 1272-1273, 1274-1276, *in camera*, 1277, 1278-1284, *in camera*, 1285, 1286-1290, *in camera*, 1291, 1292-1293, *in camera*, 1294-1305, 1306, *in camera*, 1307-1315). These market conditions show that competitors, MCOs, employers, and patients all have the means to defeat any attempt by ProMedica to raise its or St. Luke's prices above competitive levels. These same facts establish that Complaint Counsel have not carried their burden of proving that the challenged joinder will enable ProMedica to charge supra-competitive rates.

In addition to examining the market-specific facts when evaluating the likely effects of a transaction, the Court also must consider St. Luke's likely competitive significance in the absence of the transaction. *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004) (analyzing acquired entity's financial condition as part of competitive effects analysis). Here

too, Complaint Counsel have failed to prove that absent the joinder St. Luke's would have continued to be a significant competitor. Prior to the joinder, St. Luke's financial condition was abysmal and worsening, in absolute terms and relative to that of its competitors. (RPF 1612-1625, 1626-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644). And, because {

} St. Luke's had little potential to financially improve its performance. (RPF 1792, *in camera*, 1793, 1794-1804, *in camera*, 1823-1826, 1827, *in camera*, 1828, 1829-1842, *in camera*). Indeed, in lieu of an affiliation, St. Luke's considered eliminating money-losing, but core hospital services, including {

} (RPF 1962, 1963-1965, *in camera*). The theory advanced by Complaint Counsel – that St. Luke's financial condition in the months just prior to the closing of the joinder was improving and that St. Luke's could have survived as an independent community hospital – was contradicted by St. Luke's own documents, testimony from its executives and board members, documents and testimony from independent third parties, like its credit rating agency and bond insurer, and by expert financial analysis.

As the court in *Arch Coal* noted, “weak competitive status remains relevant to an examination of whether substantial anticompetitive effects are likely from a transaction.” *FTC v. Arch Coal*, 329 F. Supp. 2d 109 (D.D.C. 2004). Here, St. Luke's poor financial condition meant that it would be unable to invest in the significant capital projects it needed to compete in the future. For example, St. Luke's {

} (RPF 1979, *in camera*). St. Luke's also could not afford to invest in private patient rooms and the information technology (“IT”) needed to achieve “meaningful use” of electronic

health records (“EHR”) as required by healthcare reform legislation. Today, private patient rooms represent the standard of care because they aid in improving quality by reducing the risk of infection, for example, and increase patient satisfaction. (RPF 815-818). But, St. Luke’s lags its Toledo area competitors by having a very low proportion of private rooms. (RPF 2222). Worse, because of its financial condition, St. Luke’s lacked the capital needed to add more private rooms, even though its Toledo area competitors had done so in recent years. (*Compare* RPF 1756 with RPF 172, *in camera*, 206-207, 1197-1201). Likewise, although St. Luke’s budgeted funds to install the IT upgrades needed to achieve “meaningful use,” it could not allocate any actual funds to pursue the project. (RPF 1733). In sum, the evidence of St. Luke’s financial difficulties demonstrates that absent the joinder, St. Luke’s competitive influence would continue to wane, not wax, as Complaint Counsel would have the Court believe.

Although the joinder occurred only a year ago, St. Luke’s and the community it serves have already begun experiencing benefits as part of ProMedica that they would not have experienced otherwise. For example, ProMedica has infused St. Luke’s with badly needed capital to address its neglected capital needs. (RPF 2115, 2116, *in camera*, 2117, 2118-2119, *in camera*). Also, with the FTC’s approval, ProMedica and St. Luke’s have {

} at St. Luke’s so it no longer needs to divert ambulances away from its emergency room for a lack of available beds. (RPF 2225-2231, *in camera*, 2232). This is just one example of the type of beneficial clinical integration that ProMedica and St. Luke’s plan to accomplish together, in addition to {

} (RPF 2137-2139, 2140, *in camera*).

The trial record exposes Complaint Counsel's failure to meet their burden of showing by a preponderance of the evidence that the joinder of St. Luke's and ProMedica is reasonably likely to lead to a substantial lessening of competition by allowing ProMedica to raise rates to supracompetitive levels. An analysis of the "structure, history, and probable future" of the markets at issue in this case compels dismissal of the Complaint. *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 498 (1974). Moreover, to grant Complaint Counsel the divestiture they seek would reverse the benefits St. Luke's and the community have already begun experiencing and prevent the likelihood of further community benefits by consigning St. Luke's to its distressed and deteriorating pre-joinder state. For these reasons, the Court should dismiss the Complaint and deny Complaint Counsel's prayer for relief in its entirety.

## II. FACTUAL BACKGROUND

To evaluate the joinder at issue and its potential competitive effects requires an understanding both of how hospitals offer their services to MCOs and employers and the demographics of the geographic area – Toledo in Lucas County, Ohio – where ProMedica Health System and St. Luke's Hospital compete.

### A. Hospital Services

Hospitals in Lucas County compete with each other on the scope and level of services they offer and the quality of care they provide to patients. (RPF 1). Hospitals provide services on both an inpatient and outpatient basis. Both inpatient and outpatient services encompass a wide range of procedures with varying levels of intensity or complexity. (RPF 3, 18, 31-33). Inpatient services, however, require a patient's admission to the hospital for a period of 24 hours or more. (RPF 2).

1. Inpatient Hospital Services

- a. Primary, Secondary, Tertiary, and Quaternary Services

Inpatient services are commonly classified as one of four categories of service – primary, secondary, tertiary, or quaternary – based upon the level of complexity or acuity of service provided. (RPF 3-7). Primary services are routine services that treat conditions of mild to moderate severity that occur regularly in the community, like hernias, gallbladders, and inpatient pediatrics. (RPF 4). Secondary services are more complex than primary services and may require specialized training or resources. (RPF 5). Examples include complex orthopedic surgery, bariatric services, and many emergency room procedures. (RPF 5). Tertiary services are even more complex, invasive, and specialized than primary and secondary services. (RPF 6). Examples of tertiary services include complex electrophysiology, burn units, or neurological intensive care. (RPF 7). Quaternary services include the most complex procedures like organ transplants. (RPF 10). Higher level tertiary and quaternary services typically require specialized technology and additional resources and, as a result, they typically cost more for hospitals to provide than less complex services. (RPF 6, 10-11). Hospitals that offer tertiary and quaternary services can and do provide lower-intensity services as well. (RPF 8-9).

No brightline demarcation exists between the four levels of inpatient services. (RPF 3, 12). In addition, as treatment methods and technology improve over time, more complex procedures may be performed in lower intensity settings. (McGinty, Tr. 1186-1187). For example, highly specialized procedures that once required tertiary facilities may come to be performed in community hospitals, and procedures previously classified as primary or secondary services requiring inpatient admission are now increasingly done on an outpatient basis. (RPF 41; McGinty, Tr. 1186-1187).

## b. Obstetrical Services

Obstetrical ("OB") services are provided on both an inpatient and outpatient basis. (RPF 13). Inpatient OB services include services related to childbirth, recovery, and some immediate postpartum services, but do not include care for the baby once it is delivered. (RPF 14, 18).

Inpatient OB services are also categorized by their complexity. (RPF 19). Level I services are services related to uncomplicated, low-risk deliveries. (RPF 20). Level II services correspond to more complicated deliveries and babies needing ventilation for up to 24 hours. (RPF 21). Level III inpatient OB services correspond to the most complicated deliveries and babies that require ventilation for an extended period of time. (RPF 23). Hospitals providing Level III OB services must have specialized staff, doctors, and facilities, including a neonatal intensive care unit. (RPF 24). Hospitals that offer more complex OB services also provide basic Level I OB services. (RPF 25).

Level III hospitals draw patients for various reasons. Physicians will typically direct a patient to a Level III hospital if he or she knows that a pregnancy is high-risk or that complications may arise. (RPF 29). Some patients also choose to receive care in a Level III facility because of the peace of mind they gain by using a more specialized facility. (RPF 47). A patient who presents at a Level I facility and develops complications during labor may have to be transferred to a higher-level facility prior to delivery or her baby may be transferred immediately after delivery. (RPF 28).

## 2. Outpatient Hospital Services

Outpatient services range from common diagnostic services (*e.g.*, laboratory and radiology services) and therapeutic services (*e.g.*, physical and respiratory therapy) to more complex services (*e.g.*, general medical-surgical procedures that do not require overnight admission) and specialized care (*e.g.*, oncology, wound care, or sleep studies). (RPF 31-32).

Gynecological care and OB services other than actual childbirth, recovery, and immediate postpartum services are generally delivered on an outpatient basis. (RPF 17, 33). These services may include office visits and ultrasound or lab tests. (RPF 17).

Outpatient services, which already constitute the largest part of a hospital's business, continue to grow in volume. (RPF 35, 40, *in camera*, 42). In fact, hospitals anticipate a reduction of the inpatient population by up to 40% within the next ten years. (RPF 42). This growth in outpatient services is due, in part, to technological advances that no longer require hospital admission for some conditions. (RPF 41). In addition, health insurance companies exercise significant influence over whether hospitals treat patients on an inpatient or outpatient basis, with strict rules governing who hospitals may classify as an inpatient. (RPF 40).

## B. The Toledo Area

### 1. Demographics

Toledo's population is aging and is not forecast to grow in the near future. (RPF 57). This negatively impacts the healthcare industry in Lucas County in two ways. First, an increasing number of residents are being covered by Medicare as opposed to commercial health insurance. (RPF 58, 60, 247). Medicare reimbursement rates, however, do not cover a hospital's costs of providing services to its patients. (RPF 250). Second, the OB population in the Toledo metropolitan area is projected to decline consistently in the next five to ten years, resulting in a decreased need for OB services. (RPF 59).

### 2. Economic Conditions

Joblessness is a significant economic problem in Toledo. Between 2001 and the recession of 2008, the unemployment rate in Toledo never rose above 8 percent. (RPF 62). During the 2008 recession, however, unemployment soared above 13 percent, and by 2011, had only improved to 9.5 percent. (RPF 63). Toledo's high unemployment rates resulted from an

exodus of employers from the city, which has led to a decline in patients covered by commercial health insurance. (RPF 61).

### 3. Travel Times

Travel in the Toledo area is rapid and easy. Hospitals in Lucas County are all located conveniently to patients, with short drive times to and between any hospitals in Toledo. (RPF 1210). In fact, patients frequently travel to more distant hospitals than the one closest to their home. (RPF 218, 1217-1218). For example, in several of St. Luke's closest zip codes, St. Luke's did not attract the majority of patients seeking general acute care inpatient services. (RPF 227, 230, 235). Even within St. Luke's home zip code, St. Luke's was unable to attract the majority of patients seeking general acute care inpatient services. (RPF 223-224).

Patients admitted to St. Luke's would face no significant additional travel time to go to a different hospital. (RPF 1210). In fact, for approximately half of all of St. Luke's patients, another hospital was located closer than St. Luke's; for them driving to an alternative hospital would actually reduce their travel time. (RPF 239, 1213). For other patients, travel time would increase by a few additional minutes, but in no case by more than seventeen minutes. (RPF 240, 1214).

### C. The Parties

#### 1. ProMedica Health System, Inc.

ProMedica is a nonprofit, integrated healthcare delivery system in northwestern Ohio and southeastern Michigan, consisting of hospitals, a physician group, and an insurance company. (RPF 64, 66). ProMedica has a total of eleven hospitals in Ohio and Michigan, four of which are located in Lucas County, Ohio: The Toledo Hospital ("TTH"), Toledo Children's Hospital, Flower Hospital ("Flower"), and Bay Park Community Hospital ("Bay Park"). (RPF 68, 71).

TTH, ProMedica's flagship hospital, provides high-end tertiary level care along with general primary and secondary acute care hospital services. (RPF 72-73). TTH also houses a Level I trauma center, and is one of only two Lucas County hospitals to offer Level III inpatient OB services. (RPF 73-74). Although registered for 769 beds, TTH only has 660 beds in use. (RPF 75). In 2009, TTH had 32,000 discharges across all payors (including commercially-insured, Medicare, Medicaid, and charity care patients) and \$1.3 billion in billed charges. (RPF 75, 78).

Flower is a full service community hospital located in Sylvania, Ohio, and has been a member of ProMedica since 1995. (RPF 79, 88). Flower offers general acute care services, general medical-surgical, Level I inpatient OB services, outpatient radiation and chemotherapy, and post-acute services such as a rehab center and an Alzheimer's center. (RPF 80-81). Although registered for 292 beds, Flower only has 257 beds in use. (RPF 82). In 2009, Flower had 11,655 discharges across all payors and \$315.8 million in billed charges. (RPF 82). Flower is located in the northwest quadrant of Sylvania, placing it close to the Michigan border. (RPF 83).

Bay Park, which ProMedica opened in 2000, is a full service community hospital in Oregon, Ohio, located approximately 40 minutes from Flower, and 20 minutes from TTH. (RPF 84, 86). Bay Park offers Level I inpatient OB services, and has 86 registered and staffed beds. (RPF 85, 87). In 2009, it had 4,000 discharges across all payors and \$113 million in billed charges. (RPF 87).

ProMedica recently constructed an orthopedic satellite hospital, known as Wildwood Medical Center ("Wildwood"). (RPF 89). Wildwood will offer dedicated orthopedics and orthopedic surgeons, podiatrists, spine surgeons, and neurosurgeons when it opens in October,

2011. (RPF 89, 91). Wildwood is located approximately 15-20 minutes from both Flower and TTH. (RPF 90).

a. ProMedica Physicians Group

ProMedica employs approximately 330 physicians through its ProMedica Physicians Group (“PPG”). (RPF 93). Although it is not profitable – ProMedica loses over \$10 million each year on its physician practices – ProMedica continues to employ physicians because it views employed physicians as an important part of a traditional integrated delivery system and believes physician employment is essential to the retention of its medical staff. (RPF 96-99). PPG is a multi-specialty group, with approximately half of its physicians practicing in primary care, and half practicing in specialty care. (RPF 95).

b. Paramount Healthcare

The ProMedica Insurance Corporation, known by its trade name, Paramount Healthcare (“Paramount”), is a health plan owned by ProMedica that provides health insurance to local employers and members in northwest Ohio and southeastern Michigan. (RPF 100, 343, 348). TTH and St. Vincent Medical Center (“St. Vincent”) formed Paramount as a joint venture because they wanted to ensure that the discounted prices healthcare providers were giving to MCOs were passed on to local employers. (RPF 101, 103-104). When St. Vincent wanted to be bought out, ProMedica obliged and continued to operate Paramount as its sole owner. (RPF 102).

Paramount offers a range of health insurance products, including: a traditional health maintenance organization (“HMO”), a preferred provider organization (“PPO”), and a point-of-service (“POS”) product. (RPF 109). Paramount’s major MCO competitors in Lucas County include Medical Mutual of Ohio (“MMO”), Anthem Blue Cross Blue Shield (“Anthem”), UnitedHealth Care (“United”), CIGNA, Aetna, and others. (RPF 110). Although Paramount is

one of the largest MCOs in Lucas County, its membership is not large enough to support the financial needs of the entire ProMedica provider system. (RPF 112).

Paramount's hospital provider network is also narrower than its competitors' networks. Compared to its competitors in Lucas County, Paramount's hospital provider network is the smallest and does not include the Mercy hospitals. (RPF 314-315). Paramount's physician network, however, is on par with the networks of its Lucas County competitors. (RPF 320). Approximately 80 percent of the physician providers in Paramount's network are independent (that is, they are not employed by a hospital or health system). (RPF 322). Paramount also contracts with physicians employed by hospitals that are not in Paramount's hospital provider network. (RPF 323). For example, although Mercy is not an in-network hospital provider for Paramount, Paramount contracts with approximately 40 of Mercy's 125 employed physicians. (RPF 173, 324). Paramount also contracted with St. Luke's employed physicians when St. Luke's was not a Paramount hospital provider. (RPF 325).

## 2. St. Luke's Hospital

St. Luke's, which has 315 registered beds, but staffs only 214, is a single-campus community hospital located in Maumee, Ohio, {

} (RPF 119, 2204, *in camera*). St. Luke's offers a variety of inpatient and outpatient services, including emergency, medical-surgical, intensive care, and imaging services. (RPF 121). St. Luke's offers Level I OB services only, and delivered approximately 600 babies a year over the past ten years. (RPF 122, 131). In 2009, St. Luke's had 10,600 discharges across all payors, and \$200 million in billed charges. (RPF 119). In total, St. Luke's has approximately 1900 employees, 1500 of whom are full-time equivalent employees. (RPF 123).

Although St. Luke's draws most of its patients from the zip codes closest to the hospital, it treats a substantial number of patients from outside of Lucas County, including nearby Wood,

Fulton, and Henry Counties. (RPF 128). Prior to its joinder with ProMedica, St. Luke's major competitors were the University of Toledo Medical Center ("UTMC"), Mercy, ProMedica, Wood County Hospital ("WCH"), Fulton County Health Center ("FCHC"), and Blanchard Valley Hospital. (RPF 132).

a. St. Luke's Lost Millions of Dollars on Its Operations for Each Year from 2007 through August 31, 2010

St. Luke's and its parent, OhioCare, each experienced large operating losses for several consecutive years preceding the joinder. (RPF 1616-1617). St. Luke's suffered operating losses of \$7.6 million in 2007, \$8.8 million in 2008, \$15.1 million in 2009, and \$2.7 million in the first eight months of 2010. (RPF 1617). These losses resulted in negative operating margins of -5.8 percent in 2007, -6.5 percent in 2008, -10.3 percent in 2009, and -2.6 percent for the first eight months of 2010. (RPF 1617). St. Luke's operating performance from 2007 through 2010 was significantly below that of other Ohio hospitals, similarly-sized urban, nonprofit hospitals, and hospitals with Moody's bond ratings comparable to St. Luke's. (RPF 1618-1620). Even St. Luke's "EBITDA" margin (earnings before interest, taxes, depreciation, and amortization) – which does not reflect a hospital's true cash flow because it does not consider capital expenditures – was significantly below the EBITDA margin of comparably Moody's-rated hospitals for the years 2007 through 2009. (RPF 1623, 1627).

St. Luke's funded its losses by dipping into its reserve fund, which is only supposed to be used for emergency cash needs that arise outside of normal operations. (RPF 1634-1635). Consequently, St. Luke's unrestricted reserves had decreased by over 50 percent, from \$92.4 million in 2007 to \$46.1 million at the time of the joinder. (RPF 1641).

b. St. Luke's Received Below-Cost Reimbursement Rates from Its Largest MCOs

In the fall of 2009, St. Luke's learned that its inpatient commercial insurance rates were approximately { } (RPF 1789-1790, *in camera*). That prompted St. Luke's to approach its two largest MCOs, { } to renegotiate its contracts in order to cover the cost of care it was providing to their insureds. (RPF 1792, 1802, 1839-1841, *in camera*).

As of August 31, 2010, { } comprised more than { } of St. Luke's net revenue and more than { } of its commercial revenue. (RPF 1792, *in camera*). { } members alone made up { } of St. Luke's net revenue. (RPF 1794, *in camera*). Because { } paid St. Luke's the lowest rates of any of St. Luke's MCOs, however, its reimbursement rates did not even cover St. Luke's cost of treating { } patients. (RPF 1795-1796, *in camera*). St. Luke's average loss for each { } was: { }

{ } (RPF 1797, *in camera*).

In 2009, St. Luke's informed { } that its reimbursement rates were below its cost of delivering care to { } insureds, and proposed to renegotiate its contract. (RPF 1802, *in camera*). In response, { } offered a { } increase on January 1, 2010, another { } increase on July 1, 2010, a { } increase on January 1, 2011, and an additional escalator on January 2, 2012. (RPF 1812, *in camera*). { } counterproposal also included a bonus formula that, if achieved, would result in a { } rate increase after the first full year for St. Luke's. (RPF 1814, *in camera*). Although St. Luke's agreed to { } counterproposal, these rates never went into effect because { } required St. Luke's to obtain

similar increases from its other major MCOs, which St. Luke's was not able to do. (RPF 1816-1819, *in camera*).

St. Luke's 2009 negotiations with { } similarly stalled. { } rejected St. Luke's initial request for higher rates, noting that their contract did not expire until { } (RPF 1841, *in camera*). In January, 2010, St. Luke's notified { } but needed {

{ } (RPF 1843, 1847-1848, *in camera*). Without accepting St. Luke's proposal, { } requested the opportunity to administer St. Luke's employee health benefit plan. (RPF 1857, *in camera*). When St. Luke's rejected that proposal, { } notified St. Luke's that it would not renegotiate rates. (RPF 1858-1859, *in camera*).

In contrast to its efforts with { } St. Luke's successfully negotiated a contract amendment with { } in 2009 for new inpatient and outpatient rates, among other provisions. (RPF 1872-1876, *in camera*). This 2009 contract yielded an estimated { } for St. Luke's of approximately { }; that is, St. Luke's reimbursement would not only exceed its costs of treating { } insureds, it also should yield a positive margin to contribute to shortfalls generated by its treatment of government insureds and charity care patients. (RPF 1876, *in camera*).

c. In Lieu of a Joinder, St. Luke's Considered Deep Service Cuts and Layoffs

In August 2009, St. Luke's management communicated to its board that to remain independent, it would need to { } (RPF 1963, *in camera*). Specifically, St. Luke's would have had to eliminate major unprofitable service lines, such as its {

}, and  
downsize other parts of the organization by { } (RPF  
1964, *in camera*). If forced to make these cuts, St. Luke's could no longer fulfill its mission to  
serve the community; however, if St. Luke's did not make significant changes, including cutting  
services, it would only be able to survive as an independent hospital for another {  
} (RPF 1969, 1971, *in camera*).

d. Independent Assessments by Moody's and Ambac Confirmed St.  
Luke's Deteriorated/Distressed Financial Condition

In November 2008, Moody's downgraded St. Luke's Series 2004 revenue bonds by two  
grades, from "A2" to "Baa1." (RPF 1981). Just sixteen months later, Moody's further  
downgraded St. Luke's bonds from "Baa1" to "Baa2," one step above junk status, citing St.  
Luke's "third consecutive year of large operating losses." (RPF 1983-1986). Moody's also  
noted St. Luke's "unfavorable commercial contracts and ongoing challenges with negotiating  
higher commercial reimbursement rates" and the "very competitive market with the presence of  
a number of hospitals that are part of two larger and financially stronger systems." (RPF 1987-  
1988).

AMBAC, St. Luke's bond insurer, also downgraded St. Luke's credit after completing a  
credit analysis of St. Luke's bonds in late 2008 and early 2009. (RPF 977, 1995). That credit  
analysis evaluated Moody's and S&P's ratings for St. Luke's bonds, as well as three years of  
financial metrics including admissions, net patient service revenue, operating margin, EBITDA  
margin, and debt coverage. (RPF 1996). In its analysis, AMBAC noted that St. Luke's  
{

} (RPF 1997-1998, *in*

camera). Despite St. Luke's { } EBITDA margin and days cash on hand, AMBAC put St. Luke's rating on a downward trend. (RPF 1999-2000, *in camera*).

D. Other Hospitals Located in Lucas County, Ohio

1. Mercy Health Partners

Mercy is a not-for-profit hospital system that is part of Catholic Health Partners, which has hospitals in five states and is headquartered in Cincinnati, Ohio. (RPF 138-139, 142).

Mercy is a financially-strong system that shares a bond rating with Catholic Health Partners of A1 from Moody's and AA- from Standard and Poor's. (RPF 141).

Mercy operates three hospitals in the Toledo area: St. Vincent; St. Anne; and St. Charles. (RPF 143). St. Vincent is a large, tertiary facility with eight intensive care units, a Level I trauma center, a Level III OB unit, and a large cardiology service known as the Regional Heart and Vascular Center. (RPF 145). A children's hospital is also located on St. Vincent's campus. (RPF 153). St. Vincent's staffs 445 of its 568 registered beds. (RPF 148). St. Anne is a general medical-surgical hospital that offers primary and secondary services. (RPF 154). St. Anne staffs approximately 70 of its 120 registered beds. (RPF 155). St. Anne had offered inpatient OB services when it opened in 2002, but discontinued them in 2008 because it was not performing enough deliveries to maintain quality standards or to break-even financially. (RPF 156). Prior to closing, St. Anne delivered about 400 babies a year, 400-500 fewer than Mercy estimated a hospital needed to deliver annually to break-even financially. (RPF 157). St. Charles is a general medical-surgical hospital that offers primary and secondary services, as well as psychiatry, rehabilitation, and a Level II NICU. (RPF 162). St. Charles staffs about 264 of its 390 registered beds. (RPF 163).

Each of Mercy's hospitals is located close to a ProMedica hospital. (RPF 144). St. Vincent is located in downtown Toledo, near TTH. (RPF 150, 152). St. Anne is located in

western Toledo, near Flower. (RPF 154, 160). St. Charles is located in eastern Toledo and is less than a mile from Bay Park. (RPF 161). Mercy's three Toledo-area hospitals overlap with ProMedica's Toledo-area hospitals in terms of services offered and geographic area served. (RPF 166).

{

}

(RPF 169, *in camera*). In 2007, Mercy opened its Regional Heart and Vascular Center at St. Vincent. (RPF 172). That project cost Mercy about \$59 million and added about 75 private rooms to St. Vincent. (RPF 172). In addition, the system was { }, and Mercy is currently making extensive renovations at St. Vincent to add more private beds. (RPF 165, 170, *in camera*).

## 2. University of Toledo Medical Center

UTMC is a state-owned facility and the only academic medical center in the Toledo-area. (RPF 176). UTMC's academic mission differentiates it from the other hospitals in Lucas County. (RPF 179). It offers primary, secondary, tertiary, and quaternary services, including specialized care in cardiology, neurology, orthopedics, cancer, surgery, trauma, and transplants. (RPF 178, 180). UTMC staffs about 226 of its 319 beds. (RPF 181). UTMC treats patients from Lucas County, Wood County, and Bowling Green, and competes with hospitals in Cleveland and Michigan. (RPF 190-191, 193). Many of UTMC's employees are unionized. (RPF 195). In the past few years, UTMC has completed a facility modernization project that renovated heart and vascular space and created a new outpatient orthopedics center, renovated its emergency department, and opened a new 22-bed intensive care unit, at a total cost of more than \$13 million. (RPF 1200-1203). In addition, UTMC's board recently approved a \$25 million project

to create private rooms, implement electronic health records, improve outpatient care, and construct a cancer center. (RPF 1197).

E. Health Insurers

1. Government Health Insurers

Medicare, which is administered by the federal government, provides health insurance coverage to persons over age sixty-five; Medicaid is a health insurance program administered by the states. (RPF 245-246). Unlike commercial MCOs, the two government payors do not “negotiate” with individual hospital providers. (RPF 249). The Centers for Medicare and Medicaid Services (“CMS”) establish the reimbursement rates for inpatient and outpatient hospital and physician services, and participating providers must accept the rates CMS sets. (RPF 249).

The rates set by CMS do not cover a hospital’s total cost to provide services to Medicare and Medicaid patients. (RPF 250-251). The reimbursement rates paid by Medicare and Medicaid have been in decline since 2000. (RPF 478). As of 2009, Medicare and Medicaid reimbursed hospitals at a rate of 89 to 90 cents on the dollar of cost incurred, even though, in Toledo, Government-insured patients represent an increasing percentage of the hospitals’ admissions (only about 29 percent of Lucas County hospital patients have commercial insurance). (RPF 58, 60, 251).

2. MCOs

Hospitals must make up the shortfall from Medicare and Medicaid reimbursements with payments from MCOs. (RPF 252-253, 475). Hospitals in Lucas County contract with several large regional and national MCOs as well as some local companies. (RPF 257). The largest MCOs operating in Lucas County, in addition to Paramount, are MMO, Anthem, Aetna, FrontPath, and United. (RPF 257, 263-264, 283, 336, 377).

a. MMO

MMO is a large, successful, and diversified mutual insurance company operating in 17 states. (RPF 258-259). MMO primarily markets its health insurance products – HMO, PPO, and POS health insurance plans – to fully- and self-insured employer groups. (RPF 261, 265). In Ohio alone, MMO's health insurance products cover 1.4 million lives and, in Lucas County, it insures about 100,000 people, representing about 25 percent of the market. (RPF 263-264).

MMO's hospital provider network currently includes all Lucas County hospitals. (RPF 268). Mercy, UTMC, and St. Luke's hospitals have all participated in MMO's provider network for more than a decade, while ProMedica only joined the network in 2008. (RPF 269-272). Prior to 2008, MMO successfully marketed a hospital provider network that excluded ProMedica. (RPF 718-720).

b. Anthem

WellPoint, the largest health benefits company in the United States, with 33.3 million insured members and \$57 billion in revenue in 2010, and a licensee of the Blue Cross/Blue Shield Association, markets its health insurance products in Ohio under the name Anthem. (RPF 275-278). Anthem thus shares the most recognized brand name in healthcare as well as access to Blue Cross/Blue Shield's national BlueCard network program, which are factors it uses to its advantage in dealings with hospitals and employers. (RPF 300-303). In Lucas County, Anthem markets its PPO product to a wide variety of fully- and self-insured companies. (RPF 281-282). It is one of the three largest MCOs in Lucas County. (RPF 283).

All Lucas County hospitals currently participate in Anthem's hospital provider network. (RPF 291). ProMedica has been in Anthem's network for many years. (RPF 292). UTMC joined Anthem's network in 2003 or 2004, while St. Luke's participated in Anthem's network through 2004 and then again, beginning in July 2009. (RPF 294-297). Mercy rejoined Anthem's

network in 2008. (RPF 293). From 2005 to 2008, when Anthem had only ProMedica and UTMC in its network, it successfully competed with other health insurance companies, who, except for Paramount, all had Mercy in their network. (RPF 726-728).

c. Aetna

Aetna is a large, successful, national health insurance company that reported profits of { } (RPF 370-371, *in camera*). Aetna primarily markets its products to large national employers like IBM that have employees in Lucas County. (RPF 378-379). It offers fully- and self-insured employers three types of commercial health insurance products, including HMO, Managed Choice, and PPO plans. (RPF 373-374). Aetna insures millions of people nationwide; in Ohio, it has between 750,000 and 1,000,000 commercially insured members, 30,000 of whom live in Lucas County. (RPF 376-377).

Aetna's national brand image is an advantage in its provider network negotiations. (RPF 394-395). Hospitals like to identify themselves as an Aetna provider, and Aetna's network has included all Lucas County hospitals since at least 2006. (RPF 390). Aetna's membership has remained steady over the years; it did not benefit from its unique position as one of the only MCOs to offer a broad provider network prior to 2008. (RPF 392).

d. FrontPath

FrontPath is a membership organization governed and managed by its "sponsors," which include corporations, labor organizations and public entities. (RPF 328). FrontPath operates in northwest Ohio, southeast Michigan, and northeast Indiana. (RPF 330). It offers its sponsors both a newly-developed fully-insured product, and a more established self-insured PPO product. (RPF 337). FrontPath has approximately 80,000 covered lives in Lucas County. (RPF 336). All Lucas County hospitals participate in FrontPath's provider network. (RPF 343).

e. United

United is a large, national insurance company active throughout the United States. (RPF 349-350). Nationwide, United markets a variety of health insurance products; in Lucas County, however, it mainly offers PPO products. (RPF 350-351). While United has one million commercial members in Ohio, it has only 15,000 in Lucas County. (RPF 352-353).

United is another MCO that benefits from a strong national brand image. (RPF 366-368). It currently has all Lucas County hospitals in its provider network but it has changed its network composition over time. (RPF 358). ProMedica participated in United's network through 2005, when United replaced ProMedica with Mercy. (RPF 359). ProMedica rejoined United's network in the fall of 2010. (RPF 360). { } began participating in United's network in 2008. (RPF 362, *in camera*). Throughout all these changes to its network composition, United's membership has remained steady. (RPF 363-364).

f. Humana

Humana is a large, diversified, national healthcare company that reported revenues of \$33.2 billion in 2010. (RPF 396-397). Humana offers a self- and fully-insured PPO product in Lucas County. (RPF 403). Humana has just 2,000 commercially insured members in Lucas County, a number that has been in decline in recent years. (RPF 405, 806).

Humana's hospital provider network currently includes all Lucas County hospitals, although the company believes the future of healthcare will be focused on narrower networks of efficient, high-quality hospitals. (RPF 413, 415). Despite Humana's offer of a broad network when other MCOs focused on narrow networks, Humana did not experience any growth in its membership. (RPF 416).

F. Employers

1. Employee Health Insurance Benefits

When employers offer health insurance benefits to their employees, they rely on MCOs to negotiate with healthcare providers and develop a provider network to service their employees. (RPF 459-460). Often, employers will use consultants to solicit and evaluate health plans and assist in negotiating with MCOs to create a benefit design that meets the employer's needs for cost and network access. (RPF 461-462).

Employers consider a variety of factors when deciding which type of health plan to select, but cost and benefit design are the most important. (RPF 435, 439-440). The MCO's hospital network is not a primary consideration because only six percent of commercially-insured members go to a hospital in any given year. (RPF 441). The location and proximity of an MCO's in-network hospitals are also factors, but less important in Toledo, where all hospitals are within 25 minutes of each other. (RPF 442).

Employers may offer their employees a choice of health plan products, including products from different MCOs. (RPF 417, 420). When an employer offers multiple plans or networks, the employer may price the options at different premium levels. (RPF 421).

2. Self-Insured vs. Fully-Insured Employers

Employers that contract with health plans are either fully-insured or self-insured by the MCO. With fully-insured health insurance products, MCOs charge a fixed premium for a set period of time. (RPF 422). The premium covers all administrative and medical expenses associated with the employer's benefit design. (RPF 425). Irrespective of whether an employer is fully- or self-insured, however, the evidence shows that approximately 90% of an employer's total healthcare cost goes to pay provider medical claims, of which approximately 30% are for physician services, 30% are for outpatient services, 25% are for inpatient hospital services, and

15% for prescription drug expenses. (RPF 427). The rest represents profit to the MCO (for fully-insured products) or the cost of administering a self-insured employer's plan.

For fully-insured employers, the risk that its employees' healthcare expenses may exceed the premiums collected is borne by the MCO, not the employer. (RPF 423). With fully-insured plans, an employer does not immediately feel an increase in a provider's reimbursement rates because the employer's premiums remain the same for the term of the contract and can only increase at the time of a policy renewal. (RPF 444-446).

Self-insured, or self-funded, employers, on the other hand, bear the risk that their employees' healthcare expenses exceed the cost estimated for them. (RPF 428-429). Self-insured employers gain access to the provider network and discounted prices negotiated by MCOs and typically fund an account that the MCO draws upon to pay the self-insured employer's employees' healthcare expenses. (RPF 430). Though some self-insured employers administer the claims themselves, most pay a fee to a third party administrator ("TPA"), typically an MCO, to handle claims and other administrative functions (including developing the provider network). (RPF 434).

#### G. Competitive Landscape and Dynamics of Inpatient Hospital Services

##### 1. Negotiations between Hospitals and MCOs

MCOs – both the large, well-known, national brands and the less familiar regional companies – enter negotiations with Lucas County hospitals with the aim of adding the hospital to the provider networks that they market to employers. (RPF 1082). In these negotiations, both parties seek to get the best rates they can achieve. (RPF 1063). MCOs wish to stay competitive with one another and offer the best possible rates to their customers. (RPF 267, 357). MCOs are sophisticated negotiators with access to a wealth of information, including the utilization history and pattern of their insureds, the hospitals that are in their competitors' networks, hospitals'

costs, and the approximate rates that their competitors have obtained from each Lucas County hospital. (RPF 588-595).

Negotiations are complex and can drag on for many months as both sides haggle over a myriad of contract terms and provisions. (RPF 1064). Although provider participation agreements between hospitals and MCOs typically last for three to five years and may renew automatically thereafter, the parties can and do engage in “off-cycle” negotiations to respond to changes in the marketplace. (RPF 1065-1067).

MCOs and hospitals bargain over a wide variety of compensation and non-compensation related terms in their negotiations. (RPF 1070). With respect to rates, the parties negotiate rates simultaneously for numerous hospital inpatient and outpatient services, all for the range of products offered by the MCO. (RPF 1071-1072, 1077, 1079-1080). The parties also will negotiate payment outlier and payment escalator clauses. (RPF 1086). In those negotiations, MCOs may seek trade-offs from a hospital system that reduce rates at one hospital in exchange for rate increases at other hospitals. (RPF 1095). Similarly, a hospital might seek higher outpatient rates in exchange for a lower DRG-base rate for inpatient services. (RPF 1081).

Reimbursement methodologies are another key compensation-related issue in negotiations. (RPF 538, 568, 1078). MCOs believe that hospitals prefer contracts based on a percent-of-charge methodology; MCOs prefer fixed-price contracts. (RPF 582). Most negotiations will result in contracts that provide – as ProMedica’s contracts do – for some mix of fixed and percent-of-charge reimbursement methodologies. (RPF 583-584).

MCOs often demand that hospitals accept so-called most-favored-nation (“MFN”) clauses to participate in their networks. (RPF 600-602). A MFN clause prohibits a hospital provider who has agreed to rates with one MCO from agreeing to lower rates with competing

MCOs unless they also extend the same rates to the first MCO. (RPF 596). Many Lucas County MCO contracts, including contracts that bind ProMedica and St. Luke's, contain MFN clauses. (RPF 600-603). The State of Ohio has enacted a moratorium against MFN clauses. (RPF 606).

Non-compensation terms are also a critical part of negotiations and may affect the total compensation an MCO pays to a hospital. (RPF 1084). Examples of important, negotiated non-compensated related terms are contract length and termination provisions, audit rights, and the definition of "medical necessity," to name a few. (RPF 1086). In addition, MCOs and hospitals bargain about issues outside the scope of the contract – such as whether the MCO can administer the hospital's health plan, whether the MCO will be allowed to use a particular third-party administrator for its network, or whether other hospitals in the hospital's statewide system will participate in one of the MCO's products. (RPF 1087, 1088, 1094, 1096).

Ultimately, MCOs approach the contracting process with a global perspective. (RPF 1082). They negotiate all the elements of a contract in conjunction with one another as part of a package that relates to total healthcare expenditure or compensation for the MCO's covered lives. (RPF 1071, 1082). Thus, the parties do not simply negotiate an inpatient rate in isolation, but discuss the inpatient rate in relation to outpatient rates and other terms, such as outlier thresholds and the payment methodology for outlier cases. (RPF 1078-1079, 1081, 1084). The parties make numerous trade-offs between and among a wide range of compensation-related provisions and non-compensation contract terms. (RPF 1089). The goal, and most common result, is to reach an agreement that is mutually acceptable to both parties. (RPF 614).

## 2. Hospital Capacity and Utilization

Lucas County has excess hospital inpatient bed capacity. Because the number of staffed beds in Lucas County exceeds the demand for them, Lucas County hospitals have the capacity to accommodate additional patients. (RPF 659-660).

Hospitals in Lucas County can also accommodate additional patients by staffing beds that are currently not in use or converting beds from one type of use (e.g., rehab or geriatric psychiatry), to another. (RPF 672). That is faster, easier, and less costly than building a new hospital or expanding existing facilities. (RPF 666).

### 3. Physician Privileges

Most physicians in Lucas County, including obstetricians, have staff privileges at multiple hospitals. (RPF 674-675). Even physicians who are employed by a particular hospital are credentialed and admit patients at competing hospitals. (RPF 677).

Physicians choose to maintain privileges at multiple hospitals for various business-related reasons. (RPF 679-680). Having privileges at more than one hospital, for example, helps ensure access to the medical and surgical facilities physicians need to treat their patients. (RPF 679). Many physicians practice at multiple hospitals to provide coverage for their partners. (RPF 679-680). Additionally, physicians may also serve more patients in the community when they maintain privileges at multiple hospitals. (RPF 684).

Most importantly, patients benefit when physicians maintain privileges at several hospitals. Because admitting privileges allow a physician to see patients, prescribe medications, and perform procedures at a hospital, a physician who can practice at several hospitals is better able to respond to patient preferences and direct commercially-insured patients to in-network hospitals for treatment to minimize the patient's out-of-pocket expenses. (RPF 680-683). Finally, the patients of physicians who have privileges at multiple hospitals are less likely to have to change physicians if the patient's MCO eliminates a hospital or system from its provider network. (RPF 683).

#### 4. History of Limited Networks

With the exception of Paramount, all of the largest MCOs operating in Lucas County currently have all Lucas County hospitals in their provider networks. (RPF 268, 291, 358, 709-717, 779). So-called “open” hospital networks have not been the norm in Lucas County during the past decade. (RPF 709-717, 1252). Rather, one or more of the largest MCOs has offered a limited network of hospitals. (RPF 709-714). MMO, for example, had all hospitals except ProMedica in its network between 2000 and 2008. (RPF 709-714). Anthem, by contrast, only included ProMedica and UTMC in its network from 2005 to 2008. (RPF 712-714, 725). United included St. Luke’s and ProMedica in its network through 2005, when United replaced ProMedica with Mercy. (RPF 359, 713). { } joined United’s network in 2008. (RPF 362, *in camera*, 793). Through that entire period – and until St. Luke’s joined ProMedica – Paramount offered a limited hospital network composed of only ProMedica and UTMC. (RPF 709-716, 782).

Limited networks in Lucas County resulted in lower hospital rates due, in part, to volume discounting. (RPF 730, *in camera*, 731, *in camera*, 732, *in camera*). In Lucas County, Anthem and MMO received discounted rates from ProMedica and Mercy, respectively, because their exclusive relationships prior to 2008 offered the hospitals the promise of a greater volume of each MCO’s members. (RPF 730, *in camera*, 731, *in camera*, 732, *in camera*, 1253). Some broad-network MCOs also leveraged the large MCO’s use of narrow networks to obtain their own discounted rates. { }, for example, parlayed Mercy and ProMedica’s fears that { } would align exclusively with the other system if they refused { } demand for significant rate discounts. (RPF 1257, *in camera*).

Despite changes in MCO hospital provider network configurations, membership levels among the MCOs have generally remained constant. (RPF 719, 728, 256). There was little shift

in membership when MCOs that offered narrow hospital networks, like MMO and Anthem, opened their hospital provider networks to additional providers. (RPF 721-722, 729). Similarly, there is no evidence that MCOs that offered broad provider networks, like Aetna, Humana, and FrontPath, derived any competitive benefit over their competitors with limited networks. Indeed, no broad-network MCO experienced any significant growth in membership from 2005 through 2010; Humana's membership actually declined. (RPF 392, 416, 802, 805-806, 808, 1256).

5. Industry Trends

a. Private Rooms

Private rooms are more efficient operationally and increase patient satisfaction compared to semi-private rooms. (RPF 815-816). Because patients of different sexes cannot share a room, the use of semi-private rooms also forces hospitals to shift patients from room to room to maximize occupancy. (RPF 817). And there are clinical reasons for hospitals to convert to private rooms – they help control and prevent the spread of infection. (RPF 815). Finally, patients prefer private over semi-private rooms. (RPF 818).

b. Healthcare Reform

The HITECH Act, passed in 2009, promises increased Medicare reimbursement to hospitals that implement and upgrade their EHR systems to meet statutory “meaningful use” requirements by certain deadlines. (RPF 1709). Hospitals that meet the “meaningful use” requirements by 2013 will receive additional Medicare reimbursements; those that fail to do so by 2015 will face penalties in the form of reduced Medicare reimbursements. (RPF 1716).

H. The Joinder

1. Rationale

a. ProMedica's Rationale for the Joinder

{

} (RPF 903, *in*

*camera*). ProMedica's initial discussions with St. Luke's revolved around a potential heart and vascular service line joint venture, as well as an IT joint venture. (RPF 904-905). However, both executives quickly realized that the issues St. Luke's faced could only be addressed by a joinder. (RPF 906).

ProMedica believed a joinder with St. Luke's would result in an increase in quality, service, and access in certain clinical service lines. (RPF 944). ProMedica also considered St. Luke's an attractive joinder partner because of its location and the commonality of services offered by both entities. (RPF 946). ProMedica ultimately decided to pursue the joinder with St. Luke's {

} (RPF 942, *in*

*camera*, 943, *in camera*).

Notably, at no time during its consideration or discussion about the joinder did ProMedica discuss the potential for increasing MCO rates at St. Luke's (or ProMedica). (RPF 948). Nor did ProMedica's board consider {

} when it decided to pursue the joinder. (RPF 947, *in camera*, 949, *in camera*).

b. St. Luke's Rationale for the Joinder

St. Luke's sought a joinder partner that would allow it to remain a viable, full-service hospital that could continue to serve the community. St. Luke's started evaluating joinder

partners because it was losing money and faced large capital expenditures for the conversion of rooms to private rooms and a new EMR system. (RPF 926, 1617, 1630, 1643, *in camera*, 1724, 1728, 1729, *in camera*, 1751-1752, 1961, 2105). The financial pillar of St. Luke's three-year plan was not working – the hospital continued to incur large losses up to the joinder. (RPF 1941-1949). {

} (RPF 1964, *in camera*, 1969, *in camera*). In addition, St. Luke's recognized that healthcare reform would place additional financial pressure on St. Luke's by shifting more risk to providers and reducing Medicare and Medicaid reimbursements. (RPF 478-479, 1716, 1737, 1961).

St. Luke's management and board considered thirteen factors in evaluating potential joinder partners:

{

}

(RPF 820, *in camera*). Of those, St. Luke's board focused primarily on {

} (RPF 821, *in camera*). St. Luke's initially looked at hospital systems outside of Toledo including The Cleveland Clinic, the University of Michigan Health System, and McLaren Healthcare Corp., but narrowed its focus to hospitals in Toledo because local governance and ties to the community were important criteria for St. Luke's board. (RPF 827-835).

{ } was one of the thirteen criteria on which St. Luke's evaluated potential partners, but it was not the most important. (RPF 820, *in camera*, 823, *in camera*). St. Luke's was concerned about reimbursement rates because its operational losses were tied to the low reimbursement rates it was receiving from its MCOs. (RPF 1787). However, St. Luke's believed that {

} (Wakeman, Tr. 2946, *in camera*). As a result, St. Luke's board did not focus most on {

} (RPF 823, *in camera*). Further, ProMedica and St. Luke's { } (RPF 949-950, *in camera*).

Although St. Luke's explored affiliating with Mercy or UTMC, St. Luke's management and board identified serious drawbacks to partnering with either entity. St. Luke's and UTMC talked for at least eight months, but could not reach an agreement due to concerns regarding potential governance, cultural compatibility, and financial support. (RPF 863, 873, 875). With respect to governance for example, St. Luke's could not accept UTMC's proposal to maintain full veto power over decisions of the combined board and plan to emphasize the University brand for the combined entity. (RPF 859, 846). St. Luke's also believed that culturally, UTMC's focus on academics, insistence that the teaching hospital ethos prevail, and {

} would cause conflict. (RPF 846, 858, 872, *in camera*, 875).

Finally, St. Luke's was concerned that UTMC would not provide the capital that St. Luke's needed to be competitive. Specifically, St. Luke's was concerned that UTMC faced possible cuts in its state funding and reduced enrollment as a result of the economic downturn. (RPF 860). St. Luke's board was also concerned that UTMC, as a subsidized public institution, would not be sufficiently financially savvy. (RPF 871).

St. Luke's concerns with an affiliation with Mercy also related to disagreements regarding governance and cultural incompatibility. A key reason that St. Luke's chose not to move forward with {

} (RPF 899, *in camera*). St. Luke's also expected that Mercy would move to a { } (RPF 1109). The other major drawback to a Mercy affiliation for St. Luke's was {

} (RPF 898, *in camera*). { } became a significant issue with St. Luke's board. (RPF 898, *in camera*).

In contrast, St. Luke's did not have the governance or cultural concerns with ProMedica that it had with UTMC and Mercy. St. Luke's management had {

} (RPF 937, *in camera*). { } (RPF 938, *in camera*). {

} (RPF 918, *in camera*). {

} (RPF 912, *in*

*camera*).

Importantly, ProMedica was local and offered St. Luke's {  
(RPF 937, *in camera*). St. Luke's board noted that the {

} and

considered a joinder with ProMedica the best way for St. Luke's to maintain its community  
focus. (RPF 911, *in camera*, 937, *in camera*).

Moreover, ProMedica offered St. Luke's the financial resources it needed to remain  
viable. ProMedica offered St. Luke's the {

} (RPF 915, *in camera*, 924, *in camera*). {

} (RPF 915-916, *in*

*camera*). Also, ProMedica was {

} (RPF 915, *in camera*, 937, *in camera*). {

} (RPF 914, *in*

*camera*, 937, *in camera*).

2. Post-joinder MCO contracting by ProMedica for St. Luke's

{

} (RPF 1351, *in camera*, 1366, *in camera*, 1397, *in camera*, 1405, *in*

*camera*). {

} (RPF 1351, *in*

*camera*). Under the conditions of the Hold Separate Agreement between ProMedica and the

FTC, {

} (RPF 1376, *in camera*,

1388, *in camera*, 1400, *in camera*). In spite of the Hold Separate Agreement provision, {

} (RPF 1376,

*in camera*, 1401, *in camera*).

For example, ProMedica and { } engaged in negotiations in {

} to enter into a new contract for St. Luke's after the expiration of St. Luke's

existing contract { }. (RPF 1364, 1366, *in camera*). In February 2011,

ProMedica and { } reached a mutually acceptable agreement to keep St. Luke's as an in-

network hospital provider for { }. (RPF 1383, *in camera*, 1387). The new contract is

expected to increase St. Luke's payments by { }

which is less than the { } that St. Luke's independently negotiated with

{ } but was unable to implement, prior to the joinder. (RPF 1384, *in camera*).

ProMedica also negotiated a new contract for St. Luke's with { }

(RPF 1397, *in camera*). Like { } ProMedica notified {

} (RPF 1400, *in camera*). { } nevertheless opted to negotiate a new contract for St.

Luke's with ProMedica. (RPF 1401, *in camera*). As a result of these negotiations, { }

agreed to a contract that increased St. Luke's rates by {

} (RPF 1399, *in camera*).

ProMedica has not reached agreement on any new contracts for St. Luke's with any other

MCOs. { } and ProMedica began discussions in { } but those discussions

did not lead to a new contract. (RPF 1405, *in camera*). { } contract was evergreen and

not set to expire; {

} (RPF 1404, *in camera*, 1415, *in camera*).

ProMedica initially sought { } views on changes { } might accept regarding St.

Luke's contract and made a proposal that was consistent with { } response – {

} (RPF

1406-1409, *in camera*). { } rejected ProMedica's request, but has since suggested its willingness to negotiate new inpatient rates for St. Luke's in the context of a broader discussion that encompasses outpatient fee schedules, rate concessions at other ProMedica hospitals and other contract provisions. (RPF 1410, *in camera*, 1418-1419, *in camera*).

3. ProMedica Obligations to St. Luke's

a. Commitment To Preserve St. Luke's as General Acute Care Community Hospital

The Joinder Agreement commits ProMedica to "maintain [St. Luke's] using its current name and identity and at its current location for a minimum of ten (10) years . . . as a fully operational acute care hospital providing for the following services: emergency room, ambulatory surgery, inpatient surgery, OB, inpatient nursing and a CLIA certified laboratory." (RPF 993).

b. Capital commitment

ProMedica committed to contributing \$5 million to St. Luke's Foundation at closing and another \$30 million to St. Luke's over three years, to be dedicated to capital projects {

996, 997, *in camera*).

4. Additional Pro-Competitive and Community Benefits Resulting From The Joinder

St. Luke's and the community that it serves have already begun experiencing benefits from the joinder that they would otherwise have not experienced. For example, at closing, ProMedica brought St. Luke's into its Obligated Group. (RPF 2131). As a result, AMBAC granted a waiver of St. Luke's prior default on its bonds and Moody's upgraded St. Luke's bond rating. (RPF 2132-2133).

Moreover, the joinder has allowed St. Luke's to reduce some of its costs. For example, St. Luke's was not large enough to fund a captive insurance plan or be a part of a captive insurance plan on its own. (RPF 2137). Following the joinder, though, St. Luke's saved about \$500,000 in malpractice insurance from becoming part of ProMedica's captive insurance company. (RPF 2138). Additionally, moving St. Luke's into ProMedica's captive insurance company had the effect of freeing up over \$8 million in cash previously reserved for potential claims on St. Luke's balance sheet. (RPF 2139). {

}

(RPF 2140, *in camera*).

Importantly, St. Luke's employees have also experienced additional benefits as a result of the joinder. Since the joinder, ProMedica has helped fund contributions to St. Luke's pension plan. (RPF 2134). Becoming part of ProMedica has also improved St. Luke's employee morale as employees feel more secure being part of a financially stable organization. (RPF 2258). In fact, St. Luke's employees received a one percent pay increase on January 1, 2011. (RPF 2259).

St. Luke's employees received a second one percent pay increase in July 2011. (RPF 2259). Similarly, in June 2011, all employees received a one-time financial thank-you. (RPF 2260). Full-time employees received \$200; part-time employees received \$100; and contingent employees received \$25. (RPF 2260). Through ProMedica's partnership with the University of Toledo, all full-time employees will receive free tuition to any undergraduate or graduate program. (RPF 2266). Part-time employees will receive 50 percent tuition. (RPF 2266). St. Luke's also improved its cash-on-hand after payroll from \$1.6 million at the time of the joinder to a current total of between \$3 and \$7 million. (RPF 2267).

Employment conditions for St. Luke's nursing staff have also improved. In the past, as its patient volumes increased before the joinder, St. Luke's was forced to place many of the nursing staff on mandatory call. (RPF 2261). Mandatory call means a nurse was on call beyond their normal hours of work and in most cases being on call meant that the nurses were called in and required to work overtime. (RPF 2262). But, being part of ProMedica enables St. Luke's to tap into the ProMedica staffing pool to help ramp up staffing at its facilities. (RPF 2263). As a result, St. Luke's has been able to use ProMedica's nurse staffing pool and reduce the number of units that have mandatory call duty. (RPF 2263).

As a standalone entity, {

} (RPF 2128, *in camera*). All of that changed as a result of the joinder.

### III. ARGUMENT

#### A. Complaint Counsel Must Demonstrate that the Joinder of ProMedica and St. Luke's Will Likely Result in a Substantial Lessening of Competition in the Relevant Market by Enabling ProMedica To Raise Rates above Competitive Levels

The Complaint alleges that the joinder between ProMedica and St. Luke's violated Clayton Act Section 7. That statute only prohibits an entity from acquiring "the whole or any part" of a business' stock or assets when the effect of the acquisition "may be *substantially* to lessen competition, or tend to create a monopoly." *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1109 (N.D. Cal. 2004) (citing 15 U.S.C. § 18 (emphasis added)). To succeed under Clayton Act Section 7, Complaint Counsel must prove: (1) the product market in which to assess the transaction, (2) the geographic market in which to assess the transaction, and (3) the transaction's probable effect on competition in a properly defined relevant market. *FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1072 (D.D.C. 1997). Complaint Counsel must prove each of these elements by a preponderance of the evidence. *See Oracle*, 331 F. Supp. 2d at 1109.

To establish anticompetitive effects, Complaint Counsel must show more than some likely impact on competition. Instead, Complaint Counsel "ha[ve] the burden of showing that the acquisition is reasonably likely to have 'demonstrable and substantial anticompetitive effects.'" *New York v. Kraft Gen. Foods, Inc.*, 926 F. Supp. 321, 358 (S.D.N.Y. 1995) (quoting *United States v. Atl. Richfield Co.*, 297 F. Supp. 1061, 1066 (S.D.N.Y. 1969)). "[E]phemeral possibilities" of anticompetitive effects are not sufficient. *United States v. Marine Bancorp., Inc.*, 418 U.S. 602, 623 (1974); *see also FTC v. Tenet Health Care, Inc.*, 186 F.3d 1045, 1051 (8th Cir. 1999). Rather, 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

Section 7. A 'mere possibility' will not suffice." *Long Island Jewish*, 983 F. Supp. at 136-37 (citing *Fruehauf Corp. v. FTC*, 603 F.2d 345, 351 (2d Cir. 1979)).

When the FTC argues, as it does in this case, that the parties' market shares and the overall market concentration, create a presumption that the transaction is anticompetitive, a defendant may rebut that presumption of illegality by showing "that the market share statistics give an inaccurate account of the merger's probable effects on competition in the relevant market." *Oracle*, 331 F. Supp. 2d at 1110. Rebuttal evidence may also include factors relating to competition in the relevant market or the competitive or financial weakness of the acquired company. *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 985 (D.C. Cir. 1990). If the defendant successfully rebuts the presumption, then the burden shifts back to the government to produce "additional evidence of anticompetitive effects." *Oracle*, 331 F. Supp. 2d at 1110. At all times, however, the ultimate burden of persuasion remains with the government. *Baker Hughes*, 908 F.2d at 983.

Complaint Counsel have failed to prove that ProMedica's joinder with St. Luke's has the potential for "creating, enhancing, or facilitating" ProMedica's ability to raise prices above competitive levels for a significant period of time or that competition has, in fact, been substantially lessened since the joinder occurred in September 2010. *See Long Island Jewish Med. Ctr.*, 983 F. Supp. at 136. Complaint Counsel's case is speculative – it believes ProMedica will raise St. Luke's and ProMedica's rates for general acute care inpatient and OB services. But Complaint Counsel's speculation is insufficient to sustain a violation of Clayton Act Section 7. Complaint Counsel must show that the joinder will enable (or has enabled) ProMedica to increase rates to *supracompetitive* levels. *See Long Island Jewish Med. Ctr.*, 983 F. Supp. at 135 (the test is whether the merged entity will increase prices "above competitive levels"); *see also*

*Rockford Mem'l Corp.*, 898 F.2d at 1282-83 (Section 7 forbids mergers that make it easier for firms to “price above or farther above the competitive level”).

B. The Only Relevant Product Market in Which To Analyze the Effects of the Joinder is General Acute Care Inpatient Services Available to Commercially Insured Patients

Complaint Counsel “bear[] the burden of proof and persuasion in defining the relevant market.” *United States v. SunGard Data Sys.*, 172 F. Supp. 2d 172, 182-83 (D.D.C. 2001); see also *FTC v. Lundbeck, Inc.*, No. 10-3458, slip op. at 4 (8th Cir. Aug. 19, 2011). If Complaint Counsel cannot properly define a relevant market, their case fails. *Long Island Jewish*, 983 F. Supp. at 140; *Bathke v. Casey’s Gen. Stores, Inc.*, 64 F.3d 340, 345 (8th Cir. 1995) (“Antitrust claims often rise or fall on the definition of the relevant market.”).

A relevant market consists of “products that have reasonable interchangeability for the purposes for which they are produced – price, use and qualities considered.” *United States v. E.I. Du Pont de Nemours Co.*, 351 U.S. 377, 404 (1956). Products are reasonably interchangeable if consumers treat them as “acceptable substitutes.” *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 46 (D.D.C. 1998). A relevant “product” may consist of a “cluster” of products, even if the individual products within the cluster are not substitutes between themselves. See, e.g., *Staples*, 970 F. Supp. at 1074; *JBL Enters., Inc. v. Jhirmack Enters., Inc.*, 698 F.2d 1011, 1016 (9th Cir. 1983). See also IIB Phillip Areeda & Herbert Hovenkamp, *Antitrust Law* ¶ 565 (3d ed. 1977). As the *Staples* court found, even though the individual pens, paper and disks that made up the basket of “consumable office supplies” were not substitutes for each other, customer purchasing patterns confirmed a particular consumer demand for this set of goods as sold by office superstores. 970 F. Supp. at 1078.

In hospital merger cases, federal courts, the FTC, and the DOJ have agreed that the proper market in which to analyze the competitive effects of a hospital merger is the market for

general “acute inpatient hospital services.” See *In re Evanston*, 2007 FTC LEXIS 210 at \*148.<sup>2</sup> This case is no different. The “consumers” Complaint Counsel are concerned about are MCOs who purchase hospital services to re-sell as part of health plans or networks that they offer to employers and others. MCOs purchase inpatient services (primary, secondary and tertiary) from hospital providers together in a single negotiated transaction. (RPF 585, 1010). On the other hand, outpatient and quaternary services are often contracted for separately, making them inappropriate to include in the relevant product market. (RPF 1013). Accordingly, the relevant market here is for general acute care inpatient hospital services.

The Complaint, however, alleges that in addition to a “general acute care inpatient services” market, there is a separate relevant market for inpatient OB services. Compl. ¶¶ 12, 14. Although Complaint Counsel bear the burden of proving the existence of a market for OB services, there is a total failure of proof in support of this claim. See *SunGard Data Sys.*, 172 F. Supp. at 182-83 (“The burden . . . is squarely on plaintiffs to establish that [inpatient obstetrics services] is a separate relevant market.”); see also *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 122 (D.D.C. 2004); *Long Island Jewish*, 983 F. Supp. at 140; *Oracle*, 331 F. Supp. 2d at 1172.

There is no legal support for carving inpatient OB services out of the cluster market of general acute inpatient services. No hospital merger case has recognized inpatient OB services as a separate relevant product market; inpatient OB services always have been included in the general acute care inpatient services market. (RPF 1027). There is no reason to abandon that precedent in this case. Complaint Counsel’s assertion that inpatient OB services constitute a separate “market” because no other inpatient hospital services can substitute for them is equally applicable to inpatient cardiac surgery, inpatient knee surgery and inpatient gastro-intestinal

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<sup>2</sup> See also *Freeman Hosp.*, 69 F.3d at 268; *Rockford Mem’l Corp.*, 898 F.2d at 1284; *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 138-40; *Butterworth Health Corp.*, 946 F. Supp. at 1290-91.

services, but Complaint Counsel do not allege those services constitute separate “markets.” That would totally defeat the purpose of alleging that all general acute care inpatient services constitute a “cluster” market. See *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1119 (N.D. Cal. 2001) (explaining that “[w]hile the treatments offered to patients within this cluster of services are not substitutes for one another (for example, one cannot substitute a tonsillectomy for heart bypass surgery), the services and resources that hospitals provide tend to be similar across a wide range of primary, secondary, and tertiary inpatient services. Accordingly, courts have consistently recognized the cluster of services comprising acute inpatient services as the appropriate product market in hospital merger cases.”).

Nor is there any basis in fact to recognize a separate market for inpatient OB services. Negotiations between hospital providers and MCOs for inpatient services cover the full range of services that a MCO’s members may need, including inpatient OB services. (RPF 1020). No MCOs testified that they negotiated separate rates for OB, but instead testified that they negotiate for the full scope of inpatient services. (RPF 1010, 1021, 1025, 1071-1072). In addition, contracts with prominent MCOs do not {

} (RPF 1026, *in camera*). For example, { } agreement with ProMedica does not carve out OB rates from general acute inpatient care rates for any ProMedica hospital. (RPF 1026, *in camera*). More importantly, there is no evidence that hospitals can price-discriminate for inpatient OB services because inpatient OB services are provided in conjunction with other services, and the terms and conditions on which they are negotiated are very similar. (RPF 1021, 1025).

Respondent agrees with all of the previous hospital merger cases that have held that a relevant product market in which to analyze the competitive effects of a hospital merger, like the

joinder of ProMedica and St. Luke's, is general acute care inpatient services, including inpatient OB services. Complaint Counsel have failed to prove, however, that a separate relevant product market exists for inpatient OB services. Accordingly, the Court should dismiss the Complaint's allegations that the joinder violated Clayton Act Section 7 as to the alleged inpatient OB services market.

C. The Proper Relevant Geographic Market in which To Analyze the Effects of the Joinder is the Area Served by Hospitals Located in Lucas County, Ohio

Complaint Counsel also have the burden of proving the relevant geographic market by a preponderance of the evidence. *United States v. Conn. Nat'l Bank*, 418 U.S. 656, 669 (1974); *SunGard Data Sys.*, 172 F. Supp. 2d at 182-83. To meet that burden, Complaint Counsel must present evidence on "where consumers of hospital services could practicably turn for alternative services should the merger be consummated and prices become anticompetitive." *Tenet*, 186 F.3d at 1052. The relevant geographic market must "correspond to the commercial realities of the industry and be economically significant." *Brown Shoe v. United States*, 370 U.S. 294, 336-37 (1962). Therefore, to sustain their burden, Complaint Counsel must present evidence of "where consumers could practicably go, not on where they actually go." *Tenet*, 186 F.3d at 1052; *Freeman Hosp.*, 69 F.3d at 268. Here, Complaint Counsel and Respondent agree that the proper relevant geographic market is defined on the basis of the hospitals' locations – in this case, Toledo in Lucas County, Ohio – because that is where the service is provided. (RPF 1028-1030).

D. Complaint Counsel Have Not Met Their Burden of Demonstrating that the Joinder of ProMedica and St. Luke's Will Provide ProMedica the Ability To Raise Rates above Competitive Levels in Either Alleged Relevant Market

Even assuming that Complaint Counsel met their burden of properly defining a relevant market, Complaint Counsel have not proved a Clayton Act Section 7 violation because they have

not shown that, as a result of the joinder, there is a “reasonable probability” of a substantial lessening of competition in the future for general acute care inpatient services, or inpatient OB services, in Lucas County. See *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 135. ProMedica has rebutted the presumption that high market shares will enhance its market power, shifting the burden back to Complaint Counsel to present additional evidence of anticompetitive effects. See *Oracle*, 331 F. Supp. 2d at 1110. Complaint Counsel have failed to meet that burden because they have not presented evidence that the joinder will enable ProMedica to raise prices to supracompetitive levels in the alleged relevant markets.

1. ProMedica Has Rebutted the Presumption of Anticompetitive Effects, to the Extent that It Applies at All, Because Market Concentration Statistics Do Not Accurately Portray Competitive Dynamics

Complaint Counsel rely on historical market shares to suggest that St. Luke’s joinder with ProMedica will likely substantially lessen competition. But the calculation of market shares and market concentration is just the start, not the end, of the analysis of whether a transaction is likely to substantially lessen competition. *FTC v. CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 46 (D.D.C. 2009). The Supreme Court has cautioned that “statistics concerning market share and concentration are ‘not conclusive indicators of anticompetitive effects.’” *Arch Coal*, 329 F. Supp. 2d at 130 (citing *Gen. Dynamics*, 415 U.S. at 498). Courts recognize that “determining the existence or threat of anticompetitive effects has not stopped at a calculation of market shares” and, therefore, “[a] finding of market shares and consideration of [the presumption created by market shares] should not end the court’s inquiry.” *Oracle*, 331 F. Supp. 2d at 1111; see also *Baker Hughes*, 908 F.2d at 992 (noting, “The Herfindahl-Hirschman Index cannot guarantee litigation victories”). Rather, the court must also examine the “structure, history, and probable future” of the market to determine whether market shares are indicative of likely anticompetitive effects from the joinder. *Gen. Dynamics Corp.*, 415 U.S. at 498.

Relying solely on market shares to analyze competitive effects is “especially problematic” when the transaction involves differentiated products, such as inpatient general acute care services. *Oracle*, 331 F. Supp. 2d at 1122; *see also Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1410-12 (7th Cir. 1995) (stating it is “always treacherous to try to infer monopoly power from a high rate of return” in a market of differentiated products because “the difference may reflect a higher quality more costly to provide”).<sup>3</sup> Particularly with differentiated products, there is no automatic correlation between market share and price. *See Blue Cross & Blue Shield United of Wis.*, 65 F.3d at 1410-12. Where, as here, market shares are not an accurate predictor of future competitive effects, they are no substitute for a rigorous analysis of actual market dynamics. *See* 908 F.2d at 983-85.

The record evidence of the market realities rebuts the presumption that high market shares may cause anticompetitive effects post-joinder. As an initial matter, Complaint Counsel have manipulated market share statistics to improperly inflate St. Luke’s significance and the existence of their alleged inpatient OB market. But a review of the “structure, history and probable future” of the general acute care inpatient services market in Lucas County establish that market shares should not be construed to reflect the power to obtain supracompetitive prices. *See United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 498 (1974). Specifically, the real world negotiating dynamics between MCOs and hospitals, the fact that ProMedica and St. Luke’s are not each other’s closest substitutes (ProMedica and Mercy are), and the short distances and travel times between hospitals in the Toledo area, all demonstrate that market share

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<sup>3</sup> The FTC’s own economists agree. *See* Deborah Haas-Wilson & Christopher Garmon, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18 Int’l J. of the Econ. of Bus. 17, 22 (2011). *See also* Timothy J. Muris (Former Chairman, Federal Trade Commission), Symposium: *Improving the Economic Foundations of Competition Policy*, 12 Geo. Mason L. Rev. 1, 28 (2003) (“Most real world markets, even those for relatively ‘homogenous’ products, and a market structure inconsistent with significant market power exhibit significant price variation. These price differences do not prove that the firms have market power.”).

statistics, viewed in isolation, belie the notion that the joinder will enable ProMedica to raise prices above competitive levels.

- a. Complaint Counsel's market concentration statistics improperly inflate St. Luke's competitive significance

Complaint Counsel's dogged reliance on ProMedica's and St. Luke's claimed market shares to argue that the joinder is presumptively anticompetitive is misplaced for several reasons. First, their economic expert has manipulated the market definitions to artificially inflate St. Luke's share of the alleged product markets. Second, MCOs view St. Luke's as an inconsequential competitor. Third, St. Luke's deteriorating financial position suggests that it would have been unable to sustain its already small market share prospectively.

To compute his market shares, Professor Town discarded Complaint Counsel's alleged product market of "general acute care inpatient services" (Compl. ¶ 12) and, instead, created his own. Professor Town began by limiting his "market" to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that *both* ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). Professor Town included, however, some DRGS with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services that were excluded from the Complaint's market definition. (RPF 1500).

Similarly, Professor Town's definition of his separate inpatient OB services market does not comport with the Complaint's definition. (RPF 1501-1503). For example, Professor Town again limits his "market" to only those inpatient OB DRGs that both ProMedica and St. Luke's offer and excludes higher case weight DRGs for which there was outmigration, even though the Complaint contains no such exclusions. (RPF 1501).

Professor Town's methodology for defining both of his relevant product markets is based solely on the characteristics of hospital providers; it is supply-side analysis. That is contrary to the *Horizontal Merger Guidelines*, which provide that market definition should focus "solely on demand substitution factors." (RPF 1512, 1514; see *Horizontal Merger Guidelines*, § 4). Moreover, the product markets for which Professor Town calculates his market shares are derived from the rote application of numerical filters, which do not accurately reflect the scope of services Lucas County hospitals offer to MCOs and which MCOs contract to purchase. (RPF 1489-1510). There is no evidence to suggest that an MCO has ever attempted to negotiate with any Lucas County hospital provider for "all inpatient hospital services representing those DRGs performed three or more times by St. Luke's Hospital," or any similar variation of that definition. Complaint Counsel have no factual or legal basis to support Professor Town's market definitions, which bear no relationship to the contracts negotiated by MCOs and hospital providers. (RPF 1489-1490).

Additionally, Professor Town's constructed market definitions capture only about 30 percent of the total commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance.

(RPF 1489, 1490, 1504, 1510). This prevents Professor Town from correctly evaluating the dynamics of the Toledo area hospital market. (RPF 1510).

Because Professor Town's market definitions are flawed, his analysis of the market fails to account for much of the actual competition between ProMedica, Mercy and UTMC. The services that Professor Town ignores represent significant volumes of general acute care inpatient services for which MCOs actually negotiate provider contracts with ProMedica (and Mercy, UTMC, and even St. Luke's) to provide. (RPF 1489, 1490, 1504-1506, 1510). By ignoring these services, Complaint Counsel distort the competitive dynamics of the market. (RX-71(A) at 000016-000018).

When market shares are measured using billed charges, rather than patient days, to reflect the fact that many DRGs and service lines cost more, require longer stays and hence generate higher revenues, St. Luke's has only a 6-7 percent share of the general acute care inpatient services market, inclusive of inpatient OB services, for Lucas County.<sup>4</sup> (RX-71(A)-000036-000037, 162). Mercy and UTMC combined have a higher share than ProMedica in Lucas County. (RX-71(A) at 000036-000037, 000162). Looking only at inpatient OB services, St. Luke's share is only 3 percent based on billed charges in Lucas County. (RX-71(A) at 000036-000037). For all general acute care services, St. Luke's tends to have the lowest share of all hospitals in Lucas County based on billed charges. (RX-71(A)-000036-000037). In contrast, Professor Town improperly constructed market shares that inflated St. Luke's importance beyond its real world competitive significance. (RX-0071 at 000016-000017).

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<sup>4</sup> Professor Town's market share measure treats all stays of the same length of time the same even though costs and billed charges can differ for the same length of stay. Using patient days as he does distorts the difference in the acuity of service provided at the different hospitals, which tends to increase the significance of the relatively low-level, low-cost, low-risk services performed at St. Luke's. (RX-71(A) at 000016-000017, 000036-000037).

A manipulated market definition cannot be a basis for valid market share calculations. *See Oracle*, 331 F. Supp. 2d at 1171-72 (holding that a “gerrymandered” market definition means that market statistics based on that definition are equally flawed). Accordingly, Complaint Counsel’s market shares neither accurately reflect the competitive market dynamics nor can they serve as a predictor of future competitive effects. *See Baker Hughes*, 908 F.2d at 983-85.

To divert attention from St. Luke’s small share in either the general acute care inpatient services or inpatient OB services markets, Complaint Counsel focus on St. Luke’s share in its “core service area.” This, too distorts St. Luke’s competitive significance. (RPF 1036-1049). As Complaint Counsel’s economic expert agrees, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030). Moreover, there is no evidence that hospitals can or do price discriminate based on St. Luke’s core service area. (RPF 1029, 1513; Guerin-Calvert, Tr. 7248-7249; *see Horizontal Merger Guidelines*, § 4.2.2). Therefore, “market shares” based on that smaller geographic area are irrelevant to any analysis of St. Luke’s competitive significance.

MCOs perceive St. Luke’s to be the unimportant competitor in Lucas County that its properly calculated share reflects, and they treat it that way. *Oracle*, 331 F. Supp. 2d at 1167 (stating that “the most persuasive testimony from customers is not what they say in court, but what they do in the market”). No major MCO witness could attest to the number of its insureds who reside in or near St. Luke’s service area or quantify the number of their insured patients St. Luke’s admitted or discharged in a single year. (*See e.g.*, Pirc, Tr. 2302-2303; Pugliese, Tr. 1447; Radzialowski, Tr. 738). The only witness from an MCO that could even estimate the number of its insureds who were treated at St. Luke’s was Humana, which had fewer than 100

discharges *annually* (or less than one every three days) from St. Luke's. (RPF 405). And it is undisputed that MCOs paid lower reimbursement rates to St. Luke's than they paid ProMedica, Mercy or UTMC (RPF 1155), and {

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(RPF 1804-1819, *in camera* 1839-1876, *in camera*). If St. Luke's was as important to MCOs in Lucas County as Complaint Counsel suggest, they would have agreed to pay St. Luke's higher reimbursement rates, or at a minimum, rates that were at or near the market average. The undisputed facts are that St. Luke's received below market rates. (RPF 1364, 1785-1786, *in camera*, 1788-1791, *in camera*).

Analysis of the origin of St. Luke's patients provides additional confirmation of its competitive insignificance. ProMedica hospitals draw from almost exactly the same zip codes as their Mercy counterparts. (RPF 1117). On the other hand, St. Luke's has significantly less overlap with ProMedica hospitals' draw areas. (RPF 1118). Even within its own zip code, St. Luke's is unable to attract a majority of patients seeking general acute care inpatient services. (RPF 224). In fact, St. Luke's attracts only ten commercially insured patients per day. (RPF 1147). That means that only a small number of commercially-insured patients need to switch from St. Luke's to a competing hospital to defeat any attempt by ProMedica to increase St. Luke's prices to anticompetitive levels. *See Tenet*, 186 F.3d at 1054 (noting that "the switch to another provider by a small percentage of patients would constrain a price increase").

Finally, St. Luke's alleged market share must be discounted by its financial weakness, which, absent the joinder with ProMedica, would have limited its ability to continue to compete effectively in the market. The financial weakness of an acquired firm is relevant to the assessment of the competitive dynamics of a market. *See United States v. Int'l Harvester Co.*,

564 F.2d 769, 773-74 (7th Cir. 1997); *FTC v. Arch Coal*, 329 F. Supp. at 155-157; *Lektro-Vend Corp. v. Vendo Co.*, 660 F.2d 255, 275-76 (7th Cir. 1981). St. Luke's financial difficulties over the ten years preceding the joinder (and particularly the four years immediately prior to it) caused St. Luke's to significantly deplete its reserve funds and defer capital improvements it needed to more effectively compete against the other Lucas County hospitals.<sup>5</sup> (RPF 1641, *in camera*). For Complaint Counsel and their economic expert to assume that St. Luke's could compete in the future at its pre-joinder level, despite its financial shortcomings, overstates St. Luke's competitive significance. *See Baker Hughes*, 908 F.2d at 984; *Int'l Harvester*, 564 F.2d at 774 (holding that the defendants successfully rebutted the presumption of anticompetitive effects by establishing that if the acquired company did not have sufficient resources to compete effectively in the market, its acquisition would not substantially lessen competition). In sum, Complaint Counsel's market share analysis present an inaccurate account of the joinder's prospective effect on competition. *See Lektro-Vend*, 660 F.2d at 275-76.

b. Hospitals and MCOs Do Not Negotiate Rates for General Acute Care Inpatient Services or Inpatient OB Services in a Vacuum

Complaint Counsel's flawed market share analyses focus solely on general acute care inpatient services and inpatient OB services. But the negotiations between MCOs and hospital providers in Lucas County over the rates paid for inpatient hospital services do not occur in a vacuum – that is, in isolation from their negotiations for all other services the hospitals provide to an MCO's insureds. Rather, MCOs and hospitals negotiate both reimbursement rates and other non-compensation terms and conditions to reach agreement for a single contract that covers all services the hospital offers (inpatient, outpatient, physician, and ancillary) for a variety of products marketed by the MCO. (RPF 584-587, 617, 1010-1016, 1020, 1070-1082). As a result,

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<sup>5</sup> *See infra* III.E for a more detailed discussion on St. Luke's financial condition.

no presumption about the joinder's competitive effects can be drawn from the hospitals' shares in the two relevant markets alleged in the Complaint, which represent a small component of the services about which MCOs and hospitals negotiate and for which they contract.

MCOs approach contract negotiations with Lucas County hospitals with the goal of limiting the total cost of healthcare for their covered lives – that is, the all-in cost for inpatient, outpatient, physician, and ancillary services for their entire fully- or self-insured patient base at a particular hospital or hospital system. (RPF 559, 585, 651, *in camera*, 1063, 1071, 1082).

Conversely, hospitals negotiate with MCOs so as to maximize the total reimbursement they will receive for treating those MCO's insureds who utilize their facilities or physicians. (RPF 482, 497, 651, *in camera*, 1063).

The evidence shows that hospital-MCO negotiations are complex and that each side tries to obtain the best rates it can. (RPF 1063-1064, 1070). Typically, that means that the MCO seeks rates that will result in lower total payments for its insureds' healthcare costs less than the premiums it collects from fully-insured employers (RPF 559, 585, 651, *in camera*, 1063, 1071, 1082); the hospital strives for total reimbursement that exceeds its total cost of treating an MCO's insureds by { }, so that the hospital can subsidize the care that it provides to Medicare and Medicaid patients (reimbursement for whom does not cover the hospital's costs) plus a margin for re-investment in the hospital's infrastructure. (RPF 475, 482, 491, *in camera*; RX-71-A at 000047; RX-56 at 000008)..

Besides rates for basic inpatient and outpatient services, the negotiations between MCOs and hospitals cover reimbursement for outlier cases (i.e., patients whose cost of treatment exceeds certain threshold levels), physician services, ancillary services (e.g., home healthcare, durable medical equipment, diagnostic procedures), escalators for inflation, the contract term,

audit rights, and other non-price terms. (RPF 1086). The negotiations between MCOs and hospitals involve many trade-offs whereby a party seeking a higher rate for a particular service (e.g. outpatient services) may accept lower rates for a different service (e.g. inpatient services), or a system seeking an increase in rates for a particular hospital in its system may need to lower the rate for another hospital in its system. (RPF 587).

Non-compensation terms are every bit as important as the compensation terms in a contract because they often affect the hospital's reimbursement amount. (RPF 1070, 1084, 1089). For example, the inclusion of an MFN clause in a contract can affect whether an MCO agrees to an increased rate or a hospital can agree to decrease its rates. (RPF 598, 1102, 1604, 1817-1819, *in camera*, 1846). Sometimes disputes or other issues between a hospital and an MCO that are outside the scope of their provider contract, including the history of their negotiations or relationship, may impact negotiations about a contract between them. (RPF 1090, 1091-1093, *in camera*).. Similarly, an {

} (RPF 1091). An MCO's provider network's size and exclusivity also affects the bargaining process between providers and MCOs. (RPF 1103). If an MCO has a narrow provider network, it may negotiate lower hospital reimbursement rates; in contrast, MCOs with open networks tend to have to pay higher reimbursement rates.<sup>6</sup> (RPF 493, *in camera*, 563, 565, 737, 740, *in camera*, 775, 1103).

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<sup>6</sup> For example, when Mercy was in MMO's network before 2008, Mercy's rates were approximately { } lower for an MMO network that excluded ProMedica.} (RPF 734, 735-736, *in camera*, 737). Effectively Mercy was providing an { } discount to MMO for the exclusivity and potential for greater volume. (RPF 734, 735-736, *in camera*, 737). Mercy negotiated the elimination of this discount when MMO broadened its network, because a broader network had less value to Mercy. (RPF 737).

Despite Complaint Counsel's economic expert's claim that he analyzed the bargaining dynamics in Lucas County, his bargaining framework does not accurately reflect how bargaining between MCOs and hospitals occurs in Lucas County. (RPF 1097-1104). Professor Town's bargaining framework does not account, for example, for the bargaining between MMO and Mercy that resulted in MMO paying higher reimbursement rates to Mercy when MMO added ProMedica to its network. (RPF 1100). Nor does his model reflect trade-offs such as higher outpatient rates in exchange for lower inpatient rates. (RPF 1101). As courts have noted, negotiations with powerful, sophisticated buyers can affect whether a merger will have anticompetitive effects. *See Oracle*, 331 F. Supp. 2d at 1171 (noting that a unilateral effects theory assumes that consumers have no buyer power, which was not the situation in Oracle's case and therefore buyer power must be considered in the analysis); *Tenet*, 186 F.3d at 1054. In this case, the evidence suggests that the large MCOs in Toledo, MMO and Anthem, have more bargaining leverage with the hospital providers who need access to their insureds to cover their losses from treating Medicare and Medicaid patients, than the hospitals have over the MCOs. The joinder between ProMedica and St. Luke's will not change that market dynamic.

c. ProMedica's Closest Competitor Is Mercy, Not St. Luke's

In differentiated markets, the merged firm may be able to raise prices unilaterally if customers accounting for a "significant fraction" of the merged firms' sales view the merging parties as their first and second choices for the product and, if, in response to a price increase, rival sellers likely would not "replace any localized competition lost through the merger by repositioning their product lines." *Oracle Corp.*, 331 F. Supp. 2d at 1123; *In re Evanston*, 2007 FTC LEXIS 210, at \*158-59. Because that is not the case here, Complaint Counsel's market share analysis is not an accurate predictor of ProMedica's post-joinder market power.

No MCO testified that, for purposes of its Toledo hospital provider network, it considers St. Luke's to be the "next best substitute" for ProMedica. Rather, {  
} (RPF 1106, *in camera*, 1110, *in camera*, 1113) . Even Complaint Counsel's economic expert agrees that Mercy was and is ProMedica's closest substitute. (RPF 1116).

ProMedica's and Mercy's hospitals are similar in their locations and the types of services and acuity of care they offer. (RPF 1109, 1114). For each ProMedica hospital, there is a Mercy hospital close by, sometimes just across the street. (RPF 144). Each system has a large flagship hospital near downtown Toledo, a children's hospital and two smaller community hospitals. (RPF 71-74, 79-80, 84-86, 145-155, 160-163). Because of their similar broad service offerings and geographic reach throughout the Toledo metropolitan area, {

} (RPF 1119, *in camera*). In contrast, St. Luke's is a small, stand-alone community hospital, offering a limited array of the least complex inpatient hospital services. (RPF 121-122, 1121-1122, 1148). It offers no unique services as compared to the other hospitals in the market. (RPF 1148-1150).

Further, MCOs do not view ProMedica and St. Luke's as reasonably interchangeable; an MCO could not substitute with St. Luke's for ProMedica in its network. (RPF 1120, 1124; RX-0204 (Pugliese Dep. at 11); RX-0205 (Radzialowski, Dep. at 10-11); RX-0023 (Pirc Dep. at 16)). Prior to the joinder, faced with an anticompetitive price increase, no MCO would have dropped ProMedica from its network in exchange for St. Luke's. 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). Until 2008, Anthem did not have Mercy in its network and MMO did not have ProMedica in its network. (RPF 712-714,

725). Both MMO and Anthem remained competitive and were able to service their members with their narrow network configurations. (RPF 719-720, 727-728). Moreover, when United and ProMedica were unable to agree on a new contract in 2005, United substituted Mercy for ProMedica in its network. (RPF 713). Complaint Counsel's economic expert agrees that {

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(RPF 1123, *in camera*). If MCOs can successfully market a ProMedica-UTMC only network, as the evidence shows they can, they can also offer a Mercy-UTMC network post-joinder by substituting Mercy for ProMedica, just as United did in 2006.

In addition, an analysis of the diversion of patients from ProMedica or St. Luke's to other hospitals shows that {

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(RPF 1138, *in camera*). For example, 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, the diversion from rate from {

} (RX-71(A) at 000028, *in camera*).

In other words, patients would seek care from Mercy or UTMC, not St. Luke's, if ProMedica were not available. Real world evidence confirms that Mercy and ProMedica are each other's closest substitute. When {

} there

was a substantial shift of volumes and revenues from {

} but no meaningful

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<sup>7</sup> {

} (Town, Tr. 3788-3789, *in camera*); *Tenet*, 186 F.3d at 1054 (noting that customer testimony is suspect).

<sup>8</sup> {

} (Town, Tr. 3771, *in camera*).

change at St. Luke's. (RPF 1135, *in camera*). {

} (RPF 1139, *in camera*).

Complaint Counsel's economic expert's theory is that ProMedica's bargaining leverage will increase because the joinder eliminates competition between St. Luke's and ProMedica.

(PX01953 (Town, Dep. at 101-102)). But, as Professor Town stated in his report, {

} (PX02148

at 018, *in camera*). It follows, therefore, that because ProMedica and St. Luke's are not close substitutes and because the combination of Mercy and UTMC is a ready alternative that can constrain ProMedica's post-joinder pricing, the joinder will not affect ProMedica's bargaining leverage. *See Oracle*, 331 F. Supp. 2d at 1172 (holding plaintiffs failed to prove unilateral effects as a result of the merger because they failed to prove that there were a significant number of customers who regard the merging companies as first and second choices); *Sutter Health Sys.*, 130 F. Supp. 2d at 1129-32 (using diversion analysis to support finding that patients would turn to other hospitals in the face of a price increase)..

d. Travel Times between Competing Hospitals Are Not a Deterrent to Patients Switching Hospitals

Complaint Counsel argue that location is a deterrent to patients switching hospitals, based on anecdotal statements from MCOs and employers that patients like to stay close to home. But courts have routinely dismissed that type of anecdotal testimony, particularly when it is unsupported by the evidence (as is the case here). *See Tenet*, 186 F.3d at 1054 (where the court found that testimony of third party MCOs that they would be forced to accept price increases from the merged entity because patients insist on going to hospital closest to home was

“suspect.”); *Sutter Health*, 130 F. Supp. 2d at 1131 (“Informal, off-the-cuff remarks and anecdotal evidence concerning the marketplace are no substitute for solid economic evidence.”) (quoting *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1220 (W.D. Mo. 1995)). In this case, the physical closeness of the hospitals in Lucas County also affects the dynamics of their competition. See *Tenet*, 186 F.3d at 1053 (finding the fact that over 22 percent of residents in the “most important zip codes” already use hospitals outside the proposed geographic market is a “check on the exercise of market power by hospitals within the service area”).

No major MCO or employer testified they had analyzed their insureds’ or employees’ willingness to travel for inpatient hospitalization. (Radzialowski, Tr. 637-638; Pugliese, Tr. 1563; Neal, Tr. 2155; Pirc, Tr. 2268-2269, 2298). A study of actual travel times, however, reveals that a majority of patients are willing to travel to the hospital of their choice and frequently drive past the closest hospital. (RPF 218-219). The evidence shows that, for residents of the zip codes comprising St. Luke’s core service area, the drive time to an alternative hospital is not materially different than the drive time to St. Luke’s. (RPF 219). In addition, the drive time analysis shows that hospitals in the Toledo area are all located conveniently to patients with short drive times.<sup>9</sup> (RPF 1210). The average drive time of St. Luke’s patients is approximately twelve minutes even though, across all DRGs, approximately half of St. Luke’s patients had a different hospital closer to them. (RPF 221, 239). Indeed, for any hospital in Lucas County, the drive time analysis shows that patients are willing to travel to more distant hospitals than their closest available hospital for both general acute care inpatient services and inpatient OB services. (RPF 241-242, 1218). The fact that a large proportion of patients are not choosing their closest

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<sup>9</sup> Complaint Counsel’s own economic expert calculated that the average travel time for patients in his general acute care inpatient services market is 11.5 minutes, with 75 percent of the patients traveling 13.1 minutes or less. (Town, Tr. 3693-3694).

hospital (RPF 241-242, 1213, 1217) means that a hospital's location or distance will not prevent an MCO from marketing an alternative network that does not include ProMedica and St. Luke's, but includes slightly more distant hospitals. (RPF 1211). Patients' demonstrated willingness to travel makes using market shares to predict an effect from the joinder meaningless. *Sutter Health*, 130 F. Supp. 2d at 1132.

2. Complaint Counsel Have Failed To Prove that the Joinder Has Resulted in, or Will Enable ProMedica to Charge, Supracompetitive Rates in the Markets Alleged in the Complaint

"Analysis of the likely competitive effects of a merger *requires* [a determination] of . . . the transaction's probable effect on competition in the relevant product and geographic markets." *Arch Coal*, 329 F. Supp. 2d at 117 (emphasis added). Plaintiffs cannot "simply [make] conclusory allegations that . . . the merger will significantly limit competition without any evidence." *Advocacy Org. v. Mercy Health Servs.*, 987 F. Supp. 967, 974 (E.D. Mich. 1997). Rather, they must show "anticompetitive effects...that will result from the merger." *Id.* "[A]ntitrust theory and speculation cannot trump facts." *Arch Coal*, 329 F. Supp. 2d at 116-17.

Complaint Counsel, relying on their economic expert Professor Town, have failed to prove that the joinder will have any anticompetitive effect in their proposed markets. Inexplicably, Professor Town not only defined relevant product markets that differ from those alleged in the Complaint, but he then analyzed the so-called price effect of the joinder using yet a different set of acute care inpatient hospital services. Professor Town compounds his error by using a flawed model purportedly to estimate the effect of the joinder for inpatient general acute care services, *including* inpatient OB services, and performing no separate analysis of the joinder's price effect on the alleged inpatient OB services market. Without a valid econometric analysis, Complaint Counsel is left with only its self-serving, speculative testimony from MCOs

and employers. That is insufficient to meet its burden of proving that the joinder will substantially lessen competition in either alleged relevant product market.

a. Complaint Counsel's Economic Expert's Econometric Analysis Is Fatally Flawed and Does Not Reflect Competitive Realities

The Court should reject Professor Town's so-called merger simulation model of the joinder's potential price effects because it is seriously flawed and does not reflect the structure, history and probable future of the market. *See Gen. Dynamics*, 415 U.S. at 498; *Tenet*, 186 F.3d at 1054 n.13 ("When an expert opinion is not supported by sufficient facts to validate it in the eyes of the law . . . it cannot support a decision."). Here, Complaint Counsel impermissibly ignore the actual competitive dynamics in the Toledo market in favor of a merger simulation model that purports to predict that the joinder will enable ProMedica to raise St. Luke's rates by more than 50 percent. (RPF 1563). Because Professor Town's model reflects neither the real world competitive dynamics either before or after the joinder nor the evidence presented at trial, the Court should reject it as a basis for predicting the joinder's potential competitive effects. *See CCC Holdings*, 605 F. Supp. 2d at 70-72 (dismissing an expert's model because "the data and predictions cannot reasonably be confirmed by the evidence."). Indeed, Professor Town's model fails to account for the numerous (and generally recognized) factors that impact price negotiations between hospitals and MCOs; it even omits factors that commonly are included in merger simulation models for the hospital industry. (RPF 1581). When corrected for just a few of these additional factors, his model's estimated "price effect" stemming from the joinder cannot be statistically distinguished from zero. (RPF 1580).

Moreover, Professor Town's estimations contradict MCOs' testimony and bear no resemblance to the real world pricing that one can easily analyze using the actual contracts

between MCOs and hospitals.<sup>10</sup> This is true for several of reasons. First, for the purpose of performing his market share analysis, Professor Town defined a narrower general acute care inpatient services market than the Complaint alleged. *See supra* III(D)(1)(a). But, when he attempted to analyze the competitive effects of the joinder, Professor Town used a completely different universe of data (comprising a broader range of services) to construct his case-mix-adjusted price estimations. (RPF 1564-1565). More importantly, as Professor Town admitted, his case-mix-adjusted price estimations, which are the starting point for his merger simulation model, do not account for *why* prices differ at all. (RPF 1515). As the FTC noted in *In re Evanston*, the bilateral negotiations between hospitals and MCOs “determine prices that often are unique to the particular negotiation.” 2007 FTC LEXIS 210, at \*166. Professor Town ignored that very same dynamic here.

As a result, Professor Town cannot eliminate the possibility that cost differences, quality differences, or differences in the negotiating skill of Lucas County hospitals explain all or some of the differences in his case-mix-adjusted prices. (RPF 1515, 1518). Because general acute care inpatient services are differentiated products, factors such as cost, quality, a negotiator’s under- or over-estimate of the increase in inflation or cost escalation, and the time period for which a contract is negotiated, can cause differences in price.<sup>11</sup> *See Blue Cross & Blue Shield*, 65 F.3d at 1412 (noting that quality can affect prices). Notably, Professor Town agrees that prices for a hospital may differ across MCOs for a number of reasons, including cost or quality.

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<sup>10</sup> For example, { } testified that ProMedica rates were { } but Professor Town’s case-mix-adjusted prices to { }, once they are disaggregated, are { } than for ProMedica. (RPF 1527, *in camera*). Similarly, { } testified that St. Luke’s prices are { }, but again Professor Town’s case-mix-adjusted prices give the opposite result. (RPF 1528, *in camera*). Further, { } documents show that proposed rates in the third year of contract its with ProMedica would be only { } in the same year. (RPF 1346, *in camera*).

<sup>11</sup> Even programs MCOs have in other states affect rates negotiated for patients in Lucas County. For example, Anthem Blue Cross Blue Shield’s “BlueCard” program in Michigan influenced Anthem’s prices at Flower and The Toledo Hospital. (Pugliese, Tr. 117).

(RPF 1522). Professor Town also agrees that general acute care inpatient hospital services are differentiated products, and in well-defined, differentiated product markets, price differences are not necessarily indicative of market power. (RPF 1526). Nevertheless, Professor Town's case-mix-adjusted prices do not account for those differences.<sup>12</sup> (RPF 1519-1520, 1525).

Furthermore, when Professor Town's case-mix-adjusted-prices are disaggregated, by hospital and MCO, they show that, contrary to his conclusion, ProMedica's prices are not always higher than other hospitals in Lucas County. (RPF 1531). For example, Professor Town's constructed case-mix-adjusted price for Mercy St. Vincent is higher than any other hospital for Aetna, and ProMedica's constructed case weighted system price is lower than Mercy's system price. (RPF 1532). The same holds for Professor Town's constructed case weighted system price for Anthem – it is lower than Mercy's system price. (RPF 1691). Thus, Professor Town's constructed case-mix-adjusted prices do not even support his conclusions.

In addition to claiming to establish a meaningful, but unexplained, difference in prices pre-joinder, Professor Town then attempts to measure a hospital's bargaining power by purporting to predict the value that consumers (MCOs) place on the individual hospital or system in a MCO's network. (RPF 1547-1548). This "willingness-to-pay" is measured in Professor Town's "utils," not dollars. (RPF 1549). In theory, the more value a consumer places on a hospital, the higher its util will be and, therefore, the more a consumer would be willing to pay, which according to Town is a reflection of bargaining power. In addition, in theory, the util will be high if there are few alternative hospitals. (Town Tr. 3878). However, real world evidence

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<sup>12</sup> Specifically, Professor Town's regression analysis to estimate case weight-adjusted prices for use in his merger simulation model does not include a cost of care variable or a variable that corresponds to the direct or indirect costs incurred by a hospital. (RPF 1519).

does not support Professor Town's model, fatally undermining it.<sup>13</sup> See *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 242 (1993). Indeed, the *Brooke Group* court ruled that "when indisputable record facts contradict or otherwise render the [expert's] opinion unreasonable, it cannot support a jury's verdict." *Id.* For example, UTMC offers the most unique services in Lucas County and has few substitutes. And, any services that St. Luke's offers are offered by all other hospitals in his dataset. Yet, Professor Town's model calculates that UTMC has the lowest util out of all Lucas County hospitals, in contradiction to what his theory suggests.

In the final steps of his analysis, Professor Town uses his willingness-to-pay measure unsuccessfully to explain variations in his constructed pre-joinder case-mix-adjusted price and the effect the joinder will have on prices. (RPF 1557-1563). However, his model fails because it does not adequately account for all of the numerous, and generally recognized, factors that may impact price negotiations between hospitals and MCOs.<sup>14</sup> Examples of variables that are commonly included in empirical models of hospital pricing and merger simulation models like Professor Town's, but that he did not include, are: hospital-level case mix index; assets per bed; percent Medicare reimbursements; percent Medicaid reimbursement; and hospital-level willingness-to-pay. (RPF 1574). All of these variables can affect the intrinsic value of a hospital, which in turn can affect prices.<sup>15</sup> When added into his model, these variables can help

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<sup>13</sup> Moreover, Professor Town combines both general acute care inpatient services and inpatient OB services in his willingness-to-pay measure and fails, once again, to analyze Complaint Counsel's alleged inpatient OB services market separately. (RPF 1550).

<sup>14</sup> Some of these factors are include quality, history and exclusivity of the network. Professor Town also did not run sensitivities on his model using alternative controls for cost and quality, calling its reliability into question. (Town, Tr. 4262). Moreover, Professor Town implies that ProMedica's ownership of Paramount could make the price effect increase from 38.38 percent to 56 percent. (Town, Tr. 3893-94).

<sup>15</sup> See, e.g., Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction*, 18 Int'l J. of the Econ. Of Bus. 65-82 (2011) (including case mix index, assets per bed and percent Medicare/Medicaid reimbursements); Deborah Haas-Wilson and Christopher Garmon, *Hospital Mergers and*

(continued...)

explain the reason for the price differences among the hospitals and show that the alleged price effect of the joinder predicted by his model may not differ from zero. (RPF 1575). Nonetheless, Professor Town arbitrarily assumed that the unexplained difference between the predicted prices and actual prices that remains from his calculations is due to ProMedica's {

} (PX02148 at 0059, 0102, *in camera*).<sup>16</sup> Thus, Professor Town simplistically adds this unexplained difference to his calculated post-joinder price effect, arriving at an estimated price increase for St. Luke's of 56 percent. (PX02148 at 0058-0059, *in camera*; RPF 1563).<sup>17</sup> He assumes that the unexplained difference between his predicted prices and actual prices is completely attributable to ProMedica's bargaining leverage, with no basis whatsoever. *See Mid-State Fertilizer Co. v. Exch. Nat'l Bank of Chi.*, 877 F.2d 1333, 1339 (7th Cir. 1989) ("[T]he judge must look behind [the expert's] ultimate conclusion . . . and analyze the adequacy of its foundation.") (internal quotations omitted).

Professor Town's merger simulation model fails to account for any competitively benign reasons for a post-joinder price increase and is unsupported by other evidence in this case. *See CCC Holdings*, 605 F. Supp. 2d at 70-72. Merger simulation models have been shown to yield

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*Competitive Effects: Two Retrospective Analyses*, 18 Int'l J. of the Econ. Of Bus. 17-32 (2011) (including interns-per-staffed-bed and percent Medicare/Medicaid reimbursement); Leomore Dafny, *Estimation and Identification of Merger Effects: An Application to Hospital Mergers*, 52 J. of Law and Econ. 523-50 (Univ. of Chi. Press 2009) (including assets per bed and percent Medicare/Medicaid reimbursements). In contrast, the variables Professor Town uses in his choice model have not appeared in any peer-reviewed academic literature. RPF 1740.

<sup>16</sup> The unexplained difference between the predicted prices and actual prices is called the residual. (RPF 1563).

<sup>17</sup> To allocate the system effect between St. Luke's and ProMedica, Professor Town {

} (RPF 1588, *in camera*). {

} (RPF 1588, *in camera*). Professor Town did not perform an analysis to determine whether the particular method of allocation is an accurate predictor of the price increase, relying solely on the MCOs' apprehensions. (RPF 1589).

unreliable and inaccurate predictions of what actually occurs in a merger when studied after the fact. (RPF 1596). The same is true here.

First, Professor Town's merger simulation model results are subject to misinterpretation, because the system willingness-to-pay variable captures all the qualities that contribute to the intrinsic value of the hospital, including those qualities that are competitively benign. (RPF 1573). However, Professor Town does not sufficiently isolate the competitively benign qualities from anticompetitive qualities, making it appear as if the post-joinder price increase is solely due to anticompetitive reasons.

Second, Professor Town's merger simulation model does not allow one to independently or directly observe a patient's second choice of hospitals if his or her first choice becomes unavailable or more expensive. (RPF 1566). Professor Town simply estimates the *probability* that a given patient would choose a certain hospital if St. Luke's were not available. (Town, Tr. 4243). But, Professor Town admits that the choice a consumer makes "is almost, by definition, going to be different" from the choice that he estimates. (RPF 1567). An inability to predict accurately consumers' choice of alternative hospitals completely undermines Professor Town's model which purports to predict a post-joinder price increase based on ProMedica's unilateral exercise of market power. Unilateral effects, of course, depend on the closeness of competition between the merger firms. *Horizontal Merger Guidelines* at § 6.1. The Court, thus, cannot rely on his model to determine what hospital a patient may choose in lieu of St. Luke's at any price point.

Third, Professor Town's merger simulation model cannot predict when ProMedica will be able to raise St. Luke's rates, only that it would occur at some point in time in the future. (RPF 1595). As Professor Town testified, "a precise time frame for [an increase in rates] would

be almost impossible to predict.” (Town Tr. 4256). To accept Professor Town’s model, implies that one could infer merger-related price effects in any industry in which higher quality products are able to command higher prices. But, that conflicts directly with established case law that holds for a merger to be condemned, the evidence must show that it will result in prices above the competitive level. *See, e.g., Long Island Jewish*, 983 F. Supp. at 145. Put differently, Complaint Counsel must show that a reliably, predicted post-joinder price increase exceeds competitive levels, not just that prices may be higher than they were pre-joinder. Because Professor Town’s analysis is methodologically flawed and contradicted by the other evidence adduced at trial, his opinion is “totally speculative,” and the Court should reject it. *Id.* at 143.

b. **Complaint Counsel’s Economic Expert Failed To Analyze the Effects of the Joinder in the Inpatient OB Services Market Alleged in the Complaint and No “Other” Evidence of Anticompetitive Effects in the Inpatient OB Services Market Exists**

Complaint Counsel have failed to present any evidence of anticompetitive effects in its alleged inpatient OB services market, which is fatal to their case. *See Oracle*, 331 F. Supp. 2d at 1172. Despite alleging and defining a separate inpatient OB services market, Complaint Counsel’s economic expert performed no analysis of the effects of the joinder on that alleged product market. Instead of analyzing the effects of the joinder on the inpatient OB services market, Professor Town’s merger simulation model combines his inpatient OB services and general acute care inpatient services into one predicted price effect. (RPF 1550, 1610). He never conducted a separate merger simulation model only for inpatient OB services. Worse, Professor Town can not isolate the joinder’s alleged price effect separately for either of his proffered markets. (RPF 1610). Thus, he provides no evidence, prediction or expectation of the

joinder's purported price effect in his inpatient OB services market.<sup>18</sup> (RPF 1550, 1611). See *Sutter Health*, 130 F. Supp. 2d at 1132 (requiring solid economic evidence). His lack of analysis also directly contradicts his own testimony that "competitive conditions for OB services are substantially different from those in the broad market of general acute care services, and thus I analyze the impact of the Acquisition on that market separately." (RPF 1550). Complaint Counsel cannot argue that the joinder will have an effect on an inpatient OB market if they do not analyze that market. *Menasha Corp. v. News Am. Mktg. In-Store, Inc.*, 354 F.3d 661, 664-65 (7th Cir. 2004) (holding that conclusory reasoning does not replace the need for actual economic analysis).

Aside from Professor Town's flawed modeling, Complaint Counsel have failed to present any other evidence that ProMedica would be able to raise prices to a supracompetitive level after the joinder for inpatient OB services. The history of contracting between hospitals and MCOs in Lucas County, in fact, shows the opposite is more likely. Prior to the joinder, only ProMedica and Mercy offered more complicated OB services. (RPF 23, 74, 145). The joinder does not change that. Thus, the joinder has no effect on shares for these services, and under Complaint Counsel's theory there would, therefore, be no change in market power or price.

Even though the Toledo area has only had two providers of high-risk inpatient OB services, The Toledo Hospital and St. Vincent, the evidence supports that prices were and are competitive for those services, even when MCOs had only one provider for those services in their networks. (Guerin-Calvert, Tr. 7230-7231). Complaint Counsel have not presented any evidence of separate negotiations for inpatient OB services between MCOs and hospitals. Rates for inpatient OB services are constrained by negotiations for all other rates and terms of the

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<sup>18</sup> The lack of analysis of competitive effects in Professor Town's inpatient OB services market also undermines Complaint Counsel's assertion that inpatient OB services should constitute a separate relevant market.

contract. Therefore, Complaint Counsel have not met their burden of proving a likely anticompetitive effect on their alleged inpatient OB services market. *See Arch Coal*, 329 F. Supp. 2d at 116-17.

c. Testimony from MCOs and Employers Is Suspect

Once one looks beyond Professor Town's model and its failings, all that remains is self-serving or speculative testimony from MCOs and employers. Testimony from industry participants is inherently suspect, particularly when the testimony is from large, sophisticated buyers. *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). The *Tenet* court noted that "large, sophisticated third-party buyers can and do resist price increases." *Id.* Moreover, large, sophisticated buyers with years of experience and access to information including hospital costs and revenues and coordination of benefits are expected to substantiate their apprehensions that the joinder would raise prices to an anticompetitive level. *Oracle*, 331 F. Supp. 2d at 1131. Otherwise, the testimony of market participants speaks only to current customer perceptions and habits, but does not address what customers would do in the event of a price increase. *Tenet*, 186 F.3d at 1054. *See also Arch Coal*, 329 F. Supp. 2d at 145-46 (noting that many cases and antitrust authorities "do not accord great weight to the subjective views of customers in the market," and stating that the concern expressed by the customers at issue "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).

Similarly, here, the Court should not credit MCO testimony regarding post-joinder price effects because it is based on nothing except preferences and apprehensions, and "unsubstantiated customer apprehensions do not substitute for hard evidence." *Oracle*, 331 F. Supp. 2d at 1131. MCOs testified that they anticipated ProMedica would increase rates, at least

at St. Luke's, and implied that they would have to unhesitatingly accept ProMedica's demand for increased rates. ({ }, Tr. 2262-2263, *in camera*; { }, Tr. 703-708, *in camera*; McGinty, 1209-1212; { }, 1523-1525, *in camera*). However, that testimony is contrary to the MCOs' economic interests and, therefore, suspect for several reasons. *See Tenet*, 186 F.3d at 1054. First, the MCOs in this case are competitors of Paramount, a managed care plan owned by ProMedica, and they may perceive Paramount as a stronger, more attractive competitor since St. Luke's became a Paramount hospital provider as a result of the joinder. Second, to support their concerns about the importance of an independent St. Luke's, MCOs rotely testified that patients prefer not to travel far for general acute care inpatient services, but none presented any studies or surveys supporting their testimony. (RPF 1261-1265, 1267, 1269-1271). This lack of objective evidence is particularly suspect from such sophisticated market participants who have teams dedicated to analyzing all aspects of the healthcare market. *See Oracle*, 331 F. Supp. 2d at 1131 (finding that the failure of large sophisticated buyers to present any cost/benefit analyses undermined their testimony). Similarly, no MCO testifying that a Mercy-UTMC network would be unmarketable offered any studies or surveys to support that statement. (RPF 1269-1270).

Complaint Counsel also rely upon employer testimony that is similarly subjective. The employers, some of whom are not in the relevant geographic market or had no knowledge of Lucas County hospitals, lack any foundation for their concerns and offered no studies or analysis as to where their employees would go if ProMedica were no longer in their health plan's network. *See Tenet*, 186 F.3d at 1054 (dismissing testimony of market participants that failed to show where consumers could practicably go for inpatient hospital services). This type of subjective testimony offers the Court no evidence of post-joinder anticompetitive effects, and the Court should disregard it. *Arch Coal*, 329 F. Supp. 2d at 146 (discrediting testimony of

customers because they lack expertise to opine on what will happen in the market in the future). For example, employers do not negotiate directly with providers, but rely on MCO or brokers to negotiate for them. (RPF 459-461). Accordingly, employers who testified that their employees *prefer* ProMedica, *prefer* not to switch hospitals, and *prefer* not to travel are two to three levels removed from the MCO-hospital contracting of which they complain. (Neal, Tr. 2155-2156; Lortz, Tr. 1703-1704, 1738; RPF 459-460). This testimony is further irrelevant because “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. *Oracle*, 331 F. Supp. 2d at 1131.

3. The Joinder Will Neither Enhance ProMedica’s Market Power Nor Enable It To Increase Rates for General Acute Care Inpatient or Inpatient OB Services above Competitive Levels

The joinder will not give ProMedica the ability to increase rates to supracompetitive levels at ProMedica’s legacy hospitals or at St. Luke’s for general acute care inpatient services or inpatient OB services. Market forces and competitive conditions in the Toledo area are such as to provide substantial competitive discipline. (RPF 1219-1228). First, rivals are well-positioned, and have already positioned themselves, to take share away from ProMedica, to attract patients, to hire more physicians and put new facilities in place. Second, MCOs have the ability to counter any attempts by ProMedica to raise rates to a supracompetitive level by taking advantage of broad physician privileges and substituting Mercy for ProMedica in their networks. Third, the history of hospital-MCO contracting in Lucas County shows that narrower networks, at the right price, are a viable option for MCOs. Fourth, employers can constrain ProMedica by providing incentives to employees to avoid more costly providers, a practice that likely will increase in the wake of healthcare reform. Finally, a comparison of pre-joinder and post-joinder rates confirms that ProMedica cannot raise rates to a supracompetitive level.

a. Substantial Excess Inpatient Hospital Capacity Exists To Constrain ProMedica's Ability To Raise Rates above Competitive Levels

Competitors in Lucas County have the incentive and ability to respond to any attempt by ProMedica to increase rates to an anticompetitive level by repositioning and repurposing their existing excess capacity. MCOs can take advantage of the hospitals' excess capacity and need for commercially-insured patients to pressure ProMedica to maintain its rates at a competitive level. Moreover, there is increased pressure on Toledo hospitals to compete for a declining population of revenue-generating commercially-insured patients to fill staffed beds in order to remain profitable. In fact, one competitor is already implementing a plan to compete more aggressively with ProMedica (and St. Luke's) post-joinder, without adding to its already high inpatient hospital capacity.

(i) Both Mercy and UTMC Have Excess Inpatient Hospital Capacity, Which Gives Them the Incentive and Ability To Compete for Additional Inpatients

Merging parties are constrained from increasing prices to supracompetitive levels if other firms can enter the relevant markets. *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 149. That can occur if new firms enter the relevant markets, or if existing firms expand their current capacity or "[expand] into new regions of the market." *Cardinal Health*, 12 F. Supp. 2d at 55. See also *Baker Hughes*, 908 F.2d at 989 n.8. Indeed, in *Baker Hughes*, the court noted the presence of existing companies "poised for future expansion" in the relevant markets to support its conclusion that the merger would not likely cause anticompetitive effects. 908 F.2d at 988-89. The *Horizontal Merger Guidelines* also evaluate repositioning like new entry. *Horizontal Merger Guidelines*, § 6.1; see also *In re Evanston*, 2007 FTC LEXIS 210, at \*159 (quoting IV Phillip E. Areeda, Herbert Hovenkamp & John L. Solow, *Antitrust Law* ¶ 914a, at 67 (2d ed. 2006) ("The degree to which a merger in a product-differentiated market might facilitate a

unilateral price increase depends on . . . the relative inability of other firms to redesign their products to make them close to the output of the merging firms.”)). Even perceived entry or expansion can constrain a possible anticompetitive price increase. *See Baker Hughes*, 908 F.2d at 988.

Because of excess inpatient hospital capacity, Mercy and UTMC both have the ability to constrain any attempt by ProMedica to raise prices to a supracompetitive level. Toledo, as compared to other similar metropolitan areas in the U.S., has substantially more beds per thousand residents. (RPF 1233-1235). In addition, Mercy and UTMC have more registered beds than staffed beds.<sup>19</sup> (RPF 1231). Thus, there is available capacity that is unnecessary to meet the current level of demand in the market. (RPF 1235). Mercy and UTMC can deploy this additional capacity almost immediately in response to an attempted exercise of market power by ProMedica.

Another metric reflecting the excess bed capacity at Toledo area hospitals is the occupancy rate, which takes the average daily census of a hospital and divides it by the number of staffed beds or registered beds. (RPF 1236). The occupancy rate shows that Mercy and UTMC could adjust their staffing and use of currently unused beds to accommodate an increase in demand and counter an anticompetitive price increase by ProMedica because they have the bed capacity to do so. (RPF 1237-1244, *in camera*, 1245-1248).

Just as hospitals can use excess inpatient hospital capacity to compete aggressively in Lucas County, MCOs can also use the excess capacity of available beds in Lucas County to constrain hospital providers' prices. First, MCOs do not need every hospital in their networks

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<sup>19</sup> Staffed beds are the number of beds that a hospital staffs and are available to patients walking in the door. Registered beds is an overall view of the number of bed capacity that could be brought to bear quickly, without regulatory hurdles. (Guerin-Calvert, Tr. 7179).

because there are enough beds to serve their members at just a few hospitals. (RPF 1316). For example, MMO grew to be one of the largest MCOs in Toledo without ProMedica in its network because the hospitals in MMO's network were able to serve its member volume. (RPF 1317). Similarly, Anthem became one of the top four MCOs in the Toledo area while serving its members with only ProMedica and UTMC in its network. (RPF 1318).

Complaint Counsel's theory, and Professor Town's analysis, inappropriately discount the competitive constraint that Mercy and UTMC can impose on ProMedica due to their substantial excess capacity. That competitive constraint, which existed prior to the joinder and will continue after, prevents ProMedica from charging prices above a competitive level after the joinder.

(ii) The Declining Demographics and Increased Percentage of Government-Insured Patients in Toledo Encourage Hospitals To Compete More Aggressively

Declining demand for a product or service can increase competition and constrain that product's or service's price. *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1283-84 (N.D. Ill. 1989) (noting that demand for inpatient care in northern Illinois hospitals had decreased due to "[t]he advent of outpatient services, cost containment and managed healthcare . . . In turn, this has led the acute inpatient care market to become more price sensitive and competitive as hospitals attempt to attract steady sources of inpatients through lower prices."). Here, the demographics of Lucas County will constrain ProMedica's ability to increase rates above a competitive level because the demand for services by commercially-insured patients, those patients that hospitals rely on to remain profitable, is declining. (RPF 1219-1224). This declining demand for inpatient services forces competitors in Lucas County to compete, on a price and non-price basis, for commercially-insured patients to fill their increasingly empty beds to remain profitable.

The number of commercially insured inpatients in Toledo declined in 2004 to 2009 from 45,000 to 35,000. (RPF 1222). Today, only approximately 29 percent of Lucas County hospital patients are commercially-insured. (RPF 58). This decrease is, in part, a result of Toledo's declining population. (RPF 1219). In addition, Toledo's high unemployment and an exodus of employers leaves more residents covered by Medicaid, and Toledo's aging population leaves an increasing number of residents covered by Medicare. (RPF 1220-1221). This puts increasing financial pressures on hospitals because a higher percentage of the hospital's revenue comes from the government, which reimburses hospitals at less than their total cost of treating government-insured patients. (RPF 1224). As a result, hospitals are trying to attract MCOs and their commercially insured patients to cover the costs of caring for government-insured patients. (RPF 1223).

The decreasing number of commercially-insured patients and increasing number of government-insured patients also puts MCOs in a stronger position to be able to reconfigure their networks and move patients among competing hospitals to get better prices. (RPF 1225). Given the declining number of commercially-insured patients, MCOs are essentially holding the purse strings. MCOs can threaten to take away these revenue-generating patients, leaving a hospital with only revenue-draining government-insured and charity patients. Even Complaint Counsel's economic expert admitted that if ProMedica was denied access to a major MCO, it would have a significant impact on ProMedica's operations. (Town, Tr. 3960). Healthcare reform will exacerbate these conditions because the rate of reimbursement from Medicare and Medicaid will decrease, the rate of reimbursement for commercial insurance will also decrease, and there will be fewer inpatients and more outpatients, all of which put increased financial pressures on the

hospitals, incentivizing them to compete aggressively for commercially-insured patients. (RPF 1228).

(iii) { } Does Not Believe that It Needs Additional Inpatient Hospital Capacity To Compete Successfully with ProMedica and St. Luke's in the Future

{ } has a well-thought out and presumably economically rational plan to compete even more vigorously for patients in the area immediately surrounding St. Luke's. (RPF 1175-1182, *in camera*). { } does not believe that it needs to build a new hospital facility to implement its plan to compete for patients in that area. (RPF 1169, *in camera*). Rather, it can and is pursuing a plan to employ primary care physicians in the belief that those physicians will refer patients to its hospitals. (RPF 1183-1186). In addition, { } is repurposing {

} (RPF 1176-1178, *in camera*). {

}.

{ } ability to implement its { }, recruit physicians and use its excess capacity is a means of expansion in the Toledo area and provides a competitive constraint against ProMedica. (RPF 1189). *See Cardinal Health*, 12 F. Supp. 2d at 55. *See also Baker Hughes*, 908 F.2d at 989 n.8. UTMC also recently completed a number of renovations, expanded its facilities and engaged in outreach activity, which is also a means of expansion and offers a competitive constraint against ProMedica. (RPF 1190-1196).

Complaint Counsel discount the competitive threat that these efforts pose to ProMedica, but there is no reason to doubt that { } is acting in its rational economic self-interest when it asserts that it intends to increase its market presence and position in the southwest Toledo area. Moreover, it is undisputed that ProMedica believes { } will pursue a vigorous plan to

compete with it in southwest Toledo. (RPF 1174). ProMedica's belief that { } will implement its plan is justified given the historic rivalry between ProMedica and { }. ProMedica's belief that { } is likely to expand its presence in southwest Toledo is independently significant because "the threat of entry can stimulate competition in a concentrated market, regardless of whether entry ever occurs." *Baker Hughes*, 908 F.2d at 988.

b. Physicians in the Lucas County Area Practice at Multiple Competing Hospital Systems Enabling Patients To Switch to Non-ProMedica Hospitals without Changing Physicians

The ability of even a few patients to switch to other hospitals for care is a key factor that can constrain any potential price increase by a merging hospital. *Tenet Health*, 186 F.3d at 1054 (finding that a switch of a small percentage of patients could render any potential price increase unprofitable). Patients in Lucas County can easily switch hospitals. Lucas County patients choose a hospital based upon many factors, but their key concerns are whether their doctor has privileges at a particular hospital and whether that hospital participates in their MCO's network. (RPF 43, 46). If a patient's insurance plan provides equal coverage at multiple participating hospitals, but her physician has privileges at only one of those hospitals, then the patient may choose to receive care at that institution without having to change physicians. On the other hand, in cases where the patient's insurance does not treat all hospitals the same and her doctor maintains privileges at multiple participating facilities, then the patient will chose to receive care at one of her MCO's preferred facilities.

Most doctors in Lucas County practice at multiple competing hospitals. (RPF 674-676). Even hospital employed physicians maintain privileges at competing hospitals and regularly admit patients to those hospitals. (RPF 686-693, 756-757). Physicians are mindful of the costs their patients face. They regularly take into account their patients' insurance coverage when recommending a hospital for care and they also already have access to multiple tools that permit

comparisons of hospital costs. (RPF 465). Having privileges at several hospitals allows them to direct their patients to in-network hospitals where they can minimize their patients' out-of-pocket costs. (RPF 682). Patients can actively influence these decisions as well, especially when the physician practices in multiple locations. (RPF 685).

MCOs can capitalize on the widespread overlap of practicing physicians at competing hospitals to pressure ProMedica to maintain competitive rates. Nothing prevents an MCO from signaling relative cost differences to physicians to encourage them to admit their patients to less expensive facilities. (RPF 1277). Because physicians maintain privileges at multiple hospitals, patients would face no disruption to their care – that is, they would not be forced to abandon a trusted family physician or specialist – if they needed to switch hospitals for insurance reasons. (RPF 683). Physicians practicing at ProMedica and St. Luke's already admit patients to other hospitals, especially Mercy.<sup>20</sup> MCOs can, therefore, credibly threaten to shift large volumes of patients away from ProMedica in the face of any post-joinder attempt to impose supra-competitive pricing. *See Sutter Health*, 130 F. Supp. 2d at 1132 (using actual physician overlapping privileges data to counter MCOs' testimony that patients would not switch hospitals in the face of a price increase).

c. History Shows that MCOs Can Successfully Market Network Products without ProMedica and St. Luke's, including a UTMC-Mercy Network

The history of MCO contracting in Lucas County shows that MCOs faced with demands for supracompetitive pricing could walk away from negotiations and successfully market a

<sup>20</sup> Data from Lucas County shows that { } physicians { } already admit patients to { }. (RPF 700, *in camera*). Just over half of all physicians that admit patients to { } also admit patients to { } (RPF 704, *in camera*). This figure actually understates the vulnerability { } (RPF 702, 704, 708, *in camera*).

limited provider network, despite MCO testimony otherwise. Although customer testimony might be used to support the claim that the joinder will have an anticompetitive effect, the Court must consider the sophistication and the basis for customer testimony. “[U]nsubstantiated customer apprehensions do not substitute for hard evidence.” *Oracle*, 331 F. Supp. 2d at 1131. Moreover, “[c]ustomer preferences towards one product over another do not negate interchangeability.” *Id.* Repeatedly throughout the past decade, and as recently as 2010, MCOs have successfully offered provider networks that did not include every hospital provider in Lucas County. (RPF 709-717). Indeed, success in Lucas County has never been tied to the breadth of a MCO’s network: MMO and Paramount – two of the largest MCOs in Lucas County – have the longest history of offering limited networks. (RPF 710, 712, 720, 779-783). Anthem, one of Lucas County’s top three MCOs, offered a limited network from 2005 to mid-2009. (RPF 293-297, 739, 744). Other major MCOs, like United, have also offered narrow provider networks for most of the past decade. (RPF 358-362). Even as many of these longstanding champions of narrow networks have shifted toward broad networks in the past couple of years, none has witnessed any significant change – either upward or downward – in its membership levels. (RPF 363, 392-393, 416). Network breadth does not translate into any significant competitive advantage.

MCOs gain no special advantage with broad networks because they can already meet all of a patient’s medical needs with narrow networks. Patients require access to a broad range of medical services, and MCOs construct their networks with the aim of offering a full complement of services. (RPF 341, 385). To achieve this goal, MCOs require at least one network hospital that can offer advanced tertiary services. (RPF 341, 388). For this purpose, ProMedica’s Toledo Hospital and Mercy’s St. Vincent Medical Center are interchangeable. (RPF 72, 145, 389).

United's 2006 network reconfiguration – swapping out ProMedica for Mercy – demonstrated this crucial fact, which other MCOs have confirmed. (RPF 359). UTMC also offers tertiary services. (RPF 178). Moreover, MMO successfully used Mercy as its sole provider of high level inpatient OB services prior to 2008, despite Mercy's relatively lower number of OB admissions, showing that MCOs do not need ProMedica to provide high level OB services. A viable network in Lucas County must have one of these three hospitals to provide advanced services; but all other medical services can be provided by various limited network configurations. (RPF 1252-1253, 1258).

For years, a network limited to ProMedica and UTMC has proven not only viable, but tremendously successful. (RPF 313-314, 316, 319). There is no evidence that success cannot be duplicated with other network configurations. On the contrary, actual market experience has shown that MCOs can and have swapped Mercy for ProMedica successfully. (RPF 359, 1111-1112, 1249-1251). *See Oracle*, 331 F. Supp. 2d at 1167 (holding that what customers do is more persuasive than what they say). Employers believe that networks that use Mercy hospitals instead of ProMedica hospitals meet all of their employees' needs and serve them well. (RPF 803-04). Moreover, experts for both Respondent and Complaint Counsel agree that ProMedica and Mercy are each other's closest substitutes. (RPF 1111, 1116-1117). A network offering that includes UTMC and swaps out ProMedica for Mercy would be just as attractive as Paramount's network prior to the joinder, and potentially more attractive than a more expensive, broad provider network. (RPF 1123, *in camera*, 1251, *in camera*, 1252, *Guerin-Calvert*, Tr. 7401-7402). MCOs can thus thwart any attempt by ProMedica to raise prices to supracompetitive levels by configuring a network without ProMedica.

d. Employers Can and Do Provide Incentives to Their Employees To Avoid More Costly Healthcare Providers

Employers can also constrain ProMedica from increasing prices above a competitive level. They can and do provide incentives to their employees to avoid more costly hospitals. The most obvious method available is for the employer to select MCOs that offer more limited provider networks. Limited network plans are less expensive for employers, and the financial disincentive imposed upon out-of-network hospitals encourages employees to use the preferred, in-network hospitals. (RPF 1296).

Even if an employer's health plan includes more expensive hospitals as in-network providers, the employer can still provide incentives to encourage employees to use less expensive options. (RPF 1274, 1300). Some incentives may be informational. For example, the MCO and employer may provide information to employees to educate them regarding the relative cost of competing healthcare providers. (RPF 1272, 1278, *in camera*). Or the incentives may be financial. (RPF 1287, *in camera*). Employers can develop "tiered" networks wherein the employee's out-of-pocket cost for seeking treatment from certain providers is lower. (RPF 1300, 1314). Alternatively, the employer may offer employees different health plan options and may pay a greater percentage of the premium for preferred plans. (RPF 1285-1286). All of these alternatives represent ways an employer can steer its employees toward certain preferred (i.e., lower cost) providers. As the *Tenet* court noted, steering can successfully change patient behavior. *Tenet*, 186 F.3d at 1049.

These alternatives are not theoretical; in fact, employers in Lucas County, including some of the county's largest employers, are already employing these tactics. (RPF 1285, 1295, 1300). The Lucas County Government, for example, covers 90 percent of an employee's health insurance premium if the employee enrolls with a certain limited network plan. (RPF 1286, *in*

camera). It covers only 70-75 percent of the cost of competing plans. (RPF 1286, *in camera*).

The program has been tremendously successful; {

}. (RPF 1288, *in camera*).

Competing MCOs and hospitals have protested these tactics, but are powerless to prevent employers from adjusting their benefit plan offerings to provide greater incentives for less expensive options. (RPF 1290, *in camera*, 1292, *in camera*).

e. Pre- and Post-Joinder Evidence Shows that the Joinder Will Not Result in Rates above Competitive Levels

Real world, structural evidence establishes that the joinder will not enable ProMedica to raise rates to a supracompetitive level. Evidence of pre- and post-joinder negotiations show that rates remain comparable. The post-joinder rates are the result of a fair and competitive negotiating process that could not have been manipulated. Actual evidence of competitive effects, pre- and post-joinder, should be given substantial weight. *See United States v. Archer-Daniels-Midland Co.*, 781 F. Supp. 1400, 1421 (S.D. Iowa 1991); *Lektro-Vend*, 660 F.2d at 276 (stating “post-acquisition evidence favorable to a defendant can be an important indicator of the probability of anticompetitive effects where the evidence is such that it could not reflect deliberate manipulation by the merged companies temporarily to avoid anticompetitive activity”). Moreover “antitrust theory and speculation cannot trump facts.” *Arch Coal*, 329 F. Supp. 2d at 116-17.

(i) St. Luke’s Pre-Joinder Negotiations with FrontPath and MMO

To assess whether the joinder gives ProMedica the ability to raise prices above a competitive level, one must first determine whether pre-joinder rates were anticompetitive. *See, e.g., Oracle*, 331 F. Supp. 2d at 1170. Complaint Counsel have not shown that pre-joinder rates were anticompetitive. They have at best shown that artificial, constructed prices for *some*

ProMedica hospital rates for *some* MCOs were higher than *some* other hospitals' rates in Lucas County. Complaint Counsel did not examine real world contracts available to them and ignore competitively benign explanations for these differences.

A comparison of St. Luke's pre-joinder contract negotiations with contract rates negotiated post-joinder provides a basis to determine the "but-for price" absent the joinder. Complaint Counsel's claim that St. Luke's pre-joinder prices were competitive ignores undisputed evidence that before St. Luke's started renegotiating its existing contracts with certain MCOs, its pre-joinder reimbursement rates were below market and not sustainable. (RPF 1790, *in camera*). The fact that, prior to the joinder, St. Luke's negotiated a new contract with { } and attempted to finalize new, mutually-agreeable rates with MMO demonstrates that St. Luke's rates would have to increase, with or without the joinder.

For example, { }  
(RPF 1872, *in camera*). { }  
} (RPF 1873, *in camera*)..

These negotiations resulted in a contract that { }  
(RPF 1875, *in camera*). Importantly for St. Luke's, { }  
{ } (RPF 1876). This coverage ratio was substantially above that for its two largest MCOs, Anthem and MMO. (RPF 1796-1797, *in camera*, 1842, *in camera*).

Realizing it would also need to increase its rates with its largest MCOs, St. Luke's approached MMO in 2009 to adjust its reimbursement rates to cover its costs. St. Luke's asked

MMO to raise its reimbursement rates to mirror the average rate of a peer group of hospitals. (RPF 1802, *in camera*, RX-71(A)-000053). The agreed upon rate increases over a three year period plus a bonus formula could have resulted in an overall reimbursement increase of about { }<sup>21</sup> The only reason the contract was not implemented with those agreed upon rate increases was because {

} (RPF 1816, *in camera*). {

} (RPF 1816, *in camera*; 1819, *in*

*camera*). Because the walk-away point in the negotiations was not the amount of the increase, but rather { } is indicative of the price increase that would have occurred but-for St. Luke's joinder with ProMedica. (RPF 1822, *in camera*).

- (ii) Post-Joinder, St. Luke's Rates with MMO and United Allow It To Recover Its Costs Like Its Pre-Joinder FrontPath Rates Do

The MCO reimbursement rates that ProMedica has negotiated on behalf of St. Luke's post-joinder are comparable to if not lower than the pre-joinder rates that St. Luke's negotiated with MCOs. This categorically refutes Complaint Counsel's unsupported assertion that ProMedica will have the ability post-joinder to significantly raise prices above a competitive level.

{

} (RPF 1397, *in camera*). {

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<sup>21</sup> Although MMO testified that the overall reimbursement would be approximately { } that calculation did not take into account compounding over the years of the contract. (RPF 1814, *in camera*, RPF 1817-1818, *in camera*). When compounding is factored in, the more accurate increase over the time of the contract is { } percent. (RPF 1822, *in camera*).

} (RPF 1399, *in camera*). {

} (RPF 1401, *in camera*). These rates are higher than the rates St. Luke's had with { }, but are lower than the rates { } has with The Toledo Hospital. Despite Complaint Counsel's implication that the rate difference is due to ProMedica's "price influencing characteristics," {

} (RPF 1402, *in camera*).

Similarly, {

} (RPF 1377, *in camera*, 1381, *in camera*). {

} (RPF 1384, *in camera*).

In addition, the post-joinder contract with {

} (RPF 1385, *in camera*). {

} (RPF 1386, *in camera*). Moreover, this cost coverage percentage is { } than the one achieved in St. Luke's and { } pre-joinder contract. (RPF 1876, *in camera*). Although the new { } contract resulted in higher rates, an increase in rates does not automatically harm consumers

because the increase in rates cover costs and allow services to be provided at an economically efficient level. (Guerin-Calvert, Tr. 7841).

In direct contrast to this real world evidence, Professor Town's merger simulation model mistakenly predicts substantially higher price changes post-joinder because he omits key explanatory variables. In addition, he does not evaluate the but-for negotiated pre-joinder rates, leaving him with no benchmarks against which to compare the post-joinder rates predicted by his merger simulation model. Most critically, Professor Town does not validate his results with any real world evidence – evidence that is available in this case – perhaps because Professor Town admitted that he has not seen any actual evidence that prices for inpatient care have increased as a result of the joinder.<sup>22</sup> (Town, Tr. 4331). Courts have discounted expert testimony when “the data and predictions cannot reasonably be confirmed by the evidence.” *CCC Holdings*, 605 F. Supp. 2d at 70-72; *see also Tenet*, 186 F.3d at 1054 n.13 (“When an expert opinion is not supported by sufficient facts to validate it in the eyes of the law, . . . it cannot support a decision.”). Finally, Professor Town does not separate the estimated price change between St. Luke's and the other ProMedica hospitals. (RPF 1587). This means that his model predicts a *single* effect for the entire post-joinder ProMedica system. In order to allocate this single effect between St. Luke's and ProMedica, he used his estimated diversion ratios, which are not reflective of the actual diversion that occurs in Lucas County and Toledo.

In sum, Complaint Counsel have failed to prove that the joinder will substantially increase ProMedica's market power or allow it to raise prices above a competitive level with reasonable probability. Their market share statistics do not reflect the actual competitive dynamics and they have not presented sufficient additional evidence of anticompetitive effects.

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<sup>22</sup> There is also no evidence of a reduction in non-price competition. (Town, Tr. 4331).

An analysis of the markets, which Complaint Counsel have not done, shows many factors exist that will constrain ProMedica and an analysis of actual pre- and post-joinder rates show that the joinder will not and has not resulted in rates above a competitive level. Complaint Counsel's failure to carry its legal burden are fatal to their claims.

E. Absent the Joinder, St. Luke's Competitive Significance Would Decrease

As part of the Court's examination of the likely competitive effects of the joinder, it must consider what St. Luke's competitive strength and the competitive dynamics would have been absent the joinder. *See, e.g., Int'l Harvester Co.*, 564 F.2d at 773-76 (holding that the district court properly considered the defendant seller's financial weakness and resultant weakness as a competitor in the context of ruling that a merger did not violate Clayton Act Section 7); *Arch Coal*, 329 F. Supp. 2d at 155-57 (seller's "weak competitive status remains relevant to...whether substantial anticompetitive effects are likely from the transactions."). Here, the record evidence demonstrates that, absent the joinder, St. Luke's competitive significance would diminish, not increase Complaint Counsel would have the Court believe.

The court's analysis in *Arch Coal* exemplifies the type of analysis the Court should apply here. 329 F. Supp. 2d at 157. There, the court assessed the acquired entity's poor financial condition in determining that the FTC's claims of its competitive significance were "far overstated." *Id.* at 157. For example, the court found the acquired entity "consistently lost money" and ruled that a "company with a positive EBITDA but a negative net income is not sustainable for the long term."<sup>23</sup> *Id.* at 155. Importantly, the court noted that even though the failing firm defense did not apply, the acquired entity's "weak competitive status remains relevant to an examination of whether substantial anticompetitive effects are likely from a

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<sup>23</sup> EBITDA stands for earnings before interest, taxes, depreciation, and amortization. (RPF 1621).

transaction.” *Id.* at 157. The evidence there showed that the acquired entity was struggling financially and would be a stronger competitor as a result of the acquisition than it would have been without. *Id.* The court considered all this evidence before ultimately concluding that the FTC had failed to establish that the merger at issue there would likely result in anticompetitive effects. *Id.*

As in *Arch Coal*, to properly evaluate the competitive significance of ProMedica’s acquisition of St. Luke’s, the Court must consider St. Luke’s deteriorating financial condition as part of its determination of whether anticompetitive effects will likely result from the joinder. 329 F. Supp. 2d at 155-57. As an initial matter, St. Luke’s deteriorating financial condition would have necessitated major cuts in services, including the complete elimination of {

}, had it remained independent. (RPF 1963-1965, *in camera*). Following those cuts, St. Luke’s would no longer be a viable competitor able to fulfill its mission to serve the community. Key financial metrics of the type examined by the *Arch Coal* court also demonstrate that St. Luke’s would have been a diminished competitor going forward. Finally, St. Luke’s poor financial condition meant that it lacked the capital it needed to invest to compete into the future, especially because the changing healthcare regulatory environment and technological trends placed St. Luke’s in greater jeopardy. (RPF 1967). As an independent entity, St. Luke’s would be ill-equipped to compete in the future.

1. In Lieu of a Joinder, St. Luke’s Considered Deep Cuts in Services and Significant Layoffs

In the fall of 2009, as St. Luke’s began exploring giving up its cherished independence, St. Luke’s management and board concluded that to remain independent St. Luke’s would have to cut major, money losing service lines such as the {

} (RPF 1964, *in camera*). Indeed, St. Luke's estimated that the service cuts required to stay independent would mean laying off between { } of its 1,500 full-time equivalent employees. (RPF 1965, *in camera*). Moreover, St. Luke's anticipated that in the future St. Luke's would have to make additional cuts, including potentially { } (RPF 1964, *in camera*).

After a November 4, 2009, board meeting, St. Luke's CEO Dan Wakeman expressed his belief to other members of St. Luke's management that St. Luke's large financial losses and need for significant investments in, for example, an underpaid workforce, aging plant and equipment, and new IT systems, would eventually persuade its board to choose a joinder partner or make more aggressive service cuts. (RPF 1974). When the board met next { } concluding that if it made the cuts required to remain independent, it could no longer fulfill its mission to serve the community, unlike if it joined with ProMedica. (RPF 939, *in camera*, 1969, *in camera*, 1980, *in camera*).

2. Key Financial Metrics Confirm St. Luke's Weak Competitive Position

Like the acquired entity in *Arch Coal*, key financial metrics reveal St. Luke's weak competitive status. In the four years immediately preceding the joinder, both St. Luke's and its parent OhioCare were consistently not profitable from an operating perspective. (RPF 1616-1617). While it was experiencing operating losses, {

} (RPF 1625, *in camera*, 1627, *in camera*). The losses that St. Luke's experienced from 2007 through consummation of the joinder were not sustainable, because it could not draw down its reserves indefinitely. (RPF 1634). In fact, St. Luke's unrestricted

reserves decreased from { } at the end of 2007 to { } at the end of August 2010, when the joinder closed. (RPF 1641, *in camera*).

Aside from these financial metrics, independent third parties confirmed St. Luke's financial and, thus, competitive weakness. Specifically, Moody's, had twice downgraded St. Luke's credit rating, for a total of three grades, in the two years prior to the closing of the joinder to just { } (RPF 1981, 1983, 1984, *in camera*).

Likewise, AMBAC, St. Luke's bond insurer, had notified St. Luke's in the spring of 2010 that it had {

} (RPF 2005, *in camera*). {

} (RPF 2025, *in camera*, 2027, *in camera*, 2030; *in camera*).

St. Luke's financial condition was further hampered by the underfunded state of its defined benefit pension plan. Despite freezing the plan at the end of 2009, St. Luke's faced an underfunding liability of about { } on its financial statements as of the time of the joinder. (RPF 1649, RPF 1657, *in camera*). St. Luke's was required by statute to completely fund its plan over { } (RPF1664, 1672, *in camera*).

From this financial evidence, the Court can conclude that Complaint Counsel have "far overstated" St. Luke's future competitive significance as an independent competitor. *Arch Coal*, 329 F. Supp. 2d at 157. Moreover, the effects of St. Luke's poor financial condition would be real, not abstract, and would have been felt in concrete ways if St. Luke's had not joined ProMedica.

3. St. Luke's Poor Financial Condition Meant that It Lacked the Capital To Compete Effectively in the Future

Without the joinder, St. Luke's poor financial condition would have handicapped its ability to compete, because St. Luke's lacked the resources to make needed capital investments. (RPF 996, 1686, 1757). {

} (Wakeman, Tr. 3014, *in camera*).

St. Luke's historically spent about \$11 million per year on routine capital expenditures, but its consistent operating losses had caused it to dramatically cut capital spending in the years prior the joinder and defer many needed investments. (RPF 1643, 1706, 1686-1702, 1703-1704, *in camera*, 1705). Its deferral of needed capital spending meant that St. Luke's average age of plant in 2009 was 13.6 years, significantly above the 10.5 years for comparably Moody's rated hospitals. (RPF 982, 1916-1918, *in camera*). By the time the joinder closed, St. Luke's average age of plant had climbed to { } years. (RP 1918, *in camera*). Additionally, St. Luke's needed to convert to private rooms to stay competitive and achieve "meaningful use" of healthcare IT to comply with healthcare reform legislation and avoid future cuts in government reimbursement. (RPF 1751-1757, 1967, 1709, 1716). As Mr. Wakeman explained, "[a]ll of those capital demands would have put us so far behind the eight-ball, we would have had a very difficult time competing in the long term after 2011 as an independent." (RPF 1961). The most critical and daunting investments were St. Luke's need to convert its semi-private rooms to private rooms and install new IT systems to achieve "meaningful use" in time to avoid reductions in government reimbursement.

a. St. Luke's Had a Low Proportion of Private Rooms

Private rooms have become the standard of care for hospitals in Lucas County and around the country. (RPF 815). They are more efficient operationally, improve patient satisfaction, help prevent and control infections, facilitate compliance with HIPAA regulations, and are widely demanded by patients. (RPF 815-818). Mercy and UTMC were in the process of converting to private rooms or had already done so. (RPF 172, *in camera*, 206-207, 213, 1197-1201). {

} (RPF 172, *in camera*).

UTMC is converting all of its remaining semi-private rooms to private rooms for about \$5 to 7 million as a part of a larger \$25 million renovation project. (RPF 1197-1198). However, St. Luke's had { } putting it at a serious disadvantage to its competitors. (RPF 1757, 2222, *in camera*). St. Luke's financial struggles constrained it from making this important investment in private rooms. (RPF 1756). It is doubtful the funds to pay for the needed St. Luke's private room conversion would have been available absent the joinder. (RPF 1961, 2233). St. Luke's restricted ability to convert to private rooms absent the joinder would make St. Luke's less attractive for patients and would have further eroded its competitive position. (RPF 2234).

b. St. Luke's Would Have Difficulties Achieving "Meaningful Use"

Regardless of whether it joined ProMedica, St. Luke's was required by recent healthcare reform legislation to achieve "meaningful use" of healthcare IT. (RPF 1709, 1737). But, St. Luke's weak financial condition meant that it would have difficulty achieving compliance in time to avoid penalties in the form of reduced reimbursement for government-insured patients. (RPF 1716, 1732, *in camera*, 1737).

St. Luke's has numerous IT systems implicated by the "meaningful use" requirements, including, for example, its patient registration, patient billing, nursing documentation, radiology, laboratory, surgery, pharmacy, cardiac cath lab, and pulmonary medicine systems. (RPF 1713). But St. Luke's cannot simply update its current systems, because many are no longer supported by the manufacturers and creating new interfaces between the old systems is costly and inefficient. (RPF 1715).

Prior to the joinder, St. Luke's had selected a vendor, Eclipsys, to help it comply with "meaningful use," and Eclipsys's proposal was estimated to cost more than \$20 million over seven years. (RPF 1724, 1729, *in camera*). Those costs did not include the IT infrastructure upgrades, in the form of networking, storage, and servers, needed to support the implementation of Eclipsys's proposal; St. Luke's estimated that would cost an additional 25 percent of the cost of the Eclipsys proposal itself. (RPF 1726). Eclipsys's proposal also did not account for the ongoing operating costs associated with the Eclipsys proposal, such as additional clinical and non-clinical staff. (RPF 1728). Nonetheless, in 2010, prior to the joinder, St. Luke's budgeted \$6 million towards complying with "meaningful use," but, given its capital freeze, St. Luke's never actually allocated any funds. (RPF 1733).

#### 4. St. Luke's Was Poorly Positioned To React to the Changing Healthcare Environment

As part of the Court's overall charge to evaluate the "structure, history, and probable future" of the hospital services market, it should examine St. Luke's future competitive state within the context of the healthcare industry and rapid changes occurring within it. *Gen. Dynamics Corp.*, 415 U.S. at 498. For example, payments from Medicare and Medicaid, which reimburse St. Luke's below its costs of providing care, comprise over 60% of St. Luke's

revenues. (RPF 250, 251, 252, 1758-1759, 1775, *in camera*, 1776). Worse, Medicare rates are likely to decline further. (RPF 1228).

St. Luke's also anticipated that federal healthcare reform legislation would shift more risk to hospitals for the health of a patient population by moving away from fee-for-service to a pay-for-performance model. (RPF 820, *in camera*, 937, *in camera*, 838, 1228, 1293, *in camera*). But, St. Luke's CEO, Mr. Wakeman, recognized that an independent St. Luke's was not in a position to take on the type of additional risk that healthcare reform legislation would require:

{

}

(RPF 1961, *in camera*). Besides regulatory change, the hospital industry continues to face technological change, with inpatient procedures increasingly shifting to the outpatient setting, depriving St. Luke's of future volume. (RPF 37-39). A competitor described St. Luke's future dilemma best:

{

}

(PX02288 at 2-3, *in camera*). Together, these facts confirm what St. Luke's management and board already realized, that St. Luke's was likely to be a diminished competitor going forward.

Its “weak competitive status” is another factor proving that substantial anticompetitive effects are not reasonably likely from the joinder. *Arch Coal*, 329 F. Supp. 2d at 157.

F. The Joinder Has Resulted in and Will Continue to Yield More Procompetitive Benefits

The Court should also consider that, as a result of the joinder, St. Luke’s is a stronger competitor than it would have been without it. Again, the court’s reasoning in *Arch Coal* is instructive. There, the court considered evidence that the seller as part of a joined entity “will be a stronger competitive force in a post-merger market than [the seller] has been or will be if no merger occurs” in holding that the merger was not anticompetitive. 329 F. Supp. 2d at 157. Similarly, in *International Harvester*, the Seventh Circuit found that district court had properly considered the fact that the merger agreement “substantially improved [the defendant seller’s] financial, operating, and competitive position” in affirming that the agreement did not violate the antitrust laws. 564 F.2d at 777.

Here too, the joinder has improved St. Luke’s competitive position and will continue to do so. ProMedica has already made significant capital investments in St. Luke’s, for example, enabling St. Luke’s to move forward with its private bed conversion and “meaningful use” compliance. (RPF 2114-2115, 2117, 2125). In addition, the joinder immediately cured St. Luke’s bond default and increased St. Luke’s bond rating as St. Luke’s became part of ProMedica’s Obligated Group. (RPF 2131-2133). As a result of the joinder, ProMedica also assumed responsibility for St. Luke’s underfunded defined benefit pension plan. (RPF 2134). The joinder also gave St. Luke’s access to the Paramount network resulting in increased patient revenues at rates that exceed St. Luke’s cost of treating those patients. (RPF 2141-2142). And as part of ProMedica, St. Luke’s is now better positioned to comply with healthcare reform legislation. (RPF 2155, *in camera*; 2129, *in camera*). All these benefits stabilized St. Luke’s

finances and enhanced St. Luke's ability to compete in Lucas County and serve its patients consistent with its mission.

1. St. Luke's Has Already Realized Certain Benefits that Would Not Have Occurred But for the Joinder

a. ProMedica Has Contributed Significant Capital to St. Luke's

The Joinder Agreement obligates ProMedica to contribute \$10 million in each of the years 2011-2013 to fund capital projects that St. Luke's deferred because it lacked the funds needed to pay for them. (RPF 2115, 2117). In addition, ProMedica contributed \$5 million to St. Luke's Hospital Foundation to spend as it saw fit immediately at closing. (RPF 2115). The influx of capital from ProMedica has allowed St. Luke's to implement strategic capital projects such as its private room expansion, facility upgrades, and IT upgrades relating to St. Luke's "meaningful use" compliance. (RPF 2125). Since the joinder, St. Luke's has allocated \$3 million of the capital it received from ProMedica to create 17 new private rooms. (RPF 2235-2236) It has also allocated a portion of its initial \$10 million investment from ProMedica to implement a new EMR system and meet "meaningful use" requirements. (RPF 2156-2157). ProMedica has also facilitated the process by providing 55 employees to assist St. Luke's in its "meaningful use" conversion process. (RPF 2159). Based on progress since the joinder, St. Luke's expects that it will comply with the "meaningful use" deadlines. (RPF 2160).

b. Access to Paramount Has Resulted in Increased Patient Volume and Revenues that Help St. Luke's Cover Its Costs of Providing Care

As part of the Joinder Agreement, St. Luke's became an in-network provider with Paramount. (RPF 2141). This has lead to greater patient volume and has {

} (RPF 2142, *in camera*). {

} (RPF 2142, *in camera*). Consequently, St. Luke's financial performance has improved after the joinder. (RPF 2144). The additional Paramount revenues will help St. Luke's remain viable and improve its services and facilities.

c. Access to ProMedica's Obligated Group Has Cured St. Luke's Bond Default and Increased Its Bond Rating

As a result of the joinder, St. Luke's became part of ProMedica's Obligated Group, increasing Moody's rating of St. Luke's outstanding bonds and curing St. Luke's bond default with AMBAC, because of the greater credit security provided by ProMedica.<sup>24</sup> (RPF 2131-2133). The joinder restored St. Luke's ability to borrow, which had been in doubt when St. Luke's was independent. (RPF 1634, 1644). Moreover, curing the default allowed St. Luke's to avoid defeasance of its bonds which would have required a cash outlay of more than \$8 million by the end of 2010. (RPF 2021, *in camera*, 2028, *in camera*, 2030, *in camera*). Because hospitals typically borrow money to fund large capital expenditures, the improvement in St. Luke's credit position as a result of the joinder has provided St. Luke's with an important competitive benefit.

d. ProMedica Is Now Responsible for St. Luke's Underfunded Defined Benefit Pension Plan

Since the joinder ProMedica has also taken responsibility for funding St. Luke's defined benefit pension plan. While St. Luke's had significant problems maintaining the 80 percent minimum funding level over the past several years, {

} (RPF 2136, *in camera*, 2310-12, *in camera*).

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<sup>24</sup> The Standard & Poor's rating for St. Luke's bonds as part of ProMedica's Obligated Group is Aa- with a positive outlook. (RPF 117).

e. Joining ProMedica Has Allowed St. Luke's To Lower Expenses

The joinder has already allowed St. Luke's to reduce its expenses and ProMedica and St. Luke's expect the joinder to generate significant additional future savings and efficiencies. For example, following the joinder St. Luke's saved about a half million dollars in professional liability insurance by becoming part of ProMedica's captive insurance company. (RPF 2138). In addition to reduced insurance premiums, joining ProMedica's captive insurance plan and spreading risk has had the effect of freeing up \$8 million on St. Luke's balance sheet that St. Luke's had previously reserved for potential claims. (RPF 2139). In addition, St. Luke's has been able to reduce expenses through the consolidation of non-clinical backroom services such as billing services, legal services, physician practice management, and IT support. (RPF 2140, *in camera*). These non-clinical cost savings anticipated and already achieved by St. Luke's and ProMedica, will free resources for St. Luke's to invest in its facility, employees, and, more generally, in improving its competitive position in Lucas County.

2. The Joinder of ProMedica and St. Luke's Will Allow Them To Lower Costs and To Improve Quality in the Future

a. The Addition of St. Luke's Will Allow ProMedica To Consolidate Clinical Services To Optimize Its Services and Facilities To Best Meet Community Needs

Evidence of qualitative and quantitative benefits to consumers of healthcare services in Toledo is recognized as relevant to a defense to a government challenge to a merger. *See Tenet*, 186 F.3d at 1053-54 (noting improved quality as a benefit of the merger); *In re Evanston*, 2007 FTC LEXIS 210, at \*225-28 (reviewing respondents' proposed efficiencies). Here, the residents of Toledo have already received and will continue to receive benefits from this joinder.

The joinder gives ProMedica the opportunity to assess community needs and {

} (RPF 2211, *in camera*). To aid in its integration efforts, ProMedica retained Navigant Consulting (“Navigant”) in mid-2010 to conduct a clinical integration study and recommend how best to distribute services across the ProMedica system following the joinder with St. Luke’s. (RPF 2163-2164).

Navigant generally recommended that {

}

(RPF 2178, *in camera*). In response, ProMedica has already {

.} (RPF 2206, *in camera*, 2225, *in camera*).

This move increased St. Luke’s capacity and virtually eliminated the need to temporarily close St. Luke’s emergency room to new patients. (RPF 2232). ProMedica also estimated that

{ } would result

in an expense savings of { }, because Flower Hospital performs the same service at a lower expense. (RPF 2231, *in camera*).

Open heart surgery represents another example of beneficial clinical integration the joinder will facilitate. Prior to the joinder, St. Luke’s did not have a sufficient number of open-heart cases a year to maintain quality thresholds or break-even, financially. (RPF 2200-2201).

Following the joinder and Navigant’s recommendations, ProMedica may transfer {

} (RPF 2198-2199, *in camera*). These changes will benefit the community by consolidating complex, low-volume cases in one location to maximize efficiency, staffing competencies, and, as a result, quality performance. (RPF 2168-2169).

A third example is { } Navigant recommended that ProMedica { } (RPF 2185-2186, *in camera*). This benefits the { } population around St. Luke's that will be able to access { } services at St. Luke's in the future. (RPF 2204, *in camera*).

By following the plan that Navigant proposed, ProMedica has the potential to reconfigure healthcare services in Toledo in a more efficient and cost-effective manner that will ultimately benefit consumers. ProMedica could not achieve the integration benefits outlined in Navigant's plan without the joinder because {

} (RPF 2214-2215, *in camera*). The joinder gives ProMedica more options and more opportunity to {

} (RPF 2214, *in camera*). Likewise, St. Luke's could not have achieved integration benefits without the joinder because {

} (RPF 2128, *in camera*).

Finally, the joinder gives St. Luke's access to ProMedica's comprehensive quality program and technologies aimed at increasing patient safety. ProMedica has quality councils for each of its hospitals, Paramount, PPG, as well as four service line quality councils for cancer, orthopedics, heart and vascular, and critical care. (RPF 2241-2242). ProMedica's corporate quality department provides balanced report cards based on valid quality metrics to each hospital, enabling ProMedica to monitor and track the quality performance of each of its hospitals. (RPF 2243-2244). Following the joinder, ProMedica began the process of bringing St. Luke's into its system-wide quality programs. (RPF 2254). St. Luke's benefits from the joinder by having access to ProMedica's quality department and councils through which it can share best practices and analyze data, to which it did not have access as a standalone hospital. (RPF 2255).

The joinder also gives St. Luke's access to ProMedica's quality-related technologies. For example, before the joinder, St. Luke's did not have an eICU or smart pumps, technologies that can save lives and improve quality outcomes and reduce the cost of care. (RPF 2250-2251). St. Luke's has access to those technologies only because of the joinder.

b. The Joinder Will Allow ProMedica and St. Luke's To Realize Additional Efficiencies

Evidence of efficiencies may be introduced to rebut a plaintiff's *prima facie* case. *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 720 (D.C. Cir. 2001); *Baker Hughes*, 908 F.2d at 982-83. The Eleventh Circuit has held that "a defendant may rebut the government's *prima facie* case with evidence showing that the intended merger would create significant efficiencies in the relevant market." *Univ. Health*, 938 F.2d at 1222-23 (holding that a defendant could overcome a presumption that the proposed acquisition would lessen competition by demonstrating that the acquisition would result in significant efficiencies to benefit consumers). Courts, therefore,

should consider “evidence of enhanced efficiency in the context of the competitive effects of the merger.” *Tenet*, 186 F.3d at 1054. Further, in the hospital merger context, evidence may show that “a hospital that is larger and more efficient . . . will provide better medical care than either of those hospitals could separately.” *Id.* Efficiencies are particularly compelling in the healthcare industry where hospitals face significant challenges to meet the demands of new healthcare legislation, and regulatory reforms are changing the competitive landscape such that “a merger, deemed anticompetitive today, could be considered procompetitive tomorrow.” *Id.* at 1054-55 (citing *United States v. Mercy Health Servs.*, 107 F.3d 632, 637 (8th Cir. 1997)). For example, in *Tenet*, the Eighth Circuit criticized the district court for not “properly evaluat[ing] evolving market forces in the rapidly-changing healthcare market.” *Id.* at 1055.

ProMedica and St. Luke’s began exploring { } in early 2010 to develop ideas and quantify possibilities. (RPF 2146, *in camera*). To do so, ProMedica {

} (RX-31 (Akenberger, Dep. at 95-96), *in camera*). ProMedica also hired

{

} (RPF 2147, *in camera*).

In the spring of 2010, ProMedica estimated that the joinder could achieve about { } in annual savings, and approximately { } in capital avoidance savings, and related operating cost savings of { } (RPF 2150, *in camera*).

Following the joinder, ProMedica and St. Luke’s have established a steering committee to oversee approximately 20 integration teams to further develop the efficiencies opportunities that Compass identified, and to identify new opportunities. (RPF 2154). Since first estimating



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I, Christine Devlin, hereby certify that I served a true and correct copy of the foregoing Respondent's Post-Trial Brief, Public Version, upon the following individuals by hand on September 15, 2011.

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