No. 14-35173

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ST. ALPHONSUS MEDICAL CENTER – NAMPA, INC., *et al.*

Plaintiffs/Appellees,

v.

ST. LUKE'S HEALTH SYSTEM, LTD. *et al.*,

Defendants/Appellants.

On Appeal From the United States District Court
For the District of Idaho
Case No. 1:12-cv-00560-BLW *et al.*

ANSWERING BRIEF FOR PLAINTIFFS/APPELLEES THE FEDERAL TRADE COMMISSION AND THE STATE OF IDAHO

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Government appellees agree with appellants' statement of jurisdiction.

QUESTIONS PRESENTED

This antitrust case involves the acquisition of the largest primary-care physician practice in a market by the second largest practice in that market. They had been one another's closest rivals for inclusion in health-plan provider networks, and together they now control nearly 80 percent of the market for adult primary-care physician services. The district court found that the acquisition violated the Clayton Act and the Idaho Competition Act, which make unlawful any acquisition "where the effect of such acquisition may be substantially to lessen competition." 15 U.S.C. §18; Idaho Code §48-106. The questions presented are:

1) Whether the district court properly defined the geographic market;
2) Whether the district court properly found that the acquisition may substantially lessen competition;
3) Whether the district court properly found that the harm to competition outweighed any efficiency benefits of the acquisition; and
4) Whether the district court properly ordered divestiture to remedy the unlawful acquisition.

STATEMENT OF THE CASE

Until the transaction at issue here, Saltzer Medical Group and St. Luke's Health System were the two largest providers of primary-care services – general practice internal medicine – in Nampa, Idaho. In December 2012, St. Luke's and Saltzer decided to stop competing for placement in insurance company physician networks and combine into a single economic entity. Formerly each other's closest rivals, they now hold a combined market share for adult primary-care services in Nampa of nearly 80 percent, leaving little remaining competition. As both parties recognized in contemporaneous documents, combining enabled them to "control market share" and thereby "pressure payors" (insurance companies) to accede to a "price increase," given that "market share in primary care is … critical to sustaining a strong position relative to payer contracting." *See* pp.9-10, *infra* (citing documents).

After extensive discovery and a 19-day trial, the district court found that, as expected, the acquisition would enable the combined practices to exploit increased market power to obtain substantially higher prices than either practice could have bargained for had they kept competing. The court also considered and rejected the argument that operational efficiencies from the combination outweighed its anticompetitive harms. The district court thus held that the acquisition violated Section 7 of the Clayton Act, 15 U.S.C. §18, and the analogous Idaho Competition

Act, Idaho Code §48-106, which prohibit an acquisition "where … the effect of such acquisition may be substantially to lessen competition."[1] To remedy the harm, the court ordered St. Luke's to divest its interests in Saltzer.

1. *The Acquisition*.

Saltzer was the largest medical practice in Idaho not owned by a hospital system. It had 16 adult primary-care physicians in Nampa, which is located roughly 20 miles west of Boise and is Idaho's second-largest city, with about 86,000 people. FOF19-21 (ER16);[2] *see* http://quickfacts.census.gov/qfd/states/16/1656260.html. Saltzer's share of the Nampa market for adult primary-care services (measured by patient visits) was about 65 percent. TX1789 (SER110).

St. Luke's owned the second-largest primary-care practice in Nampa, with a 12-percent share. FOF10, 17 (ER14, 16); TX1789 (SER110). In December 2012, St. Luke's acquired Saltzer, forming a practice with a market share for adult

[1] The Idaho Competition Act must "be construed in harmony with federal judicial interpretation of comparable federal antitrust statutes." Idaho Code §§48-102(3), 48-106. Because the analysis under the Clayton Act applies equally to the Idaho Competition Act, all references in this brief to the Clayton Act include the Idaho statute as well.

[2] We use the following abbreviations: "COL": conclusions of law; "FOF": findings of fact; "Dkt.": district court docket; "ER": excerpts of record; "SER": private appellees' supplemental excerpts of record; "GSER": government appellees' supplemental excerpts of record; "TX": trial exhibits; "Trx.": transcript.

primary-care services in Nampa of nearly 80 percent. FOF31, 80 (ER18, 26); TX1789 (SER110).

The Saltzer deal capped a series of physician acquisitions by St. Luke's. Starting in 2007, it acquired "49 physician clinics in the Treasure Valley," the region where Nampa and Boise are located, "and at least 28 physician practices in the Magic Valley," the region where Jerome and Twin Falls are located. FOF86 (ER27).

2. *The Healthcare Market*.

a. Unlike a typical two-party market, the commercial healthcare market has three sets of participants: consumers (patients who are commercial health insurance policyholders, and their employers, who select the policies offered to them), sellers (healthcare providers such as St. Luke's), and third-party payers (insurance companies such as Blue Cross of Idaho).[3] Consumers of healthcare ordinarily pay only a portion of the price of service directly through co-payments and deductibles. Insurers pay the bulk of the bills.

As with any consumer product, insurers must make their policies commercially attractive to sell them to patients and their employers. Whether a policy will be attractive to a policyholder or an employer depends on its cost and

[3] For ease of reference, we use "insurers" to refer to insurance companies and other health plans, and "doctors," "physicians," or "medical practices" to refer to all providers of healthcare, including hospitals, except when clarity requires otherwise.

on the quality and location of the doctors in that insurer's "network." *See* Trx.1298:24-1299:4; 1302:24-1303:13; 1329:8-14 (Dranove) (SER324, 325, 330). A network is the group of healthcare providers who have agreed to treat the insurer's members at rates negotiated by the provider and the insurance company. These negotiated rates are lower than the rates charged by out-of-network providers to care for an insurance company's policyholders. *See* Trx.3428:20-3429:9 (Dranove) (GSER110); FOF55, 103 (ER22, 29).

Healthcare providers, including groups of primary-care physicians, compete with each other to be included in an insurance company's network, which is an important source of patients, who bear lower out-of-pocket costs for using in-network doctors. Robust competition for inclusion enables insurers to negotiate lower reimbursement rates, which lead to lower costs for consumers and employers. FOF131, 144 (ER34, 36). Conversely, less competition leads to higher rates and consumer costs. *See* Trx.1302:19-24 (Dranove) (SER325); *see also* Gregory Vistnes, *Hospitals, Mergers, and Two-State Competition*, 67 Antitrust L. J. 671, 674-675 (2000); Katherine Ho, *Insurer-Provider Networks in the Medical Care Market*, 99 American Econ. Rev. 393, 396 (March 2009).

Once providers are in an insurance company's network, they compete to attract patients by offering and improving the quality of service offered to patients.

See Trx.3419:10-21; 3447:5-9 (Dranove) (SER477, 479). Less competition reduces the incentive to improve or maintain quality.

b. The amount an insurer reimburses network participants for healthcare services is established in a contract negotiation. Like any business deal, the negotiation turns on the relative bargaining strength of the insurer and the provider. Where the provider's position is stronger, rates will be higher; and where the insurer's position is stronger, rates will be lower. Each side has some bargaining leverage. Physicians need inclusion in insurer networks to recruit patients. Dkt.100 (St. Luke's Answer) ¶21 (ER111-112). Insurers need physicians to participate in a network to make it attractive to policyholders. The party with the greater relative strength can negotiate a more favorable rate. *See ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 562 (6th Cir. 2014); Abe Dunn and Adam Hale Shapiro, *Do Physicians Possess Market Power?*, 57 J. L. & Econ. 159, 165 (Feb. 2014).

As the district court explained, bargaining leverage "consists largely of the ability to walk away" from the negotiating table. FOF105, 106 (ER29). It called that ability a "fallback option" or a "best alternative to a negotiated agreement." FOF108 (ER29); Trx.1300:8-12 (Dranove) (SER324). If multiple medical practices are competing for inclusion in the network, an insurer facing a demand for unacceptably high reimbursement rates by one practice will be able to walk

away from the negotiation and turn to other practices to form a commercially attractive network. FOF43, 105-109 (ER20, 29); Trx.1300:2-1301:24, 1304:1-1305:4 (Dranove) (SER324, 325); *see ProMedica*, 749 F.3d at 562.

In markets with no good fallback options, however, the bargaining dynamic is quite different. "[S]tripped of acceptable alternatives" among medical practices in a given area, an insurer's bargaining strength "disappears" and the dominant practice's superior bargaining position forces the insurer to accede to its demand for higher reimbursement rates. FOF106-107 (ER29); *see also ProMedica*, 749 F.3d at 562. The more important a provider is to the formation of a marketable network, the stronger its bargaining position will be, and the higher the rates it may successfully demand. Higher rates ultimately are borne by consumers and employers.

A superior bargaining position in the primary-care market can affect reimbursement rates for both primary-care services and other services for which the provider is negotiating reimbursements. For example, St. Luke's negotiates a single system-wide contract that covers all services. It will not engage in separate negotiations for individual physicians or facilities, but requires an all-or-nothing agreement for the entire St. Luke's system. Trx.431:5-19 (Crouch) (SER251). As both plaintiffs' and defendants' experts agreed, St. Luke's negotiations therefore do not focus on the reimbursement rate for any particular service, but on the total

expected payment from the insurer to the healthcare provider for all services covered by the contract. The experts referred to that figure as the "bottom right-hand number" in an imaginary spreadsheet that tabulates all reimbursement rates and sums up the total expected yearly payment from the insurer to the provider. Trx.1302:4-11 (Argue) (SER325); Trx.2899:16-2900:14 (Dranove) (GSER100); *see also* Dkt.100 ¶21 (ER111-112); Dkt.105 ¶21 (ER91). A superior bargaining position in the primary-care market can increase the overall prices whether or not rates for primary-care services increase.

c. Pre-acquisition, Saltzer and St. Luke's competed against each other in Nampa for inclusion in insurer networks. If St. Luke's demanded excessive rates, an insurer could walk away and turn to Saltzer to form its network. Conversely, if Saltzer demanded excessive rates, an insurer could turn to St. Luke's as the core of an alternative network. FOF109 (ER29). From the patients' (and insurer's) perspective, Saltzer and St. Luke's were each other's closest substitutes. FOF99 (ER28). Patients unable to use one practice would be more likely to switch to the other practice than to any third alternative. FOF100-101 (ER28). After the acquisition, however, the combined practices hold 80 percent of the market, and there is no "attractive option" as a fallback in negotiation. FOF80, 110 (ER26, 29). The acquisition thus "weakens [an insurer's] ability to negotiate" lower rates

because it "will increase substantially St. Luke's bargaining leverage with health plans." FOF98, 111 (ER28, 30).

St. Luke's and Saltzer were well aware of those market dynamics. Before the acquisition, the CEO of a St. Luke's hospital wrote that increased bargaining leverage would allow the hospital chain to "pressure payors" for a "price increase." FOF112 (ER30). Other internal St. Luke's documents likewise show its understanding that "market share in primary care is … critical to sustaining a strong position relative to payer contracting." FOF116 (ER31-32). St. Luke's expected increased revenue from the Saltzer acquisition large enough to give the Saltzer doctors a 30-percent pay raise. FOF127 (ER33).

That recognition comported with St. Luke's experience in Twin Falls, Idaho. There, Blue Cross of Idaho initially declined to meet St. Luke's rate demand. Without St. Luke's dominant primary-care practice in its network, however, Twin Falls employers were unwilling to purchase Blue Cross policies even though they included in-network primary-care doctors located 15 miles away. Blue Cross ultimately gave in to St. Luke's demand. FOF117-120 (ER32).

Similarly, after acquiring multiple primary-care practices throughout Idaho beginning in 2007, St. Luke's was able to increase its reimbursements substantially. In 2007, St. Luke's hospitals were reimbursed at the average rate in Idaho. By 2012, after it had accumulated bargaining leverage, St. Luke's "had

three of the top five highest paid hospitals, and its top hospital was receiving reimbursements 21% higher than the average Idaho hospital." FOF87-88 (ER27-28).

Saltzer likewise understood the importance of bargaining leverage. Its chief negotiator recognized that the acquisition would give Saltzer "the clout of the entire [St. Luke's] network" to win financial concessions, including taking back past bargaining losses from Blue Cross of Idaho, the largest insurer in the state. FOF113, 114 (ER30-31). Similarly, at an internal meeting to discuss the acquisition, Saltzer's leaders listed the "fundamental reasons" in support of the deal, which included "control market share" and "one competition [sic] compared to two." TX1369 (SER862); Trx.2416:6-2420:13 (Kaiser) (SER415-416). Saltzer was the largest practice in Nampa, but it still recognized the need for increased market share.

3. *The District Court's Decision*.

After a 19-day trial on the merits that included more than 50 witnesses and 1500 exhibits, the district court held that the acquisition of Saltzer by St. Luke's violated the Clayton Act. Dkt.464, 471 (ER10, 1). The court ordered St. Luke's to "fully divest itself of Saltzer's physicians and assets and take any further action needed to unwind the Acquisition." Dkt.471 at 2 (ER2).

a. Product and Geographic Market Definitions.

The parties agreed that the relevant product market is adult primary-care physician services. FOF48-49 (ER21).[4]

The relevant geographic market, the court determined, is the city of Nampa. FOF73 (ER25). To reach that determination, the court relied on a standard economic tool of market definition. "Economists define a market by using the 'hypothetical monopolist' or 'SSNIP' test," FOF52 (ER22), which asks whether buyers would rather accept an increase in price than seek a good or service outside of a proposed geographic market. The test assesses whether a hypothetical monopolist in the proposed market could impose a "small but significant, non-transitory increase in price" – a "SSNIP" (pronounced "snip") – of between 5 and 10 percent without driving away enough consumers to make the increase unprofitable. FOF52-53 (ER22).

If the price increase in the proposed geographic market would "cause consumers to travel to adjacent areas where sellers offer lower prices," in sufficient numbers to "mak[e] the price hike unprofitable," then that proposed geographic market is defined too narrowly. FOF54 (ER22). But if the price increase *would* be profitable because enough consumers would accept it in order to stay within the

[4] The private party plaintiffs, but not the government, alleged anticompetitive effects in additional markets. The district court did not address those claims. COL63-65 (ER58-59).

defined geographic area, then that area is the relevant geographic market for antitrust purposes. *See* U.S. Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines* §§4.1.1, 4.2.1 (2010); Trx.1315:5-15 (Dranove) (SER328). The evidence showed that a hypothetical primary-care monopolist in Nampa could profitably impose a SSNIP. FOF72 (ER25).

In the healthcare market, the court found, the relevant consumer for purposes of the SSNIP test is the insurance company that directly pays for services and bargains with providers over their price. FOF54-56 (ER22). The court thus assessed whether insurers would include in their networks a hypothetical monopolist that provides all primary care in Nampa and demands a SSNIP. The district court concluded that insurers would accept the SSNIP because without Nampa-based doctors in their network, they could not successfully sell policies. FOF61-62, 71-73 (ER23, 25). Nampa thus is the proper geographic market.

Specifically, the court found, "patients like to get their medical care close to home," and "Nampa patients strongly prefer access to local [primary-care doctors]." FOF67, 69 (ER24). Indeed, the overwhelming majority – 84 percent – of Nampa residents receive primary care from doctors in Nampa or its immediate vicinity. FOF65 (ER24); s*ee* Trx.1320:4-23 (Dranove) (GSER69) (84 percent receive primary care in Nampa or an adjacent zip code). The remainder typically receive care near their workplace, underscoring the strong preference for

conveniently located care. FOF67 (ER24). Because consumers insist on local care, "commercial health plans need to include Nampa [doctors] in their networks to offer a competitive product." FOF69 (ER24); *see id*. 70 ("A health plan could not successfully offer a network … to Nampa residents that only included Boise [doctors]."") (ER24). Without local network doctors, "the health plan will not even be considered an eligible vendor" for an employer choosing a health plan for its employees. FOF62 (ER23); Trx.1313:1-21 (Dranove) (SER327). That is why Blue Cross of Idaho has primary-care physicians "in every zip code where they have enrollees" and does not "require a single enrollee to travel outside of their zip code for primary care." FOF59-60 (ER23).

b. Clayton Act Analysis.

Consistent with Clayton Act precedent, the court applied a three-part burden-shifting regime. COL16-21 (ER51-52). First, the plaintiffs had to prove a prima facie case of illegality by showing that the acquisition gave St. Luke's "an undue percentage share of the relevant market, and would result in a significant increase in the concentration of firms in that market." COL16 (ER51) (quotation marks omitted), citing *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 363 (1963). Sufficiently high market concentration can establish a presumption that the merger will substantially lessen competition. COL17 (ER52), citing *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 715 (D.C. Cir. 2001).

Second, defendants could rebut the presumption by producing evidence "clearly showing that the market's concentration inaccurately predicts the likely competitive effects" of the acquisition. COL18 (ER52), citing *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 631 (1974).

Finally, "[i]f the defendant successfully rebuts the presumption of illegality, the burden of producing additional evidence of anticompetitive effect shifts to the plaintiffs, and merges with the ultimate burden of persuasion, which remains with the plaintiffs at all times." COL21 (ER52), citing *Heinz*, 246 F.3d at 715.

i. Presumption of Illegality.

The district court found that the plaintiffs had shown the acquisition to be presumptively anticompetitive. The district court measured market concentration using the Herfindahl-Hirschman Index ("HHI"), a standard economic tool. *See ProMedica*, 749 F.3d at 568; *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1211 n.12 (11th Cir. 1991). The HHI is calculated by summing the squares of the market shares for all participants in the market. A market "is considered highly concentrated if the HHI is above 2,500, and a merger that increases the HHI by more than 200 points will be presumed to be likely to enhance market power." FOF79 (ER26); *see* U.S. Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines* §5.3 (2010).

The HHIs for the Saltzer transaction were off the charts. Post-merger, the Nampa market for primary-care service had an HHI of 6,219 – more than twice the "highly concentrated" threshold. The acquisition increased concentration by 1,600 points – eight times the amount at which increased market power may be presumed. The HHI analysis by itself raised a strong presumption that the Saltzer acquisition would be anticompetitive. FOF82 (ER26); *see ProMedica*, *supra* (comparable HHI figures "blew through [the HHI] barriers in spectacular fashion").

ii. Likely Anticompetitive Effects.

Although the market concentration figures alone stated a prima facie case of illegality, the district court also found that the evidence proved in addition that the acquisition would have several likely anticompetitive effects. First, as the parties expected and intended, St. Luke's acquisition of Saltzer "will increase substantially St. Luke's bargaining leverage with health plans," FOF98 (ER28), leading to higher reimbursement rates, FOF112-113 (ER30-31). As noted, for example, St. Luke's forced Blue Cross to increase its reimbursements for primary-care services in Twin Falls. FOF117-120 (ER32). Similarly, by acquiring primary-care practices throughout the state, St. Luke's had increased its reimbursement rates for hospital services substantially above the state average. FOF86-88 (ER27-28).

Second, the district court found that the acquisition would enable St. Luke's to "exercise its enhanced bargaining leverage … to charge more services at the higher hospital-based billing rates." FOF121 (ER32). Depending on the contract between the hospital and the insurer, reimbursement for "ancillary services" such as x-rays and lab tests will be greater when services are provided by an outpatient department of a hospital (hence, "hospital-based billing") than by an independent physician. When Saltzer was acquired by St. Luke's, it became an outpatient department and therefore could – if the insurance contract allowed – be reimbursed at higher hospital-based rates "even when those services are performed" not in the hospital, but "in the same physical location" as they were before the acquisition. FOF123-124 (ER33).

Whether St. Luke's can bill ancillary services at hospital-based rates is determined in the bargaining process. The acquisition would give St. Luke's bargaining power to command hospital-based rates for services performed at Saltzer's location and make them "stick." FOF124-125, 129 (ER33, 34). Estimated annual increases ranged as high as $750,000 in lab work and $900,000 in diagnostic imaging alone, reflecting rates 30-60 percent higher than Saltzer's prior rates. FOF124-128 (ER33-34).

c. Rejection of Efficiency Defense.

St. Luke's principal defense was that the acquisition was permissible under the Clayton Act despite the harm to competition because it would lead to greater efficiency in healthcare delivery. To successfully rebut the presumption of illegality, the court held, St. Luke's would have to produce "convincing proof" of "significant" and "merger-specific" benefits. COL37 (ER54), citing Phillip E. Areeda & Herbert Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* ¶ 971 p.48 (3d ed. 2009) (*Areeda*). The court found that St. Luke's had failed to meet that burden.

St. Luke's claimed the merger would improve patient care in three ways. First, it claimed that the acquisition of Saltzer would enable it to move away from "fee-for-service" and toward "risk-based" care. Under fee-for-service, doctors are paid for each procedure they perform and thus have an incentive to increase volume rather than provide more cost-effective care. FOF161-165 (ER39-40). Risk-based care entails payment per-patient (called "capitation"), rather than per-procedure. In that system, the financial risk of repeated procedures – for example, redoing a botched operation – is borne by the doctor, who thus has an incentive to provide better, more cost-effective care. FOF170-175 (ER41-42).

Second, St. Luke's claimed that the acquisition would allow it to provide "integrated" rather than "fragmented" care. Integrated care involves physicians

working together as a team, which allows them to treat the patient as a whole, rather than each doctor treated an individual symptom without coordination. Third, St. Luke's claimed that owning Saltzer would enable the combined practices to make better use of electronic medical records and data analytical tools, which can lead to better care. FOF186-198 (ER43-46).

The district court found that the promised benefits of integration were uncertain, amounting only to an "experimental stage" in the development of healthcare delivery, "where hospitals and other providers are examining different organizational models, trying to find the best fit." COL69 (ER59).

Just as important, the court found that any benefits of the acquisition were not "merger-specific," FOF185, 206 (ER43, 47), but could be achieved without the acquisition of Saltzer and its attendant loss of competition. "There is no empirical evidence to support the theory that St. Luke's needs a core group of employed primary care physicians beyond the number it had before the Acquisition to successfully make the transition to integrated care," the court held. FOF181 (ER43). It credited the testimony of expert witness Dr. Kenneth Kizer, who testified that "[t]he claim that employment yields greater benefit than other affiliation models is simply not supported by the empirical or experiential evidence. Employment has not been shown to be a superior organizational structure." Trx 3525:4-7 (GSER120). Indeed, the court determined, other

"independent physician groups" in Idaho (*i.e.*, ones not owned by hospital systems) "are using risk-based contracting successfully," which showed that there is "not any one specific organization structure … that is the key to integrated medicine." FOF183-184 (ER43). The court credited Dr. Kizer's testimony that "the claims about improved quality" resulting from the acquisition "are … not related to the acquisition per se." Trx.3562:10-14 (GSER124).

The court likewise found non-merger-specific the promised benefits of electronic medical records and diagnostic tools. In fact, the electronic record system already under development by St. Luke's "would allow independent physicians" – doctors not employed by St. Luke's – to access St. Luke's patient records just like an employed physician. FOF202 (ER46). Thus, the court concluded, "the efficiencies of a shared electronic record can be … achieved … without the Acquisition, and … are … not merger-specific." COL48, 49; *see* FOF206 (ER56, 47).

d. Remedy.

As a remedy, the district court ordered St. Luke's to divest its interests in Saltzer "and take any further action needed to unwind the Acquisition." COL80 (ER60). In opposing a preliminary injunction, St. Luke's had assured the court that it would "not oppose divestiture on grounds that divestiture cannot be accomplished," or that it "would be costly or burdensome." COL53 (ER57). The

court held St. Luke's to its earlier promises and imposed divestiture as "the remedy best suited to redress the ills of an anticompetitive merger." COL50 (ER56), quoting *California v. American Stores Co.*, 495 U.S. 271, 285 (1990).

e. Stay Proceedings.

The district court denied St. Luke's motion for a stay pending appeal. Dkt.506 (SER1). The court reiterated that "it could not rewrite" the Clayton Act to allow "experimentation" with anticompetitive healthcare practices, finding instead that "[t]he law itself was clear, and the facts equally so. The application of those facts to the law compelled divestiture." *Id*. at 2-3 (SER2-3). This Court later granted a stay and expedited the appeal. Order of July 25, 2014.

SUMMARY OF ARGUMENT

The Clayton Act contains no healthcare exception. It prohibits *all* acquisitions "in *any* line of commerce" in which "the effect of such acquisition may be substantially to lessen competition." 15 U.S.C. §18 (emphasis added). As the Supreme Court has explained, Congress declined to provide "an exemption" from the antitrust laws "for specific industries" because it rejected the notion that "monopolistic arrangements will better promote trade and commerce than competition." *National Society of Professional Engineers v. United States*, 435 U.S. 679, 689-90 (1978). The antitrust laws do not apply differently depending on "the special characteristics of a particular industry." *Id*. Thus, they apply to

healthcare services "in the same manner that they apply to all other sectors of the economy." *Boulware v. Nevada*, 960 F.2d 793, 797 (9th Cir. 1992).

That authority forecloses St. Luke's implicit invitation to apply the Clayton Act more leniently to healthcare acquisitions to enable judicial experimentation with healthcare initiatives involving anticompetitive aggregations of market power.

Instead, the only question here is whether "the effect of [this] acquisition *may be* substantially to *lessen competition*." 15 U.S.C. §18 (emphasis added). As the district court found, the answer is clearly yes. Before the acquisition, St. Luke's and Saltzer competed against one another for inclusion in insurer networks. They were the largest primary-care practices in Nampa, and each was the other's closest substitute in the eyes of patients. The acquisition eliminated that competition, resulted in a practice with 80 percent market share, and deprived insurers of a commercially feasible fallback option in negotiations. The acquisition thus greatly enhances St. Luke's market power and will likely result in higher reimbursement rates and lower incentives to improve quality of care, to the ultimate detriment of consumers.

1. The district court properly found Nampa to be the relevant geographic market. The SSNIP test, a widely accepted tool for market definition, showed that insurers would accept a price increase because they could not create a commercially attractive physician network without Nampa doctors. The evidence

showed what everyday experience suggests: the vast majority of Nampa policyholders – 84 percent – receive primary care locally, and insurers must cater to their strong preferences. The testimony of executives from four health plans established that insurer networks are not commercially viable if they do not include local doctors. The commercial reality of the insurance marketplace therefore demands that insurer networks include primary-care doctors in Nampa. The SSNIP analysis was not "static," as St. Luke's argues. It considered the *response* of insurers to changes in price.

2. The district court correctly held that the acquisition would likely lead to anticompetitive effects involving both primary care and ancillary services. By creating a combined company with 80 percent market share in primary care and eliminating a viable fallback option for insurer networks negotiating reimbursement rates, the acquisition greatly enhances the combined companies' bargaining power – just as they had anticipated. St. Luke's could exercise that power to demand greater reimbursements for primary-care services, as it did in Twin Falls.

Because of the way contracts between St. Luke's and insurers are negotiated, market power in primary care also enables St. Luke's to demand price increases for ancillary services. The contracts cover all services provided by the hospital system, and the negotiations focus on increases to the bottom line total. Once the

overall reimbursement increase is established, St. Luke's and the insurers are largely indifferent whether it flows through primary-care rates or any other rate covered by the contract. By substantially lessening competition, the acquisition enhanced St. Luke's market power, and the Clayton Act requires no additional showing.

3. The district court properly rejected St. Luke's "efficiency" defense. Such a defense could perhaps rebut a *presumption* of anticompetitiveness, but it cannot overcome the district court's definitive finding that this acquisition will have anticompetitive effects. In any event, St. Luke's failed to satisfy the stringent requirements of that defense. It showed neither that the efficiencies were concrete nor that they could be achieved only through the merger.

St. Luke's own expert testified that it could take ten years or more to achieve any efficiencies – if they ever come to pass. Testimony established that St. Luke's prior acquisitions of primary-care practices have not led to cost savings. The district court properly concluded that the Saltzer acquisition was (as St. Luke's own CEO had put it) a healthcare "experiment" that was part of a "broad if slow movement" toward changes in medical practices.

Equally important, the district court correctly found that the asserted efficiencies are not merger-specific. The evidence showed that it was not necessary for St. Luke's to own Saltzer and directly employ its doctors to attain the

benefits of clinical integration. Indeed, other practices in Idaho even smaller than Saltzer are already engaged in risk-based contracting and integrated care.

4. The district court acted well within its discretion in ordering divestiture. The Supreme Court established long ago that divestiture, which will redress the anticompetitive effects of the acquisition, is the natural remedy for violations of the Clayton Act proven by the government. St. Luke's may not now claim that Saltzer cannot survive independently, as it made the opposite argument to the district court in successfully opposing a preliminary injunction and raised no failing firm defense at trial. The contention fails in any event, as Saltzer still commands substantial market share in Nampa and has a built-in customer base. In addition, the district court can order St. Luke's to provide any resources Saltzer may need to restore competition in the market.

STANDARD OF REVIEW

The district court's conclusions of law are reviewed de novo and its findings of fact for clear error. *See Husain v. Olympic Airways*, 316 F.3d 829, 835 (9th Cir. 2002). The latter standard "is significantly deferential"; this Court "will accept the lower court's findings of fact unless [it is] left with the definite and firm conviction that a mistake has been committed." *N. Queen Inc. v. Kinnear*, 298 F.3d 1090, 1095 (9th Cir. 2002). The judgment below should be affirmed if "the trial court reached a decision that falls within any of the permissible choices the court could

have made." *United States v. Hinkson*, 585 F.3d 1247, 1261 (9th Cir. 2009) (en banc). The district court's decision may be affirmed on any ground supported by the record. *See Cigna Prop. and Cas. Ins. Co. v. Polaris Pictures Corp.*, 159 F.3d 412, 418 (9th Cir. 1998).

ARGUMENT

Section 7 of the Clayton Act prohibits an acquisition that "may" substantially lessen competition. 15 U.S.C. §18. Congress's use of the term "may" was no accident and creates an "expansive definition of antitrust liability." *American Stores*, 495 U.S. at 284. The Act is "designed to arrest in its incipiency … the substantial lessening of competition" from an acquisition. *United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586, 589 (1957). The Act does not demand that anticompetitive effects inevitably will result from a challenged acquisition before an acquisition may be deemed unlawful. Rather, Congress's "concern was with probabilities, not certainties." *United States v. El Paso Natural Gas Co.*, 376 U.S. 651, 658 (1964); *Brown Shoe Co. v. United States*, 370 U.S. 294, 323 (1962); *Ash Grove Cement Co. v. FTC*, 577 F.2d 1368, 1379 (9th Cir. 1978).

After considering the massive trial record, the district court properly "predict[ed]" that "the deal … will have anticompetitive effects," and that it is

"highly likely that health care costs will rise" by virtue of St. Luke's "dominant market position." ER12.

I. THE DISTRICT COURT CORRECTLY FOUND THAT NAMPA IS THE RELEVANT GEOGRAPHIC MARKET.

The district court's geographic-market analysis rested on a well-established economic tool and the undisputed commercial realities of the healthcare industry. Nampa consumers demand local primary care and are not sensitive to (or even generally aware of) its price in choosing a doctor. Insurers therefore must include Nampa primary-care doctors in their networks to offer commercially viable policies to Nampa consumers and employers and would accede to a demand for a small price increase. Nampa thus constitutes the relevant geographic market.

St. Luke's fails to refute that finding. "The definition of the relevant market is basically a fact question dependent upon the special characteristics of the industry involved." *Twin City Sportservice, Inc. v. Charles O. Finley & Co., Inc.*, 676 F.2d 1291, 1299 (9th Cir. 1982); *accord Oahu Gas Service, Inc. v. Pacific Resources, Inc.*, 838 F.2d 360, 363 (9th Cir. 1988). The Court "will not disturb such findings unless clearly erroneous." *Twin City*, 676 F.2d at 1299. St. Luke's has shown no error, let alone clear error.[5]

[5] It is unclear what St. Luke's hopes to achieve with its market-definition challenge. Uncontroverted evidence at trial showed that, even if the market were defined more broadly to include the separate cities of Caldwell and Meridian, the combined St. Luke's/Saltzer market share (56.3 percent) and the increase in

A. Nampa Is A Well-Defined Geographic Market.

"A geographic market is an area of effective competition where buyers can turn for alternate sources of supply." *Morgan, Strand, Wheeler & Biggs v. Radiology, Ltd.*, 924 F.2d 1484, 1490 (9th Cir. 1991) (internal quotation marks omitted). The geographic market must "correspond to the commercial realities of the industry." *Brown Shoe*, 370 U.S. at 336. The district court relied on both economic analysis and real-world experience to conclude that Nampa is a market because "commercial health plans need to include Nampa [primary-care doctors] in their networks to offer a competitive product." FOF69 (ER24); *see ProMedica*, 749 F.3d at 572 (insurers "assemble networks based primarily upon patients' preferences, not their own").

1. As discussed, the "SSNIP" test is an accepted (and here uncontested) methodology for defining geographic markets. It asks how customers would respond to a small but significant price increase (5-10 percent) imposed by a "hypothetical monopolist" throughout a defined geographic area. *See* p.11-12, *supra*; *Theme Promotions, Inc. v. News America Marketing FSI*, 546 F.3d 991, 1002 (9th Cir. 2008). The district court conducted that analysis and concluded that, if all Nampa primary-care practices "band[ed] together" and negotiated as a

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concentration (1437 points) would still far exceed the threshold for presumptive illegality. Trx.1341:7-1342:20 (Dranove) (SER331-332); TX1791 (GSER132). St. Luke's expert did not identify any alternative geographic market.

single entity, they could profitably demand from health plans a lasting price increase of 5 to 10 percent. Because their customers demand local care, insurers have little choice but to pay that differential rather than offer a policy with no in-network access to primary care in Nampa. The district court thus concluded that Nampa is the appropriate geographic market for antitrust purposes.

Both expert and fact testimony strongly supported that determination. The undisputed evidence showed that consumers insist on local primary care. Plaintiffs' expert in healthcare economics, Dr. Dranove, testified that "patients prefer to get their [primary] medical care close to home," Trx.1316:2-3 (SER328), and that people in Nampa "are no different from anywhere else," Trx.1316:5-6 (SER328). Data presented by Dr. Dranove showed that "68 percent" of Nampa residents "get their primary care physician services from providers who are located in Nampa." Trx.1320:11-15 (GSER69). "Another 16 percent" go "to a Nampa-adjacent zip code." Trx.1320:15-17 (GSER69). In total, 84 percent of Nampa residents receive primary care in or close to home. And, Dr. Dranove testified, most people who receive care elsewhere *work* elsewhere and visit doctors near their workplace, another convenient venue. Trx.1320:17-23 (GSER69).

Moreover, in the primary-care service market, "price is not … a major strategic factor" in consumers' decisions. Trx.1298:10-13 (Dranove) (SER324). Consumers care more about convenience, quality, and established relationships

with their doctors. That is largely because consumers do not pay medical bills directly: a ten-dollar increase in the price a doctor charges to an insurance company for an office visit may translate to a one-dollar increase in an out-of-pocket coinsurance payment for a patient. Trx.2967:2-17 (Argue) (ER499); Trx.3442:25-3443:7 (Dranove) (GSER113). Consumers thus "have a hard time seeing what the prices are." Trx.1298:10-12 (SER324). Moreover, "[i]t's difficult for patients to shop around. Most of the time when you have a problem you don't even know what's wrong with you," rendering "comparison shop[ping]" "essentially impossible." Trx.1297:22-1298:9 (Dranove) (SER323-324).

Given that ubiquitous commercial reality, insurer networks must include local primary-care practices "in order to be able to attract the business of employers," many of which will not consider an insurer who offers no local primary-care option. Trx.1318:1-2 (Dranove) (GSER69); *see* FOF61-63 (ER23). As a result, if all the practices in a local market "ask for a price increase, you've got to give it to them." Trx.1318:3-5 (Dranove) (GSER69); *see* FOF71 (ER25); *ProMedica*, 749 F.3d at 572 (insurers "assemble networks based primarily upon patients' preferences, not their own"). In other words, a hypothetical primary-care monopolist in Nampa would be able to impose a SSNIP. FOF72 (ER25).

2. Executives of four Idaho health plans confirmed that local network doctors were essential to commercially viable policies. Jeff Crouch, Vice

President of Provider Contracting for Blue Cross of Idaho, the State's largest insurer, testified that having in-network primary-care service "in the direct community" of a policyholder's residence is a "threshold" consideration for an employer considering whether to purchase a health plan. Trx.230:2-16 (GSER60); FOF61-62 (ER23). As a result, Blue Cross of Idaho offers primary-care network physicians "in every single zip code in Idaho where they have enrollees," and does not "require a single enrollee to travel outside of their zip code for primary care." Trx.1329:15-22 (Dranove) (SER350).

In Twin Falls, Blue Cross learned that policies are not marketable without local network doctors. St. Luke's owned the largest primary-care practice in Twin Falls and demanded an 8 percent increase in payments from Blue Cross. Blue Cross initially refused, and constructed a network without any physicians in Twin Falls, but with non-St. Luke's doctors 15 miles away. That network was not marketable to Twin Falls employers, and Blue Cross ultimately agreed to the demanded rate increase. Trx.247-248 (Crouch) (SER236); *see* FOF117-120 (ER32).[6]

[6] Although St. Luke's tries to distinguish Twin Falls on the ground that it is not Nampa, Br. 37 n.9, Twin Falls shows that a dominant local practice can effectively force an insurer to meet a price demand. That power had nothing to do with Twin Falls itself. St. Luke's is wrong that reimbursements in Twin Falls were merely raised to the statewide level. Jeff Crouch testified that St. Luke's rates were raised above the statewide level – which was later raised to match St. Luke's Twin Falls rate. Trx.248:3-15 (SER236).

Scott Clement of Regence Blue Shield, Idaho's second largest insurer, likewise testified that the need for local in-network doctors was sufficiently important that Regence agreed to raise Saltzer's reimbursements 5 to 6 percent higher than other practices in Idaho. Dkt.252 at 155:4-156:4 (SER535). Linda Duer of the Idaho Physician's Network (a network used by health plans with smaller shares of the Idaho market) also testified that her organization could not successfully market to Nampa employers a provider network that did not include Nampa primary-care physicians. Trx.464:16-24 (SER256). Nampa residents might drive to Boise for a major procedure such as surgery, she testified, but they will not leave Nampa for primary care. Trx.464:16-465:1 (SER256-257). Patricia Richards of insurer SelectHealth testified similarly. Trx.1763:4-1764:5 (SER366).

St. Luke's own experience and documents confirm that a network must contain local doctors to be commercially viable. Before St. Luke's first acquired a primary-care practice in Nampa in 2011, St. Luke's tried to create a physician network to offer to Nampa employers. In the process, it recognized "the need to have providers in Nampa in order to market the plan to employers." TX1196 (SER54); *see* FOF63 (ER23). In keeping with St. Luke's recognition that Nampa is a separate market, its strategic planning documents discussed market shares in the "Nampa Physician Market." TX1473 at 6 (SER928).

B. St. Luke's Has Shown No Error In The Court's Analysis.

Although St. Luke's challenges the district court's geographic-market determination, it does not even mention the economic structure of the healthcare market or the court's application of the SSNIP test. Instead, it asserts that the court erroneously "consider[ed] only where consumers *currently* obtain healthcare, and how insurers *currently* market insurance plans," Br. 30, rather than "how consumers and insurers would *change* their practices and preferences" in the event of a price increase, Br. 31.

That is a gross mischaracterization of the district court's analysis. The court did not focus on "static" consumer choices, Br. at 31, nor did it need to do so. The record abundantly confirmed, through expert and fact testimony, that Idaho insurers would absorb a small but significant price increase to keep a monopolist Nampa-based primary-care practice within their networks to meet consumers' deep-rooted preference for local primary care. That SSNIP analysis is not remotely "static." It considers "the likely *response* of insurers to a hypothetical demand by all the [primary-care providers] in a particular market for a significant non-transitory reimbursement rate hike." FOF56 (ER22) (emphasis added).

St. Luke's is also wrong to contend that the district court's geographic-market determination "cannot be reconciled with the fact that [32 percent] of Nampa residents *already* get PCP services outside of Nampa." Br. 35. To begin

with, half of the residents in that 32 percent use doctors in a zip code adjacent to Nampa, meaning that 84 percent of Nampa residents rely on practices in Nampa or its immediate surrounding area. Trx.1320:11-17 (Dranove) (GSER69). Broadening the geographic market to nearby localities would make no difference to the legal analysis because HHI figures demonstrate that the challenged acquisition would remain presumptively anticompetitive. *See* note 5, *supra*.

Of the remaining 16 percent, many work outside of Nampa and use doctors near their workplace. Trx.1320:19-23 (GSER69). But that does not show that Nampa consumers (particularly those who do not work in Boise) would travel to Boise for care if they lacked access to Nampa doctors. As Dr. Dranove put it, an insurer cannot market a policy on the strategy that "if you want to have a convenient [doctor], just get a job in Boise." Trx.1324:10-12 (SER329). The evidence shows what common sense and everyday experience suggests: that consumers demand primary care that is *convenient*, and that means primary care in Nampa. Moreover, that some Nampa residents currently receive care elsewhere shows nothing about how Nampa residents would react to a change in price.

Finally, there is no merit to St. Luke's extensive reliance on the experience of Idaho employer Micron. St. Luke's claims that Micron presents a "natural experiment" showing that consumers will switch primary-care doctors in the face

of a SSNIP, which allegedly proves that Nampa is not a well-defined market. Br. 32-34. The Micron experience shows no such thing.

In 2008, the Boise-based company changed its health plan to reduce medical costs. The new plan featured an inexpensive, on-site, primary-care clinic, plus a tiered system of off-site providers. Trx.558:12-559:2, 560:22-561:4, 598:16-599:9, 615:23-616:5 (Otte) (ER387, 395; GSER64); Trx.1357:7-25 (Dranove) (SER334). Employees paid a $10 flat fee for the clinic, 10 percent of the cost of care from providers in the first tier, 15 to 18 percent for the second tier, and 40 percent for out-of-network care. Trx.560:22-561:4, 599:2-9 (Otte) (SER266; ER395); TX2001 at SLHS000664608 (ER611). In addition, the overall rates charged by doctors in the first tier were lower than those charged by doctors outside the first tier, so the first tier cost its subscribers not only a lower percentage, but a lower base price. Trx.617:24-618:2 (Otte) (GSER64-65). Saltzer, which many employees had used under the previous health plan, initially was out-of-network, but then agreed to placement in the second tier. Trx.558:6-9; 594:6-13 (Otte) (ER387, 394). Faced with much higher costs for choosing the second tier, some Micron employees who had been Saltzer patients went elsewhere.

St. Luke's is wrong that those events show "what happened when Micron effectively imposed a SSNIP" for Nampa primary-care service. Br. 33. First, as the district court found, the SSNIP test in this case "examines the likely response

of insurers," FOF56 (ER22), not employees. Moreover, Micron employees faced an increase in the price of their insurance policy, not an increase in the price of any single medical service.

Second, Micron does not show that individual consumers will seek non-local primary care in the face of a SSNIP. As St. Luke's own expert admitted, the cost differentials between Micron's in-network and out-of-network providers – 50 to 80 percent between the first and second tiers, and 400 percent between the first tier and out-of-network – were "substantially greater" than the 5 percent threshold typically used in the SSNIP test. Trx.3043:7-16 (Argue) (GSER104). For example, even setting aside the discount for a tier 1 doctor, a $150 office visit would cost an employee using a tier-1 doctor $15, one using a tier-2 doctor $22-27, and one using an out-of-network doctor $60 or more. The on-site clinic, by comparison, would cost $10.[7]

Out-of-pocket cost differences of that magnitude "are just not relevant for doing the SSNIP." Trx.1356:15-18 (Dranove) (SER334). At some point, even a monopolist can raise its prices enough to drive buyers elsewhere, but that does not show a broader geographic market for antitrust purposes if buyers – here, insurers – would stay within it in the face of a smaller 5-10 percent price increase.

[7] St. Luke's claim (Br. 34 n.6) that the increased costs were small is wrong. In any event, even small absolute cost differences can reflect percentage differences far larger than the SSNIP test threshold. And small charges incurred multiple times each year can have large cumulative effects.

Third, that some Micron employees who lived in Nampa switched to non-Nampa doctors says little about how the general population of Nampa would react to a price increase. Because Micron is based in Boise, its employees are not fairly representative of Nampa residents who do *not* work in Boise and thus lack convenient access to Boise-based medical practices. *See* Trx.1324:10-12 (Dranove) (SER329). Micron's low-cost, on-site clinic "dramatically reduce[d] the need for enrollees to travel for their primary care if they were to drop … the Nampa doctors." Trx.1357:18-22 (Dranove) (SER334). Other Nampa consumers do not have such access to convenient, low-cost care.

Far more pertinent are the experiences of Blue Cross in Twin Falls and Regence in Nampa. In Twin Falls, Blue Cross at first refused to meet dominant provider St. Luke's demand for an 8 percent rate increase. Unable to sell policies by offering a network of doctors only 15 miles away, Blue Cross ultimately acceded to St. Luke's rate demand. *See* p.30, *supra*. To keep Saltzer in-network, Regence similarly agreed to pay it a rate higher than it paid other primary-care practices. *See* p.31, *supra*. Those experiences prove that strong consumer demand for local primary care makes primary-care markets highly localized and that the district court committed no error, let alone clear error, in defining the relevant geographic market as Nampa.

II. THE DISTRICT COURT PROPERLY FOUND THAT THE ACQUISITION WOULD HAVE ANTICOMPETITIVE EFFECTS.

"While market share is just the starting point for assessing market power, … market share, at least above some level, could support a finding of market power in the absence of contrary evidence." *Hunt-Wesson Foods, Inc. v. Ragu Foods, Inc.*, 627 F.2d 919, 925 (9th Cir. 1980). The lopsided HHI statistics here, *see* pp.15, *supra*, created a strong presumption that St. Luke's acquisition of Saltzer violated the Clayton Act. *See Heinz*, 246 F.3d at 715. Absent evidence to overcome that presumption, the district court could have stopped there. *See California v. American Stores Co.*, 872 F.2d 837, 842 (9th Cir. 1989), *reversed on other grounds*, 495 U.S. 271 (1990). But it also determined from a substantial body of evidence that the acquisition would have significant anticompetitive effects. St. Luke's has not shown those findings to be clearly erroneous.

A. St. Luke's Could Raise Prices For Primary-Care Services.

St. Luke's contends that "[p]laintiffs did not prove, and the court did not find, any likelihood of anticompetitive effects in the … market for adult [primary-care physician] services." Br. 36-37.

That is incorrect. The court assessed at length the competitive dynamics of the healthcare market and determined that by removing competition between the two largest and most closely competing practices in Nampa, the acquisition would substantially enhance St. Luke's ability to demand higher prices for primary care.

FOF97-116 (ER28-32); *see* pp.15-16, *supra*. Specifically, the district court examined how patients of the pre-merger Saltzer and St. Luke's would have responded if either practice had been unavailable to them, and determined that the two practices were each other's "closest substitutes." FOF99-101 (ER28). By consolidating the closest substitutes in the market, the acquisition left insurers with no desirable fallback option in negotiations.

Other evidence supported that finding. In the Twin Falls and Regence examples discussed at pp.30-31 above, St. Luke's and Saltzer's were able to force insurers to accept higher reimbursement rates for primary-care services. FOF117-120 (ER32). Saltzer itself expected that the extra "clout" it would gain from the acquisition would give it sufficient leverage to negotiate higher primary-care reimbursements sufficient to recapture prior negotiating losses. FOF113 (ER31). That explains why, when St. Luke's analyzed the Acquisition, it looked "at the entire business structure, including professional … fees." Trx.2037:15-2038:1 (Kee) (SER390-391).

St. Luke's likewise wrongly contends that insurers' use of statewide fee schedules means there is "no likelihood" of price increases for primary-care services. Br. 37-38. The record showed that insurers will adjust fee schedules in response to the demand of a powerful provider. In Twin Falls, for example, St. Luke's used its market power to extract a reimbursement rate for primary-care

services 8 percent above the general schedule (which was later raised for all providers to match St. Luke's rate). *See* p.30, supra; Trx.247:16-18; 248:3-15 (Crouch) (SER236). St. Luke's market power thus caused a statewide rate increase to the detriment of all Idaho consumers. Nancy Powell, Saltzer's former CFO, testified that on some occasions Blue Cross changed the statewide primary-care fee schedule as a result of Saltzer's request for higher rates. Trx.722:1-23 (SER277). Scott Clement testified similarly that Regence would accede to demands for rates above the schedule when a particular provider's absence from the network "would impact our ability to sell products." Dkt.252 at 156:6-12 (SER535).

St. Luke's further argues that because Blue Cross is a large company, that somehow neutralizes any anticompetitive increase in market power from the transaction. Br. 44. That argument is meritless. To begin with, Blue Cross is not the only insurer with interests at stake; the acquisition also harms other, smaller insurers (and employers and individuals) in the market with less bargaining leverage. Moreover, an otherwise anticompetitive combination does not comport with the Clayton Act so long as the combined entity deals with other large companies. On that theory, St. Luke's could lawfully acquire a complete monopoly throughout Idaho as long as it negotiated with Blue Cross.

That is not the law. In the absence of competitive alternatives, companies controlling essential inputs (here, primary-care services in Nampa) can often force

similarly sized or even larger companies to accept price increases, which are then passed through to consumers. *See ProMedica*, 749 F.3d at 562; *Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410, 440 (5th Cir. 2008) ("the economic argument for … rebutting a presumptive case, because a market is dominated by large buyers, is weak"); *FTC v. OSF Healthcare System*, 852 F.Supp.2d 1069, 1083-1084 (N.D. Ill. 2012); *Merger Guidelines* §8 ("the Agencies do not presume that the presence of powerful buyers alone forestalls adverse competitive effects from the merger."). The Clayton Act focuses on the change in market power from an acquisition and prohibits *all* anticompetitive combinations, not just ones with smaller buyers on the other side of the negotiating table.

In any event, the record in this case leaves little doubt that *this* combined company will use its enhanced bargaining power to force price increases even on large insurers such as Blue Cross, as it did in Twin Falls. *See* p.30. Indeed, St. Luke's own documents showed its recognition that increased bargaining leverage would allow the hospital chain to "pressure payors" for a "price increase." FOF112 (ER30). Other internal St. Luke's documents likewise show its understanding that "market share in primary care is … critical to sustaining a strong position relative to payer contracting." FOF116 (ER31-32). St. Luke's was right in its business documents and is wrong in its brief.

B. St. Luke's Could Raise Prices For Related Services.

The district court's finding that this acquisition would likely increase reimbursement rates for primary-care services alone supports the conclusion that it will harm consumers. The court found further that "it is likely that St. Luke's will exercise its enhanced bargaining leverage from the Acquisition to charge more [ancillary] services at the higher hospital-based billing rates." FOF121 (ER32). Ancillary services include x-rays, blood tests, and similar procedures that are often prescribed in the course of providing primary-care services. That finding independently supports the decision below.

St. Luke's argues that the court "did not find the existence of a Nampa market for 'ancillary services,'" and thus "did not find that defendants had market power in any market for ancillary services." Br. 39-40. That argument makes little legal or factual sense. This acquisition caused an anticompetitive aggregation of market power in the provision of primary-care services in Nampa. It eliminated insurers' fallback option in negotiations with the combined company and thereby enabled St. Luke's to raise prices. Because contracts between St. Luke's and insurers cover rates for all services provided by the St. Luke's system and negotiations focus on the bottom line total, the parties are largely indifferent to the

rate for any individual service.[8] The acquisition enables St. Luke's to extract an anticompetitive surcharge one way or another.

1. The commercial realities of St. Luke's contract negotiations are not in dispute. Both sides' economic experts agreed that contract negotiations with St. Luke's center on the "bottom right-hand number" – *i.e.*, the total amount of money the parties project will be paid for all services covered by the contract. Trx.1299:22-1301:24; 1302:1-11; 1347:2-16 (Dranove) (SER324, 325, 333); Trx.2899:16-2900:14 (Argue) (GSER100). If that aggregate amount is not satisfactory to St. Luke's, the insurer will lose access to all St. Luke's services, including its primary-care physicians. Dkt.322 at 79:23-80:1, 80:3-10 (Crouch) (SER552). Because any marketable health-insurance plan must include access to Nampa-based primary-care physicians, *see* pp.28-31, *supra*, St. Luke's stranglehold on the Nampa primary-care market enables it to raise overall reimbursements, and that increase could be reflected anywhere in the rate structure. St. Luke's could require higher primary-care rates (as it did in Twin Falls), or it could increase revenue by "moving patients from some settings where services are

[8] St. Luke's discussion of provider-based billing under Medicare (Br. 39) is irrelevant because Medicare, unlike the private insurance at issue here, does not negotiate reimbursement rates and thus is unaffected by the market power that St. Luke's gained through the acquisition.

provided at one negotiated rate to other settings where exactly the same services are provided at higher negotiated rates." Trx.1347:6-11 (Dranove) (SER333).[9]

St. Luke's therefore is wrong that this case involves "price increases in the absence of market power." Br. 40, citing *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 232 (1993). It is precisely St. Luke's acquisition of market power in the primary-care market that enables it to bargain for increased overall reimbursements that it could not otherwise obtain. The record clearly showed "how the increased 'leverage' that defendants obtained" from the acquisition "enabled them to impose" anticompetitive prices. Br. 41.

2. St. Luke's also relies on several "monopoly leveraging" cases decided under Section 2 of the Sherman Act, but those cases addressed an entirely unrelated issue and are irrelevant here. *See Cost Mgmt. Services, Inc. v. Washington Natural Gas Co.*, 99 F.3d 937 (9th Cir. 1996), *Alaska Airlines, Inc. v.*

[9] St. Luke's asserts that "no … evidence" supports the court's findings on hospital-based billing. Br. 44. But the court extensively cited the testimony of Blue Cross's Jeff Crouch, FOF123-125 (ER33), citing Trx.252-254 (SER237-238), who testified that fees for commercial services would rise 30-35 percent due to hospital-based billing. Trx.253:10-14 (SER238). St. Luke's also mischaracterizes the report of its consultant Peter LaFleur as having addressed only increases in Medicare reimbursements and not reimbursements from commercial insurers. Br. 44-45. Mr. LaFleur's report, also relied on by the district court, plainly considers hospital-based billing differentials for *both* types of reimbursement. For a Comprehensive Metabolic Panel blood test, for example, the report shows no increase in expected billings from Medicare but a 69 percent increase from "commercial" reimbursements. TX1277 at SLHS000820297 (ER594). Mr. LaFleur's analysis of the "commercial" reimbursements for a chest x-ray shows a similar increase. *Id*. at SLHS000820298 (SER595).

United Airlines, Inc., 948 F.2d 536 (9th Cir. 1991). There, companies with a lawfully acquired monopoly in one market were charged with using that monopoly power to affect competition in another market. Sometimes, but not always, such conduct is itself unlawful. The cases examine the circumstances in which another participant in the second market has a claim under the Sherman Act for anticompetitive conduct in the second market, called "monopoly leveraging." *See Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 14 n.20 (1984).

Here, however, the question is not whether it would violate the Sherman Act for St. Luke's to employ a *lawful* monopoly in the primary-care market to harm competition in another market. The question is whether the Clayton Act permits St. Luke's to acquire overwhelming market power in the primary-care market *in the first place* and then to use that power to demand increased rates in its overall contracts with insurers. The answer to that question is no, for the reasons already discussed.[10] Moreover, even under the Sherman Act, courts assessing monopoly power and unlawful monopoly conduct take into account anticompetitive effects in markets beyond the one allegedly monopolized. *See United States v. Microsoft Corp.*, 253 F.3d 34, 58-79 (D.C. Cir. 2001).

[10] St. Luke's suggests that the district court was addressing Sherman Act "monopoly leveraging" issues when it used the term "leverage" in its opinion. *E.g.*, Br. 42-43. That is mere wordplay. The court used that term to address St. Luke's *bargaining* "leverage" with insurers. That has nothing to do with the Sherman Act concept of "leveraging" a monopoly in one market to harm competition in another.

Finally, St. Luke's argues that its recent contract with Blue Cross, which – according to St. Luke's – contains only reasonable price terms, somehow proves that this acquisition cannot produce anticompetitive price increases. Br. 43. That claim fails for several reasons.

First, St. Luke's entered into that contract under threat of litigation, and the contract's terms have little probative value for that reason alone. As the Supreme Court has explained, "[i]f a demonstration that no anticompetitive effects had occurred at the time of trial or of judgment constituted a permissible defense to a §7 divestiture suit, violators could stave off such actions merely by refraining from aggressive or anticompetitive behavior when such a suit was threatened or pending." *United States v. General Dynamics Corp.*, 415 U.S. 486, 504-505 (1974). St. Luke's reliance on the Blue Cross contract is no more persuasive here. Freed of litigation, St. Luke's can exercise its anticompetitive accumulation of bargaining power in the next contract negotiation.

Furthermore, St. Luke's singular focus on the Blue Cross contract ignores its increased market power in negotiations with *other* insurers, such as Regence. Finally, as discussed, St. Luke's own documents estimate large increases in reimbursement rates, sufficient to fund multi-million-dollar aggregate raises for Saltzer doctors. Left intact, this transaction would enable St. Luke's to achieve those anticipated hikes in reimbursement rates.

III. THE DISTRICT COURT PROPERLY FOUND THAT ST. LUKE'S DID NOT DEMONSTRATE CONCRETE, MERGER-SPECIFIC EFFICIENCIES.

St. Luke's urged the court below to disregard the acquisition's anticompetitive effects on the theory that the deal would increase efficiency in the delivery of healthcare. The district court correctly declined to do so. It found that St. Luke's claims of efficiency amounted only to an uncertain "experiment" in alternative models of healthcare delivery that did not outweigh the anticompetitive aspects of the acquisition. Just as important, St. Luke's also failed to show that the efficiencies could be achieved only through the acquisition.

Before this Court, St. Luke's efficiency defense boils down to the claim that an anticompetitive acquisition is permissible where it might someday lead to some form of consumer benefits. No authority supports such a proposition, which contradicts the purpose of the Clayton Act to arrest anticompetitive harm in its incipiency and to allow competition to maximize consumer welfare. As the district court correctly determined, the Clayton Act conveys no authority to approve an acquisition that will harm competition in favor of a healthcare experiment.

A. The Legal Standard For An Efficiency Defense.

Some courts have recognized efficiency as a potential rebuttal to a prima facie case that a merger will be anticompetitive. *See Heinz*, 246 F.3d at 720 (discussing a "trend among lower courts"). This Court has not yet accepted a

claim that a presumptively unlawful acquisition "can be justified because it allows greater efficiency of operation." *RSR Corp.v. FTC*, 602 F.2d 1317, 1325 (9th Cir. 1979).

This case is a poor candidate for validating an efficiency defense under the Clayton Act. To prevail under such a defense, St. Luke's would need not only to rebut a *presumption* of anticompetitiveness, but also to overcome the district court's conclusive finding that the acquisition *will* likely harm competition substantially. St. Luke's cites no case in which a court of appeals has found that asserted efficiencies can salvage an acquisition held to be anticompetitive. The leading antitrust treatise – often relied upon by this Court and many others, and cited extensively in St. Luke's brief – states to the contrary that increased efficiency "is not … a defense to a final conclusion that a merger 'lessens competition' or is 'illegal,'" but may be used only to rebut "a first order inference from a portion of the evidence (such as market shares)." *Areeda* ¶970c2 p.31. Similarly, the *Merger Guidelines* state that "[e]fficiencies almost never justify a merger to … near-monopoly" like the one presented here. *Merger Guidelines* §10.

In any event, if the Court considers St. Luke's efficiency defense, it should affirm the district court's application of the strict, two-part analysis that the D.C. Circuit used in *Heinz* (the leading decision on the efficiency defense) and recommended by the leading antitrust treatise.

First, the court must "undertake a rigorous analysis of the kinds of efficiencies being urged … in order to ensure that those 'efficiencies' represent more than mere speculation and promises about post-merger behavior." *Heinz*, 246 F.3d at 721. "[I]t is incumbent upon the merging firms to substantiate efficiency claims," *Merger Guidelines* §10, through "evidence of either 'significant' or 'extraordinary' efficiencies." *Areeda* ¶976d p.106. An efficiency claim "based on mere possibilities" is insufficient to overcome a prima facie case of competitive harm. *Areeda* ¶970c p.32.

The test is especially demanding where, as here, there are "high market concentration levels." *Heinz*, 246 F.3d at 720. A strong presumption of anticompetitive harm requires "precise proof of a very high degree of efficiency." *Areeda* ¶970b p.26. "Few defendants will be able to make this showing." *Id*. Ensuring they have done so is critical in an industry like healthcare, in which promises of improved efficiency are easy to make, yet hard to fulfill.

Second, because an acquisition reduces competition, asserted efficiencies must be "merger-specific," meaning that merging parties must "explain[] why [they] could not achieve the kind of efficiencies urged without merger." *Heinz*, 246 F.3d at 722. "An efficiency is said to be 'merger specific' if it is a *unique consequence* of the merger – that is, if it could not readily be attained by other means." *Areeda* ¶973a p.53; *see Heinz*, 246 F.3d at 722; *In re Evanston Nw.*

Healthcare Corp., No. 9315, 2007 WL 2286195 at *70 (FTC 2007) (defendant "must show that the claimed benefits are … ones that could not practicably be achieved without the proposed merger"); *Merger Guidelines* §10 (merger-specific efficiencies are those "unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects"). If efficiencies are not merger-specific, "the merger's asserted benefits can be achieved without the concomitant loss of a competitor." *Heinz*, 246 F.3d at 722; *accord Areeda* ¶976d; *Merger Guidelines* §10.

B. St. Luke's Proved Neither Element Of An Efficiency Defense.

1. *St. Luke's Failed To Show Concrete Efficiencies.*

The district court correctly determined that the alleged efficiencies amounted only to a "broad if slow movement" toward healthcare reform. ER4. It described the efficiencies urged by St. Luke's as an "experimental stage, where hospitals and other providers are examining different organizational models, trying to find the best fit." COL69 (ER59).

St. Luke's CEO himself described the Saltzer deal as an "experiment." Trx.1685:24-1686:3 (Pate) (SER362). Its expert witness, Dr. Enthoven, testified that there would be a "long and complicated path" along a "perilous route" to integrated care that could take 10 years or more and may not ever succeed. Trx.2686:24-2687:11 (SER427). Dr. Dranove's unrebutted analysis of St. Luke's

prior acquisitions of primary-care practices confirmed that assessment and demonstrated that St. Luke's has not in fact achieved any cost efficiency through those acquisitions. Trx.1366:16-1367:10 (GSER72).

As Dr. Dranove also explained, the research literature does not show that direct employment of physicians by hospitals leads to cost efficiencies. Trx.1364:10-13, 3460:25-3461:18 (Dranove) (ER407, SER480-481). To the contrary, a substantial number of healthcare mergers in the 1990s, also premised on promised efficiency, "produced higher healthcare spending without offsetting benefits." Trx.1431:6-9 (Dranove) (GSER78); *see* Trx.1430:24-1431:18 (Dranove); Trx.2679:5-2680:10 (Enthoven) (GSER78, 95-96); Trx.3585:2-7 (Kizer) (ER518). The academic literature shows that competition among independent physicians – like that between St. Luke's and Saltzer – results in higher-quality and lower-cost care than when physicians are employed by hospitals. Trx.3535:24-3537:13 (Kizer); 3419:13-21 (Dranove) (SER484-485, 477); 3426:9-22 (Dranove), (GSER109).

In light of the district court's conclusion that the asserted efficiencies were merely an "experiment," St. Luke's is wrong that the court failed to "balance[]" efficiencies against the likelihood of anticompetitive effects. That is precisely what the court did when it found "a substantial risk that the combined entity will use its dominant market share" to "raise costs to consumers," COL74 (ER60), and

determined that it could not "set aside" the Clayton Act in order "to conduct a health care experiment." COL77 (ER60).

2. *St. Luke's Failed To Show Merger-Specificity.*

Just as important, the district court independently and correctly found that St. Luke's had not presented "proof of significant and *merger-specific* efficiencies arising as a result of the Acquisition." COL49 (ER56) (emphasis added). The evidence showed that hospitals can achieve integrated medical care as effectively with independent doctors as with employed doctors. Trx.1368:17-1369:3, 1370:11-14 (Dranove) (GSER72-73, SER337). Jeff Crouch, of Blue Cross of Idaho, testified that in Boise, provider groups as small as two physicians are participating in risk-based contracts based on capitation. Trx.184:1-185:7 (GSER55-56), 192:17-193:24 (ER359-360). In contrast, St. Luke's compensates the Saltzer doctors on a fee-for-service basis. Trx.1997:21-1998:25 (Kee) (GSER86-87); *see* n.11, *infra*.

Expert witness Dr. Kizer likewise testified that "the employment of physicians – *i.e.*, the transaction of St. Luke's acquiring Saltzer – is simply not necessary to provide integrated patient care." Trx.3522:6-9 (GSER119). Rather, "[t]he claim that employment yields greater benefit than other affiliation models is simply not supported by the empirical or experiential evidence. Employment has

not been shown to be a superior organizational structure." Trx 3525:4-7 (GSER120).

Dr. Kizer testified about a number of healthcare systems that provide integrated high-quality, low-cost care using independent physician practices. Trx.3531:12-18 (GSER121). Intermountain Health Care in Utah, for example, has implemented an integrated delivery system to provide low-cost, high-quality care using independent physicians. Trx.3531:12-18 (GSER121). Saint Alphonsus is establishing an integrated Health Alliance of 1200 physicians, 75 percent of whom are independent. Trx.3612:3-10 (Polk) (SER486); Dkt.366 130:20-131:15 (Brown) (GSER128). And St. Luke's own expert admitted that St. Luke's could "accomplish all or most" of the benefits of clinical integration, improvements in quality of care, and reductions in cost without acquiring Saltzer. Trx.3027:11-17 (Argue) (SER444). As Dr. Kizer testified, the "transaction is not necessary for either Saltzer or St. Luke's to provide improved quality of care." Trx.3562:10-14 (GSER124).

On that record, the district court properly found that the acquisition was not necessary to achieve "integrated care and risk-based reimbursement" systems. FOF168, 173, 177, 181 (ER40-43).

Nor was the acquisition necessary to enable Saltzer to take advantage of healthcare information technology. St. Luke's claimed that, without the

acquisition, Saltzer could not use Epic, an electronic health record system, or White Cloud, a data analytics tool. The evidence showed, however, that "[t]o ensure that Epic is accessible [to independent doctors], St. Luke's is developing the Affiliate Electronic Medical Records program that would allow independent physicians access to Epic." FOF201 (ER46). Thus, "the efficiencies resulting from the use of Epic do not require the employment of physicians and hence are not merger specific." FOF204 (ER47). "The same analysis applies to the White Cloud data analytics tool." FOF205 (ER47). The court credited testimony establishing that "'independent physicians currently use and have available to them a wide array'" of similar tools. FOF205 (ER47), quoting Trx.3562 (Kizer) (GSER124).

St. Luke's is wrong that the district court erred by focusing on the alternatives available to the pre-acquisition St. Luke's practice and by failing "to determine … whether *the Saltzer physicians* could have achieved integrated care by some less restrictive means" and could do so as quickly. Br. 48, 50. To begin with, that argument assumes away the court's finding that the claimed efficiencies were merely experimental.[11] More fundamentally, it misstates the law. Alleged

[11] *See* Section III.B.1, *supra*. Saltzer's past attempts at integrated care may not have reached fruition for many reasons, including reasons unrelated to physician employment or clinic ownership. *See, e.g.*, FOF25 (attempt to partner with Mercy Medical Center failed because Mercy's out-of-state parent was unwilling to participate) (ER17). Moreover, even today, St. Luke's compensates the Saltzer

efficiencies asserted to offset a prima facie showing of anticompetitiveness "must be efficiencies *that cannot be achieved by either company alone*." *Heinz*, 246 F.3d at 722 (emphasis added). Thus, "an economies defense generally requires proof that *both* [merging firms] suffer from substantial diseconomies." *Areeda* ¶976b p.103 (emphasis added). That is because the merger of "an already efficient firm and an inefficiently small firm would not" create an additional efficient competitor but "would merely increase market concentration." *Id*.

The district court found "no empirical evidence to support the theory that St. Luke's needs a core group of employed primary-care physicians beyond the number it had before the Acquisition to successfully make the transition to integrated care." FOF181 (ER43). Indeed, St. Luke's own expert witness testified that "St. Luke's could accomplish all or most of [the efficiencies] without Saltzer." Trx.3027:15-17 (Argue) (SER444). And St. Luke's CEO testified that even if Saltzer is divested, St. Luke's "would want to work with Saltzer" to provide integrated care. Trx.1674:6-9 (Pate) (GSER82).

St. Luke's claim that the district court impermissibly placed on it "the burden to prove the absence of less restrictive alternatives," Br. 54, runs afoul of

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doctors on a fee-for-service basis and not a risk-based one. Trx.1997:21-1998:25 (GSER86-87), and that arrangement will continue, Trx.1999:5-7 (Kee); 3455:20-3456:9 (Dranove); TX 2624 (SER386, GSER116, 130-131). At most, a small portion of Saltzer compensation may possibly be performance-based at some undetermined point in the future. Trx.1372:23-1373:6 (Dranove) (SER337).

Heinz and *Areeda*, as discussed above. Merging parties must "explain[] why [they] could not achieve the kind of efficiencies urged without merger." *Heinz* at 722.

There is no good reason for this Court to take a different approach. As *Areeda* explains, antitrust policy demands a strict showing of merger specificity because "society would be better off if the same or equivalent efficiency gains could be realized without the anticompetitive merger." *Id*. ¶973a p.53; *see also Merger Guidelines* §10 ("the antitrust laws give competition, not internal operational efficiency, primacy in protecting customers"). "The greater the potential adverse competitive effect of a merger, the greater must be the cognizable efficiencies." *Merger Guidelines* §10. If an efficiency defense could salvage an acquisition that – like this one – will have significant anticompetitive effects, its proponent must show that any supposedly countervailing efficiencies cannot be achieved by other, less harmful means. A party that wishes to pursue such an acquisition therefore should be required to prove that acquisition is the only way to gain the alleged benefits. *See United States v. Third Nat'l Bank in Nashville*, 390 U.S. 171, 189 (1968) ("If the injury to the public interest flowing from the loss of competition could be avoided and the convenience and needs of the community benefited in ways short of merger … it was incumbent upon those seeking to

merge … to demonstrate that they made reasonable efforts [to achieve efficiency] … or that any such efforts would have been unlikely to succeed.").

St. Luke's reliance on *Bhan v. NME Hospitals, Inc.*, 929 F.2d 1404 (9th Cir. 1991), is misplaced. *Bhan* enunciated a burden-shifting framework *under the Sherman Act* that, had the Court been called upon to apply, would have placed on the plaintiff the burden to "show that any legitimate objectives can be achieved in a substantially less restrictive manner." 929 F.2d at 1413. Its source for that framework was *Areeda* – the very same treatise that establishes *under the Clayton Act* the burden is on the *defendant* to show that only the merger can achieve the claimed efficiencies. *Areeda* ¶976d.

The difference in application of the two statutes makes sense. As noted, Congress deliberately wrote into the Clayton Act an "expansive definition of antitrust liability," *American Stores*, 495 U.S. at 284, that is forward-looking and designed to arrest the lessening of competition "in its incipiency." *E.I. du Pont*, 353 U.S. at 589, *see* p.25, *supra*. Because it addresses transactions that eliminate entire competitors from the market, the Clayton Act is "concerned with probabilities, not certainties." *El Paso*, 376 U.S. at 658. Under the Sherman Act, by contrast, a court retrospectively examines whether conduct was unreasonably anticompetitive, and "a greater showing of anti-competitive effect is required." *Twin City Sportservice, Inc. v. Charles O. Finley & Co., Inc.*, 512 F.2d 1264, 1275

(9th Cir. 1975). As this Court explained, that "heavier burden" is rooted in the difference between the statutes. *Id*.

C. The District Court Correctly Declined To Allow Policy Considerations To Trump The Clayton Act.

Ultimately, St. Luke's claims that the district court committed reversible error by making "a policy judgment" about the acquisition. Br. 51-52. In fact, the district court *declined* to make a policy judgment, opting instead to apply the law as written. In its view, "the Acquisition could serve as a controlled experiment" with possibly beneficial policy outcomes. But the court rejected using the Idaho healthcare market as a policy laboratory in the teeth of the Clayton Act, which "does not give the Court discretion to … conduct a health care experiment." COL76-77 (ER60).

Having failed to convince the district court to substitute its policy judgment for that of Congress, St. Luke's now asks this Court to do just that. The Court should decline the invitation. Congress has already determined that "a policy favoring competition is in the public interest," and it rejected the idea that "monopolistic arrangements will better promote trade and commerce than competition." *Professional Engineers*, 435 U.S. at 689, 692.[12] That is why

[12] The Idaho Legislature similarly determined that "[t]he unrestrained interaction of competitive forces will yield the best allocation of Idaho's economic resources, the lowest prices, the highest quality, and the greatest material progress." Idaho Code §48-102(1).

Congress rejected the concept, urged by St. Luke's here, that there should be "an exemption from the statute for specific industries." *Id*. at 689.[13] At bottom, "Congress determined to preserve our traditionally competitive economy. It therefore proscribed anticompetitive mergers, the benign and the malignant alike, fully aware … that some price might have to be paid." *Philadelphia Nat'l Bank*, 374 U.S. at 371.

Contrary to St. Luke's suggestion, Br. 9-10, nothing in the Affordable Care Act, 124 Stat. 119, suggests otherwise. To the contrary, regulations promulgated by the Department of Health and Human Services adopt the view that "competition in the marketplace benefits Medicare … [and] can accelerate advancements in quality and efficiency." 76 Fed. Reg. 67802, 67841 (Nov. 2, 2011). Competition in healthcare is important because it can spur not only lower prices, but higher quality of care.

There is also no merit to St. Luke's policy argument that allowing it to amass market power would benefit Medicaid patients. Br. 50-51. The Director of

[13] St. Luke's contends that *Broadcast Music, Inc. v. Columbia Broadcasting System Inc.*, 441 U.S. 1 (1979), compels this Court to consider the broad policy issues that allegedly justify St. Luke's anticompetitive acquisition. Br. 53-54. That case is inapposite. It considered whether a music licensing arrangement should be deemed per se unlawful under the Sherman Act or should be reviewed under the rule of reason. *Broadcast Music* did not involve the Clayton Act, did not concern conduct found to be anticompetitive, and does not contradict the principle of *Professional Engineers* that the antitrust laws apply consistently to all economic sectors.

Idaho's Department of Health and Welfare testified that there is no shortage of access to medical care for Medicaid patients in Nampa and that many physician groups in the area see Medicaid patients. Trx.2290:10-22 (SER404). One former Saltzer physician testified that he had never refused to treat a Medicare or Medicaid patient while at Saltzer. Trx.2484:24-2485:5 (Williams) (GSER91). Even if policy considerations could trump the Clayton Act, they would not do so on this record.

IV. THE COURT PROPERLY ORDERED DIVESTITURE.

The district court's choice of remedy is reviewed for abuse of discretion. *United States v. Alisal Water Corp.*, 431 F.3d 643, 654 (9th Cir. 2005). "An abuse of discretion occurs when no reasonable person could take the view adopted by the trial court." *Stone v. San Francisco*, 968 F.2d 850, 861 n.19 (9th Cir. 1992). St. Luke's comes nowhere close to meeting that demanding standard.

The reasonable person test must be applied here against the backdrop of the Supreme Court's repeated determinations that divestiture is the default remedy for anticompetitive acquisitions. "The very words of Section 7 suggest that an undoing of the acquisition is a natural remedy," the Court has held, *United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 329 (1961), and "in Government actions divestiture is the preferred remedy for an illegal merger or acquisition," *American Stores*, 495 U.S. at 280-81. Indeed, divestiture is "the most important of

antitrust remedies. … It should always be in the forefront of a court's mind when a violation of §7 has been found." *E.I. du Pont*, 366 U.S. at 330-31.[14]

St. Luke's claims the district court abused its discretion because, according to St. Luke's, Saltzer cannot survive on its own and thus divestiture cannot practically be accomplished. Br. 58-60. The Court should not entertain that argument. When St. Luke's opposed a motion for a preliminary injunction blocking the acquisition, it assured the district court that it had structured the acquisition "carefully and deliberately … so that the transaction could be unwound," Dkt.34 at 34 (GSER40), and that "it would be quite possible to unscramble this egg," Dkt.49 at 87:7-8 (SER13). St. Luke's thus promised the court that it would "not oppose divestiture on grounds that divestiture cannot be accomplished." COL53 (ER57). Relying on St. Luke's assurances, the district court denied the injunction, finding that the acquisition "can be unwound and divestiture ordered" if it found a Clayton Act violation. Dkt.47 at 8 (SER24). At trial, St. Luke's raised no "failing firm" defense.

Now, St. Luke's takes the opposite position. Its attempt to renege on its promise to the district court violates the principle, rooted in basic fairness, that

[14] St. Luke's mistakenly relies on an unpublished opinion for the proposition that divestiture is a "drastic and rarely awarded remedy." Br. 58, citing *Taleff v. Sw. Airlines Co.*, 554 F. App'x 598 (9th Cir. 2014). But that was a private-party case. In *government* cases, "Congress … made express its view that divestiture was the most suitable remedy." *American Stores*, 495 U.S. at 284.

"[w]here a party assumes a certain position in a legal proceeding, and succeeds in maintaining that position, he may not thereafter, simply because his interests have changed, assume a contrary position." *Baughman v. Walt Disney World Co*., 685 F.3d 1131, 1133 (9th Cir. 2012) (internal quotations and brackets omitted).

The contention fails on its merits in any event. Prior to its acquisition, Saltzer controlled 65 percent of the primary-care market in Nampa; upon divestiture, it will have a built-in customer base capable of generating both substantial revenue and referrals to surgeons to replace the ones who left. Saltzer also may keep $9 million it received in the transaction. FOF58 (ER57). Furthermore, St. Luke's and Saltzer negotiated their agreement to ensure Saltzer's ability to regain independence. In their own words, "St. Luke's and Saltzer carefully and deliberately structured their agreement so that the transaction could be unwound if necessary." Dkt.34 at 34 (GSER40). And to the degree that Saltzer needs additional assistance to rebuild its practice, the district court may order St. Luke's to provide whatever resources are needed to restore competition. *See Ford Motor Co. v. United States*, 405 U.S. 562, 575 (1972) (court may take action "designed to give the divested plant an opportunity to establish its competitive position"); *Chicago Bridge*, 534 F.3d at 441-42 (court may order acquiring firm to divest more than the acquired assets in order to restore "two competitors capable of competing on an equal footing").

St. Luke's claim that the court's order of divestiture amounted to "punishment" (Br. 59) is entirely unfounded. The court reasonably declined to allow St. Luke's to bootstrap itself into retaining an anticompetitive market position by virtue of its own actions. St. Luke's may not invoke possible adverse consequences it caused as a shield to avoid the traditional relief to remedy the effects of an anticompetitive merger.

St. Luke's remaining argument, that divestiture will eliminate procompetitive benefits (Br. 60-61), simply rehashes its contention that the acquisition will lead to economic efficiencies – and ignores that competition can spur the same benefits. It charges that the court failed to "weigh the adverse effects on consumers" from divestiture "against the supposed beneficial effect of further reducing the likelihood of already uncertain anticompetitive harm." Br. 60. Notwithstanding St. Luke's caricature of the district court's opinion, the court in fact found a substantial probability of anticompetitive harm and weighed that public harm against the uncertain outcome of a policy "experiment" and the non-merger-specific efficiencies. The balance tipped plainly toward divestiture.

"[I]t is well settled that once the Government has successfully borne the considerable burden of establishing a violation of law, all doubts as to the remedy are to be resolved in its favor." *E.I. du Pont*, 366 U.S. at 334. The remedy must "eliminate the effects of the acquisition offensive to the statute," and "assure the

public freedom from its continuance." *Ford Motor Co.*, 405 U.S. at 573 n.8 (citations omitted). Divestiture was well within the district court's discretion.

CONCLUSION

This Court should affirm the judgment of the district court.

Respectfully submitted,

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August 13, 2014

STATEMENT OF RELATED CASE

The Associated Press v. United States District Court, No. 13-73931, arises out of the same case in the district court but has no relation to the merits of this case.

CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 13,991 words excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii)

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6). It has been prepared in a proportionally spaced 14-point Times New Roman typeface using Microsoft Word 2010.

/s/ Joel Marcus

August 13, 2014

STATUTORY APPENDIX

Contents:

United States Code Annotated
Title 15. Commerce and Trade
Chapter 1. Monopolies and Combinations in Restraint of Trade (Refs & Annos)

15 U.S.C.A. § 18

§ 18. Acquisition by one corporation of stock of another

Effective: February 8, 1996
Currentness

No person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.

No person shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of one or more persons engaged in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition, of such stocks or assets, or of the use of such stock by the voting or granting of proxies or otherwise, may be substantially to lessen competition, or to tend to create a monopoly.

This section shall not apply to persons purchasing such stock solely for investment and not using the same by voting or otherwise to bring about, or in attempting to bring about, the substantial lessening of competition. Nor shall anything contained in this section prevent a corporation engaged in commerce or in any activity affecting commerce from causing the formation of subsidiary corporations for the actual carrying on of their immediate lawful business, or the natural and legitimate branches or extensions thereof, or from owning and holding all or a part of the stock of such subsidiary corporations, when the effect of such formation is not to substantially lessen competition.

Nor shall anything herein contained be construed to prohibit any common carrier subject to the laws to regulate commerce from aiding in the construction of branches or short lines so located as to become feeders to the main line of the company so aiding in such construction or from acquiring or owning all or any part of the stock of such branch lines, nor to prevent any such common carrier from acquiring and owning all or any part of the stock of a branch or short line constructed by an independent company where there is no substantial competition between the company owning the branch line so constructed and the company owning the main line acquiring the property or an interest therein, nor to prevent such common carrier from extending any of its lines through the medium of the acquisition of stock or otherwise of any other common carrier where there is no substantial competition between the company extending its lines and the company whose stock, property, or an interest therein is so acquired.

Nothing contained in this section shall be held to affect or impair any right heretofore legally acquired: *Provided*, That nothing in this section shall be held or construed to authorize or make lawful anything heretofore prohibited or made illegal by the antitrust laws, nor to exempt any person from the penal provisions thereof or the civil remedies therein provided.

Nothing contained in this section shall apply to transactions duly consummated pursuant to authority given by the Secretary of Transportation, Federal Power Commission, Surface Transportation Board, the Securities and Exchange Commission in the exercise of its jurisdiction under section 79j of this title, the United States Maritime Commission, or the Secretary of Agriculture under any statutory provision vesting such power in such Commission, Board, or Secretary.

CREDIT(S)

(Oct. 15, 1914, c. 323, § 7, 38 Stat. 731; Dec. 29, 1950, c. 1184, 64 Stat. 1125; Sept. 12, 1980, Pub.L. 96-349, § 6(a), 94 Stat. 1157; Oct. 4, 1984, Pub.L. 98-443, § 9(l), 98 Stat. 1708; Dec. 29, 1995, Pub.L. 104-88, Title III, § 318(1), 109 Stat. 949; Feb. 8, 1996, Pub.L. 104-104, Title VI, § 601(b)(3), 110 Stat. 143.)

Notes of Decisions (1274)

15 U.S.C.A. § 18, 15 USCA § 18
Current through P.L. 113-125 (excluding P.L. 113-121) approved 6-30-14

End of Document

West's Idaho Code Annotated
Title 48. Monopolies and Trade Practices
Chapter 1. Idaho Competition Act (Refs & Annos)

I.C. § 48-106

§ 48-106. Acquisitions that substantially lessen competition

Currentness

(1) It is unlawful for a person to acquire, directly or indirectly, the whole or any part of the stock, share capital, or other equity interest or the whole or any part of the assets of, another person engaged in Idaho commerce, where the effect of such acquisition may be substantially to lessen competition or to tend to create a monopoly of any line of Idaho commerce.

(2) This section shall not apply to persons purchasing the stock or other equity interest of another person solely for investment and not using those assets by voting or otherwise to bring about, or attempt to bring about, the substantial lessening of competition. Nothing contained in this section shall prevent a person engaged in Idaho commerce from causing the formation of subsidiary corporations or other business organizations, or from owning and holding all or a part of the stock or equity interest of such subsidiary corporations or other business organizations.

Credits
S.L. 2000, ch. 148, § 3.

I.C. § 48-106, ID ST § 48-106
Current through the 2014 Second Regular Session of the 62nd Idaho Legislature.

End of Document

CERTIFICATE OF SERVICE

I certify that on August 13, 2014, I electronically filed the foregoing Answering Brief for Plaintiffs/Appellees the Federal Trade Commission and the State of Idaho with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

I certify further that all participants in the case are registered CM/ECF users and will be served by the appellate CM/ECF system.

/s/ Joel Marcus