

Opening Statement

*Federal Trade Commission & State of Idaho v.
St. Luke's Health System, Ltd. & Saltzer Medical Group, P.A.*

September 23, 2013



The Parties

*St. Luke's and Saltzer are
"dominant" providers*





St. Luke's Presence Across Idaho



TX 1095

St. Luke's became the second largest provider of PCP services in Nampa when it acquired Mercy Physician Group in 2011



St. Luke's is a "Dominant" Healthcare Provider

PLAINTIFF'S EXHIBIT 481

Colleagues,

I would like to share a few concerns regarding the recent decision to request a proposal from St A's. Had I been there, I would have vigorously opposed the decision. In short, I think the decision, again largely the result of lobbying by a vocal minority, unwise, disingenuous, and a waste of time and money. Explanation to follow.

My thought is that there are a larger number of us who have NO interest in any kind of deal with St A's, making the pending proposal moot, in that we would vote it down anyway. Therefore, why proceed. Better to stop wasting their time and our money paid to Coker for a meaningless exercise. I am sure that the decision to proceed will be a waste of time and money. Best work will be done

- we have to be concerned with aligning if appropriate with the strongest partner. No one would disagree that St A's is not the dominant provider in the valley
- we are already linked in many ways to **St Luke's because we all know they are and will likely remain the dominant provider**, i.e., we have chosen to locate / move many practices to

their own people

- their dealings with med staff have been dishonest and disingenuous. Witness the firing of Nampa Radiology, no input from med staff re that or what would need to be better from new providers. Witness the development of output GI Suite at Garrity for Digestive Health GI group, no input from current staff, and no requirement of them to do consults or take call. Meanwhile, 2 of us remain to try to cover the call.
- their standard practice has been to require non-compete clauses in their contracts. How could that possibly be different for us, and HOW could that work for us when we are so concerned with "out" provisions of any deals?
- we have watched a respected family practice group leave them TWICE. There is a message there. And where did that group go? St Luke's.
- **we have to be concerned with aligning if appropriate with the strongest partner. No one would disagree that St A's is not the dominant provider in the valley**
- **we are already linked in many ways to St Luke's because we all know they are and will likely remain the dominant provider. I.e., we have chosen to locate / move many practices to portico.** The surgeons to varying degrees left or reduced practices in Nampa to go to St Luke's. The reasons for that are no less compelling today. If we aligned with St A's, they certainly would expect hospital practices to be shifted to their facilities. Are our primary care

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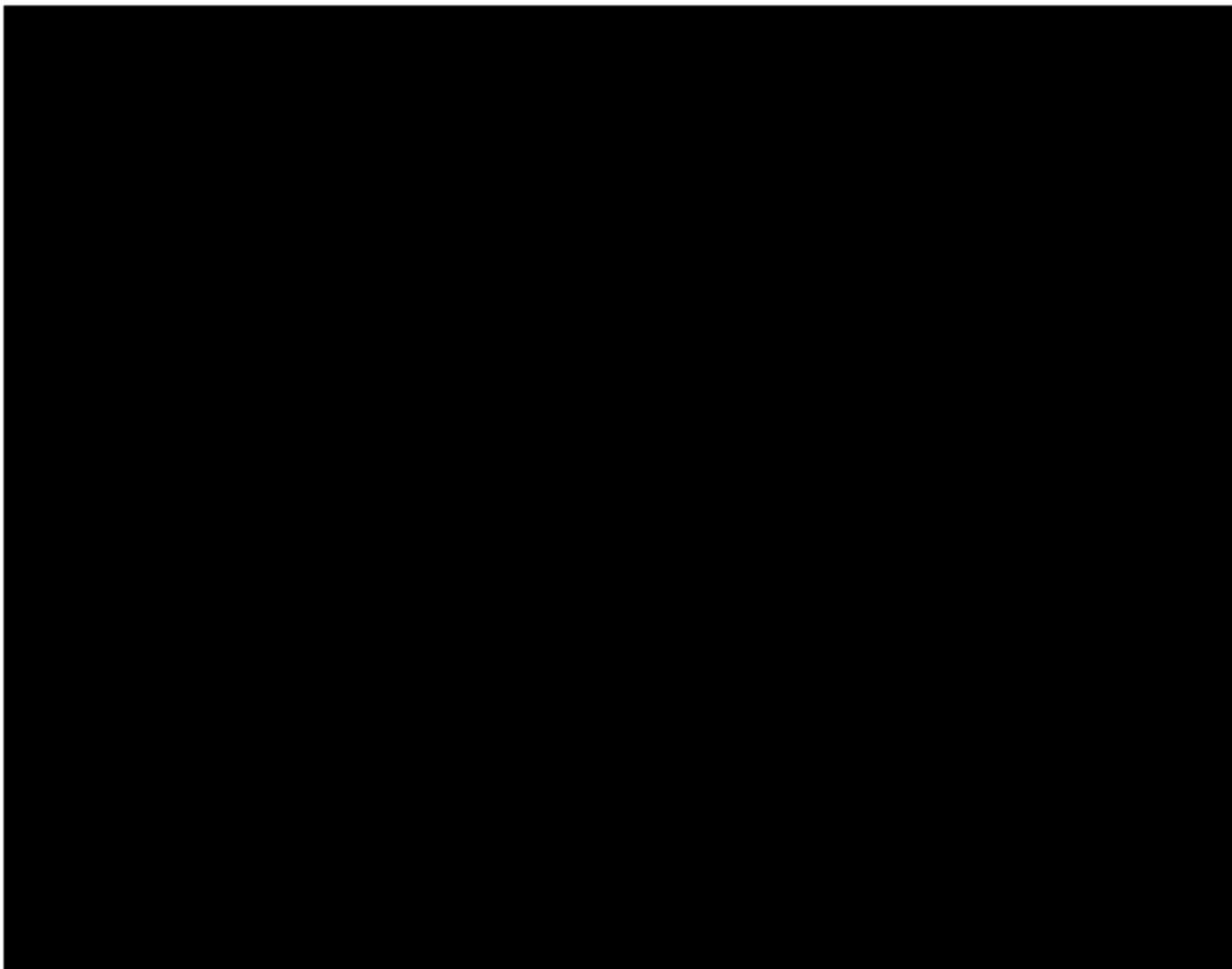
Plaintiffs' Exhibit 1366



**Dr. Randell Page,
Saltzer's Contracts
Committee Chair**



St. Luke's Projects \$ [REDACTED] Million in Annual Cash Flow by 2016





Saltzer is Dominant in the “Nampa Market”

From: Castledine, Ed <castled@slhs.org>
 Sent: Tuesday, June 28, 2011 5:15 PM
 To: Taylor, Jeff <taylorj@slhs.org>; Roth, Chris <rothc@slhs.org>
 Cc: 'peter@consultinggroupllc.com'
 Subject: stats
 Attach: Nampa Physicians.xlsx

Just finished putting this together- it is rough form but wanted to get your perspective on this type of information as it relates to your meeting tomorrow. The first two tabs are what I need your opinion on. This begins to show the dominance of Saltzer in the Nampa market. I removed all of the dentists, anesthesiologists, chiropractors etc from the list and left only the actual providers. Out of roughly 80 physicians in Nampa, Saltzer represents 47. If you add the Mercy Group, we have the opportunity to work exclusively with 54 of the 80.

I will speak with Peter as well about other relevant financial data. Also, Alan Barton found that revenue associated with the Saltzer specialists to St. Luke's is a little more than \$5m annually.

Let me know what you think - Ed

mg.slhmc.org made the following annotations

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PLAINTIFFS EXHIBIT
 349
 BP 4/28/13

ATTORNEYS EYES ONLY

CON0007045
 CX0244-001

Plaintiffs' Exhibit 1281

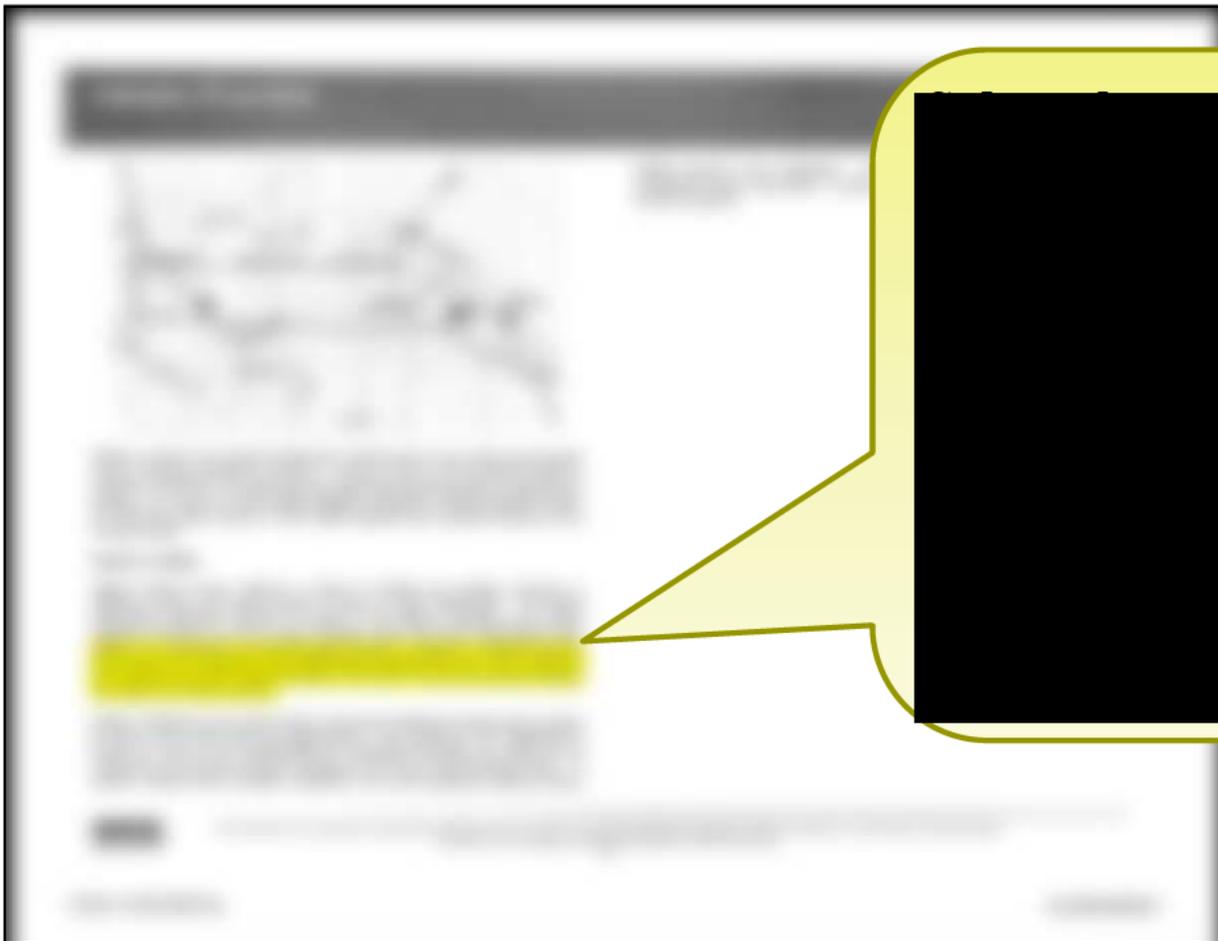
“This begins to show the dominance of Saltzer in the Nampa market. . . . Out of roughly 80 physicians in Nampa, Saltzer represents 47. If you add the Mercy Group, we have the opportunity to work exclusively with 54 of the 80.”



**Ed Castledine,
 Director of Business
 Development**



St. Luke's Consultant Reports that Saltzer Already Has Leverage with Payors



The Acquisition

St. Luke's will finance the deal with higher reimbursements

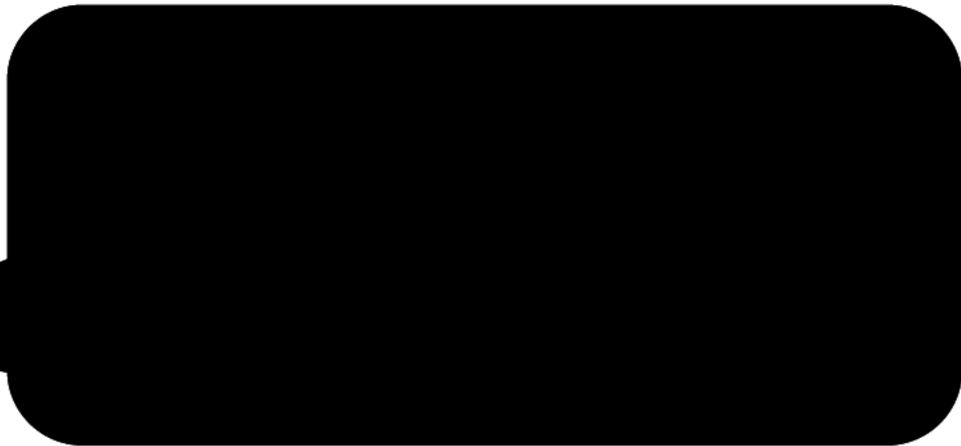
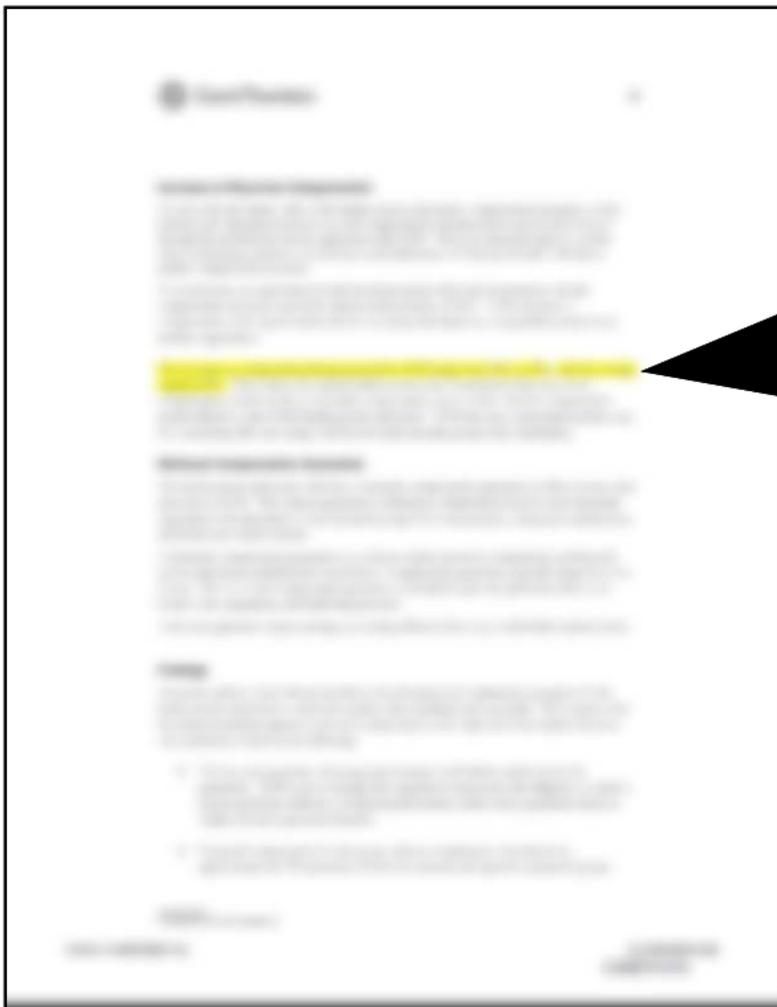


Terms of The Deal



- On December 31, 2012, St. Luke's acquired the assets of Saltzer for approximately [REDACTED] million plus working capital
 - Through the acquisition, St. Luke's received Saltzer's intangible assets, personal property, and equipment
 - St. Luke's now has the ability to negotiate with health plans on Saltzer's behalf
- Saltzer's physicians entered into a five-year professional services agreement with St. Luke's
 - Saltzer physicians are paid based on the volume of their productivity
 - If divestiture is ordered, Saltzer physicians keep over [REDACTED] million in "goodwill" and other payments from St. Luke's

Acquisition Gives Saltzer PCPs a Double-Digit Pay Boost



St. Luke's Expects to Finance Higher Pay for Saltzer By Charging More



Proposed Transaction Terms

1. Proposed purchase price of approximately \$100 million, consisting of \$75 million in cash and \$25 million in debt.

2. [Redacted]

3. [Redacted]

4. [Redacted]

5. [Redacted]

6. [Redacted]

7. [Redacted]

- 8. [Redacted]
- 9. [Redacted]
- 10. [Redacted]
- 11. [Redacted]
- 12. [Redacted]

Applicable Law

*The burden shifting framework
under Clayton Act § 7*





Section 7 of the Clayton Act

“No person shall acquire, directly or indirectly . . . the assets of one or more persons engaged in 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.”

United States v. Philadelphia National Bank Presumption



U. S. *v.* PHILADELPHIA NAT. BANK. 321

Syllabus.

UNITED STATES *v.* PHILADELPHIA NATIONAL
BANK ET AL.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF PENNSYLVANIA.

No. 83. Argued February 20-21,

behavior, or probable anticompetitive effects. Specifically, we think that a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects. See *United States v. Koppers Co.*, 202 F.Supp. 437 (D.C.W.D.Pa.1962).



Presumption of Illegality

United States Court of Appeals,
 Seventh Circuit.
 UNITED STATES of America, Plaintiff–Appellee,
 v.
 ROCKFORD MEMORIAL CORPORATION and
 SwedishAmerican Corporation, Defend-
 ants–Appellants.

No. 89–1900.

Arg
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The United States
 proposed consolidation
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 Court, for the Nor
 J. Roszkowski, J.,
 ment in favor of
 The Court of App
 that proposed merg

[11][12] The defendants' immense shares in a reasonably defined market create a presumption of illegality. Of course many factors other than the number and size distribution of firms affect the propensity to collude, but here as in *Hospital Corporation of America*, a factually similar case, most of them strengthen rather than weaken the inference

Entry Must Be Timely, Likely, and Sufficient



Timely

“It would take significantly longer than the *two-year timeframe prescribed by the Merger Guidelines* to plan, obtain zoning, licensing, and regulatory permits, and construct a new hospital in Lucas County.”

Likely

“The Merger Guidelines explain that *for entry to be considered likely, it must be a profitable endeavor*, in light of the associated costs and risks.”

Sufficient

“Under the Merger Guidelines, *for entry or expansion to be sufficient, it must replace at least the scale and strength of one of the merging firms* in order to replace the lost competition from the Acquisition.”

FTC v. ProMedica Health Sys., Inc., No. 11-cv-47, 2011 WL 1219281, at **31-34 (N.D. Ohio Mar. 29, 2011)



With High Market Concentration, Efficiencies Must Be “Extraordinary”

- “High market concentration levels require proof of *extraordinary efficiencies*, . . . and courts generally have found inadequate proof of efficiencies to sustain a rebuttal of the government’s case.”
 - *United States v. H&R Block, Inc.*, 833 F. Supp. 2d 36, 89 (D.D.C. 2011)
- “[T]he high market concentration levels present in this case require, in rebuttal, proof of *extraordinary efficiencies*.”
 - *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 721-22 (D.C. Cir. 2001)
- “When the potential adverse competitive effect of a merger is likely to be particularly substantial, *extraordinarily great cognizable efficiencies* would be necessary to prevent the merger from being anticompetitive.”
 - *Horizontal Merger Guidelines*, § 10



Efficiencies Must Be Verifiable and Merger-Specific

Verifiable

“The court must undertake a rigorous analysis . . . to ensure that those ‘efficiencies’ represent more than mere speculation and promises”

- *United States v. H&R Block, Inc.*, 833 F. Supp. 2d 36, 89 (D.D.C. 2011)

“Efficiency claims will not be considered if they are vague, speculative, or otherwise cannot be verified by reasonable means.”

- *Horizontal Merger Guidelines*, § 10

Merger-Specific

“[E]fficiencies must be ‘merger-specific’ to be cognizable as a defense.”

- *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 721-22 (D.C. Cir. 2001)

“The Agencies credit only those efficiencies . . . unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects. These are termed merger-specific efficiencies.”

- *Horizontal Merger Guidelines*, § 10

The Relevant Markets

The relevant markets will be conclusively established



There Is No Material Dispute Over the Relevant Service Markets



- Adult PCP Services is a distinct service market, even though some patients visit other specialists to receive primary care (*e.g.*, OB/GYN)
 - Defendants' economic expert agrees. Argue Report ¶ 100
- General Pediatric Physician Services also is a distinct service market
 - Defendants' economic expert agrees. David Argue Dep. Tr. at 162-163

Nampa is the Relevant Geographic Market



Nampa is a distinct geographic market, even though some patients visit PCPs outside Nampa

- Testimony from wide range of market participants confirms that patients prefer access to local PCPs
- All health plans agree: need Nampa PCPs to offer marketable networks
- Data confirms that Nampa patients demand Nampa PCPs

Patients Strongly Prefer Access to PCPs Close to Home



157

1 requ
2 phys
3 cont
4 A
5 beca
6 usua
7 minu
8 requ
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10 the n
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12 regul
13 accep
14 consu
15 that consumers would like very much and they value
16 having their primary physician close to home, within
17 a few miles, 10 to five minutes.

15 that consumers would like very much and they value
16 having their primary physician close to home, within
17 a few miles, 10 to five minutes.

18 So there's kind of a market acceptability
19 that we are trying to achieve and we also have to
20 meet the minimum regulatory standards.

21 Q. SelectHealth makes a list of the providers
22 in the BrightPath network available on its website to
23 members and the public at large, correct?

24 A. Correct.

25 Q. And a person can search that list of

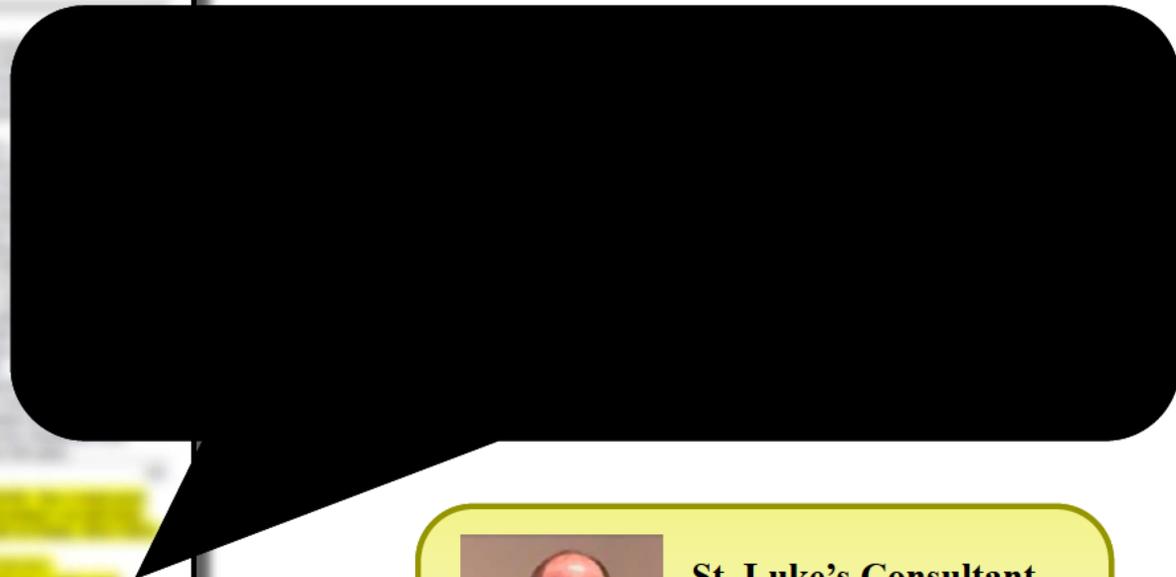


Patricia Richards,
CEO of
SelectHealth



selecthealth.

It Makes [REDACTED] to Have Nampa PCPs



**St. Luke's Consultant
Peter LaFleur**

consilium group llc



Patients Demand Access to Nampa PCPs

<p>1 primary care offices. 2 Q. Have you seen any data on ER 3 utilization for St. Luke's versus other hospitals 4 in Idaho? 5 A. No. 6 Q. Okay. 7 MR. ETTINGER: I have no further questions 8 as part of your 30(b)(6) deposition, Doctor. 9 Thank you very much. 10 MR. WITHROE: None for me at this time. 11 Thanks. 12 MR. PERRY: We can go off the record and 13 take a break. 14 THE VIDEOGRAPHER: Off the record. 15 (Recess taken.) 16 THE VIDEOGRAPHER: On the record. 17 18 EXAMINATION 19 BY MR. SCHAFFER: 20 Q. All right, Dr. Seppi, I just have a few 21 follow-up questions for you based on the questions 22 you were asked by counsel this morning. 23 First is you mentioned early in 24 response to some questions from Mr. Perry that the 25 Saltzer transaction was important to St. Luke's</p>	<p>117 1 really help to coordinate the care for these 2 patients, the care that they receive not only in 3 the Nampa area but if they have to be referred to 4 specialists in the Treasure Valley or elsewhere, 5 they can help coordinate that care. 6 And -- and so I think that is how it 7 helps further, you know, our goals of transformin 8 health care to one that improves coordination, 9 quality, cost efficiency. 10 Q. BY MR. SCHAFFER: And Mr. Ettinger 11 you some questions about whether it would be 12 possible for St. Luke's to hire more independent 13 physicians to serve in a medical director role. 14 Do you remember those questions? 15 MR. ETTINGER: Objection; mischaracterize 16 THE WITNESS: Yes. 17 Q. BY MR. SCHAFFER: Do you have any 18 to believe that doing so would be more or less 19 effective than St. Luke's current plan or 20 current -- the current method by which it deve 21 the initiatives you talked about today? 22 A. Well, we -- you know, we do have 23 some -- and as I said, there are independent 24 doctors who are -- who serve as medical directors 25 for certain roles within the St. Luke's system</p>
<p>118 1 goals of achieving clinical integration and 2 improving quality -- 3 MR. ETTINGER: Objection; mischaracterizes 4 his testimony and leading. 5 Q. BY MR. SCHAFFER: -- because there 6 was -- 7 MR. ETTINGER: Oh, now he's really getting 8 that way. 9 Q. BY MR. SCHAFFER: -- because you said 10 there was an access point needed in Nampa. Can 11 you explain what you meant by that and why -- why 12 that was? 13 MR. PERRY: Same objection. 14 THE WITNESS: Yeah. We -- so we have -- we 15 have patients that live in Nampa that have access 16 to St. Luke's Health System outside of the Nampa 17 area, and we -- we really believe that it is 18 important to have access points for those patients 19 close to home. And -- and in that regard, the 20 Saltzer clinic is a -- mainly a primary care base. 21 It would improve access for those patients close 22 to home. 23 But then again, it also acts as this 24 nucleus or this aligned group of physicians, 25 financially aligned group of physicians that can</p>	<p>119 1 now, mainly in the hospital setting. 2 A lot of the initiatives that I pointed 3 out here in Plaintiffs' Exhibit 397, these are 4 initiatives that really were the brainchild 5 times of our employed physicians. They 6 they're the ones with most of the 7 that this is something that they've led that 8 they've led that. 9 They've led these initiatives, and they 10 have the -- through human resource and 11 capital resources to get involved in these and 12 carry them through. 13 We don't see the same kind of 14 participation with independent physicians, for 15 obvious reasons. Not because they are not 16 excellent physicians and interested in doing this, 17 but they have to run their own offices. And they 18 don't have access to the human resources or 19 capital resources that financially aligned 20 physicians have. 21 So it just seems to be more effective 22 in -- in many ways when we have medical 23 directorships within the aligned physician 24 community and the things they are able to do and 25 accomplish.</p>

[W]e have patients that live in Nampa that have access to St. Luke's Health System outside of the Nampa area, and we -- *we really believe that it is important to have access points for those patients close to home.*



**Dr. Kurt Seppi,
Executive Medical
Director**





To Be Marketable, Provider Networks Must Include Local PCPs

Case 1:12-cv-00560-BLW Document 34-23 Filed 12/04/12 Page 1 of 9

13. If we are to be competitive in the market for health insurance in southern Idaho, we need to have substantial primary care physician coverage in Canyon County. But we need more than just numbers; we need physicians who are dedicated to quality enhancement, use of

DECLARATION OF PATRICIA R. RICHARDS

PATRICIA R. RICHARDS declares, under penalty of perjury and pursuant to 28 U.S.C. § 1746, as follows:

1. I am the President and Chief Executive Officer of SelectHealth. I earned my nursing degree from St. Joseph's Hospital School of Nursing, affiliated with the University of Wisconsin. I have a bachelor's degree in General Studies, with a major area of concentration in Communications, and completed coursework in the masters in public administration program at the University of Toledo. Prior to joining SelectHealth in November 2009, I served as executive vice president and chief operating officer of the Health Alliance Plan of Michigan. I have also held senior leadership positions at Anthem Health Plan in Maine, Paramount Health Care in Ohio, and Blue Cross Blue Shield of Ohio.



Patricia Richards,
CEO of
SelectHealth



To Be Marketable, Provider Networks Must Include Nampa PCPs



Jeffrey Crouch, Vice President of Provider Relations for Blue Cross of Idaho, will testify that:

- Patients demand access to PCPs in the communities where they live
- In his experience, BCI cannot offer a competitive network without local PCPs, even if the network includes PCPs in nearby areas
- A network without PCPs in Nampa would not be commercially viable



**Jeffrey Crouch, VP of
Provider Relations**





St. Luke's Own Documents Analyze the "Nampa Physician Market"

Nampa Physician Market Share

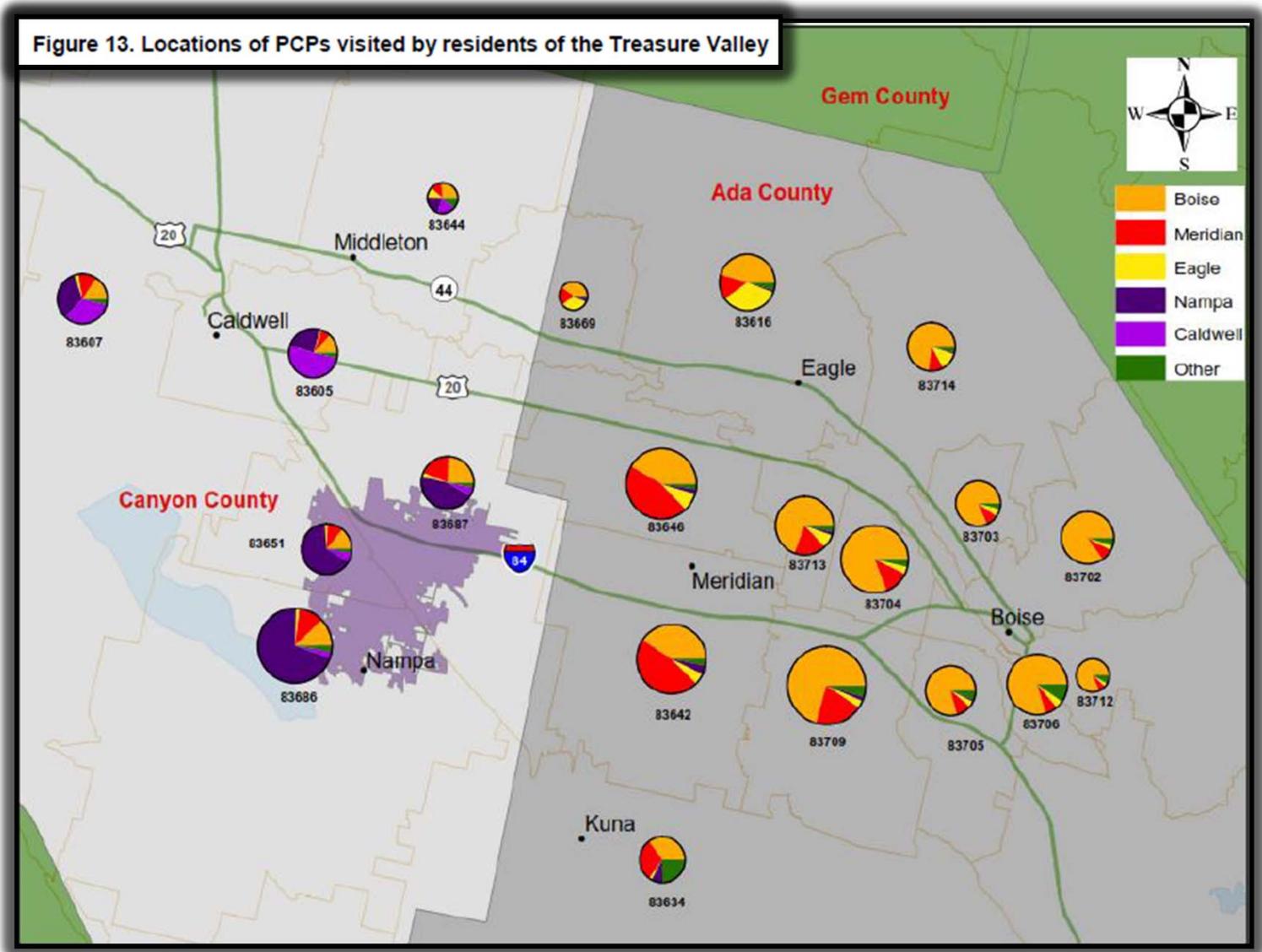
Potential SLHS Practices							Total	Potential SLHS Practices	% of Total
Specialty	Saltzer	Mercy Group	St. Al's	PHMG	Independent				
Family Practice	11	7	14	2	4	38	18	47%	
Internal Medicine	6	0	0	0	4	10	6	60%	
Pediatrics	11	0	0	0	1	12	11	92%	
OB	1	0	0	0	7	8	1	13%	
General Surgery	2	0	1	0	1	4	2	50%	
Orthopedics	4	0	0	0	0	4	4	100%	
ENT	1	0	0	0	1	2	1	50%	

♦ Saltzer and Mercy Group physicians represent the majority of primary care and surgical providers in Nampa.

♦ Saltzer and Mercy Group physicians represent the majority of primary care and surgical providers in Nampa.



Nampa Is a Distinct Market from Boise





Dr. Argue's Critical Loss Analysis Is Flawed

- Defendants' expert relies heavily on "critical loss analysis" to suggest a much broader geographic market. *But . . .*
 - Dr. Argue ignores the role of health plan-provider negotiations in setting healthcare prices
 - Dr. Argue failed to execute a basic element of proper critical loss analysis
 - Dr. Argue presents two different calculations of the critical loss; neither is correct

Defendants Offer No Viable Alternative Geographic Market



14 Q. So, sitting here today, can you say what the
15 properly defined geographic market for primary care
16 physician services is, in fact, in this case?

August 28, 2015
David A. Argue, Ph.D.

1 A. I have not specified the exact parameters of the
2 geographic market.



For The Record, Inc.
(301) 870-8025 - www.ftrinc.net - (800) 921-5555



David Argue, VP and Principal
Economists Incorporated

Economists
INCORPORATED

Market Concentration

*The acquisition is presumptively
illegal by a wide margin*



Courts Use Market Concentration to Determine the *Philadelphia National Bank* Presumption



- “Statistics that indicate excessive post-merger market share and market concentration create a presumption that the merger violates the Clayton Act.”
 - *California v. Am. Stores Co.*, 872 F.2d 837, 842 (9th Cir. 1989)
- “Sufficiently large HHI figures establish the FTC’s prima facie case that a merger is anti-competitive.”
 - *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 716 (D.C. Cir. 2001)



The Merger Guidelines Provide Generally Accepted Thresholds for Market Concentration

HORIZONTAL MERGER GUIDELINES

Based on their experience, the Agencies generally classify markets into three types:

- Unconcentrated Markets: HHI below 1500
- Moderately Concentrated Markets: HHI between 1500 and 2500
- **Highly Concentrated Markets: HHI above 2500**

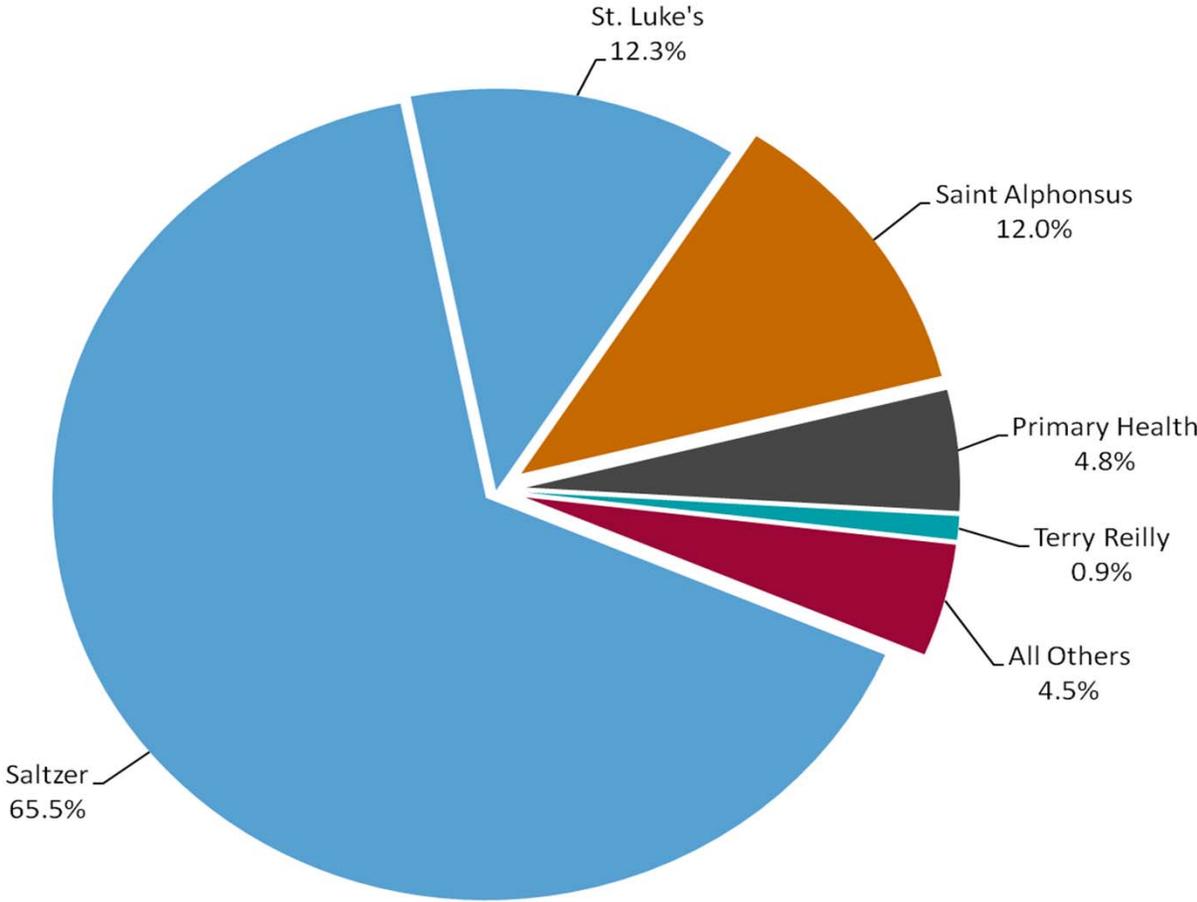


U.S. DEPARTMENT OF JUSTICE
AND THE
FEDERAL TRADE COMMISSION

ISSUED: AUGUST 19, 2010



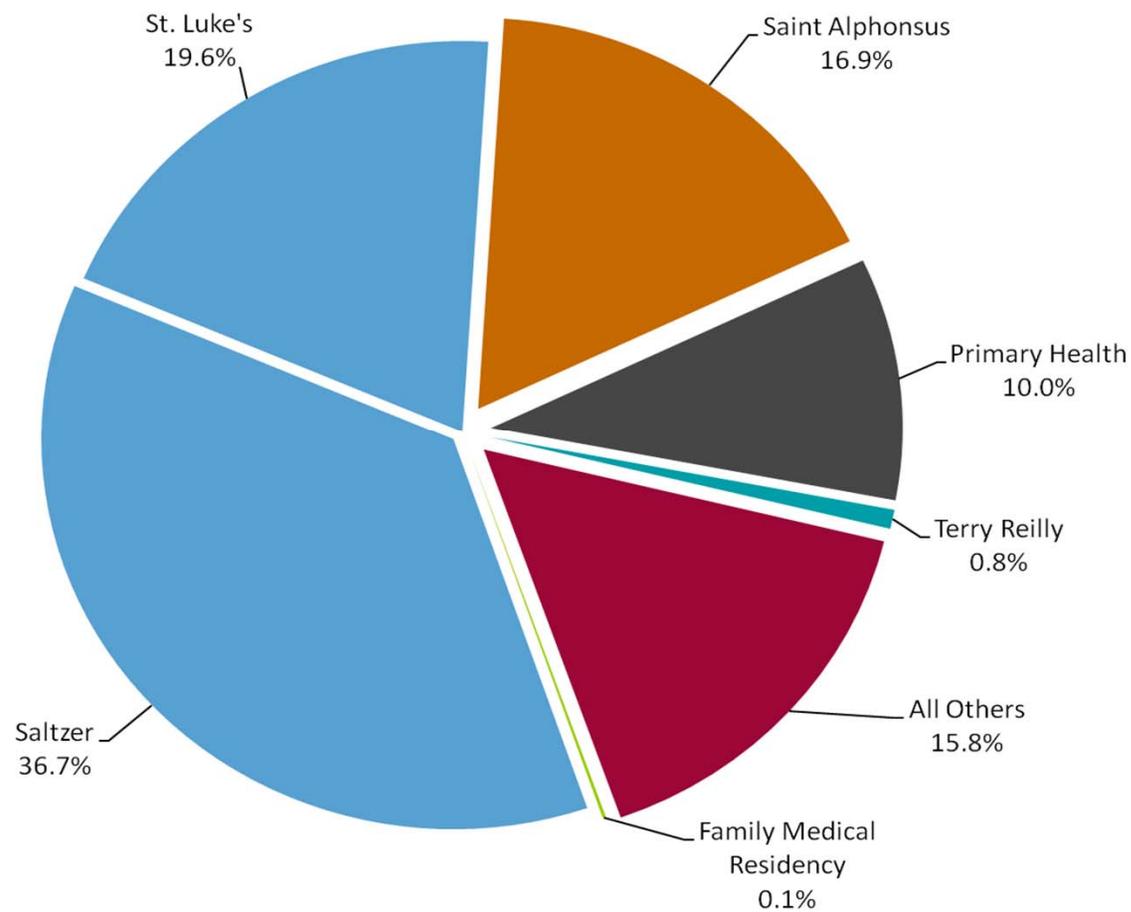
St. Luke's and Saltzer Account For Nearly 80% of PCP Services In Nampa



Market shares for Adult PCP Services in Nampa



Even If the Geographic Market Is Much Broader, the Acquisition Remains Presumptively Illegal



Market shares for Adult PCP Services in Nampa/Caldwell/Meridian

Post-Merger HHIs Here Far Exceed Other Transactions Found Unlawful



Case	Combined Share	Pre-Merger HHI	HHI Increase	Post-Merger HHI	Holding
<i>Phila. Nat'l Bank</i> (Supreme Court 1963)	30%	N/A	N/A	N/A	Enjoined
<i>Rockford Mem'l</i> (N.D. Ill. 1989)	68%	2789	2322	5111	Enjoined
<i>Univ. Health Inc.</i> (11 th Cir. 1991)	43%	2570	630	3200	Enjoined
<i>Cardinal Health, Inc.</i> (D.D.C. 1998)	37% 40%	1648	1431	3079	Enjoined
<i>H&R Block, Inc.</i> (D.D.C. 2011)	28%	4291	400	4691	Enjoined
<i>ProMedica</i> (N.D. Ohio 2011)	58%	3313	1078	4391	Enjoined
<i>OSF Healthcare</i> (N.D. Ill. 2012)	59%	3353	2052	5406	Enjoined
<i>St. Luke's (Adult PCP)</i> (D. Idaho 2013)	78%	4612	1600	6219	TBD

Anticompetitive Effects

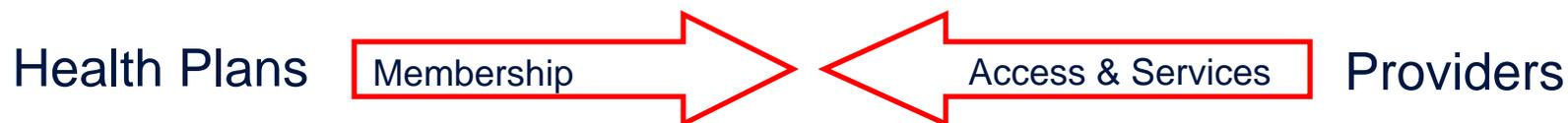
*Evidence of anticompetitive
effects bolsters the strong
presumption of illegality*





Bargaining Leverage Overview

- Bargaining Leverage: Health Plans vs. Providers
 - Health plans and providers determine rates through bilateral negotiations
 - Each side's leverage is determined by the other side's "outside option"



- The acquisition makes health plans' outside options ***much less attractive***, giving St. Luke's/Saltzer the ability to extract higher reimbursements from health plans



St. Luke's Likely Will Exercise Its Additional Market Power to Increase Prices

Expert Report of David Dranove X. St. Luke's ACO and risk-based contracting claims

Both forms of ACO organization are emerging and we will soon have empirical evidence as to which is superior.

(282) I am not arguing that financial integration in general will be less effective than looser forms of affiliation, or that physician-led integration is superior to hospital-led integration. I am arguing that there is a legitimate disagreement and uncertainty about these key issues, and that we should rely on market forces to sort this out. Where alternative models are in competition, the more effective model will grow at the expense of the less effective model. This will tend to create a direct benefit as patients are serviced by the most effective models. It will also tend to create an indirect benefit as the less effective model must adapt and innovate in order to succeed. Mergers that substantially reduce competition will short-circuit this efficiency-enhancing process. This is precisely why the Brookings Institution report calls for enhanced antitrust enforcement against integration of ownership via mergers and acquisitions, which are difficult to break up once they are established.

(283) Specifically with respect to the St. Luke's acquisition of Saltzer, the acquisition is likely to enhance St. Luke's market power and to give it the ability to increase price. In contrast, the benefits of the acquisition, particularly in comparison to alternative delivery models that do not give rise to the same market power concerns, are unproven and speculative. Given the evidence showing that the acquisition will do little to change the Saltzer physicians' incentives relative to their current volume-promoting fee-for-service (see section IX.B.1), there is every reason to be skeptical about the benefits.

(284) As evidence of the difficulties that vertically integrated health systems may encounter in achieving the kind of clinical integration required by a successful ACO, we need look no further than St. Luke's. As St. Luke's head of Clinical Integration, Geoffrey Swanson, wrote in a series of internal emails to his physician colleagues as recently as December 2012:

- "Agree that if the [St. Luke's] SELECT Network had achieved Clinical Integration as was its intended plan from 2010, the formation of the SLCCC as an entity composed of the participating Medicare billing TINs, would not have been necessary. However, as the Clinical Integration process has struggled as it was not a resource priority, hence we are where we are."²⁵⁷
- "I do not believe that our administrative leaders fully appreciate or understand what this means nor do I believe, despite their best intentions, they fully understand or appreciate the complexities of care delivery, physician engagement or patient needs. Therefore, I do not

hospital admissions than hospital-led organizations. Executives at hospital-led organizations may feel it is imperative to maintain a certain level of inpatient operations, which was, historically, the backbone of their business and core of their expertise. A physician-led organization may feel no compunction about dramatically scaling back the inpatient business.

²⁵⁷ SLH5000776012-013 at 012 (emphasis added).

For Attorneys' Eyes Only Page 111

“Specifically with respect to St. Luke’s acquisition of Saltzer, *the acquisition is likely to enhance St. Luke’s market power and to give it the ability to increase price.*”



Professor David Dranove
Kellogg School of Management
Northwestern University





St. Luke's Expects Market Share in PCPs to Provide a "Strong Position" with Insurers

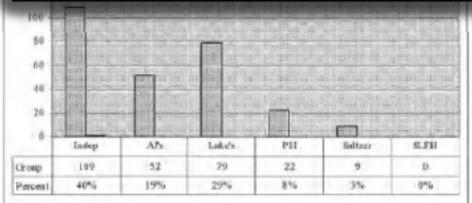
Primary Care Physician Market Share

St. Luke's Treasure Valley recognizes that market share in primary care is a key success factor, critical to sustaining a strong position relative to payer contracting and supporting ancillary, procedural, inpatient, specialty and other services. For purposes of this analysis, primary care is defined as family medicine, internal medicine, OB/GYN and pediatrics.

Primary Care Physician Market Share

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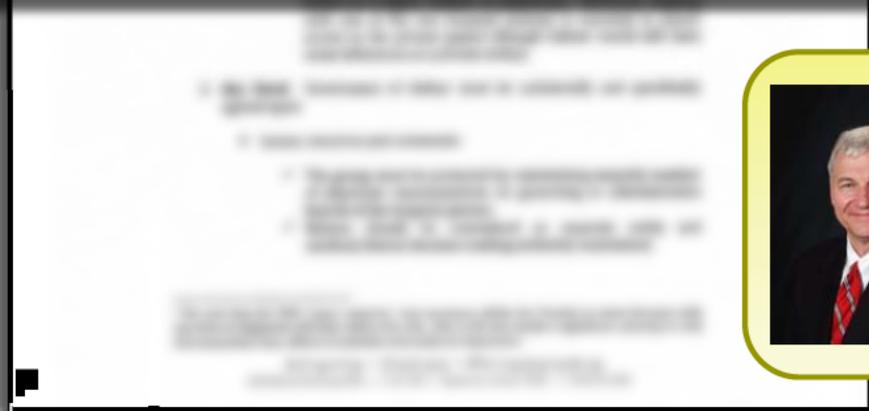
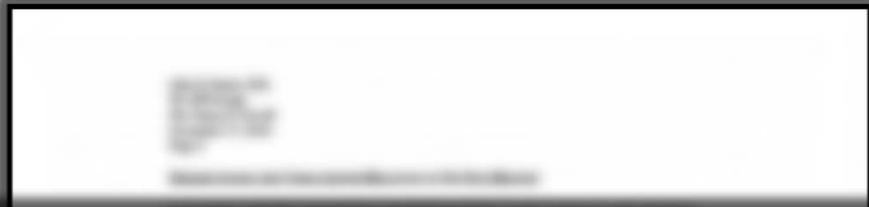
St. Luke's has a risk practice...



HIGHLY CONFIDENTIAL

SLHS000039821

Saltzer's Consultant Predicted the Deal Would Increase Negotiating Leverage



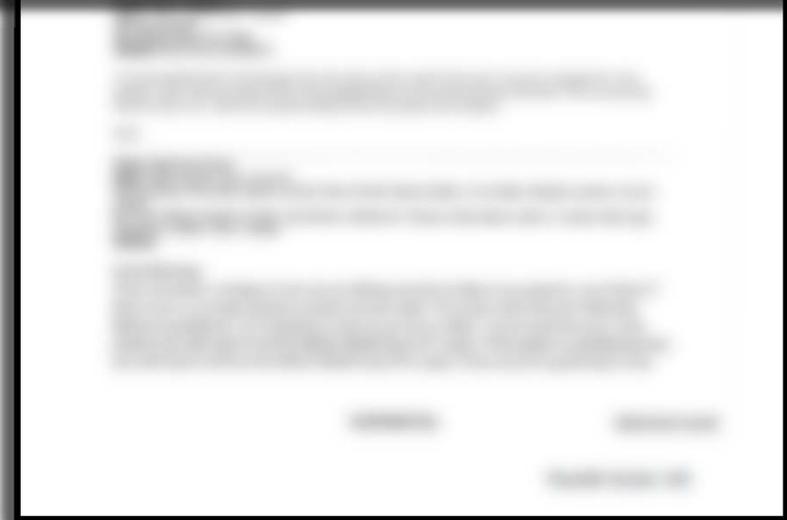
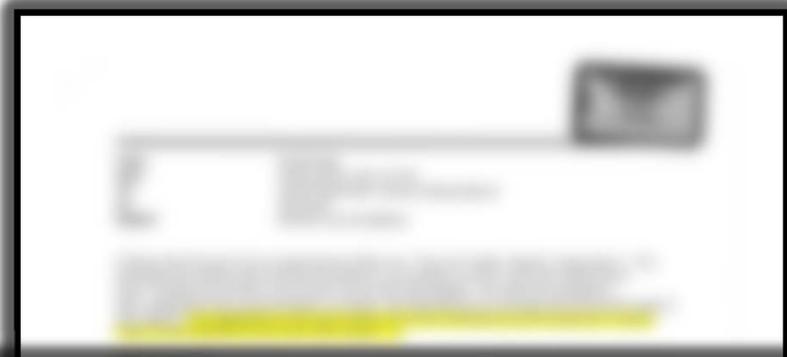
Max Reiboldt, President and CEO



Coker
GROUP

Business Advisors for the Healthcare Industry

The Acquisition Also Augments Saltzer's Negotiating "Clout"




**Randell Page,
Chairman, Saltzer
Contracts Committee**





Past Is Prologue

St. Luke's Magic Valley Region

1 Family Practice

a) **Recruitment:** We have been successful in recruiting excellent family physicians to Twin Falls over the past year. These efforts will continue.

hospitals. Kurt Seppi was unanimously selected as the group chairman. The global goals of the group are listed below.

development and implementation of communication strategies that result in improved dialogue between the various specialties involved within the group structure, the regional participants in the St. Luke's Health

1 System Contracting: System contracting staff was able to jointly negotiate both the physician and hospital Blue Cross agreements in the Magic Valley. This is a good example of hospitals and physicians working together to achieve mutually beneficial outcomes. We see this type of negotiation as a precursor to what we may be able to achieve across the region if we can attain the critical mass of physicians committed to partnering in the St. Luke's Health System.

intercepted in providing coverage.

3 **Internal Medicine:** Recruitment for both hospitalist and outpatient practice remains a significant challenge. We are short physicians today, and absent Dr. Lobb and Dr. Desmond remaining in practice, we would be particularly challenged to cover patient demand. As in Boise, the future may lie in teaming the dwindling supply of internists with mid levels, and in recruiting additional family physicians.

St. Luke's Clinic Physician Network Leadership

1 **St. Luke's Magic Valley:** The initial meeting of the St. Luke's Magic Valley physician leadership group has taken place will begin structuring a work plan to begin integrating the physician activities and governance into the community health system leadership structure. I believe this structure is essential in bridging the cultural gaps that exist between physician groups and the traditional hospital environment. In essence, we do not want to perpetuate the silos that exist between specialties, and between physicians

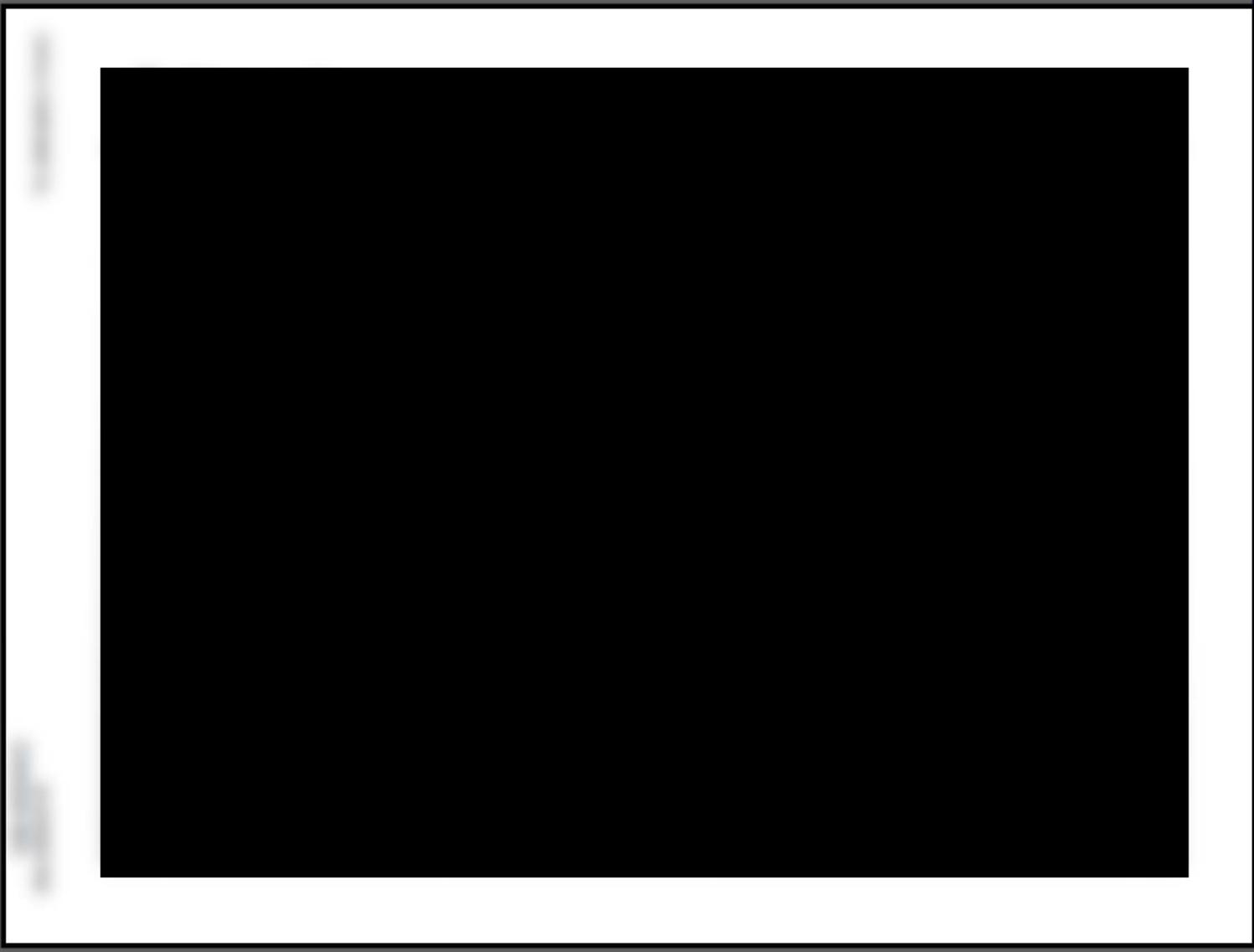
pected the initial group agenda and goal development will mirror the one established by the Magic Valley group.

General Information:

System Contracting: System contracting staff was able to jointly negotiate both physician and hospital Blue Cross agreements in the Magic Valley. This is a good example of hospitals and physicians working together to achieve mutually beneficial outcomes. We see this type of negotiation as a precursor to what we may be able to achieve across the region if we can attain the critical mass of physicians committed to partnering in the St. Luke's Health System.

Information Technology: A group is being developed to assess our current information technology strategy and systems. Efficient and effective information technology systems will be critically important to assure effective and efficient management of clinical information, and to ensure excellent support our provider based physician community.

Past Is Prologue





Past Is Prologue

Need critical mass to initiate negotiations / push back
MV has required critical mass and can negotiate



**Steve Drake, Director
of Payer Contracting**



7 Q. So Mr. Pomeroy was saying at this
8 meeting that we need critical mass in order to
9 push back in negotiations with payers, isn't that
10 right?
11 A. That appears to be what the statement
12 says.
13 Q. And he was saying in the Magic Valley
14 we have that critical mass, correct?
15 A. It says they can negotiate, yes.

St. Luke's Does Not Want a [REDACTED]



Randy Billings, VP of Payor Relations



St. Luke's Modeled Reimbursement Increases From Commercial Payors



Preliminary Lab Differential
1.0000

Item	2019	2020	2021	2022	2023	2024
Commercial Payors	1000000	1000000	1000000	1000000	1000000	1000000
Medicaid	1000000	1000000	1000000	1000000	1000000	1000000
Medicare	1000000	1000000	1000000	1000000	1000000	1000000
Other	1000000	1000000	1000000	1000000	1000000	1000000
Total	4000000	4000000	4000000	4000000	4000000	4000000

Based on the preliminary analysis, total annual lab reimbursement differences appear to be \$1,000,000.

\$1,000,000



Idaho's Largest Health Insurer Has Faced St. Luke's Use of Market Power to Increase Reimbursements

- St. Luke's successfully used its market power from other acquisitions to increase reimbursements via enhanced negotiating leverage
- Physicians and facilities in other locations – even as little as ten miles away – are not a commercially viable solution
- St. Luke's can “harvest” greater market power in many ways
- St. Luke's/Saltzer is necessary to have a viable commercial insurance product in Nampa



**Jeffrey Crouch, VP
of Provider Relations**





A Commercial Network Without Saltzer Is Much Less Attractive to Consumers



Q: You felt that in order for the Regence PPO statewide network to be competitive, you had to have Saltzer in that network as well.

A: That's correct.



**Scott Clement,
Former VP of Provider
Services**



St. Luke's Exercises Its Market Power



- Past experience with Magic Valley
- St. Luke's stopped negotiating over price with IPN
- Need for Saltzer / St. Luke's in Nampa
- Substitutes within Nampa are not realistic alternatives



**Linda Duer,
Executive Director**



Entry

Entry will not be timely, likely, or sufficient to offset the acquisition's likely anticompetitive effects





Entry Is Unlikely

Dr. David Peterman of Primary Health Medical Group will testify about the difficulties his physician group has encountered recruiting PCPs to Nampa



Dr. David Peterman



Nancy Powell of Saint Al's will testify that existing physicians cannot reposition to provide PCP services in Nampa

Nancy Powell
Chief Administrative Officer

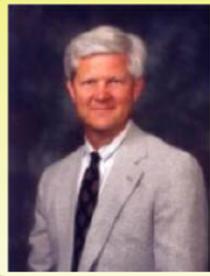




Entry Is Unlikely

<p>77</p> <p>1 recruiting physicians, is there any other reason 2 why you don't think Saltzer was well positioned to 3 build the provider network in Canyon County on its 4 own? 5 A. I'm sorry. Ask me again. 6 Q. Let -- let me step back a minute. 7 We've discussed how Saltzer is the largest 8 multispecialty physician practice in Canyon 9 County. And I'm asking whether Saltzer is well 10 positioned to build the provider network in 11 Canyon County. Do you understand that? 12 A. Yes. 13 Q. And you said that one problem Saltzer 14 has had is its ability to recruit new physicians; 15 is that right? 16 A. Yes. 17 Q. Are there any other problems that 18 Saltzer would have in building a provider network 19 in Canyon County? 20 A. I think -- and I think the main one is 21 just the ability to recruit and support new 22 people. 23 Q. Turning back to Exhibit 478. 24 Further down in the first paragraph of your 25 E-mail, you state, "We need to try to bring the</p> <p>78</p> <p>1 Mercy Physician Group family does into Saltzer if 2 possible. That would be huge for maintaining/ 3 improving the referral base in Canyon County as 4 Al's begins more recruiting of peps and other 5 specialists to be in direct competition." 6 Do you see that? 7 A. I do. 8 Q. The Mercy Physician Group family does 9 that you refer to in Exhibit 478, is that the 10 group of physicians that we discussed earlier that 11 is now part of St. Luke's? 12 A. In general. I couldn't say if Doctor 13 by Doctor if it is exactly the same, but in 14 general, yes. 15 Q. That's the group you're referring to 16 when you mentioned, I think it is called -- 17 correct me if I'm wrong -- "Saint Al's Family 18 Practice Nampa"? 19 A. Yes. 20 MR. ETTINGER: You said "Saint Al's Family 21 Practice." 22 Q. BY MR. PERRY: I'm sorry. St. Luke's 23 Family Practice, Nampa. 24 A. Yes. Excuse me. 25 MR. PERRY: Thanks for the correction.</p>	<p>79</p> <p>1 Q. BY MR. PERRY: Why was it so important 2 to bring this group of family practice physicians 3 into Saltzer if possible? 4 A. Well, they were respected 5 practitioners. They already had existing 6 practices, so they wouldn't be providers that you 7 would be bringing in trying to build a practice. 8 So you wouldn't have that impediment. 9 Plus, a multispecialty group needs to 10 have healthy primary care physician practices to 11 support referrals to the specialists within that 12 practice. 13 Q. Let's unpack that just a little bit to 14 make sure I understand it. When you say that they 15 are an existing provider group, they don't have 16 the impediment of having to build a practice, 17 you're referring again to the difficulty in terms 18 of recruiting; is that right? 19 A. I'm referring to that if these would be 20 physicians who would bring a practice to the 21 group, a lot of their patients would follow them, 22 presumably, as opposed to a new provider coming 23 who wouldn't have any patients and would have to 24 build a practice from scratch. 25 Q. A new provider coming into the</p> <p>80</p> <p>1 community who had to build a patient base from 2 scratch, how long would that take in your -- based 3 on your knowledge? 4 A. I don't think you can generalize about 5 that. And to be honest with you, I don't know the 6 numbers even on our own people as to when they get 7 to the point where they are, you know, exceeding 8 their guaranteed salaries. I don't know those 9 numbers. 10 Q. But it is much more difficult for a new 11 provider coming into the market to build a 12 thriving practice than it is for an existing 13 established practice with a panel of patients 14 to -- to grow; is that right? 15 MR. KEITH: Objection to form. 16 THE WITNESS: Well, that seems like that's a 17 moot point. The -- the existing provider already 18 has a practice. He's not -- he's not growing a 19 practice. He already has one. 20 I wasn't trying to evade your question. 21 I just -- 22 Q. BY MR. PERRY: I understand. It was 23 probably a poorly worded question. 24 Turning back to Exhibit 478, the 25 section that we had been discussing previously</p>
---	---

[P]hysicians who would bring a practice to the group, a lot of their patients would follow them, presumably, as opposed to *a new provider coming in who wouldn't have any patients and would have to build a practice from scratch.*



**Randell Page,
Chairman, Saltzer's
Contracts Committee**





Entry will Not Offset St. Luke's Additional Market Power

Expert Report of David Dranove

I. Summary of opinions

(DOJ) and Federal Trade Commission (FTC) *Horizontal Merger Guidelines (Merger Guidelines)*.¹ After the merger, the combined share will be nearly 80 percent and the HHI concentration index will be over 6,000. This increase in concentration far exceeds the threshold at which the *Merger Guidelines* specify that mergers are (rebuttably) presumed "likely to enhance market power." This conclusion is not sensitive to the precise boundaries of the relevant geographic market. For example, even if, notwithstanding patients' preferences for local provider options, the geographic market were expanded to include the neighboring cities of Caldwell and Meridian, the post-merger share would be 56 percent and the HHI index will increase from 2,169 to 3,607; this too is well within the range at which a merger is presumed likely to enhance market power.

- (8) I conclude that the merger will substantially reduce competition in the market for PCP services in Nampa and is likely to increase healthcare costs for area consumers.
- (9) While data on patient travel show that most individuals prefer to receive primary care close to home, the data also reveal that some individuals receive primary care farther away from where they live. Some analysts might incorrectly interpret these "outflows" as evidence that the geographic market should be expanded well beyond Nampa. Recent economic theory and empirical studies show that conclusions about market definition drawn from flow data are often unreliably biased towards identifying overly large relevant geographic markets. Many individuals who travel for care have idiosyncratic reasons for travel that often have nothing to do with price, and evidence about their travel does not inform us about the pricing power of local providers or the likely responses of consumers to price increases. Put simply, the fact that some people travel for care does not nullify the concept of option demand—even individuals who travel occasionally may balk at a network that forces them to always travel for care.
- (10) Detailed examination of patient travel patterns based on an empirical model of the demand for PCP services reveals that, for Nampa residents, Saltzer and St. Luke's are each other's closest substitutes. A merger between Saltzer and St. Luke's would eliminate each other's closest competitor in this market.
- (11) Not only does the acquisition limit competition for PCP services in Nampa, it increases St. Luke's market leadership in the Treasure Valley. This will enhance St. Luke's bargaining position vis-à-vis commercial health insurers, giving the combined entity the ability to obtain higher reimbursements in contract negotiations.
- (12) **Both theory and evidence suggest that entry is unlikely to limit St. Luke's/Saltzer's exercise of market power in the Nampa PCP market. Patients are reluctant to switch to new PCP practices; indeed, in recent years, nearly all new PCPs in the Treasure Valley have joined established practices.**

¹ United States Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines*, Issued August 19, 2010, § 5.3, available at <http://www.justice.gov/atr/public/guidelines/hmg-2010.html>, [hereinafter *Merger Guidelines*].

"Both theory and evidence suggest that entry is unlikely to limit St. Luke's/Saltzer's exercise of market power in the Nampa PCP market. Patients are reluctant to switch to new PCP practices; indeed, in recent years, nearly all new PCPs in Treasure Valley have joined established practices."



Professor David Dranove
Kellogg School of Management
Northwestern University





No Likely Entrants

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1 occurring between the two integrated hospital systems,
 2 that there's an advantage that those systems have by
 3 their size, by their spectrum of services, that would
 4 eventually have outweighed any advantage that Saltzer
 5 would have in competing on a day-to-day basis.
 6 BY MR. ETTINGER:
 7 Q. So, I gather that you think that independent
 8 profitable entry into primary care physician services or
 9 pediatric services in Nampa is not going to be
 10 profitable?
 11 A. It's hard to say over a -- it depends on the
 12 time period you're looking at. What I was answering
 13 this previous question I was thinking in a fairly -- in
 14 a longer run, and I don't have -- and I can't tell you
 15 it's not a year, is it ten years, it's probably
 16 somewhere in between, that as the St. Luke's and Saint
 17 Al's develop their integrated networks more thoroughly
 18 and become more connected with risk-based products and
 19 so forth with health plans, it's going to be harder for
 20 any independent group, new entrant or Saltzer or anybody
 21 else, to continue to be, you know, as competitive or as
 22 effective as they were in the past.
 23 Q. So, are you saying that new entrants into
 24 primary care physician services or pediatric services in
 25 Nampa will in the longer run, as you've just described

218

1 it, not be profitable?
 2 A. I don't know whether they'll be profitable or
 3 not, I don't know how they make their business models
 4 work.
 5 Q. Okay. Would you agree that successful entry, or
 6 expansion, can vary depending on the physician special
 7 or the particular geographic area that you're looking
 8 at?
 9 A. As a general matter, yes.
 10 Q. Is there anyone you can identify by -- as a
 11 likely entrant into primary care physician services or
 12 pediatric services in Nampa?
 13 A. You mean a new provider who is not already
 14 there?
 15 Q. Right.
 16 A. No.
 17 Q. I'm sorry?
 18 A. No.
 19 Q. Okay. You understand that one of the merger
 20 guidelines criteria relates to timely entry or
 21 expansion, correct?
 22 A. Yes.
 23 Q. Is the relevant time period to look at in
 24 deciding whether entry is timely the time period between
 25 the decision to recruit and those physicians arriving

219

1 and becoming profitable?
 2 A. It would seem to me it's -- between the deci
 3 to recruit, presuming that people are, you know, n
 4 dilly-dallying, but yes, it's between the recognitio
 5 that they need patients -- or sorry, they need
 6 providers, and the time that those providers are th
 7 in the market and available to work.
 8 Q. Was it until they're in the market or un
 9 are in the market and operating profitably?
 10 A. I don't think that it -- there's a requirement
 11 that they operate profitably, there may be initial
 12 losses as somebody enters the market. The impor
 13 point is that they're drawing patients away from the
 14 provider that's exercising or attempting to exercise
 15 market power, enough patients in order to constrai
 16 and discipline them from exercising that market p
 17 Q. So, but it's not merely the fact that the
 18 physician is on the scene, it's that the physician
 19 the scene and at least having a measurable effe
 20 marketplace by attracting substantial number
 21 patient, correct?
 22 MR. SCHAFER: Object to form.
 23 THE WITNESS: To make a de
 24 draw enough patients from the
 25 to raise market power in c

220

1 BY MR. ETTINGER:
 2 Q. And
 3 decision
 4 the
 5 the exerc
 6 that right?
 7 I think that's generally right, although it's
 8 not any individual physician that needs to draw all the
 9 patients, it's whatever the aggregation of entry
 10 happened to be.
 11 Q. Okay. And you have not analyzed that time
 12 period in this case, have you?
 13 A. For new entry, no.
 14 Q. Or for expansion, have you?
 15 A. I have not.
 16 Q. Now, if it were the case that entry or expansion
 17 of primary care physicians or pediatricians into Nampa
 18 was unsuccessful because there were few available
 19 patients because of great patient loyalty to Saltzer in
 20 significant part, that would lead to the conclusion that
 21 entry was not entry in the merger guidelines sense,
 22 correct?
 23 A. In the guidelines sense we're talking about
 24 entry being successful if it gets to that point, where
 25 it's able to discipline the incumbent, right, that's

55 (Pages 217 to 220)

Q: Is there anyone you can identify by – as a likely entrant into primary care physician services or pediatric services in Nampa?

A: You mean a new provider who is not already there?

Q: Right.

A: No.



David Argue, VP and Principal Economists Incorporated



Efficiencies

Defendants' efficiencies claims are unverifiable and non-merger specific





St. Luke's Efficiencies Claims Are Speculative

- St. Luke's quality claims are unverified
 - No link between purported quality improvements and physician acquisitions
 - Claims of 40+ percent improvements not supported by internal quality reports
 - No measurable benefits from St. Luke's use of health information technology – e.g., EMR and WhiteCloud
- No evidence that St. Luke's prior PCP acquisitions lowered the cost of healthcare

Defendants' "Nucleus" Theory Is a Moving Target



- Defendants claim that “[i]t is essential to have a core or nucleus of employed or closely affiliated physicians in the region in order to achieve the benefits of coordinated, integrated care there.”
 - “I think that you probably need in the area something 3[00] to 400, at least to begin with, **3[00] or 400** physicians.”
 - *Dr. Kurt Seppi, St. Luke’s Executive Medical Director*
 - “I haven’t counted them, but I would say that we’re probably looking at several dozen, . . . probably **two to three dozen.**”
 - *David Pate, CEO of St. Luke’s Health System*
 - “I’m thinking of something like **four to six per specialty.**”
 - *Prof. Alain Enthoven, Defendants’ Efficiencies Expert*

St. Luke's Head of Clinical Integration Confirms That Their Efficiencies Claims Are Speculative



Dr. Geoffrey Swanson,
VP of Clinical Integration





Defendants' Claims of Future Efficiencies Are Highly Speculative

Q: Do you have a view of how long it takes to fully change the incentives?

A: *I would have to say years . . . I think maybe a decade or more.*

This is a complex and perilous route, and others trying to take this route have tripped and fallen

1 made mistakes
2 complex field.
3 Q. So I go
4 align incentive
5 integrated del
6 A. Well, as
7 think what I've
8 fact, my under
9 investigated th
10 St. Luke's has
11 and a couple of
12 the model is, r
13 that's producti
14 that is quality-
15 have the inform
16 to work with th
17 fairness and re
18 And that
19 would this take
20 anyway. Becau
21 their incomes,
22 And so they can
23 economic interest,
24 this is working. And so
25 develop it, to explain it to them, to persuade them. 11:16

1 that this is a good idea, and that it will be fair.
2 That comes to the whole culture -- you
3 know, there is a common culture where I trust the
4 management, I trust my teammates, and confident that
5 they won't treat me unfairly as we go into a new
6 uncharted area of physician payment based on a
7 blend of productivity and quality care.
8 Q. So is it possible that the physician groups
9 will never give
10 opposed to
11 MR.
12 Incomplete
13 MR.
14 Q. Is
15 willing to
16 compens
17 model?
18 MR.
19 Incomplete
20 THE
21 some doc
22 to be very
23 the fir
24 There are
25 These are

1 this case that success is not guaranteed. This
2 complex and somewhat perilous route, and others
3 trying to take this route have tripped and fallen
4 in the case as we discussed, the failures in the
5 1990s.
6 And so far, from what
7 of what St. Luke's is doing,
8 are smart, like they are not

1 a straw man. So Dr. Enthoven, would you like to
2 finish your answer?
3 A. Right. Thank you. Here are two examples.
4 He says, "Dr. Enthoven thinks that these incentives
5 are irreconcilably opposed." I think I didn't say
6 see a lot of people out
7
8
9
10
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1 into the -- today's healthcare financing system.
2 That happened many years ago, because the medical
3 profession at the time insisted on fee for service as
4 a principle of ethical medicine.
5 So that got baked into the whole system, and
6 so that makes the transition difficult to make. But
7 I think people like Advocate and Hill and others are
8 making the beginning. They are beginning, and I
9 welcome that. I applaud that, hope for that. But I
10 think in many cases, it is just a beginning. They
11 are a long way from the top. They are a long way
12 from being five-star programs or dominant market
13 share programs.
14 Q. Do you have a view of how long it takes to
15 fully change the incentives?
16 MR. KEITH: Objection to form.
17 THE WITNESS: I would have to say years.
18 I'm speculating now, if you forgive me for
19 speculating. But I don't have a settled view on
20 that. But I think maybe a decade or more. One
21 factor in this is fee for service and financial
22 incentives are only a part of the story. A very
23 important part of the story is culture. And I think
24 Dr. Kaiser said in his commentary, "Seems like money
25 isn't everything." I absolutely and completely agree

1 with that, that money isn't everything.
2 One of the wisest doctors I know says
3 "Culture eats strategy for lunch." This is referring
4 to with the Kaiser Permanente culture. It's they've
5 accumulated the docs so they all believe and
6 understand and are totally signed on to the
7 commitment to quality, efficiency, affordability and
8 so forth. And they trust each other. They know each
9 other. And so they got this strong
10 think for this to work, it's not just
11 getting off of fee for service,
12 culture.
13 And I think you can do
14 building a culture if all the do
15 the same payroll. They are ve
16 team, and they get to know ea
17 meetings where they talk abo
18 doing, these are our principles
19 board on that?"
20 So it's probably because
21 start thinking about financial i
22 think that building a cultura
23 of the things about can't serve
24 if you're wondering about, co
25 different systems? Well, wis



Professor Alain Enthoven
Marriner S. Eccles
Professor, Emeritus
Stanford Graduate
School of Business





St. Luke's Strategy of Employing Physicians Is About "Achieving Better Profit"

From: Taylor, Jeff <taylorj@slhs.org>
Sent: Wednesday, September 19, 2012 9:35 AM
To: Kee, John <keejo@slhs.org>
Subject: Fwd: Two out of Three

57
Plaintiffs'

Better cost is a worthy goal and I totally back that. I also understand market forces involved. But- let's be realistic. Employing physicians is not achieving better cost, it's achieving better profit.

Better cost is a worthy goal and I totally back that. I also understand market forces involved. But- let's be realistic. Employing physicians is not achieving better cost, it's achieving better profit.

expectations. I intended for my response to communicate that I do have concerns that our strategy to become an aligned system may be offensive to some and go against the general independent nature of certain physicians. To the extent this strategy forces some to pursue alternative strategies, this can impact our financial performance. My comment was not intended to pass judgement on that position, just indicate the financial risk.

Regarding the issue of cost and "achieving more profit", this requires more discussion and analysis. Aggregating pieces and parts of a fragmented environment in an attempt to create an aligned system will undoubtedly highlight examples as you describe. The question and challenge ahead of us is whether the combined system will lead to a lower cost for the combined population, with all parts playing a role (eg payers, hospitals, physicians etc.).

I agree with your comment that added transparency regarding provider based billing

HIGHLY CONFIDENTIAL

Plaintiffs' Exhibit

is not the intended recipient, you are hereby notified that any dissemination,

distribution, or copying of this information is strictly prohibited.

received this message by error, please notify us immediately.

the related message."

HIGHLY CONFIDENTIAL

**Dr. Thomas Huntington, St. Luke's
Treasure Valley Board Member**

No Evidence That St. Luke's Prior PCP Acquisitions Lowered Costs



- Professor Dranove evaluated the claims of St. Luke's and its experts that past acquisitions have led to lower cost healthcare
 - To do so, Professor Dranove compared costs to patients of St. Luke's acquired PCPs with those of PCPs who were not acquired by St. Luke's
- St. Luke's past PCP acquisitions resulted in either:
 - *No significant spending changes; or*
 - *Increased total spending*
- If anything, the evidence suggests that the acquisition of Saltzer is more likely to result in cost-increasing *inefficiencies* than the reverse

Defendants' Efficiencies Claims Are Not Merger Specific



- Defendants' experts never considered any of the viable alternative alignment options that Saltzer could pursue if the acquisition was unwound
 - *Enthoven Dep. Tr. at 123:23-124:7*
- St. Luke's own executives acknowledged the existence of such alignment alternatives for Saltzer, noting that physician groups can provide integrated care without aligning with a hospital
 - *Kee Dep. Tr. at 96:24-97:10; Seppi Dep. Tr. 26:20-27:2*
- Plaintiffs' expert, Dr. Kenneth Kizer, will testify that Saltzer could accomplish any purported benefits from the acquisition through alignment strategies



The Acquisition Is Not Necessary For Saltzer To Work With St. Luke's On Quality Improvements

6 metrics. Because even if this unwound, we would
7 still want to work with Saltzer in the area of,
8 you know, quality improvement and clinical
9 outcomes.

May 15, 2013
John Kee

Condensed Transcript with Word Index



**John Kee, VP of
Physician Services**





Independent Providers Are “Essential” for Clinical Integration

Saint Alphonsus v. St. Luke's 4/24/2013 Randy Billings

Page 1 Page 2

SAINTE ALPHONSUS HOSPITAL CENTER

ST. LUKE'S

REPORT

1 APPEARANCE FOR

2 FOR

3 Jordan Haller, Esq.
SYSTEM LEGAL DEPARTMENT
190 East Bascom Street
Boise, Idaho 83712

4 ALSO PRESENT:

5 Ron Attard, Videographer
JOHN GLENN HALL COMPANY
P.O. Box 2683
Boise, Idaho 83701-2683
206-345-4120

6 *****

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4 Presentation by Mr. Billings 4
5 Examination by Mr. Katz 128
6 Further Examination by Mr. Billings 135
7 *****

8

9 EXHIBITS

10 270 A document, undated, Bates Numbered
11 SLJHS000728341, consisting of one page 10
12

13 271 A letter, dated January 24, 2011,
14 Bates Numbered SLJHS001137684,
15 consisting of one page 11

16

17 272 An Advocate Health Care document,
18 dated 4/23/2013, consisting of two pages 20
19 273 The 2012 Value Report,
20 consisting of 24 pages 22

21

22 274 A blog by Dr. Patel, dated 05/14/12,
23 consisting of three pages 24

24

25 275 St. Luke's Health System Network Scope & Key
26 Position Status FRO Board Presentation,
27 May 11, 2011, the cover page Bates Numbered
28 SLJHS000152011, consisting of 38 pages 28

29

30 276 St. Luke's Health System Clinical Integration
31 Strategy Status FRO Board Presentation,
32 May 11, 2011, the cover page Bates Numbered
33 SLJHS000159008, consisting of 14 pages 33

34

35 277 An email string, the top one being dated
36 November 21, 2011, Bates Numbered SLJHS000152802
37 through 2003, consisting of two pages 34

38

39 278 Careway County Integration, A Strategic Overview,
40 January 2, 2011, Bates Numbered SLJHS000212119
41 through 1241, consisting of 23 pages 37

42

43 279 An email string, the top one being dated
44 May 11, 2012, Bates Numbered SLJHS000153663
45 through 3054, consisting of two pages 38

1 (Pages 1 to 4)

Tucker & Associates, 605 W. Fort St., Boise, ID 83702 (208) 345-3704



Randy Billings, VP of Payor Relations





Other Systems Improve Quality with Few Employed Physicians – e.g., Advocate Health

Saint Alphonse v. St. Luke's 4/24/2013 Randy Billings

<p>Page 17</p> <p>1 clinical places were the scope of the medical staff at 2 Advocate. 3 Q. Okay. And were doctors -- did doctors have, 4 including independent doctors, have financial incentives 5 to meet or exceed certain clinical integration metrics? 6 A. Yes. 7 Q. Well, could you describe generally the nature of 8 those financial incentives that the independent doctors 9 had? 10 A. There was a scorecard that scored each physician 11 based on clinical innovation metrics. And then there were 12 incentives that were paid out based upon their score 13 compared to their peers. 14 Q. Okay. 15 A. And external peers as well. 16 Q. And those payments were to both independent and 17 employed physicians? 18 A. Yes. 19 Q. And in your judgment and in Advocate's judgment, 20 did those financial incentives work to encourage the 21 doctors to do better? 22 MR. KETTY: Objections to firm, foundation. 23 He's not here to testify as to Advocate's 24 understanding. 25 BY MR. ETTINGER.</p>	<p>Page 18</p> <p>1 Q. In your judgment as -- in your role as vice 2 president at Advocate, is it the case that those metrics 3 worked to encourage physicians to improve their clinical 4 performance in connection with those metrics? 5 A. They helped. I don't know what you mean by 6 worked. 7 Q. Okay. They helped in the sense that 8 got better, performed better? 9 A. I'm not sure of the 10 But 11 shared savings incentives 12 BlueShield of Illinois. 13 A. Uh-huh. 14 Q. Can you tell me what that shared savings model 15 was, a general description of it, please. 16 A. It was a contract that over a period of two years 17 initially measured the per member per month of a 18 population and compared Advocate's performance against the 19 rest of the market. 20 Q. And was payment made based on that comparison? 21 A. I'm not sure. I wasn't there when the 22 payments -- I negotiated that right before I left.</p>
<p>Page 19</p> <p>1 Q. Well, you say here you were "a central figure" in 2 that negotiation, correct? 3 A. I was. 4 Q. Do you recall whether -- I'm asking what I think 5 -- maybe I'm not being clear, but what I think is a pretty 6 basic question, which is: Did the providers get rewarded 7 or financially penalized, depending on where they came out 8 in that per member per month performance? 9 A. You asked whether there was a payout. 10 Q. Yeah. Okay. 11 A. And I don't know. I negotiated this contract in 12 2010. 13 Q. Yeah. 14 A. It was effective January of 2011. I left three 15 weeks later. I left, actually, two days later. 16 Q. I understand. 17 A. So, I don't know if there was a payout. 18 Q. As I finished my last question, I realized my 19 mistake. 20 What I meant to ask was: Was the contract 21 structure such that there would be a payout depending upon 22 how well the providers did as compared to that per member 23 per month measure? 24 A. Yes. 25 Q. Okay. And how was that payout to be measured for</p>	<p>Page 20</p> <p>1 independent physicians; how did that work generally? 2 A. It was based on their report card score, like I 3 said before. 4 Q. Okay. So, if an individual doctor did well on 5 the report card score, he might receive a payment. 6 If he did poorly, might he receive some kind of 7 debit or was it all just gain sharing? 8 A. The contract had an added downside as well. 9 THE REPORTER: The contract had a -- 10 THE WITNESS: A downside. A deficit, potential 11 deficit, as well as a surplus sharing potential. 12 (Whereupon, Exhibit Number 272 was marked for 13 identification.) 14 BY MR. ETTINGER: 15 Q. You've been shown what's been marked as 16 Exhibit 272. This is from the Advocate website. And it's 17 current. So, it postdates your time at Advocate. 18 But I want to ask you a few questions about parts 19 of it that don't postdate your time at Advocate, if I 20 might. I want to ask you about the second paragraph of 21 this printout. 22 You see it talks about Advocate Physician 23 Partners' situation in 2004? 24 A. Yes. 25 Q. And what position did you have at Advocate in</p>

5 (Pages 17 to 20)

Tucker & Associates, 605 W. Fort St., Boise, ID 83702 (208) 345-3704

Q: Well, could you describe generally the nature of those financial incentives that the independent doctors had [at Advocate]?

A: There was a scorecard And then there were incentive that were paid based upon their score compared to their peers.

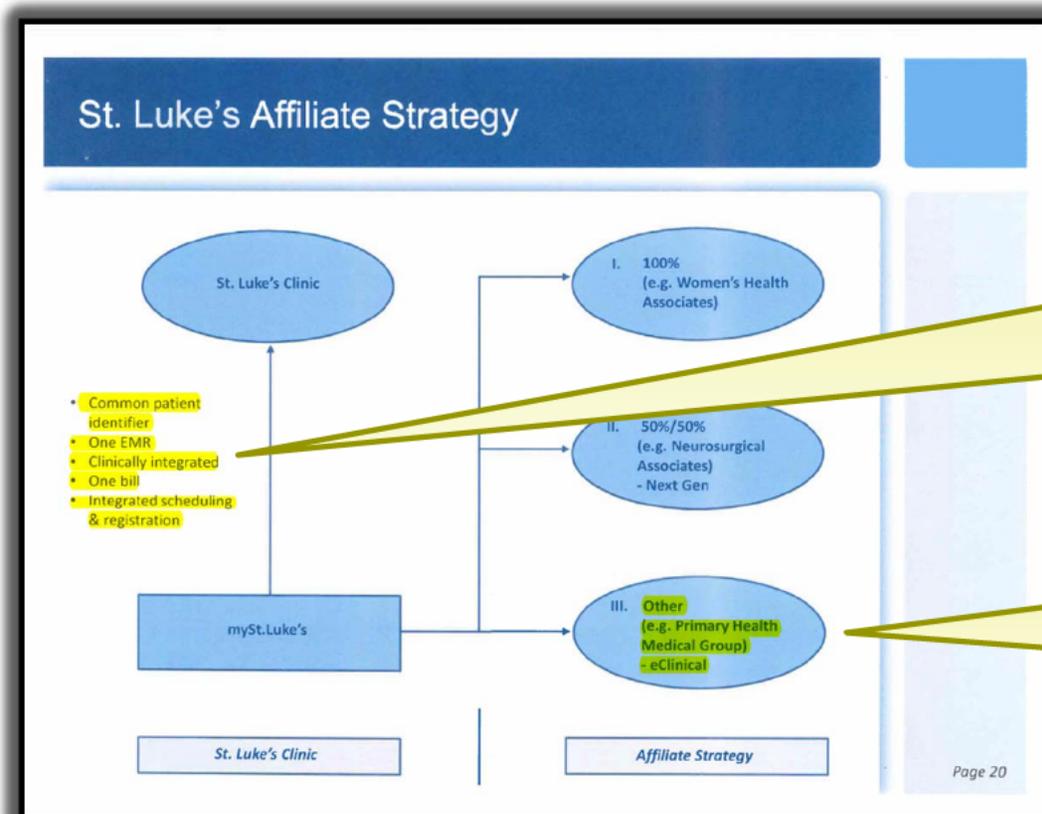


Randy Billings, VP of Payor Relations





St. Luke's EMR Claims Are Not Merger Specific – Affiliate EMR Program



- **Common patient identifier**
- **One EMR**
- **Clinically integrated**
- **One bill**
- **Integrated scheduling and registration**

Other
 (e.g. Primary Health Medical Group)
 - eClinical

Providers Need Not Be on the Same EMR To Coordinate Care



Plaintiffs' Expert, Dr. Kenneth Kizer, will testify:

- Providers do need not be on the same EMR to exchange patient care information
- Health Information Exchanges facilitate the exchange of patient care information between providers on different EMR system
- Idaho has a functional health information exchange – *i.e.*, Idaho Health Data Exchange



Dr. Kenneth Kizer
Director, Institute for
Population Health
Management

UCDAVIS
HEALTH SYSTEM



St. Luke's EMR Claims Are Not Merger Specific – eClinicalWorks

Meaningful Use of Electronic Health Records » Primary Health

Primary Health Medical Group

Occupational Health Urgent Care Family Practice Pediatrics Specialists Patient Portal Newsletter

HOME OUR CLINICS PATIENT INFORMATION MEET THE PROVIDERS CAREERS FOI/HS CONTACT US

OCCUPATIONAL HEALTH What are the benefits? LEARN MORE

URGENT CARE QUESTIONS Urgent care vs. Emergency Room FAQ

Primary Health Medical Group implemented eClinicalWorks electronic health records in all clinics in 2007. With the conversion to paperless electronic health records, every Primary Health patient now has one electronic chart accessible in all 11 locations. Health care providers can easily review patient histories, medications, allergies, lab work and more to provide consistent health care. The number of steps for the coordination of patient care and possibility for errors were reduced with electronic prescribing, interfaces for lab tests and radiology, and tracking of referrals.

Meaningful Use November 17, 2011

Primary Health Medical Group successfully attest to the Meaningful Use guidelines in my practice," stated James Weiss, MD, a Family Physician at Primary Health Medical Group. "I believe demonstrating our effective use of electronic health records is vital to promoting cost-effective 21st century medicine. I would never dream of going back to paper charts now that I use the electronic health record. My patients love the convenience of being able to access their health records from their smartphones, their hospital records, and their personal email if they wish. I would encourage every physician in the United States to adopt an electronic health record system that meets the Meaningful Use standards."

Primary Health Medical Group is directly related to improved patient care," said David Peterman, MD, Primary Health Medical Group. "Our electronic health records system has increased access for patients to their health records. There is less room for errors with tools such as ePrescriptions, eReferrals, and a single source of information. Patients can access their health records from their smartphones, their hospital records, and their personal email if they have questions. The opportunities for control of their health are quite remarkable."

Primary Health Medical Group implemented eClinicalWorks electronic health records in all clinics in 2007. With the conversion to paperless electronic health records, every Primary Health patient now has one electronic chart accessible in all 11 locations. Health care providers can easily review patient histories, medications, allergies, lab work and more to provide consistent health care. The number of steps for the coordination of patient care and possibility for errors were reduced with electronic prescribing, interfaces for lab tests and radiology, and tracking of referrals.

Now Open!

Primary Health Medical Group is pleased to announce the Downtown Boise. The new location is located at 3rd Street in a historic building. [Read More](#)

<http://www.primaryhealth.com/2011/11/17/meaningful-use-of-electronic-health-records> [9/12/2013 1:36:18 PM]

- Saltzer currently uses eClinicalWorks as its EMR system

Other “Defenses”

No court has ever adopted any of Defendants’ other “defenses”



The “Give Monopoly a Chance” Defense



Professor Alain Enthoven
Marriner S. Eccles
Professor, Emeritus
Stanford Graduate
School of Business



STANFORD
GRADUATE SCHOOL OF BUSINESS



The “Healthcare Reform” Defense

Case 1:12-cv-00560-BLW Document 34 Filed 12/04/12 Page 1 of 52

Indeed, the procompetitiveness of the Saltzer transaction is underscored by the fact that it accords with, and carries out, the federal policy, reflected in the Patient Protection and Affordable Care Act (“ACA”), 42 U.S.C. § 1395jjj, of encouraging large, clinically-integrated physician-hospital networks designed to reduce the overall cost of health

NAMPA, INC., TREASURE VALLEY HOSPITAL LIMITED PARTNERSHIP, SAINT ALPHONSUS HEALTH SYSTEM, INC., AND SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC.,

Plaintiffs,

Case No. 1:12-cv-00560-BLW

MEMORANDUM OF ST. LUKE'S HEALTH SYSTEM, LTD. IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

care through the precise methods that will be implemented as a consequence of this transaction.



The "Healthcare Reform" Defense Is Contradicted by the Affordable Care Act

Federal Register / Vol. 76, No. 212 / Wednesday, November 2, 2011 / Rules and Regulations 67841

Competition among ACOs can accelerate advancements in quality and efficiency. All of these benefits to Medicare patients would be reduced or eliminated if we were to allow ACOs to participate in the Shared Savings Program when their formation and participation would create market power.

thereby potentially increasing providers' incentives to provide care for private payers and enrollees of higher-paying health plans rather than for Medicare beneficiaries. We stated that competition in the Shared Savings Program would replace benefits Medicare and the Shared Savings Program because it would improve the quality of care for Medicare beneficiaries and protect beneficiary savings. Furthermore, competition in the Shared Savings Program by providing an opportunity for the formation of one or more ACOs in an area would create market power among ACOs that would reduce or eliminate all of these benefits to Medicare patients. If we were to allow ACOs to participate in the Shared Savings Program when their formation and participation would create market power, a significant number of commenters opposed mandatory participation, because an ACO is a business model designed to encourage integration and coordination of care, while still providing beneficiaries with a choice of providers and services. The commenters raised the following points:

commenters cited a concern that the proposed rule would confer unreviewable antitrust authority on antitrust Agencies to disallow participation in the Shared Savings Program and therefore violate the delegation doctrine.³ We had public policy to challenge antitrust enforcement authority to a regulatory review process involving a mandatory review of ACOs with PSA shares greater than 50 percent for common services.

- The mandatory review should be modified such that an ACO's size, not its size, should be monitored because if an ACO produces savings while maintaining quality and patient-centeredness, market share is an appropriate measure of anticompetitive behavior.
- Require mandatory notification of PSA shares, but do not require notification for ACOs with greater than a 50 percent PSA share to obtain a mandatory review.

³ Richard D. Kaskin, Ben J. Koth, & John J. Jentz, "Delegation Dilemma: Can 1105(b) Medicare ACOs Undergo Pre-Clearance Antitrust Agencies?," 20 Health L. Rep. 11

Policy Statement. Those ACOs would be required to submit to us, as part of their Shared Savings Program applications, a letter from the reviewing Antitrust Agency confirming that it had no present intent to challenge or recommend challenging the proposed ACO. Absent such a letter, the proposed ACO would not be eligible to participate in the Shared Savings Program. In addition, the proposed Antitrust Policy Statement explained that ACOs that are outside the safety zone and below the 50 percent mandatory review threshold frequently may be pro-

participating in the Shared Savings Program would not present competitive problems that could subject them to antitrust challenge that may prevent them from completing the term of their agreement with us. Second, it would maintain competition for the benefit of Medicare beneficiaries by reducing the potential for the creation of ACOs with market power. In this context market power refers to the ability of an ACO to reduce the quality of care furnished to Medicare beneficiaries and/or to raise prices or reduce the quality for commercial health plans and enrollees,



FEDERAL REGISTER

Vol. 76 Wednesday,
No. 212 November 2, 2011

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services
42 CFR Part 425
Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule



Defendants Imply That Professor Herzlinger Endorses Their Deal

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO	
SAINT ALPHONSUS MEDICAL CENTER, NAMPA, INC., TREASURE VALLEY HOSPITAL LIMITED PARTNERSHIP, SAINT ALPHONSUS HEALTH SYSTEM, INC., AND SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC.,	Case No. 1:12-cv-00560-BLW (L)
Plaintiffs,	DEFENDANTS' PRETRIAL MEMORANDUM
v.	
ST. LUKE'S HEALTH SYSTEM, LTD, and ST. LUKE'S REGIONAL MEDICAL CENTER,	

Case 1:12-cv-00560-BLW-REB Document 194 Filed 09/10/13 Page 7 of 4

INTRODUCTION

In *Why Innovation in Health Care Is So Hard*,¹ Professor Regina E. Herzlinger of the

Harvard Business School writes:

The integration of health care activities—consolidating the practices of independent physicians, say, or integrating the disparate treatments of a particular disease—can lower costs and improve care. But doing this isn't easy

As with consumer-focused innovations, ventures that experiment with new business models often face opposition from local hospitals, physicians, and other industry players for whom such innovation poses a competitive threat. Powerful community-based providers that might be harmed by a larger or more efficient rival work to undermine the venture, often playing the public policy card by raising antitrust concerns

Elsewhere in the article, Professor Herzlinger notes that a "company with a new health care idea should also be aware that regulators, to demonstrate their value to the public, may ripple their muscles occasionally by tightly interpreting ambiguous rules or punishing a hapless innovator."

Professor Herzlinger's cogent article anticipates and summarizes this case. St. Luke's Health System has sought to integrate the delivery of health care—in part by affiliating with the Saltzer Medical Group in Canyon County, whose physicians share its vision of providing coordinated care for patients utilizing a unified electronic health record ("EHR"), best medical practices, and rigorous quality control and utilization review metrics. St. Luke's will demonstrate through the testimony of its CEO, David Pate, M.D., and others, that this affiliation is part of a larger plan to improve the quality and lower the costs of health care for patients in Ada and Canyon Counties. We will likewise show that another part of this plan is a strategic alliance with Utah-based insurer, SelectHealth, to offer a risk-based insurance product in southern Idaho—and that the affiliation with Saltzer is critical to the success of that venture.

¹ Harv. Bus. Rev. 2006, May 84(5): 58-66 (attached hereto as Ex. A).

DEFENDANTS' PRETRIAL MEMORANDUM - 1

As with consumer-focused innovations, ventures that experiment with new business models often face opposition from local hospitals, physicians, and other industry players for whom such innovation poses a competitive threat. Powerful community-based providers that might be harmed by a larger or more efficient rival work to undermine the venture, often playing the public policy card by raising antitrust concerns

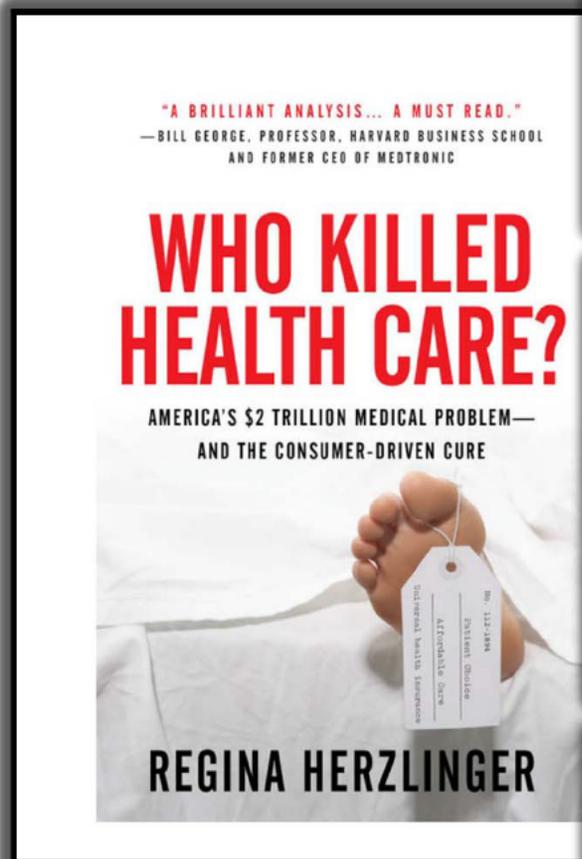


Professor Regina Herzlinger, Nancy R. McPherson Professor of Business Administration, Harvard Business School





But Professor Herzlinger Warns Against Unsubstantiated Promises of “Community Benefits”



Hospitals gained approval of these mergers by claiming that they would bring about economies of scale,¹⁹ but the promised economies have yet to appear as reduced prices to insurers or patients. To the contrary, consolidation has led to price increases of at least 40 percent and reduced quality.²⁰ Thus, hospital mergers increased the

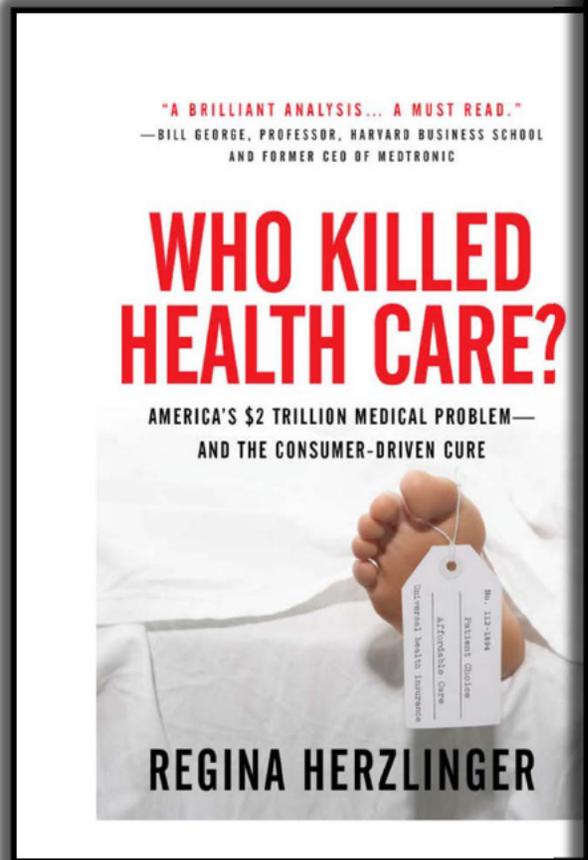
Hospitals assured the public that the mergers had only the purest of motives: economies of scale would lower costs and enable the hospitals to provide more community benefits. Many local judges and juries bought the argument and permitted the mergers. Virtually overnight, in some parts of the country, the mergers almost eliminated any competition among hospitals.

But, far from providing more community benefits, the mergers created massive increases in prices and probable diminution in quality. One study showed that severely ill Medicare heart attack

Both nonprofit and for-profit hospitals acted alike in raising prices: one analysis revealed no difference between the willingness of nonprofit and for-profit hospitals to “exploit merger-related market power.”²⁸ Nonprofits set lower prices but had higher markups.²⁹



Professor Herzlinger Likewise Warns that Hospital Acquisitions of Doctors Raise Serious Competitive Problems



Orville Redenbacher and Francis Ford Coppola's Love Child: Vertically Integrated Health Care Systems

Some hospitals not only merged with each other but also bought the practices of independent physicians and hired salaried doctors. The number of self-employed doctors dropped sharply, while those salaried by a hospital increased.³⁹ The strategy of owning the sources of your customers and your suppliers is called *vertical integration*.

By hiring salaried doctors, hospitals acquired their sources of customers. A physician who works for herself will refer patients to the hospital that she believes will best meet their needs, but a salaried physician in a vertically integrated hospital system is more likely to refer patients to the hospital that employs her. In other words, you lose.

Vertical integration is an old business strategy. For example, in the early days of Hollywood, movie producers owned theaters so they could guarantee that their films would be shown and that their rival producers' movies would not. Although vertical integration is an old strategy, it is not a good one. For one, it may work against the pub-

lic interest by restraining competition. And second, it is very hard to

Remedy

Divestiture is the appropriate remedy





The Appropriate Remedy is Divestiture

316 OCTOBER TERM, 1960.

Syllabus. 366 U. S.

UNITED STATES *v.* E. I. DU PONT DE NEMOURS
& CO. ET AL.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF ILLINOIS.

No. 55. Argued February 20-21, 1961.—Decided May 22, 1961.

“Congress also made express its view that divestiture was the most suitable remedy in a suit for relief from a § 7 violation”

CALIFORNIA *v.* AMERICAN STORES CO. 271

Syllabus

CALIFORNIA *v.* AMERICAN STORES CO. ET AL.

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR
THE NINTH CIRCUIT

No. 89-258. Argued January 16, 1990—Decided April 30, 1990

Divestiture is “the most important of antitrust remedies” and “should always be in the forefront of a court’s mind when a violation of § 7 has been found”



St. Luke's Purported Concerns About Remedy Are Contrary to Its Prior Commitments and Current Advocacy

Case 1:12-cv-00560-BLW-Rfg Document 49 Filed 12/26/12 Page 25 of 70	
<p>1 certainly over the next year or so, the time it 2 would take by any stretch of the imagination, to 3 get this -- to get to a trial in this case, we 4 don't think that referral patterns will 5 dramatically change. Certainly, we haven't asked 6 for that to happen, and we have sworn affidavits 7 from numerous Saltzer physicians who say that this 8 will not have any impact on their referral 9 decisions.</p> <p>10 I think for the court to order that 11 there be no change in referral patterns is to sort 12 of require people to act contrary to what's in the 13 best interest of patients.</p> <p>14 But I think the court should get some 15 comfort in the fact that, even absent a court 16 order, there is very unlikely to be significant 17 changes in referrals as a -- in the next few 18 months as a result of this transaction.</p> <p>19 THE COURT: Okay.</p> <p>20 MR. BIERIG: In any event, let me begin by 21 talking about what we really should be talking 22 about, which is the likelihood of irreparable 23 injury. As I have just said, plaintiffs try to 24 characterize this transaction as a merger. 25 Your Honor just used the term "merger." But it</p>	<p>1 really isn't.</p> <p>2 The transaction, as I said, is for a 3 five-year initial term with three-year renewal 4 terms. And it's very important to note that the 5 Saltzer Medical Group will remain in existence as 6 an independent corporation.</p> <p>7 Its current landlord will retain real 8 title to the real property at which all its 9 facilities are located. St. Luke's will acquire 10 the tangible assets of Saltzer, but Saltzer 11 retains the right to repurchase those assets.</p> <p>12 And should the transaction have to be 13 undone for any reason, Saltzer will be given 14 access to the personnel, facilities, medical 15 records, and other resources that it needs to 16 provide uninterrupted care to patients.</p> <p>17 Finally, it's worth noting St. Luke's 18 has no plans whatever to close any of Saltzer's 19 clinics or other facilities or to dispose of any 20 major equipment, nor does St. Luke's have any 21 plans to eliminate any change in lines of services 22 that Saltzer currently provides.</p> <p>23 Taken together, these structural 24 features of the transaction demonstrate, without 25 more even, why a preliminary injunction is not</p>
<p>1 necessary in this case.</p> <p>2 Typically, preliminary injunctions are 3 entered against transactions because, to use the 4 worn-out metaphor, once the transaction is 5 consummated, it is impossible to unscramble the 6 egg.</p> <p>7 Here it would be quite possible to 8 unscramble this egg if, after full factual 9 development -- which is really what's called for 10 here -- and review, it were found to be unlawful.</p> <p>11 Specifically, the Saltzer physicians 12 would return to practice through the Saltzer 13 Medical Group Corporation. St. Luke's would 14 assign the leases back to the Group. And Saltzer 15 would repurchase the tangible assets and be given 16 access to all of the patient records and all of 17 the other resources it would need to provide 18 uninterrupted care to patients.</p> <p>19 I should also note that, unlike Saint 20 Alphonsus, St. Luke's imposes no covenant not to 21 compete on Saltzer physicians. So that if this 22 transaction were undone, there would be absolutely 23 no contractual bar on the ability of Saltzer 24 physicians to resume practice as the Saltzer 25 Medical Group.</p>	<p>1 In those circumstances, to answer the 2 question that I think Mr. Ettting posed, we, 3 St. Luke's, will not oppose the divestiture -- if 4 ultimately this court and courts were to hold that 5 this transaction is unlawful, we will not oppose 6 divestiture on grounds that divestiture cannot be 7 accomplished.</p> <p>8 Because this -- this transaction was 9 carefully structured so that, in fact, there could 10 be an unscrambling of the egg, not only if the 11 court were to order it, but also if it turns out 12 that the efficiencies and the benefits that are 13 anticipated from this transaction, in fact, don't 14 occur.</p> <p>15 Now -- so that should give the court 16 some comfort. But what the plaintiffs say is that 17 they're going to suffer irreparable injury in the 18 six months or nine months or whatever time it 19 takes before we get to an actual hearing on the 20 merits where Mr. Argue speak for himself, and 21 Dr. Wilson will be subject to cross-examination.</p> <p>22 They say that they will suffer 23 irreparable injury as a result of two factors. 24 First, they say as a result of the transaction, 25 Saltzer physicians will cease making referrals to</p>

United States Courts, District of Idaho

“Here it would be quite possible to unscramble this egg . . . We will not oppose divestiture on grounds that divestiture cannot be accomplished.”

(St. Luke's Counsel at Preliminary Injunction Hearing)

Conclusion

The acquisition is unlawful





Conclusion

- Post-merger HHI of 6,219 create a legal presumption that this merger will have anticompetitive consequences
- Testimony, documents, and empirical evidence confirm the acquisition's likely anticompetitive effects
- There are no verifiable, merger-specific efficiencies that justify taking the risk of this acquisition
- The evidence warrants divestiture and a permanent injunction