(ORAL ARGUMENT SCHEDULED MARCH 24, 2017)

Nos. 17-5024, 17-5028

United States Court of Appeals for the District of Columbia Circuit

UNITED STATES OF AMERICA, *et al.*,
Plaintiffs-Appellees,

v.

ANTHEM, INC., and CIGNA CORPORATION,
Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA
No. 1:16-cv-01493-ABJ (The Honorable Amy Berman Jackson)

BRIEF FOR THE AMERICAN MEDICAL ASSOCIATION AND THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA AS AMICI CURIAE IN SUPPORT OF APPELLEES AND AFFIRMANCE

Thomas L. Greaney
Saint Louis University School of Law
100 N. Tucker Boulevard
St. Louis, MO 63101
Telephone: (314) 977-3995

Joe R. Whatley, Jr.
Edith M. Kallas
Henry C. Quillen
WHATLEY KALLAS, LLP
1180 Avenue of the Americas
20th Floor
New York, NY 10036
Telephone: (212) 447-7060

March 17, 2017

Attorneys for Amici Curiae American Medical Association and Medical Society of the District of Columbia

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Except for the American Medical Association; the Medical Society of the District of Columbia; the American Antitrust Institute, professors with expertise in the subjects of health economics, antitrust, and competition policy; consumer groups; and the American Hospital Association, all parties, intervenors, and amici appearing before the district court and in this court are listed in the Briefs for Anthem and the Appellees, to the best of the knowledge of the American Medical Association and the Medical Society of the District of Columbia. References to the rulings at issue appear in the Briefs for Anthem the Appellees. All related cases are listed in the Briefs for Anthem and the Appellees.

CORPORATE DISCLOSURE STATEMENT

The American Medical Association and the Medical Society of the District of Columbia have no parent company, and no publicly held company has a 10% or greater ownership interest in the American Medical Association or the Medical Society of the District of Columbia.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases **Page**

Statutes

Other Authorities

GLOSSARY

AMA: American Medical Association

JA: Joint Appendix

GSA: Government's Supplemental Appendix

MSDC: Medical Society of the District of Columbia

INTEREST OF AMICI CURIAE

The American Medical Association (AMA) is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all United States physicians, residents and medical students are represented in the AMA's policymaking process. AMA members practice and reside in all states and in the District of Columbia. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health.

The Medical Society of the District of Columbia (MSDC) is a not-for-profit corporation, chartered by an Act of Congress in 1819. MSDC members primarily practice in the District of Columbia and in nearby counties. MSDC seeks to promote the well-being of patients, to establish high standards of character and professionalism for physicians, and to safeguard the integrity of the physician-patient relationship in metropolitan Washington, D.C. MSDC is part of the federation of state, county, and specialty medical societies that constitute the AMA.

The AMA and MSDC join this brief on their own behalves and as representatives of the Litigation Center of the AMA and the State Medical Societies (Litigation Center). The Litigation Center is a coalition among the AMA

and the medical societies of each state, plus the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

The amici and their members have an interest in ensuring that physicians can deliver high-quality care to their patients. The amici believe that a merger between Anthem and Cigna would damage physicians' ability to do so.

No party's counsel authored this brief in whole or in part, no party or its counsel contributed money that was intended to fund preparing or submitting the brief, and no person—other than the AMA, MSDC, and the Litigation Center, their members, or their counsel—contributed money that was intended to fund preparing or submitting the brief.

All parties have consented to the filing of this brief.

STATUTES AND REGULATIONS

All applicable statutes and regulations are contained in the addenda to Anthem's brief and the Appellees' brief.

SUMMARY OF ARGUMENT

To Anthem, the most important financial consequence of a merger with Cigna is the ability to reduce payments to healthcare providers by billions of dollars. Anthem describes these savings, to the extent they are passed onto employers and patients, as an increase in "consumer welfare" that outweighs the distortions to the health insurance market that the merger will cause. But paying providers less comes with significant costs: it will damage patient care, stifle innovation, and cause patients to use more healthcare services. Anthem's claim that the merger will enable it to offer a new product—Cigna's products at Anthem's prices—was contradicted by the evidence at trial and the experience of the market. The district court was right to reject Anthem's "efficiencies" as neither verifiable nor merger-specific and to enjoin the merger.

ARGUMENT

Imagine two health insurers. Both have contracts with large national employers to administer those employers' health plans and provide access to the insurers'

networks of healthcare providers. One insurer, Insurer A, tries to keep costs low by using its market power to drive down the prices it pays for providers' services. Insurer C tries to keep costs low through programs designed to keep its plan members healthy. Even though Insurer C typically pays providers at a higher rate to compensate for the investment of time and money these programs require, it remains competitive because its members stay healthier and require less healthcare.

Now imagine two employers, X and Y, who are both self-insured. Employer X, attracted by Insurer A's low prices, contracts with Insurer A to administer its health plan. Thus, Employer X pays the costs of its employees' healthcare, and it also pays Insurer A for the costs of processing claims and other administrative tasks. The employees of Employer X do not have access to extensive wellness programs. Employer X's employees receive favorable pricing for healthcare services, but they are less healthy and use more of those services. Employer Y, attracted by Insurer C's extensive wellness programs, contracts with Insurer C, even though it pays more for the individual healthcare services its employees use. Employer Y values the programs Insurer C offers, which improve the health of its workforce. Although Employer Y pays more for any given healthcare service, it pays less than Employer X in the long run because its employers need fewer services.

Who is better off, Employer X and its employees, or Employer Y and its employees? Employer X's employees are sicker, visit the doctor more often, and spend more on healthcare. Employer Y's employees are healthier, visit the doctor less often, and spend less on healthcare. The illogical assumption at the heart of Anthem's brief is that Employer X is better off solely because it gets better prices for the services its employees use. Looking only at the fees that Anthem and Cigna pay for various services, Anthem claims that the difference between its generally lower fees and Cigna's generally higher fees represents "consumer welfare" that the district court improperly ignored. Anthem Br. at 10–19. This argument ignores extensive record evidence that Anthem and Cigna buy different services from providers. GSA111. Thus, the court properly found that Anthem's promised transformation of Cigna plans was not akin to bulk purchasing discounts or similar efficiency enhancements. Indeed, it found that, rather than causing an increase in output or quality, Anthem's reimbursement cuts could cause quality to degrade and patients to be deprived of choice. GSA125–26 (citing testimony of Cigna's Chief Executive Officer that substituting Anthem for Cigna would "dramatically unwind" Cigna's collaborative relationships with providers and "rapidly destroy the Cigna value proposition").

But even if Anthem could lower Cigna's fees after a merger, Anthem has never explained how or why healthcare providers, having lost significant revenue, would

continue to invest in the programs they and Cigna use to keep patients healthy. Anthem's assertion that "a change in a provider's contracted rates does not result in changes to the customer-facing programs the insurer offers pursuant to customer contracts, and vice versa," Anthem Br. at 33, is unsupported and was extensively contradicted at trial. It also runs counter to the expectations of the amici's members, who are on the front lines of the development of new strategies for delivering healthcare, and to a basic purpose of the antitrust laws, which is to set prices through competition. Therefore, the district court correctly refused to save an otherwise anticompetitive merger on the basis of Anthem's proposed pay cuts.

I. New Models of Collaborative Care Like Cigna's Improve Consumer Welfare by Focusing on the Health of the Patient Population.

Spending on healthcare in the United States is large and growing, and it has been for decades. In 2015, healthcare spending totaled almost $10,000 per person, representing 17.8% of the nation's gross domestic product.[1] Needless to say, it is vital that spending on healthcare be as efficient and effective as possible. An important trend in controlling healthcare spending is the shift from traditional "fee-for-service" medicine, in which insurers reimburse healthcare providers for their services without respect to the quality of those services, to "value-based"

[1] Centers for Medicare and Medicaid Services, *National Health Expenditures 2015 Highlights*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf.

purchasing, which adjusts payments to account for the quality of services and providers' ability to keep their patients healthy. GSA119–21.[2] The idea behind this shift is that reducing the amount of healthcare services that patients require ("reducing utilization," in industry parlance) will reduce overall medical costs. With the adoption of the Medicare Access and CHIP Reauthorization Act of 2015, Congress created strong incentives to move the nation to value-based, coordinated care. *See* 42 U.S.C. § 1395w-4(q). That movement is reverberating in the commercial insurance sector.[3]

Although value-based purchasing may reduce overall medical costs, providing healthcare services under a value-based contract requires greater investments of time and money than a fee-for-service arrangement does. At trial, Cigna's Chief Executive Officer gave the example of using a nurse or health coach to sit down with a patient for thirty minutes or more to help the patient understand his pharmaceuticals and dietary needs—longer than a physician can typically give for these topics. Tr. 418:15–24. Evidence at trial also showed the importance of

[2] *See also* Centers for Medicare and Medicaid Services, *Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume*, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html.

[3] For a general discussion of the expansion of value-based reimbursement for healthcare providers, see Bruce Merlin Fried and Jeremy David Sherer, *Value-Based Reimbursement: The Rock Thrown Into The Health Care Pond*, Health Affairs Blog (July 8, 2016), http://healthaffairs.org/blog/2016/07/08/value-based-reimbursement-the-rock-thrown-into-the-health-care-pond/.

collaboration between insurers and providers in developing value-based programs, as opposed to a "one size fits all" or "take it or leave it" approach like Anthem's. GSA111, 120 n.50, 121 n.51. For instance, the Chief Executive Officer of Granite Health, a partnership of New Hampshire hospitals, described how Granite Health and Cigna worked together to identify the best metrics for evaluating the quality of patient care, and how Cigna pays a "care coordination fee" that has allowed Granite Health to save money while maintaining its quality. JA549:2–553:13.

In short, finding innovative ways to improve patients' health and reduce costs requires collaboration and investments that Cigna has been more willing to undertake than Anthem. Accepting Anthem's claims would turn the efficiencies defense on its head, rewarding Anthem for playing catch-up through an acquisition instead of developing its own products as a result of competition.

II. Anthem's "Best-of-Best" Strategy for Reducing Provider Reimbursement Would Damage Patient Care and Consumer Welfare.

The foundation of Anthem's appeal is the idea that a merged company would supply Cigna-quality products at Anthem's lower prices. Anthem Br. at 5, 17, 34. The "billions of dollars in lower healthcare costs" that Anthem touts, *id.* at 8, come from a so-called "best-of-best" methodology developed by Anthem's expert Dr. Mark Israel. He "calculated what the savings would be if the lowest provider rates already negotiated by Anthem were made available to existing Cigna

customers, and if the prevailing Cigna rates were made available to existing Anthem customers in the few instances where the Cigna rates were lower." GSA95–96.[4]

Even if Anthem were to give its customers all the savings from "best-of-best" pricing,[5] the resulting social harm from lower quantity and quality in the market for healthcare services would undermine the benefit of these savings. Anthem never explained at trial how the merged company could force Anthem's providers to participate in Cigna's resource-intensive programs without an increase in compensation, or how it could force Cigna's providers to continue to offer those programs for less compensation. Dr. Israel admitted that he had not analyzed the issue in any detail. GSA105. Even in its own appeal brief, Anthem's citation for the proposition that "[t]he merger will allow the combined firm to offer those lower discount rates to Cigna customers" is testimony by the *government's* expert, Dr. David Dranove, that the merger might make it more difficult for the combined company to implement Cigna's innovative models of care. Anthem Br. 17 (citing

[4] While Anthem's rates are usually lower, there was testimony that some providers agree to contract with Cigna at lower rates "to help it sustain its collaborative model and compete against the more dominant Anthem and United." GSA115. This incentive to offer lower rates to Cigna will be lost if Anthem and Cigna merge.

[5] It is doubtful that the merged company would pass on all its savings, for the reasons described in the district court's opinion and the government's brief. GSA126–27; Appellees' Br. 58.

JA324:16–325:9). Thus, the record in this case demonstrates the exact opposite of Anthem's argument.

Further, the evidence showed that imposing "best-of-best" rates on providers would destroy consumer welfare by undermining the collaborative relationships with providers for which Cigna is known. GSA119. Cigna's Chief Executive Officer discussed concerns that trying to combine Anthem's and Cigna's offerings would cause Cigna's clients to "have an erosion [of] value so their costs will go up because discounts would erode or collaboratives become dismantled." Tr. 493:22–494:4. And the government's expert, Dr. Dranove, testified that "trying to push [Anthem's] rates on to Cigna's existing providers … could interfere with collaborative relationships that have currently been established and ultimately reduce the quality of the product." Tr. 2313:5–9.

The evidence at trial echoes what state medical associations learned when they canvassed their members about the likely effects of an Anthem–Cigna merger. Of the nearly one thousand physicians who responded to a survey by the California Medical Association, 89% said that it was very likely or somewhat likely that "[r]eimbursement rates for physicians will decrease such that there would be a reduction in the quality and quantity of the services that physicians are able to offer

patients."[6] Eighty-two percent reported that they would be very likely or somewhat likely to feel pressured *not* to engage in aggressive patient advocacy as a result of the merger.[7] Surveys in other states found similar results.[8]

In addition to the immediate effect of Anthem's single-minded drive to pay healthcare providers less, the amici are concerned about the long-term effect on the medical profession and consumers. The district court found *no evidence* that the rates charged by providers within Anthem's service area are "inflated due to the providers' market power." GSA128. Therefore, reducing reimbursement to providers will likely reduce patient care and access by motivating physicians to retire early or seek opportunities outside of medicine that are more rewarding,

---

[6] California Medical Association, *CMA Survey Shows Strong Physician Opposition to Health Insurer Market Consolidation* (Mar. 28, 2016) at 14 (California Medical Association Survey), https://www.cmanet.org/files/assets/news/2016/03/merger-survey-results-032816.pdf.

[7] *Id.*

[8] Medical Association of Georgia, *Summary of the Medical Association of Georgia's Survey Concerning Proposed Mega-Health Insurance Mergers*, http://www.mag.org/sites/default/files/downloads/SUMMARYOFMAGSURVEYONPROPOSEDMEGA-HEALTHINSURANCEMERGERS.pdf; Memorandum to Colorado Medical Society (Feb. 16, 2016), https://drive.google.com/file/d/0B6oiUaUvJzHbdDNCd05reklrSzQ/view; Missouri State Medical Association, *Summary of the Missouri State Medical Association's Survey Concerning Proposed Mega-Health Insurance Mergers*, http://www.msma.org/uploads/6/2/5/3/62530417/msma_physician_survey_on_insurance_mergers.pdf; Medical Society of Virginia, *Medical Society of Virginia Merger Survey Summary*, https://goo.gl/6O4goC; *Statement of the American Medical Association to the Indiana Department of Insurance Re: Anthem Application for the Proposed Acquisition of Cigna* (Apr. 26, 2016), https://www.ismanet.org/pdf/news/AMAStatementtotheIDOI4266.pdf.

financially or otherwise. A recent survey by the Physicians Foundation showed that 48% of physicians plan to cut back on hours, retire, take a non-clinical job, switch to "concierge" medicine, or take other steps limiting patient access to their practices.[9] According to a study released by the Association of American Medical Colleges, the U.S. will face a shortage of between 61,700 and 94,700 physicians by 2025.[10] An Anthem–Cigna merger threatens to swell these figures; the California Medical Association found that 15% of California physicians believe that if they are not able to contract with a merged Anthem and Cigna, they will have to close their practice.[11] Given that there are already too few physicians, it will not enhance consumer welfare to drive down reimbursements so far that physicians are driven from the practice of medicine.

These findings are consistent with the conclusions of academics and consumer advocates who have examined the proposed merger. Professor Leemore Dafny, a Harvard economist who focuses on the healthcare industry, testified to the United States Senate:

---

[9] The Physicians Foundation, *2016 Survey of America's Physicians: Practice Patterns and Perspectives* at 7, http://www.physiciansfoundation.org/uploads/default/Biennial_Physician_Survey_2016.pdf.

[10] American Association of Medical Colleges, *2016 Update: The Complexities of Physician Supply and Demand: Projections from 2014 to 2025* (Apr. 5, 2016), https://www.aamc.org/download/458082/data/2016_complexities_of_supply_and_demand_projections.pdf.

[11] California Medical Association Survey, *supra* note 6, at 12.

> [E]ven if price reductions [for healthcare services] are in fact realized and passed through [to consumers], if they are achieved as a result of monopsonization of healthcare service markets then consumers may experience an offsetting harm. Monopsony is the mirror image of monopoly; lower input prices are achieved by reducing the quantity or quality of services below the level that is socially optimal.[12]

At the same hearing, the Senior Policy Counsel of Consumers Union testified that "a dominant insurer could force doctors and hospitals to go beyond trimming costs, to cut costs so far that it begins to degrade the care and service they provide below what consumers value and need."[13]

In fact, the California Department of Insurance cited this very concern when it recommended that the United States challenge the merger: "Allowing Anthem to increase its already enormous bargaining power will further limit network size and excessively squeeze reimbursement rates, thereby discouraging provider contracting and unacceptably reducing consumer choice and quality of care."[14] The

---

[12] Testimony of Leemore S. Dafny, Ph.D before the Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights (Sept. 22, 2015) at 10, https://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf.

[13] Statement of George Slover before the Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights (Sept. 22, 2015) at 3, https://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Slover%20Testimony.pdf.

[14] Letter from Dave Jones, California Insurance Commissioner, to Loretta E. Lynch, United States Attorney General, and Renata B. Hesse, Principal Deputy Assistant Attorney General (June 16, 2016) at 13, http://www.insurance.ca.gov/0400-news/0100-press-releases/2016/upload/LetterUSDOJAnthem-Cigna06-16-16.pdf.

Department of Insurance also pointed out that it had discovered that Anthem violated laws regarding claims handling 16,000 times, and that the California Department of Managed Health Care ranked Anthem third worst among ten companies on "coordination of care."[15] Describing a merger between United Healthcare and PacifiCare in 2005, the Department of Insurance noted that while the combined company met its cost-cutting goals, it did so at the expense of quality and service; after the merger, PacifiCare violated the California insurance laws more than 900,000 times.[16]

In the end, Anthem's proposed "efficiencies" from reducing payments to healthcare providers are a chimerical free lunch—a way to get something for nothing. "There ain't no such thing as a free lunch, even in the insurance business." *Great Lakes Dredge & Dock Co. v. City of Chicago*, 260 F.3d 789, 794 (7th Cir. 2001).

III. Agreements Between Purchasers to Depress Provider Prices Are Manifestly Anticompetitive.

While the district court did not categorically decide whether implementing "best-of-best" pricing would always violate the antitrust laws, it rightly questioned whether an agreement to depress prices for healthcare services is a cognizable efficiency. GSA123–26, GSA130. The court concluded:

[15] *Id.* at 11.

[16] *Id.* at 13–14.

> [S]ince [Anthem's] efficiencies defense is based not on any economies of scale, reduced transaction costs, or production efficiencies that will be achieved by either the carriers or the providers due to the combination of the two enterprises, but rather on Anthem's ability to exercise the muscle it has already obtained by virtue of its size, with no corresponding increase in value or output, the scenario seems better characterized as an application of market power rather than a cognizable beneficial effect of the merger.

GSA130.

It is absurd to suggest that an agreement between purchasers to lower their purchase prices solely through an exercise of buyer-side market power should be seen in the merger context as a procompetitive efficiency powerful enough to offset other anticompetitive effects of the merger. Mergers whose effect may be to lessen competition substantially among buyers have been found to violate Section 7 of the Clayton Act. See *United States v. Rice Growers Ass'n of Cal.*, No. S-84-1066, 1986 WL 12562, at *12 (E.D. Cal. Jan. 31, 1986) (acquisition would substantially lessen competition in the purchase of paddy rice in California); *United States v. Pennzoil Co.*, 252 F. Supp. 962, 985 (W.D. Pa. 1965) (merger would substantially lessen competition in the purchase of Penn grade crude). As in those cases, the plaintiffs here challenged the merger between buyers of provider services as a Section 7 violation.

Further, cases decided under Section 1 of the Sherman Act show why an agreement to depress purchase prices cannot be treated as a procompetitive efficiency. For example, in *Mandeville Island Farms v. Am. Crystal Sugar Co.*,

334 U.S. 219, 235, 242 (1948), the Supreme Court concluded that an agreement among purchasers to lower their purchase prices is no less serious than that of a price-fixing agreement by sellers and is unlawful per se, without regard for any potential benefit to consumers. Other cases include *Knevelbaard Dairies v. Kraft Foods Inc*, 232 F.3d 979, 988 (9th Cir. 2000) ("[T]he central purpose of the antitrust laws, state and federal, is to preserve competition[,]" and cases discussing competition causing low prices for consumers "do not mean that conspiracies among buyers to depress acquisition prices are tolerated"); *Khan v. State Oil Co*., 93 F.3d 1358, 1361 (7th Cir. 1996) (Posner, J.), *vacated on other grounds*, 522 U.S. 3 (1997), *cited with approval in Weyerhaeuser Co. v Ross-Simmons Hardware Lumber Company Inc*., 549 U.S. 312, 322 (2007) (monopsony price fixing "is analytically the same as monopoly or cartel pricing and so treated by the law"); *see also W. Penn Allegheny Health Sys. Inc. v. UPMC*, 627 F.3d 85, 105 (3d Cir. 2010) (holding that an alleged agreement between a hospital system and a health insurer to reduce the plaintiff hospital's reimbursement rates "was anticompetitive and cannot be defended on the sole ground that it enabled [the insurer] to set lower premiums on its insurance plans"); *Todd v. Exxon Corp*, 275 F.3d 191, 214 (2d Cir. 2001) (Sotomayor, J.) (holding that an agreement to exchange salary information violated Section 1 where the effect was to depress salaries). Because agreements between purchasers to depress input prices are

manifestly anticompetitive, the district court was justified in doubting Anthem's contention that its otherwise anticompetitive merger was redeemed by using its newly acquired market power to depress prices.

CONCLUSION

Anthem's appeal to "consumer welfare" ignores the vast evidence in the record that its own merger strategy will harm consumer welfare by damaging patient care and stifling innovation in the healthcare industry. The amici's own experience is consistent with this evidence. For the foregoing reasons, the judgment of the district court should be affirmed.

March 17, 2017

/s/ *Joe R. Whatley, Jr.*

Joe R. Whatley, Jr.
Edith M. Kallas
Henry C. Quillen
WHATLEY KALLAS, LLP
1180 Avenue of the Americas
20th Floor
New York, NY 10036
Telephone: (212) 447-7060

Thomas L. Greaney
Saint Louis University School of Law
100 N. Tucker Boulevard
St. Louis, MO 63101
Telephone: (314) 977-3995

CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(a)(7)(C) and D.C. Circuit Rule 32(a), I hereby certify that the foregoing brief complies with the applicable type-volume limitations. This brief was prepared in proportionally spaced typeface using Microsoft Word in 14-point Times New Roman font. The brief, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii) and D.C. Circuit Rule 32(a)(1), contains 3,645 words. This certification is made in reliance on the word-count function of the word processing system used to prepare the brief.

March 17, 2017

/s/ *Joe R. Whatley, Jr.*

WHATLEY KALLAS, LLP
1180 Avenue of the Americas
20th Floor
New York, NY 10036
Telephone: (212) 447-7060

CERTIFICATE REGARDING SEPARATE BRIEF

Pursuant to D.C. Circuit Rule 29(d), I certify that a separate amicus brief was necessary because of the expedited schedule associated with this appeal and because of the American Medical Association's and the Medical Society of the District of Columbia's need to focus on arguments relating to the delivery of healthcare by physicians.

March 17, 2017

/s/ *Joe R. Whatley, Jr.*

WHATLEY KALLAS, LLP
1180 Avenue of the Americas
20th Floor
New York, NY 10036
Telephone: (212) 447-7060

CERTIFICATE OF SERVICE

I hereby certify that on March 17, 2017, a true and correct copy of the foregoing brief was electronically filed with the Clerk's Office of the U.S. Court of Appeals for the District of Columbia Circuit, and further certify that counsel of record will be notified of, and receive, this filing through the "Notice of Docket Activity" generated by this electronic filing. Pursuant to this Court's order dated February 17, 2017, the original and eight copies of this brief were also delivered to the Clerk's Office of the U.S. Court of Appeals for the District of Columbia Circuit by courier.

/s/ *Joe R. Whatley, Jr.*
WHATLEY KALLAS, LLP
1180 Avenue of the Americas
20th Floor
New York, NY 10036
Telephone: (212) 447-7060