No. 16-2492

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

FEDERAL TRADE COMMISSION *et al.*,

Plaintiffs-Appellants,

v.

ADVOCATE HEALTH CARE NETWORK *et al.*,

Defendant-Appellees

On Appeal from the United States District Court
for the Northern District of Illinois
No. 1:15-cv-11473
Hon. Jorge L. Alonso

AMICUS CURIAE BRIEF OF THE ASSOCIATION OF INDEPENDENT DOCTORS *In Support of Appellants* TO REVERSE THE DISTRICT COURT DECISION

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Dated: July 22, 2016

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CORPORATE DISCLOSURE STATEMENT

The Association of Independent Doctors ("AID") is a non-profit trade organization. It does not have a parent corporation or issue publicly traded securities. AID has sought representation in this matter from Artz McCarrie Health Law.

INTEREST OF THE *AMICUS*

AID was founded in Winter Park, Florida, in 2013. A national nonprofit trade association that now has nearly 1,000 doctor members in 16 states coast to coast, AID was established to ensure that doctors, lawmakers, businesses, media, consumers, and health advocates understood the negative impact that consolidation was having on the cost of health care, patient choice, and the economy. These harmful ramifications occur not only when hospitals acquire independent medical practices, but also when they merge with other hospitals.

In the medical field, as in any other industry, competition is an important check against higher prices, diminished quality, and loss of consumer choice. The accelerating trend of increasing consolidation within the industry – whether hospitals and medical groups or hospitals with other hospitals – is a leading driver behind rising health care costs.

Just as the number of independent hospitals is shrinking, the number of independent doctors as a percentage of total doctors has declined dramatically in recent years, from 57 percent in 2000 to 36 percent in 2013. *See* Victoria Stagg Elliott, *Doctors Describe Pressures Driving them from Independent Practice*,

American Medical News (Nov. 19, 2012) (http://bit.ly/24morWC). During the same period, there has been a 55 percent surge in hospitals' employment of doctors. *See* Medicare Payment Advisory Commission, *Report to Congress: Medicare and the Health Care Delivery System* 33 (June 2013) (http://bit.ly/1U2egFt). Meanwhile, hospitals have been amassing other hospitals. As a result, massive regional hospitals now have far greater market share, and far less competition, than they did just ten years ago.

This tectonic shift—the rapid decline of independent practices and commensurate rise of dominant hospital systems—has coincided with the doubling of health care costs over the last decade. Annual health care costs for an average family of four exceeded $22,000 per year in 2013. *See* Dan Munro, *Annual Healthcare Costs for Family of 4 Now at $22,030*, Forbes (May 22, 2013) (http://bit.ly/29YBacG).

It will come as no surprise that hospital consolidations have followed the same trajectory. Stemming these trends is vital to the future of the Illinois health care system in particular, and the nation's health care system as a whole. AID's members have a strong interest in the proper resolution of this appeal.

The Association of Independent Doctors' counsel secured the consent of Matthew Hoffman, Esquire, representing the Federal Trade Commission; Robert W. McCann, representing the Advocate Health parties; and David E. Dahlquist, representing the NorthShore University Health System, to file this *Amicus* brief. The Association of Independent Doctors' counsel has authored this brief in whole

and the Association of Independent Doctors has borne all expenses.

No party or counsel for any party authored this brief in whole or in part or otherwise contributed monetarily towards its preparation or submission. No other person other than *amici*, their members, and their counsel contributed monetarily towards the preparation or submission of this brief.

ARGUMENT

Advocate Health Care Network and Advocate Health and Hospitals Corporation ("Advocate") and NorthShore University HealthSystems ("NorthShore") insist that their merger would be in the best interest of patients because it would improve the quality and efficiency of care and lower costs. The Association of Independent Doctors' broad experience, significant academic literature, and ample record evidence indicate otherwise.

If Advocate and NorthShore were to merge, significant evidence exists to suggest that contrary to what the hospital systems argue, costs would increase, quality would decrease, and the patient community would suffer. The two hospital systems are already among the state's largest. Combined, their 15-hospital conglomerate would generate $7 billion. *FTC & State of IL v. Advocate Healthcare, Advocate Health and Hospitals Corporation, and NorthShore University HealthSystem* (http://bit.ly/2a6kELW). On its own, Advocate is the state's largest health system with 11 general acute care hospitals, and $5 billion in revenue (2014). Two of Advocate's hospitals – Advocate Lutheran General Hospital and Advocate Condell Medical Center – are in the Northern suburbs of Chicago, and are direct

competitors of NorthShore's four hospitals, which are all in the Northern suburbs. Their merger, should the court decide not to enjoin it, would create a sizable dominant firm capable of significant increase in market power. Conversely, if left as separate health systems competing in this geographic area, their competition would help control prices and boost the quality of care.

This merger would hurt patients, not only because they would pay higher prices for lower quality health care, but also because, studies further show, when large health systems merge, patients have less choice and less voice. These adverse effects are becoming more common as hospitals across American are merging with increasing frequency. Indeed, the rate of hospital mergers and acquisitions has more than doubled since 2009. In 2014, the United States saw a record-setting 100 mergers, up 14 percent from the prior year. *See* Wharton School, Univ. of Penn., *Hospital Consolidation: Can It Work This Time?* Knowledge@Wharton (May 11, 2015) (http://whr.tn/1H527oK).

As the New York Times recently reported, "[t]he rhetoric is all about efficiency," but "[t]he reality is all about higher prices." *See* Julie Creswell & Reed Abelson, *New Laws and Rising Costs Create a Surge of Supersizing Hospitals*, N.Y. Times (Aug. 12, 2013) (http://bit.ly/1UjmqFB).

A. Large hospital systems provide higher cost, lower quality care

Were Advocate and NorthShore to merge their already sizable health systems (Advocate's 11 hospitals plus NorthShore's four), their combined hospital system would include 15 hospitals with a total of more than 4,000 beds in a concentrated

geographic area. The resulting conglomerate would become one of the largest hospital systems in the country.

The merger would eliminate the competition between Advocate and NorthShore in northern Cook and southern Lake Counties. The record evidence, academic literature, and AID's body of experience overwhelmingly demonstrate that such competition among hospitals offers a number of very important benefits to both quality and cost for individual patients and the health system as a whole—benefits that are undermined when hospitals merge to become one behemoth system dominating a market. Thus, AID respectfully asks the Court to consider the following:

1. *The merger will increase the cost of care.*

It would be bad enough if mergers by large hospitals simply reduced the quality of care and eliminated competition. But it is worse than that—they also increase the cost of care, often dramatically. And this case would be no exception.

Hospital spending is today "the largest category of health care costs, consuming nearly one-third of national health expenditures." *See* Bob Kocher & Ezekiel J. Emanuel, *Overcoming the Pricing Power of Hospitals*, 308 J. Am. Med. Assoc. 1213, 1213 (2012) (http://bit.ly/1r5m11v). In 2012 alone, Americans spent a staggering $880 *billion* on hospital-based care, exceeding the amounts spent on all of Social Security ($769 billion) and the national defense ($671 billion) during the same year. *Id*. Crucially, "hospital price increases are now the largest contributor to increases in insurance premiums." *Id*. Put simply, large hospital systems

provide the costliest care possible. And if Advocate and NorthShore merge, nothing indicates that their combined system would be an exception.

A principal explanation for such inflated hospital costs is that third-party payers, including private insurers, reimburse hospital systems at far higher rates than independent hospitals for otherwise identical services.

One academic study of 4.5 million patients compared average total expenditures for patients receiving treatment by a physician working within a free-standing hospital and one working within a multi-hospital system. The study found that patients receiving care within a multi-hospital system had mean per-patient costs 10.7 percent higher than those receiving care within a hospital ($4,776 mean cost compared to $4,312). *See* James C. Robinson & Kelly Miller, *Total Expenditures per Patient in Hospital- Owned and Physician-Owned Physician Organizations in California*, J. Am. Med. Assoc., 312(16) (2014) (http://bit.ly/1UjndWO).

"The findings are not encouraging for proponents of integration...(and) are in contrast to the hope and expectation that organizational consolidation … would result in greater coordination, hence lower expenditures…. Antitrust law and policy need to find the appropriate balance between permitting hospital acquisitions that improve efficiency, on the one hand, and preventing acquisitions that increase expenditures, on the other." *Id.*

Other studies note that post-merger costs are higher: "[T]he recent wave of hospital consolidation has led to price increases for hospital care. A recent summary

cites eight studies that show price increases in the range of 10% to 40% due to mergers." *See* David Cutler & Fiona Scott Morton, *Hospitals, Market Share and Consolidation*, J. Am. Med. Assoc. Vol. 310 No. 18 (Nov. 13, 2013) (http://bit.ly/1Y44vrB).

Yet another recent study found that patients who go to large multi-hospital systems rather than independent hospitals pay $4,000 more per patient, or 25 percent more ($19,600 compared to $15,600). The larger systems "used their market power to demand higher prices" from insurance companies, the authors concluded. *See* University of Southern California, *Hospital Prices Increase in California, Especially Among Hospitals in the Largest Multi-Hospital Systems*, The Journal of Healthcare Organization, Provision and Financing (June 2016) (http://bit.ly/29MzAhO).

When hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent. *See* Martin Gaynor & R. Town, *The Impact of Hospital Consolidation*, Robert Wood Johnson Foundation, The Synthesis Project (June 2012) (http://bit.ly/25BteWP).

Against this backdrop, several other recent econometric studies have addressed the relationship between price and hospital concentration in markets throughout the United States and found that "for the most part, hospital mergers in concentrated markets result in significant price increases." *See* Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation—Update* 2 (June 2012) (http://bit.ly/25BteWP).

All of this is well corroborated by the evidence before the district court.

The academic literature also consistently demonstrates that a "large variation in the relative prices [exists]… across markets" for the same services, because there are "large differences in the bargaining clout of hospitals relative to health plans that allow some hospitals to negotiate much higher prices than others." *See* James D. Reschovsky & Chapin White, *Hospital Outpatient Prices Much Higher than Community Settings for Identical Services* 2 (June 2014) (http://bit.ly/1TSMXyZ). *See* also Chapin White et al., *Understanding Differences Between High- and Low-Price Hospitals: Implications for Efforts to Rein in Costs*, 33 Health Affairs 324 (2014) (http://bit.ly/29X6hr4).

Currently, Advocate and NorthShore are direct competitors. From the perspective of third party payers, they are close substitutes. Were they to become a single entity, their market power would increase while the ability of insurers to negotiate pricing would weaken.

2. *The merger will lower the quality of care.*

"Moving from [a model of] hospitals [as] price setters to a market in which patient demand drives hospital prices and quality improvement" necessarily requires "systems that [concentrate on] outcomes as opposed to activity, [and that] are focused on service and quality" as opposed to volume. *See* Kocher & Emanuel, 308 J. Am. Med. Assoc. at 1214 (http://bit.ly/1r5m11v). Recent literature concerning the effects of competition on health care quality and cost repeatedly has shown that "both mortality and expenditures are lower in less concentrated markets" that are sensitive to competition. *See* Martin Gaynor et al., *The Industrial Organization of*

Health Care Markets 13 (Jan. 7, 2014) (http://bit.ly/1UAJWQV).

Put another way, "introduction of competition l[eads] to an increase in quality without a commensurate increase in expenditure." *See* Martin Gaynor et al., *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Services* 4, National Bureau of Economic Research Working Paper 16164 (2010) (http://bit.ly/1O7x4mg).

These results suggest that competition is an important mechanism for enhancing the quality of care patients receive "without chang[ing the] total expenditure or increas[ing the] expenditure per patient." *Id*. at 31-32. Thus, while consolidation may help hospitals' bottom lines, competition is what helps patients.

Simply put, "hospital competition save[s] lives." *See* Zack Cooper, et al., *Does Hospital Competition Save Lives? Evidence from the English National Health System Patient Choice Reforms*, 121 Econ. J. F228, F251 (2011) (http://bit.ly/288xT4I). When hospitals compete for physician referrals and patients, as is the case with Advocate and NorthShore today, that leads them to offer better care and better services for a better price.

In short, as competition diminishes, it takes with it the opportunity for patient choice. The competitive edge is dulled when there is no competitor to keep it sharp. Specifically, the incentive to have a better heart program, or better cancer program, or better orthopedics program than a competitor goes away when the competitors become one.

Evidence also suggests that patients of smaller health-care settings are better able to get appointments when they want them, better able to navigate through

the departments, and benefit from the fact that "physicians, patients, and staff know each other better" in smaller settings. *See* Lawrence P. Casalino et al., *Small Primary Care Physician Practices Have Low Rates of Preventable Hospital Admissions*, 33(9) Health Affairs 1, 6 (2014) (http://bit.ly/29QJCMo). "[T]hese closer connections," also "result in fewer avoidable admissions." *Id.* These facts—which directly address the consumer welfare that is at the core of antitrust policy (*see Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979))—are well known and clearly established; Advocate and NorthShore simply ignore them.

Against this backdrop, Advocate and NorthShore are wrong to assert that no likelihood of anticompetitive effects would exist in the North Shore area. It is well settled that artificially limiting patient choice and diminishing the quality of care are forms of antitrust injury in their own right. As this Court has explained, it is an "anticompetitive effect" to limit, override, or otherwise "interfer[e] with consumers' free choice in choosing a product of their liking." *Wilk v. Am. Med. Ass'n*, 895 F.2d 352, 371 (7th Cir. 1990) (parenthetical omitted); *see also Glen Holly Entertainment, Inc. v. Tektronix, Inc.*, 352 F.3d 367, 374 (9th Cir. 2003). Commentators agree. *See, e.g.*, Herbert Hovenkamp, *The Monopolization Offense*, 61 Ohio St. L.J. 1035, 1041 (2000) (it is an antitrust harm to "reduc[e] the array of choices that consumers would face under more competitive conditions") (http://bit.ly/1RT4Lme).

The "deterioration in quality of goods or services," standing alone, can be an "anticompetitive effect." *United States v. Brown Univ.*, 5 F.3d 658, 668 (3d Cir.

1993). That, too, is the inevitable effect of the transaction challenged here.

And that is an effect with human as well as economic costs, because the "deterioration in quality" is a deterioration in patient care and well-being.

B. The speculative efficiencies identified by the defendants as following from the merger can be achieved by other means that do not hurt competition.

Advocate and NorthShore assert that the merger would promote the procompetitive goal of integrated care and risk-based compensation. As other hospitals seeking permission to merge have insisted, the cost and quality of health care in the United States suffer from fragmented care. The "cure" for this troubling fragmentation is "integrated" care and risk-based pricing, which hospitals seeking consolidation say are possible only by creating massive health systems, which have the "technological infrastructure" to provide such advantages as shared electronic medical records ("EMR").

Advocate and NorthShore are not the only hospitals asserting this position.

And to justify these consolidations, the common refrain is that by consolidating, hospitals can achieve greater integration of care. *See also* Thomas C. Tsai & Ashish K. Jha, *Hospital Consolidation, Competition, and Quality: Is Bigger Necessarily Better?* 312 J. Am. Med. Assoc. 29, 29 (2014) (the argument "that merging of hospital systems can provide better care" typically relies on the assertion that "high-volume institutions . . . achieve more 'integrated' care").

But there are two notable problems with the claim that only "a larger health system" can achieve the "benefits of integrated care" and risk-based compensation.

First, there is no basis—apart from Advocate and NorthShore's assertions—for thinking that the merger actually would achieve either of those speculative goals. As demonstrated below, the academic literature, based on broad empirical experience, indicates that it would not. *Second*, the evidence—both in the record and more broadly—is crystal clear that, however the merger might encourage better coordination of care, those benefits may be achieved without consolidation and thus are not "merger-specific."

1. *There is no evidence that the merger will promote integration of health care at all.*

No credible evidence—on this record or anywhere else—demonstrates that merging large hospitals actually promotes integrated care or any other procompetitive efficiencies.

That finding is consistent with earlier studies explaining that, because "economic integration is not designed primarily to promote clinical integration," the evidence points to a "lack of [any] relationship" between the two. *See* Lawton Robert Burns & Ralph W. Muller, *Hospital-physician collaboration: landscape of economic integration and impact on clinical integration*, 86 Milbank Q. 375, 404 (2008) (http://bit.ly/1XVTNmW). *See also, e.g.*, Alison Evans Cuellar & Paul J. Gertler, *Strategic integration of hospitals and physicians*, 25 J. Health Econ. 1 (2006) (similar) (http://bit.ly/1X2yq4k). A separate report published in 2012 concluded that, while consolidation has "the *potential* . . . for creating integration," recent "research evidence" indicates that "consolidation d[oes] *not* lead to true integration," and that "[c]onsolidation is often motivated," instead, "by a desire to enhance bargaining

power by reducing competition." *See* Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation,* at 4-5 (emphasis added; other emphasis omitted) (http://bit.ly/25BteWP). Just so here.

These studies confirm what common sense suggests. Mergers like the one at issue are driven by the lure of increased profit, not coordination of care. "Not only are merged hospitals struggling to reap efficiency gains, [but] they're also failing to pass along any benefits of size to their end customers – the patients… The preponderance of the evidence is that consumers lose. They lose because prices rise, and that gets translated into higher premiums." Wharton School, *supra.*

2. *The purported benefits of the merger are speculative and not merger-specific.*

Even if there were evidence that meaningful clinical integration or other procompetitive efficiencies might result from the merger, no evidence suggests that any such benefits would be merger-specific.

The legal framework is familiar. An antitrust defendant may rebut the presumption of harm by showing efficiencies, which must be 'merger-specific' to be cognizable as a defense. *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 721 (D.C. Cir. 2001); *see also ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 572 (6th Cir. 2014) (efficiencies must "result from th[e] merger" itself, and not from independent initiatives by "the merging parties"). "An efficiency is said to be 'merger specific' if it is a unique consequence of the merger—that is, if it could not readily be attained by other means or if the social cost of attaining it by other means is at least as high as the social cost of the merger." Areeda & Hovenkamp, *supra*, ¶ 973a. *See also* U.S.

Dep't of Justice & FTC, *Horizontal Merger Guidelines* § 10 (2010) (hereinafter "Guidelines") (http://bit.ly/1RT4KyC) (an efficiency is "merger-specific" when it is "likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of [it]"). Efficiencies are not "merger-specific if they could be attained by practical alternatives that mitigate competitive concerns." Guidelines § 10 n.13.

Here, there is no doubt that "practical alternatives" to the merger are available to achieve integration of care. "Clinical integration requires meaningful data sharing, systems for effective hand-offs [of patients], and streamlined care transitions," which "can be achieved through other mechanisms" than mergers of hospital systems. *See* Tsai & Jha, *Hospital Consolidation, Competition, and Quality: Is Bigger Necessarily Better?*, 312 J. Am. Med. Assoc. at 29 (2014) (http://bit.ly/29S9S8g).

One alternative approach for achieving clinical integration, for ex- ample, is "participating in health information exchanges." Tsai, *supra*. Such exchanges provide seamless, electronic transfer of clinical information among different health care information systems. Crucially, "there has been a rapid increase in the availability of health information exchanges across the nation and many hospitals are now participating in these arrangements." *Id*. But, ironically, "[l]arger systems may be less motivated to join health information exchanges" because "information is seen as a tool to retain patients within their system, not as a tool to improve care." *Id*.; *see also* Amalia Miller & Catherine Tucker, *Health Information Exchange,*

System Size and Information Silos, 33 J. Health Econ. 28 (2014) (http://bit.ly/1Y6tr1Z). In this way, "hospital mergers may create new islands of data" that *hinder* rather than promote integration. Tsai, *supra.*

Regardless, "simply demonstrating that clinicians and health care provider entities have increased access to a common EMR in a large system, for example, will not outweigh the harm from higher prices." *See* Cutler & Morton, *supra.*

Accordingly, the transaction of the Advocate and NorthShore merger is simply not necessary to provide integrated patient care.

While the Court's decision on this matter could have profound implications for health care in the United States, and will potentially set a precedent for future mergers, a decision to enjoin this merger does not constrain procompetitive consolidations, but reaches only anticompetitive consolidations. Most obviously, if a future merger does *not* increase market power—that is, if the merging hospitals could not impair competition once combined—no antitrust concerns would arise, and the transaction should be allowed to proceed.

Moreover, simply because Advocate and NorthShore identify what they believe could be possible benefits of the transaction, they should not assume the burden shifts back to the government to prove that the benefits were not merger-specific. That is not the law. As the D.C. Circuit has recognized, "the asserted efficiencies must be 'merger-specific' to be cognizable as a defense." *Heinz*, 246 F.3d at 721. *See also* Areeda & Hovenkamp, *supra*, ¶ 973a ("the efficiency defense requires a showing that claimed efficiencies are 'merger specific'"). And because "it

is incumbent upon the merging firms to substantiate efficiency claims" (Guidelines § 10), Advocate and NorthShore bear the burden of demonstrating, from the outset, that the merger would have not just procompetitive benefits, but *merger-specific* procompetitive benefits.

Advocate and NorthShore have not come close to making that showing in this case. Any claims about improved quality are speculative. Without evidence of merger-specificity, the asserted benefits do not weigh in the balance at all. And so it is here.

C. Violations of the Clayton Act should be judged apart from impacts of the Affordable Care Act.

One cannot discuss the issue of hospital consolidation adequately without putting it in the context of the Affordable Care Act ("ACA"). The ACA creates incentives for hospitals and physicians to create Accountable Care Organizations[1] ("ACOs"). Yet an important and often forgotten prerequisite for this model is hospital competition. *See* Marty Makary, *The Obamacare Effect: Hospital Monopolies*, The Wall Street Journal (Apr. 19, 2015) (http://bit.ly/1srGeQB).

As one Harvard economist observed:

> *The Affordable Care Act has unleashed a merger frenzy, with hospitals scrambling to shore up their market positions, improve operational efficiency, and create organizations capable of managing population*

[1] Accountable care organizations, or ACOs "are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their . . . patients." Centers for Medicare & Medicaid Services, *Accountable Care Organizations (ACO)* (archived at perma.cc/QG7N-EQWL). Although "[p]articipating in an ACO is purely voluntary for providers" (*id.*), the Affordable Care Act encourages health care providers to participate through the Medicare Shared Savings program. *See* Patient Protection and Affordable Care Act § 3022, Pub. L. No. 111-148, 124 Stat. 119, 395-399 (2010) (codified at 42 U.S.C.1395jjj) (http://bit.ly/1t6eRMs).

> *health…. This activity could have lasting repercussions for consumers; the last hospital-merger wave (in the 1990s) led to substantial price increases with little or no countervailing benefit. Since the primary driver of growth in private spending in recent years has been price increases for health care services, a compelling argument can be made for putting the brakes on consolidation. But, unless new public and private initiatives are developed to discourage consolidation and to support enforcement of antitrust law, most of these deals will proceed unchallenged.*

Dr. Leemore Dafny, *New England Journal of Medicine* (Jan. 2014) (http://bit.ly/1m8ZhEQ).

Occasionally, as here, the deals are challenged. In *Saint Alphonsus Medical Center-Nampa Inc v. St. Luke's Health System, LTD*, 778 F.3d 775 (9th Cir. 2015), the Ninth Circuit upheld the Idaho district court's decision to unwind a merger between a hospital and a large medical group. In doing so, it reasoned: "As the district court recognized, the job before us is not to determine the optimal future shape of the country's health care system, but instead to determine whether this particular merger violates the Clayton Act." *Id*. at 781.

The merger of Advocate and NorthShore will be in fact be anticompetitive, and raise prices while lowering quality, as the FTC has argued.

AID's experience supports the same conclusion: when hospital systems merge and dominate a market, inevitably costs rise, quality falls, and patients bear the brunt. That is not a result the antitrust laws should countenance.

CONCLUSION

For the foregoing reasons, the order of the district court denying preliminary injunctive relief should be reversed and the case remanded for further proceedings.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMITATION, TYPEFACE REQUIREMENTS, AND TYPE STYLE REQUIREMENTS

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/s/ Charles I. Artz
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Dated: July 22, 2016

CERTIFICATE OF SERVICE

I certify that on July 22, 2016, I filed the foregoing *Amicus Curiae* Brief for the Association of Independent Doctors via the Court's electronic filing system. All parties have consented to receive electronic service and will be served by the ECF system.

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