NO. 14-35173

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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

Plaintiffs/Appellees,

v.

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

Defendants/Appellants

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

BRIEF OF *AMICI CURIAE* ECONOMICS PROFESSORS IN SUPPORT OF PLAINTIFFS/APPELLEES URGING AFFIRMANCE

Whatley Kallas, LLP
Joe R. Whatley, Jr.
Edith M. Kallas
1180 Avenue of the Americas, 20th Floor
New York, New York 10036
Tel: (212) 447-7060
Fax: (800) 922-4851
jwhatley@whatleykallas.com
ekallas@whatleykallas.com

Attorneys for Amici Curiae

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INTEREST OF *AMICI CURIAE*

Amici are professors at major universities with expertise in the subjects of antitrust, competition policy, and health economics. A list that provides the titles and affiliations of each of these individuals appears in the Appendix. This submission describes what *Amici* believe to be rigorous modern economic analysis on some questions that are before the Court in connection with the appeal of the district court's ruling in *Saint Alphonsus Medical Center – Nampa et al.* v. *St. Luke's Health System et al*., now pending before this Court. *Amici* file solely as individuals and not on behalf of any institutions with which they are affiliated. *Amici* have not been retained by any party with regard to this action.

No party's counsel has authored this brief in whole or in part, no party or party's counsel has contributed money that was intended to fund preparing or submitting this brief, and no person other than *Amici* has contributed money that was intended to fund preparing or submitting this brief.

SUMMARY OF ARGUMENTS

Our review of the public documents in this matter, together with our collective understanding of healthcare organizations and markets developed through academic research, public service, and advisory and consulting roles, leads us to believe that the district court's analysis and conclusions are based on sound economic reasoning and are in the public interest. In this brief, we explain that the

district court correctly analyzed the interactions between insurers and providers when defining the relevant geographic market, and we explain why the defendants' counterargument regarding patient outflow as evidence of competitive restraints on St. Luke's exercise of market power is irrelevant and misleading in this setting.

We discuss academic research on hospital employment of physicians, and incorporate the insights from this research into our analysis of the district court's rulings. We conclude that efficiencies arising from hospital acquisitions of physician groups are not merger-specific and there is no evidence in the academic literature that such benefits are likely. Lastly, we explain why the suggested alternative remedy of behavioral restrictions on St. Luke's future conduct is unlikely to offset the anticompetitive effects that the district court predicts will result from the transaction under scrutiny.

ARGUMENT

I. The Two-Stage Model of Healthcare Provider Competition Is an Appropriate Lens Through Which to Analyze Physician Competition.

In order to market their health plans to consumers, insurers must construct networks of healthcare providers who are identified in advance as being professionally qualified to render the services that an enrollee requires for any given medical problem. Healthcare provider networks generally include a wide

variety of provider types such as hospitals, surgical centers, and primary care physicians. Although provider network types vary, the conceptual framework for how the market works does not. These networks determine which providers the insurer's enrollees turn to for care (at least in the first instance), as well as the out-of-pocket costs the enrollees will incur when they receive care from a provider in a given network. The breadth and quality of these networks play an important role in determining the value consumers place on the insurer's health plans.

Healthcare providers compete with one another for inclusion in an insurer's network. From a provider's economic perspective, inclusion in an insurer's network means that the insurer's enrollees can visit the practice and receive care at much lower out-of-pocket expense than if the provider were out of network. Inclusion in the insurer's network therefore implies that the provider will be able to treat more (often significantly more) of the insurer's enrollees and earn greater revenues from the insurer than if the provider were not in-network.

From the insurer's perspective, a broader, higher quality network will attract more customers. However, in constructing its network the insurer must be mindful of the reimbursement levels (i.e., total payments under the contract) it negotiates with providers. Higher reimbursements lead to higher costs, higher premiums, lower enrollment and lower profits, all else being equal. Consequently, an insurer will have the incentive to attempt to negotiate lower reimbursements from a

provider in exchange for including that provider in its network. The ability to do so depends, of course, on the availability of alternative providers.

The locus of price competition for healthcare providers is therefore centered on competition among providers for inclusion in insurers' networks. This competition is well captured by the "two-stage" model of provider competition. In the two-stage model, providers compete for network inclusion in the first stage, and for in-network patients in the second stage.[1] Competition for inclusion in the network occurs across a number of dimensions, including reimbursement amounts. Once in the network, providers then compete for patients on non-price dimensions like clinical quality, wait-times and patient experience.

As mentioned above, reimbursement levels are determined via negotiations between individual insurers and individual providers. The outcomes of these negotiations reflect the relative bargaining leverage of each party. Basic economic theory indicates that this bargaining leverage is determined by the loss in profits each side incurs if a deal is not struck. From the insurer's perspective, the loss in profits is directly tied to its ability to include in its network other providers who are regarded as close substitutes (from the patient's perspective). The more important

[1] Greg Vistnes (2000), "Hospitals, Mergers, and Two-Stage Competition," *Antitrust Law Journal*, 67(3): 671−692; Robert Town and Greg Vistnes (2001), "Hospital Competition in HMO Networks," *Journal of Health Economics*, 20(5): 733−752; Cory Capps, David Dranove and Mark Satterthwaite (2003), "Competition and Market Power in Option Demand Markets," *RAND Journal of Economics*, 34(4): 737−763.

is a particular negotiating provider to the insurer's network (because of the lack of close substitutes), the greater will be the provider's bargaining leverage and the higher will be the resulting reimbursements paid by the insurer, all else being equal.

Given the above dynamic, a horizontal merger between two competing physician practices will increase their combined bargaining leverage if the two practices are viewed as close substitutes by enough of the insurer's enrollees. This occurs because prior to the merger, if the insurer and the first practice cannot reach agreement (and the first practice is therefore not included in the insurer's network), the insurer's network would lose some of the value it generates for patients. Patients will generally turn to their next-best in-network practice. Prior to the merger, the next-best choice could be the second practice. Thus, if the two practices are close substitutes, then the value of the network would be little diminished by exclusion of the first practice. In short, the insurer is fairly indifferent to inclusion of the first practice and therefore enjoys a good deal of bargaining leverage in negotiating with that practice. The reimbursement levels needed to recruit the first practice to the network will be relatively low.

In contrast, after the merger, if an insurer cannot reach an agreement with the combined entity, then the value of the insurer's network would now be significantly diminished. This reduction in value arises because patients who

previously viewed the merging practices as the next-best substitutes for each other now must turn to their third-preferred practice. The increase in bargaining leverage from the merger will be determined by the prevalence of patients who viewed the merging practices as close substitutes and by how much they dislike having to turn to their third-preferred practice.[2]

The two-stage competition model captures this fundamental competitive dynamic. It serves as the theoretical foundation of current, refereed and published economic research on provider competition.[3] From the provider-insurer bargaining model that characterizes the first stage of competition, it follows that the total reimbursements paid by an insurer to a provider organization will depend on that organization's combined bargaining leverage across all services it supplies to enrollees. Importantly, the empirical predictions of this framework have been

[2] "Mergers that Increase Bargaining Leverage," (January 22, 2014) by Aviv Nevo, Deputy Assistant Attorney General for Economics at the Antitrust Division of the U.S. Department of Justice, describes this dynamic similarly.

[3] Robert Town and Greg Vistnes (2001), *id.*; Cory Capps, David Dranove and Mark Satterthwaite (2003), *id.*; Jessica Vistnes, Philip Cooper and Greg Vistnes (2001), "Employer Contribution and Health Insurance Premiums: Does Managed Competition Work?," *International Journal of Health Care Finance and Economics*, 1: 159−187; Matthew Lewis and Kevin Pflum (2014), "Diagnosing Hospital System Bargaining Power in Managed Care Networks," *American Economic Journal: Microeconomics*, forthcoming, and Gautam Gowrisankaran, Aviv Nevo, and Robert Town (2014), "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," Accepted, *American Economic Review*, June 2014.

verified using national data on physician pricing.[4] Specifically, mergers between substitute providers in concentrated markets generally lead to price increases. While this research focuses on physician prices, the market power arising from the merger of physician practices could be exercised, in whole or in part, through increases in price or reductions in the quality of other services jointly supplied or controlled by the owners of these practices.

II. Relevant Market Definition

Relevant market definition is used to help frame competitive analysis. In order for the relevant market definition to capture appropriately the impact of a provider merger on competition, it should align with the principles of the two-stage model. Modern market definition analysis for horizontal mergers generally uses the "hypothetical monopolist test" set out in the *Merger Guidelines*. In the context of physician practice acquisitions, the district court correctly considered whether a hypothetical monopolist of Nampa-based physician practices would have sufficient bargaining leverage to negotiate a small but significant price increase from insurers. Importantly, approaches to market definition that omit the bargaining dynamic and rely exclusively on patient flow analysis, such as the Elzinga-Hogarty

[4] Abe Dunn and Adam Shapiro (2014), "Do Physicians Possess Market Power," *Journal of Law and Economics*, 57(1): 159−193.

(EH) test employed in some previous challenges to hospital mergers, can lead to wildly wrong and grossly inflated geographic market definitions.

The EH test was originally developed to delineate geographic markets for consumer goods like coal and beer.[5] An Elzinga-Hogarty market is one in which the combined market share of suppliers located inside the market equals or exceeds at some threshold percentage (e.g., 75 or 90 percent) ["low outflows"], and the consumers within that market account for at least that threshold percentage of the suppliers' customers ["low inflows"]. The defendants argue against the FTC's proposed market definition of Nampa, Idaho, stating that it "cannot be reconciled with the fact that nearly one-third of Nampa residents *already* get adult PCP services outside of Nampa". But the application of this EH-style analysis to healthcare markets has been thoroughly discredited by many economists, including Professor Kenneth Elzinga, one of the originators of the EH test.[6]

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[5] Kenneth Elzinga and Thomas Hogarty (1978), "The Problem of Geographic Market Delineation Revisited: The Case of Coal," *Antitrust Bulletin*, 23: 1−18; Kenneth Elzinga and Thomas Hogarty (1973), "The Problem of Geographic Market Delineation in Antimerger Suits," *Antitrust Bulletin*, 18: 45−81.

[6] Kenneth Elzinga and Anthony Swisher (2011), "Limits of the Elzinga-Hogarty Test in Hospital Mergers: The *Evanston* Case," *International Journal of the Economics of Business*, 18(1): 133−146. Professor Elzinga himself testified in a hospital merger case that the test was not appropriate for healthcare provider markets. *In re Evanston Nw. Healthcare Corp. and ENH Medical Grp., Inc.*, No. 9315, 2007 WL 2286195, at **63−66 (FTC Aug. 6, 2007).

One key limitation of the EH test in healthcare markets has been termed the "Silent Majority Fallacy."[7] The E-H test implicitly assumes that purchasing decisions are a function solely of the price of the goods or services in question. In the case of, say, mattresses, it is plausible to think that the fact that a few consumers are ordering mattresses from a seller 50 miles away is largely due to the fact that that seller is offering better prices (for the same product and delivery service) than a rival seller only 5 miles away. In healthcare markets, most insured patients do not face the full reimbursement price of provider services, hence their travel patterns largely reflect heterogeneous preferences regarding travel time and other non-price attributes of providers. As a result, the fact that a minority of patients currently travel farther to receive care says little about what the (silent) majority of "non-travelers" would do in response to a post-merger price increase.

Another limitation has been termed the "Payer Problem" by Professor Elzinga in the context of his expert testimony in the *Evanston* hospital merger case.[8] In the second stage of the two-stage competition model described above, providers compete for patients on non-price dimensions like clinical quality, wait-times and patient experience. Price competition takes place during the first stage,

[7] Cory Capps et al. (2001), "The Silent Majority Fallacy of the Elzinga-Hogarty Criteria: A Critique and New Approach to Analyzing Hospital Mergers," *NBER Working Paper No. 8216*, http://www.nber.org/papers/w8216.

[8] Elzinga and Swisher (2011), *id.*

when providers compete for inclusion in an insurer's network. Patient flow analysis in the form of the E-H test is informative with regard to consumer preferences along *non*-price dimensions. This fact undermines the basic precept of the E-H test, which is that observed movements of products or consumers ought to reflect responses based on price. Responses to price and non-price dimensions are not necessarily the same. The proper resolution of both the Silent Majority Fallacy and the Payer Problem imply that courts should focus on the likely responses of insurers, not patients, to post-merger price increases when defining geographic markets in healthcare.[9]

As noted above, the defendants emphasize the fact that 30% of consumers in Nampa receive primary care outside of Nampa as evidence for a broader geographic market. However, the fact that some consumers in a geographic market consume outside that market does not, by itself, imply that the geographic market is not a relevant antitrust market. The correct question is: faced with a small price increase, would an *insurer* be willing to exclude all Nampa primary care physicians from a network, thereby requiring members to travel to primary care physicians outside Nampa or incur substantially higher costs for seeing those

[9] Professor Elzinga points out that the E-H test is not the same as the hypothetical monopolist test under the Merger Guidelines because it is based solely on pre-merger flows of products (or consumers) and does not ask "what if" questions relating to post-merger price increases. Elzinga and Swisher (2011), *id.* at 144.

physicians in Nampa? The district court rightly focuses on the evidence responsive to this query in arriving at the market definition.

III. There Is No Credible Evidence That Physician Employment by Hospital Systems Leads to Efficiencies That – If Present Cannot be Realized Through Affiliations That Pose a Lesser Risk to Competition.

In this case, the defendants claim that the transaction will generate efficiency benefits to consumers in the form of more integrated care. We share the district court's concerns that these efficiencies will be difficult to realize and are unlikely to be merger-specific.

There is no convincing evidence to date that combining physicians and hospitals under common ownership tends to result in cost savings. In a lengthy review of the literature, Burns, Goldsmith, and Sen (2013) conclude that "Research on the effect of integration on physician productivity and hospital profitability has produced *mixed results*."[10] A recent study found that increases in the market share of hospitals that own physician practices are associated with *increases* in area prices and spending.[11] As two faculty members from the Harvard School of Public Health recently explained in an article published in the flagship medical journal

[10] Lawton Robert Burns, Jeff Goldsmith, and Aditi Sen (2013), "Horizontal and Vertical Integration of Physicians: A Tale of Two Tails," *Advances in Health Care Management*, 15: 39−117.

[11] Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler (2014), "Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending," *Health Affairs*, 33(5): 756−763.

JAMA, merging parties "often point to large, integrated hospital systems—organizations like Geisinger and Intermountain Health—as examples of 'larger is better.' However, these organizations are exemplars not because they are large but because they have had a longstanding commitment to quality. The delivery of high-quality care reflects priorities more than resources or size."[12]

The stated objectives of organizations formed through hospital-physician partnerships have much in common with a key initiative of the Affordable Care Act, the Accountable Care Organization (ACO). Hence the early performance of ACOs is probative. The Centers for Medicare and Medicaid Services recently reported that slightly less than half of ACOs participating in the Medicare Shared Savings Program achieved savings relative to the CMS benchmark – about what one would expect from a random sample of healthcare delivery organizations.[13] However, ACO sponsors presumably expected better-than-average savings given the significant fixed and ongoing investments required to form and operate these novel and heavily-regulated entities.

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[12] Thomas Tsai and Ashish Jha (2014), "Hospital Consolidation, Competition, and Quality - Is Bigger Necessarily Better?" *JAMA*, 312(1): 29−30. doi:10.1001/jama.2014.4692.

[13] CMS reported that 54 of 114 ACOs participating in MSSP in 2012 "had lower expenditures than projected. Of these, 29 achieved savings sufficiently large to trigger shared savings. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2014-Press-releases-items/2014-01-30.html.

We do not intend to claim that ACOs or their analogues for non-Medicare populations are not promising mechanisms for improved care delivery (both in terms of cost and quality). Rather, we observe that the success of ACOs is yet unknown, and permitting combinations that involve the creation of an ACO-like entity while also creating or enhancing market power requires a significant leap of faith on three dimensions: (1) clinical care coordination can be successful in a timely fashion; (2) the benefits of clinical care coordination cannot be achieved through joint ventures, contracts, or other relationships short of merger of full financial integration – indeed, ACOs and other risk-bearing provider collaborations can take a number of different organizational forms; and (3) the benefits exceed the likely anticompetitive effects. Judge Winmill concluded that, absent the Clayton Act, "the Acquisition could serve as a controlled experiment." Of course, he rightly noted that the Act does not grant courts "discretion to set it aside to conduct a healthcare experiment."[14]

The recent experience with ACOs suggests the first condition is unlikely to hold. The second condition is carefully addressed by the district court. One important efficiency cited by the defendants is the use of the Epic EMR by acquired physicians. However, an EMR can be shared across corporate boundaries, and indeed St Luke's had already taken steps toward interorganizational

[14] Findings of Fact and Conclusions of Law, 76−77.

functionality. As the district court found, "[t]o ensure that Epic is accessible [for independent physicians], St Luke's is developing the Affiliate Electronic Medical Records program that would allow independent physicians access to Epic."[15] With regard to the second condition, we note that the district court implicitly considered and rejected it, observing in the Findings of Fact that "there are other ways to achieve the same effect that do not run afoul of the antitrust laws." There is little evidence that existing best practices cannot be adopted by physicians who are affiliated rather than owned. ACOs and other risk-bearing provider collaborations can and do take a number of different organizational forms.

It is clear that the third condition will not hold based on the district court's finding of substantial increases in horizontal concentration and bargaining leverage of the merging parties. If the benefits – which, in any event, are not merger-specific are speculative and may not materialize, while the anticompetitive effects arising from the horizontal merger are known and immediate, then on balance the merger is not likely to benefit consumers.

The defendants had an opportunity at trial to provide evidence of efficiencies from prior integration efforts, including acquisitions of other primary care practices. Their failure to introduce such evidence suggests that efficiencies have not yet arisen – or are not yet known – in this particular organization. U.S. antitrust

[15] *Id.* at 201.

laws would have little force if merging parties could simply assert speculative future efficiencies to offset anticompetitive harms from a merger.

IV. The Parties' Proposed Conduct Remedy Would Do Little to Curb the Exercise of Market Power.

Antitrust enforcers generally favor structural remedies – e.g., blocking or dissolving mergers – for a variety of reasons well-described in the "Guide to Merger Remedies" issued in 2001 by the Antitrust Division of the Department of Justice.[16] Perhaps the most important of these reasons is that any attempt to design conduct requirements that seem likeliest to replicate lost competition is fraught with potential pitfalls, not the least of which is hindering the very competition the remedy is intended to foster. To the extent they are ever effective, such endeavors are likely to be most successful in industries where price and quality are relatively easy to measure, demand and cost are relatively stable, and innovation is limited.[17] These conditions do not characterize the healthcare markets of today. Nevertheless, the defendants assert that a conduct remedy "would have largely preserved the transaction's procompetitive benefits while eliminating the potential for anticompetitive effects." Economic theory and evidence suggest otherwise.

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[16] Deborah L. Feinstein, "Antitrust Enforcement in Health Care: Proscription, Not Prescription," June 18, 2014, at 14−15. Available at http://www.ftc.gov/public-statements/2014/06/antitrust-enforcement-health-care-proscription-not-prescription.

[17] Ken Heyer (2012), "Optimal Remedies for Anticompetitive Mergers," *Antitrust* 26(2): 26−31.

St. Luke's proposes that the district court require St Luke's and Saltzer to negotiate separately for fee-for-service contracts. The parties argue that the efficiency benefits of the transaction could then be captured for risk-based contracts (where the incentive to reduce spending is stronger). This remedy is insufficient to constrain the exercise of post-merger market power for three key reasons. First, separate negotiations do not eliminate the unilateral incentive for each party to raise price following a merger. Second, at a minimum, payers seeking risk-based contracts will be subject to the heightened market power of the newly merged entity. Third, given the rapidly-changing healthcare reimbursement climate, it is difficult for the courts to define and then enforce a process for classifying business as "fee-for-service."

To clarify why separate negotiations do not adequately address anticompetitive effects arising from a provider merger, consider the general logic underlying firm pricing decisions (quality decisions are analogous). Ordinarily, firms are reluctant to raise price because they may lose customers to rivals. But if two erstwhile competitors share a corporate parent, then when one raises its price, some of its customers will shift their business to the other firm. Both parties know that this will happen and are therefore much more willing to raise price and lose a customer. The lost revenues will stay "in the family," which blunts any incentive to lower prices. Thus, a merger of two large competitors will result in prices above

the levels that would prevail if the rivals were truly independent. This is true even in the absence of explicit price coordination among the co-owned former rivals.

Indeed, the Evanston Northwestern-Highland Park hospital merger in the northern suburbs of Chicago in 2000 provides a case in point. Shortly after the merger, inpatient prices charged to commercial payers increased by nearly 50%, far exceeding price increases among various control groups in the Chicago area.[18] Moreover, extensive empirical analysis showed that quality did not improve relative to other area hospitals.[19] In light of this evidence, the merger was deemed anticompetitive by an administrative law judge in 2005, a determination that was affirmed on appeal to the full Federal Trade Commission (FTC) in 2007.[20] Concluding, however, that "divesting Highland Park after seven years of integration would be a complex, lengthy, and expensive process," the FTC ordered the parent entity (Evanston Northwestern Healthcare) to establish a separate and independent contract negotiating team for Highland Park Hospital. We are not aware of any insurer that has availed itself of this option, which suggests that

[18] Deborah Haas-Wilson and Christopher Garmon (2011), "Hospital Mergers and Competitive Effects: Two Retrospective Analysis," *International Journal of the Economics of Business*, 18(1): 17−32.

[19] Patrick S. Romano and David J. Balan (2011), "A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare," *International Journal of the Economics of Business*, 18(1): 45−64.

[20] In the *Matter of Evanston Nw. Healthcare, id.*, available at www.ftc.gov/os/adjpro/d9315/070806opinion.pdf.

payers recognize the competitive benefits of separate negotiation teams under a single corporate parent to be minimal. To the best of our knowledge, prices have not reverted back to competitive levels, despite the supposed return of competitive pricing incentives. A senior FTC staff member has since indicated this remedy is highly unusual.[21] A recent simulation of such a remedy in a different setting – a proposed hospital acquisition in Northern Virginia – also shows that separate bargaining would have done little to mitigate post-merger price increases had the FTC and Virginia Attorney General not successfully blocked the transaction.[22]

The divested primary care physicians in Saltzer Medical Group will serve to increase competition for Nampa-area patients. Due to the divestiture, insurers will have more choice of which primary care physicians to include in their network. If they find that St Luke's primary care physicians are charging high prices or providing low quality, they can turn to a network that includes Saltzer and Saint Alphonsus physicians. Saltzer, as a free-standing physician group, will have

[21] "The Commission did accept a conduct remedy in its challenge to the combination of Evanston and Highland Park hospitals....We have repeatedly rejected this sort of conduct remedy since." Deborah Feinstein, "Antitrust Enforcement in Healthcare: Proscription, not Prescription," June 19, 2014, at footnote 43.

[22] Gautam Gowrisankaran, Aviv Nevo, and Robert Town, "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," Accepted, *American Economic Review*, June 2014. For additional details on the transaction in question, see http://www.ftc.gov/enforcement/cases-proceedings/061-0166/inova-health-systems-foundation-prince-william-health-system.

greater incentive to compete for business for its physicians, both in terms of price and quality.[23] Competition among multiple physician practices accrues to the benefit of consumers by holding down the price of medical care and providing strong incentives to enhance quality.

CONCLUSION

In closing, we emphasize that there is broad agreement in the economics academic community that provider competition is beneficial to consumers. There is a significant body of academic research that finds competition enhances quality, and limited competition raises prices and total healthcare spending.[24] In contrast, there is significant evidence that efficiencies do not necessarily or generally follow from provider mergers. St Luke's track record of integration paired with high prices and high medical costs (*see, e.g.*, FOF 86-89) casts serious doubt on its assertions that the proposed acquisitions would yield substantial, merger-specific efficiencies, let alone of the magnitude necessary to outweigh the alleged anticompetitive effects.

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[23] We understand that the defendants are arguing that Saltzer would not survive long as an independent entity if it were divested from St. Luke's. The merits of that argument are outside the scope of this brief, and we assume, for the purposes of our comments, that the facts would demonstrate otherwise.

[24] Martin Gaynor and Robert Town (2012) "Provider Competition," in *Handbook of Health Economics*, Vol 2., M. Pauly, T. McGuire, P.P. Borras, eds., summarize the research on the effects of competition on quality and price.

We urge the Court to affirm the district court's findings and remedy, which are grounded in well-founded economic analysis.

Dated: August 20, 2014

/s/Joe R. Whatley, Jr.
Joe R. Whatley, Jr.
Edith M. Kallas
Whatley Kallas, LLP
1180 Avenue of the Americas, 20th Floor
New York, New York 10036
Tel: (212) 447-7060
Fax: (800) 922-4851
jwhatley@whatleykallas.com
ekallas@whatleykallas.com

Attorneys for Amici Curiae

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitations of Fed. R. App. P. 29(d) and Fed. R. App. P. 32(a)(7)(B) and because it contains 4,493 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

This brief complies with the typeface requirements of Fed. R. App. P.32(a)(5) and type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionately spaced typeface using Microsoft Word 2007 in 14-point Times New Roman font.

By: /s/Joe R. Whatley, Jr.

Attorneys for Amici Curiae

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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on August 20, 2014.

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

By: /s/Joe R. Whatley, Jr.

Attorneys for Amici Curiae

APPENDIX

List of Amici

Fiona M. Scott Morton, Professor of Economics, Yale School of Management

Robert J. Town, Associate Professor, The Wharton School at the University of Pennsylvania

Amitabh Chandra, Professor, Harvard University

Roger Feldman, Professor, University of Minnesota

H.E. Frech III, Professor, University of California, Santa Barbara

Steven C. Salop, Professor of Economics and Law, Georgetown University Law Center

Amanda Starc, Assistant Professor, University of Pennsylvania

Joseph Newhouse, Professor, Harvard University

Zack Cooper, Assistant Professor, Yale University

Robin Lee, Assistant Professor, Harvard University

Vivian Ho, Professor, Rice University

Gautam Gowrisakaran, Professor, University of Arizona