No. 14-35173

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

SAINT ALPHONSUS MEDICAL CENTER–NAMPA INC., ET AL.,

Plaintiffs-Appellees, and

IDAHO STATESMAN PUBLISHING, LLC, ET AL.,

Intervenors,

v.

ST. LUKE'S HEALTH SYSTEM, LTD., ET AL.,

Defendants-Appellants.

Appeal from the United States District Court for the District of Idaho, Case Nos. 1:12-cv-00560-BLW (Lead) and 1:13-cv-00116-BLW, Hon. B. Lynn Winmill

AMICUS BRIEF OF AMERICA'S HEALTH INSURANCE PLANS IN SUPPORT OF THE DISTRICT COURT'S RULING

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, amicus curiae America's Health Insurance Plans makes the following disclosure:

1. Is said party a subsidiary or affiliate of a publicly owned corporation?

   No.

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome by reason of insurance, a franchise agreement, or indemnity agreement?

   No.

s/ Pierre H. Bergeron
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STATEMENTS REQUIRED UNDER RULE 29 OF THE FEDERAL RULES OF APPELLATE PROCEDURE

Pursuant to Federal Rule of Appellate Procedure 29(a), all parties have consented to the filing of this brief. Pursuant to Federal Rule of Appellate Procedure 29(c)(5), this brief was not authored in any part by counsel for any of the parties, and no person or entity other than amicus, its members, or its counsel has made a monetary contribution to the preparation or submission of this brief.

Date: August 20, 2014

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INTEREST OF AMICUS CURIAE

America's Health Insurance Plans ("AHIP") is the national trade association representing the health insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

Amicus and its members have a strong interest in the application of antitrust laws to hospital acquisitions of physician practices. Anticompetitive provider consolidation directly affects health plans' ability to benefit consumers by negotiating competitive rates, increasing accountability, broadening access, and offering innovative products. Moreover, amicus is uniquely positioned to assist the Court by explaining why the district court was correct when it concluded that provider consolidation is not necessary for integrated, better quality care. As explained below, AHIP's members are actively developing systems and relationships with providers and reforming payment methodology to transform the healthcare system to produce higher quality healthcare for consumers at competitive prices. None of these ongoing changes depend on anticompetitive acquisitions like the one the district court unwound here.

SUMMARY OF ARGUMENT

An important issue before this Court is whether claimed clinical integration justifies the anti-competitive acquisition of a medical group by a hospital with an already significant medical group. The district court correctly required Defendants to show merger-specific efficiencies. Instead, Defendants made claims of clinical integration efficiencies and suggested that the policy goals of the Affordable Care Act (ACA) overrode antitrust concerns. Those assertions are wrong, as "the goals of the ACA and antitrust enforcement are aligned and compatible," Julie Brill, *Promoting Healthy Competition in Health Care Markets: Antitrust, the ACA, and ACOs*, FTC Speeches, 3 (June 11, 2013).[1] Defendants' efficiencies claims do not satisfy the high bar necessary to overcome the antitrust laws.

The efficiencies suggested by Defendants are being achieved through relationships between health plans and providers – in other words through market innovation – without the need for anti-competitive mergers by hospitals and providers. At the same time, Defendants are arguing here that clinical integration efficiencies justify their anti-competitive combination. Unfortunately, the market reality has not matched the pre-combination rhetoric. Indeed, anti-competitive

[1] Available at http://www.ftc.gov/sites/default/files/documents/public_statements/promoting-healthy-competition-health-care-markets-antitrust-aca-and-acos/130611cprspeech.pdf

combinations have had the opposite result and have, therefore, caused harm to consumers. As the court below noted, "[t]here are other ways to achieve the same effect that do not run afoul of the antitrust laws and do not run such a risk of increased costs." (Findings of Fact and Concl. of Law 3, ECF No. 464). Hospitals do not need to employ physicians directly in order to create "a unified and committed team of physicians." (*Id*. Concl. of Law ¶¶ 46-47). Nor do they need to undertake anticompetitive mergers to experience "the efficiencies of a shared electronic record." (*Id*. ¶ 48). They likewise do not need to engage in anticompetitive behavior in order to explore alternatives to the traditional fee-for-service payment model.

On the contrary, these and other efficiencies are being realized across the country without anticompetitive consolidation. These efforts benefit consumers by creating affordable, accessible, and accountable systems. These efforts depend upon competitive provider markets. Consolidation in concentrated provider markets would likely impede the changes already underway by giving providers greater incentive and ability to refuse to participate in payment reform and clinical care initiatives. Accordingly, robust enforcement of traditional antitrust principles in the context of provider consolidations is fully consistent with, and in fact supports, positive transformation of the health care system.

On the other side of the ledger, traditional concerns with creation of provider market power through consolidation are antithetical to positive transformation of the health care system. An acquisition that eliminates significant competition between providers increases the ability of providers to lower their quality of care, abandon innovation, and demand and obtain higher prices for medical care. Consolidation of providers results in a well-documented record of harm to consumers, with price increases of 20-40 percent after consolidation. Rising prices of medical care are one of the leading drivers of premium increases, which are paid by consumers. In short, if anything, the changes that have, and continue to occur, in the healthcare system should suggest *greater* scrutiny of potentially anticompetitive provider transactions, not the opposite.

ARGUMENT

I. Health Plan Reforms are Making Healthcare More Accessible, Accountable, and Affordable

Defendants argue their presumptively anticompetitive acquisition was justified by efficiencies specific to their transaction. For example, Defendants assert the consolidation allows Saltzer physicians to be "involved in all aspects of care." (Br. of Appellants 13-14, ECF No. 20). They likewise argue that the acquisition afforded Saltzer "state-of-the-art information technology." (*Id.* at 13).

And, Defendants contend the acquisition made it possible for Saltzer physicians to begin a "transition from fee-for-service to value-based care." (*Id*. at 20).

As the district court correctly found, each of these efficiencies is possible without anticompetitive consolidation. Indeed, as explained and described in examples below, AHIP's members already are making such health transformations possible today throughout the country. Through health plans' care management support services, practices like Saltzer can become directly involved in all aspects of their patients' care. Similarly, such practices can access the latest technology and analytical capabilities. Finally, health plans have implemented new and varied approaches to help providers evolve from fee-for-service to accountable, shared risk, population-based care.

These reforms respond directly to consumers' needs. New delivery models empower patients to choose high-performing providers and receive the benefits of care coordination and case management for chronic conditions. Patient choice plays a critical role in reducing the cost of care and improving value.

A. Health Plans are Redesigning Payment and Health Care Delivery Models

Defendants repeatedly imply that without anticompetitive consolidations it will be difficult for physicians to transition away from a fee-for-service model toward "value-based care." (Br. of Appellants 13, 20). This is not true.

Health plans already are reducing the cost of care and improving value by transforming their relationships with healthcare providers. Karen Ignagni, *Health Plan Innovations in Delivery System Reforms*, AJMC.com, Apr. 16, 2013.[2] Health plans and providers have pursued three key means of transformation:

(1) Clinical integration of providers.
(2) Investment in and deployment of technology.
(3) Payment reform.

Below is a discussion of each, as well as illustrative examples of particular approaches taken by individual plans with providers. Approaches vary beyond those that can be discussed in a few examples, but this transformation is occurring in all regions of the country, with large and small plans, and with promising results. These real-world changes show, as the district court correctly observed, that the asserted benefits of the acquisition are not specific to this particular merger.

1. *Clinical Integration*

Numerous forms of clinical integration have emerged, including through accountable care organizations, patient-centered medical homes, and bundled payments. While varied in structure, the approaches share important similarities, including care managers and case managers to coordinate care for patients; data and information sharing to help providers manage their patients; and infrastructure

[2] Available at http://www.ajmc.com/pdf-access/16133/1.

development assistance to support physician practices that may not have the capital to invest at the start of the partnership.

A few examples illustrate the innovative approaches in today's marketplace:

- Blue Cross Blue Shield of Massachusetts has launched an Alternative Quality Contract model that currently has 16 participating health care provider organizations consisting of 18,000 primary care physicians and specialists who care for over 70,000 HMO members.[3] One of its key components is integration across the continuum of care. "[S]ome of the most significant quality improvements come from the more loosely-affiliated, smaller provider organizations in the [Alternative Quality Contract]." *Roundtable Discussion on Medicare Physician Payment Policy: Lessons from the Private Sector: Before the S. Comm. on Finance*, 112th Cong. 6 (2012) (testimony of Dana G. Safran, Senior Vice President, Blue Cross Blue Shield of Massachusetts).

- Cigna created the Cigna Collaborative Care initiative, which includes more than 39,000 primary care and specialty physicians covering more than one million commercial consumers. *Cigna Achieves Goal of 100 Collaborative Care Arrangements Reaching One Million Customers* (July 8, 2014).[4] The initiative utilizes registered nurses employed by practices to serve as embedded care coordinators. *Id.* Cigna provides training and support to the coordinators as well as daily and monthly patient-specific reports to assist them in improving patient care. Richard B. Salmon et al., *A Collaborative Accountable Care Model in Three Practices Showed Promising Early Results on Costs and Quality of Care*, 31 Health Aff. 2379, 2380 (2012).

- Humana created an Accountable Care Continuum to encourage primary care physicians to develop population health management capability and focus. As physicians develop capabilities, they advance to full accountability for the cost and quality of care for their patients. Over 33,000 providers have targets for specific clinical initiatives and patient experience ratings for one million members. Participants may receive assistance from Humana in infrastructure development and certification, and use electronic medical records and care coordinators. *See Provider Medicare Quality Rewards Program*, Humana (Aug.

[3] As of August 2013.

[4] Available at http://newsroom.cigna.com/NewsReleases/cigna-achieves-goal-of-100-collaborative-care-arrangements-reaching-one-million-customers.htm.

19, 2014)[5]; *see also* Mike Funk, *Humana's Approach to Value-Based Reimbursement*, Florida HFMA (Jan. 24, 2014).[6]

Positive results flow from integrating care managers and nurses into physician practices, which allows the practices, in turn, to gain a better understanding of the health of their patient population. *See* Ruth S. Raskas et al., *Early Results Show WellPoint's Patient-Centered Medical Home Pilots Have Met Some Goals for Costs, Utilization, and Quality*, 31 Health Aff. 2002, 2006 (2012).

Based on their experience implementing such changes around the country, amicus and its members agree with the district court's finding that it "is the committed team – and not any one specific organization structure – that is the key to integrated medicine." (Findings of Fact ¶ 184). Indeed, the "same efficiencies have been demonstrated with groups of independent physicians." (Concl. of Law ¶ 46). Thus, "a committed team is not a merger-specific efficiency of the Acquisition." (Findings of Fact ¶ 185).

2. *Technology*

Health plans make data and decision-support tools available to providers in many settings. For example, plans have introduced a variety of tools to support physicians offering patient-centered medical homes. Depending on physicians'

[5] Available at https://www.humana.com/provider/support/clinical/quality-resources/medicare-rewards-program.

[6] Available at http://www.floridahfma.org/presentations.lib/items/humanas-approach-to-/Humanas%20Approach%20Accountable%20Care%20Relationships%20%20.pdf.

existing capabilities, health plans offer detailed claims data; hospital and emergency department census reports; analytic reports detailing potential medication interactions, gaps in care, and site of service opportunities; and predictive modeling reports on risk, out-of-network use, comparisons to benchmarks, and progress toward quality and resource use targets. These data help physicians recognize gaps in care, such as those patients in need of comprehensive case management, most at risk of developing serious conditions, and in need of immunizations and preventive care. In one state, health plans collaborate to make patient medical records available to any treating physician or nurse. Tim Logan & Stuart Pfeifer, *Insurance Giants Creating Massive Database of Patient Records*, LA Times, Aug. 4, 2014.[7] Examples abound:

- WellPoint's patient-centered medical home initiative supports population health management and care planning by providing physicians with useful data and the integration of care managers and nurses into physician practices to focus on prevention initiatives. *See* Raskas, *supra*, at 2002-07.

- Aetna's accountable care program uses integrated data to allow the care team to efficiently share patient information so the team can better manage the patient's condition, deliver more timely care, and ultimately improve clinical outcomes. *Building a Better Accountable Care System: A Q&A with Dr. Charles Kennedy*, Aetna (June 18, 2014).[8]

- Humana offers a program which assists providers in successfully transitioning to "full accountability." The program includes advanced

[7] Available at http://www.latimes.com/business/la-fi-insurance-database-patient-records-20140804-story.html.

[8] Available at http://news.aetna.com/building-better-accountable-care-system-qa-dr-charles-kennedy/

> capabilities such as clinical analysis, predictive modeling, clinical inferencing, aging in place solutions, and chronic care management. They also deliver real-time identification of gaps in care by linking disparate electronic health records systems to enable all health care providers to exchange essential health information in real-time. Funk, *supra*.

These examples show that the district court was right when it found the "efficiencies resulting from the use of Epic [St. Luke's electronic health record system] do not require the employment of physicians and hence are not merger-specific." (Findings of Fact ¶ 204). Indeed, as noted, St. Luke's is developing a system to allow independent physicians to access Epic. (*Id.* ¶¶ 201-02).

3. *Payment Reform*

Finally, health plans are at the forefront of efforts to replace the fee-for-service system with a system of paying for value – leading to better health outcomes and increased affordability. These alternative payment models evolve from retroactive payment to prospective models that focus on accountability, shared risk, and population-based care.

The district court found that capitation or value-based care promotes innovation and properly aligns incentives so that providers deliver higher-value care at lower cost. (*Id.* ¶¶ 172-77). The following examples illustrate implementation of these reforms *without* provider consolidation:

- UnitedHealthcare tested an alternative payment model for cancer therapy that bundled payments and standardized treatment regimens to reduce costs and remove incentives for using ineffective interventions. After three years, the five participating medical oncology groups across the country reduced

medical costs by 34%. Lee N. Newcomer et al., *Changing Physician Incentives for Affordable, Quality Cancer Care: Results of an Episode Payment Model*, J. of Oncology Prac. July 8, 2014, at 3.

- CareFirst's Patient-Centered Medical Home focuses on financial incentives to primary care providers at the center of patient care. Providers can receive supplemental fee payments if they achieve better overall quality and cost outcomes for the cohort of members in their panels. The focus on overall outcomes reflects the important role of primary care providers in making referrals for care, particularly in patient centered medical homes.
- Cigna's Collaborative Accountable Care initiative, discussed above, offers practices a care coordination fee on top of fee-for-service payments. The fee allows practices to make investments to improve patient care (e.g., offering more urgent care appointments) while keeping total medical costs down. Practices that are the most successful in addressing medical costs and improving quality receive an increase in the fee for the following year.

B. Plan-Led Collaboration with Providers is Producing Important Results

The initiatives described above are already producing benefits for patients. For private-sector accountable care organization models, some health plans' initial quality improvements have been approximately ten percent, readmissions and total inpatient days have decreased fifteen percent, and annual savings of $336 per patient have been generated. Aparna Higgins et al., *Early Lessons from Accountable Care Models in the Private Sector: Partnerships Between Health Plans and Providers*, 30 Health Aff. 1718, 1727 (2011). With respect to a few of the specific initiatives discussed above:

- A study conducted on the seven provider organizations that entered in Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract model found that the rate of increase in spending slowed compared to control groups, even more so in year two than in year one. Zirui Song et al., *The 'Alternative Quality Contract,' Based on a Global Budget, Lowered Medical*

Spending and Improved Quality, 31 Health Aff. 1885, 1891 (2012). Quality of care also improved compared to control organizations, with chronic care management, adult preventive care, and pediatric care within the contracting groups improving more in year two than in year one. *Id.* at 1890-91.

- Third year results for the CareFirst Patient-Centered Medical Home have shown positive trends in quality, cost reduction and stabilization. Results include: (1) an average rate of increase in medical spend for 2013 of 3.5%, the same as 2012; (2) health care costs $130 million less than projected in 2013; (3) avoided costs of $267 million when measured against projected costs from 2011 to 2013; (4) hospital admissions down 6.4%: 11.1% fewer days in the hospital, 8.1% fewer hospital readmissions for all causes, and 11.3% fewer outpatient health visits as compared to those members who are not in the patient-centered medical home program; (5) approximately 69% of the participating physician Panels in 2013 earned quality rewards and will receive an almost 36% increase in primary care fees paid by CareFirst. *Patient-Centered Medical Home Program Shows Promising Quality Trends and Continued Savings on Expected Costs*, CareFirst (July 10, 2014).[9]

- CIGNA's Collaborative Accountable Care program participating physician groups have a 3% better-than market average quality performance, 4-5% lower total medical cost trend versus peers, and 50% fewer emergency room visits compared to market. Cigna Collaborative Care, Cigna (May 2014).[10]

These plan-led advancements and others have been implemented and are available today to additional partners and do not depend on provider consolidation.

II. Anticompetitive Provider Consolidation Would Impede Reform

All of the initiatives described above rely upon competitive provider markets. Health plans see firsthand how efforts to drive quality improvement and cost control rely upon competitive provider markets. The "core to the whole …

[9] Available at https://member.carefirst.com/individuals/news/media-news/2014/patient-centered-medical-home-year-3-results.page

[10] Available at ttp://newsroom.cigna.com/images/9022/Collaborative_Care_Whitepaper_ v10.pdf

design is to build a *market driven* model in which the pursuit of informed self-interest by primary care providers drives the whole system to better outcomes." CareFirst, *Description and Guidelines: Patient-Centered Medical Home Program and Total Care and Cost Improvement Program*, (2014) at II-1(emphasis added).

As part of these reform efforts, providers *compete* to be the best in improving quality and reducing cost. Take, for example, CareFirst BlueCross BlueShield's network-wide patient-centered medical home program. Participants are able to earn annual Outcome Incentive Awards – monetary rewards for better cost and healthcare quality outcomes. Roughly 80% of CareFirst primary care physicians in the region participate. *Id*. at 10 (About 3400 primary care doctors and almost 500 nurse practitioners participate). Competition has caused small group practices to excel: Importantly, over the three-and-a-half years that the patient-centered medical home has been operating, the top performers have been independent and single-site group practices. *Id*. at 19 (Most primary care physicians "in the CareFirst region practice in solo practice settings or in groups of fewer than three physicians." Panels are composed of between five and fifteen primary care physicians or nurse practitioners. *Id*. at III-2).

Anticompetitive provider transactions move the market in the opposite direction of these reforms. Historically, with the acquisition of market power, large health systems are able to negotiate higher prices with private insurers. "'Larger

organizations have greater market power to demand higher prices from those plans for doctor visits and hospital stays….'" AHIP, *The Top Driver of Premiums? The Cost of Health Care Services* (June 23, 2014)[11] (quoting Austin Frakt, *Bigger Health Companies: Good for Medicare, Maybe not for Others*, N.Y. Times, June 23, 2014). "Research shows that consumers may face price increases of 20-40 percent for health care services following a hospital or provider merger." AHIP, *supra*; *see also* AHIP, *When Providers Merge, Consumers Pay* (June 26, 2014).[12] Indeed, PricewaterhouseCoopers highlighted price increases due to hospital acquisitions of physicians in its recent cost trend report:

> As physician practices are acquired, they may be reclassified as 'hospital outpatient' departments, which allow hospitals to charge a 'hospital facility fee' even though services are not performed in a hospital…. this not only affects hospital prices for services and drugs, but can ultimately be passed on to patients who may end up with a higher bill. PricewaterhouseCoopers, *Medical Cost Trend: Behind the Numbers* 11 (2015).

Another recent study also found that when a hospital-owner of a physician group increases its market share, it concomitantly increases its prices. Laurence Baker et al., *Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending*, 22 Health Aff. 756, 756-63 (2014).

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[11] Available at http://www.ahipcoverage.com/2014/06/23/the-top-driver-of-premiums-the-cost-of-health-care-services/

[12] Available at http://www.ahipcoverage.com/2014/06/26/when-providers-merge-consumers-pay/

"It is almost perfectly true that the larger the integrated system, the higher the unit fees/rates they are paid." CareFirst, *Description*, *supra*, at I-15.

The district court's findings fit comfortably within these broader experiences. As the court explained, St. Luke's would gain "a dominant bargaining position over health plans" and it would likely use this leverage "to receive increased reimbursements." (Findings of Fact ¶¶ 143-44). The district court also found that one of the anticompetitive effects will be that referrals favor the inpatient services of St. Luke's, the acquiring hospital. (Findings of Fact ¶¶ 132-40 ("After the Acquisition, it is virtually certain that this trend [where St. Luke's purchases a physician practice and referrals increase dramatically] will continue and Saltzer referrals to St. Luke's will increase.")). After all, it has been repeatedly shown that when hospitals "assimilate physician practice groups, they seek to capture more physician referrals..." Frakt, *supra*. "In this environment, an employed [primary care physician] . . . is seen by an integrated health care delivery system as an inlet valve – most useful for revenue preservation or enhancement through referrals to specialists in the larger system." CareFirst, *Description*, *supra*, at I-15. Clearly, referrals based on ownership of the physician practice can distort referral decisions based on the cost and quality of care – key features of the healthcare system transformation that is underway and will benefit consumers.

In short, to the extent that this Court considers the impact such acquisitions

would have on the transformation underway in the healthcare system, those policy considerations strongly favor affirming the district court's ruling. Anticompetitive provider consolidation presents a real and direct threat to the important transformation now underway.

CONCLUSION

No court has ever allowed an anticompetitive acquisition to stand based on a balancing of efficiencies over harm. *FTC v. ProMedica Health Sys.*, No. 3:11 cv 47, 2011 WL 1219281, at *57 (N.D. Ohio, Mar. 29, 2011). Instead, where, as here, markets are highly concentrated, courts require "proof of extraordinary efficiencies." *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 720 (D.C. Cir. 2001). Here, no balancing of efficiencies was even required, as the Defendants failed to show that any alleged efficiencies were merger-specific. The court also correctly refused to allow the policy goals of the Affordable Care Act to override the concerns of the antitrust laws. Indeed, the pursuit of those goals is entirely consistent with blocking this transaction. The marketplace is moving strongly toward reform without a need for anticompetitive provider consolidation; and anticompetitive provider consolidation will undercut and impede reform. AHIP, accordingly, asks this Court to affirm the decision of the district court.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with Federal Rules of Appellate Procedure 29(c)-(d) and 32(a)(7)(B). The brief was prepared in Microsoft Word, using Times New Roman 14-point font. According to the word count function, the word count, including footnotes and headings, is 3,655.

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CERTIFICATE OF SERVICE

I certify that a copy of the foregoing brief was filed electronically with the Court via the CM/ECF system and further certify that a copy was served on all parties or their counsel of record through the CM/ECF system.

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