Case No. 14-35173

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

ST. LUKE'S HEALTH CARE SYSTEM; SALTZER MEDICAL GROUP P.A.,

Defendants-Appellants,

v.

FEDERAL TRADE COMMISSION; STATE OF IDAHO,

Plaintiffs-Appellees.

On Appeal from the United States District Court
for the District of Idaho

No.1:13-CV-00560-BW,
Honorable B. Lynn Winmill, Judge

BRIEF OF *AMICUS CURIAE* THE STATES OF CALIFORNIA, WASHINGTON, PENNSYLVANIA, CONNECTICUT, DELAWARE, ILLINOIS, IOWA, KENTUCKY, MAINE, MARYLAND, MISSISSIPPI, MONTANA, NEVADA, NEW MEXICO, OREGON, AND TENNESSEE

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IDENTITY AND INTEREST OF *AMICUS CURIAE*

The California, Washington, and Pennsylvania Attorneys General, joined by the Attorneys General of the States of Connecticut, Delaware, Illinois, Iowa, Kentucky, Maine, Maryland, Mississippi, Montana, Nevada, New Mexico, Oregon, and Tennessee, are the chief law enforcers of their States.[1] Affordable quality health care for all residents is important to these States,[2] which can be achieved only through strong competition among providers. Accordingly, the States regularly use federal and state antitrust law to enjoin anti-competitive mergers.[3] The States also have special responsibilities to oversee not-for-profit charities, including charitable health care providers, and to review proposed mergers to ensure consistency with these entities' charitable missions.[4] Based on these experiences and responsibilities, the States have a special interest in, and are in a unique

[1] *See, e.g.*, Cal. Const. art. V, §13; 71 Pa. Stat. §732-204(c).

[2] *See, e.g.*, Consent Decree, *Commonwealth of Pennsylvania v. Geisinger Health System Foundation, et al.*, No. 1:13 CV-02647-YK (M.D. Pa. Nov. 1, 2013); Anna Mathews, *Doctor, Hospital Deals Probed*, WALL. ST. J., HEALTH (Sept. 13, 2013), *available at* http://online.wsj.com/news/articles/SB10000872396390444433504577649523985288422.

[3] *See, e.g.*, Consent Decree, *Commonwealth v. Geisinger*, *supra*; *see also, e.g.*, Steve Tenn, *A Case Study of the Sutter Summit Transaction*, FEDERAL TRADE COMMISSION WORKING PAPER NO. 293, 1-2 (Nov. 2008).

[4] *See, e.g.*, Cal. Gov. Code § 12588; Cal. Corp. Code § 6010.

position to opine on, the appropriate standard under federal antitrust law for reviewing mergers of health care providers.

SUMMARY OF ARGUMENT

Amicus Curiae States require vibrant competitive health care markets to control costs and to make affordable health care available to our States' citizens. We have seen the growth of large health care systems through the systematic acquisition of hospitals and physician groups, and experienced the effects of the systems' increased bargaining power in negotiations with insurers on the terms of their inclusion in the insurance plan networks offered to employers in our States. Events in our own States have confirmed the district court's conclusion in Idaho: that employers compete to provide health care benefits for which employees do not have to drive more than a reasonable distance to obtain health care; that to compete effectively for employers' business the commercial health insurers must offer them provider networks of hospitals and physician groups that are located near the homes of their employees; that the unwillingness or inability of most employees to travel great distances for medical care is exacerbated by the power of physicians to steer employees to certain hospitals; and that the ensuing demand for nearby network providers enhances the large health care systems' bargaining power. These developments have all led to higher

prices for insurers, resulting in consumers paying higher premiums, deductibles, and copays.

The "Option Demand" model used by Plaintiffs-Appellees to assess the market impact of Defendants-Appellants' merger properly focuses on the price effects of the increased bargaining leverage that Defendants-Appellants gained from their merger. The localized geographic market resulting from this methodology accurately models the market dynamic that we see in our States today.

For all of these reasons, we believe that the District Court opinion reached the correct result based on the proper analysis of this merger. *See* Findings of Fact and Conclusions of Law, at 13-23 *Federal Trade Commission et al. v. St. Luke's Health System, Ltd. et al.*, No. 1:13-CV-00560-BLW (D. Idaho Jan. 24, 2014). We note that this analysis, and its results, are nearly untouched by the arguments of Defendants-Appellants and their amici.

The States will briefly address the remaining arguments of Defendant-Appellants and their amici. We recognize that the integration of hospitals and physician groups can produce quality improvements through the implementation of integrated electronic patient care recordkeeping, the use of best practices in medical care, and most importantly, coordinated patient

outreach. However, the benefits of integration can be achieved by means that preserve competition. In our experience, other forms of integration or coordination among providers can access needed capital and accomplish improvements in quality of care without sacrificing antitrust goals and condoning anti-competitive mergers.

Large hospital systems argue that the Affordable Care Act ("ACA")[5] creates a need to grow through acquisitions. In fact, the ACA relies on competition to control costs. Further, the quality improvements that are used to justify mergers can be achieved by means that do not disserve competition.

Finally, while charitable not-for-profits play an important role in the health care sector, there is no basis in policy or law to afford this particular type of institution special antitrust status or immunity so that it may cater to Medicare, Medicaid, or uninsured patients. Even among not-for-profit health care providers, the growth in economic power through acquisitions leads to price increases—used to fund salary increases for the board or management, or yet more acquisitions—rather than more affordable patient care or an expansion of the charitable reach of that care.

[5] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1003, 124 Stat. 119 (2010).

ARGUMENT

I. INTRODUCTION

Health care is viewed as a matter of traditional local concern falling well within the police powers of the States. *See, e.g.*, *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996); Department of Health and Human Services, *Health Insurance Market Rules*, 78 Fed. Reg. 13406, 13435 (Feb. 27, 2013); Department of Health and Human Services, *Establishment of Exchanges and Qualified Health Care Plans et al.*, 77 Fed. Reg. 18310, 18413, 18417-19, 18443 (Mar. 27, 2012). From an antitrust perspective, virtually all markets have a local component, but health care, in particular, is a quintessentially local matter. *See* Stephen Calkins, *Perspectives on State and Federal Antitrust Enforcement*, 53 DUKE L.J. 673, 679–80 (2003). Over time, we *Amicus Curiae* States have reviewed local transactions in our health care markets in the exercise of our powers both under federal and state antitrust laws, *see, e.g.*, Consent Decree, *Commonwealth v. Geisinger*, No 1:13 CV-02647-YK (M.D. Pa. Nov. 1, 2013); Steve Tenn, *A Case Study of the Sutter Summit Transaction*, FEDERAL TRADE COMMISSION WORKING PAPER NO. 293, 1-2 (Nov. 2008), and under state charitable trusts law, *see, e.g.*, Cal. Gov. Code § 12588. We have gained a great understanding of those markets. Although the vast majority of health care provider acquisitions

have gone unchallenged to date for various reasons, we have come to see how large health care providers can acquire market power and successfully impose price increases on payors [6] without risking significant patient defection to markets located farther away. *See, e.g., Sutter Summit Transaction, supra,* at 2-3. We are concerned about the failure of earlier methodologies to predict competitive effects accurately, and are particularly interested in and supportive of the prevailing model at issue here called "Option Demand." *See, e.g.*, Cory Capps, *From Rockford to Joplin and Back Again, The Impact of Economics on Hospital Merger Enforcement*, ANTITRUST BULLETIN (Forthcoming), manuscript 1, 5 (2014).

This model, unlike previously favored approaches, is grounded in the negotiations between the payor and health care providers, which take place in what is known in economic literature as an "option demand" market. "Option Demand" is a term that describes markets like healthcare where consumers buy a set of options—such as access to a group of healthcare providers (i.e., a network)—before they know precisely what services they will need. Cory Capps, David Dranove & Mark Satterthwaite, *Competition*

[6] The term "payors" embraces commercial insurers as well as employers that self-insure but rely on commercial insurers to administer their networks.

and Market Power in Option Demand Markets, RAND J. of Econ. 732, 738 (Dec. 2003). Providers that are more critical to those networks will have greater bargaining leverage to negotiate higher prices with health plans. *Id.* This is because the health plan's best alternative to a negotiated agreement with that provider—i.e., its "BATNA"—is to attempt to market a less attractive network to employers. Findings of Fact and Conclusions of Law, *supra*, at 20. Where, as in this case, providers merge and make a health plan's BATNA much less attractive, they gain the ability to demand significantly higher payments from health plans, which are then passed on to consumers in the form of higher premiums, copayments, or deductibles. *See id.* at 20-23, 27.

Set against this backdrop, the *Amicus Curiae* States discuss the following points: (1) the need to contain costs in order to deliver affordable, high quality, medical care; (2) the ability of large health care providers to exercise market power and successfully raise the prices charged to payors as the condition for their inclusion in payors' networks; (3) the correctness of the Option Demand model used by the District Court in this case; and (4) the lack of any justification for this merger on the basis of the asserted need for full financial integration, the goals of the ACA, or the role of Defendant-

Appellant St. Luke's Health Care System as a not-for-profit in providing charity care to Medicare, Medicaid, or uninsured patients.

II. THE ACCELERATION OF HEALTH CARE COSTS DUE TO THE GROWTH OF LARGE HEALTH CARE PROVIDER SYSTEMS HAS BECOME A MATTER OF GRAVE CONCERN FOR THE STATES

Escalating health care costs directly threaten the affordability of health care delivered to the citizens of the *Amicus Curiae* States. A number of studies and reports have set out the problem of rapidly escalating health care costs. For example, "[a] recent study has shown that in California, after a downward trend in hospital prices for private-pay patients in the 1990s, a rapid upward trend began about 1999 that produced average annual increases of 10.6 percent over the period 1999–2005." Robert Berenson, Paul Ginsburg, and Nicole Kemper, *Unchecked Provider Clout in California Forecloses Challenges to Health Care Reform*, 29 HEALTH AFFAIRS 699, 699 (Apr. 2010) (internal citation omitted). In 2010, the Massachusetts Attorney General issued a report on health care markets in that State noting similar increases in costs that, "consistently outpace growth in the economy, gross domestic production (GDP), and wages." Massachusetts Attorney General, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS, REPORT FOR ANNUAL PUBLIC HEARING, 2 (May 2010). And, just this year, the

Connecticut Attorney General issued a report documenting the escalation of health care costs over a ten-year period in his State. *See* Connecticut Attorney General, REPORT OF THE CONNECTICUT ATTORNEY GENERAL CONCERNING HOSPITAL PHYSICIAN PRACTICE ACQUISITIONS AND HOSPITAL-BASED FACILITY FEES, 4 (Apr. 2014) ("In 2012 the annual family premium was 30% higher than in 2007 and 97% higher than in 2002.").

The unchecked growth in health care costs, as observed in these studies and reports, poses a real threat to the delivery of affordable, quality health care. For example, in testimony before the Pennsylvania Insurance Department in 2013, the executive director of the Pittsburgh Business Group on Health summarized the concerns of its members, who range from major U.S. employers, such as U.S. Steel, H, J. Heinz Company and Alcoa, Inc., to smaller local entities, including local school districts. She noted that if healthcare costs rise, "[e]mployers would be forced to take action to mitigate any future cost increases, choosing from a number of strategies, including reducing or eliminating benefits, reducing or eliminating work forces and/or not expanding or opening new operations in the region." Whipple Testimony at 182-183, *In Re Application of UPE*, No. ID-RC-13-06 (Pa. Insur. Dept. 2013); *see also, e.g.,* EXAMINATION OF HEALTH CARE COST TRENDS, *supra*, at 2; FACILITY FEES REPORT, *supra*, at 4.

A key component of this escalation of costs has been the growth of large health care provider systems with market power, leading to higher prices. In the study *Unchecked Provider Clout*, the authors examined six California geographic regions in 2008 to determine the source and magnitude of regional differences in health care affordability and access for those with insurance. The study found that large health care provider systems possessing market power can acquire the upper hand with insurers in negotiating their compensation for inclusion in the networks marketed to employers, leading to higher premiums. *Unchecked Provider Clout*, *supra*, 29 HEALTH AFFAIRS at 702. The Massachusetts Attorney General, in her report EXAMINATION OF HEALTH CARE COST TRENDS, reviewed market data from 2004-2008 and interviewed market participants throughout Massachusetts. She found that the greater the provider system's market leverage, the higher the prices charged; she also ruled out other factors, such as the percentage of Medicare and Medicaid patients, as causing higher prices. EXAMINATION OF HEALTH CARE COST TRENDS, *supra*, at 10-28.

Similarly, the Connecticut Attorney General found that the sizeable "facility fees" charged by hospitals after they acquired physician practices increased prices for surgical procedures and that these price increases would not have occurred but for provider consolidation. FACILITY FEES REPORT,

supra, at 12-13. The findings of the district court here that the merger would allow the physicians' group to bill at the much higher rate of the hospital system's own hospital-employed physicians echoes this point. Findings of Fact and Conclusions of Law, at 23-25, *Federal Trade Commission et al. v. St. Luke's Health System, Ltd. et al.*, No. 1:13-CV-00560-BLW (Jan. 24, 2014). These situations are not unique. It is common that a merged entity with market power will increase its rates for acquired physician services through hospital-based billing. *See, e.g.*, Consent Decree, *Commonwealth v. Geisinger*, No 1:13 CV-02647-YK (M.D. Pa. Nov. 1, 2013) (as part of consent decree, health system agreed not to bill acquired primary care physicians as hospital-based).

This observed trend of substantially higher prices corresponding to health care provider systems with market power fits recent studies of health care markets. For example, in 2011, Dr. James Robinson published a study examining the relationship between hospital market concentration, prices, and profits, using 2008 patient data involving 11,300 patients treated in 61 hospitals scattered across 27 markets and 8 States. James Robinson, *Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology*, 17 AM. J. MANAGED CARE 241 (2011). Dr. Robinson found that hospitals in concentrated markets were able

to charge commercial insurers more than similar hospitals in competitive markets. *Id.* at 244. He also found that the price differentials for various types of cardiology and orthopedic procedures ranged from 19% to 25% more for hospitals in concentrated markets, giving those hospitals earnings *per patient* that amounted to 64% to 95% more than hospitals in competitive markets. *Id.* at 244, 247.

In response to these observed trends, our States are pursuing a variety of health care measures to increase competition. For example, state entities, policymakers, market participants, employers, and unions are exploring ways to encourage commercially insured health care consumers to make more informed choices so that they can receive the same (or better) quality medical care at a lower cost. *See, e.g.,* Amanda Lechner, Rebecca Gourevitch, Paul Ginsburg, *The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer*, HSC RESEARCH BRIEF NO. 30, 2-3 (Dec. 2013); Pacific Group on Business on Health, PBGH POLICY BRIEF: PRICE TRANSPARENCY, 1-4 (2013). Measures include price transparency that give patients and self-insured employers access to specific cost and quality information, high-deductible plans that increase a patient's incentives to seek cost-effective care, and prohibitions on certain contractual provisions such as anti-steering and anti-tiering that can, for example,

prevent payors from giving particular providers a non-preferred provider status in a Preferred Provider Organization plan). *See, e.g.*, Cal. Health & Safety Code, § 1367.49 [Ca. Sen. Bill 751]; Mass. Gen. Laws Ch. 176J § 11; Mass. Gen. Laws Ch. 176O, § 9A; FACILITY FEES REPORT, *supra*, at 4; Massachusetts Attorney General, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS, REPORT FOR ANNUAL PUBLIC HEARING, 1-2, 10-18, 37-44 (Apr. 24, 2013) (hereinafter "EXAMINATION OF HEALTH CARE COST TRENDS II"); Order, *In re Application of UPE*, No. ID-RC-13-06 (Pa. Insur. Dept. 2013); *Reference Pricing*, *supra*, at 2-7; PBGH POLICY BRIEF: PRICE TRANSPARENCY, *supra*, at 3-7; Morgan Muir, Stephanie Alessi, & Jaime S. King, *Clarifying Costs: Can Increased Price Transparency Reduce Healthcare Spending?*, 4 WILLIAM & MARY POLICY REV. 320-21, 362-65 (2013). However, all of these cost-control measures will have limited effectiveness at best if continued consolidation efforts result in large provider systems with market power. *Cf.* EXAMINATION OF HEALTH CARE COST TRENDS II, *supra*, at 19-37, 62-63; *Clarifying Costs*, *supra*, at 359-62.[7]

[7] The stakes here are even higher for "self-insured" employers, who "rent" a health care plan's network for a fee such that these employers bear the full brunt of any increase in the health care costs of their employees. *Amicus Curiae* States believe, based on their experience, that the proportion of self-insured employers in their States is quite sizeable. *See, e.g., State* (continued…)

III. MERGERS CONTRIBUTE TO LARGE HEALTH CARE PROVIDER SYSTEMS ACQUIRING MARKET POWER AND DRIVING UP COSTS

The *Amicus Curiae* States have seen mergers contribute to large health care provider systems' acquiring market power. That market power, in turn, gives those systems bargaining leverage that they can use in contract negotiations with payors to drive up costs. For example, in 1999, Sutter Health—already a large hospital provider system pre-merger—acquired Summit Medical Center in the San Francisco Bay Area. After the California Attorney General's unsuccessful challenge to the merger, the Federal Trade Commission conducted a retrospective study to determine whether that acquisition in fact increased prices. This retrospective study confirmed that the merger led to prices 23–50% above those that would have prevailed absent the merger. *Sutter Summit Transaction*, *supra*, at 19-23. In 2013, a study modeled the price effects of a proposed acquisition in Northern Virginia of Prince William Hospital by Inova Health Systems, a merger that was abandoned only when the FTC and Virginia tried to block it. Gautam Gowrisankaran, Aviv Nevo & Robert Town, *Mergers When Prices Are*

(…continued)
Trends In Employer-Sponsored Health Insurance, A State-By-State Analysis, April 2013, http://www.shadac.org (in 2011, almost 60% of employers, with more than 50 employees, offered self- insured coverage).

Negotiated: Evidence from the Hospital Industry, working paper (Mar. 1, 2013), *available at* http://www.u.arizona.edu/~gowrisan/pdf_papers/hospital_merger_negotiated_prices.pdf. Examining 2003–2006 claims data from payors and discharge data from Virginia Health Information, a not-for-profit health data organization set up under Virginia law, for a geographical market of approximately 30 minutes driving time for acute in-patient services, the authors found that, had the merger gone through, it would have increased by 3.1% payors' prices for services provided by Prince William Hospital and increased Inova's profits by 9.3%. *Id.* at 17-19, 30-31. Considering that Inova was already dominant with 64% of all of the patients in this geographical area, whereas Prince William Hospital was only the third largest hospital in the area with a 6.6% market share, *id.* at 24, the study's authors correctly considered this price increase to be significant, *id.* at 31.

The acquisition of physician groups by hospital provider networks has had similar effects. *See, e.g.*, Laurence Baker, Kate Bundorf, Daniel Kessler, *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending*, 33 HEALTH AFFAIRS 756, 757 (2014). Using 2001 to 2007 claims data, a 2014 study examined hospital prices, admissions, and spending to determine the effects of hospital-

physician vertical integration, hospital market competitiveness, and other characteristics of hospital markets. *Vertical Integration*, 33 HEALTH AFFAIRS at 757-58. The study concluded that the market share of fully integrated vertical hospital-physician organizations had increased from 23% to 35%; that this market share increase was associated with an increase in hospital prices of 3.2% for each one-standard deviation percentage increase in market share; and that there was a 4.2% price increase for each one-standard deviation increase in market concentration. *Id.* at 760-61.

The effect of these price increases on health care affordability has been of such concern that some States have imposed conditions on the acquisitions of hospitals or physician groups even under levels of market concentration lower than those present in this case. For example, the Pennsylvania Office of Attorney General has imposed remedies for several such prospective mergers even when, in contrast to this case, actual efficiencies existed or financial conditions precluded the parties' continued independent operation. That range of remedies has included requirements to maintain existing health plan contracts and, for future contracts, to negotiate in good faith with health plans or become subject to binding arbitration; to prohibit most-favored-nation provisions and anti-tiering and anti-steering provisions in contracts with health plans; prohibiting hospital-based billing

of physicians; and to maintain an open medical staff. *See, e.g.*, Consent Decree, *Commonwealth v. Geisinger*, No. 1:13 CV-02647-YK (M.D. Pa. Nov. 01, 2013); Consent Decree, *Comm. of Pennsylvania v. Urology of Central Pennsylvania,* No. 1:11-CV-01625-JEJ (M.D. Pa. Aug. 31, 2011).

The reasons that price increases flow from acquisitions by hospital provider systems with increased market power are simple: health care markets are local and, in such markets, patients are insensitive to price. That is, patient demand for general, acute care health services is inelastic because insured patients pay out-of-pocket only a very small fraction of their total health care costs, about 2–3%. *See, e.g.*, Gowrisankaran, Nevo, Town, *supra,* at 26, 30, 35.[8] If health care costs to payors increase, this increase does not result in individual, insured consumers seeking lower-cost health care further from where they live and work. That is why *Amicus Curiae* States believe that merger analysis in the health care sector must focus on the negotiations between health care providers and payors. It must take

[8] However, even if patients paid a far greater percentage of costs, it is not necessarily the case that a sufficient number of patients would travel farther for care in response to price increases. Such a conclusion would depend upon other circumstances in the relevant market such as the availability of price transparency as to the provider alternatives for a given procedure as well as the available alternatives within a *reasonably* convenient travel time.

account of the ability of large health care provider systems to increase prices without significant impact on demand where acquisitions of hospitals or physician groups give them market power in negotiations with payors. *See, e.g., id.* at 35.

IV. APPLYING THE PROPER "OPTION DEMAND" MODEL, THE COURT BELOW REACHED THE CORRECT RESULT IN HOLDING DEFENDANTS-APPELLANTS' MERGER UNLAWFUL

Two principal, competing economic approaches have been used to determine the scope of geographic markets in health care merger cases involving hospitals or hospitals and physician groups. One is the older Elzinga-Hogarty test ("E-H" test), which purports to delineate a market's boundaries by estimating patient inflows and outflows (using admission and discharge data) from a proposed geographic market to determine whether enough patients would go elsewhere in response to a price increase such that an increase would not be feasible. *See, e.g.*, *California v. Sutter Health Sys.*, 130 F. Supp. 1109, 1124 (N.D. Cal. 2001). In this case, though the expert for the Defendants superficially disclaimed use of the E-H test, he applied a patient flow analysis that in effect amounted to a use of this test. The model that more accurately mirrors the facts on the ground in health care and has replaced the E-H test is known as Option Demand, which focuses on the alteration in bargaining strength between a payor and a hospital provider as

the result of an acquisition. *See, e.g.*, *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 569-72 (6th Cir. 2014); *see also In re Evanston Nw. Healthcare*, No. 9315, 2007 WL 2286195, at **63-66 (FTC Aug. 6, 2007). *Amicus Curiae* States' experiences have led them through an evolution in thinking similar to that of their federal counterparts. *See* Fed. Trade Comm'n & U.S. Dep't of Justice, *Improving Healthcare: A Dose of Competition* ch. 4, at 6, 8-10 & nn.38-48 (July 2004). Like the FTC, the *Amicus Curiae* States are replacing the E-H test in their investigations with the Option Demand model. *Amicus Curiae* States have found that the Option Demand model better reflects the economic realities of their local markets and, as used in the findings of fact and conclusions of law of the court below, fits squarely within prior case law.

More specifically, like their federal counterparts, *Amicus Curiae* States have determined that that the older E-H test suffered from several flaws insofar as reviewing prospective mergers was concerned: (1) it did not reflect the fact that most patients travel for reasons other than price; (2) it did not factor in how highly patients value the ability to visit a local hospital as opposed to a more distant one because they cannot know their medical needs in advance; (3) it did not reflect how prices are actually negotiated between insurers and providers; and (4) it predicted that mergers were unlikely to

result in price increases when, in fact, retrospective analysis found the exact opposite to have occurred. *See, e.g.*, *From Rockford to Joplin and Back Again*, *supra*, at 16-18, 26 & n.38; *Sutter Summit Transaction*, *supra*, at 1-2, 19-23; Opinion of the Federal Trade Commission at 10-11, *In re Evanston Nw. Healthcare*, 2007 WL 2286195, at **63-66. In contrast, the Option Demand methodology sets out a robust analysis, based on multiple studies of health care markets, which focuses on the negotiations between insurers and providers over inclusion in the insurance networks marketed to employers for use by their employees, and then calculates the change in bargaining position occasioned by a proposed merger. *See, e.g.*, *From Rockford to Joplin and Back Again*, *supra*, at 19-36; *Sutter Summit Transaction*, *supra*, at 11-14. In our view, that methodology can and should be applied to a hospital acquisition of a physician group just as it can be applied to a hospital acquisition of another hospital. Julie Carlson, Leemore Daffny, Beth Freeborn, et al., *Economics at the FTC: Physician Acquisitions, Standard Essential Patents, and Accuracy of Credit Reporting*, SPRINGER ONLINE 303, 306-11 (2013).

The use of this Option Demand methodology can often generate more localized geographical markets than the older E-H test, *see, e.g.*, *From Rockford to Joplin and Back Again*, *supra*, at 26 & n.38, as it did here when

the district court found Nampa, Idaho to be its own market. But, based on the *Amicus Curiae* States' experiences, these more localized geographic markets accurately reflect the realities of those markets. Various limitations and barriers contribute to such local markets, ranging from the potential for traffic jams at inconvenient times of the day to the need for employers in competitive industries to offer to their workers health care networks with close-at-hand alternatives. *Cf.*, *e.g.*, Joy Grossman, Ha Tu, Dori Cross, *Arranged Marriages: The Evolution of ACO Partnerships in California*, CALIFORNIA HEALTH CARE ALMANAC, REGIONAL MARKETS ISSUES BRIEF, 10 (September 2013) (postulating that there are few Accountable Care Organizations ("ACO") in the San Francisco Bay Area because the dominant hospital provider system, Sutter, faces little competitive threat aside from an integrated insurance-provider organization known as Kaiser due to geographic barriers); *In re Evanston Nw. Healthcare*, 2007 WL 2286195, at **7-8, 63-66 (employers need to offer health care plans that are attractive to their employees and employees prefer health plans that are geographically convenient for them and their families). Moreover, as we have seen in our investigations, because some treatments are extended or ongoing, such as radiation oncology for cancer patients, which must be received five days a week for eight to nine weeks, it is important for such

patients who work, are elderly or infirm, rely on public transit, or have family responsibilities to have such alternatives close by. Consent Decree, *Commonwealth v. Urology of Central Pennsylvania, Inc.*, No. 1:11-CV-01625-JEJ (M.D. Pa. Aug. 31, 2011).

The District Court's local, Nampa-only geographic market, Findings of Fact and Conclusions of Law, *supra*, at 12-23, 51, thus fits our experiences in reviewing health care acquisitions. These findings also fit the case law. Courts have been willing to affirm the existence of local geographic markets involving physician groups or hospitals. *See, e.g., Oltz v. St. Peter's Cmty. Hosp.*, 861 F.2d 1440, 1447 (9th Cir. 1988) (concluding it was "inescapable" that the geographic market for hospital anesthesia services was limited to Helena, Montana); *see also, e.g., Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1411 (7th Cir. 1995) ("[T]he market for physician services . . . for primary care anyway (an important qualification—people will go a long way for a liver transplant) . . . is a local one."). Moreover, courts have affirmed the use of the Option Demand model. *See, e.g., ProMedica*, 2014 WL 1584835, at *2. And no court has held that only the E-H test can be used to analyze hospital mergers. *Cf. Sutter Health Sys.*, 130 F. Supp. 2d at 1124 ("[T]he E-H test is only a starting point in analyzing a geographic market."); *see generally Alaska*

Rent-A-Car, Inc. v. Avis Budget Group, Inc., 738 F.3d 960, 969-970 (9th Cir. 2013) (citing *inter alia Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 141, 150-51, 153 (1999) for the proposition that the district court does not abuse its discretion in refusing to choose between competing expert methodologies so long as one of those methodologies is not "unreliable nonsense").

Finally, the States have, in light of their own experience, begun to understand that anti-competitive effects arising from hospital acquisition of physician groups are exacerbated by physician referrals that funnel patients to the acquiring hospital and away from that hospital's competitors. *Cf. Vertical Integration, supra,* at 756 ("By employing or contracting with physicians, hospitals may increase their market power by amassing control over a larger bundle of services or depriving their rivals of a source of, or destination for, referrals."); Ann O'Malley, Amelia Bond, and Robert Berenson, *Rising Hospital Employment of Physicians: Better Quality, Higher Costs?*, CENTER FOR HEALTH SYSTEM CHANGE, ISSUE BRIEF NO. 36, 1, 2, 4 (Aug. 2011) (increase in hospital employment of physicians leads to an increase in referrals that can raise costs without increasing quality absent reform of the payment structure); *see also, e.g.*, Consent Decree, *Commonwealth v. Geisinger*, *supra* (proposed transaction would result in health care system controlling almost 70% of the primary care physicians in

the relevant market; the physicians would be "revenue drivers" as they would control referrals to specialty physicians, inpatient services, and outpatient services). The findings of the District Court—that the anti-competitive effects of the proposed merger are enhanced by the referral problem, Findings of Fact and Conclusions of Law, *supra*, at 25-27—match this experience.

V. AN ANTI-COMPETITIVE HEALTH CARE MERGER SHOULD NOT RECEIVE SPECIALIZED IMMUNITY FROM THE ANTITRUST LAWS IN ORDER TO REALIZE POLICY GOALS, ESPECIALLY WHEN LESS RESTRICTIVE ALTERNATIVES ARE AVAILABLE

Defendants-Appellants contend that the instant merger is justified by (1) the need to implement clinical integration to improve the quality of medical care, (2) the requirements of the ACA that encourage clinical integration efforts, and (3) the often not-for-profit status of hospital provider systems in carrying out charity care for Medicare, Medicaid, and indigent patients. However, none of these justifications applies.

A. Less Restrictive Alternatives Can Achieve Clinical Integration Goals

First, the need for clinical integration can be and is being addressed by means that are consistent with maintaining healthy competition. Integration does not require anti-competitive acquisitions by hospitals. In particular, integrated joint venture-type organizations involving payors, physician

groups, and (sometimes) hospitals are presently being set up in the States—with potentially very promising results for improvements in the delivery of quality health care at a lower cost. *See, e.g.*, Stephen Shortell, Sean McClellan, Patricia Ramsay, et al., *Physician Practice Participation in Accountable Care Organizations: The Emergence of the Unicorn*, HEALTH SERVICES RESEARCH 1 (2013). These integrated health care management organizations are jointly accountable for the quality and care of a patient population, and agree to share cost savings. Examples include local network or tiered network integrated health care management organizations in small geographical areas—formed by a partnership of a payor, a physician group, and (in some cases) a hospital—that incentivize patients to use those networks and that are in turn incentivized to meet cost and quality goals. *See, e.g.*, *Arranged Marriages*, *supra*, CALIFORNIA HEALTH CARE ALMANAC, at 5-9.

The upgrades to information technology necessary to share patient records do not require a merger. *See, e.g.*, *id.* at 11 (speaking to need of a sizeable physician's group in California participating in integrated venture to spend $1 million to upgrade information infrastructure and improve case management). But many of these entities are of sufficient size to upgrade their information technology themselves. *See Physician Practice*

Participation, supra, HEALTH SERVICES RESEARCH at 11-12. To date, it is mostly large physician organizations of 100+ members that have joined these integrated ventures but, as the report further asserts, it is especially important that large multi-specialty and independent patient home organizations are interested in joining such ventures because they can give physicians in smaller practices the opportunity to share case management and resources. Additionally, health care plans have, in at least one instance, confirmed that the payors themselves can provide assistance for these upgrades. *See* Brief of *Amicus Curiae* America's Health Insurance Plans at 21-22, *Promedica Health Care Systems v. Federal Trade Commission*, No. 12-3583 (Nov. 21, 2012). Further, the streamlining of processes among the participants in such ventures can enable them to realize cost savings to make these upgrades without the need for participants to merge. *See, e.g.*, *Arranged Marriages, supra*, CALIFORNIA HEALTH CARE ALMANAC, at 11-12. In fact, though it is too early to know as a definite matter how successful these organizations will be, there are some initial promising signs. *See, e.g.*, *id.* at 13 (one integrated health care management organization involving some of *Amicus Curiae* State of California's employees held premium growth to 0% in 2010, resulting in premium savings to the State of $15.5

million, with the partners to the venture sharing an additional $5 million in premium savings).

Against this backdrop, parties to an anti-competitive merger involving competing hospitals, or hospitals and physician groups, bear the burden to show why such alternatives cannot work and lay out measurable and achievable clinical integration benefits that will result and that are sufficient to counterbalance the merger's otherwise anti-competitive effects. *Cf.* Patrick Romano, David Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare*, 18 INT. J. ECONOMICS BUS. 45, 46 (2011) (analyzing publicly available quality measures and data, authors found little evidence that the otherwise anti-competitive merger improved the quality of medical care at the acquired hospital); *Rising Hospital Employment of Physicians*, *supra*, at 3 (based on market surveys, authors of study concluded that "[w]hile hospital employment of physicians may spur clinical integration that will ultimately improve efficiency and help to control costs, they are more likely to increase costs in the short run"). The district court properly found that Defendants-Appellants had not met their burden here. Findings of Fact and Conclusions of Law, *supra*, at 33-38, 47.

B. The Affordable Care Act Does Not Provide Immunity for an Anti-Competitive Merger

Nor does the ACA provide a defense against an anticompetitive merger. The ACA expressly makes clear that nothing about it is intended to limit the reach of the antitrust laws: "Nothing in this title (or an amendment made by this title) shall be construed to modify, impair, or supersede the operation of any of the antitrust laws." 42 U.S.C. § 18118(a). While the ACA contains provisions allowing physicians and hospitals participating in the Medicare Shared Savings Program to form Accountable Care Organizations that invite a limited degree of competitor collaboration, the federal antitrust agencies' official enforcement policy regarding ACOs notes explicitly that it "does not apply to mergers." Fed. Trade Comm'n & Dep't of Justice, *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*, 76 Fed. Reg. 67,026, 67,027 (Oct. 28, 2011). Moreover, the Centers for Medicare and Medicaid Services, which enforce the ACO provisions of the ACA, have expressly stated that "[t]he statute permits ACO participants that form an ACO to use a variety of collaborative structures, including collaborations short of a merger. . . . We reject the proposition that an entity under single control, that is an entity formed

through a merger, would be more likely to achieve this [ACA's] aim." Centers for Medicare and Medicaid Services, *Medicare Shared Savings Program for Accountable Care Organizations*, 76 Fed. Reg. 67802, 67843 (Nov. 2, 2011).

C. The Not-for-Profit Role of a Health Care Provider in Providing Charity Care Does Not Provide Immunity for an Anti-Competitive Merger

Finally, *Amicus Curiae* States often have special oversight over, and thus special insight into, charitable, not-for-profit organizations in the health care sector. This can include special oversight responsibilities whenever a not-for-profit hospital is acquired or wishes to engage in an acquisition of its own. *See, e.g.*, Cal. Gov. Code §§ 12588, 12598, 12591.2; Cal. Corp. Code § 6010. Thus, we can speak to the issue of whether the not-for-profit role of one of the merging parties in providing charity care entitles the proposed transaction to special consideration under the antitrust laws.

Generally speaking, nonprofit organizations are not immune from antitrust liability based on their choice of corporate form, and can seek monopoly profits and cause competitive injury just as effectively as a for-profit company. 1B Phillip Areeda & Herbert Hovenkamp, ANTITRUST LAW ¶ 261a (3d ed. 2006). A nominally "not for profit" hospital may earn a healthy accounting profit, *Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1390–

91 (7th Cir. 1986), and then apply that surplus to lucrative rewards for board members and managers or to subsidizing non-hospital activities that are part of a larger organization, 1B Areeda & Hovenkamp, *supra*, ¶ 261a, rather than to lowering the cost, or increasing the reach, of patient services. And a not-for-profit can invest monopoly surpluses in acquisitions that further entrench its dominant position as in the instant case. Clark Havighurst & Barak Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 859–60 (2011). It is true that not-for-profit health care institutions have a fiduciary duty to engage in charity care involving Medicare, Medicaid, and uninsured patients. But the ability of not-for-profits to accomplish this mission does not depend on acquiring market power and charging monopoly prices to those who are commercially insured. *Cf. Medicare Savings Program*, *supra*, 76 Fed. Reg. at 67843; *In re Evanston Nw. Healthcare*, 2007 WL 2286195, at **39-41, 70-73; *Sutter Summit Transaction*, *supra*, at 19-23. The District Court thus properly found that Defendant-Appellant St. Luke's Healthcare System was not entitled to special status or immunity insofar as its acquisition of Defendant-Appellant Saltzer Medical Group was concerned. *See* Findings of Fact and Conclusions of Law, *supra*, at 40-41, 50-51.

CONCLUSION

For all of the foregoing reasons, the States of California, Washington, and Pennsylvania, joined by the States of Connecticut, Delaware, Illinois, Iowa, Kentucky, Maine, Maryland, Mississippi, Montana, Nevada, New Mexico, Oregon, and Tennessee respectfully submit that this Court should affirm the district court's opinion.

Dated:

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Case No. 14-35173

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

ST. LUKE'S HEALTH CARE SYSTEM; SALTZER MEDICAL GROUP P.A.,

Defendants-Appellants,

v.

FEDERAL TRADE COMMISSION; STATE OF IDAHO,

Plaintiffs-Appellees.

STATEMENT OF RELATED CASES

To the best of our knowledge, the case of *The Associated Press v. United States District Court*, No. 13-73931, while it arises out of the same case in the district court, has no relation to the merits of this case.

/s/ Emilio Varanini

August 20, 2014

CERTIFICATE OF SERVICE

I certify that on August 20, 2014, I electronically filed the foregoing BRIEF OF AMICUS CURIAE THE STATES OF CALIFORNIA, WASHINGTON, PENNSYLVANIA, CONNECTICUT, DELAWARE, ILLINOIS, IOWA, KENTUCKY, MAINE, MARYLAND, MISSISSIPPI, MONTANA, NEVADA, NEW MEXICO, OREGON, AND TENNESSEE with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

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

/s/ Emilio Varanini

August 20, 2014

CERTIFICATE OF COMPLIANCE
PURSUANT TO FED.R.APP.P 32(a)(7)(C) AND CIRCUIT RULE 32-1
FOR «Matter Primary Court Case #»

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August 20, 2014
Dated

/s/
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