No. 14-35173

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

SAINT ALPHONSUS MEDICAL CENTER-NAMPA INC., *et al.*,
Plaintiffs-Appellees,

v.

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

Appeal from the United States District Court for the
District of Idaho, Case No. 1:12-cv-00560-BLW, *et al.*

BRIEF FOR *AMICUS CURIAE* CENTER FOR PAYMENT REFORM IN SUPPORT OF PLAINTIFF/APPELLEE THE FEDERAL TRADE COMMISSION AND AFFIRMANCE OF THE DISTRICT COURT'S ORDER

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, *Amicus Curiae* Center for Payment Reform ("CPR") certifies that it is a non-profit organization that does not have any parent company and no entity or individual owns any stock in CPR.

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No party's counsel authored this brief in whole or in part. No party, party's counsel, or any other person – other than the *Amicus Curiae* – contributed money intended to fund the preparation or submission of this brief.

Amicus Curiae has obtained the consent of all parties to file this brief.

INTEREST OF AMICUS CURIAE

Amicus Curiae Catalyst for Payment Reform ("CPR") is an independent, nonprofit organization working to promote high-value health care in the United States by catalyzing improvements in how consumers pay for health care services. CPR is composed of over 30 private and public health care purchasers, including the Boeing Company, GE, Wal-Mart Stores, Inc., four state Medicaid agencies, and four state employee and/or retiree agencies. A full list of our members is in Appendix A.

CPR members spend more than $59 billion on health care expenditures annually and cover almost 12 million people. While setting high expectations for the quality of care, CPR identifies and coordinates workable payment reforms, tracks our nation's progress in this area, and promotes alignment between public and private sector strategies. This work has led CPR directly to examining the effect of the consolidation of health care providers[1] on rising health care costs, which are increasing at an unsustainable rate.

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[1] Consolidation is defined as "the joining together of multiple parts into one whole." Specifically, in the healthcare industry, provider consolidation is the joining of one or more providers (either physicians, hospitals, or any combination of physicians and hospitals) into one entity with the ability to coordinate its overall business strategy. This consolidation often influences the level of concentration of firms within a given market. Market concentration is a function of the number of firms in a market and their respective market shares. Most studies of the relationship between competition and hospital prices have found that high hospital concentration (*i.e.*, the market is dominated by one or two hospitals or hospital systems) is associated with increased prices, regardless of whether the hospitals are (footnote continued)

Employers, who provide almost 50 percent of the U.S. population with health care benefits, are struggling to manage healthcare costs, the rise of which results in higher premiums, lower benefits, and lower wages for employees.[2,3] Concerned about providing affordable benefits to their employees over time, employers see the maintenance of competition in health care markets as critical to quality improvement and cost reduction. Moreover, given the local nature of health care delivery, even national employers still only represent a small portion of any given local market and typically lack adequate leverage to impact the price of care. Therefore, ensuring competition among providers is critical to all employers' ability to afford health care.

Amicus Curiae's interest is to promote competition in health care markets and limit unwarranted increases in health care costs due to provider market power. With almost half of the U.S. population receiving health care benefits through employers, the business community has a strong interest in antitrust enforcement to

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for-profit or nonprofit. *See* Catalyst for Payment Reform, *Provider Market Power in the U.S. Health Care Industry: Assessing its Impacts and Looking Ahead* (Nov. 2013), *available at* http://catalyzepaymentreform.org/images/documents/Market_Power.pdf.

[2] Kaiser Family Foundation, Health Insurance Coverage of Total Population, *available at* http://kff.org/other/state-indicator/total-population (last accessed July 30, 2014).

[3] Katherine Baicker and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums." 24 *Journal of Labor Economics* No. 3 (2006).

help maintain competition in health care markets as part of managing its overall health care costs.[4]

SUMMARY OF ARGUMENT

Competition in health care markets is associated with lower prices and better care, as providers compete against one another for patients and dollars.[5] However, health care markets throughout the United States are becoming less competitive as health care providers continue to consolidate.[6] This reduction in competition has increased the market power[7] of providers, who leverage that power to increase their prices for health care services.[8] In fact, rising health care prices—as distinguished from other aspects of health care markets—are the single biggest driver of health care cost growth today.[9] Although many health care providers

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[4] Kaiser Family Foundation, *supra* note 2.
[5] David Dranove, Mark Shanley, and William D. White, "Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition," 36 *Journal of Law and Economics* No. 1, 179-204 (1993); Glenn A. Melnick, Yu-Chu Shen, and Vivian Yaling Wu, "The Increased Concentration of Health Plan Markets Can Benefit Consumers Through Lower Prices," 30 *Health Affairs* No. 9, 1728-1733 (2011).
[6] David M. Cutler, PhD and Fiona Scott Morton, PhD, "Hospitals, Market Share, and Consolidation," 310 JAMA No. 18, 1964-70 (2013).
[7] N. Gregory Mankiw, *Principles of Microeconomics*, Cengage Learning (7th ed. 2014).
[8] Jean Marie Abraham, Martin Gaynor, and William B. Vogt, "Entry and Competition in Local Hospital Markets," 55 *Journal of Industrial Economics* No. 2 (2007)
[9] Paul B. Ginsberg, "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power," HSC Research Brief No. 16, *available at*
(footnote continued)

argue that improved efficiencies and economies of scale achieved through mergers will decrease costs and improve the quality of care, there is virtually no evidence to support such claims.[10] There is, however, overwhelming evidence that consolidation among health care providers leads to increases in health care prices and that the quality of care improves with greater competition among health care providers.[11]

Entities opposed to antitrust scrutiny of provider consolidation also argue that employers and other health care purchasers may use their purchasing practices to stimulate competition among health care providers. This argument ignores the fact that each of these employers typically represents only a relatively small number of insured people in any particular market, and therefore typically lacks the leverage necessary to lower prices. Antitrust enforcement offers a more powerful

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http://www.hschange.com/CONTENT/1162/1162.pdf; *see also* Office of Attorney General Martha Coakley, Examination of Health Care Cost Trends and Cost Drivers (pursuant to G.L. c. 118G, § 6 ½(b)) 3-4 (March 16, 2010), *available at* www.mass.gov%2Fago%2Fdocs%2Fhealthcare%2F2010-hcctd-full.pdf ("Price variations are not correlated to [*inter alia*] the sickness of the population … [or whether] … a large portion of patients [are] on Medicare or Medicaid … [but] … Price variations are correlated to market leverage as measured by the relative market position of the hospital or provider group.").

[10] Cutler, *et al.*, *supra* note 6.

[11] Martin Gaynor, PhD and Robert Town, PhD, "The impact of hospital consolidation—Update," Robert Wood Johnson Foundation: The Synthesis Project, Policy Brief No. 9, *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.

and critical tool to maintain and enhance competitive health care markets. Given the research, CPR supports the district court's ruling to prohibit the St. Luke's-Saltzer merger. Specifically, CPR supports the court's determinations that: 1) the burden of proof with respect to efficiencies should fall upon the merging parties once market power is demonstrated; 2) the Affordable Care Act ("ACA" or "the Act") does not explicitly endorse provider consolidation and clinical integration can be achieved without consolidation; and 3) primary care services are an inherently local service.

ARGUMENT

I. Employers Have a Strong Interest in Lowering Health Care Costs While Improving Health Care Quality to Improve the Health Services They Offer Their Employees

Patients, purchasers, health plans, providers, and policymakers all agree today's health care system does not consistently provide value, *i.e.*, high-quality care delivered efficiently at an affordable price. Perhaps the most difficult challenge to achieving value is lowering costs or at least slowing their growth. Health care expenditures account for nearly all projected structural deficits at the federal level[12] and for a major—if not *the* major—component of state budget

[12] Judith Hibbard, Dr. P.H. and Shoshanna Sofaer, Dr. P.H., "Best Practices in Public Reporting No. 1: How To Effectively Present Health Care Performance Data To Consumers," prepared for Agency for Healthcare Research and Quality (footnote continued)

outlays each year.[13] Despite a slowdown in health care spending in 2009 and 2011, national health expenditure projections show spending on health care services will increase to 20 percent of Gross Domestic Product by 2020.[14,15]

With employers footing the bill for the nearly 50 percent[16] of Americans enrolled in employer-sponsored insurance today, representing approximately 21 percent[17] of the nation's overall health care spending, the unsustainable growth of health care costs is a critical concern. Health care benefits represent 30 percent of total compensation paid out by employers.[18] In a recent survey of almost 600 national employers, 95 percent of respondents indicated that health care benefits

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(2010); Ginsburg, "Shopping for Price in Medical Care," 26 *Health Affairs* No. 2, 208-216 (2007).

[13] Kaiser Family Foundation, 2010 Employer Health Benefits Survey, *available at* http://ehbs.kff.org/pdf/2010/8085.pdf.

[14] Kaiser Family Foundation, "Assessing the Effects of the Economy on the Recent Slowdown in Health Spending," Issue Brief, April 22, 2013, *available at* http://kff.org/health-costs/issue-brief/assessing-the-effects-of-the-economy-on-the-recent-slowdown-in-health-spending-2/.

[15] Centers for Medicare & Medicaid Services, National Health Expenditure Projections 2012-2022, *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2012.pdf.

[16] Kaiser Family Foundation, *supra* note 2.

[17] California Healthcare Foundation, Supplement to *Health Care Costs 101* (2013 Edition), *available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HealthCareCostsQRG13.pdf.

[18] Employee Benefit Research Institute, "FAQs About Benefits- General Overview," *available at* http://www.ebri.org/publications/benfaq/index.cfm?fa=ovfaq1.

for active employees are a very important offering.[19] Facing unsustainable increases in the cost of care, employers have been shifting an increasing proportion of the cost to their employees. Employees' average out-of-pocket expenses, including copayments and deductibles, increased almost 13 percent in 2013, totaling $2,239, and are expected to continue to rise in the coming year.[20, 21] Ultimately, the increases in health care costs are passed on to consumers in the form of higher premiums, lower benefits, and lower wages.[22]

II. Antitrust Enforcement, Including the District Court's Ruling to Enjoin the Merger in Question, is the Best Tool to Address Provider Market Power and the Higher Healthcare Costs that Result from Excessive Consolidation

As referenced above, employers alone do not have sufficient leverage to lower prices through their purchasing practices, and therefore must rely on antitrust enforcement by federal and state agencies and courts to address the growing issue of provider market power.

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[19] Towers Watson, "U.S. Employers Experiencing Smallest Increases in Health Care Costs in 15 Years," March 6, 2014, *available at* http://www.towerswatson.com/en-US/Press/2014/03/us-employers-experiencing-smallest-increases-in-health-care-costs-in-15-years.

[20] Aon, "Aon Hewitt Analyses Shows Lowest U.S. Health Care Cost Increases in 15 Years," Aon News Release, October 17, 2013, *available at* http://aon.mediaroom.com/2013-10-17-Aon-Hewitt-Analysis-Shows-Lowest-U-S-Health-Care-Cost-Increases-in-More-Than-a-Decade.

[21] *Id.*

[22] Baicker, *et al.*, *supra* note 3.

A. The history of health care consolidation supports the district court's decision to allocate the burden of demonstrating efficiencies on the merging parties once market power is demonstrated

Substantial health services research demonstrates that health care consolidation can increase market power, which is associated with higher prices, less efficient outcomes, and misallocation of resources, whereas only minimal research supports the claim that such consolidations produce cost savings.[23] The major concern, therefore, is that health care providers will use the enhanced market power from consolidation to raise prices. Although there are many factors that affect health care costs, there is broad agreement among health care economists that provider consolidation is a major cost driver and is associated with significant payment variation across and within markets for both hospital and physician services.[24]

Basic economic theory predicts that competition, occurring when many parties sell similar goods and services, lowers prices and improves quality, as sellers must compete against one another.[25] In cases where no competition exists and there is one dominant seller—a monopoly—or in cases where little competition exists—such as an oligopoly—prices are generally higher and the

[23] Cutler, *et al.*, *supra* note 6.
[24] Ginsburg, *supra* note 9.
[25] Mankiw, *supra* note 7.

seller can essentially set and control the price.[26] In addition to creating a market where firms can charge higher prices, economic theory predicts that concentrated markets also prevent new firms with potentially greater efficiencies from entering the market and charging lower prices.[27] The U.S. health care market has become less competitive as consolidation among health care providers has increased, leaving the market vulnerable to increases in prices by dominant providers without a corresponding increase in quality.

Over the past two decades, hospitals in the United States have become highly concentrated as they have shifted away from independent status and merged with other competing facilities, or integrated with multi-hospital systems. The hospital Herfindahl-Hirschman Index (HHI),[28] which measures market structure, has increased by 40 percent in health care markets since the mid-1980s.[29] By 2006, over 75 percent of U.S. metropolitan statistical areas ("MSAs") had

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[26] Timothy F. Bresnahan, "Empirical studies of industries with market power," *Handbook of Industrial Organization*, ed. 1, vol. 2, n. 2; Carl Shapiro, "Theories of Oligopoly Behavior," *Handbook of Industrial Organization*, ed. 1, vol. 1, n. 1.

[27] *Id.*

[28] The HHI is the sum of squared market shares in the market. The Index increases as market shares are more concentrated among a small number of hospitals. It reaches its maximum value of 10,000 for a monopoly (the square of the monopolist's market share of 100 percent), and reaches a minimum value when the market is equally divided. The Department of Justice (DOJ) and Federal Trade Commission (FTC) guidelines define a market as "highly-concentrated" if the HHI exceeds 2,500.

[29] Cutler, *et al.*, *supra* note 6.

experienced enough provider consolidation to be considered "highly consolidated."[30] From 2007 to 2012, 432 hospital merger and acquisition deals were announced, involving a total of 835 hospitals.[31] This trend accelerated; there was a noted increase in hospital mergers and acquisition activity from 2010 to 2012, accounting for a 25 percent increase in the number of deals compared to the previous three-year period.[32]

U.S. health care providers' capacity to extract higher prices is growing. Chart 1 below shows the growth in prices paid by private payers for hospital inpatient care and the growth in the hospital market basket index from 1992 to 2010. The "hospital market basket index" (bottom line in the chart) tracks year-to-year growth in the cost of hospital inputs (wages, supplies, utilities, contractual services and capital, etc.). The "hospital producer price index, private payers" (top line) measures the prices hospitals get paid per discharge by private payers. The growing divergence between the two lines demonstrates that over the past decade hospitals have used their increasing negotiating leverage to obtain higher prices from private payers, over and above the growth in input costs.

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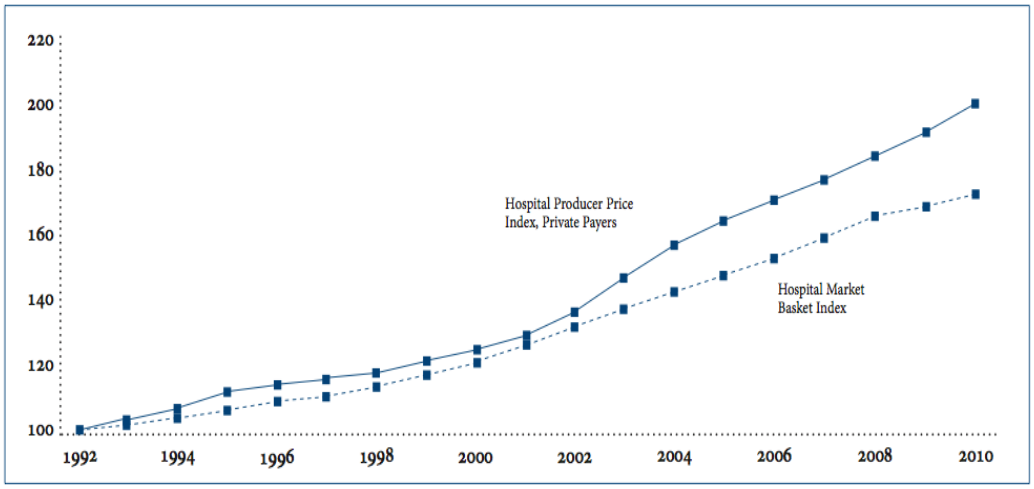
[30] Martin Gaynor, Statement before the Committee on Ways and Means, Health Subcommittee, U.S. House of Reps, Washington, D.C. (Sept. 9, 2011), *available at* http://waysandmeans.house.gov/uploadedfiles/gaynor_testimony_9-9-11_final.pdf.
[31] Cutler, *et al.*, *supra* note 6.
[32] Irving Levin Associates, Inc., "Hospitals: Buying, Selling, and Valuing," Report recorded Apr. 8, 2013, *available at* http://www.levinassociates.com/pr2013/pr1304bconference.

Chart 1: Growth in Prices Paid by Private Payer for Hospital Inpatient Care vs. Growth in the Hospital Market Basket Index, 1992-2010[33]



Note: The "hospital producer price index, private payers," measures trends in the price paid per hospital discharge and includes data for patients who are not covered by Medicare or Medicaid (private payers) and who are treated at general medical and surgical hospitals. The "hospital market basket index" measures trends in the prices of hospital inputs (i.e. goods and services, such as nurse labor, used to produce hospital care).

Sources: Data for the hospital producer price index are from the Bureau of Labor Statistics (series ID: PCU62211A62211A6). Data for the hospital market basket index are from two different sources. For the years 1992 through 1995, data are from The Lewin Group, The Balanced Budget Act and Hospitals: The Dollars and Cents of Medicare Payment Cuts *(May 1999). For the years 1995 through 2010, data are from Centers for Medicare & Medicaid Services (CMS), Quarterly Index Levels in the CMS Prospective Payment System (IPPS) Hospital 2006 Input Price Index using HIS Global Insight Inc.(IGI) Forecast Assumptions, by Expense Category: 1995-2020 (2011).*

An analysis of existing research examining the impact of provider consolidation on health care price and quality concluded the following four points[34]:

1. *Increases in hospital market concentration increase the price of care*[35]

Multiple studies have modeled, with varying methodologies, the impact of provider consolidation on healthcare prices and found that increases in hospital

[33] Anna Sommers, Chapin White, and Paul B. Ginsberg, "Addressing Hospital Pricing Leverage through Regulation: State Rate Setting, NIHCR Policy Analysis No. 9 (May 2012).
[34] Gaynor, *et al.*, *supra* note 11.
[35] Abraham, *et al.*, *supra* note 8.

market concentration increase the price of care.[36,37] Analyses consistently show that highly concentrated markets experience a greater increase in prices than less concentrated markets.[38,39,40]

In addition, a few studies have taken a retrospective look at the impact on price of hospital mergers in already concentrated markets and determined that, in these markets, consolidation increases prices significantly[41]—at least 20 percent[42] to as high as 40 percent.[43] For example, in a comparison of pre-merger claims with post-merger realities, an analysis of the Sutter-Summit transaction in Northern

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[36] William B. Vogt, Ph.D and Robert Town, Ph.D, "How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?" Robert Wood Johnson Foundation: The Synthesis Project, Research Synthesis Report No. 9 (Feb. 2006), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1.

[37] Gaynor, *et al.*, *supra* note 11.

[38] Dranove, *et al.*, *supra* note 5.

[39] Melnick, *et al.*, *supra* note 5.

[40] Steven Tenn, "The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction," FTC Bureau of Economics Working Paper No. 293 (Nov. 2008), *available at* http://www.ftc.gov/sites/default/files/documents/reports/price-effects-hospital-mergers%C2%A0-case-study-sutter-summit-transaction/wp293_0.pdf.

[41] Gaynor, *et al.*, *supra* note 11.

[42] Deborah Haas-Wilson and Christopher Garmon, "Hospital Mergers and Competitive Effects: Two Retrospective Analyses," 18 *International Journal of the Economics of Business* No. 1, 17-32 (2011).

[43] Leemore Dafny, "Estimation and Identification of Merger Effects: An Application to Hospital Mergers," 52 *Journal of Law and Economics* No. 3 (2009); Aileen Thompson, "The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover-Cape Fear Transaction," 18 *International Journal of the Economics of Business* No. 1 (2011).

California found the "post-merger price change … among the largest of any comparable hospital in California." This analysis found price increases ranging from 29 percent to up to 72 percent depending on the insurer.[44]

2. *Overall growth in health care prices is related to market concentration*

Numerous recent studies have shown that the increase in unit prices—defined here as the cost of hospital and physician services, including medications—in both inpatient and outpatient settings is the single biggest driver of increases in health care spending. Data released recently by the Health Care Cost Institute (HCCI), a nonprofit research entity with access to private insurance claims data from four large private insurers accounting for more than 40 percent of the private market, substantiate this conclusion.[45] Health care economists broadly agree that provider consolidation is a major driver of price increases across all kinds of care, contributing to significant payment variation for both hospital and physician services.[46] Nationwide, payments to hospitals on behalf of the privately insured are an estimated 3 percent higher than they would be absent hospital consolidation.[47]

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[44] Tenn, *supra* note 40.
[45] Health Care Cost Institute, "Health Care Cost and Utilization Report: 2010" (2012), *available at* www.healthcostinstitute.org/files/HCCI_HCCUR2010.pdf.
[46] Ginsburg, *supra* note 9.
[47] Catalyst for Payment Reform, *supra* note 1.

3. *Competition improves the quality of care whereas market concentration can reduce quality*[48]

A number of studies have also examined the impact of hospital consolidation on various quality of care measures, primarily risk-adjusted mortality.[49] A majority of these studies show consolidation tends to reduce quality of care, but the results are not yet conclusive.[50] The results are strongest when examining populations that fall under regulated pricing, such as Medicare.[51,52] For example, researchers found that risk-adjusted, one-year mortality for Medicare heart attack (acute myocardial infarction, or "AMI") patients is significantly higher in more concentrated markets; as of 1991, the most recent date for which such data are available, patients in the most concentrated markets had mortality that was 4.4 percent higher than those in the least concentrated markets. This divergence alone amounts to more than 2,000 fewer statistical deaths in the least concentrated versus most concentrated markets.[53]

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[48] Gaynor, *et al.*, *supra* note 11.
[49] The risk adjusted mortality rate (RAMR) is a mortality rate that is adjusted for predicted risk of death. RAMR = (Observed Mortality Rate/Predicted Mortality Rate)* Overall (Weighted) Mortality Rate.
[50] Gaynor, *et al.*, *supra* note 11.
[51] Gaynor, *supra* note 30.
[52] Gaynor, "What Do We Know About Competition and Quality in Health Care Markets?" 2 *Foundations and Trends in Microeconomics* No. 6 *(*2006), *available at* http://www.nowpublishers.com/product.aspx?product=MIC\&doi=0700000024.
[53] Daniel P. Kessler and Mark McClellan, "Is Hospital Competition Socially Wasteful?" 115 *Quarterly Journal of Economics* No. 2, 577–615 (2000).

4. *Concentration in physician markets leads to increased costs*

Like hospital consolidation, physician consolidation "has caused about an 8 percent increase in fees on average over the last 20 years and substantially higher increases in concentrated markets."[54] Indeed, according to the authors of a 2014 study in the University of Chicago's Journal of Law and Economics, "physician concentration is positively and significantly correlated with service price levels."[55] As a consequence, antitrust officials must "remain wary of the potential anticompetitive effects of mergers among physicians" and this "is especially important for mergers in markets that are already concentrated."[56] Moreover, a recent study of physician-hospital consolidation, where the hospital owns physician practices, found such consolidations to be "associated with higher hospital prices and spending."[57] This was particularly true for "tight" employment-type arrangements, like those at issue in this case, which "lead to statistically and economically significant increases in hospital prices and spending."[58]

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[54] Abe Dunn and Adam Hale Shapiro, "Do Physicians Possess Market Power?" 57 *Journal of Law and Economics* 159 (2014).
[55] *Id.* at 162.
[56] *Id.* at 186.
[57] Laurence C. Baker, M. Kate Bundorf and Daniel P. Kessler, "Vertical Integration Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending," 33 *Health Affairs* No. 5, 756-763 (2014).
[58] *Id.*

The study did note a "small" association between tightly integrated systems and reduced hospital admissions, but it concluded that these results were decidedly mixed, with those receiving services under commercial health plans facing higher prices. Nevertheless, the study also found that looser forms of financial integration resulted in effective clinical integration, but without the increased costs associated with consolidation."[59] As discussed above, consolidation does not typically improve efficiencies or decrease health care costs, but rather, it tends to increase market power, which increases health care costs. Given these historical data, the district court correctly placed responsibility on the merging parties to prove that their claimed efficiencies are real, substantial, and merger-specific.

B. The Affordable Care Act does not immunize health care providers from the antitrust laws

The ACA promotes the creation of accountable care organizations ("ACOs") focusing on patient-centered care. Notwithstanding, the ACA does not state that these goals should be achieved at the expense of market competition. Rather, the ACA specifically states that nothing in the Act "shall be construed to modify, impair, or supersede the operation of any of the antitrust laws."[60] Likewise, federal regulations implementing the ACA state:

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[59] *Id.*

[60] 42 U.S.C. § 18118(a).

> The intent of the Shared Savings Program and the focus of the antitrust enforcement are both aimed at ensuring that collaborations between health care providers result in improved coordination of care, lower costs, and higher quality including through investment in infrastructure and redesigned care processes for high quality and efficient service delivery…[The Center for Medicare and Medicaid Services does] not believe that mergers and acquisitions by ACO providers and suppliers are the only way for an entity to become an ACO. The statute permits ACO participants to use a variety of collaborative organizational structures, including collaborations short of a merger. Indeed, we are also finalizing a proposal that entities that on their own are not eligible to form an ACO can participate in the Shared Savings Program by forming joint ventures with eligible entities. We reject the proposition that an entity under single control, that is an entity formed through a merger, would be more likely to achieve the triple aim.[61]

This rejection of the idea that mergers are required to achieve the goals of the ACA is informed by, among other experiences, the last wave of hospital mergers in the 1990s, which led to substantial price increases with few or no measureable benefits.[62] Similarly, a recent study comparing costs and quality in large integrated delivery systems with those in small independent practice associations (IPA) in the Midwest found that the "large complex structures might increase costs with no gain in quality."[63]

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[61] Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67802, 67822 (Nov. 2, 2011) (codified at 42 C.F.R. pt. 425).
[62] Gaynor, *et al.*, *supra* note 11.
[63] John Kralewski, Bryan Dowd, Megan Savage, and Junliang Tong, "Do Integrated Health Care Systems Provide Lower-Cost, Higher-Quality Care?" *Physician Executive Journal (PEJ)*, 14-18 (2014).

Based on the evidence outlined above detailing the negative consequences of reduced competition and the limited evidence that consolidation results in improved quality of care, the ACA's reliance on antitrust law and competition to achieve its goals reflects current scholarship, as well as market realities in the health care industry.

Although scant evidence exists to suggest that consolidation results in coordinated, high-quality care, significant evidence demonstrates that providers can effectively coordinate care without tight financial integration. For example, the Intensive Outpatient Care Program (IOCP), piloted by the Boeing Company, provides coordinated, patient-centered care[64] through care management teams including various disciplines that support patients with chronic conditions in adhering to their care management plans. This program produced an approximately 20 percent drop per unit in price-standardized per capita spending, primarily due to lower spending for emergency department ("ED") visits and hospitalizations.[65] These results did not involve hospital-employed physicians; rather, these improvements were secured "by three organizationally diverse

[64] Arnold Milstein and Pranav Kothari, "Are Higher-Value Care Models Replicable?" *Health Affairs* (2009), *available at* http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable.
[65] *Id.*

physician groups, including an IPA composed of many small physician practices."[66]

Similarly, Blue Shield of Michigan's Patient Centered Medical Home (PCMH) program, which includes 2,500 independent primary care practices, produced an estimated $155 million in savings over its first three years.[67] The program also demonstrated a 13.5 percent decrease in pediatric ED visits and 10 percent fewer adult ED visits.[68] Without consolidation, PCMH continues to produce more coordinated care, relying on independent physicians, resulting in higher quality care while lowering costs.[69]

The Agency for Healthcare Research and Quality (AHRQ) explains on its website that health care providers can achieve coordinated care using broad approaches that include care management and health information technology, with specific activities that include assessing patient needs and establishing patient

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[66] *Id.*
[67] Patient Centered Primary Care Collaborative, "The Medical Home's Impact on Cost & Quality: An Annual Update of the Evidence, 2012-2013," *available at* http://www.pcpcc.org/resource/medical-homes-impact-cost-quality.
[68] *Id.*
[69] *Id.*

responsibility.[70] None of the approaches AHRQ outlines requires providers to consolidate before delivering more coordinated care.

Changes in the health care delivery system must balance the need for coordinated, high-quality, affordable care with the need to prevent potential anti-competitive behavior. Studies of hospital-physician integration have not produced evidence of increased efficiencies, but instead, are associated with an increase in prices.[71] Thus, the district court's conclusion that achieving the goals of the ACA does not require consolidation is correct. Indeed, the court's determination is paramount to limiting the unthinking push for unneeded financial consolidation in the name of clinical coordination.

C. The district court properly understood that primary care services are local

Health care is generally a service to which patients gain access locally, and is shaped by the local market. Although there has been an increase in the number of programs aimed at steering patients to seek higher-value care outside of local markets for very specific high-cost, non-emergent services (*e.g.*, Centers of

[70] Agency for Healthcare Research and Quality. Care Coordination (2014), *available at* http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html.
[71] Alison Evans Cuellar and Paul J Gertler, "Strategic Integration of Hospitals and Physicians," *Journal of Healthcare Economics* 25, 1-28 (2006).

Excellence[72]), primary care services are, by definition, typically delivered locally.[73] Most employers depend on their health plans to provide robust networks of health care providers, covering their employees' health care needs within a geographic market. In a consolidated market with few alternatives for primary care services, insurers are left without negotiating leverage when setting prices with the dominant health system. The insurer, needing to provide local access to primary care providers, no longer has the option to contract outside of the dominant provider. Without viable competitors, the dominant provider is able to leverage higher prices from the insurer.

Due to the local nature of primary care services, even the largest employer is likely to have only a small market share, leaving it with no leverage against consolidated providers. Research indicates that variations in price are not correlated with the quality of care, but rather "are correlated to market leverage as measured by the relative market position of the hospital or providing group compared with other hospitals or provider groups within a geographic region or

[72] Generally, the term "Center of Excellence" is used in reference to a specific package of services aimed at treating a specific disease—for example, bariatric surgery services, stroke care, or breast care. Centers of Excellence are distinguished by the level of quality they deliver.

[73] American Academy of Family Physicians, "Definition: Primary Care," *available at* http://www.aafp.org/about/policies/all/primary-care.html.

within a group of academic medical centers."[74] For services, like primary care treatment, where patients are less likely to seek services outside of their local market, employers are left with limited alternatives to help mitigate the impact of provider market power on health care prices.

CONCLUSION

For the forgoing reasons, the Ninth Circuit Court of Appeals should uphold the district court's ruling to block the acquisition of Saltzer Medical Group P.A. by St. Luke's Health System, Ltd. The United States District Court for the District of Idaho correctly concluded that: 1) the burden of proof with respect to efficiencies should shift to the merging parties once market power is demonstrated; 2) the Affordable Care Act does not endorse provider consolidation and clinical coordination can be achieved without consolidation; and 3) primary care services are inherently local.

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[74] Office of Attorney General Martha Coakley, *supra* note 9.

APPENDIX A: List of Catalyst for Payment Reform Members

3M
Aircraft Gear Corporation
Arizona Health Care Cost Containment System
(Arizona Medicaid)
Aon Hewitt
AT&T
Bloomin' Brands, Inc.
The Boeing Company
CalPERS
Capital One
Carlson
Comcast
Delhaize America
The Dow Chemical Company
eBay Inc.
Equity Healthcare LLC
GE
Group Insurance Commission, Commonwealth of MA
The Home Depot
Marriott International, Inc.
Mercer
Ohio Department of Jobs and Family Services (Ohio Medicaid)
OhioPERS
Pennsylvania Employees Benefit Trust Fund
Pitney Bowes
Safeway, Inc.
South Carolina Department of Health and Human Services (South Carolina
Medicaid)
TennCare (Tennessee Medicaid)
Towers Watson
Verizon Communications, Inc.
The Walt Disney Company
Wal-Mart Stores, Inc.
Wells Fargo & Company

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitations of Fed. R. App. P. 32(a)(7)(B) because it contains 4,901 words (based on the word count of the word-processing system used to prepare the brief), excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

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CERTIFICATE OF SERVICE

I certify that I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit through the appellate CM/ECF system. I further certify that all participants in the case are registered CM/ECF users and therefore will be served by the appellate CM/ECF system.

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