No. 16-2492

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

FEDERAL TRADE COMMISSION *et al.*,
Plaintiffs-Appellants,

v.

ADVOCATE HEALTH CARE NETWORK *et al.*,
Defendants-Appellees.

On Appeal from the United States District Court
For the Northern District of Illinois Eastern Division
Hon. Jorge L. Alonso
Case No. 15 C 11473

BRIEF OF THE STATES OF CONNECTICUT, IDAHO, IOWA, MAINE, MASSACHUSETTS, MINNESOTA, MISSISSIPPI, MONTANA, OREGON, PENNSYLVANIA, AND WASHINGTON AS AMICUS CURIAE IN SUPPORT OF THE APPELLANTS

LAWRENCE G. WASDEN
Attorney General of Idaho
*BRETT DELANGE
Deputy Attorney General
Office of Attorney General
Consumer Protection Division
954 W. Jefferson St, Second Floor
Boise, ID 83702
Tel: (208) 334-2424
Email: brett.delange@ag.idaho.gov
**Counsel of Record for Amici Curiae*

LORI SWANSON
Attorney General of Minnesota
JUSTIN R. ERICKSON
Assistant Attorney General
Office of the Minnesota Attorney General
445 Minnesota Street
Suite 1400
St. Paul, MN 55101-2131
Tel: (651) 757-1119
Email: justin.erickson@ag.state.mn.us

[Additional Counsel Listed on Next Page]

JIM HOOD
Attorney General
State of Mississippi
Post Office Box 220
Jackson, MS 39205
Tel: (601) 359-3680

ELLEN F. ROSENBLUM
Attorney General
State of Oregon
Salem, OR 97301
Tel: (503) 378-6002

THOMAS J. MILLER
Attorney General
State of Iowa
Hoover State Office Building
Second Floor
1305 E. Walnut St.
Des Moines, IA 50319
Tel: (512) 281-5166

JANET T. MILLS
Attorney General
State of Maine
6 State House Station
Augusta, ME 04333
Tel: (207) 626-8800

GEORGE JEPSEN
Attorney General
State of Connecticut
55 Elm St.
Hartford, CT 06106
Tel: (860) 808-5318

TIM FOX
Attorney General
State of Montana
Justice Building
215 N. Sanders
Helena, MT 59620-1401
Tel: (406) 444-2026

BRUCE L. CASTOR, JR.
First Deputy Attorney General
Commonwealth of Pennsylvania
Strawberry Square
Harrisburg, PA 17120
Tel: (717) 787-3391

ROBERT W. FERGUSON
Attorney General
State of Washington
800 Fifth Ave, Ste. 2000
Seattle, WA 98104
Tel: (206) 389-3806

MAURA HEALEY
Attorney General
Commonwealth of Massachusetts
One Ashbutton Place
Boston, MA 02108
Tel: (617)727-2200

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STATEMENT OF INTEREST

Pursuant to Fed. R. App. P. 29(a), the Attorneys General of the State of Idaho and Minnesota respectfully submit this brief, joined by the States of Connecticut, Iowa, Maine, Massachusetts, Mississippi, Montana, Oregon, Pennsylvania, and Washington (hereinafter *Amicus Curiae* States or States). The *Amicus Curiae* States have a strong interest in ensuring the availability of affordable, quality health care for their citizens. This interest is best served by protecting vibrant competition in local healthcare markets. Mergers that substantially increase provider market power hinder the ability of States to control the escalating cost of medical care. The Attorneys General of the *Amicus Curiae* States, as the chief law enforcers of their respective states, are thus in a unique position to opine on the appropriate standards under federal antitrust law for mergers of healthcare providers.

SUMMARY OF ARGUMENT

Competition in healthcare is a quintessentially local issue. Competitive local markets ensure access to affordable, high-quality healthcare. The *Amicus Curiae* States work to make certain that consumers reap the benefits of competitive healthcare markets in their local communities. The States have witnessed the consequences of acquisitions that substantially lessen competition in local provider markets. The recent wave of hospital consolidation has resulted in the creation of large healthcare systems that wield substantial market power. Even when a considerable number of patients in those markets travel for medical care, providers are able to successfully demand post-merger rate increases from commercial payors because payors need local hospitals to sell attractive, commercially-viable insurance networks. The payors are forced to pass on provider-imposed rate increases to patients in the form of higher prices, the effect of which may ultimately reduce access to care.

In this case, the district court committed an error of law by concluding that the plaintiffs failed to meet their burden to define a relevant geographic market. The court did so without ever assessing whether the plaintiffs' proposed market satisfied the hypothetical monopolist test. The court instead emphasized the travel patterns of some patients, ignoring evidence that the willingness of those patients to travel would not discipline a hypothetical monopolist's ability to increase rates in an 11 hospital market in the North Shore Area. The court's decision ignored the realities of healthcare markets, resulting in an erroneous conclusion on the merits—i.e., that the Government failed to meet its burden on the ultimate likelihood of success in the case. If upheld, the court's decision creates ill-informed law that would impede the ability of law enforcers to ensure consumers receive the benefit of vigorous competition in healthcare markets around the country.

ARGUMENT

Healthcare competition is a matter of local concern that falls within the police powers of the States. *See e.g.*, *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996); Dep't of Health and Human Serv., *Health Ins. Market Rules*, 78 Fed. Reg. 13406, 13435 (Feb. 27, 2013); Dep't of Health and Human Serv., *Establishment of Exch. and Qualified Health Care Plans, et al*., 77 Fed Reg. 18310, 18413, 18417-19, 18443 (Mar. 27, 2012); Stephen Calkins, *Perspectives on State and Federal Antitrust Enforcement*, 53 Duke L.J. 673, 679-80 (2003). Given the importance of competition to local healthcare markets, the States frequently review healthcare mergers under both state and federal antitrust laws. *See, e.g.*, Consent Decree, *Commonwealth v. Geisinger*, No. 1:13 CV-02647-YK (M.D. Pa. Nov. 1, 2013); Steve Tenn, *The Price Effect of Hospital Mergers: A Case Study of the Sutter Summit Transaction* (Fed. Trade Comm'n, Working Paper No. 293, Nov. 2008), *available at* https://goo.gl/2zum2k. Through these merger reviews, the States have acquired a sophisticated understanding of local hospital markets.

The *Amicus Curiae* States write to discuss two points.[1] First, the district court erred as a matter of law[2] by failing to assess whether the plaintiffs' geographic market satisfied the hypothetical monopolist test. Appropriately defining a geographic antitrust market in a hospital

[1] The States' arguments are raised only in response to issues considered by the district court and are not intended to address anything outside the scope of that opinion. Any other issues that might be raised are best considered by the district court on remand.

[2] While market definition is typically a factual inquiry, circuit courts apply *de novo* review when confronted with "errors of law, including those that may infect a so-called mixed finding of law and fact, or a finding of fact that is predicated on a misunderstanding of the governing rule of law." *Teva Pharm. USA, Inc. v. Sandoz, Inc.*, 135 S. Ct. 831, 833 (2015), citing *Bose Corp. v. Consumers Union of U.S., Inc.*, 466 U.S. 485, 501 (1984); *cf. FTC v. Whole Foods Mkt., Inc.*, 548 F.3d 1028, 1041 (D.C. Cir. 2008) (explaining that the district court's review of the product market was "an error of law, because in some situations core consumers, demanding exclusively a particular product or package of products, distinguish a submarket"); *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 570 (6th Cir. 2014), *cert. denied*, 135 S. Ct. 2049 (2015) (applying *de novo* review when assessing whether the use of "cluster markets" to define the relevant product market was appropriate). However, if this Court should disagree, and apply an abuse of discretion standard, the *Amicus Curiae* States believe there is sufficient evidence to conclude that the district court abused its discretion.

merger entails application of the hypothetical monopolist test. *See e.g., ProMedica Health Sys.*, 749 F.3d at 570 (discussing that competition in healthcare markets reflects the respective bargaining positions of hospital providers relative to commercial payors); *St. Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 784 n.10 (9th Cir. 2015) (affirming geographic market based on application of the hypothetical monopolist test). Changes in payor-provider bargaining positions properly predict the geographic area where a merger may have anticompetitive effects. This is no less true in metropolitan areas, as each community demands access to local providers despite the presence of "downtown" alternatives.

Rather than apply the hypothetical monopolist test, the district court concluded, based on the travel preferences of a subset of patients, that the plaintiffs did not meet their burden of proving a geographic market. Op. at 12 (citing evidence discussing some patients prefer hospitals near where they work or based on their physicians' preferences). The district court's focus on a subset of patients' travel preferences is akin to a patient flow analysis, a discredited approach to defining geographic markets in hospital cases. Patient flow analysis systematically underestimates post-merger increases in provider market power because it incorrectly "infers from the existence of pre-merger travelers that *even more* patients would travel in response to a price increase." Kenneth Elzinga and Anthony Swisher, *Limits of the Elzinga-Hogarty Test in Hospital Mergers: The Evanston Case*, 18 Int'l. J. of Econ. of Bus. 133, 137 (Feb. 2011) (emphasis in original). Here, the district court improperly inferred, from the willingness of some patients to seek inpatient care at hospitals in downtown Chicago, a corresponding willingness of all patients to use downtown hospitals should payors, in response to an attempted post-merger price increase, try to market a health plan to North Shore Area residents that excluded local providers.

Second, mergers that increase a provider's bargaining leverage (market power) result in anticompetitive increases in the price of healthcare services. These mergers also reduce the incentives of providers to compete on service quality. Consumers are, therefore, forced to pay higher prices for reduced access and lower quality care.

I. THE COURT'S ANALYSIS OF THE GEOGRAPHIC MARKET WAS FLAWED.

A. The Multi-Stage Model of Competition in Healthcare.

It is important to analyze the question of the appropriate geographic market in the context of the particular dynamics of the healthcare industry. Competition between healthcare providers is a multi-stage process. Greg Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67(3) Antitrust L. J. 671, 673–75 (2000); Gautam Gowrisankaran, et al., *Mergers When Prices Are Negotiated: Evidence from the Hospital Industry*, 105 Am. Econ. Rev. 1, 26, 30, 35 (Jan. 2015), *available at* http://goo.gl/tUzwLu. In the first stage, providers engage in negotiations with payors for inclusion in networks. Vistnes, *supra*, at 673-75. Patients pay significantly less out-of-pocket when they receive care from an in-network provider, making them much more likely to choose in-network providers over out-of-network providers. *Id*. at 681. At the same time, to attract customers, payors must create commercially viable networks that include local providers demanded by members. *Id*. at 677-78. Employers and individuals will only buy insurance products that provide in-network access to their preferred providers. *Id*.

Given the dynamics of this first stage, the prices for healthcare services are generally based on the relative bargaining position of payors and providers. Insurers have leverage when they can substitute alternative providers to defend against a demanded rate increase. *Id*. Providers with fewer viable alternatives have greater leverage because they are more important to insurers' networks. *Id*. A merger that removes a viable provider alternative from the market

may significantly affect these bargaining dynamics, typically resulting in higher prices for an insurer and its members.

In the second stage of competition, providers compete with one another to attract patients. *Id*. at 681–82. Because patients' out-of-pocket costs for in-network providers do not vary significantly from one in-network provider to another, most of this competition takes place on non-price dimensions, including factors like quality of care, wait-times, and patient experience. *Id*. While price is not a particularly relevant factor in the second stage, competition at this stage increases quality of care and levels of consumer access.

B. Utilizing the Hypothetical Monopolist Test to Define Antitrust Markets.

Courts evaluating a merger must define a geographic market that accurately reflects both relevant economic analysis and the "commercial realities" of the market based on the "context of its particular industry." *Brown Shoe Co. v. United States*, 370 U.S. 294, 320–22, 337 (1962); *see also St. Luke's*, 778 F.3d at 784. Case law and economic literature make clear that the "hypothetical monopolist" test is best suited to define geographic antitrust markets. *St. Luke's*, 778 F.3d at 784; *In re Se. Milk Antitrust Litig.*, 739 F.3d 262, 277–78 (6th Cir. 2014); *Whole Foods*, 548 F.3d at 1038. The test asks: what is the *smallest* set of products and *smallest* geographic area where such products are sold such that a hypothetical monopolist could profitably implement a small but significant non-transitory increase in price ("SSNIP")—typically defined as a 5 percent increase—on buyers at *any one* of the merging parties' locations. U.S. Dept. of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines* §§ 4.1.2, 4.2 (Aug. 19, 2010).

To align with the commercial realities of healthcare markets, a proper antitrust market exists when commercial payors cannot substitute providers located inside the candidate market

with providers located outside that geographic area without becoming less attractive to potential members. Put another way, a relevant antitrust market occurs because a commercial insurer will pay a SSNIP to ensure members have in-network access to providers located in the proposed market. *See St. Luke's*, 778 F.3d at 784–86 (affirming geographic market based on whether hypothetical provider could impose SSNIP on insurers and whether commercial health plans must include providers in that market "to offer a competitive product"). Without in-network access, the payor's members will not purchase its insurance because members do not view the providers (here hospitals) outside the candidate market as viable alternatives (or meaningful substitutes) for the provider's services. A proper antitrust market does not require inclusion of *all* competitors to be economically sound; it need only include the smallest number of those providers that together could successfully impose a SSNIP on a health plan.

C. The District Court Failed to Account for Economic Realities when Defining the Geographic Market.

In examining the plaintiffs' proposed North Shore Area market, the district court did not assess whether an insurer would rather pay a SSNIP than sell a network to members that excluded all providers located in that area. The legal standard applied by the district court is erroneous and would lead to an unduly broad geographic market that does not reflect the North Shore Area's market realities.[3] If left in place, the court's decision marks a major shift in the law, setting forth a dangerous legal precedent with far-reaching policy implications.

[3] Likewise, it was also legal error for the district court to rely on other evidence—namely, the payor-provider negotiations for a single contract for inpatient and outpatient rates, the decline in inpatient admissions over the last few years, and testimony that physicians were the primary driver of determining where a patient receives inpatient care. As with patient travel patterns, these factors do not alter the reality of the multi-stage bargaining model. Insurers still must form networks that are attractive to their members. Those networks must still include options for inpatient care. Hospitals with few substitutes therefore still have leverage regardless of who admits the patient or trends regarding the total volume of

(*continued* . . .)

Instead of applying the hypothetical monopolist test, the district court mistakenly relied on evidence relating to the current hospital preferences of a subset of patients. It misconstrued the relevance of that information to conclude that "destination hospitals" not located in the North Shore Area, and hospitals that compete with either of the merging providers (but not both), were viable substitutes for North Shore Area residents. Op. 9, 12. By relying on what is essentially patient flow information, the district court implicitly adopted the predominant economic theory used to define geographic markets in hospital merger cases during the 1980s and 1990s. This approach, however, was shown to be flawed in the early 2000s because it relied on a classic analytical mistake that economists refer to as the "Silent Majority Fallacy." Cory Capps et al., *The Silent Majority Fallacy of the Elzinga-Hogarty Criteria: A Critique and New Approach to Analyzing Hospital Mergers* 28 (Nat'l Bureau of Econ. Research, Working Paper No. 8216, 2001), *available at* http://www.nber.org/papers/w8216 [hereinafter, *Silent Majority Fallacy*]; Elzinga & Swisher, *supra*, at 137. The Silent Majority Fallacy arises from the assumption "contrary to fact, that the non-traveling 'silent majority' is similar to the traveling (pre-merger) minority and is protected against a post-merger price increase by those patients poised to join those already willing to migrate." Elzinga & Swisher, *supra*, at 137. The hypothetical monopolist test manages to avoid falling victim to this fallacy by focusing on the substitutability of competitors in response to a price increase.

While some patients for some service lines are willing to travel across metropolitan areas for healthcare services, empirical evidence consistently demonstrates that the mere existence of pre-merger travelers does *not* mean that enough additional patients would be willing to travel in

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inpatient admissions because insurers will have no credible threat to exclude those hospitals from their networks. *See St. Luke's*, 778 F.3d at 785 (upholding district court finding that insurers are unable to defend against a SSNIP by steering consumers to other facilities).

response to a price increase to allow an insurer to exclude local hospitals and defeat the proposed price increase.[4] David Dranove and William White, *Emerging Issues in the Antitrust Definition of Healthcare Markets*, 7 Health Econ. Letter 2, 169 (1998) (explaining that "[p]atients may occasionally travel, but may be willing to pay a premium to assure local access. Thus, a patient flow analysis might indicate that local hospitals could not successfully raise prices, yet option demand pricing may enable them to do so.").

The district court's opinion does not properly address the reality of patient travel. Members of the silent majority—which includes the sick, the young, the elderly, and others with limited means of transportation—find such travel unreasonably costly[5] or unduly burdensome. Elzinga & Swisher, *supra*, at 5; *cf.* Compl. ¶ 32 (alleging that "approximately 73% of patients residing within the North Shore Area stay there to receive GAC inpatient hospital services"). These patients will continue to demand that their insurance provide in-network access to local healthcare services despite the pre-merger travel patterns of other patients for some services. Elzinga & Swisher, *supra*, at 137; Cory Capps et al., *Antitrust Policy and Hospital Mergers: Recommendation for a New Approach* 4 (Inst. For Policy Research, Working Paper No. 02-24, Feb. 2002), *available at* http://goo.gl/utRAXX (explaining some metropolitan mergers with pre-existing outflows of patients of 30 percent or more still "generate[d] price increases of 10 percent or higher"). They are the ones who will bear the burden of a reduction in provider competition through higher premiums, greater deductibles, increased out-of-pocket expenses, reduced access to care, and lower quality services.

[4] The existence of pre-merger travelers does not mean that members would find a network that excluded local providers attractive.

[5] Cost in this context includes out-of-pocket costs like travel expenses, lodging, etc., as well as the opportunity cost of additional time spent reaching the distant hospital site. Elzinga & Swisher, *supra*, at 5. Cost also refers to the costs incurred by the patient's family and friends, and any additional costs imposed upon the patient's physician. *Id.*

The effect of the court's decision, should it stand, will reverberate broadly. Health systems will respond by aggressively pursuing partnerships, citing this decision as evidence that consumers travel great distances for healthcare services. *See e.g.*, Op. 10 (finding "the notion that patients prefer to receive GAC services near their homes . . . equivocal"). Health systems will also use this decision to assert that consolidation within any metropolitan area will have a minimal effect on competition. Courts that follow this precedent will adopt analyses relying on unduly broad geographic markets that grossly underestimate the anticompetitive effects of certain transactions. Meanwhile, the practical effect of such consolidation is already known, as evidenced by the economic literature and investigations discussed below. Consumers will be deprived of the benefits of competition, paying increasing portions of their income for diminishing healthcare services and choice. The travel patterns of some should not dictate cost and choice of healthcare providers for all.

D. The Practical Effect of Courts Applying Improper Geographic Markets in Hospital Merger Cases.

Application of the hypothetical monopolist test is crucial in all hospital mergers, but is particularly vital when evaluating mergers between competing healthcare providers in metropolitan areas. Empirical evidence clearly demonstrates that, in these cases, geographic market definitions based on patient travel patterns lead courts to define unduly expansive antitrust markets that consistently underestimate market concentration[6] and post-merger price

[6] *See also* Gregory Werden, *The Limited Relevance of Patient Migration Data in Market Delineation for Hospital Merger Cases*, 8 J. of Health Econ. 4, 376 (Feb. 1990) (explaining that "tests based on patient migration data yield erroneous market delineations"); William B. Vogt and Robert Town, *How has Hospital Consolidation Affected the Price and Quality of Hospital Care?* (Robert Wood Johnson Foundation Research Synthesis Report No. 9, 2006), *available at* https://goo.gl/5VVdt7 (explaining that "[g]eographical markets for hospital services appear to be narrower than courts have typically found . . . [c]onsolidation between closely neighboring hospitals appears to lead to significant price increases even in markets that would appear to be relatively competitive under typical market

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effects. *See e.g.*, *Silent Majority Fallacy*, *supra*, at 28 (explaining a merger between two hospitals located twelve miles from downtown San Diego led to a 5 to 9 percent price increase, and that prices increased 19 percent when a third facility lying midway between the two hospitals and downtown was added); Tenn, *supra*, at 3 (confirming that "substantial patient flows across two geographic areas is insufficient to conclude that competition from hospitals in one area will prevent a post-merger price increase in the other"). Reliance on information relating to the preferences of a subset of patients in any metropolitan hospital merger case may lead a court to incorrectly conclude that a single provider market exists in the entire metropolitan area. The real-world effects of such a mistake are best evidenced by litigation involving two different metropolitan hospital mergers.

In the first case, Highland Park Hospital ("Highland Park") merged with Evanston Northwestern Healthcare Corporation ("ENH") in 2000. Four years later, the FTC filed an administrative complaint challenging the merger, alleging that the merger increased ENH's market power and allowed it to negotiate price increases "far beyond those achieved by comparable hospitals during this time period." Compl. at ¶ 1, *In the Matter of Evanston Nw. Healthcare Corp.*, 2007 WL 2286195 (F.T.C. Aug. 6, 2007), *available at* http://goo.gl/xDUxIK.

At the administrative trial and proceeding before the Commission, there was substantial evidence of patient travel to other hospitals in downtown Chicago. *In the Matter of Evanston Nw. Healthcare Corp.*, 2007 WL 2286195, at *63, 78 (F.T.C. Aug. 6, 2007) (Op. of the

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definition strategies"); Dranove, *supra* at 169 (finding that "payer-driven competition may enhance the potential for consumer injury resulting from mergers in geographic markets previously considered immune to antitrust concerns; e.g. suburban components of large metropolitan areas"); Martin Gaynor et al., *A Structural Approach to Market Definition within an Application to the Hospital Industry*, 61 J. of Indus. Econ. 2, 285 (June 2013) (finding that failing to correctly apply the SSNIP test results in oversized geographic market definitions, particularly in areas with greater hospital density . . . [which] has the potential to mislead the courts").

Comm'n). The evidence also established that, despite this significant patient flow, the merger increased ENH's market power in the North Shore suburbs, which allowed ENH to successfully demand *at least* a 9 to 10 percent post-merger price increase. *Id.* at *13, 58, 63. The post-merger exercise of market power demonstrated that the relevant geographic market was "narrower than the patient flow data might suggest." *Id*. at *63, 78. Ultimately, the Administrative Law Judge sided with the FTC and ordered the divestiture of Highland Park Hospital.[7] *In the Matter of Evanston Nw. Healthcare Corp.*, 2005 WL 2845790, at *34 (F.T.C. Oct. 20, 2005) (Initial Decision). The Commission affirmed the Administrative Law Judge's finding that the merger violated Section 7 of the Clayton Act. *Evanston Nw. Healthcare Corp.*, 2007 WL at *63 (Op. of the Comm'n).

In the second case, Sutter Health, a network of non-profit hospitals in Northern California, acquired Summit Hospital, a non-profit hospital in Berkeley, California in December 1998. *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1115 (N.D. Cal. 2001). Sutter's extensive holdings already included Alta Bates Hospital, which was located approximately two and a half miles from Summit. The California Attorney General attempted to block the transaction. *Id*. at 1137. The California Attorney General argued that the proper antitrust market was the "Inner East Bay" where Summit and Alta Bates' 50 percent market share would allow it to successfully leverage a post-merger price increase. *Id.* at 1121. The court disagreed,

[7] At the same time as it investigated *Evanston*, the FTC reviewed the Vista Health transaction; a merger between two community hospitals located in the north shore Chicago suburb of Waukegan, Illinois. Statement of the Fed. Trade Comm'n, *Victory Memorial Hospital/Provena St. Therese Medical Center*, File No. 011-0225 (July 1, 2004) *available at* https://goo.gl/HzyEIh. The investigation concluded that there was insufficient evidence to support a likelihood of consumer harm because, in response to a proposed price increase, payors seeking to create commercially viable networks turned to other hospitals in the North Shore. *Id.* The fact that Vista Health did not raise competitive concerns while *Evanston* was anticompetitive underscores the importance of defining a geographic antitrust market that reflects how the merger will change payor-provider bargaining leverage. Deborah Haas-Wilson and Christopher Garmon, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18 Intl. J. of the Econ. of Bus. 1, 18 (Feb. 2011), *available at http://goo.gl/zRM7YE*.

determining that based on patient travel patterns the presence of more than twenty hospitals throughout the San Francisco Bay Area would constrain Sutter's ability to demand any anticompetitive price increase. *Id*.

In 2008, an economist undertook a retrospective analysis of this transaction. Tenn, *supra*, at 1. The analysis concluded that "for this transaction, the merger of a higher priced hospital [Alta Bates] with a lower priced competitor [Summit] produced two higher priced hospitals." *Id*. Post-merger, Summit's price change was 28.4 to 44.2 percent larger than the average price change for the control group. *Id*. at 19-20. Those results are consistent with a finding of increased bargaining power, as well as the parties' prediction that Summit would have "more clout in negotiating with insurers" following the transaction. Sabin Russell, *Summit Medical to Join Sutter*, SF Gate (March 27, 1998), *available at* http://goo.gl/8LUYPK. The study also concluded that even though Summit and Alta Bates were "located in a large urban area with many other hospitals that offered a similar range of services," patient flow data incorrectly suggested that patients would turn to alternative hospitals for care in response to a demanded rate increase from commercial payors. Tenn, *supra*, at 22.

Notably, on July 1, 2016, the San Francisco Chronicle reported that Sutter plans to close Alta Bates Medical Center. *Berkeley's only hospital, Alta Bates, to close by 2030*, S.F. Chron., July 1, 2016, *available at* http://goo.gl/YSk96n. Alta Bates will move all services to Summit, leaving Berkeley without an ER. The Alta Bates emergency department treated 46,000 patients in 2015. *Id*. Patients are resigned to the fact that they will end up going to Summit, which effectively reduces patient choice and access to care.[8] *Id*; *see also, Sutter plans future closing of*

[8] City officials acknowledge that retrofitting is expensive, but note that "the city's doing it, the university's doing it, the landlords are doing it . . . And Sutter says, 'Oh we're just going to close down.' We all have to pay the price." *Id*; *see also FTC v. ProMedica Health Sys.*, 2011 WL 12192181, at ¶ 247 *(continued . . .)*

Berkeley emergency services, The Mercury News, Apr. 25, 2016, *available at* http://goo.gl/xrKgDL (quoting Councilman Jesse Arreguina as outraged that "[m]oving care to Summit is going to make it that much more (difficult) for somebody in dire need of medical attention").

The lessons of both cases are clear and consistent with the States' experience. Improper reliance on information relating to patient flows in healthcare mergers may lead to unduly expansive geographic markets that fail to adequately predict post-merger levels of competition or potential anticompetitive effects. The anticompetitive effects include increases in price and reduced access to services. To protect consumers from anticompetitive mergers, courts must carefully apply the hypothetical monopolist test and then focus on how the merger affects the bargaining dynamics between local providers and commercial payors over in-network rates.

Because the district court failed to properly apply that test, the *Amicus Curiae* States urge this Court to reverse the lower-court's decision. Ignoring the hypothetical monopolist test and relying solely on patient travel patterns to defeat a proposed geographic market is a profound backslide in the law (and economics), causing courts to define unduly expansive geographic antitrust market. Such changes will drastically impact law enforcers' ability to challenge anticompetitive mergers, which will affect the type of transactions even attempted in the first place. Allowing this decision to stand ultimately inhibits the ability of law enforcers to carry out their statutorily imposed duty—ensuring that consumers receive the benefits of vigorous competition in healthcare markets around the country.

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(N.D. Ohio 2011) (explaining that an avoidance of capital costs that diminishes capacity is not a procompetitive justification because "[f]irms invest in their businesses to better compete and thus enhance consumer welfare, and if these competition driven investments are 'avoided,' consumers generally are left worse off."). Absent the merger, competitive forces, not the actions of a monopolist, would have determined the fate of Alta Bates.

II. IF LEFT UNCHECKED, HOSPITAL SYSTEM MERGERS WILL CONTINUE TO RESULT IN SUBSTANTIAL INCREASES IN HEALTHCARE COSTS.

This Court has recognized the need to avoid "theoretical guesses as to what particular market-structure characteristics portend for competition." *U.S. v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1286 (7th Cir. 1990). Twenty-six years ago, this Court urged that more effort be "put into studying the actual effect of concentration on price in the hospital industry as in other industries" rather than place "an insuperable burden of proof" on federal and state enforcers. *Id*. (explaining, if "the government is right in these cases, then, other things being equal, hospital prices should be higher in markets with fewer hospitals").

In the years since, independent economists and state agencies have heeded this Court's call by researching the effect that provider consolidation has on prices. The research has repeatedly concluded that hospital prices are higher in markets with fewer hospitals. *See Silent Majority Fallacy, supra*, at 28; Dranove, *supra*, at 169; Gaynor et al., *supra*, at 285; Capps et al., *supra*, at 24; Gowrisankaran et al., *supra*, at 26, 30, 35.

Price increases occur because providers utilize post-merger increases in market power to gain the upper hand and demand higher reimbursement rates in network-inclusion negotiations with payors. Robert Berenson, et al., *Unchecked Provider Clout in California Forecloses Challenges to Health Care Reform*, 29 Health Affairs 699, 699 (Apr. 2010) (internal citation omitted) (finding that a trend in provider consolidation led to a 10.6 percent annual increase in the cost of healthcare from 1999 to 2005); James Robinson, *Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology*, 17 Am. J. Managed Care 241, 244, 247 (2011) (finding that price differentials for various types of cardiology and orthopedic procedures ranged from 19 to 25 percent more for hospitals in concentrated markets and that hospitals earnings *per patient* amounted to 64 to 95 percent more

than hospitals in competitive markets); Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation – Update*, The Synthesis Project, June, 2012, (*available at* http://goo.gl/agTrxF) (finding some cost increases as high as 20 percent). Those higher prices are passed on to consumers in the form of higher premiums and deductibles without any measurable increase in quality or access.

The conclusions of this research are consistent with the States' own findings. In 2010, the Massachusetts Attorney General found that healthcare costs "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 at 3 (Mar. 2010), *available at* http://goo.gl/gpmEuB [hereinafter, "2010 Massachusetts Healthcare Report"]; *see also* Massachusetts Attorney General, *Examination of Health Care Cost Trends and Cost Drivers*, Report for Annual Public Hearing at 2 (Sept. 2015), *available at* http://goo.gl/IpyN62 (explaining among other findings that: (1) "market dysfunction persists, with continued cost and access consequences for consumers"; (2) "price variation [is] unexplained by quality"; and (3) "enrollment in tiered insurance products has increased, but the presence of these products has not resulted in an overall shift in patient volume away from higher priced providers"). The Massachusetts Attorney General concluded, based on market data and interviews with market participants, that generally, the greater the provider system's market leverage, the higher the prices the provider charged. 2010 Massachusetts Healthcare Report at 10-28 (ruling out other factors, such as the percentage of Medicare and Medicaid patients, as the cause of higher prices).

Similarly, in 2014, the Connecticut Attorney General issued a report finding that the cost of an average family health insurance premium increased 97 percent between 2002 and 2012.

See Connecticut Attorney General, *Report of the Connecticut Attorney General Concerning Hospital Physician Practice Acquisitions and Hospital-Based Facility Fees*, 4 (Apr. 2014), *available at* http://goo.gl/Wi8LkF. Like the Massachusetts Attorney General, the Connecticut Attorney General concluded that consolidation among healthcare providers was at least partially to blame for those price increases. *Id*. at 1.

These studies and reports establish that rapid, unchecked consolidation among healthcare providers poses a real threat to the economies of the States and the well-being of their citizens. When healthcare costs rise, employers are forced to take action to mitigate the effect of those cost increases, including reducing or eliminating benefits, reducing or eliminating work forces, and *not* expanding or opening new operations in the region. *See e.g., In Re Application of UPE*, No. ID-RC-13-06 (Pa. Insur. Dept. 2013).

Likewise, consolidation will continue to erode the quality and convenience of healthcare because providers have fewer incentives to compete. An analysis conducted three years after a hospital merger in Grand Rapids, Michigan found that the merger resulted in the closure of urgent care centers, reductions in patient convenience, and diminished the quality of treatment. David Balto and Meleah Geertsma, *Why Hospital Merger Antitrust Enforcement Remains Necessary: A Retrospective on the Butterworth Merger*, 34 J. Health L. 129, 152 (2001).

It is against this backdrop that the *Amicus Curiae* States request that this Court reverse the lower-court's decision. In so doing, this Court need not make "theoretical guesses." Viewing the transaction through the lens of the appropriate geographic market, it is clear the Government met its burden of demonstrating a likelihood of success on the merits. The merger between Advocate and Northshore will eliminate vital competition. If allowed to proceed, the result will be higher prices, diminished quality, and a reduced prospect of innovation or

improvement to the detriment of North Shore Area residents. Patients would be better served by a competitive marketplace that promotes the delivery of high quality, cost effective healthcare.

CONCLUSION

For the foregoing reasons, the *Amicus Curiae* States respectfully submit that this Court should reverse the district court's opinion in this case and grant the requested preliminary injunction.

Respectfully submitted,

/s/ BRETT DELANGE

BRETT DELANGE (ID BAR NO. 3628)
DEPUTY ATTORNEY GENERAL
Office of Attorney General
Consumer Protection Division
954 W. Jefferson St., Second Floor
Boise, ID 83702
Tel: (208) 334-2424
brett.delange@ag.idaho.gov
JULY 22, 2016
ATTORNEY FOR AMICI CURIAE STATES

COMBINED CERTIFICATES OF COMPLIANCE

I hereby certify that this brief complies with Fed. R. App. P. 29(d) and 32(a)(7)(B) in that it contains 5,551 words as counted by Microsoft Word 2010, excluding the parts of the brief exempted by Rule 32(a)(7)(B)(iii).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirement of Circuit Rule 32(b) because it has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 12-point Times New Roman.

Dated: July 22, 2016

/s/ Brett DeLange

BRETT DELANGE
DEPUTY ATTORNEY GENERAL
Office of Attorney General
Consumer Protection Division
954 W. Jefferson St., Second Floor
Boise, ID 83702
Tel: (208) 334-2424
brett.delange@ag.idaho.gov

CERTIFICATE OF SERVICE

I hereby certify that on July 22, 2016, I filed and served the foregoing with the Court's appellate CM/ECF system. I certify that I caused the foregoing to be served through the CM/ECF system on all other parties in this case who are registered ECF users.

Dated: July 22, 2016

/s/ Brett DeLange

BRETT DELANGE (ID BAR NO. 3628)
DEPUTY ATTORNEY GENERAL
Office of Attorney General
Consumer Protection Division
954 W. Jefferson St., Second Floor
Boise, ID 83702
Tel: (208) 334-2424
brett.delange@ag.idaho.gov