IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

NO. 16-2365

Federal Trade Commission and *Commonwealth of Pennsylvania*,

Plaintiffs-Appellants,

v.

Penn State Hershey Medical Center and *PinnacleHealth System*,

Defendants-Appellees.

On Appeal from the United States District Court
For the Middle District of Pennsylvania (No. 1:15-cv-02362)

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

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Other Authorities

STATEMENT OF INTEREST

Pursuant to Fed. R. App. P. 29(a), the Attorneys General of the States of Idaho and Washington respectfully submit this brief, joined by the States of California, Connecticut, Iowa, Illinois, Massachusetts, Maine, Minnesota, Mississippi, Montana, and Oregon (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 strong competition among health care providers. The anticompetitive effects of mergers hinder the States from preserving the competitive environment necessary to control the escalating cost of medical care.[1] 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 standard under federal antitrust law for reviewing mergers of health care providers.

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[1] *See, e.g.,* Steve Tenn, *The Price Effect of Hospital Mergers: A Case Study of the Sutter-Summit Transaction*, FEDERAL TRADE COMMISSION WORKING PAPER NO. 293, 1-2 (Nov. 2008) *at* https://www.ftc.gov/sites/default/files/documents/reports/price-effects-hospital-mergers%C2%A0-case-study-sutter-summit-transaction/wp293_0.pdf

SUMMARY OF ARGUMENT

Competition in healthcare is a quintessentially local issue. Thus, *Amicus Curiae* States require vibrant competitive healthcare markets in their local communities to control costs and to make affordable healthcare available to the States' citizens. The States have experienced the growth of large healthcare systems through the systematic mergers of hospitals. This growth has resulted in increased, if not lopsided, bargaining power of those healthcare systems in negotiations with health insurers. That increased leverage translates to higher healthcare prices for citizens.

The District Court's opinion erroneously failed to examine the impact of the merger on contract negotiations between healthcare providers and insurance companies. This is a key aspect of the merger that affects the pricing of the provider networks marketed to self-insured and fully-insured employers. In the States' experience, and as confirmed by recent economic research, providers increase prices for their participation in insurance networks after a merger. Prices for network inclusion increase even if some patients are willing to drive farther for their medical care. Additionally, mergers can decrease incentives for providers to compete on quality.

Simply put, an acquisition of one hospital (or hospital system) by another can remove a health insurer's leverage in trying to provide an affordable, quality

network for consumers. Most patients in urban and suburban areas prefer geographically close, or easily accessible, options for their medical care. That some patients may drive farther to seek health care does not prevent post-acquisition price increases vis-à-vis health insurers. Moreover, patients themselves are not price sensitive since they are not exposed directly to provider price increases. Those increases are imposed upon health insurance companies and then only indirectly on patients through insurance-wide premium increases.

The District Court erroneously reasoned that private fix-it-first remedies employed by the merging parties in the form of temporary price caps will ensure that the proposed merger will not harm consumers. Those caps, however, attempt to address only some of the anti-competitive effects of this merger. Their temporary nature means that price increases can be imposed in the future when it would be more difficult, if not impossible, to unravel the merger. Moreover, the District Court erred by including price caps in the geographic market analysis. The States agree with the FTC and Pennsylvania that these private agreements should not be taken into account for that purpose while analyzing the legality of a merger.

The District Court compounded its errors in rejecting the Government's proposed geographic market, and in relying on temporary price-caps, concluding that the claimed efficiencies make the merger procompetitive and beneficial to consumers. The District Court reached this erroneous conclusion without even

inquiring (much less determining) if those efficiencies are merger-specific, verifiable, or do not arise from anticompetitive reductions in output or service. The District Court further erred in failing to examine whether the claimed benefits, including the avoidance of the expansion of hospital bed capacity or the implementation of risk-sharing pricing, could be accomplished absent a merger. The requirement that efficiencies must, among other things, be merger-specific and be done by least restrictive means is not frivolous. Arrangements that preserve the independence of competitors are far less likely to lead to price increases than actual mergers.

Finally, the District Court erred in ruling that the Affordable Care Act[2] ("ACA") in effect blesses healthcare mergers. The District Court went so far as to view merging providers as part of an inevitable future in which "local community hospitals" are "antiquated." That view seriously misconstrues the language of the ACA. Indeed, the ACA expressly states that "[n]othing in this title (or an amendment made by this title) shall be construed to modify, impair, or superseded the operation of any of the antitrust laws." The District Court's opinion on this point also delegates to private parties a policy decision about healthcare that has properly been within state and federal government purview since 1941.

[2] The Affordable Care Act or ACA refers to the Patient Protection and Affordable Care Act, Pub. L. No. 11-48, 124 Stat. 119 (2010).

ARGUMENT

I. HEALTHCARE COMPETITION IS A MATTER OF LOCAL CONCERN

Healthcare competition 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 can have a local component, but healthcare 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, the States have reviewed local transactions in their healthcare markets in exercising their powers under both federal and state antitrust laws. *See, e.g.,* Steve Tenn, *The Price Effect of Hospital Mergers: A Case Study of the Sutter-Summit Transaction*, FEDERAL TRADE COMMISSION WORKING PAPER NO. 293, 1-2 (Nov. 2008). Unfortunately, the *Amicus Curiae* States have repeatedly experienced large healthcare providers acquiring overwhelming market power. Far too often, these providers have repeatedly imposed price increases on insurers attempting to assemble viable health insurance networks in local communities. And these providers can impose

price increases without risking significant patient defection to other markets; a factor which ordinarily would discipline these price increases. *See, e.g., Sutter-Summit Transaction, supra,* at 2-3.

Set against this backdrop, the District Court erred by defining an overly broad geographic market. The District Court committed this error by using outdated economic methodology that focused on whether certain patients will travel farther for medical care than others. The proper economic methodology recognizes that insurers bargain with providers over their inclusion in networks. Insurers attempt to create healthcare networks that accommodate consumers who prefer to obtain medical services close to, or easily accessible from, their homes or work. That methodology thus focuses on the degree of bargaining leverage that the merged healthcare providers gain against the insurers as result of the transaction. It is that type of increased bargaining leverage that enables healthcare providers to impose price increases that ultimately harm consumers. Additionally, the District Court erred in ruling that the merger will be beneficial to consumers even though the proffered efficiencies are not merger-specific or verifiable. Finally, the District Court erred by holding that the merger is justified, if not encouraged, by the ACA.

II. HOSPITAL SYSTEM MERGERS RESULT IN SUBSTANTIAL INCREASES IN PRICES AND HEALTHCARE COSTS

A number of studies and reports have examined rapidly escalating healthcare costs in the States. 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 healthcare 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). In 2014, the Connecticut Attorney General issued a report documenting the escalation of healthcare costs over a ten-year period in that 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 healthcare costs, as detailed in these studies and reports, poses a real threat to the economies of the States and the well-being of

their citizens. 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, including major U.S. employers such as U.S. Steel, H. J. Heinz Company and Alcoa, Inc., and smaller local entities and 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.[3]

A key reason for the escalation of costs has been the post-merger increase in market power of healthcare providers. 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 healthcare affordability and access for those with insurance. The study found that large healthcare provider systems,

[3] The stakes here are even higher for "self-insured" employers, who "rent" a healthcare plan's network for a fee such that these employers bear the full brunt of any increase in the healthcare 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 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).

possessing significant market power, can gain the upper hand on insurers in compensation and network-inclusion negotiations. This enhanced leverage leads to higher premiums for consumers. *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.

According to several recent studies, substantially higher prices are driven by healthcare providers with enhanced market power. For example, in 2011, Dr. James Robinson published a study examining the relationship between hospital market concentration, prices, and profits. He used 2008 patient data from 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. Those hospitals earnings *per patient* amounted to 64% to 95% more than hospitals in competitive markets. *Id.* at 244, 247. And in 2016, Dr. Richard Scheffler and his colleagues found that in two different state exchange markets for the sale of individual healthcare policies—New York and California—higher premiums were associated with market concentration. Richard Scheffler, Daniel Arnold, Brent Fulton, Sherry Giled, *Differing Impacts of Market Concentration on Affordable Care Marketplace Premiums*, 35 J. HEALTH AFF. 880, 881, 883-85, 886 (2016) (*Differing Impacts*). Similarly, relatively recent published decisions have found the same phenomenon of providers successfully implementing post-merger price increases. *E.g., ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 570 (6th Cir. 2014); *In re Evanston Nw. Healthcare*, No. 9315, 2007 WL 2286195 at **13, 53-54 (FTC Aug. 6, 2007).

Consolidation erodes the quality and convenience of healthcare due to fewer incentives to compete. For example, 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 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 (2011). Price increases resulting from provider

mergers, and their concomitant increase in market power, are not mitigated by the willingness of some patients to travel farther from their home or work. For example, in 1999, Sutter Health merged with Summit Medical Center in the San Francisco Bay Area. The merging parties claimed that any price increases would be mitigated by some patients' willingness to travel farther for their medical care. After the California Attorney General's merger challenge failed, 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 occurred absent the merger. *Sutter-Summit Transaction, supra,* at 19-23.

The reason that price increases flow from acquisitions by hospital provider systems with increased market power is because healthcare markets are local. In local markets, patients are insensitive to price. Patient demand for general acute care health services is inelastic because insured patients pay out-of-pocket only a very small fraction (2-3%) of their total direct healthcare costs. *E.g.,* Gautam Gowrisankaran, et al., *Mergers When Prices Are Negotiated: Evidence from the Hospital Industry,* working paper (Mar. 1, 2013) at 26, 30, 35, *at*

http://www.u.arizona.edu/~gowrisan/pdf_papers/hospital_merger_negotiated_prices.pdf.[4]

III. THE DISTRICT COURT ERRED IN FOCUSING ON THE PATIENTS' CHOICE OF MEDICAL SERVICES RATHER THAN ON THE RESPECTIVE NEGOTIATION STRENGTH BETWEEN INSURERS AND PROVIDERS.

Historically, two principal economic approaches have been used to determine the scope of geographic markets in healthcare provider merger cases involving hospitals or hospitals and physician groups. One is the older discredited Elzinga-Hogarty test. This test attempted to delineate a market's boundaries by estimating patient inflows and outflows (using admission and discharge data) from a proposed geographic market. It analyzed 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.2d 1109, 1124 (N.D. Cal. 2001).

In more recent cases, courts have employed a model that focuses on whether a merger will result in a significant shift in bargaining strength between insurers and a hospital provider. *See, e.g., St. Alphonsus Medical Center-Nampa Inc. v. St.*

[4] However, even if patients paid a far greater percentage of direct 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. Additionally, patients rely on their treating physicians for referral and admission for hospital services; this is normally to hospitals where the physicians have privileges or established referral relationships.

Luke's Health System, Ltd., 778 F.3d 775, 784 (9th Cir. 2015); *ProMedica Health Sys.*, 749 F.3d at 569-72; *see also In re Evanston Nw. Healthcare*, 2007 WL 2286195 at **63-66. "This two-stage model of healthcare competition is the accepted model. In the first stage, providers compete for inclusion in insurance plans. In the second stage, providers seek to attract patients enrolled in the plans. Because patients are largely insensitive to price, the second stage takes place primarily over non-price dimensions. Thus, antitrust analysis focuses on the first stage" where providers bargain with insurers. *Saint Alphonsus*, 778 F.3d at 784 fn. 10 (internal quotations omitted) (citing John J. Miles, 1 Health Care & Antitrust L. § 1:5 (2014) and Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 Antitrust L.J. 671 (2000)). Like the courts, the States and their federal counterparts have come to view this bargaining model as best reflecting the realities of competition in the healthcare marketplace. *See, e.g.,* 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).

The District Court erred in relying on the Elzinga-Hogarty model to define the geographic market. Indeed, the District Court relied on Elzinga-Hogarty model (E/H model or E-H test), even though one of the creators of the test (Kenneth Elzinga) "testified [in *In re Evanston Nw. Healthcare*] that the E-H test was not an appropriate method to define geographic markets in the hospital sector." *In re*

Evanston Nw. Healthcare, 9315, 2007 WL 2286195, at *64. Specifically, the problems[5] with the E/H model in analyzing hospital markets are that it does not account for the fact that the "majority of patients are truly reluctant to travel and do not view distant hospitals as close substitutes for most services"; that those who travel "have distinct reasons for doing so"; and that patient-travel "would not inhibit merging local hospitals from increasing prices substantially." Ultimately, however, the E/H model "permits many mergers that, in fact, may lessen competition because E/H points towards a much broader scope of geographic competition than is truly present." CORY S. CAPPS, DAVID DRANOVE, SHANE GREENSTEIN, AND MARK SATTERTHWAITE, *The Silent Majority Fallacy of the Elzinga-Hogarty Criteria: A Critique and New Approach to Analyzing Hospital Mergers*, Working Paper 8216, National Bureau of Economic Research, pg. 3, at http://www.nber.org/papers/w8216.

In contrast, the appropriate bargaining model analyzes the effects of a provider merger at the contract negotiations' stage between insurers and healthcare providers. During negotiations, insurers must bargain in advance for a sufficiently viable and deep network that offers a comprehensive range of medical services for

[5]In *Evanston*, Dr. Elzinga testified that the Elzinga-Hogarty model was not created for use in hospital mergers and is ineffective because of the "silent majority fallacy" – that patients who do travel for care do not discipline prices for those patients who do not travel for care – and because of the payor problem – payors, not patients, pay hospital providers for services. *In re Evanston Nw. Healthcare*, 9315, 2007 WL 2286195, at *64.

consumers, who generally will not know in advance exactly what services will be needed. *See, e.g.,* Cory Capps, David Dranove, Mark Satterthwaite, *Competition 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.*; *see In re Evanston Nw. Healthcare*, 2007 WL 2286195 at * 61.

Various limitations and barriers contribute to relevant geographic markets being quite small when an insurer is attempting to create a viable provider network. These variables range from traffic jams at inconvenient times of the day, to the need for employers in competitive industries to offer healthcare networks with close-at-hand alternatives to recruit and retain workers. *See e.g., In re Evanston Nw. Healthcare*, 2007 WL 2286195 at *7 (employers need to offer healthcare plans that are attractive to their employees and employees prefer health plans that are geographically convenient for them and their families); 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 ("ACOs") in the San Francisco Bay Area because the dominant hospital provider system, Sutter, faces little competitive threat aside from an integrated insurance-provider, Kaiser, due to geographic barriers).

Moreover, some treatments are extended or ongoing (sometimes for months). For these patients, and for those who work, are elderly or infirm, rely on public transit, or have family responsibilities, it is important to have alternatives close by. And the States are well-aware that patients do not directly incur the costs of price increases to insurers from anti-competitive provider acquisitions. *See, e.g., St. Luke's*, 778 F.3d at 785; *In re Evanston Nw. Healthcare*, 2007 WL 2286195 at *8.

According to the United States Supreme Court, courts should adjust the analytical framework they use to determine violations of antitrust law to fit the evolution of economic thinking. *Kimble v. Marvel Entertainment,* LLC, 135 S.Ct. 2401, 2412-2413 (2015). Because "Congress neither adopted nor rejected specifically any particular tests for measuring the relevant markets, either as defined in terms of product or in terms of geographic locus of competition, . . . a merger ha[s] to be functionally viewed, in the context of its particular industry." *Brown Shoe Co. v. United States*, 370 U.S. 294, 320-22 (1962). And that evolution of economic thinking is reflected in recent court decisions in the form of the more up-to-date bargaining methodology to block anti-competitive mergers. In contrast, the District Court analyzed the relevant geographic market using the inappropriate

E/H model. As a result, it rejected the Government's proffered geographic market. *See* Op. at 9-10.[6] In doing so, the District Court erred.

IV. TEMPORARY PRICE CAPS DO NOT PERMANENTLY CURE ANTI-COMPETITIVE HARM

The District Court also credits the merging parties' temporary price cap agreements with defeating the price increases that, under the hypothetical monopolist test, the proposed merger would create within the geographic market. Op. at 11. Again, the District Court erred in including these private agreements as part of geographic market definition. The District Court also erred in agreeing with Defendants' argument that these fix-it-first private remedies would resolve the Governments' concerns as to anti-competitive effects and thus enable the transaction to go forward. *See* United States Department of Justice, Policy Guide to Merger Remedies, at 22-23 (2011), *at* https://www.justice.gov/sites/default/files/atr/legacy/2011/06/17/272350.pdf. As noted above, the *Amicus Curiae* States agree with the FTC and Pennsylvania that such unilateral, private, price caps should not be considered in assessing the legality of a merger under the antitrust laws.

Here, the proposed remedy—a limited duration price cap in contracts executed by the merging parties with two insurers—is especially problematic.

[6] The term "Op." refers to the Memorandum Opinion and Order, No. 1:15-cv-02362-JEJ, Doc. No. 132, *Federal Trade Comm'n and the State of Pennsylvania v. Penn State Hershey Medical Center et al.* (M.D. Pa. May 9, 2016).

Their imposition over the opposition of antitrust enforcers poses significant concerns, both on their own and as compared to divestiture. *See, e.g., St. Luke's*, 778 F.3d at 793; *see also, e.g., In re Evanston Nw. Healthcare*, 2007 WL 2286195 at **77, 79 (noting that it is only in a "highly unusual case" regarding a horizontal merger in which the Federal Trade Commission will select conduct remedies over divestiture). Even conduct remedies that are judicially supervised, and not opposed by the enforcers, still risk being too complex for effective judicial oversight. *See, e.g., St. Luke's*, 778 F.3d at 793; *ProMedica Health Sys.*, 749 F.3d at 573; *see also, e.g.,* JOHN KWOKA, MERGERS, MERGER CONTROL, AND REMEDIES: A RETROSPECTIVE ON U.S. POLICY, at loc. 2281, 2296, 2311, 2342, 2358 (2015 ebook). In any event, the effectiveness of these remedies is quite limited. A recent retrospective analysis of mergers subject to conduct remedies found that they led to price increases even greater than those in which the government had imposed a divestiture of certain assets. KWOKA, *supra* at loc. 1780, 1795, 1971, 1985.[7]

[7] The States may, on their own accord, resort to conduct remedies in extreme circumstances such as where one of the two merging hospitals might fail or where the merger would result in substantially large merger-specific efficiencies that would otherwise be lost. *See generally* KWOKA, *supra* at loc. 2342 (making similar points). However, an accord between a state enforcer and the merging parties addressing exceptional circumstances is vastly different than a limited-time price cap with two payors, unilaterally proposed by the merging parties, which would only defer some of the merger's anti-competitive effects to the future when it would be more difficult to unwind that merger.

Price caps, such as those proposed here (over the objections of antitrust enforcers), are particularly ineffective because even if they prevented price increases for a period of time with two payors, their ultimate expiration can lead to an increase in prices. *See, e.g.,* Balto and Geertsma, *Why Hospital Merger Antitrust Enforcement Remains Necessary*, *supra*, 34 J. HEALTH L. 129-165 (2011) (expiration of three-year price cap and four-year limitation of price growth to CPI led to price increases; price caps were judicially imposed only at insistence of court and over objections of federal antitrust enforcers); Stewart Ain, *After Merger's Bumpy Start, North Shore-L.I.J. is Clicking*, NEW YORK TIMES, (December 17, 2000), http://www.nytimes.com/2000/12/17/nyregion/after-merger-s-bumpy-start-north-shore-lij-is-clicking.html?pagewanted=all (when two year price cap imposed as conditional remedy on New York hospital merger lifted, the merged hospitals obtained increased reimbursement rates due to their stronger position in negotiations). The District Court correctly notes that a retrospective challenge to the merger can be brought post-expiration if there is an increase in prices (Op. at 10-11, 24). Nevertheless, such a challenge assumes the merged entity can be readily unwound to create two separate and equally effective competitors. *See, e.g., In re Evanston Nw. Healthcare*, 2007 WL 2286195 at *78-79.

Furthermore, in 2004, the price caps in this case would have been only a partial remedy for the panoply of anticompetitive effects. Now, the 2011 Policy

Merger Guidelines do not recognize price caps as an available remedy. This is likely because this remedy required post-merger monitoring. A fix-it-first remedy is unacceptable if the remedy must be monitored. *See*, United States Department of Justice, Policy Guide to Merger Remedies, at 22-23 *at https://www.justice.gov/sites/default/files/atr/legacy/2011/06/17/272350.pdf*.

Moreover, even if these fix-it-first remedies did not require post-merger monitoring, they do not prevent all forms of anti-competitive price increases. They cap fee-for-service pricing. And they maintain the existing differential between the two hospitals, albeit for only two insurers (Op. at 11). They do not however, address the *additional* price competition that might otherwise result from a decrease in costs as to those two insurers. "To the extent that the price arrangement in a decree freezes price or provides a cap that effectively acts as a floor, future cost savings and competition that would otherwise reduce the market price are no longer sufficient for that to occur." Farrell Malone & J. Gregory Sidak, *Should Antitrust Consent Decrees Regulate Post-Merger Pricing?*, Journal of Competition Law and Economics 3(3), 471, 481-82 (2007). Furthermore, price caps can also give "other competitors in the market an excuse to not compete on price." *Id.* Nor do they prevent the merger from having anti-competitive effects on non-price related competition such as providing cost-effective quality medical care. *See, e.g.,* United States Department of Justice, Policy

Guide to Merger Remedies (2004), *at* *https://www.justice.gov/sites/default/files/atr/legacy/2011/06/16/205108.pdf*.

Ultimately, relying on fix-it-first remedies to counter anti-competitive effects (*see* Op. at 11, 24) defeats the purpose of the Clayton Act in proscribing anti-competitive mergers. The Clayton Act allows for *ex ante* challenges to mergers that may reduce competition in a relevant geographic market. Thus, federal and state antitrust enforcers can stop those mergers before the anti-competitive effects have become a certainty, and the merged entity has become impossible to unwind. *See St. Luke's*, 778 F.3d at 783; *see also, e.g., In re Evanston Nw. Healthcare*, 2007 WL 2286195 at *44. That is why courts reviewing proposed mergers have refused to look to commercial relationships in assessing the metes and bounds of a relevant market under the hypothetical monopolist test. *Queen City Pizza v. Domino's Pizza*, 124 F.3d 430, 438-439 (3d Cir. 1997) ("no court has defined a relevant product market with reference to the particular contractual restraints of the plaintiff.")

V. THE DISTRICT COURT ERRED IN PRESUMING A MERGER WITH CLAIMED EFFICIENCIES IS BENEFICIAL. IT ALSO ERRED IN FAILING TO DETERMINE WHETHER CLAIMED EFFICIENCIES ARE VERIFIABLE, MERGER-SPECIFIC, DONE BY THE LEAST RESTRICTIVE MEANS, AND WILL BENEFIT CONSUMERS

The District Court erred in presuming that hospital mergers with purported efficiencies provide "beneficial effects to the public" (Op. at 14-15); a presumption

wrong both legally and empirically. Even when a merger may result in economies or efficiencies, Congress has struck the balance "in favor of protecting competition." *St. Luke's Health Sys.*, 778 F.3d at 788-789. Thus, the "Clayton Act does not excuse mergers that lessen competition or create monopolies simply because the merged entity can improve its operations" or achieve some economies. *Id.* Tellingly, the District Court acknowledged the absence of Supreme Court recognition of an efficiencies defense. It then crafted its own version of the defense under the guise of "balancing the equities," and stripped it of the traditional safeguards and limitations of cognizable efficiencies.

Legal skepticism of an efficiencies defense is supported by the empirical evidence that demonstrates that cost savings from mergers are rarely passed on to the consumer. Indeed, mergers generally produce higher prices, less quality, and fewer options for consumers. Indeed this is the conclusion of a recent comprehensive retrospective analysis of numerous merger studies across numerous industries. *See* KWOKA, at loc. 2642 ("While less frequently studied, the nonprice effects of mergers generally mirror the measured price effects. Anticompetitive price increases tend to be accompanied by reductions in quantity, quality, and R&D. However, evidence suggests that costs may decrease subsequent to merger, but in conjunction with measured price increases, which suggests that benefits of cost savings are not passed through to consumers.")

By conflating efficiencies with equities, the District Court completely sidesteps the rigorous analysis required to credit any claimed efficiency in merger review. That analysis requires Defendants' prove that any proffered efficiency is verifiable and achievable, merger-specific, not output limiting, and not capable of being achieved by less restrictive means than a merger. *See, e.g., St. Luke's*, 778 F.3d at 789-791; *F.T.C. v. Sysco Corporation*, 113 F.Supp.3d 1, 82 (D.C. 2015); *In re Evanston Nw. Healthcare*, 2007 WL 2286195 at *71-72. The court must also determine whether savings from the efficiencies will flow to the consumer. *F.T.C. v. CCC Holdings, Inc.* 605 F.Supp.2d 26, 74 (D.C. 2009).

To be merger-specific, defendants must "show that their efficiencies cannot be achieved by either company alone because, if they can, the merger's asserted benefits can be achieved without the concomitant loss of a competitor." *U.S. v. H & R Block, Inc.* 833 F.Supp.2d, 36, 90 (D.C. 2011). Antitrust policy recognizes that "society would be better off if the same or equivalent efficiency gains could be realized without the anticompetitive merger." Phillip E. Areeda and Herbert Hovenkamp, Antitrust Law ¶973a, at 53. In turn, these requirements fit economic thinking given that contractual combinations present a lower risk of price increases than a full merger, holding all other factors equal. KWOKA, *supra* at loc. 1592, 1608, 1618, 1635, 1710, 1827, 1842.

In imputing benefits to the merger, the District Court ignored these fundamental precepts. Indeed, the District Court considered the risk-based pricing to be merger-specific even though price-caps were implemented prior to the merger. Op. pg. 11. Moreover, a bevy of non-merger options exists that facilitate risk-based pricing. These options include local networks and tiered network integrated healthcare management organizations. They further include collaborative and integrated joint venture-type organizations involving insurers, physician groups, or hospitals that are increasingly used in the States with promising results for delivering quality healthcare 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); *Arranged Marriages, supra*, CALIFORNIA HEALTH CARE ALMANAC, at 5-9.

Likewise, the merging enables one party to use the excess bed capacity of the other. This offends fundamental merger principles. In embracing this argument, the Court sanctioned a potential output limitation agreement and ignored Defendants' concession that they can reduce capacity constraints without a merger. In fact, Defendants had pre-merger plans to reduce capacity constraints by building a new tower or transferring patients. (Op. pgs 16-18).

VI. THE DISTRICT COURT ERRED IN FINDING THAT THE MERGER WAS JUSTIFIED AS A COMPELLED REACTION TO THE AFFORDABLE CARE ACT.

At the end of its opinion, the District Court doubled-down on its apparent view that provider mergers must be presumed beneficial regardless of potential anti-competitive effects because they are blessed by the ACA. It further opined that local community hospitals were becoming "antiquated" and need to merge to "survive". Op. at 25. In fact, the ACA expressly makes clear that: "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).

The ACA contains provisions allowing physicians and hospitals participating in the Medicare Shared Savings Program to form ACOs that permit a limited degree of competitor collaboration. That said, the federal antitrust agencies' official enforcement policy regarding ACOs "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 ("CMS"), 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." Centers for Medicare and Medicaid Services, *Medicare Shared Savings Program for Accountable Care*

Organizations, 76 Fed. Reg. 67,802, 67,843 (Nov. 2, 2011). CMS further explained that competition promotes the goals of federal health policy, and market power threatens to undermine these goals. Indeed, competition in the marketplace benefits Medicare and the Shared Savings Program because it promotes quality of care and protects beneficiary access to care. Furthermore, CMS recognizes that competition benefits the Shared Savings Program by allowing the opportunity for the formation of multiple ACOs in an area; which in turn can accelerate advancements in quality and efficiency. Importantly, *all* of these benefits to Medicare patients would be *reduced or eliminated* if we were to allow ACOs to participate in the Shared Savings Program when their formation and participation would create market power. *Id., at* 67,841 (emphasis added).

Most notably, CMS rejected "the proposition that an entity under single control, that is an entity formed through a merger, would be more likely to achieve the three-part aim," *Id.* at 67,843, *i.e.*, "(1) Better care . . . ; (2) better health . . . ; and (3) lower growth in expenditures," *Id.* at 67,804. Nothing in the District Court's opinion raises, let alone addresses, any of these points.[8]

[8] The trial court also claims that consolidation is necessary in light of the ACA because community hospitals will not be able to keep their doors open otherwise. However, this "weakened competitor" argument has long been disfavored, and is cognizable only in rare cases where the acquired firm's weakness cannot be resolved by any competitive means and is fiscally fatal. *ProMedica*, 749 F.3d at 572 (citing *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1339 (7th Cir.1981) and *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1221 (11th Cir.1991)) (internal quotations and brackets omitted). Nothing in the ACA gives this "hail-Mary" defense any further support

Furthermore, this argument ignores the well-established principle that "implied repeal" of the antitrust laws is not favored. The Supreme Court has held that the antitrust laws represent a fundamental national economic policy. It explained that the guiding principle to reconciling two statutory schemes is that implied antitrust immunity is not favored, and can be justified only by a convincing showing of clear repugnancy between the antitrust laws and the regulatory system. And repeal is to be regarded as implied only if necessary to make the [subsequent law] work, and even then only to the minimum extent necessary. *Nat'l Gerimedical Hosp. & Gerontology Ctr. v. Blue Cross of Kan. City*, 452 U.S. 378, 388–89 (1981) (quotations omitted).

Finally, it is also a long-standing principle of antitrust law that anti-competitive mergers (or other private anti-competitive conduct) cannot be justified on the ground that they effectuate non-competition related goals. *See Fashion Originators' Guild of America v. Federal Trade Comm'n*, 312 U.S. 457, 467-68 (1941); *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1095 (N.D. Ill. 2012) (rejecting "defendants' claim that the merger is essential to meet the challenges of healthcare reform"); *FTC v. ProMedica Health Sys., Inc.*, No. 11-CV-47, 2011 WL 1219281, at *41-42 (N.D. Ohio Mar. 29, 2011) (concluding that healthcare reform measures do not justify the acquisition). Whether anti-competitive activity can or should be justified by health-care goals in this case is, in any event, a decision that

belongs to the States and to the federal government, not to private parties. *See Fashion Originators' Guild of America*, 312 U.S. at 467-68.

VII. CONCLUSION

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

Respectfully submitted,

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COMBINED CERTIFICATES OF COMPLICANCE

I hereby certify that:

1. This brief complies with the type-volume limitation of Fed. R. App. P. 29(d) and Fed. R. App. P. 32(a)(7)(B). It has 6283 words as counted by Microsoft Word 2010.

2. Pursuant to Local Rule 31.1(c), the electronic version of this brief is identical to the version sent in hard copy to this Court.

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DATE: June 8, 2016

s/ Brett DeLange
Brett DeLange

CERTICATE OF SERVICE

I, Brett DeLange, certify that I filed the electronic version of this brief with the Court via the CM/ECF system. The Notice of Docket Activity generated by CM/ECF system constitutes service upon all Filing Users in this proceeding. The docket for this proceeding indicates that all parties are Filing Users.

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