No. 14-35173

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Saint Alphonsus Medical Center–Nampa Inc.; Saint Alphonsus Health System Inc.; Saint Alphonsus Regional Medical Center, Inc.; Treasure Valley Hospital Limited Partnership; Federal Trade Commission; and State Of Idaho,

Plaintiffs-Appellees,

and

Idaho Statesman Publishing, LLLC; The Associated Press; Idaho Press Club; Idaho Press-Tribune LLC; Lee Publications Inc.,

Intervenors

– v. –

St. Luke's Health System, Ltd.; St. Luke's Regional Medical Center, Ltd.; and Saltzer Medical Group,

Defendants-Appellants.

Appeal from the United States District Court for the District of Idaho
Case Nos. 12-cv-560 and 13-cv-116
Honorable B. Lynn Winmill, Presiding

BRIEF OF THE ASSOCIATION OF INDEPENDENT DOCTORS AS *AMICUS CURIAE* IN SUPPORT OF APPELLEES

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CORPORATE DISCLOSURE STATEMENT

The Association of Independent Doctors is a non-profit trade organization. It does not have a parent corporation or issue publicly traded securities.

/s/ *Robert E. Bloch*

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INTRODUCTION & INTEREST OF THE *AMICUS*[*]

St. Luke's insists that its acquisition of the Saltzer Medical Group should not be enjoined because it will improve the quality and efficiency of care in and around Nampa, Idaho. But our broad experience, significant academic literature, and ample record evidence show otherwise. Now that Saltzer is a part of the St. Luke's hospital system, it operates as a "hospital-based outpatient facility," and its physicians can bill inflated "hospital-based rates" for the same services they provided before the merger at far lower prices. And because St. Luke's now controls 80% of the market for primary care services in Nampa as a result of the acquisition, it has the market power to make these price increases stick.

That is not all. Before the acquisition, independent Saltzer physicians were free to refer patients to whichever specialists or facilities they judged to serve their patients' best interests, taking account of quality, convenience, and cost. Now, as employees of a multi-billion-dollar business, Saltzer physicians (and, by extension, their patients) no longer have that choice. The record demonstrates that, in practice, Saltzer physicians

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* No party or counsel for any party authored this brief in whole or in part or otherwise contributed monetarily towards its preparation or submission. No other person other than *amici*, their members, and their counsel contributed monetarily towards the preparation or submission of this brief. All parties have consented to the filing of this brief.

now must refer their patients exclusively to high-cost specialists employed by St. Luke's, in a scheme that would be civilly sanctionable under the Stark Law and criminally sanctionable under the Anti-Kickback Statute if the Saltzer physicians remained independent. This hurts patients, not only because it means they pay higher prices for lower quality health care, but because they lose their only real advocates in the system—independent doctors who place patient interests ahead of profit motive.

These adverse effects are not unusual, but are becoming all too routine. With increasing frequency, large hospital systems are swallowing up independent physician practices. Indeed, the rate of hospital mergers and acquisitions has more than doubled since 2009. These systems use huge salaries and hospital privileges as leverage to force independent physicians to become captive hospital employees so the hospital can acquire market power and the inflated profits that attend it. As the New York Times recently reported, "[t]he rhetoric is all about efficiency," but "[t]he reality is all about higher prices." *See* Julie Creswell & Reed Abelson, *New Laws and Rising Costs Create a Surge of Supersizing Hospitals*, N.Y. Times (Aug. 12, 2013) (available online at tinyurl.com/m67qmps). And patients are the ones that get the bill.

The Association of Independent Doctors (AID) is a national trade association established to ensure that decisionmakers at every level under-

stand the importance of independent physician practices to the quality and cost of health care, patient choice, jobs, and the economy. In the medical field, as in any other industry, competition is an important check against higher prices, diminished quality, and loss of consumer choice. Yet the number of independent doctors as a percentage of total doctors has declined dramatically in recent years, from 57% in 2000 to 36% in 2013. *See* Victoria Stagg Elliott, *Doctors describe pressures driving them from independent practice*, American Medical News (Nov. 19, 2012) (archived at perma.cc/8ZBL-JQQT). During the same period, there has been a 55% surge in hospitals' employment of doctors. *See* Medicare Payment Advisory Commission, *Report to Congress: Medicare and the Health Care Delivery System* 33 (June 2013) (archived at perma.cc/S538-HEP5). As a result, massive regional hospitals now have far greater market share, and far less competition, than they did just ten years ago.

This tectonic shift in the organization of medical practice—the rapid decline of independent practices and commensurate rise of dominant hospital systems—has coincided with the *doubling* of health care costs over the last decade. In fact, health care costs for an average family of four exceeded $20,000 per year in 2012 for the first time. *See* Jessica Dickler, *Family health care costs to exceed $20,000 this year*, CNN Money (Mar. 29, 2012) (archived at perma.cc/5H6W-MDXZ). Because stemming these

trends is vital to independent physicians and the health care system as a whole, AID's members have a strong interest in the proper resolution of this appeal.

ARGUMENT

A. Large hospital systems provide lower quality and more costly care.

There are two predominant models of physician practices today: independent family doctors who are a part of their communities, and corporate employees whose loyalty lies with their hospital-system employers. The hospital-system employer in this case has more than 11,000 employees and about $1.5 billion in annual gross revenue. *See* Audrey Dutton, *Under fire, St. Luke's says it's trying to fix broken system*, Idaho Statesman (Aug. 11, 2013) (archived at perma.cc/6L3N-M26Z).

According to St. Luke's, the corporate model means higher quality of care at lower cost—indeed, "a new and superior form of healthcare" altogether. Opening Br. 4. But the record evidence, academic literature, and our own body of experience overwhelmingly demonstrate that the opposite is true. Physician independence offers a number of very important benefits to both quality and cost for individual patients and the health system as a whole—benefits that are undermined when physicians are "acquired" and employed by large hospital systems.

1. *The acquisition will lower the quality of care.*

a. We begin with the issue of quality. Hospital acquisitions of independent physician practices harm quality of care because they limit physician choice—and, by extension, *patient* choice. Most fundamentally, they limit a doctor's ability to refer patients to specialists outside the hospital system. That can only harm patients whose best interests are subordinated to the economic benefit of the physician's employer.

"A term that some hospitals use to describe the referral of patients to providers and facilities outside their system is 'leakage,'" which represents "lost revenue." Richard Gunderman, *Should Doctors Work for Hospitals?*, The Atlantic (May 27, 2014) (archived at perma.cc/U55B-GA44). One easy way to solve the "leakage" problem is simply to pay independent doctors for referrals—but that would be a violation of both the civil Stark Law and the criminal Anti-Kickback Statute, both of which prohibit kickbacks for referrals. *See* 42 U.S.C. § 1395nn; 42 U.S.C. § 1320a-7b. *See also* Robert S. Huckman, *Hospital Integration and Vertical Consolidation: An Analysis of Acquisitions in New York State*, 25 J. Health Econ. 58, 61 (2005) ("the 'purchase' of patient referrals" is "labeled [a] 'kickback[]' and [is] subject to legal and professional sanction").

It is not necessarily illegal, however, for a hospital to encourage its employed doctors to refer patients to its *other* employed doctors. 42 U.S.C.

§ 1395nn(b). Thus, rather than paying kickbacks, hospitals seeking "to plug up the holes" of a leaky referral practice simply employ physicians directly and require them to refer internally. Gunderman, *supra*.

The record evidence shows that is going on here. *See* ER35-36 ¶¶ 136-139 (citing evidence). To be sure, the employment contracts in this case, on their face, permit the Saltzer physicians to "refer patients to any practitioner or facility regardless of its affiliation with St. Luke's." ER35 ¶ 134. But that typical language has limited practical effect, in our experience. Hospitals of course understand that *express* internal referral requirements could raise serious antitrust concerns by foreclosing competition in the market for referral services. But contract language and practical expectations are not always aligned, however, and here they are not. At large systems like St. Luke's, employed physicians are expected to refer internally. *See generally* ER35-36 ¶¶ 135-140. In our experience, they are pressured to do so by hospital management, who can (and do) threaten to terminate (or to decline to renew) employment contracts.

In the months and years since St. Luke's acquired practices similar to Saltzer on similar terms, for example, referrals by the acquired physicians to hospitals outside the St. Luke's system almost entirely ceased. *See* ER35-36 ¶¶ 136-139. And numerous documents in the record suggest that the same would happen here. *See* St. Alphonsus Br. 25-27 (collecting and

describing evidence). Thus, as the district court found, it is "virtually certain" that, "in practice," Saltzer physicians will refer exclusively within the St. Luke's system if the transaction is not unwound. ER35-36 ¶¶ 135, 140. Far from clearly erroneous, that finding is undeniably correct.

It also is borne out by the academic literature. A recent study of health care mergers in New York found, for example, that one of the most pronounced effects of "vertical consolidation" of medical practices is "that acquirers steal business within target markets" by controlling referrals. Huckman, 25 J. Health Econ. at 77. In other words, "hospital consolidation[s] . . . do not simply reduce the number of firms providing substitute products"; rather, they also "alter the allocation of customers across firms with differentiated levels of quality and cost" by manipulating referral patterns. *Id.* And the impetus for this secondary effect is no mystery. By gaining "control of referrals," hospital systems "both get more patients and generate more revenue per patient." Gunderman, *supra*.

b. All of this matters to quality of care because there is no guarantee that the most highly-skilled, best equipped, or most convenient specialists will be employed by the same hospital as the referring doctor. What the managers of hospital systems deride as "leakage" often means only that a patient is receiving the best care available irrespective of the provider's affiliation. A competing hospital may have a particular medical tool that

would be most appropriate for a certain patient; may employ a specialist who is particularly skilled at a given procedure; or may be more conveniently located for a patient whose travel options are limited. These superior care options are closed off by hospital-system referral practices. Worse still, when patients of hospital-employed doctors are "choosing a [specialist] or course of treatment," they are "kept in the dark" about the profit-driven limitations on referrals imposed by the hospital system; indeed, "few patients would suspect their doctors to have any motive in mind but their patients' health." Steven D. Wales, *The Stark Law: Boon or Boondoggle?*, 27 Law & Psychol. Rev. 1, 4-5 (2003). But when it comes to hospital-employed doctors, they would be wrong. And their care would suffer as a result.

Pressure to make internal referrals impedes quality of care in another way: It "increase[s] physicians' incentives to supply unnecessary treatment [when] such treatments are used as a vehicle to pay what are effectively [internal] kickbacks for inappropriate referrals." Laurence C. Baker et al., *Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending*, 33 Health Affairs 756, 756 (2014). Before Congress passed the Stark Law, it became clear that "physicians who have a financial interest in referrals" tend to "provide excess care in order to generate more fees by referring a patient . . . re-

gardless of whether the patient is in need of the given medical service." Wales, 27 Law & Psychol. Rev. at 4. Again, it is the patients subjected to unnecessary hospital stays—and the patients' families—who pay the price.

In contrast, independent physician practices are not hindered by the same arbitrary limitations or influenced by the same economic incentives; the Stark Law ensures as much. Because independent physicians have the freedom to refer their patients to the best, most appropriate specialists without concern for who *employs* the specialists, they are able to offer higher-quality and more patient-centric care. Thus, there is little surprise that "medium-sized and large independent physician groups perform[] consistently better on process measures of quality of care" as compared with large "hospital-based groups," including lower rates of hospital readmissions and more effective diagnostic testing. J. Michael McWilliams, et al., *Delivery System Integration and Health Care Spending and Quality for Medicare Beneficiaries*, 173 J. Am. Med. Assoc. Intern. Med. 1447, 1451-1452 (2013).

There also "is evidence that patients in smaller practices are better able to get appointments when they want them and better able to reach their physician via telephone, compared to larger practices," and "that physicians, patients, and staff know each other better in small practices." Lawrence P. Casalino et al., *Small Primary Care Physician Practices Have*

*Low Rates Of Preventable Hospital Admission*s, 33(9) Health Affairs 1, 6 (2014) (published online before print; available at http://content.healthaffairs.org/content/early/2014/08/08/hlthaff.2014.0434.full.html). "[T]hese closer connections," possible only when doctors play the role of community members rather than corporate employees, also "result in fewer avoidable admissions." *Id.* These facts—which directly address the consumer welfare that is at the core of antitrust policy (*see Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979))—are well known and clearly established; St. Luke's simply ignores them.

c. Against this backdrop, St. Luke's is wrong to assert that "the undisputed evidence" shows "that there was no likelihood of anticompetitive effects in any Nampa adult PCP services market." Opening Br. 37. It is well settled that artificially limiting patient choice and diminishing the quality of care are forms of antitrust injury in their own right. As the Seventh Circuit has explained, it is an "anticompetitive effect" to limit, override, or otherwise "interfer[e] with consumers' free choice in choosing a product of their liking." *Wilk v. Am. Med. Ass'n*, 895 F.2d 352, 371 (7th Cir. 1990) (parenthetical omitted); *see Glen Holly Entertainment, Inc. v. Tektronix, Inc.*, 352 F.3d 367, 374 (9th Cir. 2003). Commentators agree. *See, e.g.*, Herbert Hovenkamp, *The Monopolization Offense*, 61 Ohio St. L.J. 1035, 1041 (2000) (it is an antitrust harm to "reduc[e] the array of

choices that consumers would face under more competitive conditions"). The basis for this rule is plain: conduct with no effect apart from eliminating a consumer's ability to choose a rival's product is, by its definition, a foreclosure of competition. *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 605 (1985); *see also* Robert Bork, The Antitrust Paradox 138 (1978). That is just what St. Luke's referral scheme accomplishes. Similarly, the "deterioration in quality of goods or services," standing alone, can be an "anticompetitive effect." *United States v. Brown Univ.*, 5 F.3d 658, 668 (3d Cir. 1993). That, too, is the inevitable effect of the transaction challenged here. And that is an effect with human as well as economic costs, because the "deterioration in quality" is a deterioration in patient care and well-being.

2. *The acquisition will increase the cost of care.*

It would be bad enough if the acquisition of independent physician practices by large hospitals simply reduced the quality of care and eliminated competition for referrals. But it is worse than that—it also increases the cost of care, often dramatically. And this case is no exception.

a. Hospital spending is today "the largest category of health care costs, consuming nearly one-third of national health expenditures." Bob Kocher & Ezekiel J. Emanuel, *Overcoming the Pricing Power of Hospitals*, 308 J. Am. Med. Assoc. 1213, 1213 (2012). In 2012 alone, Americans spent

a staggering $880 *billion* on hospital-based care, exceeding the amounts spent on all of Social Security ($769 billion) and the national defense ($671 billion) during the same year. *Id.* Crucially, "hospital price increases are now the largest contributor to increases in insurance premiums." *Id.* Put simply, large hospital systems provide the most costly care possible. And St. Luke's is a prime offender—its system includes three of the top five highest-paid hospitals in Idaho (ER28 ¶ 88), where healthcare spending already substantially exceeds the national average (ER39 ¶¶ 156-160).

A principal explanation for such inflated hospital costs is that third-party payers like Medicare and private insurers reimburse hospitals at far higher rates than independent physician practices for otherwise identical services. *See* James D. Reschovsky & Chapin White, *Hospital Outpatient Prices Much Higher than Community Settings for Identical Services* 2 (June 2014) (archived at perma.cc/97YT-UWWA). Thus, "[r]ecent increases in the employment of physicians and acquisition of community-based physician practices by hospitals . . . are resulting in more and more services being paid at higher hospital outpatient rates." *Id.*

But it is not just higher billing rates that explain the higher cost of care in hospital-based outpatient facilities. One recent academic study showed that, even after "controll[ing] for payment rates and case mix," "integrated health care delivery systems" "are often outperformed" on

efficiency and cost measures "by relatively small physician-owned practices." John Kralewski et al., *Do Integrated Health Care Systems Provide Lower-Cost, High-Quality Care?*, 40 Physician Exec. J. 14, 18 (2014). As we have discussed, one possible explanation for higher costs is hospital systems' encouragement of employed doctors to order unnecessary care. Baker, 33 Health Affairs at 756. Another recent academic study confirmed that "hospital ownership of physician practices leads to [*both*] higher prices *and* [overall] higher levels of hospital spending." *Id.* at 762 (emphasis added).

Against this backdrop, "several [recent] econometric studies have [addressed] the relationship between price and hospital concentration" in markets throughout the United States and found that "for the most part, hospital mergers in concentrated markets result in significant price increases." Martin Gaynor & Robert Town, *The impact of hospital consolidation—Update* 2 (June 2012) (archived at perma.cc/UX6D-WUSM).

All of this is well corroborated by the evidence before the district court. "St. Luke's own analysis of the Acquisition considered the possibility that it could increase commercial reimbursements by insisting that health plans pay higher 'hospital-based' rates for routine ancillary services, such as X-rays and laboratory tests, even when those services are performed in the same physical location as before the Acquisition." ER33 ¶ 123 (citing

Exhibit 1277, SLHS000820291 at -297; Trial Tr. 252-253 (J. Crouch)). And "if St. Luke's were to bill for these ancillary services at the higher 'hospital-based' rates," as it surely will if the acquisition is not unwound, costs to payers "would increase by 30 to 35 percent." *Id.* ¶ 125 (citing Trial Tr. 253-254 (J. Crouch)). The evidence shows that St. Luke's plans to bill "office/outpatient visits" at the Saltzer office at "hospital-based" rates as well, reaping a staggering 60% increase in billings. ER34 ¶ 128 (citing LaFluer Deposition (Exhibit 54) at 74; Trial Tr. 735-36 (N. Powell); Exhibit 1480 at CON0000984-026, -027).

b. For its part, St. Luke's does not deny that it is using its acquisition of Saltzer to charger higher hospital-based reimbursement rates across the board. Instead, it argues that the price increases are "meaningless" for antitrust purposes because they are not a consequence of "market power," but are instead the result of pre-negotiated reimbursement rates set "unilaterally" by Medicare and insurers; it also argues that because increased prices for ancillary services are outside the defined market, those increases are irrelevant to establishing anticompetitive harm. *See generally* Opening Br. 37-45.

Those arguments are misleading. This case inovlves reimbursement rates for commercial health insurance, not Medicare, and the evidence shows that these prices are determined through *bilateral* negotiations

between providers and insurers. *E.g.*, ER29 (¶ 109) (citing Trial Tr. 1354 (Dr. Dranove); Trial Tr. 239 (J. Crouch)); *see also* Trial Tr. 3425 (Dr. Dranove). Before the acquisition, St. Luke's and Saltzer were direct competitors; indeed, from the perspective of third-party payers, each was the "best alternative to a negotiated agreement" with the other. *Id.* But because they are now a single entity, "[t]he Acquisition adds to St. Luke's market power and weakens BCI's ability to negotiate with St. Luke's," allowing St. Luke's to drive up prices above the competitive level. ER30 ¶ 111.

The academic literature also consistently demonstrates that, contrary to St. Luke's assertion that prices are dictated uniformly throughout Idaho, there is "large variation in the relative prices . . . across markets" for the same services, precisely because there are "large differences in the bargaining clout of hospitals relative to health plans that allow some hospitals to negotiate much higher prices than others." Reschovsky & White, 16 Nat'l Inst. for Health Care Reform at 5. *See also* Chapin White et al., *Understanding Differences Between High- and Low-Price Hospitals: Implications for Efforts to Rein in Costs*, 33 Health Affairs 324 (2014). Again, that general observation is borne out in the record evidence here. *See* St. Alphonsus Br. 34 (collecting and describing evidence). The economic significance of negotiation is, moreover, a necessary predicate to

St. Luke's argument that, as an alternative to divestiture, "[t]he court could have required Saltzer and St. Luke's to negotiate separately with health plans for fee-for-service contracts, so that both Saltzer and St. Luke's would be free to enter independently into agreements with payers." *See* Opening Br. 61-62; ER 58 ¶¶ 59-62 (rejecting this argument); St. Alphonsus Br. 51 (further explaining why this rejection was correct).

Finally, it makes no practical difference that higher prices resulting from the transaction are, in part, for ancillary services rather than primary care services; it is just as much a harm to competition for a defendant to use market power in a primary market to "foreclos[e] rivals in [a] complementary market even [when] the defendant sells the two products separately." Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law ¶ 1757a (3d ed. 2007). *Cf.* Sze-jung Wu et al., *Price Transparency For MRIs Increased Use Of Less Costly Providers And Triggered Provider Competition*, 33 Health Affairs 1391 (2014) (demonstrating that markets for ancillary services are competitive when patients are given choice and prices are transparent). And, regardless, the evidence demonstrates that St. Luke's will have the power to bill inflated rates for primary care services *themselves*, and that "[t]he leverage gained by the Acquisition would give St. Luke's the ability to make these higher rates 'stick' in future contract negotiations." ER34 (¶¶ 128, 129).

B. The speculative efficiencies identified by St. Luke's as following from the acquisition can be achieved by other means that are not harmful to competition.

In response, St. Luke's asserts that preserving the acquisition would "promot[e] the procompetitive goal of integrated care" and risk-based compensation. Opening Br. 46. As St. Luke's sees it, "the cost and quality of healthcare in the U.S. suffer because the system is dominated by fragmented care." Opening Br. 6. In this "fragmented" system, "there is no reward for . . . teamwork among providers," and isolated doctors never really "accept risk and accountability for patient care." Opening Br. 7-8. The "cure" for this troubling fragmentation, according to St. Luke's, is "integrated" care and risk-based pricing, which it says are possible only through massive health systems, which have the "technological infrastructure" and "the scale and breadth of service capacity necessary to become fully integrated." Opening Br. 8, 11.

St. Luke's is not the only hospital telling this tale. In recent years, "[h]ospitals [have been] buying up [independent] medical practices at a feverish pace." Gunderman, *supra*. And to justify these acquisitions, it is a common refrain "that by employing physicians, hospitals can achieve greater integration of care." *Id.*; *see also* Thomas C. Tsai & Ashish K. Jha, *Hospital Consolidation, Competition, and Quality: Is Bigger Necessarily Better?*, 312 J. Am. Med. Assoc. 29, 29 (2014) (the argument "that merging

of hospital systems can provide better care" typically relies on the assertion that "high-volume institutions . . . achieve more 'integrated' care").

But there are two notable problems with the claim that only "a larger health system that employs physicians and that has invested in high-quality health information technology can achieve the benefits of integrated care" and risk-based compensation. Opening Br. 47. *First*, there is no basis—apart from St. Luke's bald assertions—for thinking that the merger actually would achieve either of those "speculative" goals. Trial Tr. 3562, 3582 (Dr. Kizer). As we demonstrate below, the academic literature, based on broad empirical experience, indicates that it would not. *Second*, the evidence—both in the record and more broadly—is crystal clear that, however the merger might encourage better coordination of care and results-oriented compensation, those benefits may be achieved without consolidation and thus are not "merger-specific." The district court was therefore correct to reject St. Luke's arguments on this score.

1. *There is no evidence that the acquisition will promote integration of health care at all.*

a. Notwithstanding St. Luke's contrary suggestion, there is no credible evidence—on this record or anywhere else—demonstrating that merging physician groups with large hospital systems actually promotes integrated care or any other procompetitive efficiencies. St. Luke's

identifies no such evidence in its opening brief; instead, it merely cites the district court's description of what St. Luke's *believed* the merger would accomplish (Opening Br. 46 (citing ER56 ¶¶ 44-45)) and what it purportedly *intended* the merger to achieve (*id.* (citing ER12)). But St. Luke's wholly ignores the district court's separate—and assuredly correct—conclusion that "[t]here is no empirical evidence to support the theory that St. Luke's needs a core group of employed primary care physicians . . . to successfully make the transition to integrated care." ER43 ¶ 181; *see also* FTC Br. 49-50 (collecting evidence demonstrating that St. Luke's proposed efficiencies are speculative and "experimental").

That omission is understandable, because the literature is clear that consolidation of physician practices with hospitals (best described as "economic integration" or "organizational integration") is *not* correlated with coordination of care across practices (understood as "clinical integration"). One recent study published in the prestigious Journal of the American Medical Association Internal Medicine found, for example, that "[i]ntegration of physicians with hospitals . . . has not been reliably associated with clinical systems to coordinate care." McWilliams, 173 J. Am. Med. Assoc. Intern. Med. at 1448.

That finding is consistent with earlier studies explaining that, because "economic integration is not designed primarily to promote clinical

integration," the evidence points to a "lack of [any] relationship" between the two. Lawton Robert Burns & Ralph W. Muller, *Hospital-physician collaboration: landscape of economic integration and impact on clinical integration*, 86 Milbank Q. 375, 404 (2008); *see also, e.g.*, Alison Evans Cuellar & Paul J. Gertler, *Strategic integration of hospitals and physicians*, 25 J. Health Econ. 1 (2006) (similar). A separate report published in 2012 similarly concluded that, while "[c]onsolidation between physicians and hospitals" has "the *potential* . . . for creating integration," recent "research evidence" indicates that "consolidation d[oes] *not* lead to true integration," and that "[c]onsolidation is often motivated," instead, "by a desire to enhance bargaining power by reducing competition." Gaynor, *The impact of hospital consolidation,* at 4-5 (emphasis added; other emphasis omitted). Just so here.

These studies—which are in accord with the expert testimony presented at trial (*e.g.*, Trial Tr. 3419-3420 (Dr. Dranove); *id.* at 3525-3527 (Dr. Kizer))—confirm what common sense suggests: Mergers like the acquisition at issue in this case are driven by the lure of increased profit, not coordination of care.[1]

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[1] St. Luke's also suggests that "scale" encourages acceptance of sophisticated information technologies and other costly quality improvements. Opening Br. 7, 11. But the expert testimony was that "independent providers certainly have available to them a variety of electronic medical

2. *The purported benefits of the acquisition are speculative and not merger-specific.*

Even if there were evidence that meaningful clinical integration or other procompetitive efficiencies might result from the acquisition, there is no evidence that any such benefits would be merger-specific.

a. The legal framework is familiar. An antitrust defendant may rebut evidence of a prima facie violation of the Sherman and Clayton Acts by showing that the challenged transaction would produce "'significant' or 'extraordinary' efficiencies" to offset the harm to competition. Areeda & Hovenkamp, *supra*, ¶ 976d. It is established, however, that "the asserted efficiencies must be 'merger-specific' to be cognizable as a defense." *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 721 (D.C. Cir. 2001); *see also ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 572 (6th Cir. 2014) (efficiencies must "result from th[e] merger" itself, and not independent initiatives by "the merging parties"). "An efficiency is said to be 'merger specific' if it is a unique consequence of the merger—that is, if it could not readily be attained by other means or if the social cost of attaining it by other means is at least as high as the social cost of the merger." Areeda & Hovenkamp, *supra*, ¶ 973a; *see also* U.S. Dep't of Justice & FTC, *Horizontal Merger*

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records [and] data analytics tools that can be used to support or facilitate providing integrated care." Trial Tr. 3522 (Dr. Kizer). *See also* St. Alphonsus Br. 41-42 (collecting additional evidence); Tsai, 312 J. Am. Med. Assoc. at 30 ("small institutions can do [sophisticated IT] quite well").

Guidelines § 10 (2010) (hereinafter "*Guidelines*") (archived at perma.cc/-32U3-P4J3) (an efficiency is "merger-specific" when it is "likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of [it]"). Efficiencies are not "merger-specific if they could be attained by practical alternatives that mitigate competitive concerns." *Guidelines* § 10 n.13.

Here, there is no doubt that "practical alternatives" to the merger are available to achieve integration of care. The evidence here shows that "physicians are committed to improving the quality of health care, and lowering its cost, whether they are employed or independent." ER42 ¶ 180 (citing Trial Tr. 3524 (Dr. Kizer)). And "[i]t is [a] committed team" of doctors, and not "a large number of physicians" or "any one specific organization structure" "that is the key to integrated medicine." ER43 ¶¶ 182, 184 (citing Trial Tr. 195 (Crouch); Trial Tr. 3525 (Dr. Kizer)). As one commentator has explained, "[c]linical integration requires meaningful data sharing, systems for effective hand-offs [of patients], and streamlined care transitions," which "can be achieved through other mechanisms" than mergers of hospital systems with physicians practices. Tsai, 312 J. Am. Med. Assoc. at 29.

One alternative approach for achieving clinical integration, for example, is "participating in health information exchanges." Tsai, 312 J. Am.

Med. Assoc. at 29. Such exchanges provide seamless, electronic transfer of clinical information among different health care information systems. Crucially, "there has been a rapid increase in the availability of health information exchanges across the nation and many hospitals are now participating in these arrangements." *Id*. But, ironically, "[l]arger systems may be less motivated to join health information exchanges" because "information is seen as a tool to retain patients within their system, not as a tool to improve care." *Id*.; *see also* Amalia Miller & Catherine Tucker, *Health Information Exchange, System Size And Information Silos*, 33 J. Health Econ. 28 (2014). In this way, "hospital mergers may create new islands of data" that *hinder* rather than promote integration. Tsai, 312 J. Am. Med. Assoc. at 29. Accordingly, as one expert in this case concluded, "employment of physicians—*i.e.*, the transaction of St. Luke's acquiring Saltzer—is simply not necessary to provide integrated patient care." Trial Tr. 3522 (Dr. Kizer); *see also* FTC Br. 51-52 (detailing additional evidence).

St. Luke's claim that only behemoth hospital systems are capable of effectively implementing risk-based compensation schemes (Opening Br. 50-51) also is mistaken. One successful emerging strategy for performance-based compensation among independent physicians is "patient-centered medical home" networks, which employ a team-based model for comprehensive and continuous care. Third-party payers like Blue Cross

Blue Shield are aggressively promoting the medical-home approach, which—in addition to promoting integrated care—eliminates fee-for-service reimbursements and instead "link[s] reimbursement to quality and outcomes." *See* Blue Cross Blue Shield Association, *Blue Plans Improving Healthcare Quality and Affordability through Innovative Partnerships with Clinicians* 1 (Feb. 13, 2014) (archived at perma.cc/SA5-DEHM). The national Blue Cross program, which is present in Idaho, already has eliminated hundreds of millions of dollars in excess costs. *Id.*; *see also* ER43 ¶ 183 ("In Idaho, independent physician groups are using risk-based contracting successfully.") (citing Trial Tr. 195-196 (J. Crouch)).

Beyond that, the record evidence demonstrated that "there are physician groups comparable in size to Saltzer, even groups smaller than Saltzer, that are forming [accountable care organizations] that are willing to take on risk." Trial Tr. 3454 (Dr. Dranove); *see also* Trial Tr. 3592-3593 (Dr. Kizer) (similar).[2] True enough, "they may not succeed, . . . [b]ut St. Luke's might not succeed either." Trial Tr. 3454 (Dr. Dranove).

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[2] Accountable care organizations, or ACOs, are "are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their . . . patients." Centers for Medicare & Medicaid Services, *Accountable Care Organizations (ACO)* (archived at perma.cc/QG7N-EQWL). Although "[p]articipating in an ACO is purely voluntary for providers" (*id.*), the Affordable Care Act encourages health care providers to participate through the Medicare Shared Savings

There also is evidence that "independent groups of Saltzer's size can and do participate in risk-based arrangements" like "health maintenance organizations" and simple "risk contracting," with notable success. Trial Tr. 3500-3501 (Dr. Dranove). In short, "employment" of physician groups by hospitals "is [neither] necessary nor sufficient to move away from fee-for-service" and "providing higher-quality, lower-cost care." Trial Tr. 3523 (Dr. Kizer); *see also* Trial Tr. 196 (J. Crouch) ("ownership is not what differentiates success in the system"). That is, whatever effects may be tied to the merger, those are not the effects that help patients.

b. Perhaps recognizing the broad availability of these alternative approaches, St. Luke's shifts focus by criticizing the district court for "focusing on generalities, rather than the facts of *this* transaction and healthcare in *this* region." Opening Br. 51. According to St. Luke's, Saltzer attempted to implement integration and other quality improvement strategies in the past and failed. Opening Br. 48-51. As St. Luke's sees it, the district court's decision thus effectively outlaws all acquisitions of physician practices by hospital systems because, if mere "aspirational generalities" (Opening Br. 47) are sufficient to overcome the efficiencies realized

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program. *See* Patient Protection and Affordable Care Act § 3022, Pub. L. No. 111-148, 124 Stat. 119, 395-399 (2010) (codified at 42 U.S.C. 1395jjj).

by a transaction, "there is no case in which the benefits of integrated care could be deemed 'merger-specific'" (Opening Br. 51). That is incorrect.

To begin with, St. Luke's is manifestly wrong that the district court's decision here will have "profound implications for the U.S. healthcare system" by outlawing all future mergers. Opening Br. 51. The decision does not constrain procompetitive acquisitions, but reaches only anticompetitive consolidations. Most obviously, if the post-acquisition firm resulting from a future merger does *not* have market power—that is, if the acquiring hospital and the physician practice could not impair competition once combined—no antitrust concerns will arise, and the transaction will be allowed to proceed. Otherwise, it will not. And that is as it should be.

Beyond that, St. Luke's appears to believe that once it identifies possible procompetitive benefits of the transaction, the burden shifts back to the government to prove that the benefits were not merger-specific. *See* Opening Br. 54-57. That is not the law. As the D.C. Circuit has recognized, "the asserted efficiencies must be 'merger-specific' to be cognizable as a defense." *Heinz*, 246 F.3d at 721. *See also* Areeda & Hovenkamp, *supra*, ¶ 973a ("the efficiency defense requires a showing that claimed efficiencies are 'merger specific'"). And because "it is incumbent upon the merging firms to substantiate efficiency claims" (*Guidelines* § 10), *St. Luke's* bore the burden of demonstrating, from the outset, that the acquisition would

have not just procompetitive benefits, but *merger-specific* procompetitive benefits.

St. Luke's has not come close to making that showing in this case. In fact, it merely asserts that the merger would be procompetitive, as though saying it makes it so, without pointing to any *evidence* to that effect. As one expert explained, "[St. Luke's] claims about improved quality are speculative," and the various initiatives the St. Luke's touts in its brief "have not [actually] been demonstrated to improve quality." Trial Tr. 3562, 3582 (Dr. Kizer). Even now, St. Luke's points to no evidence that whatever benefits the merger might achieve could not be achieved by other means. Thus, as the district court explained: "There is no empirical evidence to support the theory that St. Luke's needs a core group of employed primary care physicians . . . to successfully make the transition to integrated care." ER43 ¶ 181. St. Luke's does not even acknowledge that finding, much less attempt to refute it. Without evidence of merger-specificity, the asserted benefits do not weigh in the balance at all. And so it is here.

C. Competition, not consolidation, will better ensure efficiency and quality.

One final observation follows inescapably: Contrary to St. Luke's unsupported assertions, competition, not consolidation, better ensures efficiency and quality in the delivery of healthcare services.

"Moving from [a model of] hospitals [as] price setters to a market in which patient demand drives hospital prices and quality improvement" necessarily requires "systems that [concentrate on] outcomes as opposed to activity, [and that] are focused on service and quality" as opposed to volume. Kocher & Emanuel, 308 J. Am. Med. Assoc. at 1214. Recent literature concerning the effects of competition on healthcare quality and cost repeatedly has shown that "both mortality and expenditures are lower in less concentrated markets" that are sensitive to competition. Martin Gaynor et al., *The Industrial Organization of Health Care Markets* 13 (Jan. 7, 2014) (draft archived at perma.cc/HBP2-3QGW). Put another way, "introduction of competition l[eads] to an increase in quality without a commensurate increase in expenditure." Martin Gaynor et al., *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Services* 4, National Bureau of Economic Research Working Paper 16164 (2010) (archived at perma.cc/WBR6-FWLG). "These results suggest that competition is an important mechanism for enhancing the quality of care patients receive" "without chang[ing the] total expenditure or in-creas[ing the] expenditure per patient." *Id.* at 31-32. In a word, while consolidation may help hospitals' (and some physicians') bottom lines, competition is what helps patients.

These observations are not just about numbers and statistics; rather, they strike at the core of our professional and ethical obligations as physicians. Simply put, "hospital competition save[s] lives." Zack Cooper, et al., *Does Hospital Competition Save Lives? Evidence from the English National Health System Patient Choice Reforms*, 121 Econ. J. F228, F251 (2011). Our experience supports the same conclusion: When massive hospital systems take over independent physician practices, inevitably costs rise and quality falls. And, while independent doctors often feel the pinch as a result, far more important, *patients* do. That is not a result the antitrust laws should countenance.

CONCLUSION

The judgment below should be affirmed.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(a)(7), the undersigned counsel for the Association of Independent Doctors certifies that this brief:

(i) complies with the type-volume limitation of Rule 29(d) because it contains 6,466 words, including footnotes and excluding the parts of the brief exempted by Rule 32(a)(7)(B)(iii); and

(ii) complies with the typeface requirements of Rule 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared using Microsoft Office Word 2007 and is set in Century Schoolbook font in a size equivalent to 14 points or larger.

/s/ *Robert E. Bloch*

CERTIFICATE OF SERVICE

I hereby certify that all participants in this case are registered CM/ECF users and that, on August 20, 2014, service of the foregoing brief was accomplished electronically via the Court's CM/ECF system.

/s/ *Robert E. Bloch*