No. 12-3583

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

PROMEDICA HEALTH SYSTEM, INC.,

Petitioner,

v.

FEDERAL TRADE COMMISSION,

Respondent.

On Petition for Review
from the Federal Trade Commission
Commission Docket No. 9346

BRIEF OF *AMICUS CURIAE* AMERICA'S HEALTH INSURANCE PLANS IN SUPPORT OF RESPONDENT

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and Circuit Rule 26.1, *amicus curiae* America's Health Insurance Plans makes the following disclosure:

1. Is said party a subsidiary or affiliate of a publicly owned corporation?

No.

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome by reason of insurance, a franchise agreement, or indemnity agreement?

No.

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INTEREST OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE*[1]

America's Health Insurance Plans ("AHIP") is a national trade association representing companies that administer or provide insurance benefits, including health, pharmaceutical, long-term care, disability, dental and supplemental coverage to more than 200 million Americans. AHIP advocates for public policies that expand access to affordable healthcare coverage for all Americans through a competitive marketplace that fosters choice, quality, and innovation.

Health plans have a significant stake in ensuring that healthcare provider markets remain competitive. In fact, the Petitioner has cited the role of health plans as critical to the Court's review of the Federal Trade Commission's ("FTC") order. *See* Pet. Br. 13. AHIP and its members accordingly seek to assist the Court by providing information about the role health plans play in ensuring that their members receive high quality healthcare at competitive prices. Anticompetitive hospital consolidation can directly affect the ability of health plans to negotiate competitive rates and offer innovative products, thus having a direct impact on health plan customers, including individuals and group customers. AHIP has

[1] All parties have consented to the filing of this brief. This brief was not authored in any part by counsel for any of the parties, and no person or entity other than *Amicus*, its members, or its counsel has made a monetary contribution to the preparation or submission of this brief.

focused in this brief on competitive issues that can arise as a result of such consolidation.

SUMMARY OF ARGUMENT

Anticompetitive hospital mergers harm consumers by leading to higher prices and diminishing hospitals' incentives to innovate and improve quality. The Federal Trade Commission has used its resources judiciously, challenging only the most clearly harmful hospital mergers. The FTC's efforts to prevent hospitals from illegally accumulating market power should be encouraged—if the FTC has met its burden, the Court should uphold the Commission's findings in this case.

Health insurance plans bring a unique and important perspective to the antitrust review of hospital mergers. They represent millions of individual consumers of healthcare and as such are a relevant customer whose insights and experiences are important to the antitrust review. Health plans have been directly affected by anticompetitive hospital mergers. It is the health plans who may be forced to accept higher prices and who may lose their ability to implement innovative approaches to improving quality. And of course, anticompetitive hospital mergers have also affected health plans' members. The individuals and employers who receive insurance from health plans, or who self-insure with their assistance, have seen tremendous increases in prices without corresponding increases in quality as a result of anticompetitive hospital mergers.

The individual experiences of health insurance plans, and the individuals covered by their policies, are supported by an array of academic studies, which

collectively point to the same conclusion: Consumers have borne a tremendous cost from anticompetitive hospital mergers.[2] Such costs are predicted by antitrust theory: A hospital transaction that eliminates competition between significant competitors increases the ability of those formerly competing hospitals to demand and obtain higher prices. Those increased prices are ultimately paid by consumers, who also must bear the additional harm created by reduced incentives to improve quality.

Despite the theory and evidence indicating that anticompetitive hospital mergers diminish competition and result in higher prices and lower quality, the parties to the transaction and some amici curiae suggest that such hospital mergers are necessary to improve healthcare quality. There are many reasons to reject this suggestion. First, in spite of the assertions of merging hospitals, anticompetitive hospital mergers are not necessary for improved quality or other goals of health care reform, and indeed are antithetical to such reforms. Second, even assuming that some of these reforms are dependent on hospital access to additional capacity

[2] A number of these studies are cited in the text that follows or are incorporated in the synthesis study by the Robert Wood Johnson Foundation and the update to that study, which collectively reflect the results of 50 such studies. William B. Vogt & Robert Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?*, Robert Wood Johnson Found., Research Synthesis Report No. 9 (Feb. 2, 2006), www.rwjf.org/pr/product.jsp?id=15231 [hereinafter *RWJ Report*]; Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation – Update*, Robert Wood Johnson Found., Research Synthesis Report No. 9 (June 2012), www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261 [hereinafter *RWJ Update*].

or capital, there are many pathways to obtaining such capital and technology that do not produce the harm caused by anticompetitive consolidation. Finally, whatever benefits can flow from hospital consolidation can continue to be achieved in the many hospital consolidations occurring every year that are not challenged as anticompetitive by the FTC or the Department of Justice.

The goals of health care reform are fully consistent with, and in fact depend on, vigorous antitrust enforcement. Continued competition among hospitals to deliver high quality, low cost services to consumers is both what the antitrust laws demand and an important incentive for reform. Allowing an anticompetitive hospital merger to proceed is never the right outcome. The FTC's decision should be upheld.

ARGUMENT

I. HEALTH PLANS PROVIDE AN IMPORTANT POINT OF FOCUS FOR THE ANTITRUST ANALYSIS OF A HOSPITAL MERGER

Commercial health insurance plans play a critical role in the delivery of healthcare for a large majority of Americans. Health insurance plans act on behalf of their members—individuals, employers, unions, and others who purchase their health insurance products—to negotiate the best possible rates and terms and conditions of services from hospitals, physicians and other providers of healthcare. The health plans then use these provider network arrangements to offer different, often innovative, health insurance and network products that best meet the needs of their members. If a merger of two hospitals led to a substantial lessening of competition in violation of Section 7 of the Clayton Act, it is the commercial health plans that contract with the hospitals to establish networks for their members that would see their network designs frustrated and rates increased. Anticompetitive hospital mergers ultimately lead to a loss of consumer choice and higher premiums and out of pocket costs for individuals, employers, government entities, and others—everyone who receives or offers health care through a health plan.

A. Health Plans Are Relevant Consumers in an Antitrust Analysis of a Hospital Merger

Section 7 of the Clayton Act forbids mergers in which "the effect of such acquisition may be substantially to lessen competition." 15 U.S.C. § 18. When

evaluating a transaction's effects on competition, the customers of the Petitioner can provide valuable insight. U.S. Dep't of Justice and Fed. Trade Comm'n, *2010 Horizontal Merger Guidelines*, § 2.2.2 ("The conclusions of well-informed and sophisticated customers on the likely impact of the merger itself can also help the Agencies investigate competitive effects, because customers typically feel the consequences of both competitively beneficial and competitively harmful mergers.").

In a competitive effects analysis of a hospital merger, health plans are relevant customers in that they negotiate with hospitals for rates and other terms and conditions of service on behalf of their customers and their members—individual consumers of healthcare and employers, government entities and others who provide health insurance through health plans. The plans' preferences necessarily reflect the preferences of the consumers, and the rates at which the health plans are able to contract with hospitals are reflected in the premiums, copays, and deductibles that are borne by the consumers. Just as individuals and consumers receive the benefits of competition among hospitals through negotiations undertaken by health plans, individuals and consumers suffer the harm that results when anticompetitive hospitals mergers undermine marketplace competition.

Some individual consumers purchase health insurance directly from health plans in the individual health insurance market. In purchasing such a plan, individual consumers select the health plan that best suits their needs based on factors such as the cost of the plan (as reflected in the premium and cost sharing amounts) and the network of providers offered by the plan. The work done by health plans in establishing networks of providers that offer quality care at affordable prices is of vital importance to these consumers of individual health insurance.

Most individual consumers with commercial health insurance receive coverage through their employer. Employers typically do not negotiate directly with hospitals and other healthcare providers for employee healthcare coverage, but rather contract with health plans for the solution that best meets their needs. Some employers choose to "self-insure," meaning the employer assumes the risk that an employee's healthcare expenses will exceed the premiums collected. Self-insured employers may contract with health plans to administer the claims, provide access to provider networks, and provide stop-loss coverage. Other employers choose to be fully insured by a health plan, in which case the health plan collects premiums and bears the risk of loss. *FTC v. ProMedica Health Sys., Inc.*, No. 3:11-cv-47, 2011 WL 1219281, at *5 (N.D. Ohio Mar. 29, 2011) [hereinafter *District Court Opinion*]; U.S. Dep't of Justice and Fed. Trade Comm'n, *Improving*

Health Care: A Dose of Competition, Executive Summary at 10 (July 2004) [hereinafter *DOJ/FTC Health Care Report*].[3]

Commercial health plans often play a similar role for individuals that receive health insurance through the federal and state programs for seniors, the disabled and the needy. Health plans contract for additional and improved services in provider networks to which government beneficiaries can gain access through the federal Medicare Advantage program or state-specific managed Medicaid programs.

The critical role health plans play in negotiating with hospitals and other healthcare providers to assemble attractive networks has led this court and others to recognize that health plans are relevant customers in the competitive effects analysis of antitrust hospital merger challenge. *See, e.g.*, *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1299 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997) (depublished) ("managed care organizations . . . may be viewed as 'consumers'"); *FTC v. Freeman Hosp.*, 69 F.3d 260, 270 n.14 (8th Cir. 1995) (in health care, "'consumers' often means not individual patients but large purchasers of health care such as managed care coalitions").

[3] *Available at* www.justice.gov/atr/public/health_care/204694.htm. The findings in the DOJ/FTC Health Care Report were based on 27 days of hearings, a workshop, and independent research. The hearings alone involved testimony from approximately 250 witnesses, including representatives of various provider groups, insurers, employers, patient advocates, and leading scholars.

B. Health Plans Establish Provider Networks in Order to Meet Individual Consumer Needs and Preferences

Health plans serve as close proxies for the needs and preferences of the patients of the hospitals: those patients are the health plans' members. A health plan makes decisions regarding which hospitals and other healthcare providers to include in the health plan's provider network in response to the needs and preferences of both the plan sponsors and the individual members. Health plans assemble such networks with an eye towards including high quality providers at the most reasonable prices. The plans similarly attempt to assemble provider networks that are themselves appealing to the employers in an area because it is the employers who must decide which products offered by the health plans will best serve their employees. For example, health plans must create hospital networks that include a sufficient number of hospitals with an adequate range of specialties in an area such that the plans' insurance products are appealing to employers and their employees. *DOJ/FTC Health Care Report*, ch. 4 at 17.

Attributes of a hospital or hospital system that affect its attractiveness to employers and individuals include its: location(s); reputation; medical staff physicians' reputations; and the range and quality of services it offers. Robert A. Berenson, et al., *Unchecked Provider Clout In California Foreshadows Challenges to Health Reform*, 29 Health Affairs 699, 702 (2010). In a competitive market, these factors, as well as price, can be points of competition distinguishing hospitals

competing to be included in a health plan's provider network. *District Court Opinion* at *29 ("Hospitals compete on the basis of clinical quality, amenities, overall patient experience, and price."). Health plan contracting decisions thus can both help to control costs and enhance the quality of care offered by the hospitals through this competition. *DOJ/FTC Health Care Report,* Executive Summary at 15. In short, consumers benefit when plans are able to choose among different hospital systems:

> [w]hen [health plans] have a credible threat to exclude providers from their networks and send patients elsewhere, providers have a powerful incentive to bid aggressively to be included in the network. Without such credible threats, providers have less incentive to bid aggressively, and even [health plans] with large market shares may have less ability to obtain lower prices.

Id. at 11-12.

II. ANTICOMPETITIVE HOSPITAL CONSOLIDATION LEADS TO DECREASED COMPETITION AND HAS DRIVEN UP HEALTH CARE COSTS

The joinder of ProMedica and St. Luke's, and its possible effects on competition, should be viewed in the context of the historical impact of hospital consolidation on health care costs. There are, of course, circumstances in which hospital consolidation can be efficiency-enhancing and pro-competitive. *Amicus curiae* American Hospital Association ("AHA") has provided examples of the benefits that can flow from pro-competitive hospital consolidations. *See* AHA Br. 26-29. However, hospital consolidation can also have an adverse effect on

competition. *See, e.g., FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069 (N.D. Ill. 2012) (district court granted preliminary injunction finding likelihood that merger of two Rockford, Illinois hospitals would be anticompetitive); *Evanston Northwestern Healthcare Corp.*, Dkt. No. 9315 (F.T.C. Apr. 28, 2008) (FTC successfully challenged a Chicago-area hospital merger four years after the deal closed, finding that the combined entity substantially raised prices); James C. Robinson, *Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology*, 17 Am. J. of Managed Care e241-e248 (2011), www.ajmc.com/articles/AJMC_11jun_Robinson_e241_248 (concluding that hospitals in concentrated markets charge significantly higher prices than hospitals in competitive markets).

If this Court determines, consistent with the district court's decision granting an injunction, that there is substantial evidence for the FTC's conclusion that the transaction will harm competition, there is no reason to let the transaction proceed. As numerous studies confirm, anticompetitive hospital consolidation can lead to higher rates charged to health plans, and ultimately to higher costs borne by consumers, with no increase in quality. Moreover, many of the quality of care improvements that ProMedica claims might result from this transaction, such as improved healthcare technology, *see* Pet. Br. 65 n. 12, are improvements that health plans and many others involved healthcare, including hospitals, are already

undertaking and will continue to undertake whether or not this transaction is allowed to proceed.

If the transaction were allowed to proceed, it would necessarily eliminate competition between the parties. When determining whether that loss of competition will result in higher costs, history provides a useful guide. Both the Commission's decision and the earlier U.S. district court decision are consistent with scholarly articles documenting the adverse effects that can result from an increase in concentration in hospital markets.[4]

A. Past Anticompetitive Hospital Consolidations Led to Higher Prices

Beginning in the 1990s and continuing in recent years, a wave of hospital consolidations occurred in metropolitan areas throughout the United States. Robert Town et al., *The Welfare Consequences of Hospital Mergers*, Nat'l Bureau of Econ. Research, Working Paper No. 12244, at 1 (2006); *RWJ Report*; *RWJ Update*. As William B. Vogt and Robert Town reported in a research synthesis for the Robert Wood Johnson Foundation, in 1990, 71 percent of metropolitan statistical areas (MSAs) with a population of over 100,000 had what the *1992 Merger Guidelines* would classify as highly concentrated hospital markets; by 2003,

[4] In an earlier preliminary injunction proceeding, the district court found that the joinder between ProMedica and St. Luke's would raise concentration among general acute care hospitals in Toledo, Ohio to levels that are presumptively unlawful under Section 7 of the Clayton Act. *District Court Opinion* at *56.

hospital consolidation had led to 88 percent of such MSAs having highly concentrated hospital markets. *RWJ Report* at 1 n.2.[5] By 2006, the mean Herfindahl-Hirschman Index for hospital markets was 3161, well in excess of the 2500 level considered highly concentrated under the *2010 Merger Guidelines*, and hospital consolidations have been on the rise again in recent years. *Hearing on Health Care Industry Consolidation Before the Subcomm. On Health of the Comm. On Ways and Means*, 112th Cong. (Sept. 9, 2011) (statement of Martin Gaynor, Professor of Econ. and Health Policy, Carnegie Mellon Univ., at 2-3).

The majority of the empirical studies concerning the impact of the wave of hospital consolidations found that many of the consolidations led to higher prices. *Id*. at 4-8; *RWJ Update* at 1*; DOJ/FTC Health Care Report*, Executive Summary at 15 ("Most studies of the relationship between competition and hospital prices have found that high hospital concentration is associated with increased prices, regardless of whether the hospitals are for-profit or nonprofit."). And the higher prices do not necessarily reflect better care. The overwhelming majority of recent studies found that following a reduction in hospital competition, the quality of care provided either did not improve or deteriorated. *RWJ Update* at 4 ("All of the U.S.

[5] The *1992 Merger Guidelines* in effect at the time classified markets with a Herfindahl-Hirschman Index (HHI) of 1800 or above as highly concentrated. The *2010 Merger Guidelines*, in effect since August 2010, classify markets as highly concentrated with an HHI of 2500 or above. Regardless of which version of the *Merger Guidelines* is used, the relative change in concentration levels evidences a significant amount of hospital consolidation throughout the 1990s.

studies except for one find that competition improves quality"); *id.* at 5 (citing studies finding, *inter alia*, that "[h]ospital mergers … did lead to increases in mortality" for certain patients and mortality "is lower in less concentrated markets").

Doubtless there are a number of reasons explaining why some past hospital consolidations tended to result in higher prices. But consistent, well-established, and current scholarship shows that one factor is that hospitals in more concentrated markets are able to negotiate higher rates from health plans. *RWJ Update* at 1 (finding, based on review of ten post-2006 studies, that "[i]ncreases in hospital market concentration lead to increases in the price of hospital care"); James Robinson, *Hospitals Respond to Medicare Payment Shortfalls by Both Shifting Costs and Cutting Them, Based on Market Concentration*, 30 Health Affairs 1265, 1268-1269 (2011) ("Hospital margins on privately insured patients were significantly higher in concentrated markets than in competitive markets …, indicative of the stronger bargaining power obtained in contexts where private insurers cannot credibly threaten the hospitals with network exclusion."); Katharine Levit, et al., *Health Spending Rebound Continues in 2002*, 23 Health Affairs 147, 155 (2004) ("Additionally, hospitals have regained market power since the mid-1990s, improving their negotiating power and ability to secure rate increases from private insurance plans."); Cory Capps & David Dranove, *Hospital*

Consolidation and Negotiated PPO Prices, 23 Health Affairs 175, 175 (2004) "[C]onsolidations may increase hospitals' market power, allowing hospitals to raise prices and possibly resulting in higher premiums.").

B. The Possibility of Selective Contracting Helps Keep Hospital Rates and Insurance Premiums Lower

When a health plan and a hospital or hospital system negotiate whether and at what rates a hospital will be included in a health plan's provider network, the health plan's bargaining leverage comes in part from its ability to refuse to allow the hospital into its network. Such selective contracting "can intensify price competition" among hospitals and let health plans "negotiate volume discounts and choose providers based on a range of discounts." *DOJ/FTC Health Care Report*, Executive Summary at 11. As the district court found, "[h]ospitals compete with each other for inclusion in health plans' provider networks and, once included, for the use of their hospital by health plans' members." *District Court Opinion* at *5. However, the health plan must ensure that it has within its network sufficient hospitals to meet the geographic, quality and service preferences of its members. Or put another way, a health plan cannot credibly threaten to exclude from its network a hospital that contains needed attributes that the plan cannot get elsewhere, such as access to pediatric specialists or critical care facilities.

Hospital consolidation will necessarily impact the ability of health plans to negotiate the composition of the provider networks that offer the services members

need as well as the prices and ultimate quality of those services. The concentration level of the market directly correlates to the competitiveness of the market, and consolidation increases concentration. When there are either fewer hospitals in a market or fewer entities controlling the same number of hospitals in a market, a health plan's ability to negotiate the lowest rates from the hospitals decreases. James C. Robinson, *More Evidence of the Association Between Hospital Market Concentration and Higher Prices and Profits*, Nat'l Inst. for Health Care Mgmt., at 1 (Nov. 2011) ("[H]ospitals in concentrated markets, where there is less competition, are able to extract significantly higher payments from private insurers."). And increases in hospital rates charged to health plans lead to higher insurance premiums paid by health plan members. Bob Kocher & Ezekiel Emanuel, *Overcoming the Pricing Power of Hospitals*, 308 J. Am. Med. Ass'n 1213, 1213 (2012) ("[H]ospital price increases are now the largest contributor to increases in insurance premiums.").

Consistent with the literature on the effects of high levels of hospital consolidation on competition, both the district court and the Federal Trade Commission have determined that a ProMedica/St. Luke's joinder is also likely to lead to reduced competition and higher prices. *District Court Opinion* at *56; *ProMedica Health Sys., Inc.*, Dkt. No. 9346 (F.T.C. June 25, 2012).

III. THE HIGHER COST AND OTHER HARM OF ANTICOMPETITIVE HOSPITAL CONSOLIDATION ARE NEITHER MITIGATED NOR JUSTIFIED BY HEALTHCARE REFORM

The Petitioner and the AHA have suggested that the goals of healthcare reform require anticompetitive hospital transactions to be evaluated differently. The argument is that such transactions, though anticompetitive, are necessary for hospitals to achieve improvements in quality, upgrades in technology, and other goals of reform that may offset the harm. *See* AHA Br. 25-32. The implication is that enforcement of the antitrust laws in inconsistent with the goals of healthcare reform. This argument is, quite simply, incorrect. It is incorrect in its assertion of necessity. As discussed below, there are many paths to improving hospital quality and upgrading hospital technology that do not require consumers to bear the many costs of hospital market power. It is also bad policy. Competition does not thwart the goals of healthcare reform, but rather can aid those goals. There is evidence that anticompetitive hospital mergers *reduce* quality; preserving competition can help preserve quality. *RWJ Update* at 4. Hospitals seeking to pursue the goals of healthcare reform have many options without undertaking an anticompetitive consolidation.

AHIP's members support reforms that hold the promise of improving the quality and lowering the costs of healthcare, and indeed are at the forefront of driving positive change throughout the healthcare industry. AHIP also supports

the dissemination of knowledge and technology to hospitals and other healthcare providers to allow better and more consistent clinical coordination. Ongoing capital investment in the industry as a whole—not just in hospitals—will allow the deployment of technological advances such as electronic health records and systems for tracking and evaluating adherence to clinical protocols.

These reforms do not require a suspension of the antitrust laws, nor must they be obtained at the cost of allowing anticompetitive hospital transactions to proceed. Health plans, individuals and employers have aligned interests, strong incentives, and the ability to improve quality and reduce the costs of healthcare regardless of changes in the hospital industry. Higher quality and lower cost healthcare makes insurance and other network products more attractive and increases the demand for and satisfaction with plans' services. Accordingly, health plans have been a driver of efforts to lower cost and improve quality. *See, e.g.*, AHIP, *Transforming Care Delivery* (Jan. 2012), www.ahip.org/Issues/Health-Care-Quality.aspx [hereinafter *Transforming Care Delivery*].

A. Health Plans Have Been Driving Quality and Cost Reforms in Both Private Sector and Public Sector Programs

Health plans have addressed healthcare quality and costs in both the private sector and the public sector through programs that do not depend on anticompetitive hospital consolidation or hospital economies of scale. Examples of these efforts in the private sector include patient-centered medical homes and

accountable care organizations. The patient-centered medical home attempts to replace episodic care with a sustained relationship between patient and physician. The idea is to redesign the healthcare delivery model by promoting coordination of care across providers and improving accountability for outcomes, patient experience, and utilization of services. Press Release, AHIP, AHIP Board of Directors Releases Principles on Patient-Centered Medical Home (June 25, 2008), www.ahip.org/News/Press-Room/2008/AHIP-Board-of-Directors-Releases-Principles-on-Patient-Centered-Medical-Home.aspx; Robert A. Berenson, et al., *A House Is Not a Home: Keeping Patients at the Center of Practice Redesign*, 27 Health Affairs 1219 (2008). Similarly, accountable care organizations are often partnerships between health plans and healthcare providers who agree to be accountable for the quality and cost of a patient population and who share cost savings. *Transforming Care Delivery*; Aparna Higgins, et al., *Early Lessons From Accountable Care Models in the Private Sector: Partnerships Between Health Plans and Providers*, 30 Health Affairs 1718, 1718 (2011). Although they are still new, an initial study of several accountable care organizations reported significant reductions in costly hospital utilization, including a fifteen percent reduction in readmissions and total inpatient hospital days. Higgins, *supra*, at 1727.

These collaborative efforts between health plans and providers to improve the quality and efficiency of health care delivery have not depended on

anticompetitive hospital consolidation. Indeed, it is quite likely that such consolidation would have the opposite impact on such efforts. Just as anticompetitive consolidation has been recognized to have a chilling effect on innovation in many other markets, such consolidation among hospitals is likely to reduce and perhaps foreclose innovative collaborations between plans and providers such as the ones described above.[6] And of course, fewer innovative collaborations would disadvantage consumers who could benefit from the quality and efficiency improvements generated by these innovative collaborations.

The notion that anticompetitive hospital mergers are needed to improve quality and efficiency is belied by the variety of approaches to such improvements that do not create antitrust problems. The AHA focuses upon necessary investments in information technology. *See* AHA Br. 15. But there are many avenues, short of price-increasing anticompetitive consolidation, to further information technology reform. For example, in Ohio, health plans sponsored an information technology initiative estimated to save hundreds of billions of dollars by providing one-stop service in electronic transactions for physicians. *See* Press Release, AHIP, Health Plans Collaborate on Landmark Initiative to Reduce Time, Expense for Physician Office Practice "Paperwork" (Oct. 5, 2009),

[6] *See United States v. H & R Block, Inc.*, 833 F. Supp. 2d 36, 79 (D.D.C. 2011) (enjoining proposed merger in tax software industry because it would eliminate competitor with "impressive history of innovation"); *2010 Horizontal Merger Guidelines*, § 6.4.

www.ahip.org/News/Press-Room/2009/Health-Plans-Collaborate-on-Landmark-Initiative-to-Reduce-Time,-Expense-for-Physician-Office-Practice--Paperwork-.aspx.

Other sets of examples relate to the work of Medicare Advantage health plans in partnering with healthcare providers and a government payor to improve healthcare quality and lower costs. A Medicare Advantage plan is a health insurance plan offered by a commercial health insurer that has contracted with the Medicare program to provide Medicare benefits to eligible recipients. Medicare Advantage plans have a track record of reducing costs and improving healthcare quality by coordinating care among providers to ensure timely delivery of care, while also emphasizing both prevention and disease management. *Hearing Before the Subcomm. On Health of the Comm. On Ways and Means*, 112th Cong. (Sept. 21, 2012) (statement of Karen Ignagni, President and CEO, AHIP); *see also,* Niall Brennan & Mark Shepard, *Comparing Quality of Care in the Medicare Program*, 16 Am. J. of Managed Care 841 (2010).

Studies suggest Medicare Advantage members have fewer unnecessary hospital readmissions, were more likely to visit a primary care doctor, and evidenced higher quality care. *See, e.g.*, Jeff Lemieux, et al., *Hospital Readmission Rates in Medicare Advantage Plans*, 18 Am. J. of Managed Care 96, 97 (2012) (finding hospital readmission rates, adjusted for risk of readmission,

were thirteen to twenty percent lower for Medicare Advantage members as compared to fee-for-service patients); Brennan & Shepard, *supra*; Robb Cohen, et al., *Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients*, 31 Health Affairs 110, 116 (2012) (finding strategies used by Medicare Advantage special-needs plans to enhance primary care reduced hospitalization and readmission rates).

A number of Medicare Advantage plan efforts have involved collaborations between such plans and health care providers. Unlike anticompetitive hospital mergers, such collaborations improve quality while lowering costs. For example, Aetna and NovaHealth, an independent physician association based in Portland, Maine, successfully collaborated to improve health outcomes in a Medicare Advantage pilot program. The patients in the program had fewer hospital days, fewer admissions, and fewer readmissions than statewide unmanaged Medicare populations. Thomas F. Claffey, et al., *Payer-Provider Collaboration in Accountable Care Reduced Use and Improved Quality in Maine Medicare Advantage Plan*, 31 Health Affairs 2074 (2012).

B. Anticompetitive Hospital Consolidation Is Neither the Only Nor an Appropriate Path to Capital for IT and Other Improvements

The health plan experience with coordinated care programs shows that cost savings and improvements in healthcare quality do not require, and indeed will be impeded by, anticompetitive hospital consolidation. The AHA argues that without

such consolidation, hospitals may lack access to the capital required to make the IT and other infrastructure improvements necessary to achieve greater efficiency. *See* AHA Br. 19-22. But, as discussed above, improving hospitals' access to capital or economies of scale is not the only way to achieve more efficient, higher quality care. Nor is allowing anticompetitive hospital mergers the only way to improve hospitals' access to capital.

When access to capital is needed for hospital improvements, hospitals have many places to turn. First, hospitals have access to traditional sources of capital such as the equity and debt markets. Greg Bordonaro, *Hospitals Using Debt for Growth*, Hartford Business J., Nov. 12, 2012 (noting two-hospital network raised $170.8 million since 2011, principally through the issuance of tax-exempt bonds); George Huang et al., Wells Fargo Securities, *Municipal Securities Research: 2012 Not-for-Profit Hospital Bond Volume and Yield Projections*, at 1 (Jan. 9, 2012), www.cdfa.net/cdfa/cdfaweb.nsf/0/38AFC256BF6702A3882579810056F69D/$file/2012%20NFP%20Hospital%20Bond_010912.pdf (noting over three hundred bond issues by not-for-profit hospitals in 2011). In addition, hospitals can consider a range of other transactions that allow for capital, including consolidations with hospitals that will not substantially lessen competition. *See, e.g.*, Terry Leavitt, *Memorial Hospital Presents Plan to Join MaineHealth Network*, Conway Daily Sun, Oct. 18, 2012, www.conwaydailysun.com/index.php/newsx/local-

news/93303-memorial-hospital-presents-plan-to-join-mainehealth-network (citing increased affordability of capital improvements, New Hampshire hospital presents plan to join out-of-state not-for-profit hospital network); *Vanguard Deal for Detroit Medical Center Complete*, FierceHealthcare (Dec. 31, 2010), www.fiercehealthcare.com/story/vanguard-deal-detroit-medical-center-complete/2010-12-31) (Nashville-based Vanguard Health Systems agreed to pay for $850 million in capital improvements and specific capital projects as part of its purchase of Detroit Medical Center); *HCA to Acquire Health Midwest*, L.A. Times, Oct. 17, 2002 (HCA agreed to spend $450 million for capital improvements over five years as part of its purchase of Health Midwest in Kansas City). Hospitals can also partner with health plans or other industry participants to obtain access to capital. *See, e.g., UnitedHealthcare Provides $20 Million in Technology Investments to Improve Patient Care in Rural Communities Throughout California*, Daily Finance (Oct. 2, 2012), www.dailyfinance.com/2012/10/02/unitedhealthcare-provides-20-million-in-technology.

Neither the Petitioner nor the AHA have cited any evidence to suggest that anticompetitive hospital consolidation provides better access to capital than other transactions that do not burden market efficiency and reduce innovation and quality. On the other hand, there is significant evidence that anticompetitive hospital consolidation will not lead to capital being used in a manner that lowers

prices or improves quality for consumers. *See RWJ Report* at 8 (finding that "[o]n balance, the evidence suggests that increasing hospital concentration lowers quality," although more study is needed); Alison Evans Cuellar & Paul J. Gertler, *How The Expansion Of Hospital Systems Has Affected Consumers*, 24 Health Affairs 213, 217 (2005) (finding that "following consolidation, hospital market power, not the efficiency of care delivery, increased; and hospitals gained higher prices but did not translate them into higher quality of inpatient care or the provision of more community goods").

The health plan experience with patient centered medical homes, accountable care organizations, and Medicare Advantage all suggest that health plan provider networks already take advantage of health plan technology and care coordination expertise in achieving significant cost control while maintaining high quality and consumer satisfaction. Much of this occurs without significant capital investment from hospitals. Indeed, one of the benefits of coordinated care is a reduction in unnecessary re-hospitalizations that are a significant inefficiency and an aspect of poor clinical quality that financially benefits hospitals. In short, the continuing evolution of higher quality and greater efficiency in healthcare delivery systems will not be put in jeopardy by enjoining this transaction, if it is anticompetitive.

IV. PROHIBITING AN ANTICOMPETITIVE HOSPITAL MERGER WILL NOT CHILL BENEFICIAL HOSPITAL CONSOLIDATION

Enjoining a hospital merger that harms competition will not deter hospital consolidations that are pro-competitive or competitively benign. The record of limited intervention by the federal government despite continuing hospital consolidation demonstrates that such enforcement actions do not chill the pursuit of beneficial hospital mergers. Publicly available information on recent hospital mergers makes clear that the enforcement agencies seek to block only the most egregiously anticompetitive hospital mergers.

Of the nearly 300 hospital transactions between 2008 and 2011, the FTC and DOJ challenged a very small number. Over this time period, the pace of hospital transactions, if anything, appeared to increase. In 2008, there were approximately 60 hospital mergers and acquisitions, which increased to approximately 90 transactions by 2011. Am. Hosp. Ass'n, *Trendwatch Chartbook 2012*, Chart 2.9 (June 6, 2012). Since 2000, the FTC has challenged only four other hospital transactions in addition to its challenge in this matter. *See OSF Healthcare Sys.*, 852 F. Supp. 2d 1069 (after district court granted a preliminary injunction, the parties abandoned a proposal to join hospitals in Rockford, Illinois); *FTC v. Phoebe Putney Health Sys., Inc.*, 663 F.3d 1369 (11th Cir. 2011) *cert. granted*, No. 11-1160, 2012 WL 985316 (June 25, 2012) (Supreme Court to address issues related to the state action doctrine); *Inova Health Sys. Found.*, Dkt. No. 9326

(F.T.C. June 17, 2008) (parties abandoned a proposal to join hospitals in northern Virginia after the district court granted the FTC a preliminary injunction); *Evanston Northwestern Healthcare Corp.*, Dkt. No. 9315 (F.T.C. Apr. 28, 2008) (full Commission upheld Administrative Law Judge's finding that the merger of two hospitals in the Chicago area was anticompetitive).[7]

Other seemingly problematic hospital transactions have been allowed to proceed without challenge. *See, e.g.*, Letter from Donald S. Clark, Secretary, FTC, to Michael S. McFalls, Counsel for Saint Raphael Healthcare System, Regarding the acquisition of Saint Raphael Healthcare System by Yale-New Haven Health Services Corporation (June 1, 2012). In 2009, the FTC closed an investigation into a merger despite "serious concerns" over whether the transaction violated the antitrust laws. Statement of Bureau of Competition Director Richard Feinstein on the FTC's Closure of Its Investigation of Consummated Hospital Merger in Temple, Texas (Dec. 23, 2009), www.ftc.gov/os/closings/

[7] In addition, last week the FTC announced that it would challenge a transaction that did not involve a merger of two acute care hospitals, but rather a health system's acquisition of a surgery center that, according to Bureau of Competition Director Richard Feinstein, had "injected important price and quality competition" into the area even though it is not an acute-care hospital. Press Release, FTC and Pennsylvania Attorney General Challenge Reading Health System's Proposed Acquisition of Surgical Institute of Reading (Nov. 16, 2012), www.ftc.gov/opa/2012/11/reading.shtm.

091223scottwhitestmt.pdf.[8] These numbers suggest that preventing ProMedica from acquiring St. Luke's will do nothing to slow the tide of pro-competitive or competitively neutral hospital consolidation.

CONCLUSION

Historically, anticompetitive hospital consolidation has led to less competition for health plan provider networks and higher prices. There is no reason to believe that anticompetitive hospital consolidations improve healthcare quality, to the contrary, the available evidence suggests that competition can provide incentives to improve quality. Moreover, the benefits that have been suggested will flow from this consolidation—higher quality healthcare at lower cost through coordinated care—are already occurring regardless of hospital consolidation. If this transaction is anticompetitive—as the district court and the FTC have already found—then there is no reason to allow the transaction to proceed.

[8] The FTC's serious concerns did not cause it to block the transaction because the parties established that the hospital might fail without the transaction. *See 2010 Horizontal Merger Guidelines,* § 11. Of course, the parties in the ProMedica – St. Luke's transaction are not claiming that St. Luke's would fail absent the merger.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

The foregoing brief is in 14-point Times New Roman proportional font and contains 6,120 words, and thus complies with the type-volume limitation set forth in Rules 29(d) and 32(a)(7)(B) of the Federal Rules of Appellate Procedure.

s/Hyland Hunt
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November 21, 2012

CERTIFICATE OF SERVICE

I hereby certify that, on November 21, 2012, I served the foregoing brief upon all parties or their counsel of record by filing a copy of the document with the Clerk through the Court's electronic docketing system.

s/Hyland Hunt
Hyland Hunt