

NO. 16-2365

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

FEDERAL TRADE COMMISSION, *et al.*

Plaintiffs/Appellants,

v.

PENN STATE HERSHEY MEDICAL CENTER, *et al.*,

Defendants/Appellees

On Appeal From the United States District Court
For the Middle District of Pennsylvania
Case No. 1:15-cv-02362 Hon. John E. Jones, III

**CONSENT BRIEF OF *AMICI CURIAE* ECONOMICS PROFESSORS
IN SUPPORT OF PLAINTIFFS/APPELLANTS URGING REVERSAL**

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Pursuant to Rule 29(a), Federal Rules of Appellate Procedure, Amici have obtained the consent from all parties to this appeal for the filing of this Brief.

INTEREST OF AMICI CURIAE

Amici are economists with expertise in the subjects of antitrust, competition, and health economics. The Appendix lists the titles and affiliations of each of these individuals. This brief reflects what amici believe to be rigorous, current economic analysis on questions that are before the Court in connection with the Federal Trade Commission's appeal of the district court's ruling in *Federal Trade Commission and Commonwealth of Pennsylvania v. Penn State Hershey Medical Center and Pinnacle Health System*, now pending before this Court. *Amici* file solely as individuals and not on behalf of any institutions with which they are affiliated. *Amici* have not been retained by any party with regard to this action.

Amici and their counsel authored this brief in total. No part of it was written by any party or party's counsel. No party, party's counsel, or person other than an *Amici* has contributed any money to fund the preparing or submitting of this Brief.

SUMMARY OF ARGUMENTS

Our review of the public documents in this matter, together with our collective understanding of healthcare organizations and markets developed through academic research, public service, and advisory and consulting roles, leads

us to believe that the district court's analysis and conclusions are incorrect in several respects. In this brief, we explain that the district court relied upon outdated methodologies that have been thoroughly studied and discredited by academic economists as well as the courts over the past 10 to 15 years. First, we explain why negotiations between insurers and hospitals – rather than data on percentages of patients who come into or leave an area for hospital care – are paramount in appropriately defining relevant geographic markets in this matter. Second, we explain why a sizeable inflow of patients into a proposed geographic market does not imply that an alleged relevant geographic market is overly narrow. Third, we explain that, when a transaction does substantially lessen competition, temporary contractual commitments, or “behavioral or conduct remedies,” do not preserve the benefits of competition – generally, lower price and higher quality – for consumers.

We conclude that the district court's order denying the Preliminary Injunction sought by Plaintiffs is based on faulty economic reasoning, particularly as relates to geographic market definition. Consequently, we believe a preliminary injunction should be issued in order to maintain the status quo and protect the public interest while a full administrative hearing is held in which both sides present their arguments to the finder of fact.

ARGUMENT

- I. The District Court Premised its Market Definition Analysis on an Unsound Interpretation of Patient Flow Data, Instead of Correctly Focusing on the Critical Role of Negotiations between Hospitals and Insurers in Determining Prices**
 - A. Hospital prices are determined via negotiations with insurers**

In order to market their health plans to customers, insurers must construct networks of credentialed healthcare providers qualified to render the services that enrollees may require for treatment of covered medical benefits. A network generally includes a wide variety of provider types such as hospitals, surgical centers, physician specialists, and primary care practitioners. The provider network available to an individual or household is determined by the health insurance plan in which they are enrolled. This network dictates the out-of-pocket costs an enrollee will pay when receiving care, with the enrollee paying substantially less out-of-pocket for care rendered by a provider that is in their health plan network (“in-network”). Accordingly, patients are very likely to select in-network providers.

Healthcare providers compete with one another on the basis of price and non-price dimensions (e.g., quality of care or reputation) for inclusion in insurers’ networks. From a provider’s economic perspective, inclusion in an insurer’s network means that the insurer’s enrollees can visit the provider and receive care at

much lower out-of-pocket expense than if the provider were out of network. Inclusion in the insurer's network therefore implies that the provider will be able to treat more (typically significantly more) of the insurer's enrollees and earn greater revenues from the insurer than if the provider were not in-network.

From the insurer's perspective, a broader, higher quality network will attract more customers. However, in constructing its network the insurer must be mindful of the reimbursement terms (i.e., prices) it negotiates with providers. Paying higher prices to providers will lead to higher costs and higher premiums for the insurer, which will reduce its enrollment and profits, all else being equal. Consequently, insurers have the incentive to negotiate lower reimbursements from a provider in exchange for including that provider in its network. Of course, the ability to negotiate an attractive price with a given provider depends on the availability of alternative providers.

Therefore, the locus of price competition among healthcare providers is centered on competition to be included in insurers' networks. This competition is reflected in the "two-stage" model of provider competition - as well as in related multistage models that incorporate these stages - utilized in economic research on hospital price-setting and espoused by the FTC in this and other proceedings,

dating back to the FTC's *Evanston* complaint in 2004.¹ In the first stage, providers compete, on price and non-price dimensions, to be included in insurers' networks. In the second stage, in-network providers compete to be selected by patients. Because insurance eliminates or sharply attenuates differences in out-of-pocket costs for patients who choose in-network providers, in the second stage hospitals compete primarily on non-price dimensions like clinical quality, wait-times and

¹ Greg Vistnes (2000), "Hospitals, Mergers, and Two-Stage Competition," *Antitrust Law Journal*, 67(3): 671–692; Robert Town and Greg Vistnes (2001), "Hospital Competition in HMO Networks," *Journal of Health Economics*, 20(5): 733–752; Cory Capps, David Dranove and Mark Satterthwaite (2003), "Competition and Market Power in Option Demand Markets," *RAND Journal of Economics*, 34(4): 737–763; and Joseph Farrell et al., *Economics at the FTC: Hospital Mergers, Authorized Generic Drugs, and Consumer Credit Markets*, 39 REV. INDUS. ORG. 271 (2011).

See also, Opinion, Saint Alphonsus Med. Ctr. – Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 784 n. 10 (9th Cir. 2015) ("This 'two-stage model' of health care competition is 'the accepted model.'" Citing John J. Miles, 1 Health Care & Antitrust L. § 1:5 (2014)). *In re Evanston Northwestern Healthcare Corp.*, FTC Docket No. 9315, FTC File No. 011 0234 (Feb. 10, 2004) (Complaint).

Some recent publications elaborate on the two-stage framework. For example, amici Martin Gaynor, Kate Ho, and Robert Town describe a five-stage model ("The Industrial Organization of Health-Care Markets," *Journal of Economic Literature* 53(2): (June 2015). The two stages described in this amicus brief correspond to stages 2 and 5 in their five-stage version. (These stages are: (1) hospitals "make investments that determine their quality"; (2) hospitals and insurers negotiate over network inclusion and prices; (3) premiums are determined; (4) consumers select health plans; (5) patients select providers). None of the arguments in this brief are sensitive to this expansion of the basic two-stage model, nor to other recent expansions (e.g., Gautam Gowrisankaran, Aviv Nevo, and Robert Town, "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," *American Economic Review*, 105(1): 172-203 (2015)).

patient experience. In sum, price plays a leading role in stage one competition but a significantly smaller role in stage two competition.

As mentioned above, prices are determined via negotiations between individual insurers and individual providers. The outcomes of these negotiations reflect the relative bargaining leverage of each party. Basic economic theory indicates that bargaining leverage is determined by the loss in profits each side would incur if a deal is not struck. At a high level, the party with more to lose will have less bargaining leverage. From the insurer's perspective, the loss in profits from failing to reach agreement with one provider is directly tied to the insurer's ability to include in its network other providers who patient/enrollees regard as close substitutes. The more important a particular provider is to the insurer's network (because of the lack of close substitutes), the greater will be the provider's bargaining leverage and the higher will be the resulting prices paid by the insurer, all else being equal.

B. Hospital mergers and hospital-insurer bargaining

A horizontal merger among hospitals will increase their combined bargaining leverage if the merging hospitals are viewed as close substitutes by a sufficient number of the insurer's enrollees (and sufficient other comparably close substitute providers are not available). The following chain of logic describes how an increase in bargaining leverage would arise from a merger of hospitals A and B:

(1) Some patients prefer A to all other providers, and some prefer B. (2) If A is excluded, patients who would otherwise select A will turn to their next-best alternative(s); the more closely substitutable is that alternative for A, the less will be the reduction in network value. The presence of a close substitute for hospital A constrains A's bargaining leverage and its ability to negotiate higher prices. With a close substitute available, the price the insurer must offer to recruit hospital A into its network will be relatively low. (3) Now suppose that hospital B is a close substitute for A (but other hospitals are not) and that the two propose to merge. After the merger, if an insurer cannot reach an agreement with the *combined* entity, then the value of the insurer's network would be significantly diminished. This reduction in value arises because patients who previously viewed the merging parties as the next-best substitutes for each other must turn to their third-preferred option if hospitals A and B (now merged) are not in-network.² This would leave the insurer with a significantly less attractive network, and the ability to impose that outcome on the insurer gives the merged entity bargaining leverage. The increase in bargaining leverage from the merger will be determined by the

² Two merging hospitals (or hospital systems) need not be one another's *closest* substitutes in order for their merger to substantially enhance bargaining leverage; they merely need to be close enough substitutes for a sufficient number of patients such the merging hospitals (or systems) jointly wield greater bargaining power vis a vis an insurer than they would as separate negotiating entities.

prevalence of patients who view the merging practices as close substitutes and by how much they dislike having to turn to their third-preferred practice.³

The two-stage competition model captures this fundamental competitive dynamic. It serves as the theoretical foundation of current, refereed and published economic research on provider competition.⁴ Importantly, the empirical predictions of this framework have been verified in several studies of hospital mergers, as well as in other healthcare services markets.⁵ Specifically, mergers between substitute healthcare providers in concentrated markets generally lead to price increases. While most research focuses on prices, the market power arising from provider mergers could be exercised, in whole or in part, through reductions in the quality

³ “Mergers that Increase Bargaining Leverage,” (January 22, 2014) by Aviv Nevo, Deputy Assistant Attorney General for Economics at the Antitrust Division of the U.S. Department of Justice, describes this dynamic similarly.

⁴ Robert Town and Greg Vistnes (2001), *ibid.*; Cory Capps, David Dranove and Mark Satterthwaite (2003), *ibid.*; Jessica Vistnes, Philip Cooper and Greg Vistnes (2001), “Employer Contribution and Health Insurance Premiums: Does Managed Competition Work?,” *International Journal of Health Care Finance and Economics*, 1: 159–187; Matthew Lewis and Kevin Pflum (2014), “Diagnosing Hospital System Bargaining Power in Managed Care Networks,” *American Economic Journal: Microeconomics*, and Gautam Gowrisankaran, Aviv Nevo, and Robert Town, “Mergers When Prices Are Negotiated: Evidence from the Hospital Industry,” *American Economic Review*, 105(1): 172-203 (2015).

⁵ William B. Vogt & Robert J. Town, “How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?” Robert Wood Johnson Foundation Synthesis Project (2006); Martin Gaynor & Robert J. Town, “The Impact of Hospital Consolidation—Update,” Robert Wood Johnson Foundation Synthesis Project (2012); Martin Gaynor, Katherine Ho, and Robert J. Town (2015), *ibid.*

of services provided, and indeed there is empirical evidence that hospital mergers are associated with quality reductions.⁶

II. In Rejecting the Geographic Market Proposed by the Federal Trade Commission, the District Court Incorrectly Relied upon Inflow/Outflow Analysis.

A. Relevant Markets

Relevant market definition is used to help frame competitive analysis.⁷ In order for a defined relevant market to accurately capture the impact of a provider merger on competition, it should align with the principles of the two-stage model. That is, the relevant market should include providers that constrain the merging parties when it comes to stage one negotiations with insurers over price and other network participation terms.

An analysis in this matter should therefore begin with Hershey Medical Center and the Pinnacle Health System hospitals, and consider which additional

⁶ *Id.* See also, Zack Cooper et al., “Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms,” *Economic Journal* 121, no. 554 (2011): F228–60; Martin Gaynor, Carol Propper, and Stephan Seiler, “Free To Choose? Reform, Choice and Consideration Sets in the English National Health Services,” *American Economic Review*, (2016); Martin Gaynor, Rodrigo Moreno-Serra, and Carol Propper, “Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service,” *American Economic Journal: Economic Policy* 5, no. 4 (2013): 134–166; and Daniel Kessler and Mark McClellan, “Is Hospital Competition Socially Wasteful?” *Quarterly Journal of Economics* 115, no. 2 (2000): 577–615.

⁷ As the *Merger Guidelines* note, the purpose of defining markets and calculating market shares is to “illuminate[] the merger’s likely competitive effects.” DOJ and FTC, *Horizontal Merger Guidelines*, issued Aug. 19, 2010, § 4.1.

hospitals are close substitutes for those hospitals from the perspective of insurers assembling provider networks. To ensure that market boundaries are not too small, economists have proposed, and the federal antitrust enforcement agencies and courts have endorsed, the “hypothetical monopolist test.”⁸ If a hypothetical monopolist comprising all sellers in a proposed market could not profitably execute a small, significant, non-transitory increase in price (SSNIP), the market is too small because it excludes the alternative sellers that make such a price increase unprofitable. Conversely, if the hypothetical monopolist could profitably impose a SSNIP, then the excluded sellers are not sufficiently close substitutes. In this case, the market is properly defined: it includes hospitals that are close substitutes for the merging parties and excludes hospitals that are not.

The defined relevant market need not include all substitutes to which customers may turn if deprived of the products or services supplied by the hypothetical monopolist. Instead, the defined market need only include those sellers to which customers would turn in volumes sufficient to defeat a price increase by all sellers in the proposed relevant market.⁹ Critically, if a sufficient number of patients are unlikely to utilize a provider outside the proposed market in

⁸ *Id.*

⁹ “Properly defined antitrust markets often exclude some substitutes to which some customers might turn in the face of a price increase even if such substitutes provide alternatives for those consumers.” *Id.*, § 4.

the face of a hypothetical, collective price increase by all sellers in the proposed market, then that market is relevant for purposes of merger analysis. As we discuss below, this remains true even if a sizeable share of patients travel into or out of the proposed geographic market.

B. The District Court incorrectly relied upon an unreliable and inappropriate methodology for defining geographic markets for general acute inpatient care services

In arriving at the conclusion that the FTC’s geographic market definition is “unrealistically narrow,” the court relied on the “uncontroverted fact” that 43.5 percent of Hershey Medical Center’s (“Hershey”) patients travel to Hershey from outside the Harrisburg Area, and “several thousand of Pinnacle’s patients reside outside of the Harrisburg Area. (DX1698-0048).”¹⁰ The court concluded that the FTC’s definition is “too narrow because it does not appropriately account for where the Hospitals, particularly Hershey, draw their business.”¹¹

A substantial body of economic research, and legal precedent, recognizes that geographic markets defined using customer flow data (referred to “Elzinga-Hogarty markets,” after the originators of the concept) are overly broad when it comes to predicting the competitive impacts of a hospital merger.

¹⁰ *Opinion*, 9–11.

¹¹ *Opinion*, 10.

The Elzinga-Hogarty (EH) method was originally developed in the 1970s to delineate geographic markets for goods like coal and beer.¹² The EH method defines a market as an area that has both low inflows and low outflows. The outflow percentage for a candidate market is the proportion of consumers who reside in that area but purchase from a seller located outside the area (e.g., the percentage of Harrisburg area residents who travel to a hospital located outside the Harrisburg area for hospital care).¹³ The inflow percentage for a candidate market is the percentage of sales by firms in an area to consumers who reside outside the area (e.g., of all patients treated by a Harrisburg area hospital, the percentage who come from outside that area).

In the 1980s and 1990s, courts and many expert witnesses in hospital cases relied on the EH method and related techniques to define relevant geographic markets. In healthcare cases, EH-style approaches commonly result in expansive relevant geographic markets and correspondingly low market shares. Thus, courts' reliance on EH-style analyses in past decades led them, on the basis of low market shares, to allow a series of hospital mergers challenged by DOJ and the FTC to

¹² Kenneth Elzinga and Thomas Hogarty (1978), "The Problem of Geographic Market Delineation Revisited: The Case of Coal," *Antitrust Bulletin*, 23: 1–18; Kenneth Elzinga and Thomas Hogarty (1973), "The Problem of Geographic Market Delineation in Antimerger Suits," *Antitrust Bulletin*, 18: 45–81.

¹³ The FTC alleged a relevant market "roughly equivalent to the Harrisburg Metropolitan Statistical Area (Dauphin, Cumberland and Perry Counties) and Lebanon County." *Opinion*, 8.

close.¹⁴ However, subsequent empirical research has shown that hospital mergers that combine closely competing hospitals (when sufficient other closely substitutable hospitals are not present) have resulted in substantial post-merger price increases, even though such mergers often would be deemed innocuous in the more expansive geographic markets that result from EH-style methods.¹⁵

Ultimately, EH analysis has been shown to generate unreliable and incorrect conclusions regarding market definition and market power in the case of hospital mergers. For this reason, the application of EH-style analysis to define healthcare markets has been sharply questioned, reassessed, and replaced by many

¹⁴ Competition Law: Hospitals, in *Improving Health Care: A Dose of Competition*, FTC and DOJ, chap. 4 (2004). In the 1990s, the FTC and DOJ lost 6 consecutive hospital merger challenges. Cory Capps, “From Rockford to Joplin and Back Again: The Impact of Economics on Hospital Merger Enforcement,” *Antitrust Bulletin* 59, no. 3 (2014): 443–478.

¹⁵ Cory Capps and David Dranove, “Hospital Consolidation And Negotiated PPO Prices,” *Health Affairs* 23, no. 2 (2004): 175–181; Leemore Dafny, “Estimation and Identification of Merger Effects: An Application to Hospital Mergers,” *The Journal of Law & Economics* 52, no. 3 (2009): 523–550; Deborah Haas-Wilson and Christopher Garmon, “Hospital Mergers and Competitive Effects: Two Retrospective Analyses,” *International Journal of the Economics of Business* 18, no. 1 (2011): 17–32; Steven Tenn, “The Price Effects of Hospital Mergers: A Case Study of the Sutter–Summit Transaction,” *International Journal of the Economics of Business* 18, no. 1 (2011): 65–82. See also, the research surveys referenced in *supra* n. 5. For a thorough analysis showing that geographic markets that result from EH analysis are much larger than the markets that result from modern approaches, see Martin Gaynor, Samuel Kleiner, and William Vogt, “A Structural Approach to Market Definition With an Application to the Hospital Industry,” *The Journal of Industrial Economics*, 61, no. 2 (2013): 243–289.

economists, including Professor Kenneth Elzinga, one of the originators of the approach.¹⁶

One key limitation of the EH method in healthcare markets has been termed the “Silent Majority Fallacy.”¹⁷ The EH method assumes, incorrectly, that purchasing decisions are a function solely of the price of the goods or services in question. In the case of coal, say, it is plausible to think that the fact that some power plants are purchasing coal from a seller 300 miles away is largely due to the fact that the remote seller is offering better prices (for the same product and delivery service) than a rival seller only 5 miles away. In healthcare markets, most insured patients do not face the full reimbursement price of provider services (and often, they face an out of pocket payment that does not vary with the choice of provider so long as they select an in-network provider). Hence rather than reflecting responses to price differences, patient travel patterns largely reflect other factors, such as where patients work, where their relatives live, where a particular

¹⁶ Kenneth Elzinga and Anthony Swisher (2011), “Limits of the Elzinga-Hogarty Test in Hospital Mergers: The *Evanston* Case,” *International Journal of the Economics of Business*, 18(1): 133–146. Professor Elzinga himself testified in a hospital merger case that the test was not appropriate for healthcare provider markets. *In re Evanston Northwestern Healthcare*, No. 9315, 2007 WL 2286195, at **63–66 (FTC Aug. 6, 2007).

¹⁷ Cory Capps et al. (2001), “The Silent Majority Fallacy of the Elzinga-Hogarty Criteria: A Critique and New Approach to Analyzing Hospital Mergers,” *NBER Working Paper No. 8216*, <http://www.nber.org/papers/w8216>.

inpatient service that is not available locally is offered, or that a patient happened to be away from home when the need for care arose. Consequently, the fact that a minority of patients currently travel relatively far to receive care says little about what the (silent) majority of “non-travelers” would do in response to a post-merger price increase.

Overall, Professor Elzinga summarizes the flaws of the EH approach as follows:¹⁸

Ignoring the Silent Majority Fallacy can make the geographic market for hospital services appear ‘too big’ in circumstances where market definition is based on patient flow data. When that happens, the E-H test produces a perverse result: the boundaries, being too broad, may embrace nearby hospitals whose existence has no competitive consequence in disciplining the pricing discretion of the merging hospitals. . . .

The inference of expansive geographic markets may be particularly mistaken in the provision of hospital services because the existence of a significant number of premerger travelers does not mean that enough additional patients would travel in response to a hypothetical price increase to render that price increase unprofitable. Other researchers have reached consistent conclusions. For example,

¹⁸ Kenneth G. Elzinga and Anthony W. Swisher, “Limits of the Elzinga-Hogarty Test in Hospital Mergers: The *Evanston* Case,” *International Journal of the Economics of Business* 18, no. 1 (2011): 133–46, at 137.

Frech, *et al.*, show that the EH method can lead to geographic market definitions that lack any semblance of face validity.¹⁹

In 2003, the FTC and DOJ held 27 days of hearings on a broad set of healthcare competition law and policy topics, including hospital geographic market definition. In their ensuing joint report, the agencies stated that “[h]ospital geographic markets should be defined properly” and that “[T]he Agencies’ experience and research indicate that the Elzinga-Hogarty test is not valid or reliable in defining geographic markets in hospital merger cases.”²⁰

Turning to the matter before the Court, we observe that the district judge relied upon what in essence is an EH analysis in rejecting the FTC’s market definition (“Of particular import to our analysis is the uncontroverted fact that, in 2014, 43.5% of Hershey’s patients . . . travel to Hershey from outside of the FTC’s designated Harrisburg Area. . .”)²¹ The fact that 43.5% of Hershey’s patients come

¹⁹ H.E. Frech III, James Langenfeld, and R. Forrest McClure, “Elzinga-Hogarty Tests and Alternative Approaches for Market Share Calculations in Hospital Markets,” *Antitrust Law Journal* 71 (2004). The authors conduct a detailed analysis of the sensitivity of the defined market to alternative assumptions and find that small changes in those assumptions can generate large changes in the defined market, an indication that EH is not a robust or reliable methodology for defining markets.

²⁰ Competition Law: Hospitals, in *Improving Health Care: A Dose of Competition*, FTC and DOJ, chap. 4, at 5 (2004).

²¹ *Opinion*, 9. Although the court did not use the label “Elzinga-Hogarty” or any similar term, the approach described in the opinion is in fact the Elzinga-Hogarty

from outside the Harrisburg area does not reveal whether a hypothetical monopolist of all hospitals within the Harrisburg area could impose a price increase.²² The answer to that question, which is central to assessing whether a relevant market has been appropriately defined, depends on whether hospitals outside the Harrisburg area are sufficiently substitutable that a SSNIP would be unprofitable. The court's opinion does not analyze the commercial viability of an insurer network without any Harrisburg area hospitals, the lynchpin for assessing whether the proposed market is too narrow. Instead, it rejects the FTC's alleged market because "the relevant geographic market proffered by the FTC is not one in which 'few patients leave . . . and few patients enter.'"²³

C. Summary

The court accepted the Defendants' arguments that substantial patient inflow constitute evidence for a broader geographic market.²⁴ However, the fact that some

method. *Opinion*, 8–9, 10 (twice referencing delineation of an area for which "‘few’ patients leave. . . and ‘few’ patients enter.”).

²² Professor Elzinga has also pointed out that the EH method is not the same as the hypothetical monopolist test under the Merger Guidelines because it is based solely on pre-merger flows of products (or consumers) and does not ask "what if" questions relating to post-merger price increases. Elzinga and Swisher (2011), *ibid.* at 144.

²³ *Opinion*, 10 (citing *Little Rock Cardiology Clinic PA v. Baptist Health*, 591 F.3d 591 (8th Cir. 2009), a monopolization case, not a merger case).

²⁴ The court did not discuss outflow but noted that the FTC stated that "very few patients travel to hospitals outside of the Harrisburg Area." *Opinion*, 8.

consumers in a proposed geographic market come from outside that market does not, by itself, imply that the geographic market is not a relevant antitrust market. The correct question for purposes of market definition is: faced with a small price increase, would an *insurer* be willing to exclude all Harrisburg-area hospitals from a network, thereby requiring members to travel to hospitals outside the area or incur substantially higher costs for receiving care in Harrisburg? The district court makes no mention of insurers' or brokers' testimony in this regard, nor does the opinion discuss whether networks without Harrisburg-area hospitals are likely to be attractive enough to patients to induce them to select such a network in the wake of an anticompetitive price increase passed through via their insurance premiums. The district court's opinion does not reflect the two-stage bargaining dynamic described above, and the court has rejected Plaintiff's market definition based on a partial set of facts and an inappropriate and discredited methodology.

III. The Parties' Agreements with Insurers Have No Bearing on the Appropriate Market Definition in this Matter, and Moreover Would Not Eliminate Harm from a Post-Merger Increase in Market Power.

In an attempt to assuage concerns about potential anticompetitive pricing effects of their merger, the Hospitals have voluntarily entered into 5 or 10-year agreements with central Pennsylvania's two largest payors.²⁵ The opinion asserts

²⁵ *Opinion*, 11.

that “rates cannot increase for at least 5 years,” and notes that the “Court simply cannot be blind to this reality.” The court seemingly finds these agreements relevant to the hypothetical monopolist test. However, the hypothetical monopolist test requires the hypothetical scenario of a monopolist selecting its optimal monopoly price, i.e. not subject to any price caps or contractual price increase. In other words, the purpose of the hypothetical monopolist test is to identify close substitutes; a contractual agreement that restricts price has no bearing on which hospitals are close substitutes and which are not—the agreements do not help the analyst to perform the hypothetical monopolist test or to define the proper scope of the relevant geographic market.

With respect to these agreements, we would advise the Court to reject them as a meaningful substitute for competition among the merging parties for four key reasons: (a) these commitments do not address important non-price dimensions of competition (e.g., quality), which are particularly relevant for patients due to the two-stage dynamic previously described; (b) these commitments rely on fee-for-service contracts, but do not address alternative payment models (e.g., risk-based arrangements), which are becoming increasingly common; (c) the commitments are time-limited; and (d) due to the “rapidly changing arena of healthcare and

health insurance,”²⁶ these agreements may become difficult to enforce or they may cease to be relevant.

In rejecting a proposed non-structural settlement between *Partners Healthcare* and the Massachusetts Attorney General in 2014 – one that contained broader commitments than those volunteered by the hospitals in this matter, and that would have been overseen by the Attorney General – Judge Janet Sanders wrote, “the remedies that are proposed are temporary and limited in scope – like putting a band-aid on a gaping wound that will only continue to bleed (perhaps even more profusely) once the band-aid is taken off.”²⁷

Moreover, this band-aid may not even “stick.” As new payment mechanisms, delivery systems, and insurance models develop, a commitment to maintain existing fee-for-service rates will cease to provide a meaningful constraint on hospitals’ actions, if it places such a constraint on their conduct in the first instance. Alternatively, a mutual commitment “to maintain existing rate structures for fee-for-service contracts and preserve the existing rate-differential between the [h]ospitals”²⁸ may impede progress toward alternative reimbursement structures that may better serve patients and employers.

²⁶ *Opinion*, 11.

²⁷ *Commonwealth v. Partners Healthcare System, Inc. & others*, SUCV2014-02033-BLS2, Mass. Super. Ct. (Jan. 29, 2015) (Memorandum Decision and Order at 3).

²⁸ *Opinion*, 11.

CONCLUSION

In closing, we emphasize that there is broad agreement in the economics academic community that provider competition is beneficial to consumers. There is a significant body of academic research that finds that competition enhances quality, and that limited competition raises prices and total healthcare spending.²⁹ In contrast, there is significant evidence that efficiencies do not necessarily or generally follow from provider mergers. In a full administrative trial on the merits – which would follow a preliminary injunction – the administrative law judge would consider whether substantial, merger-specific efficiencies exist and outweigh potential anticompetitive effects of the proposed transactions.

We urge the Court to reverse the district court’s findings and order, which are grounded in faulty economic analysis and are likely to harm the public interest in promoting competitive hospital markets.

Dated: June 8, 2016

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²⁹ See *supra* nn. 4–6.

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitations of Fed. R. App. P. 29(d) and Fed. R. App. P. 32(a)(7)(B) and because it contains 5,071 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

This brief complies with the typeface requirements of Fed. R. App. P.32(a)(5) and type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionately spaced typeface using Microsoft Word 2010 in 14-point Times New Roman font.

By: /s/Richard P. Rouco

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Third Circuit by using the appellate CM/ECF system on June 8, 2016. All parties have consented to receive electronic service and will be served by the ECF system.

By: /s/Richard P. Rouco

CERTIFICATE OF IDENTICAL COMPLIANCE OF BRIEFS

I certify that the text of the electronically filed brief is identical to the text of the original copies that were sent on June 8, 2016, to the Clerk of the Court of the United States Court of Appeals for the Third Circuit.

By: /s/Richard P. Rouco

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I certify that on June 8, 2016, a virus check on the electronically filed copy of this brief was performed using VIPRE Business, v7.0.5725.0 virus scanning program, Updated 06/08/16. No virus was detected.

By: /s/Richard P. Rouco

APPENDIX

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