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Saint Alphonsus v. St. Luke's: The Future of Health Care Transactions and Antitrust

BY DAVID ETTINGER AND DEREK W. KELLEY

Introduction

The U.S. Court of Appeals for the Ninth Circuit has now affirmed the district court's decision in *Saint Alphonsus v. St. Luke's*, which found that the acquisition of a physician group by a hospital was unlawful, and ordered divestiture.

As lead counsel for the private plaintiffs in *St. Luke's*, we believe that the case offers a number of precautionary lessons to parties considering hospital or physician transactions. But the decision certainly does not shut the door on provider transactions, even those involving apparently high market shares. While the antitrust environment created by the recent case law will be a more difficult and complicated one for some transactions, it is also an environment that is changing with the growing transformation of health care markets. Just as the new trends in health care provide new challenges to providers, they may also provide additional antitrust defenses.

David Ettinger, a partner with Honigman Miller Schwartz & Cohn LLP, Detroit, has led Honigman's Antitrust and Trade Regulation practice for more than 30 years and has represented clients in health antitrust matters in more than 30 states. He has successfully acted as lead counsel in a wide variety of major matters, including (in addition to the St. Luke's case) defense of a hospital merger against Justice Department challenge and one of the foundational cases on IPA and HMO antitrust liability. He can be reached at dettinger@honigman.com or (313) 465-7368.

Derek W. Kelley is an associate in the litigation department at Honigman, Detroit, and is in the firm's antitrust and trade regulation practice group. He has worked on the St. Luke's case. He can be reached at dkelley@honigman.com or (313) 465-7650.

The *St. Luke's* Opinion and Its Implications

For providers considering transactions, the most important ''takeaways'' from the Ninth Circuit decision are as follows:

1. The Ninth Circuit affirmed that on the evidence in Boise, consumers do not choose providers based on price.[1] Therefore, provider prices are set, and markets defined, based on the needs of health plans to include local providers in their networks.[2] This is the ''two stage competition'' model advocated by the FTC, in which provider price is determined at the ''first stage'' where plans negotiate with providers.[3] Adoption of this approach means that antitrust analysis will increasingly define very localized markets (which tend to have higher market shares).

2. The court found that on the facts presented, high (80 percent) market shares coupled with high barriers to entry were more than sufficient to establish a prima facie case of illegality.[4] The FTC guidelines presume that market power can be attained at shares in the 45 percent to 50 percent range or higher.[5]

[1] *Saint Alphonsus Med. Ctr.–Nampa, Inc. v. St. Luke's Health Sys., Ltd.*, 2015 BL 33471, 2015 WL 525540, at *4, n. 10 (9th Cir., Feb. 10, 2015).

[2] *Id.* at *4; *Saint Alphonsus Med. Ctr.–Nampa, Inc. v. St. Luke's Health Sys., Ltd.*, No. 1:12-cv-00560-BLW, 2014 WL 407446, at *7 (D. Idaho, Jan. 24, 2014).

[3] *St. Luke's*, 2015 WL 525540, at *4, n 10 (9th Cir.) (citing Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 ANTITRUST L.J. 671 (2000)).

[4] *Id.* at *7; *see St. Luke's*, 2014 WL 407446, at *22 (D. Idaho).

[5] 2010 Horizontal Merger Guidelines § 5.3 (Aug. 19, 2010).

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3. The Ninth Circuit expressed extreme skepticism about the defense of health care mergers based on claimed quality improvements.[6] In particular, it affirmed the district court's conclusion on the facts that the improvements claimed by St. Luke's could be achieved without an acquisition, and therefore were not a valid antitrust defense.[7]

4. The court concluded that it was within the district court's discretion to order divestiture, and to conclude that lesser ''conduct'' remedies would not restore competition.[8]

The decision establishes clear and strong rules applicable to health care transactions that would result in a high market share in a localized area. This may cause some hospitals to forgo acquisitions, and to adopt clinical integration through a nonexclusive network as a less fraught legal path.

However, as described below, this need not be the end of the story.

Antitrust Merger Defense: The Next Generation

Several emerging trends in health care may provide a strong basis to argue that some merging parties face significantly more competition than would be expected under the FTC's current approach. The ''old models'' we successfully attacked in *St. Luke's* may not work, but these changes in health care may make ''new models'' available to providers. These changes include a focus on narrow and tiered networks; higher copays and deductibles; new forms of primary care; and even shortages of primary care physicians.

The key to the FTC's ''two stage competition'' theory is the conclusion that consumers are not directly affected by providers' prices, and therefore will not shift to providers outside of a local area in the event of high provider prices. But several trends may provide a basis for questioning the continued accuracy of that assumption in some markets. More and more plans are adopting narrow or tiered networks, which provide financial incentives for consumers to shift away from higher cost providers.[9] And more and more plans impose very large copays and deductibles on consumers, which means that more consumers bear direct financial responsibility for much of their health care, and therefore need to be price conscious.[10]

Certainly none of these trends had advanced sufficiently in Idaho to provide an effective argument against the two stage model in *St. Luke's*. Indeed, the evidence showed that employers were largely unwilling to adopt narrow and tiered plans.[11] But the evidence may support a different approach in other markets.

Where these changes have become more significant, providers outside a local area may offer realistic choices for consumers who will travel to avoid high prices. This can ''open up'' the geographic market and may support the kind of broad markets that courts found in merger litigation in the 1990s. Once markets are broader, of course market shares tend to be smaller, and the antitrust analysis becomes radically different. But this will depend on a specific analysis of current and expected near future activity in a particular area.

Emerging trends may also change the analysis of market share and market power. For example, the increasing growth of employer clinics, retail clinics, and the use of mid-levels provide more competition in primary care markets.[12] This may change the analysis of primary care market share and market power in some markets.

Another possible defense responds to the *St. Luke's* analysis that a merger of competing physician groups can be problematic where it eliminates the acquired group as a significant independent option for managed care plans. With one less option, managed care plans may have less bargaining power and providers may have more power.[13] This can be important in a market with few significant competitors. Under these circumstances, according to the FTC's analysis, providers can demand higher prices.

But the increasing shortage of primary care physicians may rebut this argument in particular markets. If a physician group which is to be acquired is sufficiently busy and unable to recruit, it may be unable to take on significant numbers of new patients. Under those circumstances, the group may not provide a good alternative option for managed care plans, since they would not be able to shift substantial numbers of patients to that group in response to a price increase by other providers. Therefore, a merger may not reduce the realistic options available to managed care plans, and may not change the bargaining dynamics or prices.

The decision in *Saint Alphonsus v. St. Luke's* and other recent cases certainly makes some health care mergers and acquisitions more difficult. But a detailed analysis is still necessary to determine whether what appears to be problematic can nevertheless be defended in light of these emerging changes in health care.

The Decline of the Efficiencies Defense

One defense that is *not* likely to be productive in the future relates to efficiencies. The Ninth Circuit decision

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[6] *St. Luke's*, 2015 WL 525540, at *9 (9th Cir.).

[7] *Id.* at *11.

[8] *Id.* at *12.

[9] *See e.g.* William T. Eggbeer and Dudley E. Morris, *Narrow, Tailored, Tiered and High Performance Networks: An Emerging Trend*, BDC Advisors (Jan. 1, 2013), http://www.bdcadvisors.com/insight/narrow-tailored-tiered-and-high-performance-networks/. *See also* Kristin Bowers and William T. Eggbeer, *Health Care's New Game Changer: Thinking Like a Health Plan*, BDC Advisors (Oct. 1, 2014), http://www.bdcadvisors.com/insight/health-cares-new-game-changer-thinking-like-health-plan/; Bob Herman, *GE will steer workers to Northwestern Memorial for hips and knees*, Modern Healthcare (Nov. 24, 2014), http://www.modernhealthcare.com/article/20141124/NEWS/311249944.

[10] *See e.g.* Bob Herman, *High-deductible plans dominate next open enrollment*, Modern Healthcare (Nov. 13, 2014), http://www.modernhealthcare.com/article/20141113/NEWS/311139966; Tara Siegel Bernard, *High Health Plan Deductibles Weigh Down More Employees*, New York Times (Sept. 1, 2014), *available at* http://nyti.ms/1usG5Y5.

[11] Answering brief of Saint Alphonsus at 18, *St. Luke's*, 2015 WL 525540 (9th Cir.).

[12] *See, e.g.*, *The Case for Urgent Care*, Urgent Care Association of America (Sept. 1, 2011), http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/Files/WhitePaperTheCaseforUrgentCa.pdf.

[13] *See St. Luke's*, 2014 WL 407446, at *9-10 (D. Idaho).

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in *St. Luke's* follows a consistent pattern in the recent health care merger cases. All have rejected an efficiencies defense, not only based on the specific proofs offered, but through broad statements about the inadequacy of *any* defense depending on certain efficiencies claims.

In *FTC v. ProMedica Health Sys., Inc.*, the merging hospitals alleged efficiencies from revenue enhancement and capital cost avoidance. The court rejected both claims. It stated that revenue enhancements ''merely shift revenue among the participants in the market'' and do not ''reduce costs or increase output.''[14] It found that capital costs are ''competition-driven investments'' made ''to better compete and thus enhance consumer welfare.'' When they are avoided, ''consumers generally are left worse off.''[15]

In *FTC v. OSF Healthcare Sys.*, the court rejected efficiencies claims based on ''clinical effectiveness'' and the adoption of ''best practices'' because it found that these alleged efficiencies could be attained without a merger.[16] The court reached the same conclusion as to other improvements, including better recruiting of specialists and subspecialists.[17] The court also rejected arguments that the merger would improve quality of care, finding that there was conflicting evidence on whether an increase in the volume of procedures leads to improved quality of care.[18]

In *Saint Alphonsus v. St. Luke's*,[19] the defendants asserted that operation of an integrated delivery system would improve quality and allow a move to a risk-based reimbursement system.[20] But the district court rejected the claimed efficiencies because ''a committed team can be assembled without employing physicians'' and ''a committed team is not a merger-specific efficiency. . . .''[21]

St. Luke's efficiencies defense was also rejected in the Ninth Circuit. The appeals court held that the district court's findings were not clearly erroneous.[22] In dicta, the Ninth Circuit raised additional concerns. ''It is not enough to show that the merger would allow St. Luke's to better serve patients. The Clayton Act focuses on competition, and the claimed efficiencies therefore must show that the prediction of anticompetitive effects from the prima facie case is inaccurate.''[23] ''At most, the district court concluded that St. Luke's might provide better service to patients after the merger.''[24] But the district court also concluded that ''reimbursement rates for [primary care physician] services likely would increase'' despite the ''likely beneficial effect of the merger on patient care.''[25] Thus, ''whatever else St. Luke's proved, it did not demonstrate that efficiencies resulting from the merger would have a positive effect on competition.''[26]

The Ninth Circuit's conclusion was consistent with earlier case law. In *United States v. Rockford Mem'l Corp.*, the district court rejected the asserted defense that as a result of merger ''the number, depth and quality of services . . . will improve.''[27] The court acknowledged that ''the improvement in services would have a positive impact of consumers of healthcare,'' but concluded that that was ''not relevant for our purposes today.''[28] The court noted that its ''exclusive role is to evaluate the mergers' effect on competition for the relevant market and no more.''[29]

These decisions have relied in part on the Supreme Court's statement in *United States v. Phila. Nat. Bank* that an anticompetitive merger is ''not saved because, on some ultimate reckoning of social or economic debits and credits, it may be deemed beneficial. A value choice of such magnitude is beyond the ordinary limits of judicial competence and, and in any event, has been made for us already by Congress, when it enacted the amended Section 7.''[30]

Additionally, recent economic studies have called into question whether large integrated health care systems are more effective at lowering costs or improving quality.[31] Several studies found that hospital ownership of physician groups was associated with higher costs.[32] One study also found that physician groups of 400 to 500 or greater were not more efficient than groups of around 100 physicians.[33] Another study concluded that ''single specialty primary care group practices have lower costs, indicat[ing] that less costly care systems can be organized by primary care practices that depend on nonowned medical practices and hospitals for specialty services.''[34]

One study also examined differences in quality between physician groups based on whether the group was hospital-owned. The authors found that ''[r]elative to small physician groups, medium-sized and large independent physician groups performed consistently better on process measures of quality, but hospital-based groups did not.''[35]

Conclusion

Under the circumstances, an efficiencies defense in health care mergers based on claims of improved qual-

[14] *FTC v. ProMedica Health Sys., Inc.*, No. 3:11-cv-47, 2011 WL 1219281, at *36 (N.D. Ohio, March 29, 2011).
[15] *Id.*
[16] *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1092-93 (N.D. Ill. 2012).
[17] *Id.* at 1093-94.
[18] *Id.* at 1093.
[19] *St. Luke's*, 2014 WL 407446 (D. Idaho).
[20] *Id.* at *16.
[21] *Id.* at *17.
[22] *St. Luke's*, 2015 WL 525540, at *11 (9th Cir.).
[23] *Id.* at *10.
[24] *Id.*
[25] *Id.* at *10.
[26] *Id.* at *11.
[27] *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1288 (N.D. Ill. 1989).
[28] *Id.*
[29] *Id.*
[30] *United States v. Phila. Nat. Bank*, 374 U.S. 321, 371 (1963).
[31] J. Michael McWilliams, *et al.*, *Delivery System Integration and Health Care Spending and Quality for Medicare Beneficiaries*, 173(15) J. AMA. INTERNAL MEDICINE 1447 (Jun. 17, 2013); John Kralewski, *et al., Do Integrated Health Care Systems Provide Lower-Cost, Higher-Quality Care?,* 40:2 J. OF THE ACAD. OF PHYSICIAN EXECS. 14 (March/April 2014); Laurence C. Baker, *et al.*, *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending*, 33:7 HEALTH AFFAIRS 756 (May 2014).
[32] McWilliams at 1451; Kralewski at 15-16; Baker at 762.
[33] McWilliams at 1452.
[34] Kralewski at 16.
[35] McWilliams at 1451.

ity appears very difficult to sustain. Efficiencies defenses are generally very unlikely to overcome the prima facie case when a merger results in a high market share. Market-based defenses, as described above, likely deserve more serious attention by providers considering new transactions.

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