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St. Luke's-Saltzer: Where Does the Ninth Circuit Opinion Leave Quality-Enhancing Provider Integration in Allegedly Concentrated Markets?

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I. INTRODUCTION

On February 10, 2015, the Ninth Circuit Court of Appeals issued its opinion in the St. Luke's–Saltzer matter, upholding district court Judge B. Lynn Winmill's opinion that St. Luke's Health System's (St. Luke's) acquisition of the Saltzer Medical Group (Saltzer) should be undone through a divestiture of Saltzer.[2] Judge Andrew Hurwitz, on behalf of the Panel, summarized the Court's decisions that the "district court did not clearly err" in its conclusions regarding three issues in dispute:

- "Nampa, Idaho was the relevant geographic market;"
- "the plaintiffs established a prima facie case that the merger will probably lead to anticompetitive effects in that market;" and
- "the defendant did not rebut the plaintiffs' prima facie case where the defendant did not demonstrate that efficiencies resulting from the merger would have a positive effect on competition."

The Panel disagreed with Judge Winmill's opinion that "prices in the hospital-based ancillary services market," would rise due to market power created by the acquisition, concluding that the District Court made no findings regarding market power in such a market.

[1] Monica Noether, Ph.D. is a Vice President at Charles River Associates, where she specializes in antitrust analysis and other issues pertaining to the health care industry. The views expressed herein are the views and opinions of the author and do not reflect or represent the views of Charles River Associates or any of the organizations with which the author is affiliated.

[2] Saint Alphonsus Medical Center–Nampa Inc.; Saint Alphonsus Health system Inc.; Saint Alphonsus Regional Medical Center, Inc.; Treasure Valley Hospital Limited Partnership; Federal Trade Commission; State of Idaho, Plaintiffs-Appellees, and Idaho Statesman Publishing LLC; The Associated Press; Idaho Press club; Idaho Press-Tribune LLC; Lee Publications Inc., Intervenors, v. St. Luke's Health System, Ltd.; St. Luke's Regional Medical Center, Ltd.; Saltzer Medical Group, Defendants-Appellants. U.S. Court of Appeals for the Ninth Circuit, No. 14-35173, February 10, 2015, Opinion. (St. Luke's-Saltzer Appeal Opinion). On April 21, 2015, the 9th Circuit issued an order denying defendants' petitions for panel rehearing and for rehearing en banc.

Below, I focus primarily on a discussion of the Appeal Panel's third decision, regarding the likely effect of efficiencies brought about by the merger. I also comment briefly on the Court's discussion of the likely effects on ancillary services.[3]

II. THE FRAMEWORK FOR EVALUATING EFFICIENCIES

The Horizontal Merger Guidelines indicate that "a primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm's ability and incentive to compete….Efficiencies also may lead to new or improved products, even if they do not immediately and directly affect price."[4] The Guidelines also counsel that, in order to be relevant to the antitrust analysis, efficiencies must be "merger-specific." That is, they must be "unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects."

The District Court concluded that "the Acquisition was intended by St. Luke's and Saltzer primarily to improve patient outcomes."[5] While the Panel did not expressly disagree with that finding, it did note that while "better service to patients after the merger…is a laudable goal…the Clayton Act does not excuse mergers that lessen competition or create monopolies simply because the merged entity can improve its operations."[6]

Several commentators have written about the legal issues in this case and more generally associated with what many perceive is an asymmetry between the plaintiff's burden to demonstrate its *prima facie* case of likely anticompetitive effects and the defense's requirement to demonstrate that pro-competitive effects predominate. For example, a group of law and economics professors and the International Center of Law and Economics recently filed an *amicus curiae* brief urging the Ninth Circuit to rehear the matter *en banc,* largely based on the argument that the burden placed by the courts on defendants to demonstrate the merger-specificity of efficiencies was too high.[7] More generally, FTC Commissioner Joshua Wright has

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[3] A more complete background on the facts and issues presented in this case can be found in Monica Noether, *The St. Luke's-Saltzer Antitrust Case: Can Antitrust and Health Care Reform Policies Converge*? 4(2) CPI ANTITRUST CHRON. (April 2014 (2)) [Noether, 2014] as well as a variety of other sources.

[4] U. S. Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines §10 (August 19, 2010).

[5] Saint Alphonsus Medical Center–Nampa, Inc., Treasure Valley Hospital, Limited Partnership, Saint Alphonsus Health System, Inc., and Saint Alphonsus Regional Medical Center, Inc. v. St. Luke's Health System, Ltd. Case no. 1:12-CV-560-BLW. Federal Trade Commission; State of Idaho v. St. Luke's Health System, Ltd.; Saltzer Medical Group, P.A. Case No. 1:13-CV-00116-BLW. Memorandum Decision and Order. January 24, 2014.

[6] St. Luke's–Saltzer Appeal Opinion, §III.D.2, p. 29. Surprisingly, the Panel also noted that "even if we assume that the claimed efficiencies were merger-specific, the defense would nonetheless fail." It is unclear whether the Panel was opining that the merger benefits would not be conveyed on to consumers or that it did not believe that quality improvements are relevant efficiencies.

[7] Saint Alphonsus Medical Center–Nampa Inc.; Saint Alphonsus Health system Inc.; Saint Alphonsus Regional Medical Center, Inc.; Treasure Valley Hospital Limited Partnership; Federal Trade Commission; State of Idaho, Plaintiffs-Appellees, and Idaho Statesman Publishing LLC; The Associated Press; Idaho Press club; Idaho Press-Tribune LLC; Lee Publications Inc., Intervenors, v. St. Luke's Health System, Ltd.; St. Luke's Regional Medical Center, Ltd.; Saltzer Medical Group, Defendants-Appellants. Appeal from the U.S. District Court for the District of

voiced concern with the welfare implications of what he argues are different standards imposed upon plaintiffs and defendants in merger cases.[8]

III. EFFICIENCIES IN THE CONTEXT OF HEALTH CARE MERGERS

Rather than addressing the legal debate associated with the appropriate efficiency standard, I focus here on the critical policy issue of whether it is likely that alternative affiliation strategies, short of merger or acquisition, can be equally effective in creating the conditions necessary to achieve the various laudable goals of health care reform. In particular, hospitals and other health care providers are all currently grappling with how to make progress toward the "Triple Aim" of improving the individual patient care experience, improving "population health," and slowing the rate of increase in per capita health care spending.[9] Both public and private payors are increasingly substituting "value-based payments" based on achieving good *outcomes* for traditional fee-for-service payments that are based solely on *inputs*, in an attempt to make health care more cost-effective.[10]

Whatever jargon is used to describe these widespread reform initiatives, any cursory review of health care or general press reveals the universal belief by providers that vertical and horizontal integration is key to making progress. A recent article enumerated four characteristics of successful integrated managed care models:

1. a vertically and horizontally integrated structure,
2. a prepayment method of reimbursement that puts providers at risk,
3. an advanced IT system, and
4. a culture of physician leadership.[11]

Idaho, No. 14-35173. Brief for Professors and Scholars of Law and Economics and International Center of Law and Economics in Support of Defendants-Appellants Urging Rehearing En Banc, April 6, 2015.

[8] "Merger analysis is by its nature a predictive enterprise. Thinking rigorously about probabilistic assessment of competitive harms is an appropriate approach from an economic perspective. However, there is some reason for concern that the approach applied to efficiencies is deterministic in practice. In other words, there is a potentially dangerous asymmetry from a consumer welfare perspective of an approach that embraces probabilistic prediction, estimation, presumption and simulation of anticompetitive effects on the one hand but requires efficiencies to be *proven* on the other. Joshua Wright: Dissenting Statement of Commissioner Joshua D. Wright, *In the Matter of Ardagh Group S.A., and Saint-Gobain Containers, Inc., and Compagnie de Saint-Gobain,* FTC File No. 131-0087, April 11, 2014. [Ardagh dissent.]

[9] Donald Berwick, et al., *The Triple Aim: Care, Health and Cost*, 27(3) HEALTH AFFAIRS, 759-769 (2008), *available at* http://content.healthaffairs.org/content/27/3/759.full.pdf+html.

[10] The Centers for Medicare and Medicaid Services ("CMS") recently announced that it expected to tie half of all traditional Medicare payment to alternative payment models and 90 percent to quality or value metrics by the end of 2018. (Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value, January 26, 2015 press release, *available at* http://www.hhs.gov/news/press/2015pres/01/20150126a.html). A recent national survey of physicians by Deloitte found that they expect about 50 percent of their compensation to be tied to value within 10 years. Mitchell Morris, M.D. *Preparing for the Inevitable: The Path to Success in a Value-Based World* (2015), *available at* http://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-chs-value-based-world-021615.pdf.

[11] Becker's Hospital Review, *4 key characteristics of successful integrated managed care models* (April 10, 2015).

In opening remarks at the recent Hearings on Examining Health Care Competition organized by the Federal Trade Commission and Department of Justice, Dr. Ezekiel Emanuel, a former special advisor on health policy to the Director for the Office of Management and Budget and National Economic Council, noted that "….you need some scale to be able to do integration….It costs money to upgrade IT. To do process improvement. To employ health workers. To be able to provide more care at home…." However, he also described this consolidation as a necessary, but not sufficient, precursor to true integration in which "people would have the infrastructure, the capital, to actually innovate on the continuum of care…." and "to operate in a value-based, risk-based payment system."[12]

This last shift—to a payment system that rewards providers for their outputs (of high quality, effective health care)—is the move that is particularly critical for a real transformation of health care.[13] It is also the change that many providers believe is impossible to attain without the combination through ownership of hospitals, physicians, and perhaps other providers. Indeed, the recent two-day FTC-DOJ hearings mentioned above focused on the potential for different forms of integration to achieve the transformation of health care delivery. Commentators have described the relationship between a continuum of integration and the amount of financial risk that an integrated entity could assume.[14]

This debate about the merger specificity of the integration efficiencies is at the heart of the antitrust dispute in St. Luke's-Saltzer. In particular, the St. Luke's-Saltzer matter focuses on the horizontal combination of physicians through hospital acquisition of multiple physician groups. Both the District Court and the Appeal Panel found that there was "no empirical evidence to support the theory that St. Luke's needs a core group of employed primary care physicians…to successfully make the transition to integrated care."[15] Rather, they appeared to conclude that looser affiliations that maintained competition between the St. Luke's physicians and the Saltzer Medical Group could still enable the investments necessary to develop and operate the information infrastructure, care protocols, physician monitoring, and feedback tools necessary to improve the delivery of health care services to the residents of Nampa, Idaho.

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[12] Ezekiel Emanuel, Opening Remarks to Examining Health Care Competition, an FTC-DOJ Workshop, February 24-25, 2015, pp. 8-16, *available at* https://www.ftc.gov/system/files/documents/public_events/618591/transcript-day1.pdf. [Emanuel Remarks]

[13] Many have noted in the absence of a shift away from fee-for-service payment system, providers have incentives to deliver more, rather than more efficient or higher quality, health care. For example, Brent James and Lucy Savitz describe Intermountain's implementation of a protocol designed to reduce the rate of delivery by elective induction that succeeded in reducing the payments associated with elective inductions by $50 million annually. However, it only reduced Intermountain's own costs by $41 million. Brent James and Lucy Savitz, *How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts*, 30(6) HEALTH AFFAIRS 1185-1191 (2011), *available at* http://content.healthaffairs.org/content/30/6/1185.full.pdf+html?sid=cb8e5301-5113-4ea0-a53f-4b7f15e5fd21.

[14] *See*, for example, the presentation of Lisa McDonnel of UnitedHealthcare Networks, *Alternative to Traditional Fee-for-Service Models, available at* https://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition.

[15] Saint Alphonsus Medical Center–Nampa, Inc., Treasure Valley Hospital, Limited Partnership, Saint Alphonsus Health System, Inc., and Saint Alphonsus Regional Medical Center, Inc. v. St. Luke's Health System, Ltd. Case no. 1:12-CV-560-BLW. Memorandum and Order, December 20, 2012.

Even more importantly, they apparently believed that looser affiliations, presumably achieved through contracts, could foster the move from fee-for-service reimbursement to value-based payments. But as Commissioner Wright has cautioned, "the merger-specificity requirement could be interpreted narrowly to exclude any efficiency that can be recreated with any form of creative contracting"[16] regardless of whether the contract is practical.[17]

The St. Luke's-Saltzer Courts' conclusions ignore the fact that the very health care delivery systems that are frequently touted as the poster children for successful delivery of integrated care all have large "core group[s] of employed primary care physicians." For example, Kaiser Permanente Medical Group employs over 17,000 physicians;[18] Mayo Clinic has 4,200 staff physicians and scientists;[19] and Intermountain's Medical Group Clinics employ 1,300 physicians.[20] Chicago-based Advocate Health, which is often touted as an example of a successful model of integrated care delivered primarily through independent physicians, includes 1,100 employed physicians.[21] Even plaintiff, St. Alphonsus, apparently employs about 300 physicians.[22]

Thus, it appears that even those health systems that affiliate with physicians in arrangements short of employment also rely on a substantial core group of employed physicians. These examples are confirmed by recent studies. A new analysis by the Rand Corporation of physician responses to alternative payment methodologies notes that surveyed physician practices "were changing their organizational models—predominantly by affiliating or merging with other physician practices or aligning with or becoming owned by hospitals—in response to new payment models."[23] Similarly, a summary by two well-known health economists of several studies on the current progress of Accountable Care Organizations in achieving the goals of health care reform asserts: "Larger physician groups deliver care that is higher quality and more efficient…."[24]

While the St. Luke's-Saltzer Courts were correct to note that currently existing empirical work does not conclusively demonstrate a definitive causal link between integration through ownership/employment and the successful implementation of the principles of health care

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[16] Ardagh dissent, *supra* note 8.

[17] In Noether, 2014, *supra* note 3, I discuss the economic theory regarding the situations in which contracts tend to be inferior to ownership.

[18] Kaiser Permanente by the Numbers, *available at* http://www.kaiserpermanentejobs.org/infographic.aspx.

[19] Mayo Clinic Facts, *available at* http://www.mayoclinic.org/about-mayo-clinic/facts-statistics.

[20] Intermountain Medical Group Clinics, *available at* http://intermountainhealthcare.org/services/medicalgroup/Pages/home.aspx.

[21] About Advocate Medical Group, *available at* http://www.advocatehealth.com/documents/newsroom/AMG%20Fact%20Sheet%20-%20FINAL.pdf.

[22] "Saint Alphonsus is establishing an integrated Health Alliance of 1200 physicians, 75 percent of whom are independent." Answering Brief for Plaintiffs/Appellees the Federal Trade Commission and the State of Idaho. Saint Alphonsus Regional Medical Center, Inc. *et al.* v. St. Luke's Health System, Ltd. *et al.* On Appeal From the United States District Court For the District of Idaho Case No. 1:12-cv-00560-BLW *et al.* (page 60).

[23] Friedberg, Mark W., *et al. Effects of Health Care Payment Models on Physician Practice in the United States. Santa Monica, CA,* RAND Corporation, 41 (2015), *available at* http://www.rand.org/pubs/research_reports/RR869.

[24] Lawton Burns & Mark Pauly, *Accountable Care Organizations May Have Difficulty Avoiding the Failures of Integrated Delivery Networks of the 1990s*, 31(11) HEALTH AFFAIRS 2407-2416 (November 2012) *available at* http://content.healthaffairs.org/content/31/11/2407.full.pdf+html?sid=49d183dd-b616-4545-938c-d4d01d164105

reform, that is not surprising given the current state of transition in the industry. As Dr. Emanuel concluded his remarks at the FTC/DOJ Health Care Competition Hearings by cautioning, "Let's not over-rely on the past models we have had, because I don't think they're going to be as predictive going forward as we would like….[O]ur past models for what constitutes competition may not apply in a new and changing environment."[25]

IV. THE EVALUATION OF CONTRACTUALLY RELATED PRICE INCREASES

The Panel disagreed with the District Court's finding that "St. Luke's would 'exercise its enhanced bargaining leverage from the Acquisition to charge more services at the higher hospital-based billing rates.'"[26] Rather, it concluded that this finding "is not supported by the record." It indicated that the Court made no findings with respect to market power in the market for ancillary services; nor did it provide evidence that St. Luke's intended to raise ancillary prices anticompetitively. Moreover, the Panel noted that documents cited by the Court regarding St. Luke's desire to increase revenue in ancillary services could have many competitively benign explanations.[27]

As I explained in my previous discussion of the District Court Opinion,[28] Medicare reimbursement policy fosters a substantial differential between payments to freestanding physicians' offices and those affiliated with hospital outpatient departments. Regardless of its merits, this differential does not imply that hospitals possess market power in the provision of outpatient services, but rather reflects a historic concern over the higher costs associated with potentially higher acuity patients as well as the infrastructure necessary to provide services on a 24-7 basis.

To the extent that private payors have adopted similar payment approaches, they likely have done that as part of an aggregate package of reimbursement policies aimed to achieve an overall medical spending level for their members. The Panel appears to have recognized that if St. Luke's acquisition of Saltzer led to an increase in ancillary spending because of the higher rates that St. Luke's contracts allow, without market power in ancillary services it would be unable to maintain this higher reimbursement with managed care organizations beyond its current contracts.

This distinction between price increases occasioned by merger-induced increases in market power and those that result temporarily from existing contract provisions is important. While the latter may cause temporary non-market based price disruptions, these disruptions are likely to be rectified in the next contract renegotiation absent any change in market power.[29]

V. CONCLUSION

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[25] Emanuel Remarks, *supra* note 12.

[26] St. Luke's-Saltzer Appeal Opinion, § III.C.3, p. 21.

[27] St. Luke's–Saltzer Appeal Opinion, § III.C.3, p. 19.

[28] Noether, 2014, *supra* note 3.

[29] Many believe that the spate of recent hospital acquisitions of physician practices has been fueled solely by the substantial reimbursement differential. If this is true, the solution is not to use the antitrust laws to prevent these mergers, but rather, as the White House recommends, to address any inappropriate payment differentials. *See*, Margot Sanger-Katz, *When Hospitals Buy Doctors' Offices, and Patient Fees Soar*, N.Y. TIMES (February 6, 2015), *available at* http://www.nytimes.com/2015/02/07/upshot/medicare-proposal-would-even-out-doctors-pay.html.

Evolution of the delivery of and reimbursement for health care services is clearly in a state of unfinished transition. The Ninth Circuit Panel decision in St. Luke's-Saltzer runs the risk of furthering a "chicken-and-egg" problem with respect to continued progress toward the widespread development of delivery organizations that can effectively assume financial risk to deliver value-based health care. Without clear evidence that such organizations often function optimally when they are horizontally and vertically integrated through ownership, the antitrust laws may not permit them to advance. If they do not progress, it will be difficult to develop the evidence necessary to demonstrate their effectiveness.