

WHEN PROVIDERS MERGE, IS KAISER A COMPETITOR?



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¹ The authors are with Davis Wright Tremaine LLP in its Seattle and Washington, D.C. offices. The firm represented a physician group in recently concluded litigation (discussed in the article) brought by the State of Washington to reverse acquisitions of two physician groups on the Kitsap peninsula. Defendants argued that Kaiser Permanente physicians should be included in the relevant geographic markets at issue in that case. The authors also have represented, and on an ongoing basis represent, physicians and hospitals making the same argument in matters under investigation by the FTC and other antitrust enforcement agencies.

CPI ANTITRUST CHRONICLE MAY 2019

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CPI Antitrust Chronicle May 2019

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I. INTRODUCTION

When providers — whether hospitals or physicians — propose to merge, an important initial question to consider is who else competes with the merging providers in the relevant market. If the merging parties have no or few competitors, they may be able to raise prices above pre-merger levels. If they face vigorous competition from other market players, however, the ability of the merging parties to raise prices may be constrained, such that the proposed merger poses little or no threat to competition.

According to the Horizontal Merger Guidelines issued by the Department of Justice and the Federal Trade Commission, “[a]ll firms that currently earn revenues in the relevant market are considered market participants.”² So, if two groups of adult primary care providers in a properly defined relevant geographic market propose to merge, all other adult primary care providers in that market are considered market participants and should be included in market share calculations.³ Similarly, if an acute-care hospital proposes to acquire another such hospital in the same relevant geographic market, all other acute-care hospitals in the market should be included before market shares are calculated and the effect of the acquisition on competition is judged.⁴

II. KAISER PERMANENTE: A VERTICALLY INTEGRATED HEALTH SYSTEM

But what should courts and antitrust enforcers do when some of the providers in the relevant geographic market where a provider merger has been proposed are part of the Kaiser Permanente system? Kaiser Permanente is a vertically integrated system that combines health care coverage (often simply referred to as health insurance) with a delivery network of hospitals, physicians, and other providers. Kaiser’s model has been very successful: it provides health care for over 12 million people in eight states through 23,000 employed physicians and more than 730 medical centers and facilities.⁵ But Kaiser largely operates a “closed” network. Physicians, employed by regional Permanente Medical Groups, provide services on an exclusive basis to members in the Kaiser Foundation Health Plan. Facilities, owned by Kaiser Foundation Hospitals, are exclusively available to those

² U.S. Dep’t of Justice & Fed. Trade Comm’n, HORIZONTAL MERGER GUIDELINES § 5.1 (2010).

³ For example, in the FTC’s challenge to the acquisition of a physician group in the greater Boise area, the court focused on the adult primary care market in Nampa, Idaho. It included all adult primary care providers in Nampa in its market calculation when it found that the combination of eight providers employed by St. Luke’s with the 16 providers in the Saltzer medical group was unlawful. *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke’s Health Sys., Ltd.*, No. 1:12-CV-00560-BLW, 2014 WL 407446 (D. Idaho Jan. 24, 2014), *aff’d*, 778 F.3d 775 (9th Cir. 2015).

⁴ See, e.g. *F.T.C. v. ProMedica Health Sys., Inc.*, 3:11 CV 47, 2011 WL 1219281, at *11-*12 (N.D. Ohio Mar. 29, 2011).

⁵ Kaiser Permanente, *At a Glance*, available at <https://atagance.kaiserpermanente.org/> (last accessed April 6, 2019).

members who need hospitalization.⁶ Individuals who receive their health care coverage through other commercial insurers, such as a regional Blue Cross or Blue Shield plan, UnitedHealth, or Aetna, don't have the option to obtain care from a Permanente doctor or a Kaiser hospital.

Kaiser Permanente's closed structure has led some enforcers to argue that its physicians and hospitals should be ignored when a merger of non-Kaiser providers takes place in the same relevant market. In recent cases brought by California and Washington, the attorneys general of those states have made precisely this argument. Last year, California sued Sutter Health, a 24-hospital system in northern California, claiming the system's contracting practices violate the Cartwright Act, the State's antitrust law.⁷ California's complaint claims Kaiser Permanente should be excluded from the relevant market because Kaiser is a closed system that does not make its provider network available to other commercial insurers or to self-funded employers. California (and the other plaintiff in the litigation, UFCW & Employers Benefit Trust) filed a motion in March 2019 (which, as of the date of this article, has not yet been decided) to exclude the opinion of Sutter's expert economist that Kaiser and Sutter compete in the same antitrust market.⁸

The State of Washington made a similar argument in its just-concluded litigation challenging two transactions into which CHI Franciscan Health entered in 2016.⁹ The State claimed the transactions lessened competition in the markets for adult primary care physician services and orthopedic physician services. The State moved to exclude testimony from CHI's expert economist because he included Kaiser physicians in both markets.¹⁰ Both the State of Washington's expert economist and CHI's economist relied on the now-familiar "two-stage" competition model to analyze the competitive effects of the transactions. This model was described succinctly by the Seventh Circuit when it upheld the FTC's recent challenge to the proposed merger of Advocate Health Care Network and NorthShore University HealthSystem:

In the first [stage], which is highly price-sensitive, insurers and hospitals negotiate to determine whether the hospitals will be in the insurers' networks and how much the insurers will pay them. Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 *Antitrust L.J.* 671, 674–75 (2000). In the second stage, hospitals compete to attract patients, based primarily on non-price factors like convenience and reputation for quality. . . . Concerns about potential misuse of market power resulting from a merger must take into account this two-stage process.¹¹

According to the State,

[P]ayers cannot contract with Kaiser-employed physicians for healthcare services because Kaiser-employed physicians are exclusively contracted with Kaiser. . . . [S]ince Kaiser-employed physicians do not compete with other [market] physicians to be included in other payer's plans, they should not be included in the markets for orthopedic and adult PCP services . . .¹²

6 In certain markets, Kaiser contracts with non-Permanente physicians to provide specialty medical services not provided by Permanente-employed physicians. Kaiser also contracts with non-Kaiser hospitals and hospital systems in markets where Kaiser does not maintain its own hospital facilities. For example, in Seattle (where Kaiser does not have a hospital), it contracts for most inpatient care to be provided at Swedish Medical Center, a community hospital open to all.

7 Complaint, *California v. Sutter Health*, No. CGC-18-565398 (filed Mar. 29, 2018), available at <https://www.courthousenews.com/wp-content/uploads/2018/03/Sutter-California-COMPLAINT.pdf>. After the complaint was filed the case was consolidated with *UFCW & Employers Benefit Trust v. Sutter Health*, No. CGC 14-538451. The motion was noted for hearing on April 30; trial is scheduled for August 12, 2019.

8 Notice of Motion and Motion to Exclude Expert Opinion of Dr. Gowrisankaran that Kaiser and Sutter Compete in the Same Antitrust Market, *UFCW & Employers Benefit Trust and California v. Sutter Health*, No. CGC 14-538451 (filed Mar. 8, 2019).

9 *State of Washington v. Franciscan Health System et al.*, No. 3:17-cv-05690-BHS, Dkt. No. 1 ¶ 85 (filed Aug. 31, 2017). The State challenged the acquisition by CHI Franciscan of a small group of orthopedic surgeons as a violation of Section 7 of the Clayton Act. *Id.* The state asserted also that CHI Franciscan and a second group — of about 55 physicians in various specialties — violated Section 1 of the Sherman Act when they entered into a transaction by which the group sold its assets to CHI, assigned its leases to CHI, and agreed to see exclusively CHI patients. CHI Franciscan, in turn, was responsible for the group's expenses and for contract negotiation. CHI Franciscan paid the group according to its productivity. The case has settled on so-far undisclosed terms. *Id.*, docket notice dated Mar. 14, 2019 (terminating trial date pursuant to notice from the parties the matter was resolved and ordering dismissal/settlement papers be filed by April 29, 2019).

10 State's *Daubert* Motion to Exclude Portions of the Expert Reports and Testimony of Lawrence Wu, Ph.D., *Franciscan Health System*, No. 3:17-cv-05690, Dkt. No. 177 at 8 (filed Dec. 21, 2018).

11 *F.T.C. v. Advocate Health Care Network*, 841 F.3d 460, 465 (7th Cir. 2016); see also *Saint Alphonsus Med. Ctr.-Nampa Inc.*, 778 F.3d at 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)).

12 See *supra* note 10.

In the State's view, then, if the only other primary care physicians in a market in which two groups of primary care physicians merge are Kaiser Permanente doctors, the merger is unlawful because the Kaiser Permanente doctors do not constrain the ability of the merging doctors to raise prices. And, in a similar situation where two hospitals merge and the only other hospitals in the market are Kaiser hospitals, a similarly minded enforcer presumably would argue that the Kaiser hospitals do not constrain the ability of the merging hospitals to raise prices.

III. IS IT SENSIBLE TO EXCLUDE KAISER AS A MARKET PARTICIPANT?

The Merger Guidelines assert that vertically integrated firms must be included in the relevant market, “to the extent that their inclusion accurately reflects their competitive significance.”¹³ What is the competitive significance of Kaiser providers located in the same market where non-Kaiser providers plan to merge?

The issue arose 20 years ago, when two hospitals in Oakland and Berkeley, California, sought to merge.¹⁴ The district court held that a Kaiser hospital in Oakland was part of the relevant product market for the purpose of assessing the merger:

All forms of acute inpatient care, however, are substitutes for the services offered by defendants because they all accomplish the task of delivering acute inpatient services to patients in the Bay Area. . . . Although Kaiser hospitals may not directly provide services to non-member patients, *they do provide viable substitutes for services offered at other hospitals in the region*; if faced with an anticompetitive price increase, patients may choose to join the Kaiser network for acute inpatient services.¹⁵

While the precise Kaiser issue appears not to have arisen again in any of the decided cases, the district court's decision to include Kaiser when considering the Sutter merger was cited with approbation in the Areeda & Hovenkamp treatise.¹⁶ Other decisions involving vertically integrated firms support this result. The Ninth Circuit, in *ITT v. GTE*,¹⁷ squarely held that “captive sales” cannot be excluded from the relevant market. In that case, the district court found that GTE's acquisition of telephone operating companies threatened competition in the sale of telephone equipment. It did so based on an alleged “submarket” that excluded purchases of telephone equipment by members of the Bell System from their affiliate, Western Electric. The Ninth Circuit held this was error: “vertical foreclosure in itself does not justify defining a customer market to exclude ‘captive’ sales.”¹⁸

The Ninth Circuit has applied this principle specifically to health care services. In *Morgan, Strand, Wheeler & Biggs v. Radiology, Ltd.*,¹⁹ radiologists argued that because osteopathic physicians referred only to osteopathic radiologists, and University physicians referred only to University radiologists, both sets of radiologists should be excluded from the relevant product market in which plaintiffs competed. The Ninth Circuit concluded that, even if referral patterns were “quite fixed, or exclusive” among these providers, *all* radiologists were part of the same market.²⁰ The Court affirmed the entry of summary judgment, concluding that the radiologists failed to present evidence of the product market.²¹

Morgan, Strand is also discussed with approval in the Areeda & Hovenkamp treatise. The authors state that “the integrated firm's . . . output belongs in the market,” and “[p]recisely the same reasoning applies when the [integrated] firm provides through employees a service in competition with independent service providers.”²²

¹³ Horizontal Merger Guidelines § 5.1.

¹⁴ *California v. Sutter Health System*, 84 F. Supp. 2d 1057 (N.D. Cal. 2000), *aff'd*, 217 F.3d 846 (9th Cir. 2000).

¹⁵ *Id.* at 1068 (emphasis added). In an odd move, the district court opinion was later amended to state there was no dispute over the fact that the Kaiser hospitals belonged in the relevant market, 130 F. Supp. 2d 1109, 1119-1120 (N.D. Cal. 2001), despite the fact that the court's initial decision shows the issue was hotly contested by the parties.

¹⁶ Philip E. Areeda & Herbert Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* (“ANTITRUST LAW”), Vol. IIA, ¶ 535e, n.19. (4th ed. 2013).

¹⁷ 518 F.2d 913, 930-931 (9th Cir. 1975), *overruled on other grounds*, *California v. American Stores, Inc.*, 495 U.S. 271 (1990).

¹⁸ *Id.* at 931.

¹⁹ 924 F.2d 1484 (9th Cir. 1991).

²⁰ *Id.* at 1489-90.

²¹ *Id.* at 1489.

²² ANTITRUST LAW, Vol. IIA, ¶ 535e, n.19.

By the same logic, Kaiser should be included in any market where it provides the same physician or hospital services as those provided by the merging parties. As Areeda & Hovenkamp wrote, with specific reference to the district court's decision to include Kaiser when analyzing the merger of Suter and Summit, "each provision of services by Kaiser reduces in like amount the provision of services by other hospitals; further, Kaiser compete[s] with alternative health care arrangements in the signing up of members."²³ Because patients and employers who use other providers (and insurers) could shift to Kaiser in response to a price increase by those providers (which will manifest itself in their premiums), it should make sense always to include Kaiser in the relevant market when considering a provider merger.

While the issue remains open in the courts, several health care researchers have asserted Kaiser should be considered in a market analysis. For example, in the wake of an assignment undertaken in 2013 on behalf the California Department of Justice to consider the effects of a proposed hospital affiliation in the Bay Area, two consultants with Health Management Associates prepared a paper detailing the model the firm used to analyze the merger.²⁴ Their assignment required them to confront the question whether Kaiser should be considered in the analysis. They acknowledged that "non-Kaiser enrollees do not access Kaiser hospitals and that Kaiser enrollees do not access non-Kaiser hospitals," but noted that "Kaiser's strong market power in California affects the bargaining process between a non-Kaiser hospital and another commercial insurer through insurer competition for enrollees" and so they included Kaiser hospitals in their model.²⁵ They explained that "while a Kaiser hospital may not be a viable immediate choice for a non-Kaiser patient, if it has high utility to the patient it may be that they would choose Kaiser during the next re-enrollment, and therefore we believe including Kaiser hospitals in the model is justified."²⁶

IV. BUILDING A CASE FOR KAISER'S INCLUSION IN THE RELEVANT MARKET

In the absence of binding case law requiring that Kaiser's doctors and hospitals be considered as market participants when non-Kaiser providers merge, courts and enforcers will treat the issue as an open one. Lawyers urging the inclusion of Kaiser as a market participant will be expected to marshal facts specific to the market under scrutiny to support this result. What facts would be helpful — or harmful — to the argument? In general, advocates of Kaiser-as-a-market-participant will want to show that Kaiser competes with other commercial insurers for members who obtain health care in the relevant market. If non-Kaiser providers in that market merge, and attempt to raise prices to the commercial insurers through whom they obtain their patients, the necessary result will be that those insurers must raise premiums. But this puts the insurers at risk of losing members, who can switch to Kaiser at the next open enrollment period. And once those members have switched to Kaiser, they are lost to the non-Kaiser providers whose price increase started this chain of events.

More specifically, a convincing narrative would seek to establish as many of the following facts as possible:

- A trend over time showing an increase in Kaiser's share of the health care coverage market compared to commercial payers. If Kaiser has increased its share in a geographic market by a substantial amount (at the expense of non-Kaiser commercial plans), this would be consistent with a theory that subscribers switch from non-Kaiser commercial products to Kaiser. The larger Kaiser's share, the stronger the argument.
- Evidence of particular subscribers who switched. In Washington's challenge to the CHI Franciscan transactions discussed above, for example, defendants planned to introduce evidence at trial of patient switching, including testimony from Franciscan physicians that they often lost patients to Kaiser — and sometimes regained those same patients when commercial insurers narrowed the difference between their premium costs and Kaiser's.²⁷

²³ *Id.*

²⁴ Lisa Maiuro and Paul Niemann, "Evaluating the Effects of Hospital Consolidation: How Sensitive is the Discrete Choice of Econometric Model in Identifying Hospital Competitors?" (Aug. 2015), available at <https://www.chcf.org/wp-content/uploads/2017/12/PDF-EvaluatingEffectsHospitalConsolidation.pdf>.

²⁵ *Id.* at 19. The authors relied on research by Kate Ho and Robin Lee that showed "most hospitals negotiate lower prices when Kaiser is present." *Id.* The Ho and Lee paper appears in *Econometrica*, Vol. 85, No. 2 p. 379–417 (Mar. 2017).

²⁶ *Id.*

²⁷ Defendants' Pre-Trial Memorandum, at 34 (Case 3:17-cv-05690-BHS, Dkt. 249) (filed Feb. 27, 2019). The case settled before trial however. *Supra* note 8.

- Evidence that many employers offer their employees a choice between Kaiser and a non-Kaiser commercial plan. To the extent evidence could be gathered on how many employees choose one compared to the other, and how that has changed over time (and perhaps in response to differing employee contribution payments) the evidence could be very persuasive. The ability of a party undergoing a merger review to access this information is limited, however. Only if the government challenges a merger do parties ordinarily have the ability to subpoena employers and brokers. In the absence of subpoena power, employers or brokers might be approached and interviewed to see if they would provide some of this information informally.
- Documents in a merging providers' files, created in the ordinary course of business, showing that providers consider Kaiser to be a competitor. Similarly, documents (perhaps e-mails in the payer negotiating files) that show commercial payers put pressure on providers to control costs to stem the tide of subscribers exiting commercial plans for Kaiser should be very persuasive.

Kaiser, as a vertically integrated organization, can directly realize the cost savings that result from controlling utilization of its services, and is incentivized to develop patient-centric models of care that emphasize prevention and early intervention. Kaiser can pass these cost savings to its members (and their employers) in the form of reduced premiums and out-of-pocket costs. These reduced costs, in turn, allow Kaiser (both as an insurer and delivery system) to capture more share, allowing Kaiser to achieve further cost savings through efficiencies. Available evidence supports the conclusion that Kaiser is good at lowering costs. Kaiser's health insurance exchange products in California are priced at or below the offerings from Blue Shield, Anthem, and Health Net.²⁸ Kaiser offers a strong brand, high clinical quality, and loyal customers. Kaiser is consistently one of the top-rated health plans according to the NCQA.²⁹ Kaiser's Medicare Advantage plans consistently score highly according to CMS's STAR ratings.³⁰

The pressure Kaiser places on non-Kaiser providers in a market may have additional effects, beyond forcing non-Kaiser providers to keep prices they charge insurers at levels that will not incentivize their patients to drop those insurers and switch to Kaiser. Kaiser's prowess as a competitor may motivate mergers or other innovative joint ventures. If two health care systems have hospitals and affiliated physicians in different cities and towns across a broader geographic area where Kaiser provides coverage for a substantial segment of the population, the systems may be motivated to merge or form a joint venture so they can better control costs and work together, perhaps also with a like-minded payer in the region, to develop a Kaiser-like vehicle that can better manage care and compete more effectively with Kaiser. Several years ago, for example, eight well-known systems spread across a broad swath of southern California (including among them Cedars-Sinai, UCLA, and Huntington Memorial) joined with Anthem Blue Cross to form Vivity — a narrow network, low-cost product designed specifically to offer integrated care in direct competition with Kaiser.³¹

28 For example, Kaiser has consistently offered insurance products through Covered CA (whereas some firms have exited) and Kaiser offers some of the lowest priced products available there. See Covered California's Health Insurance Companies and Plan Rates for 2018, available at https://www.coveredca.com/newsroom/PDFs/CoveredCA_2018_Plans_and_Rates_8-1-2017.pdf.

29 Available at <http://healthinsuranceratings.ncqa.org/2018/search/Commercial/CA>;
<http://healthinsuranceratings.ncqa.org/2017/search/Commercial/CA>;
<http://healthinsuranceratings.ncqa.org/2016/search/Commercial/CA>;
<http://healthinsuranceratings.ncqa.org/2015/search/Commercial/CA>.

30 Available at <https://www.medicare.gov/find-a-plan/results/planresults/plan-details.aspx?pp=planlistbynameorid>.

31 See, e.g. Modern HealthCare, "How Anthem's Vivity venture is faring in Southern Calif. showdown with Kaiser?" (Oct. 23, 2015), available at <https://www.modernhealthcare.com/article/20151023/NEWS/151029953/how-anthem-s-vivity-venture-is-faring-in-southern-calif-showdown-with-kaiser>.

V. CONCLUSION

The fundamental issue that antitrust counsel for providers and the antitrust enforcement agencies alike must confront is whether the presence of Kaiser providers in a market constrains the ability of merging, non-Kaiser providers to raise prices. In two separate enforcement actions, California and Washington have argued that because commercial payers can't switch from non-Kaiser providers to Kaiser providers immediately in the event of a price increase by the non-Kaiser providers, the two-stage competition model requires the exclusion of the Kaiser providers from the market. If non-Kaiser hospitals and physician groups adopt the State enforcers' theory that Kaiser providers don't compete with them — and raise prices in that belief — they likely will suffer economically during subsequent open enrollment periods when commercially insured individuals switch from commercial health care coverage to Kaiser to take advantage of lower premiums and out-of-pocket costs. This reality can be a powerful constraint on providers' ability profitably to raise price. Rote application of the two-stage competition theory to exclude Kaiser from the competitive calculus when two providers merge in a market where Kaiser has a strong presence would be a triumph of theory over fact. The two-stage competition model may work well to explain how competition operates in markets dominated by commercial insurers, who stimulate providers to compete against each other to be included in the insurers' networks. But in markets where Kaiser is strong, ignoring Kaiser ignores the competitive reality faced by providers. It would seem better economics to adjust the two-stage competition theory to account for the reality of Kaiser's competitive effects on providers, than to ignore that reality so as to preserve the simplicity of the theory. After all, it was an economist who first said, "when the facts change, I change my mind."³²

³² But who that economist was remains a subject of dispute. Some accounts suggest that John Maynard Keynes said it first; others credit Paul Samuelson. See Quote Investigator, "When the facts change, I change my mind. What do you do sir?," available at <https://quoteinvestigator.com/2011/07/22/keynes-change-mind/>.

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