

St. Luke's Merger Decision Highlights Enforcement Trends



Law360, New York (February 19, 2014, 12:36 PM ET) -- In late January, the Federal Trade Commission prevailed in a challenge to a hospital merger involving an issue of great significance in the current health care marketplace: the acquisition of physician practice groups.

In *Saint Alphonsus Medical Center-Nampa v. St. Luke's Health System Ltd.*, Judge B. Lynn Winmill of the U.S. District Court for the District of Idaho held that St. Luke's Health System's acquisition of the Saltzer Medical Group PA violated Section 7 of the Clayton Act and the Idaho Competition Act. The case is not only the latest in a long line of cases applying merger principles to the health care industry, but also shows some of the tensions between those principles and the promotion of more efficient health care delivery through the cooperation and integration of health care providers.

St. Luke's Litigation and Decision

Private plaintiffs filed the initial complaint against St. Luke's in 2012; the FTC and Idaho filed in 2013 and the cases were consolidated. After a bench trial, the court predicted that the merger between St. Luke's and Saltzer, which had become effective in December 2012, would have a number of anti-competitive effects. It would give St. Luke's 80 percent of the market for adult primary care services for commercially insured patients in Nampa, Idaho, and increase the Herfindahl-Hirschman Index (HHI) by 1,607 to 6,219, making the acquisition presumptively anti-competitive.[1] The court also concluded that the merger would allow the combined entity to increase prices charged to health plans and to obtain higher, hospital-based reimbursement for ancillary and certain other services.

St. Luke's raised both efficiency and market entry defenses. It argued that the merger would allow it to move toward more efficient, risk-based reimbursement provided to a team of physicians, and to provide the Saltzer doctors with access to a high-end electronic health record (EHR) system. While the court agreed that the primary purpose and effect of the merger would be to "improve patient outcomes" through a more "integrated" medical system, it concluded that these efficiencies were not merger-specific and that there were other ways to accomplish the same goals. The court also rejected the market entry defense, finding that the difficulty of recruiting family doctors to Nampa would make entry unlikely.

The court ordered St. Luke's to divest the Saltzer physicians and assets, noting that divestiture is the favored remedy in Section 7 cases. The court rejected St. Luke's alternative proposal to negotiate health plan reimbursement rates separately from Saltzer, finding such a remedy more appropriate where divestiture is unworkable. St. Luke's has said that it will likely appeal.

Health Care Industry and Antitrust Enforcement Trends

The St. Luke's case is particularly significant given the recent growth in physician practice group acquisitions, which jumped 139 percent from 2010 to 2011.[2] Pressure to provide more integrated care appears to be one factor driving this growth (though reasons for the trend are admittedly varied and complex).

Efforts toward informal provider alliances to integrate care were codified in the Affordable Care Act, which provided for the establishment of accountable care organizations through which providers work collaboratively to manage and coordinate care for Medicare beneficiaries. In October 2011, the FTC and the U.S. Department of Justice released a statement of antitrust enforcement policy regarding ACOs.[3] The statement set forth an antitrust "safety zone" for ACOs meeting criteria established by the Centers for Medicare and Medicaid Services, but explicitly excluded merger transactions, noting that these would continue to be evaluated under the agencies' horizontal merger guidelines.

In fact, hospital-practice group mergers have drawn the attention of both federal and state antitrust enforcers in recent years. In 2012, the FTC and the Nevada attorney general settled charges against Renown Health of Reno, Nev. Renown had acquired two cardiology practices, giving it an alleged 88 percent market share in adult cardiology services in Reno. The cardiologists' contracts included noncompete clauses preventing them from competing with Renown for two years after leaving. Under the settlement, Renown agreed to suspend the noncompete agreements until at least six, and up to 10, cardiologists had terminated their contracts.[4]

In Washington state, the FTC and the Washington attorney general investigated a hospital's acquisition of two cardiology practices and preliminarily concluded that it would have anti-competitive effects. As a result, the hospital abandoned the acquisition in February 2011.[5] Finally, in Maine, the state attorney general challenged Maine Medical Center's acquisition of two cardiology groups. The AG and the hospital entered into a consent decree limiting the rates the combined entity could charge and preventing the inclusion of non-compete clauses in the physicians' contracts.[6]

Implications for Future Hospital-Practice Group Mergers

As the first recent litigated challenge to a physician practice acquisition, St. Luke's may foreshadow future court battles and increased leverage for antitrust enforcers. Physicians and hospitals wishing to partner thus may face a number of challenges.

First, if they choose to merge, rather than partner informally, federal regulators will evaluate the merger under the horizontal merger guidelines. Although physician practice acquisitions are unlikely to trigger Hart-Scott-Rodino premerger review, competitors or other third parties may alert enforcers to antitrust concerns or sue separately. Moreover, St. Luke's shows that federal and state enforcers will litigate challenges to these mergers when they find antitrust problems and that courts are willing to unwind already-consummated transactions.

Several factors may affect whether a merger is allowed to proceed or, if already consummated, remain

intact. Market definitions are key and will be limited not only by the particular geographic area, which may be sparsely populated, but also may be limited by physician specialty, patient age, and payer mix.

In *St. Luke's*, for example, the market was for adult primary care services paid for by commercial payers in Nampa, Idaho; Boise, about 20 miles away, was excluded. Additionally, it is not entirely clear how much market share is "too much." In the *Renown Health* matter, the FTC entered an agreement that could have ultimately left *Renown* with a market share as high as around 70 percent. However, the government has challenged lower market shares as well.[7]

Mergers in smaller markets or in rural or medically underserved areas could be particularly difficult. First, combined market share may be problematic if a local hospital acquires a mid- to large-size physician practice. Market definitions may magnify this effect. For example, in *St. Luke's*, the exclusion of Boise from the relevant market made *St. Luke's* market share higher than it otherwise would have been.

Moreover, where an area has historically had difficulty recruiting providers, the merged entity may not be able to show that competitor entry will mitigate any anti-competitive effects. Although the FTC and DOJ statement of enforcement policy regarding ACOs addresses some of the challenges faced by rural ACOs, merging entities are assessed under the merger guidelines.

Arguments for consolidation as a quality improvement mechanism may not overcome anti-competitive effects. First, even where providers have tried (and failed) to integrate informally, as in *St. Luke's*, courts and enforcers may find that there remain other ways to partner, short of a merger. Moreover, technological developments may undermine arguments that mergers are necessary to promote integration. As data sharing becomes cheaper and more prevalent, it may be easier to integrate care between providers without formally combining. (In fact, in *St. Luke's*, the hospital's own efforts to develop an affiliate-type EHR system undermined its efficiency defense because the Saltzer physicians could access this system even if the merger did not proceed.)

In *St. Luke's*, the court was concerned that, post-merger, *St. Luke's* could obtain higher, hospital-based reimbursement for ancillary and other services. Higher, hospital-based reimbursement is available not only through private insurance, but also under Medicare, where hospitals can bill for both physician and other services and for separate facility fees. To the extent that private reimbursement tracks Medicare rules, this raises interesting questions about the extent to which such effects are considered "anti-competitive" under Section 7. Additionally, given the push by some to equalize Medicare payments across hospital and physician office settings,[8] any future Medicare reimbursement changes could prompt private insurers to follow suit and thereby alter the extent to which hospital-practice group acquisitions are alleged to be anti-competitive.

Comparison of *St. Luke's* with the *Renown* and *Maine* cases illustrates the different remedies that may be available when a merger is found to be anti-competitive. In *St. Luke's*, the court favored the structural remedy of divestiture, and rejected a proposed conduct remedy (separate rate negotiations). However, in *Renown*, the FTC was willing let *Renown* restructure its contracts, rather than fully divest, to allow physicians to leave and compete with the hospital. Similarly, in the *Maine* case, the state AG set limits on price increases.

This split in remedies is due in part to how far each merger had proceeded. It may also illustrate a difference between the remedies enforcers will accept in settlement negotiations versus those a court may impose. Ultimately, however, federal antitrust regulators are unlikely to accept the types of price

restrictions imposed in the Maine case in place of more stringent structural remedies.

In short, parties considering physician practice group acquisitions need to take into account the wide range of factors influencing enforcement decisions and should involve antitrust counsel early on when considering such mergers.

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[1] Under the FTC and DOJ horizontal merger guidelines, a market is highly concentrated if the HHI is above 2500; a merger that increases the HHI by over 200 points will be presumed likely to enhance market power. U.S. Dep't of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines 19 (rev. ed. 2010), available at <http://www.justice.gov/atr/public/guidelines/hmg-2010.pdf>.

[2] See Deloitte Ctr. for Health Solutions, Issue Brief, Physician-Hospital Employment: This Time It's Different (2013), available at http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Center%20for%20health%20solutions/us_lshc_PhysicianHospitalEmployment_090313.pdf.

[3] See U.S. Dep't of Justice & Fed. Trade Comm'n, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (2011), available at <http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf> [hereinafter ACO Statement of Policy].

[4] Renown Health; Analysis of Agreement Containing Consent Orders to Aid Public Comment, 77 Fed. Reg. 47844 (Aug. 10, 2012).

[5] Press Release, Fed. Trade Comm'n, FTC Bureau of Competition Director Issues Statement on Providence Health & Services Abandonment of its Plan to Acquire Spokane Cardiology and Heart Clinics Northwest (Apr. 8, 2011), available at <http://www.ftc.gov/news-events/press-releases/2011/04/ftc-bureau-competition-director-issues-statement-providence>.

[6] See *State of Maine v. MaineHealth*, No. BCD-CV-11-08 (Me. B.C.D. Jan. 3, 2012) (Order Approving Consent Decree).

[7] For example, in late 2011, the FTC sought to preliminarily enjoin the merger of two hospitals in Rockford, Illinois that would have resulted in a combined market share of 64 percent of the acute-care inpatient hospital services market and 37 percent of the market for primary care physician services. See Complaint for Temporary Restraining Order and Preliminary Injunction, *FTC v. OSF Healthcare Sys.*, No. 11-cv-50344 (N.D. Ill. Nov. 18, 2011). Similarly, although not relevant to horizontal mergers, the FTC/DOJ Statement of Policy on ACOs suggests an even lower threshold, limiting "safety zone" protection to ACOs in which independent ACO participants provide no more than 30 percent of a given service in the ACO's "primary service area." See ACO Statement of Policy, *supra* n.3. While an ACO's "primary service area" differs from a relevant antitrust geographic market, it "nonetheless serves as a useful screen for

evaluating potential competitive effects.” Id.

[8] See, e.g., Medicare Payment Advisory Comm’n, Report to the Congress: Medicare Payment Policy ch. 3 (2012); Medicare Payment Advisory Comm’n, Report to the Congress: Medicare and the Health Care Delivery System ch. 2 (2013).

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