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I. INTRODUCTION

For nearly the last decade, there has been increased emphasis on controlling healthcare spending and costs in the United States. State and federal antitrust enforcement agencies have taken on a renewed focus of provider consolidation in attempts to implement cost containment in the healthcare system for both consumers and payors.[2] These agencies, specifically the Federal Trade Commission ("Commission"), have been reinvigorated in recent years to litigate and prevent potentially anticompetitive healthcare provider mergers.[3] However, whereas previously the focus of the Commission and other enforcement agencies has been on horizontal mergers—i.e. a hospital acquiring another hospital—there is also now increasing interest in vertical combinations—i.e. a hospital acquiring a physician practice.[4]

As a result of heightened scrutiny by the enforcement agencies, provider groups seeking both vertical and horizontal acquisitions and collaborations face complex antitrust and regulatory challenges. As Assistant Attorney General Bill Baer recently said, "merger enforcement, in particular, is a predictive exercise."[5] Merging provider parties aware of the recent agencies actions will be better prepared to defend their transactions before the agencies, or a court if necessary. First, understanding the agencies' stance on merger efficiencies is key for merging parties. Second, there are likely different remedies to potentially anticompetitive mergers depending on whether a transaction is being reviewed by the federal government or a state government. Third, knowing the regulations of various states is necessary to understanding the pulse of the state agency reviewing a merger.

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[2] *See generally* Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation—Update*, ROBERT WOOD JOHNSON SYNTHESIS PROJECT, 1, 1 (2012), *available at* http://goo.gl/KVtEyF (discussing numerous economic studies finding price increases as a direct consequence of hospital and provider consolidation).

[3] While the Commission typically handles healthcare provider mergers, the Department of Justice Antitrust Division has also shown an interest in preventing mergers between providers that they deem would harm competition. *See* Bill Baer, Assistant Attorney General, U.S. Dep't of Just, Antitrust Div., Opening Remarks: Workshop on Examining Health Care Competition (Feb. 25, 2015), *available at* http://goo.gl/anQvw6 (in discussing healthcare provider mergers, "we stand ready to take appropriate enforcement action against transactions that harm competition.").

[4] *See* Edith Ramirez, *Antitrust Enforcement in Health Care—Controlling Costs, Improving Quality*, 371 NEW ENG. J. MED. 2245, 2246 (2014) ("Similar concerns arise when physician groups combine or when doctors sell their practices to hospitals.").

[5] *DOJ's Antitrust Division Kept Busy by Increased M&A*, BLOOMBERG BUS. (July 15, 2015 8:53 AM), http://goo.gl/ToBH5V (at 1:49).

This article discusses recent developments in healthcare provider mergers following the above. First, it notes the role of efficiencies post-*St. Luke's*. Second, the article scrutinizes the use of remedies by federal and state enforcers. Third, it examines the increased usage of state legislation and regulation. And finally, the article briefly discusses the potential impact of health insurance mergers on healthcare providers.

II. NON-COST EFFICIENCIES DEFENSE IN PROVIDER MERGERS: THE *ST. LUKE'S* DECISION CLOSES DOORS

Merging parties have often relied on pro-competitive efficiencies as a rebutting presumption to potential anticompetitive harm. In the healthcare context, beyond cost-savings, providers have previously relied on efficiencies that establish "better medical care" to survive a merger challenge.[6] However, there has been a systemic shift in reviewing efficiencies associated with mergers among healthcare entities. This shift stems from increased reliance on the structural presumption and the 2010 Merger Guidelines.

The structural presumption model from *United States v. Phila. Nat'l Bank*[7] requires plaintiffs only prove undue concentration through presumptive models, not actual anticompetitive effects.[8] In contrast, under the structural presumption, defendants are required to rebut the presumption of competitive harm via actual proof.[9] In instances where parties rely on an efficiencies defense to rebut the presumption of harm, the Department of Justice and Federal Trade Commission's 2010 Horizontal Merger Guidelines further complicate the issue. Under the Guidelines, a party's stated efficiencies must be "merger-specific," "substantiated," and "cognizable," making proving efficiencies for merging parties decidedly more difficult.[10]

The recent *St. Luke's* case provided an in-depth view of how federal enforcers and courts view healthcare efficiencies using this analysis. The case involved a vertical transaction between St. Luke's Health System ("St. Luke's") and Saltzer Medical Group ("Saltzer")—an independent physician practice with 41 physicians including 16 primary care doctors in Nampa, Idaho.[11] Along with a private lawsuit, the Commission reviewed the transaction under a horizontal theory, analyzing the horizontal overlap between Saltzer's and St. Luke's combined market share in the adult primary care market.[12]

However, St. Luke's responded that such a transaction was purposed with moving the parties away from ineffective fee-for-service payments towards integration between the provider groups, thus leading to better coordination and care. In assessing the transaction's efficiencies, the district court agree with St. Luke's analysis finding that, if the merger were "left intact," the

[6] *See FTC v. Tenet Health Care*, 186 F.3d 1045, 1054 (8th Cir. 1999).

[7] 374 U.S. 321 (1963).

[8] *See St. Alphonsus Med. Ctr. v. St. Luke's Health Sys.*, 778 F.3d 775, 788 (9th Cir. 2015) (stating that "the extremely high HHI (Herfindahl-Hirschman Index) on its own establishes the prima facie case.").

[9] *See ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 571 (6th Cir. 2014) ("The remaining question is whether ProMedica has rebutted that presumption.").

[10] *See* § 10.

[11] *St. Luke's Health Sys.*, 778 F.3d at 781.

[12] *Id.*

efficiencies it created would improve care for patients in Nampa.[13] Yet, the lower court determined that the touted quality of care enhancing efficiencies could not be counted because they lacked merger-specificity.[14]

On appeal, the Ninth Circuit went a few steps further in dismissing non-cost-savings related efficiencies. After reviewing both the relevant case law and the Merger Guidelines, the Ninth Circuit stated that an efficiencies defense must demonstrate "that the prima facie case 'portray[s] inaccurately the merger's probable effects on competition.'"[15] Under that standard, the Ninth Circuit found that improvements in care should not be considered:

> But even if we assume that the claim efficiencies were merger-specific, the defense would nonetheless fail. At most, the district court concluded that St. Luke's might provide better service to patients after the merger. That is a laudable goal, but the Clayton Act does not excuse mergers that lessen competition or create monopolies...[16]

The Ninth Circuit's decision in *St. Luke's* raises the question if merging parties should offer quality of care efficiencies in merger cases. In response to scholarly analysis of the decision, the Commission has publicly stated that the opinion is "consistent" with the Merger Guidelines' standard of requiring parties prove efficiencies instead of relying on potential outcomes.[17] Providers considering using improvement in quality of care as a merger efficiency and defense must present clear, concrete evidence of improvement. Yet, under the analysis of the structural presumption, no federal appellate court has ever relied on any type of efficiency to overturn a *prima facie* case.[18] Therefore, quality-enhancing efficiencies in the healthcare merger context should be considered as bolstering arguments for a merger, not the only line of defense against objections to that merger.

III. MERGER REMEDIES: GOVERNMENT SAYS DIVESTITURE IS KING, STATES CONSIDER BEHAVIORAL FIXES

As part of the renewed interest in healthcare mergers, in 2007, the Commission sought and won a case involving the combination of two hospitals in the Chicago area, the first victory for the Commission since 1991.[19] However, instead of requiring the parties to divest and return to operating separately, the Commission issued a conduct remedy requiring the hospitals use "separate and independent negotiating teams" for payor contracting.[20] Yet, since the *Evanston*

[13] Findings of Fact and Conclusions of Law, *F.T.C. v. St. Luke's Health System, Ltd.*, Case No. 1:13- CV-00116-BLW at *3 (D. Idaho Jan. 24, 2014).

[14] *See Id.* at *34 ("a committed team can be assembled without employing physicians").

[15] *St. Luke's Health Sys.*, 778 F.3d at 790 (citation omitted).

[16] *Id.* at 791-92.

[17] *See* Terrell McSweeny, Commissioner, Fed. Trade Comm'n, 2015 Annual Antitrust Spring Seminar (Apr. 28, 2015), *available at* http://goo.gl/anQvw6 (noting that "St. Luke's had a desire to improve quality" but "there was nothing in the record to show it had increased quality in previous acquisitions, or that it had anything more than a 'laudable goal'").

[18] *See St. Luke's Health Sys.*, 778 F.3d at 789.

[19] Opinion of the Commission, *In the Matter of* Evanston Northwestern Healthcare Corp., F.T.C. No. 9315 (Aug. 6, 2007).

[20] *Id.* at 89-90.

case, the Commission has rarely employed a conduct or behavioral remedy,[21] and instead has consistently relied on structural remedies such as divestitures.[22] Federal courts have followed the lead of the Commission rejecting merging parties proffered conduct remedies in both *St. Luke's* and *ProMedica*.[23]

While the federal enforcers are unlikely to offer or grant a conduct remedy, state antitrust enforcers are more willing to engage merging parties. In recent years, there have been a number of potential anticompetitive provider mergers wherein parties entered into consent decrees with states attorney generals.[24] The most complex and encompassing attempted conduct remedy involved Massachusetts' Partners HealthCare ("Partners").

Partners, the largest healthcare provider in Massachusetts, sought to acquire both South Shore and Hallmark hospital systems—a transaction involving three hospitals and 450 physicians in the greater Boston area. Instead of litigating the matter and seeking divestiture, former Attorney General Martha Coakley sought a court order consent decree allowing the parties to merge, but with a number of conditions.[25] The conduct remedy was incredibly complex and included provisions for (1) price caps; (2) limiting future hospital and physician acquisitions; (3) component contracting for payors; and (4) an appointed, unaffiliated monitor of the merger that would serve for ten years.[26]

The conduct remedy was supported by Pennsylvania Attorney General's Office, a state that has entered into numerous conduct remedies with a number of healthcare provider groups over the last five years.[27] However, the Partners conduct remedy did not come to fruition. Due in

[21] *See In the Matter of* Renown Health, F.T.C. C-4366 (Dec. 4, 2012) (consent decree involving Renown suspending usage of non-compete agreements until at least six cardiologists terminated contracts); Agreement Containing Consent Order, *In the Matter of* Phoebe Putney Health Sys., Inc., F.T.C. No. 9348 (Aug. 22, 2013) (after the Supreme Court decision finding that state immunity did not apply, the Commission entered into a consent decree with Phoebe Putney requiring that the hospital not acquire additional acute care hospital or physician practices and prohibited Phoebe Putney from objecting to certificates of needs).

[22] *See* Deborah L. Feinstein, Director, Bureau of Competition, Fed. Trade Comm'n, Antitrust Enforcement in Health Care: Proscription, not Prescription (June 19, 2014), *available at* https://goo.gl/n7mDKf (noting that the Commission now "repeatedly reject[s] this sort of conduct remedy.").

[23] *St. Luke's Health Sys.*, 778 F.3d at 793-94; *ProMedica Health Sys.*,749 F.3d at 573.

[24] *E.g.* Press Release, N.Y. Att'y Gen., A.G. Schneiderman Announces Settlement With Utica Hospitals To Address Competitive Concerns (Dec. 11, 2013), *available at* http://goo.gl/HjSPXI (allowing merger of Utica's two largest hospitals but requiring parties eliminate usage of most-favored-nation contracting clauses and achieve stated efficiencies); Consent Decree, State of Maine v. MaineHealth, No. BCD-CV-11-08 (Me. B.C.D. Jan. 3, 2012) (allowing vertical acquisition of cardiologists by hospital as long as parties accepted a number of conditions including not requiring hospital rates for outpatient cardiology services).

[25] *See* Press Release, Massachusetts Attorney General Martha Coakley, AG Final Resolution with Partners Would Alter Provider's Negotiating Power, Restrict Growth and Health Costs (June 24, 2014), *available at* http://goo.gl/oXJRya.

[26] *Id.*

[27] Public Comment by James A. Donahue, Executive Deputy Attorney General for Penn., *In re* Comm. of Mass. v. Partners Health Sys., Inc., South Shore Health and Ed. Corp., and Hallmark Health Corp., Civil Action No. 14-2033-BLS (Mass. Superior Ct. Aug. 28, 2014).

large part to outcry from economists, consumers groups, and other Boston-area hospitals, Judge Sanders rejected the settlement noting that it would "cement Partners' already strong position."[28]

As providers move forward with mergers, it is important to note how different agencies, federal and state, could respond in the event of litigation. Given its recent public statements and the case law, it appears that the Commission has a well-established pension for only using structural remedies. And while states are more willing to consider a conduct remedy, it is not guaranteed to be successful in the courts or necessarily in the best interests of the parties.

IV. STATE LEGISLATION: ENGAGING AND DISENGAGING ANTITRUST REVIEW

Along with federal and state antitrust laws, most states have an extra layer of regulatory compliance mandating merging providers meet state requirements. These additional requirements can be burdensome or helpful to merging parties depending on the state.

Nowhere is healthcare provider merger regulation more pronounced than in the Commonwealth of Massachusetts. As part of the Commonwealth's policies to reduce healthcare cost growth and improve quality of care, the state passed Chapter 224, or the health cost containment law, which created the Health Policy Commission ("HPC").[29] The HPC has been granted the power to "assess[] the impact of healthcare market changes" by investigating provider mergers within the state.[30] In fact, it was data collected by the HPC that greatly influenced Judge Sanders to reject the Partners settlement.[31]

More recently, the Commonwealth has looked to expand the HPC's powers. A proposed bill would allow the HPC's report on any merger to act as "'prima facie evidence' to prove a violation of the state's consumer protection statute."[32] By increasing the power of the HPC, the Commonwealth's Attorney General will now have more tools to block potential anticompetitive mergers between healthcare providers.[33]

On the other side of the spectrum is New York. New York is implementing a Delivery System Reform Incentive Payment ("DSRIP") program, designed to improve the state's Medicaid program with a primary goal of reducing avoidable hospital visits by 25 percent within five years.[34] Payouts of the program require significant coordination and collaboration among

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[28] *In re Commonwealth of Mass. v. Partners Healthcare Sys., Inc.*, No. SUCV2014-02033-BLS2, 2015 Mass. Super at *2 (Mass. Super. Court, Suffolk County, Jan. 29, 2015).

[29] *Health Policy Commission*, MASS.GOV, http://goo.gl/uLddQ8 (last visited July 17, 2015).

[30] *Id.*

[31] *See generally Partners Healthcare Sys., Inc.*, No. SUCV2014-02033-BLS2 (discussing the HPC's findings throughout).

[32] Shira Schoenberg, *AG Maura Healey backs bill giving more power to Massachusetts' Health Policy Commission*, MASSLIVE (Apr. 7, 2015 6:08 PM), http://goo.gl/xkSGyp.

[33] Connecticut has also taken a similar approach. Under Section 1 of P.A. 14-168, An Act Concerning Joint Ventures and Affiliations of Group Medical Practices, "[a]ny party to a transaction that results in a 'material change to the business or corporate structure of a group practice'" must submit written notice to the Attorney General within 30 days. *Notice of Material Change Form*, CONNECTICUT, OFFICE OF THE ATTORNEY GENERAL, http://goo.gl/OOYEEy (last visited July 17, 2015).

[34] *Delivery System Reform Incentive Payment Program*, HEALTH.NY.GOV, https://goo.gl/YBN8fp (last visited July 17, 2015).

providers as benchmarks are tied to clinical management and public health indicators.[35] As part of this program, providers may apply for Certificates of Public Advantage ("COPA"), allowing provider entities, including competitors, to enter into collaborative agreements under active state supervision granting the parties state action immunity.[36] To date, three different New York providers entities have submitted COPA applications for the DSRIP program.[37]

In response to these providers seeking state action immunity for participation in the DSRIP program, the Commission authored a letter to the State of New York. In the letter, the Commission noted that COPA applications were unnecessary as pro-competitive collaborations, particularly those between healthcare providers, are embraced by the antitrust laws.[38] The Commissions believes that COPA, and potentially other healthcare provider antitrust immunity laws, could "encourage healthcare providers to share competitively sensitive information and engage in joint negotiations with payers in ways that will not yield efficiencies or benefit consumers."[39]

With different states using very different tactics, merging provider parties must be aware of the additional level of scrutiny that awaits them outside of the traditional antitrust regime.

V. HEALTH INSURANCE MERGERS: BUYING POWER ENHANCED

Lastly, while this article focuses on trends within health provider merger antitrust, we would be remiss to not mention consolidation within the buyer side of the market and its potential impact on providers—i.e. the recent news of major health insurance mergers. To date, Aetna has made an offer to purchase Humana while Anthem is discussing a merger with Cigna.[40] If these deals were to be consummated, the American public and providers would be left with three dominant insurers nationwide.[41] There would also likely be significant and lengthy review by the Department of Justice's Antitrust Division ("Division") for each transaction. In recent insurance mergers matters, the Division has utilized consent decrees requiring only that the parties divest significantly concentrated overlapping assets.[42]

Unlike past deals, these potential mergers involve the nation's largest insurers. A combination of these entities would create insurers with significant buying power and the ability

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[35] *Id.*

[36] *Certificate of Public Advantage*, HEALTH.NY.GOV, http://goo.gl/8MaICT (last visited July 17, 2015).

[37] Letter from Marina Lao, Director, Office of Policy Planning Fed. Trade Comm'n, to New York State Department of Health (Apr. 22, 2015), *available at* https://goo.gl/0Xtf42.

[38] *Id.* at 1.

[39] *Id.* at 2.

[40] Reed Abelson, *With Merging of Insurers, Questions for Patients About Costs and Innovation*, N.Y. TIMES (July 5, 2015), http://goo.gl/NPp38y.

[41] Brent Kendall and Anna Wilde Mathews, *DOJ Girds for Strict Review of Any Health-Insurer Mergers*, WALL ST. J. (June 28, 2015 5:13 PM), http://goo.gl/q1P3Ay.

[42] *See* Complaint, United States v. Humana, Inc., No. 1:12-cv-00464 (D.D.C. March 27, 2012) (Divestitures of Medicare Advantage plans in five states and in 45 counties); *see also* Press Release, Dep't of Justice, Amerigroup Corp.'s Divestiture of Its Virginia Operations Addresses Department of Justice's Concerns with Wellpoint Inc.'s Proposed Acquisition of Amerigroup (Nov. 28, 2012), *available at* http://goo.gl/5npDzs (requiring Amerigroup divest its Medicaid managed care plans in Northern Virginia).

to limit provider pay.[43] However, the merging parties could argue that increased insurer consolidation could be beneficial as a counterbalance and enable insurers to reduce provider reimbursement.[44]

Such an argument would be misguided and would be unlikely to gain traction before the Division or the courts. If an insurer secures market power from an acquisition, there is no reason to assume that lower provider reimbursement will be reflected in lower premiums.[45] Moreover, a remedy involving divestitures, even of significant assets, may not alleviate antitrust concerns within health insurance markets, specifically those from provider groups.

VI. CONCLUSION

With increased attention from both state and federal regulators, as well new challenges from remedies and regulations to insurer consolidation, healthcare providers seeking acquisitions and mergers face new and ever-increasing challenges. Healthcare provider merger antitrust is a fluid field with constantly changing dynamics. Providers considering a merger should be well aware of all potential pitfalls prior to agreeing to terms.

[43] *See generally* Thomas Greaney, *Examining Implications Of Health Insurance Mergers*, HEALTH AFFS. BLOG (July 16, 2015), http://goo.gl/ETT1DB (noting that "enhanced market power" may allow the firms to reduce payment to physicians).

[44] *Id.*

[45] *See* David Lazarus, *As health insurers merge, consumers' premiums likely to rise*, L.A. TIMES (July 10, 2015 4:00 AM), http://goo.gl/nF7HRS (noting lower reimbursement offerings to providers will not produce reduced premiums for consumers).