Provider Consolidation, Competition, and Antitrust Enforcement in a Value-Based Environment
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Doug Hastings, Chair Emeritus
Epstein Becker Green

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Merger vs. Non-Merger Collaboration

What Are the Strategic Imperatives?
Achieving Economies of Scale

- Aggregation does not equal accountability, but some size and scale is necessary to succeed under evolving reimbursement models
- Need to be of sufficient size to support comprehensive performance measurement and value-based payments
- Need to be able to manage the continuum of care for patients as a fully integrated delivery system
- Need capital to make infrastructure investments necessary to achieve integration (care redesign, information technology)
- CMS and commercial payers setting aggressive value-based payment goals; SGR fix likely to accelerate value-based payments to physicians
How Do You Determine A Collaborative Strategy?

- Will it improve access to capital or address important capital needs?
- Will it provide access to new markets or service lines?
- Will it produce substantial efficiencies and/or economies of scale?
- Will it position the system for success under value-based payment models?
- Will it continue to support service to the community in a population health environment?
Sale Transactions

Changes of Ownership/Control

• Basic Forms
  – Member Substitution
  – Sale of Assets
  – True merger or consolidation

• Key differences relate to transfer of liabilities and regulatory steps

• Difficult to avoid Medicare liabilities

• All are mergers in the eyes of antitrust agencies; likely HSR filing requirement; analyzed under merger guidelines
Sale Transactions

Changes of Ownership/Control

• Potential Advantages
  – Large short-term investments in infrastructure
  – Greater financial stability
  – Common control can facilitate clinical and financial integration across facilities
  – Advantage of size and economies of scale
  – Permanence of structure
  – Copperweld argument for antitrust purposes
Non-Sale Transactions

STRATEGIC COLLABORATIONS

• Basic Forms
  – Joint Venture
  – Clinically Integrated Network/Quality Collaborative
  – Purchasing Collaborative

• “Downstream” arrangements; the organizations remain separate at ultimate governance levels

• Shared risk is limited

• Antitrust may still be relevant depending on degree of geographic overlap; analyzed under network guidelines (degree of clinical and financial integration)
Non-Sale Transactions

STRATEGIC COLLABORATIONS

• Potential Advantages
  – Pathway for achieving economies of scale without giving up total autonomy
  – Can serve as a means of accessing resources that may be difficult for smaller hospitals to acquire and develop on their own (EHRs, clinical protocols, administrative and clinical expertise)
  – Can create opportunities for participation under value-based payment models (CINs, ACOs – commercial and MSSP, bundled payment initiatives, medical homes, etc.)
  – It’s easier to unwind a non-merger collaboration than a sale (which can be beneficial in an antitrust analysis)
Evolving Antitrust Enforcement at the Federal Level

Is a Merger or Non-Merger Collaboration Easier to Accomplish Under the Antitrust Laws?
Historical Legal Barriers To Provider Integration

• Federal and state regulatory schemes, particularly relating to antitrust, fraud and abuse, and tax exemption, create barriers to health care provider integration

• These laws evolved in an era in which provider separateness was assumed to be appropriate and financial incentives and certain other agreements between providers were assumed to be improper

• There is new recognition by federal and state regulators that provider collaboration and integration can be beneficial, but regulatory response in specific situations is uneven
Coordinated Federal Agency Guidance for Accountable Care Organizations

• The regulatory dialogue that has taken place around accountable care seeks to distinguish “good” collaboration from “bad” and relies heavily on clinical and financial integration as a basis for allowable collaboration

• The guidance taken together suggests that qualified and effectively operating ACOs and CINs do gain a degree of legal protection (arguably, a rebuttable presumption) under these regulatory schemes through waivers, safety zones, and announced agency protocols
Legal Analysis of Mergers vs. Non-Merger Collaborations

- **Mergers**: Primarily raises antitrust issues where there is geographic overlap; payer perspective important; agency merger guidelines applicable

- **Non-Mergers**: May raise antitrust issues where there is geographic overlap, but analytical principles differ in certain respects; exclusive contracting is the key antitrust issue where there is high-market share
Antitrust

RULE OF REASON IN NON-MERGER COLLABORATIONS

• CMS’ definition of and requirements for ACOs align with the Antitrust Agencies’ historical thinking about clinical and financial integration, and therefore the agencies will accord rule of reason treatment to the commercial market activities of ACOs participating in the MSSP assuming that they basically operate in the same way.

• But do these same principles apply in a non-MSSP setting?

• Joint ventures also are reviewed under the rule of reason.
Antitrust

Market Power Issues and Mergers

- Notwithstanding the useful guidance in the Final Statement, market concentration and market power concerns remain the subject of an ongoing national policy debate.
- DOJ and FTC clearly state that they will continue to protect competition in markets served by ACOs, using CMS data, and will “vigorously monitor complaints.” And merger enforcement is not affected – the Agencies will continue to enforce under the current merger guidelines.
Antitrust Analysis

Staff Interpretations of the Merger Guidelines

- Showing that an integration is likely to produce significant efficiencies or quality improvements could strongly influence the outcome of an antitrust rule of reason analysis
  - Can you show that the merger/affiliation is likely to produce significant efficiencies or quality improvements?
  - Is there detailed and compelling evidence that the affiliation would result in meaningful improvements in the quality or efficiency of care?
- The FTC has stressed that for this evidence to be taken seriously, it needs to be detailed, persuasive, and demonstrated within ordinary course documents
ProMedica

• Failed to argue that the merger would enhance consumer welfare
• FTC alleged merged entities would have more than 50% of market for primary and secondary services and 80% for obstetrical services
• Court found “weakened competitor” argument totally unconvincing
• Lack of showing of compelling efficiencies or population health benefits was fatal
St. Luke’s/Saltzer

- Challenge of physician group acquisition by hospital in Idaho
  - Challenge by both private parties and the FTC as well as Idaho AG
  - Challenged as an unlawful merger of primary care physicians
  - FTC prevailed at trial; trial court ruling recently upheld by the 9th Circuit
  - Amicus brief in support of FTC filed by several state AGs
  - St. Luke’s ordered to fully divest itself of Saltzer’s physicians and assets
St. Luke’s

• In findings of fact and conclusions of law, Court stated:

“There are a number of organizational structures that will create a team of unified and committed physicians other than that selected by the Acquisition, a structure that employs physicians and creates a substantial concentration of market power.”

• So in this case, an ACO/CIN approach may have been preferable
Practical Realities of Antitrust Enforcement

- Payer opposition in local market critical to FTC willingness to fight; competitor and employer views important, but absent payer willing to testify that prices will go up, FTC reluctant to challenge
- Conversely, local payer support will greatly lessen likelihood of challenge; having a payer deal in place is very helpful
- Each side will have offsetting experts, minimizing likelihood of impact
- If FTC really doesn’t like the market concentration and has payer support, ability to convince them on quality and efficiencies is low
A Deeper Dive Into the FTC’s Thinking

What is the Competitive Effect of the Proposed Merger?
FTC Two-Stage View of Competition Between Healthcare Facilities

Stage 1

- Health plans form networks through negotiations with providers
- Health plans market their networks to area employers and individuals

Stage 2

- In-network providers compete for patients by offering better services than their competitors

- Exclusion of important providers reduces the value of a plan’s network.
- Mergers of close substitutes can increase a provider’s negotiating leverage by making health plans’ outside option much less attractive.
- Employers have an incentive to select health plans with networks that meet the needs of their employees and is affordable for the employer.
- Highly valued hospitals draw higher volumes in Stage Two and have more leverage in Stage One.
- Insurance benefits make price a secondary consideration for patient choice of in-network providers.

Source: Competition Economics
Increased Provider Leverage Harms Consumers

Source: Competition Economics

Provider with increased leverage → Higher negotiated rates for services → Health Plans pay more → Higher Premiums → Local employers and consumers pay more (e.g., out-of-pocket costs)
Two Approaches for Examining Competitive Effects

**Structural Approach/Merger Simulation**

- **Structural Approach (Traditional)**
  - Defines relevant product and geographic market(s)
  - For each defined market, examines pre-merger and post-merger market shares and concentration
  - Examines barriers to entry

- **Merger Simulation (More Recent)**
  - Examines how acquisition increases the merged firm’s bargaining leverage with insurers
  - Derives the incremental value of the merged firm being part of the insurer network as compared to situation in which each firm is in the network separately
  - Predicts (post-merger) change in prices based on this change in incremental value

*Source: Competition Economics*

Closing Statement


November 7, 2013
The Acquisition Substantially Lessens Competition

- Substantially increases concentration in a highly concentrated market, creating a strong presumption of anticompetitive effects
- Enhances market power by combining the two largest providers of Adult PCP Services in Nampa, eliminating each provider’s closest competitor
- Documents, testimony, and economic analysis confirm that the Acquisition will increase healthcare costs to Idaho consumers
Defendants’ Claimed Efficiencies Are Speculative and Not Merger-Specific

The Acquisition is neither necessary nor sufficient for St. Luke’s or Saltzer to achieve higher quality, lower cost care:

- Employment of physicians is not a superior organizational model to other affiliation strategies
- Benefits of St Luke’s Health IT tools are speculative, and Saltzer would have access to such tools if it remained independent
- St. Luke’s and Saltzer can engage in risk-based contracting without the Acquisition
- Defendants’ “core” theory is unsupported
- No evidence that St. Luke’s prior acquisitions of physician groups have resulted in higher quality or lower cost care
Bargaining Leverage Overview

- Bargaining Leverage: Health Plans vs. Providers
  - Health plans and providers determine rates through bilateral negotiations
  - Each side’s leverage is determined by the other side’s “outside option”

- Health plans then market their networks to employers and patients
  - Patients choose among in-network providers and are generally not sensitive to small differences in price

- The Acquisition makes health plans’ outside options much less attractive, giving St. Luke’s/Saltzer the ability to extract higher reimbursements from health plans
Better cost is a worthy goal and I totally back that. I also understand market forces involved. But let's be realistic. Employing physicians is not achieving better cost, it's achieving better profit.
States Playing Increasing Role

WHAT IS HAPPENING IN YOUR STATE?
State Activity

• Several states are encouraging collaboration among providers
  – COPAs (Certificate of Public Advantage)
    • Process which allows collaborating providers to seek approval of state for various collaborations/mergers
    • Must agree to meet certain criteria
    • Must agree to “active supervision”
  – ACO regulations
    • Creating state-level process for “MSSP-like” arrangements
  – Medicaid managed care expanding
States Are Monitoring Collaborations

- More states are requiring notification of health care transactions
- Pre-notification may include physician acquisitions, or other "vertical" arrangements
- Massachusetts and Connecticut have adopted such notification requirements
- State AGs generally not as rigid in market analysis, more willing to consider state-level health planning framework, and more willing to implement conduct remedies through consent decrees
Partners Proposed Settlement

Massachusetts Attorney General

- Proposed settlement ended five-year state and federal investigation of Partners
- Allows Partners acquisition of three community hospitals
- Seven-year freeze on additional takeovers and limits price increases to the rate of inflation for 65 years; compliance monitored
- Twenty-one national antitrust experts and health economists sent petition opposing settlement asking to block merger; arguing settlement offered insufficient protection
- Feds don’t like consent decrees and conduct remedies
- In late January Massachusetts trial court rejected proposed settlement, evidencing discomfort with conduct remedy
The Promising But Uncertain Future
WHERE DOES ANTITRUST ENFORCEMENT GO FROM HERE?
Evolving Market Power Issues

• Market extension mergers may begin to come under scrutiny
• Physician-hospital deals will likely be reviewed more commonly as horizontal, as in St. Luke’s
• New retail and urgent care entrants may constitute new competitors affecting market analysis
• More advanced payer-provider accountable care deals may replace mergers in some markets – Is Vivity a prototype? Health Care Transformation Task Force?
Market Power Issues

PRIVATE MARKET SOLUTIONS?

- Given consolidating markets, non-merger collaborations among providers, including in some cases high market share providers, working with payers, to accomplish accountable care goals may be able to create antitrust-acceptable pathways.
- Failure to do so will put more onus on the government to regulate the prices of both and to micromanage the contract provisions between them.
- Payers, providers, and employers could adopt voluntary protocols relating to quality measures and cost efficiency, and the allocation of savings between them (and consumers), including appropriate contract provisions.
Market Power Issues

PRIVATE MARKET SOLUTIONS?

• Such voluntarily contracting protocols would include quality measures, benchmarks, and a savings allocation formula that includes giving some savings back to consumers, as outlined in Brookings’ *Bending the Curve*.

• Appropriate data would need to be collected and shared among payers, providers, and consumers.

• Models and results developed, including those in CMS programs, could be adapted for antitrust review purposes.

• Both mergers and non-merger collaborations could be evaluated according to these developing “value” criteria, incorporating clinical and financial integration.