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Attorneys for Defendant

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

SAINT ALPHONSUS MEDICAL CENTER, NAMPA, INC., TREASURE VALLEY HOSPITAL LIMITED PARTNERSHIP, SAINT ALPHONSUS HEALTH SYSTEM, INC., AND SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC.,

Plaintiffs,

v.

ST. LUKE'S HEALTH SYSTEM, LTD,

Defendant.

Case No. 1:12-cv-00560-BLW

ST. LUKE'S HEALTH SYSTEM, LTD.'S MOTION FOR SUR-REPLY IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

COMES NOW Defendant St. Luke's Health System, Ltd. ("St. Luke's") and moves this Court for permission to file the attached Supplemental Declaration of David A. Argue, Ph.D. as a sur-reply in support of its Opposition to Plaintiffs' Motion for Preliminary Injunction (Dkt. 34). St. Luke's seeks to address the characterization of the earlier-filed Declaration of David A. Argue, Ph.D. (Dkt. 34-1) by Plaintiffs' expert Deborah Haas-Wilson in her Reply Declaration filed December 11, 2012 (Dkt. 38).

DATED: December 13, 2012.

STOEL RIVES LLP

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on December 13, 2012, I filed the foregoing **ST. LUKE'S HEALTH SYSTEM, LTD.'S MOTION FOR SUR-REPLY IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION** electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected in the Notice of Electronic Filing:

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J. Walter Sinclair

UNITED STATES DISTRICT COURT
IN THE DISTRICT OF IDAHO

SAINT ALPHONSUS MEDICAL CENTER – NAMPA, INC., TREASURE VALLEY HOSPITAL LIMITED PARTNERSHIP, SAINT ALPHONSUS HEALTH SYSTEM, INC., and SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC. Plaintiffs, v. ST. LUKE'S HEALTH SYSTEM, LTD. Defendant	Case No. 1:12-cv-00560-CWD

SUPPLEMENTAL DECLARATION OF DAVID A. ARGUE, Ph.D.

1. My name is David A. Argue. I am a Corporate Vice President and Principal at Economists Incorporated, an economic consulting firm with offices in Washington, D.C. and San Francisco, California. I have previously submitted a declaration in this matter filed on December 4, 21012 ("Argue Declaration") to which my curriculum vitae is attached.

2. I submit this supplemental declaration to address some misrepresentations in the Declaration of Deborah Haas-Wilson filed on December 11, 2012 ("Haas-Wilson Declaration") with regard to the methodology that I have used to analyze antitrust markets and competition. Professor Haas-Wilson states that in effect I have used a discredited test of market definition, the "Elzinga-Hogarty" test.[1] That assertion is simply wrong. Like Professor Haas-Wilson, I have analyzed patient flows from the physician practices of St. Luke's Clinic, Saltzer Medical Group and Saint Alphonsus

[1] Haas-Wilson Declaration at ¶16.

Medical Group. We both recognize the value in doing so.[2] But I have not suggested that markets should be defined by thresholds of patient flows into and out of a service area as would be done with an Elzinga-Hogarty analysis. Further, I have explained that service areas do not constitute antitrust markets.[3] Markets comprise groups of providers rather than groups of zip codes.

3. The Elzinga-Hogarty analysis requires two statistics that can be derived from patient origin data. The first is the outflow of patients from a specified geographic area to providers located elsewhere, and the second is the inflow of patients to providers located in that area.[4] If only a small portion of patients who live inside the area travel to providers outside (i.e., small outflow) and only a small portion of patients served by the physicians located in the area travel in from outside locations (i.e., small inflow), then the Elzinga-Hogarty test would conclude that the area is a geographic market. The Elzinga-Hogarty test has a threshold for a "weak" market definition in which at least 75% of patients using the physicians in the area reside in the area (i.e., inflow of less than 25%) and at least 75% of the patients who reside in the area use local physicians (i.e., outflow of less than 25%). The "strong" market definition under the Elzinga-Hogarty test has thresholds of 90% for both measures. Nowhere in my declaration have I undertaken this analysis. Moreover, I do not even calculate the portion of patients from Nampa that use non-Nampa physicians because, as I stated in my original declaration, any measure of outflow of patients from Nampa is necessarily downward biased. The bias arises because the available data do not include patients who travel out of Nampa to practices other than St. Luke's Clinic, Saltzer Medical Group, and Saint Alphonsus Medical Group.[5]

4. Ironically, Professor Haas-Wilson's analyses of patient inflows into Nampa and outflows from Nampa in both of her declarations have all of the hallmarks of the Elzinga-Hogarty

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2 Haas-Wilson Declaration at ¶14. Argue Declaration at ¶30.

3 Argue Declaration at ¶36.

4 Kenneth G. Elzinga and Thomas F. Hogarty, The Problem of Geographic Market Delineation in Antimerger Suits, 18 ANTITRUST BULL. 45 (1973).

5 Argue Declaration at note 36. This bias may be more significant since the three physician groups for which we have data all have practice locations in Nampa while the others do not.

test. In her first declaration, she states, "I find that 78 percent of the patients receiving care at one of the adult primary care SAMG clinics in Nampa come from Nampa. In addition, 78 percent of SAMG patients who reside in Nampa receive their adult primary care at one of the SAMG clinics located in Nampa."[6] These two percentage calculations are the Elzinga-Hogarty inflow and outflow figures.[7] In her second declaration, she modifies her share calculations slightly to 78.6% and 75.5%, respectively.[8] In other words, the shares calculated by Professor Haas-Wilson indicate that both the inflow and outflow are below 25% and the area passes the Elzinga-Hogarty test for a weak market.

5. The greater difference between Professor Haas-Wilson's methodology and mine is that she relies on a static, structural view of the market as exhibited in shares and HHIs. In my original declaration, I conducted a dynamic analysis by evaluating the ability of health plans to respond to attempts to raise prices. Among the approaches I used were illustrations of payors having already shown a willingness to be responsive to market conditions[9] and current physician use patterns by patients.[10]

6. Although Professor Haas-Wilson examines the same patient flow information that I evaluated, she states that my review of the patient flow data constitutes a focus on the "wrong" set of customers in a two-stage model and hers, by implication, is on the "right" set of customers.[11] She states that "the 'right' stage of the competitive process is [the first stage,] the one in which market processes are determined."[12] I believe that the patient flow data from the second stage of the model is useful to understand how health plans determine in the first stage of the model which providers are likely to be reasonable

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6 Haas-Wilson Declaration filed 11/12/2012 at ¶74.

7 As I indicated above, Professor Haas-Wilson's outflow figures are biased downward.

8 Haas-Wilson Declaration at ¶33 ("I find that 78.6 percent of the Nampa residents used an adult primary care physician located in Nampa and that Nampa-based adult primary care physician clinics drew 75.5 percent of their patients from Nampa.")

9 I discussed three examples in Treasure Valley of insurers who used strategies designed to encourage enrollees to use lower cost providers. Argue Declaration at ¶26-27.

10 Argue Declaration at ¶29-57.

11 Haas-Wilson Declaration at ¶¶17-25.

12 Haas-Wilson Declaration at ¶17.

substitutes for their enrollees. Even the opinion of the Federal Trade Commission in *FTC v. Evanston Northwestern Healthcare*, a case in which Professor Haas-Wilson was the FTC's expert economic witness, explains the value of patient origin data in this manner.[13] As health plans negotiate prices with providers in the first stage of the model and try to understand the desirability of providers in the network, they take into account the provider choices made by their enrollees in the second stage of the model. The assessment of patients' choices would be highly informative for health plans to learn which providers are considered by their enrollees to be reasonable substitutes. That is how I used the patient origin data throughout my declaration. Professor Haas-Wilson's critique of my supposed focus on the "wrong" set of customers rests on her apparent misunderstanding that I used the patient origin data to assess health plans' options.

7. Another important methodological difference between Professor Haas-Wilson's analysis and mine is that I also incorporated the important Merger Guidelines concept of "marginal" customers, i.e., the potentially small number of customers who would switch providers to avoid a price increase, whereas she focused only on the "inframarginal" customers, i.e., those who she asserts would not switch providers. Yet marginal customers are a central part of merger analyses.[14] The "hypothetical monopolist test" in market definition of the Merger Guidelines framework is also a good example. The hypothetical monopolist test essentially says that to test whether a provisional market (such as the physicians in Nampa) is a properly defined geographic market, consider a hypothetical monopolist of the suppliers in that market (in this case, imagine all of the

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13 In the Matter of Evanston Northwestern Healthcare Corporation, Docket No. 9315, Opinion of the Commission at p. 77 ("MCO demand for hospital services is partially a derived demand based on patient preferences, and the percentage of patients in a given area who use a hospital can, in certain circumstances, provide some rough indication of MCO preferences when they form a network.")

14 See, for example, FTC v. Tenet Healthcare Corp., 186 F.3d 1045 (8th Cir. 1999). ("The proximity of many patients to hospitals in other towns, coupled with the compelling and essentially unrefuted evidence that the switch to another provider by a small percentage of patients would constrain a price increase, shows that the FTC's proposed market is too narrow.") David T. Scheffman and Joseph J. Simons, The State of Critical Loss Analysis: Let's Make Sure We Understand the Whole Story, The Antitrust Source, November 2003 ("This simplicity and ease of practical application is the reason why Critical Loss Analysis has been readily "adopted" by courts and used frequently by the federal antitrust agencies. As discussed above, the key factual issues are: (1) what is the (incremental) margin on sales at the current level and "new" level of sales; and (2) what will be the AL relative to the CL for a given hypothetical price increase.")

primary care physicians or pediatricians located in Nampa acting as one) and test whether an attempted increase in price or decrease in quality from competitive levels would be profitable. If the price increase would induce enough consumers (health plans and patients) to switch to providers in another geographic area such that the loss of business would render the price increase unprofitable, then the providers in that other geographic area should also be included in the geographic market.[15] The hypothetical monopolist test does not say that the provider attempting to increase price or reduce quality must lose *all* of its customers in order for the attempt to be unprofitable, only that enough customers switch to other sellers. In many instances, including in hospital and physician services, losing a small number of patients is sufficient to render the price increase unprofitable.[16]

8. It is not conceptually difficult to understand how, in a two-stage model of competition, health plans would evaluate attempted price increases by providers. Any health plan making the decision to exclude the Nampa physicians from its network will weigh (a) the loss of profits of enrollees who will switch health plans if Nampa physicians are excluded from the network against (b) the loss of profits if the Nampa physicians are included in the network and enrollees use these higher-priced physicians.[17] More specifically, a health plan could offer a product with a network that includes St. Luke's/Saltzer in the network, but is higher-priced because the parties have ostensibly exercised market power. Alternatively, the health plan could offer another product that includes just Saint Alphonsus Medical Group.

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15 Horizontal Merger Guidelines of the U. S. Department of Justice and Federal Trade Commission, August 2010, Section 4.1.3. ("The hypothetical monopolist's incentive to raise prices depends both on the extent to which customers would likely substitute away from the products in the candidate market in response to such a price increase and on the profit margins earned on those products.")

16 The sufficiency of a small loss of patients for rendering a price increase unprofitable is based on providers' cost structures. In my experience, I have found that physician practices have relatively high fixed costs within the appropriate range of changes in volume, and thus they suffer significant profit losses from small reductions in patient volume. Two studies find that 60% to 85% of a physician practice's costs are fixed. (Lloyd A. Froelich, The Anatomy of Medical Practice Income, wipfli Insight Article, December 1, 2009 (www.wipfli.com/resources/images/10484.pdf); T.P. Weil, Multispecialty Physician Practices: Fixed and Variable Costs, and Economies of Scale, J AMBUL CARE MGT, July 2002, pp. 70-77.)

17 This example further illustrates the link between patient choices of providers and first-stage price competition.

9. The stumbling block for Professor Haas-Wilson in this analysis is her belief that the latter product is not marketable because it excludes the Nampa physicians, leading to the conclusion that no one could switch to a non-existent product.[18] But health plans do not construct products for small areas like Nampa. Rather their plans are sold throughout entire metropolitan areas. A product without the St. Luke's/Saltzer physicians could be sold to employers throughout the rest of the Boise market, making it available for employers of Nampa residents as well.[19]

10. Given cost structures in healthcare services, the behavior of the marginal 10-20% of patients that are dismissed in plaintiffs' Reply Memorandum as unimportant could easily determine whether an attempted price increase is profitable or not.[20] Professor Haas-Wilson has looked at patient flows and focused entirely on the core of patients who reside in Nampa and, at current prices, choose providers in Nampa.[21] She has speculated, without any evidence, that the only patients who would ever leave Nampa are already doing so and that no others would do so if faced with higher physician costs or lower physician quality. Actual evidence from Canyon and Ada counties, however, show the implausibility of that assertion. This evidence is clear in the patient flow data that show a very large portion of St. Luke's Clinic patients who are Nampa residents are already using providers outside of Nampa, and a substantial portion of Saltzer's patients are doing the same.[22] I also identified evidence of patients' willingness to switch away from Nampa physicians given financial incentives at at least one major employer in the area.[23] Until Professor Haas-Wilson determines that the marginal patients who would switch providers in the face of a price increase or quality decrease are insufficient to defeat

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18 Haas-Wilson Declaration at 20.

19 Professor Haas-Wilson's analysis implies that a product without St. Luke's/Saltzer in the network would be marketable outside of Nampa. Her claim that there is no evidence that plans without Saltzer could be marketed in Nampa also misses the point that this is a prospective analysis. By that reasoning, the lack of evidence that St. Luke's/Saltzer has priced above competitive levels before the transaction means that it would not happen afterwards.

20 Reply Memorandum of Law in Support of Plaintiffs' Motion for Preliminary Injunction, p. 3.

21 Haas-Wilson Declaration filed 11/12/2012 at ¶¶74, 81. See also, Argue Declaration at ¶32.

22 Argue Declaration at ¶¶35, 43.

23 Argue Declaration at ¶27.

Nampa physician's hypothetical price increase, she cannot conclude that providers located in Nampa are a market.

11. Finally, it is important to note that Professor Haas-Wilson advocates the use of "direct evidence" of price increases to show whether providers have market power, regardless of market definition. This was a central part of her testimony in Evanston-Northwestern. My previous declaration cited that evidence for pediatricians in Nampa, and Dr. Haas-Wilson has made no attempt to refute it. The Saltzer pediatricians in Nampa who she asserts are monopolists are paid the same rate by Idaho Blue Cross as the St. Luke's pediatricians scattered throughout Treasure Valley.[24] If the Saltzer pediatricians actually possessed market power they should be paid higher rates, which means that other pediatricians are constraining their pricing and must be in the market. I have found that at least the other pediatricians located in Canyon County must be included in the market, and possibly those in Ada County as well.

David A. Argue
December 13, 2012

24 Argue Declaration at ¶58.