IV THE CHANGING HEALTH CARE SYSTEM

The New Vertical Merger Guidelines and Health Care Integration

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With an absence of fanfare recalling T.S. Eliot,[1] and after 36 years of largely anonymous service, the *Non-Horizontal Merger Guidelines* of the U.S. Department of Justice and Federal Trade Commission[2] were laid to rest with the publication of the Agencies' new *Vertical Merger Guidelines* in 2020.[3] The publication of the VMGs is an important event given that the current policy debate over antitrust enforcement is largely focused on industries characterized by a high

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[1]"This is the way the world ends / Not with a bang but a whimper." – T.S. Eliot, "The Hollow Men".

[2]U.S. Department of Justice and Federal Trade Commission, *Non-Horizontal Merger Guidelines* (1984) (the "1984 Guidelines"). In this article, the Federal Trade Commission ("FTC") and Department of Justice ("DOJ") are referred to together as the "Agencies."

[3]U.S. Department of Justice and Federal Trade Commission, *Vertical Merger Guidelines* (June 30, 2020), https://www.ftc.gov/system/files/docum

(and growing) degree of "vertical" integration, *i.e.*, business combinations among firms that are not direct competitors. These industries notably include media companies, live entertainment, agriculture, and virtually all internet-based enterprises. Oh yes, and health care.

The last ten years of the Affordable Care Act and experiments with accountable care and population health management made essential objectives of economic alignment among providers and control over clinical efficiency. Aligning physicians to reduce medical variation, improve outcomes, and successfully deal with performance-based payment reforms are frequently cited reasons for the significant increase in employment of physicians by health systems. Currently, more than 40 percent of U.S. physicians are employed by hospitals and hospital-based systems.[4]

Market considerations also have increased focus on alignments between hospital systems and post-acute providers. Presently, however, the vast majority of hospital-post-acute relationships are networking arrangements rather than common ownership.[5] In a recent study only about one percent of alignments between hospitals and skilled nursing facilities, and only two and one-half percent of alignments between hospitals and home care providers were determined to be common ownership relationships.[6] However, common owner-

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ents/public_statements/1580003/vertical_merger_guidelines_6-30-20.pdf ("Vertical Guidelines" or "VMGs").

[4]R. Popal. "What percentage of physicians are hospital employed? 4 salary, employment statistics," *Becker's ASC Review* (Jan. 2, 2020), https://www.beckersasc.com/benchmarking/what-percentage-of-physicians-are-hospital-employed-4-salary-employment-statistics.html; Physicians Advocacy Institute, UPDATED PHYSICIAN PRACTICE ACQUISITION STUDY: NATIONAL AND REGIONAL CHANGES IN PHYSICIAN EMPLOYMENT 2012-2016 (March 2018), http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/2016-PAI-Physician-Employment-Study-Final.pdf

[5]A. Maksimow and D. Samaris, "Optimizing a Health System's Post-Acute Care Network," *HFM Early Edition* (May, 2018), https://www.kaufmanhall.com/sites/default/files/Optimizing-a-Health-Systems-Post-Acute-Care-Network.pdf.

[6]R. Konetzka, et al., *The effect of integration of hospitals and post-acute providers on Medicare payment and patient outcomes*, 61 J. HEALTH ECON. 244 (2018).

ship of hospitals and post-acute providers through corporate investment has been trending upward.[7]

Increasing vertical alignment in critical industries, including health care, is attracting the attention of antitrust regulators at both the federal and state level. The publication of revised Vertical Merger Guidelines reflects the renewed interest in vertical merger enforcement at the FTC and the DOJ, and their publication presents an opportunity to better understand the antitrust issues that flow from greater integration of health care services under common control.[8]

This article explores these questions in two parts: in the first three sections, a review of the antitrust issues that attend vertical combinations and the approach of the Agencies to those concepts in the VMGs. In the concluding sections, a more specific discussion of vertical issues in health care and the critical question of whether and how vertical integration through merger or acquisition can be shown to be efficiency-enhancing.

I. Fundamentals of Vertical Integration and the Antitrust Laws

Vertical integration refers to one form of non-horizontal growth – the expansion of a firm into a market that either is upstream (*e.g.*, supply) or downstream (*e.g.*, distribution) in its own chain of production, either organically or by combination (*e.g.*, merger) with an existing firm in the upstream or downstream market. The term also is used more generically (including in the VMGs) to include "diagonal" transactions – the acquisition of an upstream or downstream firm in a *competing* production chain (*i.e.*, a competitor's supplier or distributor) – and "complementary" integration – expansion

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[7] A. Fowler, et al., *Corporate Investors Increased Common Ownership in Hospitals and the Post-Acute Care and Hospice Sectors*, 36 HEALTH AFFAIRS 1547 (Sept. 2017).

[8] As I have pointed out previously in this publication, public notoriety may attach to vertical roll-ups by companies like Amazon or Google, or to mega-mergers such as Aetna and CVS, but the enforcement policy formed by those transactions directly affects the Agencies' approach to integration transactions of local health systems. *See* McCann, R., *Thinking Big: Market Power in Consolidating Health Care Markets*, in A. Gosfield, ed., HEALTH LAW HANDBOOK, 2019 EDITION (Thomson Reuters 2019).

into a market that is not part of the firm's production chain but in which the firm's customers purchase related goods or services.[9]

The economic jargon of vertical integration is reflective of traditional manufacturing markets in which one finds suppliers, manufacturers, wholesalers, and retailers. But health care has abundant examples of all three forms of integration, even if they do not precisely match the manufacturing paradigm. When a health system acquires a group of referring physicians or a post-acute care provider to which it refers, it is integrating a portion of the patient "supply chain" of its hospitals. If the health system acquires a physician group or other provider that is not aligned with its hospitals, it is engaging in a form of diagonal integration. When a health system acquires a fitness center or a retail pharmacy, the transaction is complementary. The nomenclature is actually less important than the question of whether or how the integration affects competition in any of the markets.

Historically, the antitrust laws have had an on-and-off affair with vertical integration. Through the 1960's the climate for vertical integration was mostly inhospitable. A market structure-based view predominated antitrust jurisprudence, in which firm size, industry structure, and concentration levels explained and predicted market dynamics and the effects of mergers.[10] The behavior of firms in concentrated markets was presumed not just to result in higher prices for consumers, but also to facilitate price-fixing and the creation of impediments to new competition. The potential for economic conflicts of interest also was part of the structural

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[9]Examples of complementary mergers from case law include the acquisition of a manufacturer of after-market auto parts by an automobile manufacturer and the acquisition of a producer of liquid bleach by a manufacturer of laundry detergent. Ford Motor Co. v. United States, 405 U.S. 562 (1972); Fed. Trade Comm'n v. Proctor & Gamble Co., 386 U.S. 568 (1967). In both instances, the acquisition was found to be unlawful under the prevailing antitrust views of the time period.

[10]The Supreme Court's ruling in U.S. v. Philadelphia Nat'l Bank, 374 U.S. 321 (1963), a horizontal merger case, is illustrative. The Court found that the merger of two banks in Philadelphia, which would have given the merged firm a 30% share of the market and resulted in the four largest banks controlling approximately 60% of the market, would create a structural presumption of an unlawful reduction in competition. Many mergers that go unchallenged today would fail that analysis.

equation, particularly with respect to analysis of vertical arrangements and the threat of foreclosure, *i.e.*, the ability to deny rivals access to necessary inputs or customers. The protection of structural market competition also extended to blocking non-horizontal transactions that were thought to involve the acquisition of *potential* competitors.

Two well-known Supreme Court decisions, ten years apart, illustrate the thinking of that period. In *Brown Shoe Co. v. United States*,[11] the Court upheld an action to enjoin the vertical acquisition of a large shoe retailer by a major shoe manufacturer, primarily out of concern that the acquisition would give the manufacturer an ability to stifle competition in the shoe manufacturing market by restricting its competitors' access to the acquired retail outlets. A subsequent decision in *Ford Motor Co. v. United States*, required Ford to divest an acquired after-market spark plug manufacturer based upon a finding that, prior to the acquisition, Ford could have entered the spark plug market, that the threat of Ford's entry had been a deterrent to anticompetitive behavior in that market, and that the acquisition eliminated a possibility of further de-concentration of the market in the future. The Court also expressed concern that the acquisition presented a risk that Ford could create anticompetitive tying arrangements between its automobiles and the after-market spark plugs.[12]

Beginning in the 1980's, advocates of "Chicago School" economics significantly altered prevailing thought about how antitrust law should view changes in market structure. The Chicago School believed that market structure is the effect, rather than the cause, of market dynamics.[13] It assumed that a market's structure is created by the interplay of independent market forces and the requirements of production – in other words, that markets with rational economic actors seeking to profit-maximize will seek to align in the most efficient structure for the particular market. Antitrust law, it

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[11]Brown Shoe Co. v. United States, 370 U.S. 294 (1962). This decision also is notable for settling the question of whether Section 7 of the Clayton Act reaches vertical as well as horizontal mergers. (It does.)

[12]*Ford Motor Co.*, 405 U.S. at 567–72.

[13]R. Posner, *The Chicago School of Antitrust Analysis*, 127 U. PA. L. REV. 925, 932 (1979); L. M. Kahn, *Amazon's Antitrust Paradox*, 126 YALE L. J. 710, 719 (2017).

was argued, should not chill efficiency-enhancing conduct with rigid presumptions about market structure.[14] Under this view, the objective of antitrust enforcement is not the preservation of an unconcentrated market structure; rather it is preventing the creation or enhancement of an ability to maintain prices above competitive levels, as shown by evidence of harm to "consumer welfare," *e.g.*, actual or projected above-market price increases or output restrictions.[15]

The consequence of this change in thinking for vertical integration was seismic: because vertical combinations can (and frequently do) align the economic incentives of firms in a production chain, under Chicago School thinking those combinations acquired a strong presumption of efficiency enhancement and, thus, legality.[16] Whereas earlier jurisprudence worried that a firm's vertical integration would create

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[14]The evolution of antitrust policy to accept benign or procompetitive explanations for conduct by dominant firms that was formerly considered suspect is explained in, W. Kovacic and M. Winerman, *Competition Policy and the Application of Section 5 of the Federal Trade Commission Act*, 76 ANTITRUST L. J. 929, 937–39 (2010).

[15]The "consumer welfare" focus was most influentially articulated in Judge Robert Bork's book, THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF (1978), and also in Judge Posner's 1979 law review article (note 13, *supra*). It has been observed that Judge Bork actually advocated for the maximization of *total welfare* (*i.e.*, the maximization of allocative efficiency), which is actually a different objective than maximizing consumer welfare, and one that does not always place the consumer's interest ahead of producers' interests. *See, e.g.*, E. Fox, *The Modernization of Antitrust: A New Equilibrium*, 66 CORNELL L. REV. 1140 (1981). The suggestion has been made that the use of term "consumer welfare" was, in essence, a marketing strategy to gain broader judicial acceptance of the Chicago School arguments. D. Sokol, *The Transformation of Vertical Restraints: Per Se Illegality, The Rule of Reason, And Per Se Legality*, 79 ANTITRUST L.J. 1003, 1007 n. 18 (2014), http://scholarship.law.ufl.edu/facultypub/546. One sees the judicial acceptance in, *e.g.*, Reiter v. Sonotone, 442 U.S. 320, 343 (1979), wherein the Supreme Court stated that Congress designed the Sherman Act as a "consumer welfare prescription," a phrase taken directly from *The Antitrust Paradox*.

[16]H. Hovenkamp, *Robert Bork and Vertical Integration: Leverage, Foreclosure, and Efficiency*, 79 ANTITRUST L. J. 983, 996 (2014) ("Indeed, today most vertical integration is viewed as economically beneficial and competitively benign.") Much of this view was founded on the premise that vertical integration reduced costs through the elimination of "double marginalization." *Id.* at 997. As discussed further below, (*see* notes 31-32 and 36 and accompanying text, *infra*), the weight to be given to this

entry barriers for new competition,[17] the Chicago School belief that markets gravitate toward efficient structure led to the conclusion that to the extent vertical integration led to efficiencies (*i.e.*, lower costs), any resulting impediments faced by competitors simply would be the result of more effective competition from the vertically integrated firm. And if the integration did not enhance efficiency, it would create no impediments to competition.

More recent thinking on vertical integration recognizes that its consequences are not inevitably benign, and that barriers to effective competition, both present and future, can result. These concerns are reflected in the VMGs.

II. The Basics of the 2020 Vertical Merger Guidelines

The *Vertical Merger Guidelines* address vertical integration accomplished through a business combination, *e.g.*, merger, acquisition, or joint venture (not integration through contract or organic growth). Combinations that are thought to threaten competition may be challenged under Section 7 of the Clayton Act[18], either at incipiency or, retroactively, at the time the threat to competition is identified.[19]

For a document intended as an explication of Section 7

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premise is a fundamental aspect of commentary and debate concerning the VMGs.

[17]This concern undergirds the Second Circuit's well-known 1945 decision holding a dominant vertically integrated manufacturer liable for price-squeezing its unintegrated competitors. United States v. Aluminum Co. of Am., 148 F.2d 416, 437–38 (2d Cir. 1945). The court found no intent on the part of Alcoa to monopolize the relevant output market (for sheet aluminum), but nonetheless held that Alcoa unlawfully exercised market power in the input (aluminum ingot) market to impose a price squeeze on competing manufacturers of sheet aluminum.

[18]15 U.S.C. § 18. Combinations also may be challenged retrospectively under Section 2 of the Sherman Act (15 U.S.C. § 2), upon determining that the arrangement produces the requisite predatory or "unreasonably exclusionary" conduct. However, under the influence of the Chicago School, § 2 has become a difficult path to remedy potential anticompetitive abuses. For a more detailed discussion of § 2 issues and recent enforcement, *see* McCann, note 8*, supra*.

[19]Although Section 7 is more commonly used to challenge mergers prospectively, it also may be applied retrospectively. In 1957, the Supreme Court ruled that a challenge brought in 1949 to a stock acquisition that

enforcement policy, however, the VMGs are succinct, to say the least. Compared to the 2010 *Horizontal Merger Guidelines*[20], which are 34 pages in length, the VMGs are a mere 12 pages. In part, this reflects the Agencies' decision to incorporate sections of the Horizontal Guidelines by reference, although without necessarily addressing obvious questions about how horizontal merger policy should be understood in a vertical context.[21] This question is particularly relevant in evaluating efficiency arguments in a vertical transaction.[22]

The VMGs describe the conceptual ways in which a vertical merger could enable a firm to undertake anticompetitive conduct in a relevant market (upstream or downstream) that it could not do – or could not do profitably – without the merger. However, the Vertical Guidelines provide little in

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occurred more than 30 years earlier could proceed under § 7. United States v. E.I. du Pont de Nemours Co., 353 U.S. 586, 597 (1957) The Court ruled that a § 7 challenge may be brought at "any time that an acquisition may be said with reasonable probability to contain a threat that it may lead to a restraint of commerce . . .." *Id.* at 597. The corollary to this conclusion is that post-acquisition evidence of anticompetitive behavior can be relied upon to prove a violation of § 7. United States v. General Dynamics Corp., 415 U.S. 486 (1974). *See also* Evanston Northwestern Healthcare, No. 9315 (FTC Aug. 6, 2007) (successful post-acquisition challenge to hospital merger occurring in 2000).

[20]U.S. Dep't of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines* (2010), http://www.justice.gov/atr/public/guidelines/hmg-2010.pdf) ("Horizontal Guidelines").

[21]This is not to say that the Horizontal Guidelines are without their own share of non-self-evident and unexplained statements. *See* R. McCann, *Collaboration Without Sin? – Health Care Mergers, Joint Ventures, and the Changing Antitrust Landscape*, in A. Gosfield, ed., HEALTH LAW HANDBOOK 2011 EDITION (Thomson Reuters/West 2011). The VMGs state, for example, that the types of evidence described in the Horizontal Guidelines as relevant to an assessment of competitive effects also would be considered in assessing a vertical merger. This would include "actual effects observed in consummated mergers [and] direct comparisons based on experience." VMGs at 3, citing § 2.1 of the Horizontal Guidelines. But compared to horizontal mergers, verified experiential evidence is in short supply when it comes to vertical merger enforcement. In addition, the VMGs go to some trouble to explain that vertical merger cases are highly fact-specific, and indeed the FTC Commentary (discussed in Section III, *infra*.) specifically disclaims any inferences that might be drawn from past enforcement actions and applied to future vertical mergers.

[22]*See* notes 30–34 and accompanying text, and Section V, *infra*.

the way of concrete guidance concerning the specific circumstances or characteristics that the Agencies believe are predictive of a vertical merger's likely ability to harm competition, ultimately citing to the "facts and circumstances" of each case.[23] In that respect, the VMGs are unhelpful.

The conceptual framework described in the Guidelines is relatively simple, which belies the complexity of predicting the competitive effects of a vertical merger. The fundamental behavior at issue in a vertical merger is "foreclosure" – the potential ability to either increase competitors' costs of production (typically referred to as "raising rivals' costs") or to actually foreclose competitors (or potential competitors) from the market.[24] This ability stems from the acquisition, via the merger, of control over a product (or service) that is positioned vertically to, or is complementary to, the product or service that defines the relevant market. This could occur, for example, when a manufacturer acquires a firm from which it purchases one of its inputs. If the acquired input firm also does business with the manufacturer's competitors, it becomes theoretically possible that the manufacturer will cause the input firm to raise the price of the input to the

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[23]VMGs at 5, 7. Notably, unlike the Horizontal Guidelines, the VMGs attach no presumptions to the degree of concentration in the affected markets, notwithstanding that market concentration has long been considered a critical component of vertical merger analysis. *See, e.g.,* P. Areeda and H. Hovenkamp, ANTITRUST LAW, IVA ¶ 1032a (2016). Draft VMGs published in early 2020 for public comment contained a market share safe harbor that was deleted from the final version.

[24]The 1984 Guidelines focused primarily on the question of whether a vertical merger would prevent new competitors from entering the market. That document described the relevant analysis as whether (1) the degree to which the integration between the two related markets is so extensive that entrants to the primary market would also have to enter the secondary market; (2) the requirement of entry at the secondary level would make entry at the primary level significantly more difficult; and (3) the primary market is concentrated or otherwise unlikely to be competitive following the merger. These criteria set a high bar for enforcement; subsequent to the issuance of the 1984 Guidelines, federal challenges to vertical conduct were almost non-existent for many years. The two-level entry problem remains a consideration under the new VMGs but receives far less focus than in the 1984 Guidelines.

competitors or stop doing business with them altogether.[25] If the competitors lack an alternative source of supply or cannot self-supply, competition in the manufacturing market will be impaired.[26]

In the health care context, this concern may arise, for example, from a situation in which a health system, by vertically integrating into physician services, effectively can control the flow of patients (or at least certain categories of patients) to a competitor hospital in the same market. If the vertically integrated system has market power in the hospital services market, it also may be able to disadvantage physicians who compete with its own physician group, *e.g.*, by restricting or denying privileges, discriminating in the assignment of operating room time, etc. Thus, a hospital in this position theoretically could exercise market power to effectuate either horizontal or vertical foreclosure, or both. Similar concerns arise from vertical integration of health plans and providers, as illustrated by the *United Healthcare* litigation discussed in Section IV.

A related concern in a vertical combination is that one of the parties may gain access to competitively sensitive information about its competitors by virtue of the fact the other party does business with those competitors. Such access might permit the merged firm to adjust its competitive responses (*e.g.*, by anticipating its competitors' pricing and output decisions) or to engage in tacit or overt coordination of competition with its competitors. This circumstance is often present in vertical health care transactions, wherein an acquired physician group or post-acute provider may have access to strategic information of other providers with which it has affiliation or referral relationships.

The VMGs outline three factors central to the Agencies' assessment of the competitive risks of foreclosure in a vertical merger: (1) whether the merger provides the merged firm

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[25]The potential anticompetitive behavior could occur in the reverse direction as well. Consider a situation in which a retailer sells multiple brands of a product and merges with a manufacturer of one such product. If the retailer has a significant market share, its post-merger decision to sell only the brand of its related manufacturer could reduce competition among the multiple brand manufacturers.

[26]Similar issues can arise when the merger involves the producer of a complementary product or service, rather than an input.

the ability to injure rivals; (2) whether the merged firm would find it profitable to do so; and (3) whether there are countervailing incentives or efficiencies that would indicate that the net effect of the merger would not be harm to consumers, *e.g.*, through an increase in downstream prices.[27]

The question of ability is primarily one of market structure and market concentration. Any vertical integration will provide a theoretical ability to pursue foreclosure of competitors. But if the competitors have alternative sources of supply (or customers, as applicable), that ability cannot be realistically exercised or, if exercised, would be unsuccessful. In contrast, a firm with market power (or one acquiring a firm with market power) generally will have a more credible ability to exert leverage following a vertical merger. Many hospitals, health systems, and other providers, as well as insurers, operate in concentrated markets and will face a strong presumption of an ability to foreclose competition to some degree in their vertical mergers and acquisitions. Refuting the presumption will require market-specific evidence of competitive alternatives.[28]

If a firm has the ability to engage in foreclosure, the Agencies then consider the distinct question of whether it has an incentive to do so. In this respect, the Agencies assume that profitability is the measure of incentive, based on assessment of likely gains and losses from an exercise of market

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[27]Although not acknowledged in the VMGs, there clearly can be situations in which a refusal to deal with (supply), or charging higher prices to, competitors can be procompetitive, *e.g.*, it can promote differentiation or innovation among competitors or eliminate free riding. One finds this concept in antitrust cases on exclusive dealing. *See, e.g.*, Roland Machinery Co. v. Dresser Industries, 749 F.2d 380 (7th Cir. 1984); *see also*, J.B. Heide, et al., *Exclusive Dealing and Business Efficiency: Evidence from Industry Practice*, 41 J. Law & Econ. 387 (1998).

[28]The Agencies also may consider the past practices and experiences of the merging parties. In a hospital-physician transaction, this could include examination of, *e.g.*, whether the terms of employment imposed by the acquiring hospital on physicians it employs pre-merger restrict the ability of those physicians to practice at other hospitals, or restrict the ability of those physicians to remain in the market upon termination of employment, and whether the supply of physicians in the relevant specialty is limited, such that a competing hospital may not be positioned to recruit new physicians to the market in a timely manner.

power.[29] For example, if a manufacturer (Firm A) acquires an upstream supplier (Firm B) and then raises the price Firm B will charge Firm A's competitors, two countervailing effects could result. First, some of those competitors may switch to alternative suppliers, which would reduce Firm B's profitability. At the same time, if non-switching competitors pass through their increased input costs to their customers, some of those customers will switch to Firm A, which will not be paying higher input prices and presumably will undersell its competitors. If Firm A gains enough new business, its increased profits will compensate for the reduced profitability of Firm B, and the exercise of foreclosure will be profitable overall.

Although this analysis is easy to state conceptually, in many instances it will be very difficult to undertake. It requires economic modeling of the relevant markets, which in turn requires access to data concerning the economics of the market and the cost structures of the firms that participate in the market. Plus, models are built on assumptions about the behavior of firms and consumers in the relevant market, and research may or may not exist to validate the assumptions used in modeling.

In determining the likely effect of a merger on consumers,[30] the Agencies state that they also will consider various forms of efficiencies. One "efficiency" that is unique to vertical mergers is the "elimination of double marginalization" (commonly referred to as "EDM"). When a firm integrates vertically (whether it does so organically or by merger), it need no longer pay the profit margin of the upstream supplier. That is, the merged firm will deal with itself at cost. The effect of EDM, therefore, can be to reduce the prices that the integrated firm charges downstream consumers for

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[29]This is a one-dimensional view of organizational behavior, and there certainly could be other considerations affecting the question of whether a firm is likely to exercise its ability to engage in foreclosure. For example, a firm may face reputational constraints or, applicable to health care, mission-related constraints on its market conduct. However, the Agencies are highly skeptical of these less quantifiable arguments, and the potential existence of countervailing incentives is not acknowledged in the VMGs.

[30]The VMGs explain that the Agencies will examine effects on actual and potential direct customers of the merging parties and, absent evidence to the contrary, will presume that adverse effects on those direct customers lead to adverse effects on final consumers. VMGs at 2.

its end product.[31] The VMGs state that the Agencies will consider EDM in their own assessment of a firm's incentives following a vertical merger, but also state that "it is incumbent upon the merging firms to provide substantiation for claims that they will benefit from the elimination of double marginalization."[32]

Beyond EDM, a vertical merger (like a horizontal merger) may create operational efficiencies. Generically, those efficiencies might include streamlined production, improved resource management, and more efficient distribution resulting from the ability to combine and coordinate complementary assets. Vertical mergers also may eliminate "contracting friction," a term that refers to the additional work and cost required to negotiate, monitor, and maintain business relationships that are governed by arm's-length contracts, along with the reduction in agility (i.e., the ability to respond quickly and efficiently to change) that is inherent in a contractual relationship.

The VMGs indicate that the Agencies will apply the same criteria used under the Horizontal Guidelines to evaluate efficiency claims, *i.e.*, the efficiencies (i) must be merger-specific; (ii) must be verifiable; and (iii) must not result from anticompetitive reductions in output or service. Given the existence of arguments in some economic quarters that vertical mergers are inherently efficient, the invocation of the Horizontal Guidelines is, shall we say, interesting. Although the evaluation criteria seem quite straightforward, it is fair

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[31]That is not to say that all vertical mergers result in price reductions from EDM. First, the opportunity to eliminate double marginalization only exists if the merging firms are (or could have been) in a true vertical relationship prior to the merger. If the merging parties for any reason (*e.g.*, incompatible technologies, geographic barriers, or the existence of long-term third-party contracts) would not or could not do business with each other, the merger will not result in EDM. Further, as with the question of exercising foreclosure, the incentive to pass through cost reductions from EDM may be different, depending on, for example, the degree of market power possessed by the merged firm in the relevant market. The incentive to reduce prices based on EDM likely would be different for a monopolist compared to a firm facing meaningful competition.

[32]VMGs at 12. Technically, EDM is not an efficiency, but rather a potential unilateral (positive) price effect of vertical integration. The VMGs acknowledge this point (at p. 11) but nonetheless treat EDM substantially in the same manner as an efficiency claim.

to say that, in the recent history of horizontal provider mergers, the FTC has rarely met an efficiency argument that it considered sufficient to overcome any presumed adverse effect on competition. With predictable regularity, the FTC has dismissed claimed efficiencies as insufficiently substantiated, quantitatively insufficient, and/or not merger-specific (*i.e.*, achievable without a merger).[33] Indeed, the Agencies effectively have taken the position that there is a tipping point of predicted anticompetitive effects beyond which efficiency claims will have no bearing in horizontal mergers.[34]

Merger-specificity will be a critical question in many vertical transactions, and particularly in health care. Almost by definition, the merging parties will have had a contractual or non-contractual working relationship before the merger, and the question will be whether the merger improves that relationship in some measurable way. The VMGs provide no insight into how the Agencies assess this question beyond stating that they will look at the contracting practices of the parties and in the market generally.[35]

There is also considerable debate among antitrust economists and regulators as to whether a presumption of merger-specificity should attach to EDM claims. Some argue that the alignment of incentives that results in EDM can often, or even usually, be achieved by contract, and that the merging parties should bear the burden of proving that EDM

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[33]To use but one recent example, in its 2020 challenge of the Thomas Jefferson-Einstein Health merger, the FTC argued that "only 28% of Defendants' claimed efficiencies are potentially cognizable. . . . The remaining 72% of Defendants' claimed efficiencies are either not verifiable (as they are based on estimates a third party cannot reasonably verify), or are not merger-specific (as Defendants have not shown the merger is the only practical means to achieve the claimed savings), or are neither verifiable nor merger-specific. . . . [E]ven fully crediting 100% of Defendants' claimed efficiencies despite contrary precedent and evidence, the claimed cost savings still come up short of the amount necessary to offset the predicted anticompetitive harm to consumers from Defendants' merger." Plaintiffs' Pre-Hearing Memorandum, Federal Trade Comm'n et al. v. Thomas Jefferson University, et al., No. 2:20-cv-1113 (E.D. Pa. Sept. 2, 2020) at 21–22.

[34]Horizontal Guidelines at 31 ("When the potential adverse competitive effect of a merger is likely to be particularly substantial, extraordinarily great cognizable efficiencies would be necessary to prevent the merger from being anticompetitive.").

[35]VMGs at 12.

benefits can only be achieved through merger. Others argue that if the parties have failed to achieve EDM prior to the merger, that fact should be sufficient to demonstrate that EDM is unlikely to occur absent the merger.[36] The VMGs take no position on this point but make clear that the burden is on the merging parties to establish the merger-specificity of their efficiency claims and to provide verification.

III. The FTC's Commentary on Vertical Mergers[37]

In late 2020, in follow-up to the publication of the VMGs, the FTC issued its *Commentary on Vertical Merger Enforcement*, intended to "provide greater transparency to the public regarding [the FTC's] analysis of vertical mergers."[38] The Commentary endeavors to do so by describing or referencing 40 transactions presenting vertical issues that were reviewed by the FTC over the past 26 years, of which 36 resulted in some type of enforcement action.[39] All of the actions were

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[36]*Compare, e.g.*, State Attorneys General, Public Comment on FTC-DOJ Draft Vertical Merger Guidelines (Feb. 26, 2020), https://www.ftc.gov/system/files/attachments/798-draft-vertical-merger-guidelines/state_ags_final_vmg_comments.pdf, *with* International Center for Law and Economics, Comments of ICLE on the Draft Vertical Merger Guidelines (undated), https://www.ftc.gov/system/files/attachments/798-draft-vertical-merger-guidelines/icle_-_vmg_draft_comments_0.pdf.

[37]To the extent this article reflects a greater focus on the Federal Trade Commission, it is because the FTC is the lead Agency in reviewing combinations of health care providers. The DOJ has taken the lead in health insurance matters, however.

[38]Federal Trade Comm'n, *Commentary on Vertical Merger Enforcement* (December 2020) at 1 ("Commentary"), https://www.ftc.gov/reports/federal-trade-commissions-commentary-vertical-merger-enforcement.

[39]Within the 36 actions, two matters were not really about competition *per se*, but rather concerned vertical acquisitions that were alleged to create an ability for a price-regulated company to inflate its costs of production (*i.e.*, and thereby create a basis to charge higher prices). One of these actions was health care-related, in which a dialysis provider proposed to acquire an exclusive sublicense for manufacture of a drug commonly used in treating dialysis patients. The FTC alleged that agreement would give the provider an ability to artificially inflate its internal costs for the drug, which would result in increased Medicare reimbursement for the provider and all buyers of the drug. The consent order resolving the matter required the provider to use the current market price for the drug in reporting the average selling price to Medicare. Fresenius Medical Care AG & Co. KGaA, No. 081-0146 (FTC 2008).

concluded through consent order; none was litigated. In reviewing the Commentary, the following observations may be made about the FTC's enforcement history:

- More than two-thirds of the enforcement actions (25 of 36) arose in just three industry sectors: aerospace and defense, energy, and technology. Four actions involved pharmaceuticals or diagnostic testing supplies; two involved health care providers.
- The Commentary notes that many horizontal mergers and acquisitions also raise vertical issues and in fact, 12 of the 36 actions cited in the Commentary involved horizontal transactions. This duality is often true in health care transactions and has been evident in the FTC's health care enforcement actions. *See* Section IV, *infra.*
- There was an observable drop-off in FTC enforcement actions during the period from 2003 to 2013; only seven actions were concluded in that 11-year period. In contrast, the *Commentary* identifies ten matters involving transactions in eight industries that were investigated during the six-year period beginning in 2014, nine of which resulted in enforcement through consent orders.
- Conduct remedies are much more prevalent in the FTC's vertical cases than in horizontal cases. Of the 36 cases in which a consent order was obtained, 27 were resolved through conduct remedies (*i.e.*, agreements regarding future conduct by the merging parties), seven through structural remedies, (*i.e.*, divestiture), and two through a combination of structural and conduct remedies.
- Broadly speaking, the majority of conduct remedies were of two types: (i) establishment of firewalls to prevent sharing of competitively sensitive information and (ii) some form of required dealing with potentially affected market participants. Examples of the latter include requirements to accept transactions with non-affiliated parties, prohibitions on discriminating (on price or otherwise) in third-party dealings, requirements to offer long-term contracts, and requirements to surrender exclusive dealing rights.
- The Commentary discusses six cases in which efficiency

arguments (including the elimination of double marginalization) were considered. The six cases include the only two matters in the document in which the FTC's investigation closed without further action.[40] In the other four matters, efficiencies apparently were credited but were not sufficient to dissuade the FTC from seeking consent orders to address competitive concerns.

The Commentary is somewhat helpful, at a very high level, in illustrating the theories of competitive harm and the facts of past enforcement actions. However, like the VMGs, it provides little actual insight into *how* the FTC weighs and measures those facts. Indeed, the FTC makes clear in the introduction to the Commentary that, notwithstanding the goal of providing greater transparency through the document, readers are not to assume that the document describes all factors that were considered in each case, or that the outcome in the cases described is in any way determinative of future matters.[41]

IV. Vertical Enforcement in Health Care

As is true for all economic sectors, there is scant history of vertical merger challenges or litigation involving health care providers, notwithstanding the substantial growth in vertical provider acquisitions. However, a few cases exist that to illustrate some of the issues highlighted by the VMGs and the FTC Commentary as they arose in health care provider transactions.

United Healthcare and DaVita Medical Group

United Healthcare has taken the lead among insurers in integrating into the physician services market. As of 2019, through its OptumHealth and OptumCare subsidiaries, United had employment or affiliation relationships with some 50,000 physicians covering 40 markets in six states,

[40]Notably, in one of those matters, the Commentary indicates that the merging parties' customers were supportive of the transaction due to expected efficiencies. Commentary at 33, discussing Synopsys, Inc./Avant! Corporation, No. 021-0049 (FTC 2002). It is of course difficult for the FTC to consider challenging any transaction in which customers are not complaining, regardless of efficiencies.

[41]Commentary at 1, n. 2.

along with its MedExpress urgent care centers and more than 200 surgery centers acquired in its 2017 purchase of Surgical Care Affiliates.[42]

In 2019, United's $4 billion acquisition of DaVita Medical Group, which operated 300 medical clinics in six states and overlapped with Optum in multiple markets, prompted both federal and state investigations and, ultimately, enforcement actions at both levels. At the federal level, the FTC challenged the proposed acquisition specifically with respect to its potential effects in a two-county Las Vegas, Nevada, market. Within that geography, the FTC alleged that the transaction would lessen competition in the market for Medicare Advantage (MA) plans sold to individuals in both horizontal and vertical respects. The complaint alleged that United's OptumCare and DaVita Medical Group's HealthCare Partners of Nevada (HCPNV) served a combined 80 percent of MA plan members in the market.[43] In addition, it was alleged that United insured 50% of the MA lives in the relevant market, and that the market was highly concentrated (with non-party Humana covering approximately 35% of the MA lives).[44] In June, 2019, United and DaVita settled the FTC's complaint pursuant to a consent order requiring United to divest the operations of HCPNV to a third party, Intermountain Healthcare.[45]

The FTC's complaint in this matter was notable in several

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[42]L. Dyrda, "Optum has 50,000 employed, affiliated physicians and a vision for the future," *Becker's ASC Review* (Sept. 17, 2019), https://www.beckersasc.com/asc-transactions-and-valuation-issues/optum-has-50-000-employed-affiliated-physicians-and-a-vision-for-the-future.html; B. Japsen, "UnitedHealth: DaVita Medical Deal 'Progressing' On Path To Close," *Forbes* (Apr. 17, 2019), https://www.forbes.com/sites/brucejapsen/2019/04/17/unitedhealth-davita-medical-deal-progressing-on-path-to-close/#58352cba629f; "UnitedHealth to buy DaVita primary care unit for $4.9 billion," *Reuters Business News* (Dec, 6, 2017), https://www.reuters.com/article/us-davita-m-a-unitedhealth/unitedhealth-to-buy-davita-primary-care-unit-for-4-9-billion-idUSKBN1E01HJ.

[43]Complaint, United Health Group Incorporated, No. C-4677 (FTC June 19, 2019) at ¶¶ 15-16, https://www.ftc.gov/system/files/documents/cases/181_0057_c4677_united_davita_complaint.pdf ("United Complaint").

[44]*Id.*

[45]Decision and Order, United Health Group Incorporated, No. C-4677 (FTC June 19, 2019), https://www.ftc.gov/system/files/documents/cases/181_0057_c4677_united_davita_order.pdf; Agreement Containing Consent

respects.[46] First, it was the FTC's first challenge expressly alleging vertical effects in a health care provider acquisition. The complaint alleged that the integration of United Health Group and HCPNV would give United, as a Medicare Advantage Organization, control of a competitively significant input (physician services) required by its competitors (*e.g.*, Humana) in the MA marketplace. United, the complaint alleged, would be able to disadvantage its rivals by raising rates for the services of HCPNV physicians, restrict participation by HCPNV in care coordination and quality initiatives of rival plans, or even refusing HCPNV contracts to rival plans altogether.[47]

The case also was notable for showcasing the differing perspectives of the FTC Commissioners on the general question of vertical merger enforcement. In conjunction with the settlement, the two Democratic Commissioners issued a statement[48] critical of the decision not to pursue similar allegations regarding the effects of the United-DaVita transaction in Colorado.[49] Two Republican Commissioners issued a responsive statement noting that "vertical mergers often

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Orders, United Health Group Incorporated, No. 181-0057 (FTC June 19, 2019), https://www.ftc.gov/system/files/documents/cases/181_0057_united_davita_acco_6-19-19.pdf.

[46]In addition to the aspects of the complaint discussed in the text, the FTC's case was notable in that allegations of competitive harm were confined to the market for Medicare Advantage plans. Virtually all FTC challenges of horizontal provider combinations have been based on allegations of likely competitive harm in commercial insurance markets.

[47]United Complaint at ¶¶ 18-20.

[48]Statement of Commissioners Rebecca Kelly Slaughter and Rohit Chopra, United Health Group Incorporated, No. 181-0057 (FTC June 19, 2019), https://www.ftc.gov/system/files/documents/public_statements/1529359/181_0057_united_davita_statement_of_cmmrs_s_and_c.pdf.

[49]However, the Colorado Attorney General separately sought relief from the perceived impact of the transaction in the market for MA plans in the Colorado Springs area. The State's complaint focused solely on vertical effects, alleging that "[t]he combination of Optum and DaVita Medical Group would create significant market power with the ability and incentive to raise DaVita Medical Group's price to other insurance companies that serve Medicare Advantage patients in the Colorado Springs Area." Press Release, Office of the Attorney General of Colorado, "Antitrust Challenge and Settlement to the UnitedHealth Group and DaVita Merger Will Safeguard Competition, Cost, and Quality of Healthcare for Seniors in the Colorado Springs Area," (June 19, 2019), htt

generate procompetitive benefits that must also factor into the antitrust analysis" and that because (unlike United's acquisition in Nevada) the Colorado acquisition presented *only* vertical issues, the mixed evidence of potential harms and benefits "would not have convinced a judge that the proposed acquisition was likely, on balance, to harm consumers in Colorado."[50]

At present, the FTC's pursuit of vertical issues in the United-DaVita matter is unique. Although vertical foreclosure issues are present in most acquisitions of physician organizations by health systems, those claims have not been pursued in enforcement actions. As the Commissioners' debate in the United case illustrates, this situation almost certainly reflects the fact that these transactions also have horizontal dimensions (*i.e.*, the acquiring system is already an employer of physicians in the same specialties) and, in such cases, it is often a simpler matter to demonstrate the likelihood of adverse horizontal effects in the physician services market than the vertical effects in the hospital services market.[51] Two recent cases illustrate this point.

Sanford Health and Mid-Dakota Clinic

Also in 2019, the Eighth Circuit Court of Appeals upheld a preliminary injunction in favor of the FTC against the intended acquisition of Mid-Dakota Clinic in Bismarck, ND,

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ps://coag.gov/press-releases/06-19-19/; an unfiled version of the complaint is at https://coag.gov/app/uploads/2019/06/2019-06-19-08-00-13-United-DaVita-Complaint-final.pdf. This matter likewise was settled through a consent order, but one imposing only minor and temporary conduct restrictions on United.

[50]Statement of Commissioner Noah Joshua Phillips and Commissioner Christine S. Wilson, United Health Group Incorporated, No. 181-0057 (FTC June 19, 2019), https://www.ftc.gov/system/files/documents/public_statements/1529366/181_0057_united_davita_statement_of_cmmrs_p_and_w.pdf

[51]Indeed, vertical merger litigation has been a rarity across all industries. The Justice Department's recent effort to block the AT&T-Time Warner merger (which ultimately failed) was the first litigated federal challenge to a vertical combination case in 40 years. United States v. AT&T, Inc., 918 F.3d 1029 (D.C. Cir. 2019).

by a subsidiary of Sanford Health.[52] Mid-Dakota Clinic is a multi-specialty physician group practice that includes adult and pediatric primary care physicians, OB/GYNs, and general surgeons (which specialties comprised the relevant market in this case), as well as a number of specialists in other disciplines. Sanford is a large regional health care system that operates one of two hospitals in Bismarck. Sanford also operates physician clinics in the Bismarck area and likewise is a large employer of physicians, including physicians practicing adult and pediatric primary care, OB/GYN, and general surgery. After unsuccessfully pursuing an acquisition by Sanford's hospital competitor (CHI St. Alexius Health), Mid-Dakota entered into a stock purchase agreement with Sanford. The deal was opposed by the FTC and the North Dakota Attorney General, and a preliminary injunction was granted by the federal district court[53] and affirmed by the Court of Appeals. Among other findings, the court concluded that the merged firm would have market shares in the relevant physician specialty markets ranging from 85 percent to 99 percent, and this horizontal concentration was the basis on which the court issued the injunction.

The FTC pursued this case solely as a horizontal merger in the physician services markets, notwithstanding that the acquisition of Mid-Dakota Clinic by Sanford had clear competitive implications for competition between Sanford and CHI St. Alexius Health, the only other hospital in Bismarck. Those implications were considered only obliquely, in regard to the question of whether St. Alexius would be capable of expanding in a manner that would provide timely constraints on Sanford following the acquisition of Mid-Dakota Clinic. In considering that question, the trial court acknowledged the likely (vertical) competitive impact in the hospital services market but did not rely on that theory of harm to reach its decision.[54]

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[52]Federal Trade Comm'n v. Sanford Health, 926 F.3d 959 (8th Cir. 2019).

[53]Order Granting Plaintiffs' Motion for a Preliminary Injunction, Federal Trade Comm'n v. Sanford Health, No. 1:17-cv-133 (D.N.D. Dec. 13, 2017), https://www.ftc.gov/system/files/documents/cases/sanford_order.pdf.

[54]Memorandum of Decision, Findings of Fact, Conclusions of Law, and Order, *Federal Trade Commission v. Sanford Health*, No. 1:17-cv-133

St. Luke's Health System-Saltzer Medical Group

A more widely known example is the successful challenge by the FTC and the Idaho Attorney General to the acquisition of a multi-specialty physician group practice (Saltzer Medical Group) by St. Luke's Health System.[55] The case was styled as a horizontal merger challenge under § 7 of the Clayton Act, alleging that the addition of the Saltzer primary care physicians (PCPs) to St. Luke's existing stable of PCPs would give St. Luke's a 60 percent share of the relevant primary care services market, which would create higher prices for consumers by increasing St. Luke's negotiating leverage with commercial payors, and by increasing patient referrals to St. Luke's higher-cost laboratory, radiology, and other ancillary services.[56]

Here, too, the FTC did not challenge the acquisition's potential vertical effects in the hospital services market. Rather, that concern formed the basis of a separate complaint filed against St. Luke's by St. Alphonsus Medical Center, the only other hospital in Nampa. That complaint alleged that "St. Luke's will gain a near monopoly share in the Nampa, Idaho market for adult primary care physician services. It will continue its practice of foreclosing virtually all competition for the hospital admissions of the physician

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(D.N.D. Dec. 15, 2017) at ¶ 149, https://www.ftc.gov/system/files/documents/cases/1710019_sanfordpiorder.pdf ("Post-merger, physicians currently practicing at [Mid-Dakota Clinic] would likely refer more patients to Sanford rather than to CHI St. Alexius. The anticipated decline in referrals to CHI St. Alexius would indeed incentivize and motivate CHI to add physicians in the four service areas. But, hearing evidence did not establish that the Bismarck-Mandan area's population is sufficient to support a significant increase in total numbers of physicians in each of the four service lines.").

[55]Federal Trade Comm'n v. St. Luke's Health Sys., Ltd., 2014 WL 525540 (D. Idaho Jan. 24, 2014) *aff'd sub nom* St. Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775 (9th Cir. 2015).

[56]Complaint, Federal Trade Comm'n v. St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Mar. 26, 2013) at 3-4, https://www.ftc.gov/sites/default/files/documents/cases/2013/03/130312stlukescmpt.pdf ("FTC St. Luke's Complaint").

practices it acquires."[57] This allegation potentially involved greater consumer harm than a simple rise in the price of primary care services.[58] Nonetheless, the FTC complaint acknowledged this issue only tangentially[59] and the court's opinion focused exclusively on the acquisition's likely effects on the prices of primary care and ancillary services.

V. The Critical Question of Efficiencies in Vertical Health Care Combinations

In general, economic research on the welfare effects of vertical mergers supports the proposition that consumers benefit from vertical integration in most cases.[60] However, research on vertical integration in health care has produced more mixed signals. This is a critical issue for provider organizations defending vertical mergers and acquisitions.

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[57]Amended Complaint, St. Alphonsus Medical Center-Nampa v. St. Luke's Health Sys., Ltd., No. 1:12-cv-00560 (D. Idaho Jan. 15, 2013) at 2. The St. Alphonsus complaint went on to detail prior instances in which St. Alphonsus believed that physician practice acquisitions by St. Luke's resulted in a shift of patients to St. Luke's from St. Alphonsus. *See, e.g.*, *id.* at 18–19. St. Alphonsus's case was subsequently consolidated with the FTC's complaint for discovery and trial.

[58]The FTC's argument that health insurance premiums would rise as a result of concentration in the primary care physician market seemed not to consider the fact that PCP services are not a significant driver of commercial health insurance premiums (*i.e.*, true consumer costs). Historically, only about 11 percent of the premium of a typical health plan goes to coverage of primary care services, which means that even a 10 percent increase in PCP prices on average would produce at most only about a one percent rise in insurance premiums. *See, e.g.*, *Capitation, Rate Setting, and Risk Sharing*, *in* UNDERSTANDING HEALTHCARE FINANCIAL MANAGEMENT 627 (Louis C. Gapenski & George H. Pink eds., 5th ed. 2007), http://www.ache.org/pubs/hap_companion/gapenski_finance/online%20chapter%2020.pdf.

[59]*See* FTC St. Luke's Complaint, *supra* note 56, at 3 ("PCPs generally determine what additional care and services their patients need, and refer them to other physicians, labs, or testing facilities accordingly. As St. Luke's own documents show, St. Luke's reaps the benefits of its physician acquisitions in part by relying on those physicians to shift patients to its own facilities.").

[60]*See, e.g.*, Comment of the Global Antitrust Institute, Antonin Scalia Law School, George Mason University, on DOJ/FTC Draft 2020 Vertical Merger Guidelines (Feb. 7, 2020) at 9-14 (summarizing published research), https://www.ftc.gov/system/files/attachments/798-draft-vertical-merger-guidelines/vmg8_gai_comment.pdf.

The *St. Luke's* case remains perhaps the most instructive example of the challenges that efficiency arguments will face in vertical health care transactions. The court's conclusions regarding the parties' efficiency arguments were just as significant for the vertical aspects of the case as the horizontal combination challenged by the FTC. The merging parties essentially argued that the efficiencies of the transaction were vertical – the combination of Saltzer with St. Luke's, and the resulting *de facto* control (employment) of the Saltzer physicians by St. Luke's, would enable the delivery of integrated, value-based patient care consistent with the objectives of federal health reform legislation.[61] St. Luke's further argued that those benefits could not be achieved through a less-integrated affiliation:

> The transaction's benefits are merger-specific because the transaction will enhance the ability of the combined St. Luke's/Saltzer to offer coordinated, patient-centered care; to support physicians in the practice of evidence-based medicine in an environment that rewards teamwork and value of care rather than volume of care; to accept risk and accountability for patients' outcomes; and to manage population health.[62]

The defendants asserted that full integration was necessary because St. Luke's and Saltzer could not achieve these benefits "as effectively or as quickly by any looser affiliation or other means."[63]

But in the absence of empirical evidence as to the effectiveness of employment models in achieving the objectives of clinical integration, the court was unpersuaded. The court concluded that the proffered efficiencies were not merger-specific, *i.e.*, that St. Luke's could use less restrictive means than acquiring the Saltzer physicians (*i.e.*, contractual arrangements) and still be able to achieve the same procompetitive benefits of integrated medicine.[64] Relying in part on testimony from the Idaho Blue Cross plan, the court

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[61]Defendants' Corrected Proposed Findings of Fact and Conclusions of Law, Federal Trade Comm'n v. St. Luke's Health System, Ltd., No. 13-cv-116 (D. Idaho Jan. 7, 2014) at 200, https://www.gtc.gov/system/files/documents/cases/131104stlukefof.pdf.

[62]*Id.* at 199.

[63]*Id.*

[64]Findings of Fact & Conclusions of Law at 51, Fed. Trade Comm'n v. St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Jan. 24, 2014) at 33-

concluded that integrated care delivery does not require physicians to be employed and – significantly – that there was *no empirical evidence* to suggest that an employment model is essential.

The court further found that "[t]here are a number of organizational structures that will create a team of unified and committed physicians other than [one] . . . that employs physicians and [creates] a substantial concentration of market power."[65] In the court's view, so long as the physicians are committed to improving the quality of health care and lowering costs, it is irrelevant whether they are employed or independent,[66] and therefore, a "committed team" is not a merger-specific efficiency.[67]

This evidentiary hurdle will recur with regularity in future investigations and litigation concerning hospital-physician and hospital-post-acute combinations. The evidence concerning the results of clinical integration and disease management is conflicting, and the evidence differentiating the results of formal integration from contractual alliances is sparse, to say the least. Many studies of provider integration rely on data from past time periods when most physicians practiced in fee-for-service environments and were compensated under productivity-based arrangements.[68] In addition, until recently, most health plans (including Medicare) paid

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34, https://www.ftc.gov/system/files/documents/cases/140124stlukesfindings.pdf.

[65] *Id.* at 47.

[66] *See id.* at 33.

[67] *Id.* at 34.

[68] *See, e.g.*, L. Baker, M K. Bundorf, and D. Kessler, *Vertical Integration: Hospital Ownership of Physician Practices Is Associated With Higher Prices and Spending*, 33 HEALTH AFFAIRS 5 (May 2014) (finding a "mixed, although somewhat negative" picture of vertical integration from the perspective of commercially insured patients using data from 2001-2007); L. Burns, and M. Pauly, *Accountable Care Organizations May Have Difficulty Avoiding The Failures Of Integrated Delivery Networks Of The 1990s*, 31 HEALTH AFFAIRS 2407 (2012) (expressing doubt that accountable care will lower costs); A. O'Malley, *et al.*, *Rising Hospital Employment of Physicians: Better Quality, Higher Costs?*, Issue Brief No. 136 (Ctr. for Studying Health Sys. Change Aug. 2011) ("While hospital-employed physicians may spur clinical integration that will ultimately improve efficiency and help control costs, they are more likely to increase costs in the short run."); R. Berenson, *et al.*, *Unchecked Provider Clout in California*

higher fees for hospital-based services than for the same services performed in physician offices, which also may have been a factor in the results of older studies concerning the effects of integration on health care expenditures.

Accountable Care Organizations (ACOs) represent a significant experiment in efforts to improve clinical alignment and clinical efficiency. A number of recent studies suggest ACOs have been effective in reducing utilization and spending.[69] But it is not clear that even positive results from these studies will be helpful to vertical provider mergers because most of the research does not track the performance differences between formally integrated provider networks and informal (contractual) provider networks. Indeed, these studies may make it more difficult to argue that formal

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Foreshadows Challenges to Health Reform, 29 HEALTH AFFAIRS 699 (2010); L. Casalino, *et al.*, *Hospital-Physician Relations: Two Tracks and the Decline of the Voluntary Medical Staff Model*, 27 HEALTH AFFAIRS 1305 (2008).

[69] *See, e.g.*, A. Dobson, et al., 2017 UPDATE: MSSP SAVINGS ESTIMATES (Natl. Ass'n of ACOs Nov. 20, 2019), https://www.naacos.com/assets/docs/pdf/2019/Final-NAACOS-AsTreatedDID-SavingsEstimateReport2017.pdf (MSSP program data for 2013-2017 shows reduced spending by $3.53 billion and Medicare program savings of $755 million after paying shared savings); M. Trombley, et al., *Early Effects of an Accountable Care Organization Model for Underserved Areas*, 381 N. ENGL. J. MED. 543 (Aug. 8, 2019) (participation in ACO shared savings contracts by providers serving rural and underserved areas was associated with lower Medicare spending than that among non-ACO providers); J.M. McWilliams et al., *Medicare Spending After Three Years of the Medicare Shared Savings Program* 379 N. ENG. J. MED. 1139 (2018); D. Agarwal and R. Werner, *Effects of Hospital and Post-Acute Provider Participation in Accountable Care Organizations on Patient Outcomes and Medicare Spending*, 53 HEALTH SERV. RES. 5035 (2018) (Hospital and SNF participation in an ACO associated with lower readmission rates, Medicare spending on SNF, and SNF length of stay); S. Shortell, et al., *A Multilevel Analysis of Patient Engagement and Patient-Reported Outcomes in Primary Care Practices of Accountable Care Organizations*, 32 J. GEN. INT. MED. 640 (Feb. 2017) (Diabetic and CVD patients who received care from ACO-affiliated practices with more developed patient-centered cultures reported lower PHQ-4 depression symptom scores and better physical functioning); Office of the Inspector General, U.S. Dept. of Health and Human Services, MEDICARE SHARED SAVINGS PROGRAM ACCOUNTABLE CARE ORGANIZATIONS HAVE SHOWN POTENTIAL FOR REDUCING SPENDING AND IMPROVING QUALITY (Aug. 2017); C. Colla, et al., *Association Between Medicare Accountable Care Organization Implementation and Spending Among Clinically Vulnerable Beneficiaries*, 176 JAMA INTERN. MED. 1167 (2016).

integration (by merger or acquisition) is necessary to achieve success in a value-based/pay-for-performance environment.

Outside of the ACO context, there is a very large mixed bag of evidence concerning provider integration. In general. the weight of the studies seems to suggest that integration can have positive effects on quality,[70] but not necessarily pos-

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[70]Studies suggesting positive effects of integration on quality include: R.T. Konetzka, at al., *The Effect of Integration of Hospitals and Post-Acute Providers on Medicare Payment and Patient Outcomes*, 61 J. HEALTH ECON. 244 (Sept. 2018) (vertical integration between hospitals and SNFs reduced rehospitalization rates but increased Medicare payments); T.F. Bishop, et al., *Trends in hospital ownership of physician practices and the effect on processes to improve quality*, 22 AM. J. MANAGED CARE 172 (2016) (groups affiliated with hospitals found to be significantly better at care management); C.S. Carlin, et al., *Changes in quality of health care delivery after vertical integration*, 50 HEALTH SERV. RES. 1043 (2015) (three hospital systems in a metropolitan area showed small increases in quality of care as a result of vertical integration); W. Hwang et al., *Effects of Integrated Delivery System on Cost and Quality*, 19 AM. J. MANAGED CARE 175 (2013) ("The vast majority of studies we reviewed have shown that integrated delivery systems have positive effects on quality of care."). Cuellar, et al., *Strategic integration of hospitals and physicians*, 25 J. HEALTH ECON. 1 (2006) (fully integrated, large teaching hospitals appear to have higher quality); S. Shortell, et al., *An empirical assessment of high-performing medical groups: Results from a national study*, 62 MED. CARE RES. & REV., 407 (2005). Studies suggesting negative or no effects of integration on quality include: M. Short and V. Ho, *Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality*, 77 MED. CARE RES. & REV. 538 (2020) (Vertical integration has a limited effect on a small subset of quality measures. Increased market concentration is strongly associated with reduced quality); V. Ho, at al., *Annual Spending per Patient and Quality in Hospital-Owned Versus Physician-Owned Organizations: an Observational Study* 35 J. GEN. INTERN. MED. 649 (2019) (For adult patients enrolled in a Blue Cross PPO, no consistent difference in care quality for hospital-owned versus physician-owned practices); A. Chukmaitov, et al., *Delivery system characteristics and their association with quality and costs of care: Implications for accountable care organizations*, 40 HEALTH CARE MGMT. REV. 92 (2015) (tighter integration linked to increased mortality); J. Kralewski, et al., *The relationships of physician practice characteristics to quality of care and costs* 50 HEALTH SERV. RES. 710 (2015) (hospital-owned practices had worse screening and quality measures than physician-owned practices); K. Madison, *Hospital–physician affiliations and patient treatments, expenditures, and outcomes*, 39 HEALTH SERV. RES. 257 (2004) (no effect of physician-hospital affiliations of cardiologists on mortality of Medicare cardiac patients).

itive effects on expenditures, prices, and utilization.[71] Again, although some studies differentiate formal and informal vertical integration, many do not. Overall, "[t]here has been little research specifically on the implications of varying degrees of physician–hospital integration on quality, very little of which included nationwide analysis."[72]

If the clinical integration model is to provide a basis for a viable antitrust efficiency defense, the industry will require better research, based on current data, regarding not only the differences (if they exist) in outcomes between formally integrated vertical provider systems and traditional independent contractor arrangements or historical practice, but also identifying the specific factors that underlie those differences. Beyond building a body of supportive research,

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[71]Studies suggesting positive results of integration on expenditures and prices include: N. Carroll, et al., *Hospital ownership of postacute care providers and the cost of care*, 45 HEALTH CARE MGMT. REV. E35 (Oct./Dec. 2020) (hospital ownership of SNFs and HHAs associated with a lower episodic cost of care); L. Baker et al., *The Effects of Multispecialty Group Practice on Health Care Spending and Use*, NBER WORKING PAPER, 25915 (2019); J. Bledsoe et al., *The Salutary Effect of an Integrated System on the Rate of Repeat CT Scanning in Transferred Trauma Patients: Improved Costs and Efficiencies*, 214 THE AM. J. SURGERY, 198 (2017); *see also*, A. Wang, "Advocate-Blue Cross ACO Sees Improvement in Utilization, Costs," *Modern Healthcare* (Jan. 22, 2014), http://www.modernhealthcare.com/article/20140122/INFO/301229994 (reporting reduced admission rates, inpatient days, and lengths of stay, and an overall 2.5% reduction in cost trends). Studies suggesting negative or mixed results include: V. Ho, et al., note 70, *supra* (*P*atients in a Blue Cross PPO incurred higher utilization resulting in higher spending when treated by doctors in hospital-owned versus physician-owned practices); N. Cho, et al., *Economic Evaluation of the impact of physician-hospital integration and physician boards on hospital expenditure per patient*, MEDICINE (Oct. 2018), (Data for California hospitals 2002-2006 shows expenditures were higher in hospitals with an integrated salary model than under independent arrangements between hospitals and physicians); R.T. Konetzka, et al, note 70 *supra*, (2018) (vertical integration between hospitals and SNFs increases Medicare payments but reduces rehospitalization rates); T. Koch et al., *How Vertical Integration Affects the Quantity and Cost of Care for Medicare Beneficiaries*, 52 J. HEALTH ECON. 19 (2017) (increased utilization of acquiring hospitals' outpatient departments by acquired physicians is not wholly offset by reduced utilization by other clinicians); Baker, et al., note 68, *supra* (2014) (mixed but somewhat negative conclusions on vertical integration); Hwang, et al., note 70 supra (2013) (Few studies linked use of an integrated delivery system to lower health service utilization).

[72]Short & Ho, note 70, *supra*, at 539.

however, parties to a vertical merger should be prepared to speak to efficiencies from their own experience. If prior formal integration efforts of a party have been successful (and objective evidence exists to support the conclusion), that is important information for a reviewing agency and a court. Likewise, it will be highly advantageous if the parties can specifically define the ways in which informal contracting has not been or would not be an acceptable substitute for a formal combination. This is not a simple task and the effort may benefit from the services of consultants who specialize in business process improvement. It is important to bear in mind the almost conclusive weight given by the Agencies to the verifiability of efficiency claims and the Agencies' general skepticism of any such claims.

VI. Where Does the Vertical Path Lead for Health Care Providers?

As noted at the outset of this article, the jargon and conceptualization of vertical merger transactions as reflected in the VMGs is more consistent with traditional manufacturing industries than with health care. This is not to suggest that health care is somehow (or should be) outside of the antitrust laws when considering vertical arrangements, but rather to note that health care markets (notably for provider services) are characterized by factors that are unique to those markets. These factors are well known:

First and foremost, health care services markets are characterized by third-party insurance, which makes the cost of services to the end-user (the patient) less than the marginal cost of production. This can and does lead to overconsumption (moral hazard), both directly by patients and by the providers who prescribe treatments. A related characteristic of health care markets is that patients generally have only limited information about the cost, quality, and efficacy of the services they "purchase." In turn, providers operate under complex regulatory schemes (both public and private (*i.e.*, health plan-driven)) that are designed to compensate for market anomalies by controlling reimbursements, utilization, and quality. Prices paid to providers are typically the subject of a negotiation (as opposed to the single price-setting typical in manufacturing) that frequently involves a buyer (health plan) with market power.

These issues are relevant in assessing vertical health care transactions but, being industry-specific, are not addressed in the VMGs.[73] In an environment promoting value-based care, the improvement of clinical efficiency, both to control utilization and to improve quality, has become a critical objective for many provider organizations. Vertical integration can be a tool to address the adverse effects of moral hazard and information asymmetry, and to respond effectively to regulatory mandates. That is not to say that positive results are a given. But it does mean that making credible efficiency arguments to the FTC, as discussed specifically in Section V, will be critical for many health care integration transactions.

It is worth noting here that some sources have suggested that the anomalies of health care markets argue for a greater degree of market regulation in addition to enforcement of existing antitrust laws. Antitrust enforcement alone, it is said, can only maintain the status quo, and cannot stimulate new competition in health care markets that tend toward high concentration in the first instance.[74]

The health care industry experienced an illustrative instance of so-called "market governance" rules in the 1990's, to address concerns about hospitals "channeling" post-acute referrals to their own downstream providers. As a consequence of the *Venice Hospital* litigation and its progeny,[75] the federal government and many states adopted laws to protect

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[73]To be fair, the VMGs do contain one example discussing foreclosure in a market in which prices are set by negotiation – one in which a manufacturer merges with one of its retailers and raises input prices to competing retailers. This is not a particularly instructive example for insured health care markets.

[74]*See, e.g.*, E. Varanini, *Competition as Policy Reform: The Use of Vigorous Antitrust Enforcement, Market Governance Rules, and Incentives in Health Care*, 11 ST. LOUIS U. J. HEALTH L. & POLICY 69 (2017).

[75]These were cases from the early 1990's alleging that hospitals used their dominance over inpatient services to favor their owned and affiliated post-acute providers over non-affiliated providers. Key Enterprises v. Venice Hospital, 703 F. Supp. 1513 (M.D. Fla. 1989), *reversed,* 919 F.2d 1550 (11th Cir. 1990), *reh'g granted and opinion upheld*, 979 F.2d 806 (11th Cir. 1992), *order vacated,* 9 F.3d 893 (11th Cir. 1993); Advanced Health-care Services, Inc. v. Radford Community Hospital, et al., 910 F.2d 139 (4th Cir. 1990); M & M Medical Supplies, et al. v. Pleasant Valley Hospital, et al., 981 F. 2d 160 (4th Cir. 1992). All of those actions were

patients' rights to choose a downstream provider and to ensure greater transparency in the post-acute referral process. For example, in the Balanced Budget Act of 1997, Congress required Medicare-participating hospitals to provide a list of local, Medicare-certified home health agencies to patients requiring home care services and to disclose whether the hospital has a financial interest in any such home health agency or other entity to which it makes referrals.[76] Many states adopted similar laws.

Of course, this type of "free choice" regulation today is inconsistent with modern efforts to encourage providers to develop more clinically efficient delivery networks and accept financial risk, which by definition requires them to be discriminating in the selection of downstream providers and which in many cases might be most efficiently managed by an entirely captive referral process. Free choice regulations also are at tension with more recent Medicare rules imposing financial penalties on hospitals having excessive readmission rates, as those rules likewise create a stake for hospitals in the quality of the post-acute provider services to which their patients are referred.[77]

The continuing debate over antitrust reform, which centers on the conduct of companies like Google, Apple, and Facebook, also has provoked broader proposals that could have significant impact on vertical merger enforcement in health care. These include, for example (1) requiring mandatory pre-merger reporting under the federal Hart-Scott-Rodino Act for categories of mergers and acquisitions deemed to present a higher-than-average risk of market foreclosure, regardless of the transaction size;[78] (2) creating legal presumptions against vertical integration by firms that have

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brought as monopolization claims, not as merger challenges under Section 7, and the "monopoly leveraging" theory that underpinned the complaints in those cases has been effectively discredited by the Supreme Court. Verizon Communications, Inc. v. Law Offices of Curtis V. Trinko, LLP, 540 U.S. 398, 415 n. 4 (2004). The VMGs do not identify this form of leveraging as a basis for vertical merger enforcement actions.

[76]P.L. 105-33, § 4321, codified at 42 U.S.C. §§ 1395xx(ee)(2), 1395cc(a)(1), and 1320b-16.

[77]42 U.S.C. § 1395ww(q).

[78]The Hart-Scott-Rodino Act, 15 U.S.C. § 18a, with a few exceptions, imposes advance reporting requirements only on transactions valued

reached a high level of market dominance;[79] or (3) imposing public utility-like requirements on large integrated firms, e.g., nondiscriminatory behavior in pricing and service. Any of these approaches would present significant issues in terms of regulatory line-drawing, particularly in a market as complex as health care.

In this context, another significant aspect of the VMGs is the fact that two of the five FTC Commissioners voted against the release of the document and wrote lengthy dissents illuminating their views of its shortcomings.[80] This marked the first time a major guidance document from the FTC had less than unanimous support of the Commissioners.

The dissenting votes came from the two Democratic Commissioners, both of whom argued that the VMGs do not go far enough to support and encourage interdiction of anticompetitive transactions, a fact that has gained more relevance with the inauguration of the Biden administration.[81] Commissioner Chopra's dissent focused on broad market issues, arguing that the VMGs are far too lenient in their reliance on traditional economic thinking: "Unfortunately, the newly released Vertical Merger Guidelines support the status-quo ideological belief that vertical mergers are presumptively

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above a "size-of-transaction" threshold, which was $ 94 million in 2020. (The threshold is adjusted annually.) Many vertical health care transactions fall below this threshold.

[79]This is the policy approach undergirding the Bank Holding Company Act of 1956, for instance. 12 U.S.C. § 1841, et seq.

[80]Dissenting Statement of Commissioner Rebecca Kelly Slaughter, *FTC-DOJ Vertical Merger Guidelines,* Commission File No. P810034 (June 30, 2020) ("Slaughter Dissent"), https://www.ftc.gov/public-statements/2020/06/dissenting-statement-commissioner-rebecca-kelly-slaughter-re-ftc-doj; Dissenting Statement of Commissioner Rohit Chopra, *Regarding the Publication of Vertical Merger Guidelines*, Commission File No. P810034 (June 30, 2020) ("Chopra Dissent"), https://www.ftc.gov/public-statements/2020/06/dissenting-statement-commissioner-rohit-chopra-regarding-publication.

[81]Commissioners are selected by the President for seven-year terms, subject to confirmation by the Senate. By law, no more than three Commissioners may represent any one political party. The Chair of the Commission is selected by the President. Federal Trade Commission Act, 15 U.S.C. § 41.

benign and even beneficial."[82] His overarching concern is that the VMGs pay insufficient attention to the ways in which vertical mergers effectively restructure markets to benefit incumbents and discourage or prevent new competition and innovation.[83]

Commissioner Slaughter's dissent focused on more specific problems with the Guidelines that she believes portend less stringent enforcement. Both Commissioners specifically call out health care as an industry in which vertical integration has been, in their view, harmful to consumers. In the words of Commissioner Slaughter, "Even those who disagree on the substance of the Guidelines must share the view that how they are implemented will be critically important. This is not merely an academic or theoretical exercise. Vertical-merger enforcement will be relevant across the economy, especially in health care, agriculture, digital, and telecommunications markets, and it will affect every American."[84]

The views of Commissioners Slaughter and Chopra were echoed by many commenters on an earlier draft version of the VMGs. Beyond a number of prominent antitrust economists, these views came from the National Association of State Attorneys General and the American Antitrust Institute, among others.[85]

President Biden will have the opportunity during his term to establish a Democratic majority of Commissioners on the FTC,[86] and he will of course be able to shape the leadership of the Department of Justice, including the Antitrust Division. As a first step, the President appointed Commis-

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[82]Chopra Dissent at 2.

[83]*Id.* at 2, 6-9.

[84]Slaughter Dissent at 8.

[85]The public comments on the draft VMGs are available at https://www.ftc.gov/policy/public-comments/draft-vertical-merger-guidelines

[86]As of this writing, at least four of the five seats on the Commission will become vacant at some point during President Biden's term. Chairman Simons, a Republican, resigned effective January 21, 2021; his replacement, when designated and confirmed, will serve the remainder of his term ending in 2024. Commissioners Slaughter (Democrat) and Phillips (Republican) have terms expiring in 2022 and 2023, respectively. The term of Commissioner Chopra, a Democrat, expired in 2019; however, he may continue to serve until his replacement is confirmed. Republican Commissioner Wilson's term expires in 2025.

sioner Slaughter to be the Acting Chair of the Commission shortly after his inauguration.[87] As these facts indicate, it should be expected that vertical merger enforcement will be significantly reinvigorated under the Biden Administration. Health care almost certainly will be caught up in these changes.[88]

Postscript: Subsequent to the submission of this article, in June of 2021, the Senate confirmed Columbia University law professor Lina Khan to fill the vacant Commissioner seat on the FTC. Immediately upon her confirmation, President Biden named Ms. Khan the FTC Chair. The new Chair is a noted critic of the Chicago School and modern antitrust enforcement policy toward Amazon and other large economic actors. See her publication *Amazon's Antitrust Paradox*, cited at note 13.

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[87]Press Release, "FTC Commissioner Rebecca Kelly Slaughter Designated Acting Chair of the Agency" (FTC Jan. 21, 2021), https://www.ftc.gov/news-events/press-releases/2021/01/ftc-commissioner-rebecca-kelly-slaughter-designated-acting-chair.

[88]In that regard, as part of the FTC Bureau of Economics' ongoing merger retrospective program, the FTC announced in early 2021 that it had issued orders to six major health insurance companies to provide information that will allow the agency to assess the impact on the functioning of health care markets of "physician consolidation during this period [2015-2020], including physician practice mergers and hospital acquisitions of physician practices." Press Release, "FTC to Study the Impact of Physician Group and Healthcare Facility Mergers" (Jan. 14, 2021), https://www.ftc.gov/news-events/press-releases/2021/01/ftc-study-impact-physician-group-healthcare-facility-mergers.