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### III

## ALIGNMENT

### Chapter 6

## **Centrality, Competition, and Health Reform: Hospital-Physician Integration and the Antitrust Laws<sup>1</sup>**

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<sup>1</sup>“The tension between centrality, on the one hand, and competition, on the other, is probably the oldest of all market structure issues.”—Arthur Levitt, former Chairman of the U.S. Securities and Exchange Commission.

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## § 6:1 Introduction and background

As strategies evolve in response to the Affordable Care Act and the more generic interest in “health reform,” increasing provider consolidation has become a definable trend. Beyond the sustained impetus for hospital mergers, acquisitions, and affiliations, this trend includes a significant uptick in strategies to align physicians with hospitals and health systems, whether accomplished by direct employment, acquisition of existing clinics and practices, or looser affiliation and joint venture models. Historically, most physician alignment activity has flown below the antitrust radar (with the exception of a relative handful of physician-hospital organization (PHO) enforcement matters). For example, the omnibus report on competition in health care issued by the Federal Trade Commission (FTC) and the Department of Justice (DOJ) in 2004<sup>1</sup> contains no discussion (beyond PHOs) of vertical integration between hospitals and physicians.

However, consolidation in physician services markets is now drawing significant attention from federal and state antitrust regulators. For example:

- In 2011, the FTC and the Attorney General of Washington closed an investigation of the acquisition of two cardiology practices in Spokane by Providence Health & Services (the largest provider of hospital services in that city), indicating concerns that the transactions would violate section 7 of the Clayton Act and section 5

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### [Section 6:1]

<sup>1</sup>U.S. Department of Justice and Federal Trade Commission, *Improving Health Care: A Dose of Competition* (July 2004). In this chapter, the FTC and DOJ are sometimes referred to collectively as “the Agencies.”

of the FTC Act. The investigation closed when the transactions were abandoned.<sup>2</sup>

- In late 2012, the FTC announced a consent settlement with Renown Health in Reno, Nevada, concerning that system's acquisition of two cardiology practices. The FTC alleged that the consolidation of the two competing cardiology practices under Renown Health violated section 7 by eliminating competition and increasing the bargaining power of Renown in relation to its payors, resulting in the potential to increase prices.<sup>3</sup>
- Also in 2012, reports surfaced that the California Attorney General had initiated a wide-ranging investigation into the question of whether increasing consolidation among hospitals and physician groups is driving higher prices for medical care. The Attorney General reportedly issued subpoenas to a number of large hospital systems in the state, as well as to major health insurers.<sup>4</sup>
- An antitrust lawsuit filed by St. Alphonsus Regional Medical Center in Boise, Idaho, pending at the end of 2012, alleges that the proposed acquisition of a large physician practice by its competitor, St. Luke's Health System, will create an unlawful monopoly in the adult primary care market and foreclose competition for hospital admissions.<sup>5</sup> The transaction reportedly is under investigation by the FTC and the Idaho Attorney General as well.<sup>6</sup>

Providers are quick to note the apparent tension between the delivery reform objectives of the Affordable Care Act and the impediments to consolidation posed by the antitrust

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<sup>2</sup>*Providence Health & Services / Spokane Cardiology and Hearts Clinic Northwest*, File No. 101 1091 (FTC Apr. 8, 2011).

<sup>3</sup>*In re Renown Health*, Docket No. C-4366 (FTC Nov. 30, 2012).

<sup>4</sup>Mathews, A., "Doctor, Hospital Deals Probed" *Wall Street Journal* (Sept. 14, 2012) at B1.

<sup>5</sup>*St. Alphonsus Medical Center—Nampa, et. al v. St. Luke's Health System, Ltd.*, No. 1:12-cv-00560 (D. Idaho, complaint filed Nov. 12, 2012).

<sup>6</sup>Dutton, A., "St. Luke's Targets Saltzer Despite Antitrust Inquiry," *Idaho Statesman* (Aug. 16, 2012).

laws.<sup>7</sup> But the antitrust enforcement agencies maintain that the protection of competition is not antithetical to effective health care reform. In a statement issued in conjunction with the closing of the Providence Health & Services investigation, the Director of the FTC's Bureau of Competition stated:<sup>8</sup>

The Bureau of Competition recognizes that physicians across the country are exploring a variety of new business arrangements as part of an effort to achieve cost containment and quality objectives. Some of the new business arrangements include consolidating with other same-specialty or multi-specialty physician groups, entering into employment arrangements with hospitals, and forming other affiliations. Such arrangements have the potential to generate cost savings and quality benefits for patients. However, in some cases, such arrangements can create highly concentrated markets that may harm consumers through higher prices or lower quality of care. As is reflected by this investigation and its resolution, the Commission will aggressively enforce the antitrust laws to ensure that consolidation among health care providers will not increase health care costs in local communities across the United States

It is true that no provision of the Affordable Care Act (ACA) mandates provider consolidation, and the Accountable Care Organizations (ACOs) contemplated by the Act can be formed contractually. But the question that persists is whether cooperation without consolidation will lead to meaningful and effective results. For example, MIT economics professor Jonathan Gruber has noted that the ACA “probably does [encourage consolidation], in the sense that the idea of the law is to move toward more integrated care and more bundled care, and that happens more naturally in consolidated entities.”<sup>9</sup> Moreover, the federal fraud and abuse regulations pose significant legal risks for hospitals working with nonemployed physicians, and pending federal

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<sup>7</sup>Carlson, J., “Pulled in Two Directions: Providers Pursuing Coordinated Care Confused by Antitrust Actions,” *Modern Healthcare* (Dec. 17, 2012).

<sup>8</sup>Statement of Bureau of Competition Director Richard Feinstein on the Abandonment by Providence Health & Services of its Plan to Acquire Spokane Cardiology and Heart Clinics Northwest in Spokane, Washington (Mar. 21, 2011).

<sup>9</sup>Carlson, “Pulled in Two Directions: Providers Pursuing Coordinated Care Confused by Antitrust Actions.”

payment reductions create significant incentives to consolidate operations in ways that will reduce costs.

Thus, it is hardly surprising that interest is high in understanding how providers can pursue new organizational structures within the confines of the antitrust laws. However, the antitrust posture of hospital-physician alignment is more complex than hospital mergers, and neither providers nor the regulators are facing the market with an entirely clear picture of how antitrust challenges to those strategies may fare.

### § 6:2 Introduction and background—The trend toward physician employment by hospitals

In many respects, health reform is just an overlay on economic forces and trends that have been driving physician employment models for at least the last decade. According to the Advisory Board, physician employment by hospitals has increased 34% (about four-fold) since 2000, with about 25% of all active physicians now employed by hospitals and health systems.<sup>1</sup> The growth in hospital employment appears to be equally strong with respect to both specialists and primary care physicians (PCPs).

In part, this trend is attributed to the fact that physician reimbursement rates have lagged the increasing costs of private practice. Increasing physician practice costs are being driven by the complexity and burden of managing third party payment rules, the need to acquire health information technology, and the continuing high cost of medical malpractice insurance—all problems that can be offloaded to a hospital employer. PCPs are particularly affected by increasing costs because, unlike specialists, they typically do not generate significant additional income from procedures and ancillary services.

In addition, physicians increasingly are prioritizing work-life balance over the independence of private practice. Indeed, for new physicians, the perceived financial security and work-life balance of employment is a documented influence on their practice choices. In a 2003 survey, just 4% of

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#### [Section 6:2]

<sup>1</sup>The Advisory Board Company, “Physician Employment at Hospitals Jumps 34% in a Decade,” *The Daily Briefing* (Jan. 26, 2012).

senior medical residents stated they would be “most open” to hospital employment; four years later, that figure had risen to nearly 22%.<sup>2</sup>

Hospital interest in employing physicians likewise has increased in a changing marketplace. Physicians have become less reliant on hospitals and more directly competitive as improved medical technology permits more services to be performed in freestanding outpatient settings. Many hospitals also have seen a declining willingness among physicians to take emergency call as their ties to hospitals have attenuated. Physician employment has become a strategy to at least protect, if not grow, market share in economically essential service lines, such as cardiac, orthopedic, and cancer care. Hospitals also have turned to employed hospitalists to better manage inpatient services. Employment of specialists, in turn, has fueled interest in employment of PCPs—in order to better ensure a source of referrals for the employed specialists.

### § 6:3 Introduction and background—The impact of health reform on consolidation

Under the rubric of health reform, additional emphasis has been given to population health management and the need to improve quality and efficiency through clinical integration across care settings. Beyond Medicare’s Accountable Care Organizations, more private third party payors are testing and implementing bundled payment arrangements, shared savings programs, and financial penalties for inappropriate care (*e.g.*, preventable hospital readmissions). For hospitals—many of which have already have experimented with the looser and often unsatisfactory structures of a PHO—employment of a critical mass of PCPs and selected specialists is seen as an essential element of achieving economic alignment and driving success in a performance-based payment environment.

More specifically, health reform is expected to have three major effects on the operations of health care providers and the relationships between hospitals and physicians:

*Decreasing revenues.* Health reform (combined with

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<sup>2</sup>Merritt Hawkins and Associates, 2008 Survey of Final Year Medical Residents (2008).

continuing federal budgetary pressures) seems certain to produce stagnant or decreased payment rates, which will force providers to find new ways to reduce overhead and increase negotiating advantages with suppliers and payors. The Affordable Care Act creates a value-based purchasing program, which rewards hospitals that exceed quality measures and penalizes underperformers with payment cuts. Many commercial payers are pursuing similar models.

Health systems expect to compete more effectively in this environment by increasing their critical operating mass. Larger systems can spread fixed costs over a broader revenue base and allow better-performing operations to subsidize operations that are weaker in terms of performance and/or profitability. Larger systems also have more stable and affordable access to capital. And importantly, larger systems expect to have the critical mass required to fund the development and implementation of information systems that can measure quality—an essential criterion for success under emerging payment models.

*Increasing costs.* Reform also is anticipated to exert upward cost pressure on provider operations. Beyond increasing compliance costs, technology expenditures are increasing as both clinical and operational systems are put in place to better manage patient care.

*Integration.* Health reform is designed to foster and reward greater clinical integration through promotion of the ACO model under the Medicare Shared Savings Program and “medical home” or capitated payment models. Given the higher level of sophistication required to develop and manage ACOs, larger systems and those with more resources are perceived to be more likely to succeed under these requirements.

In this context, being “larger” is not just a matter of size but also a question of providing a comprehensive scope of services under consistent financial incentives. Thus, the trend toward integration of physician practices into hospital and health system operations—and the tension with the antitrust laws—will persist.

#### **§ 6:4 Antitrust challenges for integration**

The types of antitrust questions that the current environment presents are many. First and foremost are formational

issues that must be addressed regardless of whether integration is undertaken contractually or by “acquisition.” But antitrust issues also exist in the operations of larger and more comprehensively integrated systems as well. Ultimately, the most persistent question will be whether integrated systems will be able to demonstrate the efficiencies that providers anticipate and that antitrust analysis often requires.

### § 6:5 Antitrust challenges for integration— Contractual integration models

There are several strategies a health system may pursue to align with physicians short of “acquisition.” These include targeted, one-off clinical comanagement arrangements and service line joint ventures.<sup>1</sup> The more comprehensive nonacquisition strategy is the development of an “accountable care organization” based on contractual alignment through a network that undertakes to manage care delivery and, perhaps, accept financial risk. Like the PHOs (physician-hospital organizations) that came before them, there is no single model that describes an ACO. However, many ACOs—perhaps the majority at this time—can be described as contractually based federations of one or more hospitals (and the physicians employed by those hospitals) and independent community-based physicians.

Although an ACO arguably is a more comprehensive form of PHO, the antitrust issues are fundamentally the same. The underlying agreements between the otherwise-independent (*i.e.*, competing) providers and the ACO, and the joint contracting by providers through the ACO, are subject to challenge as *per se* unlawful price-fixing and/or market division agreements under section 1 of the Sherman Act unless the ACO evidences sufficient financial risk-sharing or clinical integration (or both) among the participants. If so, the ACO’s activities will be judged under the rule of reason. The rule of reason is a facts-and-circumstances analysis in which the fundamental issue is the network’s actual or likely ability to raise prices, reduce

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#### [Section 6:5]

<sup>1</sup>Antitrust issues can and do arise in such arrangements, but those issues are beyond the scope of this chapter.



or limit quality, or restrict access to services. These adverse effects generally are presumed to flow from excessive “market power” and may be attenuated by the network’s ability to improve the efficiency with which services are delivered—that is, to deliver a higher quality and/or lower-priced package of services.

For purposes of the Medicare Shared Savings Program (SSP), the DOJ and FTC jointly developed antitrust enforcement guidance for ACOs, defining both a “safe harbor” for ACO composition, as well as types of collaborative conduct that the Agencies consider potentially anticompetitive.<sup>2</sup> The Policy Statement applies only to ACOs that are formed as collaborations (but not mergers) among otherwise independent providers and provider groups and that are eligible and intend to participate (or have been approved for participation) in the SSP. The true focus of the Policy Statement, however, is ACOs that also intend to contract with commercial health insurance plans.<sup>3</sup> ACOs that meet the SSP regulatory requirements for governance, leadership structure, and clinical and administrative processes are presumed by the Agencies to be clinically integrated, and accordingly, their activities are evaluated for antitrust purposes under the rule of reason.<sup>4</sup>

In order to assess the antitrust risks of an ACO, the Policy Statement establishes a rubric that, first, adopts simplifying assumptions for defining the relevant product and geographic markets in which to assess competitive effects and, second,

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<sup>2</sup>*Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*, 76 Fed. Reg. 67026 (Oct. 28, 2011) (the “Policy Statement”).

<sup>3</sup>Although not expressly discussed in the Policy Statement, the Agencies appear to accept the premise that fee-for-service Medicare is not a competitive market (*i.e.*, because prices are governmentally regulated), and therefore, significant antitrust concerns about provider collaborations do not arise with respect to traditional Medicare.

<sup>4</sup>Policy Statement, § III. This premise, of course, provides little help for non-Medicare ACOs, which do not necessarily operate under the same structures and procedures required for the Medicare SSP. The Policy Statement is not clear as to what attributes of the Medicare regulatory requirements the Agencies find most compelling for their conclusion that Medicare ACOs are clinically integrated. However, the Agencies’ guidance on clinical integration has always been vague, in part because their mission is law enforcement not regulation. Outside of Medicare, the question of how much clinical integration is enough has no definitive answer.

divides the universe of ACOs into two levels of concern based principally on market share. The Policy Statement relies on Medicare payment methodology to define product markets—that is, a physician’s “product market” is defined by the Medicare Specialty Code (MSC) for the physician’s practice, outpatient “products” are classified by outpatient service categories as defined by Medicare, and inpatient “products” are defined by Major Diagnostic Category (MDC).<sup>5</sup> Geographic markets are defined by each provider’s “primary service area” (PSA), defined by the contiguous zip codes from which the provider obtains 75% of its patients.

An ACO falls into the Agencies’ “safety zone”—and therefore presumptively presents no antitrust risks—if it meets three criteria, and there are no “extraordinary circumstances”: (1) the ACO participants in combination do not provide than 30% of any relevant service (product) in any single ACO provider’s PSA, subject to certain defined (and limited) exceptions for providers in rural areas; (2) no hospital or ambulatory surgery center (ASC) participating in the ACO is exclusive to the ACO; and (3) if the ACO includes a “dominant provider” (one with more than a 50% market share of any service that no other ACO participant provides), the dominant provider does not have an exclusive relationship with the ACO, and the ACO does not restrict any payor’s ability to contract with other networks (through an exclusivity clause or otherwise).<sup>6</sup>

For ACOs that do not meet the safety zone requirements, the Policy Statement acknowledges that such entities may nonetheless be procompetitive and lawful but identifies five categories of conduct (“suspect categories”) that the Agencies believe would be indicative of competitive concerns: (1) preventing or discouraging commercial payers from directing or incentivizing patients to choose certain providers (*e.g.*, “anti-steering” clauses in payor contracts); (2) tying sales (either explicitly or implicitly through pricing policies) of the ACO’s services to the commercial payer’s purchase of other services from providers outside the ACO (or vice versa); (3) contracting with physician specialists, hospitals, ASCs, or other providers (but not primary care physicians) on an

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<sup>5</sup>This methodology is described in the Appendix to the Policy Statement.

<sup>6</sup>Policy Statement, § IV.A.

exclusive basis; (4) restricting a commercial payer's ability to make provider cost, quality, efficiency, and performance information available to its enrollees; and (5) sharing competitively sensitive pricing or similar information among the ACO's provider participants that could be used to fix or stabilize prices or other terms for services provided outside the ACO.<sup>7</sup>

Like all regulatory safe harbors, the Policy Statement's safety zone is conservative and therefore unlikely to be helpful in many cases. However, the commentary on suspect behavior raises some thorny questions with broader impact. Within the categories of suspect behavior, there is a considerable amount of "gray area" not acknowledged by the Agencies. This is significant because several of the five categories recur frequently in provider-payor contract negotiations, notably with respect to the collection and dissemination of provider performance data and in regard to the imposition by payors of limited provider networks.

The Agencies understandably would like to assure that consumers have relevant information relating to ACO providers as market information is a foundation of competition. To that end, the Agencies state that "[r]estricting a commercial payer's ability to make available to its health plan enrollees cost, quality, efficiency, and performance information to aid enrollees in evaluating and selecting providers in the health plan . . ." is likely to present competitive concerns. With some reason, however, providers have an abiding anxiety over the way in which commercial payors collect, process, and present provider performance data. To the extent that the Agencies are suggesting that an ACO could not refuse to contract with a payor that would not agree to objectively reasonable criteria to govern the data collection and reporting process, that would appear to be an unreasonable, and even counter-productive, position.

The Agencies also state that competitive concerns will be presented if an ACO "prevent[s] or discourag[es] commercial payers from directing or incentivizing patients to choose certain providers, including providers that do not participate in the ACO, through 'anti-steering,' 'guaranteed inclusion,' 'product participation,' 'price parity,' or similar contractual

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<sup>7</sup>Policy Statement, § IV.B.1.

clauses or provisions.” Again, it is by no means clear that it is always or even generally anticompetitive for a provider network to require contractual assurance against arbitrary or capricious exclusion from commercial networks.

Finally, many public comments on the Policy Statement challenged the Agencies’ negative outlook on exclusivity. Exclusivity is treated negatively both in the safety zone and in the identification of suspect categories of behavior. It may be argued, however, that the presumption against provider exclusivity, especially hospital exclusivity, is too rigid. For example, it is expected that most ACOs will be formed around hospitals and that hospitals will make significant investments in the formation and operation of the networks. Effectively requiring a hospital to participate in a competing ACO is therefore a deterrent to making the investment in the first place and certainly would deprive the ACO (and the public) of the benefits of competition between ACOs. Indeed, exclusivity can promote efficiency in terms of care coordination and resource alignment.

Further, there is a logical distinction—not made in the Policy Statement—between requirements that a provider contract exclusively with a particular ACO (and not participate in other ACOs) and requirements that a provider contract with *payors* only through the ACO (and not contract with any payor outside of the ACO). The former circumstance rarely presents a competitive concern in the absence of the second, and thus, it makes no sense to focus on the former as a disqualifying factor.<sup>8</sup>

Viewed more broadly, the question that hovers over contractually based ACO models is whether they are sustainable models for meaningful cost reduction and, in particular, whether a contractual ACO can bring enough change to health care delivery soon enough to respond to Medicare payment reductions scheduled to begin in 2014.

Long-term savings is dependent in part on rationalizing investment. But since physicians (particularly specialists) often are in competition with hospitals (as well as with each other), there is a form of “prisoner’s dilemma” that under-

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<sup>8</sup>See comments on the Policy Statement submitted by the American Bar Association Sections of Antitrust and Health Law (May 31, 2011) and by John J. Miles, Esq. (May 31, 2011), both available at [www.ftc.gov/os/comments/aco-comments/index.shtm](http://www.ftc.gov/os/comments/aco-comments/index.shtm).

mines the rationality of the economic choices that independent physicians could be expected to make in a situation where their cooperation with a hospital—and the hospital’s cooperation with them—hinges on a temporal contract.<sup>9</sup> For example, if a hospital and a multispecialty medical practice both operate ambulatory surgery facilities with excess capacity, they might well maximize their collective return (income) in an ACO/shared savings environment by closing one and consolidating operations. However, if the ACO relationship were to terminate subsequently, the party that agreed to close its ASC would be competitively disadvantaged going forward.

The uncertainty and potential instability of a cooperative model among independent parties is causing many health care systems, and some physicians, to prefer a model in which physicians are part of the same health care system as the hospital—either through direct employment or through a captive professional corporation.

#### **§ 6:6 Antitrust challenges for integration— Acquisition and employment models**

Formal corporate alignments of physicians and hospitals, in which physicians are employed by a hospital or by an entity that is owned by or in common with a hospital, potentially can be challenged under both the section 7 of the Clayton Act and sections 1 and 2 of the Sherman Act, but each provision presents somewhat different issues and challenges.

Section 7 of the Clayton Act is the principal antimerger enforcement tool in the federal statutory lineup. Section 7 prohibits mergers and acquisitions that “may” reduce compe-

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<sup>9</sup>The “prisoner’s dilemma” is a theoretical game illustrating that two persons may not cooperate with each other even if it is in their interests to do so. The premise of the game is that each person has a potentially greater reward from not cooperating with the other person than from cooperating—but *only if* the other person (without knowing what the first person will do) chooses to cooperate—and each faces a penalty if neither person elects to cooperate. Game theory suggests that the uncertainty of the risks and rewards in this situation usually results in noncooperation emerging as the dominant strategy for both players.

tition in any line of commerce.<sup>1</sup> The standard is predictive—proof of actual anticompetitive consequences is not required. In the usual case, an acquisition is considered likely to reduce competition if it would result in the concentration of significant market share in a small number of firms. The level of market share that would be “significant” depends to some degree on the characteristics of the specific affected market—notably whether there are barriers to entry of new competitors within a reasonable period of time (generally considered to be one to two years).

A merger or acquisition resulting in a presumptively anticompetitive increase in market concentration may be defended on certain, relatively limited grounds. Principally, defenses fall into two categories. One is that historical market shares are not good predictors of future competition or the competitive consequences of the merger/acquisition, *e.g.*, because the acquired party is financially distressed or otherwise has uncertain prospects, because competition is demonstrably vigorous despite market concentration, or because it is easy and feasible for new competitors to enter the market at any time, and that new entry is in fact predictable in the event of a postacquisition price increase. Alternatively, a merger or acquisition may be defended on grounds that the combination will create efficiency benefits that are both (i) unobtainable in the absence of the merger or acquisition and (ii) are of sufficient magnitude to negate concerns about postmerger/acquisition price increases or output reductions. The latter defense tends to be disfavored by the Agencies in part because it is premised on the argument that the benefits of an acquisition outweigh the harm, as opposed to a defense based on market definition and concentration, which is premised on the argument that no harm will occur in the first place.<sup>2</sup>

As an antimonopoly tool, section 7 is most commonly used

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**[Section 6:6]**

<sup>1</sup>15 U.S.C. § 18.

<sup>2</sup>The Agencies’ skepticism concerning efficiency defenses in the context of the 2010 revision of the Merger Guidelines was discussed by this author in the 2011 edition of the *Health Law Handbook*. See McCann, “Collaboration Without Sin?—Health Care Mergers, Joint Ventures, and the Changing Antitrust Landscape” § 13:9 *Health Law Handbook* (A. Gosfield, ed. 2011).

prophylactically—to enjoin questionable transactions prior to their consummation or, in some cases, within a relatively short time thereafter. However, the statute itself contains no temporal limits. In 1957, the U.S. Supreme Court ruled that a challenge brought in 1949 to a stock acquisition that occurred between 1917 and 1919 could proceed under section 7.<sup>3</sup> The Court ruled that a section 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 or tend to create a monopoly of a line of commerce.”<sup>4</sup>

The corollary of this ruling is that evidence of postacquisition anticompetitive behavior can be relied upon to establish a section 7 violation.<sup>5</sup> As the Supreme Court later observed, the comparatively limited weight given in merger investigations to the *absence* of adverse postacquisition effects under section 7 gives the Agencies a “heads-I-win, tails-you-lose” advantage over a section 7 defendant.<sup>6</sup>

The consolidation of physician services under the umbrella of a hospital-based health system may pose “horizontal” competition issues, “vertical” competition issues, or both. Horizontal issues pertain to the potential reduction in competition resulting from the acquiring system controlling a high percentage of the supply of services in a particular medical specialty, as might occur, for example, if a system serially acquired a large number of the orthopedic surgical practices

<sup>3</sup>U.S. v. E. I. du Pont de Nemours & Co., 353 U.S. 586, 597, 77 S. Ct. 872, 1 L. Ed. 2d 1057 (1957).

<sup>4</sup>*United States v. E.I du Pont de Nemours Co.*, 353 U. S. at 597.

<sup>5</sup>U. S. v. General Dynamics Corp., 415 U.S. 486, 94 S. Ct. 1186, 39 L. Ed. 2d 530, 1974-1 Trade Cas. (CCH) ¶ 74967 (1974). In 2004, the FTC challenged the 2000 acquisition of Highland Park Hospital by Evanston Northwestern Healthcare Corporation (ENH), alleging that the acquisition resulted in excessive price increases to health plans in the suburban Chicago market. In re Evanston Northwestern Healthcare, No. 9315 (FTC Aug 6, 2007). The FTC’s case relied on evidence showing that postmerger price increases at ENH exceeded those of Chicago-area hospitals and comparable hospitals in other locations. The FTC also alleged that ENH was successful in forcing payors to accept price increases by requiring payors to contracts with the ENH network, including its employed physicians, on an all-or-nothing basis.

<sup>6</sup>*U. S. v. General Dynamics* 415 U. S. at 504 n. 13. (“The mere nonoccurrence of anticompetitive effects from a merger would, of course, merely postpone rather than preclude a divestiture suit.”)

in its service area. Vertical issues arise from the combination of two distinct but related lines of business (hospital services and physician services) in a single firm.

**§ 6:7 Antitrust challenges for integration—  
Acquisition and employment models—  
Horizontal combinations of physician practices**

Consolidation in the physician services market predates and is independent of health reform. Particularly in smaller and mid-sized metropolitan areas, it is not unusual to find physicians in a particular specialty concentrated in a small number of large groups and often in a single group. Larger groups are economically rational—they spread overhead costs over a larger revenue base, facilitate more efficient scheduling and call coverage, and may improve leverage in negotiations with third party payors.

The acquisition of one specialty group by a hospital that does not already employ physicians in that specialty by definition raises no horizontal antitrust issues. In that case, the hospital and the group are not competitors, and the acquisition is simply the substitution of one owner for another. However, as the hospital “acquires” more physicians in the same specialty, horizontal competition issues may be present, and the analysis is the same as for any merger or acquisition.

*Has an acquisition occurred?* If a hospital posted a “help wanted” sign and every cardiologist in town signed up to be employed by the hospital, the hospital would have obtained a monopoly in cardiology services, but there would have been no “acquisition” subject to the Clayton Act. Indeed, it is not uncommon for arrangements between physicians and hospitals to involve no acquisition of the stock or material assets of a physician’s existing practice. Rather, the existing practice continues to be owned by the physician as it is wound down and dissolved, with the physician entering only into an employment agreement with the hospital.

Employment relationships, in and of themselves, cannot give rise to a violation of the Clayton Act or section 1 of the Sherman Act because “[t]he labor of a human being is not a commodity or article of commerce” for purposes of the



antitrust laws.<sup>1</sup> Employment agreements may be challenged only collaterally under the antitrust laws, *e.g.*, with respect to the enforcement of exclusivity clauses or non-competition covenants.

*Market power and foreclosure.* Assuming that a hospital has gained a significant share of a particular physician services market through acquisitions that could be challenged under the Clayton Act (or the Sherman Act), the question is then whether the consequence of the acquisitions is a present or likely future reduction in competition in the relevant market. More serious foreclosure issues may arise with the formation of a group with high market share in specialties such as orthopedics, urology, and cardiology, which essentially have the ability to control access to a specific category of service within a market.

Nonetheless, in the market for physician services, market power and foreclosure can be a very different analysis from the analysis of, *e.g.*, a hospital merger, particularly with respect to the potential for new competitors (physicians) to enter the market successfully (whether by independent entry or through recruitment by a competing hospital). The prospect of a competitive response to market consolidation through new entry is a significant defense to an antitrust challenge. The federal Merger Guidelines state the defense as follows:<sup>2</sup>

A merger is not likely to enhance market power if entry into the market is so easy that the merged firm and its remaining rivals in the market, either unilaterally or collectively, could not profitably raise price or otherwise reduce competition compared to the level that would prevail in the absence of the merger. Entry is that easy if entry would be timely, likely, and sufficient in its magnitude, character, and scope to deter or counteract the competitive effects of concern

Structural barriers to entry in a typical physician services market are low, and one might posit that this fact is one of

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**[Section 6:7]**

<sup>1</sup>Clayton Act § 6, 15 U.S.C. § 17. This section was enacted to immunize labor unions from antitrust scrutiny, but the declaratory effect of the first sentence of § 6 is to bar any antitrust claim based on the existence of an employment relationship.

<sup>2</sup>Merger Guidelines § 9.

the principal reasons that enforcement actions against physician practice mergers historically have been few and far between. The establishment of a new medical practice ordinarily requires neither extensive capital investment nor significant time. It is not difficult for a physician who is licensed in one jurisdiction to become licensed in another. Thus, whether new entry (or the prospect of new entry) will deter anticompetitive conduct in a particular case is likely to focus on whether the hospital that has consolidated the particular specialty can subsequently influence the likelihood of successful and sufficient entry. For example:

- Would a physician have to obtain privileges from the hospital in question in order to compete with the hospital's employed physicians, and, if so, is there reason to believe that those privileges would not be available?
- Does the hospital control a high percentage of the referral sources that a new physician would require? For example, if the specialty in question is cardiac surgery, does the hospital also employ a high percentage of the cardiologists in the market?
- Is there sufficient demand for the specialty in question for a new physician to have a reasonable likelihood of being economically successful? For example, if the market demographics indicate a need for 10 specialists and there are 12 in the market already, there would be reason to doubt that a new entrant could be successful.
- Do the hospital's payor contracts contain provisions that would incentivize payors not to contract with new physicians in the market?

Analysis of the effects of physician concentration also may present interesting market definition questions. Notwithstanding the over-simplifying assumptions of the Policy Statement, from a "product" market perspective, the boundaries of specialty practice are not always rigid, and an assessment of competitive effects often may require consideration of the extent to which competition occurs across specialties as well as within specialties. For example, both orthopedic surgeons and neurosurgeons perform spinal surgery. From a geographic standpoint, one might expect—as with the related hospital services—that physicians providing more esoteric services may compete across a larger geographic area than PCPs, for example.

**§ 6:8 Antitrust challenges for integration—  
Acquisition and employment models—Vertical  
merger analysis**

The more interesting and current issue in hospital-physician consolidation is the potential reinvigoration of vertical merger challenges. A vertical combination is one between firms at different levels in the chain of production, *e.g.*, a hospital and a physician practice. Such combinations are of antitrust concern due to the potential leveraging effects that are created by owning (and having strength in) multiple levels of production (*e.g.*, hospitals, physicians, ambulatory care, etc.). In a merger or acquisition context, these issues need not rise to the level of “predatory conduct” or “tying” in order to raise potential antitrust issues. Rather, the Clayton Act requires only proof that an acquisition is more likely than not to have anticompetitive effects.

Federal antitrust enforcement policy views the potential creation of entry barriers for new competitors as the principal competitive problem in vertical mergers and acquisitions.<sup>1</sup> Judicial decisions, by comparison, tend to focus on the related but different concern of the extent to which a vertical acquisition forecloses competitors from either a source of supply or an outlet for their products.<sup>2</sup> In context, this refers to the percentage of the relevant physician services market foreclosed to competing hospitals by the acquisition. As most vertical merger cases are old, the percentage of foreclosure necessary to raise a competitive concern is unclear. However, analogy to exclusive contracting cases would suggest that foreclosure of less than 40% of

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**[Section 6:8]**

<sup>1</sup>See U.S. Department of Justice, *Non-Horizontal Merger Guidelines* (1984) at § 4.2, stating the relevant analysis as whether (1) the degree of vertical integration between the two markets is so extensive that entrants to the primary market also would have to enter the secondary market simultaneously; (2) the requirement of entry at the secondary level must make entry at the primary level significantly more difficult and less likely to occur; and (3) the primary market is concentrated or otherwise unlikely to remain competitive following the merger.

<sup>2</sup>See, *e.g.*, *HTI Health Services, Inc. v. Quorum Health Group, Inc.*, 960 F. Supp. 1104, 1997-2 Trade Cas. (CCH) ¶ 71889 (S.D. Miss. 1997) (“It is well established that the primary vice of a vertical merger is foreclosing a competitor from a key source of supply that, absent the merger, would otherwise be open to it”).

the market may not be enough to raise a presumptive antitrust question.<sup>3</sup> However, the duration of the foreclosure also is relevant as courts have tolerated greater foreclosure in exclusive contracts of short duration or that are easily terminable and occasionally have condemned contracts involving a lesser degree of foreclosure if their actual term or practical duration is long.<sup>4</sup>

In context, if hospitals require access to specific physician (referral) services in order to compete effectively as hospitals, and if the specialist supply is constrained by extensive vertical integration (*i.e.*, because one hospital “owns” the physician supply), then further acquisitions of physician specialty practices not only will make it more difficult for any new firm to enter the market but may effectively deprive other hospitals already in the market of resources required to remain competitive. In the context of, *e.g.*, physician-hospital organizations, the Agencies also have expressed concern with the ability of an organization that controls a significant proportion of both hospital and physician services to exert leverage against payors who need to purchase services in both markets.<sup>5</sup>

Thus, as a hospital system acquires physician practices, antitrust concerns will be driven by the facts that physician services are licensed and professional in nature and therefore cannot be easily replicated or replaced, and physicians influence or control the demand for (*i.e.*, admit patients to) hospitals, and thus, control of the physician supply may enhance hospital market power.

But as to any particular acquisition, the following questions are likely to be relevant:

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<sup>3</sup>*See, e.g.*, Toys “R” Us, Inc. v. F.T.C., 221 F.3d 928, 2000-2 Trade Cas. (CCH) ¶ 72978 (7th Cir. 2000); Satellite Television & Associated Resources, Inc. v. Continental Cablevision of Virginia, Inc., 714 F.2d 351, 1983-2 Trade Cas. (CCH) ¶ 65541 (4th Cir. 1983); 11 Areeda & Hovenkamp, *Antitrust Law* ¶ 1821c (describing 20% as the floor for significant foreclosure and 50% as the level at which courts “routinely condemn” foreclosure).

<sup>4</sup>*E.g.*, Roland Machinery Co. v. Dresser Industries, Inc., 749 F.2d 380, 1984-2 Trade Cas. (CCH) ¶ 66175, 1985-1 Trade Cas. (CCH) ¶ 66329, 79 A.L.R. Fed. 1 (7th Cir. 1984) (holding that an exclusive agreement with a term of one year or less is presumptively lawful).

<sup>5</sup>*See* U.S. Dept. of Justice and Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care* (August, 1996) at 106–138.

- Is the market for hospital services competitively robust notwithstanding vertical acquisition activity?
- Is the supply of physicians in the relevant specialty limited, such that a competing hospital may not be positioned to recruit new physicians to the market?
- Do the terms of employment imposed by the hospital restrict the ability of employed physicians to practice at other hospitals, or restrict the ability of those physicians to remain in the market upon termination of employment?

The recent investigations and litigation described at the outset of this chapter all raise vertical merger issues insofar as they posit the foreclosure of hospital competition and the “leverage” that may be gained from physician integration. In this regard, several related legal questions bear discussion.

**§ 6:9 Antitrust challenges for integration—Related legal issues—Is section 2 implicated by vertical mergers?**

Section 2 of the Sherman Act contains express prohibitions on monopolization, attempted monopolization, and conspiracies to monopolize.<sup>1</sup> Although theoretically feasible, the practical usefulness of section 2 as an antimerger statute is quite limited. As interpreted by the courts, section 2 reaches only the acquisition and maintenance of monopoly power through conduct that is “predatory” or “unreasonably exclusionary” toward competitors or potential competitors.<sup>2</sup>

The concept of predatory conduct is generally understood to mean conduct that is (i) undertaken by a firm with monopoly power or substantial market power; (ii) that has (or threatens) significant harm to competitors (actual or potential) of the firm engaging in the conduct; and (iii) that

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**[Section 6:9]**

<sup>1</sup>15 U.S.C. § 2.

<sup>2</sup>Some courts use the term “exclusionary,” synonymously with “predatory.” However, the use of the former term can be misleading as even legitimate business behavior, if successful, has the effect of excluding rivals. Mere exclusion is not a basis for Sherman Act liability. Thus, the term “unreasonably exclusionary” also has been adopted to define prohibited conduct.

furthering none of the values that competition is deemed to promote (e.g., lower prices, higher output, greater efficiency).<sup>3</sup> That is, the conduct would not be rational in a more competitive market but becomes rational in light of the actor's market power and the consequent potential to impair or destroy competition.<sup>4</sup>

Further, in a section 2 case, the conduct in question almost always will be directed at competitors, not customers or suppliers. To the extent customers or suppliers may be affected by such conduct, it usually will be as part of an overall scheme to injure actual or potential competitors. Conduct directed only at customers or suppliers (i.e., and not affecting competitors) rarely forms the basis of a section 2 claim.<sup>5</sup>

It should be apparent that a vertical acquisition by a health system would rarely fit the paradigm of predatory conduct. However, some courts also have premised section 2 liability on “unreasonably exclusionary” conduct, distinct from predatory conduct. Unreasonably exclusionary conduct refers to behavior that prevents equally efficient firms from competing in the market. This theory would have more viability in a vertical merger context as it is somewhat analogous to the concern with preclusion under section 7. There is, however, judicial disagreement as to whether and to what

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<sup>3</sup>See Miles, J., *Health Care & Antitrust Law* § 5.4. The FTC has further suggested that a definition of predatory conduct should, in any given context, consider whether market factors (such as ease of, or barriers to, new entry) are likely to accentuate or attenuate the potential harmful effects. *Matter of International Telephone & Telegraph Corp.*, 104 F.T.C. 280, 1984 WL 565367 (1984).

<sup>4</sup>*U.S. v. Microsoft Corp.*, 253 F.3d 34, 2001-1 Trade Cas. (CCH) ¶ 73321 (D.C. Cir. 2001) (*per curiam*); *Neumann v. Reinforced Earth Co.*, 786 F.2d 424, 229 U.S.P.Q. 383, 1986-1 Trade Cas. (CCH) ¶ 67002 (D.C. Cir. 1986); *Matter of E. I. Dupont De Nemours & Co.*, 96 F.T.C. 653, 1980 WL 339053 (1980).

<sup>5</sup>Significantly in this context, courts are not fully in agreement on the weight to be given to a firm's procompetitive (efficiency) justifications for challenged conduct. That is, it is unclear whether proof of a legitimate business justification, in and of itself, will negate a finding of predatory conduct or whether, in the end, the competitive benefits and harms of the conduct must be balanced as in a section 1 rule-of-reason analysis. For example, in its *Microsoft* opinion, the D.C. Circuit inclined to the latter view. *U.S. v. Microsoft Corp.*, 253 F.3d 34, 59, 2001-1 Trade Cas. (CCH) ¶ 73321 (D.C. Cir. 2001) (*per curiam*).

extent section 2 reaches unreasonably exclusionary (non-predatory) conduct.<sup>6</sup>

Thus, section 2 ordinarily would not reach conduct that otherwise could not be challenged under section 7 of the Clayton Act. Nonetheless, section 2 issues could become relevant in a postacquisition environment, based on a health system's practices toward payors that may have detrimental impact on competitors (discussed below).

**§ 6:10 Antitrust challenges for integration—Related legal issues—Does the Clayton Act countenance monopoly leveraging?**

Monopoly leveraging is a once-popular Sherman Act theory based on the proposition that section 2, by implication, also prohibits a firm with substantial market power in one market from using its monopoly to gain only a “competitive advantage” (*i.e.*, something short of monopolization) in a second market.<sup>1</sup> The leveraging concern expressed in vertical merger cases is analogous insofar as one might argue that a

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<sup>6</sup>*Compare* *LePage’s Inc. v. 3M*, 324 F.3d 141, 2003-1 Trade Cas. (CCH) ¶ 73989, 61 Fed. R. Evid. Serv. 60 (3d Cir. 2003) (*en banc*) with *Cascade Health Solutions v. PeaceHealth*, 515 F.3d 883, 2008-1 Trade Cas. (CCH) ¶ 76030 (9th Cir. 2008), in light of the Supreme Court’s apparent holding in *Verizon Communications Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 124 S. Ct. 872, 157 L. Ed. 2d 823, 2004-1 Trade Cas. (CCH) ¶ 74241 (2004), that a sacrifice of profitability is a necessary condition for a section 2 claim.

**[Section 6:10]**

<sup>1</sup>Monopoly leveraging had its origin in the Second Circuit’s 1979 opinion in *Berkey Photo* and was later embraced by the Sixth Circuit. *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 1979-1 Trade Cas. (CCH) ¶ 62718, 53 A.L.R. Fed. 768 (2d Cir. 1979) (rejected by, *Alaska Airlines, Inc. v. United Airlines, Inc.*, 948 F.2d 536, 1991-2 Trade Cas. (CCH) ¶ 69624 (9th Cir. 1991)) and (rejected by, *General Cigar Holdings, Inc. v. Altadis, S.A.*, 205 F. Supp. 2d 1335, 2002-2 Trade Cas. (CCH) ¶ 73750 (S.D. Fla. 2002)); *Kerasotes Michigan Theatres, Inc. v. National Amusements, Inc.*, 854 F.2d 135, 1988-2 Trade Cas. (CCH) ¶ 68179, 11 Fed. R. Serv. 3d 1545 (6th Cir. 1988). Not all federal circuits embraced the theory, however. *See, e.g.*, *Fineman v. Armstrong World Industries, Inc.*, 980 F.2d 171, 1992-2 Trade Cas. (CCH) ¶ 70010, 24 Fed. R. Serv. 3d 162 (3d Cir. 1992); *Alaska Airlines, Inc. v. United Airlines, Inc.*, 948 F.2d 536, 1991-2 Trade Cas. (CCH) ¶ 69624 (9th Cir. 1991) (declining to extend section 2 liability to cases in which the defendant’s conduct did not threaten monopolization of the second market, reasoning that such an exception cannot be inferred from the literal proscriptions of section 2).

dominant health system, by acquiring a physician practice, may be able to extend its market power into the relevant physician services market.

However, monopoly leveraging as a section 2 theory was effectively quashed by the Supreme Court's decision in *Trinko*.<sup>2</sup> In a footnote to its opinion, the Court stated, "The Court of Appeals also thought that respondent's complaint might state a claim under a 'monopoly leveraging' theory . . . . We disagree. To the extent that the Court of Appeals dispensed with a requirement that there be a 'dangerous probability of success' in monopolizing a second market, it erred." Following this pronouncement, there is no realistic possibility that a section 2 monopoly leveraging claim, distinct from attempted monopolization, could be successfully pled or prosecuted.

However, the Clayton Act does not require proof of a dangerous probability of successful monopolization in any market. Rather, it requires only the probability of a lessening of competition. Thus, to the extent Clayton Act challenges to hospital-physician combinations express concerns about "leverage" gained by a dominant hospital in the physician services market, they may in effect be advancing a monopoly leveraging theory.

### § 6:11 Operational antitrust issues in an integrated system

As health systems grow and consolidate across levels of production, there are a number of antitrust concerns that become relevant, principally because conduct that may be lawfully be undertaken by a firm without market power can raise antitrust issues when undertaken by a firm with market power.<sup>1</sup>

If an integrated health system controls substantially all of the supply of a particular physician specialty, must it make

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<sup>2</sup>*Verizon Communications Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 124 S. Ct. 872, 157 L. Ed. 2d 823, 2004-1 Trade Cas. (CCH) ¶ 74241 (2004).

#### [Section 6:11]

<sup>1</sup>*See, e.g., Eastman Kodak Co. v. Image Technical Services, Inc.*, 504 U.S. 451, 112 S. Ct. 2072, 119 L. Ed. 2d 265, 1992-1 Trade Cas. (CCH) ¶ 69839 (1992).



that specialty available to competing hospitals or to payors? In the context of section 2, allegations of predatory conduct based on a refusal to deal usually entail a firm's refusal to deal with its competitors when the refusal impairs the competitors' ability to compete in a relevant market. These types of claims are difficult to maintain because the Supreme Court, as long ago as 1919 and as recently as 2004, affirmed that the Sherman Act generally imposes no duty on any firm (even a monopolist) to do business with any other firm.<sup>2</sup> The exceptions to this general rule fall in rather narrow categories, some of which appear to have been narrowed even further in recent decisions. These categories, each of which is discussed separately below, are as follows:

- General “predatory refusals to deal” with competitors.
- Denial of access to an “essential facility.”
- Use of market power to force or induce customers or suppliers not to deal with competitors (“tying” and “bundling”).
- Exclusive dealing requirements.

### § 6:12 Operational antitrust issues in an integrated system—Predatory refusals to deal

Until 2004, the 1984 decision in *Aspen Skiing*<sup>1</sup> constituted the principal guidance from the Supreme Court on predatory refusals to deal with a competitor. The case arose from a unilateral decision by the defendant, which controlled three of four skiing mountains in Aspen, Colorado, to discontinue a multiday ski lift ticket arrangement with the plaintiff (which controlled the smaller fourth mountain) unless the

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<sup>2</sup>U.S. v. Colgate & Co., 250 U.S. 300, 39 S. Ct. 465, 63 L. Ed. 992, 7 A.L.R. 443 (1919); Verizon Communications Inc. v. Law Offices of Curtis V. Trinko, LLP, 540 U.S. 398, 124 S. Ct. 872, 157 L. Ed. 2d 823, 2004-1 Trade Cas. (CCH) ¶ 74241 (2004); see also Surgical Care Center of Hammond, L.C. v. Hospital Service Dist. No. 1 of Tangipahoa Parish, 2001-1 Trade Cas. (CCH) ¶ 73215, 2001 WL 8586 (E.D. La. 2001), aff'd, 309 F.3d 836, 2002-2 Trade Cas. (CCH) ¶ 73830 (5th Cir. 2002) (hospital's refusal to enter into a transfer agreement with a competing ambulatory surgery center, which agreement was a legal necessity for licensure of the ASC, held not to be a violation of the Sherman Act).

#### [Section 6:12]

<sup>1</sup>Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. 585, 105 S. Ct. 2847, 86 L. Ed. 2d 467, 1985-2 Trade Cas. (CCH) ¶ 66653 (1985).

plaintiff agreed to accept a reduced share of the combined revenue. (The arrangement allowed skiers to ski any of the four mountains interchangeably.) This action ultimately led to the discontinuation of the multiarea ticket, and thereafter, the defendant refused to maintain any joint marketing relationship with the plaintiff, even one in which the plaintiff would buy the defendant's lift tickets at retail and sell them in a package.

The Court held that the defendant's conduct violated section 2. Although the Court's opinion is not particularly clear in expressing an economic theory of the case, it generally has been understood to say that a refusal to deal by a monopolist is predatory if three inter-related conditions are satisfied: (1) the motive for the refusal is to prevent competition in the relevant market, (2) the refusal has no efficiency justification (which, in effect, is the same thing as the first condition), and (3) the refusal to deal has the effect of maintaining or increasing the monopolist's power. Lower courts understandably have struggled with this approach in attempting to distinguish between predatory conduct and aggressive but legitimate competitive motives.<sup>2</sup>

However, in its more recent *Trinko* decision,<sup>3</sup> the Supreme Court significantly narrowed *Aspen Skiing*. The question in *Trinko* was whether Verizon violated section 2 of the Sherman Act by breaching its statutory obligation (under the Telecommunications Act of 1996) to make its telephone network available to competitors. (In this case, the competitor was AT&T, of which the plaintiff, Trinko was a customer.) Verizon's failure to make its network available to AT&T on reasonable terms was a noncontrovertible fact as Verizon

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<sup>2</sup>Courts have commented frequently (particularly in more recent cases) on the concern that over-extending the reach of section 2 (i.e., by failing to distinguish merely aggressive business conduct that may actually be procompetitive from predation) could chill innovation and risk-taking by firms with market power. Thus, courts tend to assign a heavy burden of proof to the plaintiff in a section 2 case to show that the challenged conduct is "more than unfair, impolite, or unethical." *Re/Max Intern., Inc. v. Realty One, Inc.*, 924 F. Supp. 1474, 1996-1 Trade Cas. (CCH) ¶ 71434, 44 Fed. R. Evid. Serv. 1001 (N.D. Ohio 1996), judgment aff'd in part, rev'd in part, 173 F.3d 995, 1999-1 Trade Cas. (CCH) ¶ 72488, 51 Fed. R. Evid. Serv. 1026, 1999 FED App. 0129P (6th Cir. 1999).

<sup>3</sup>*Verizon Communications Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 124 S. Ct. 872, 157 L. Ed. 2d 823, 2004-1 Trade Cas. (CCH) ¶ 74241 (2004).

previously had been found in violation of the Telecommunications Act requirement in a separate FCC administrative proceeding. Thus, the sole question was whether the same conduct could give rise to liability under section 2.

The Supreme Court held that the allegations regarding Verizon's conduct did not state a claim under section 2. In its opinion, the Court devoted considerable discussion to the risks inherent in forcing a lawful monopolist to share the monopoly with competitors. The Court observed that such forced sharing distorts the competitive incentive that the antitrust laws were designed to promote and also burdens the courts as potential arbiters of the terms under which sharing should occur. The Court cited (and reinvigorated) its 1919 holding in *Colgate* that the antitrust laws do not restrict the right of an entirely private business to exercise discretion as to the firms with which it will deal.

The *Trinko* court described *Aspen Skiing* as “at or near the boundary of Section 2 liability” and constituting a “limited exception” to the general rule that a firm has no duty to cooperate with competitors. The Court distinguished *Aspen Skiing* by stating that the anticompetitive nature of the conduct in that case was defined by three characteristics of the particular refusal to deal: (1) it involved the termination of a voluntary “and thus presumably profitable” course of dealing; (2) it involved the sale of publicly marketed services; and (3) it involved a refusal to sell even at retail prices. In this regard, the Court appears to have overlaid a predatory pricing standard upon the sphere of unilateral refusals to deal—*i.e.*, there must be a short term loss of profitability with the intent of ending competition between the plaintiff and defendant and with the expectation of an ability to recoup the losses after the plaintiff is eliminated as a competitor.

In other words, after *Trinko*, it appears that a refusal to deal with a competitor will be actionable under section 2 only if it involves the termination of a profitable business relationship with the competitor (*i.e.*, the sacrifice of short-term profits) for the purpose forcing the competitor out of the market.

The *Trinko* decision has been criticized for its inherent assumption that willful exclusionary conduct exists only in circumstances involving a sacrifice of profits, a contention with

which many economists and lower courts have disagreed. Commentators therefore have speculated as to whether the Court intended its “sacrifice test” to be a necessary condition for a section 2 claim or merely a sufficient condition. However, *Trinko* was decided on a motion to dismiss, and the Court gave the plaintiff no opportunity to replead the case. Thus, one is left with the clear inference that the Court indeed intended the sacrifice test to be a necessary condition (*i.e.*, that repleading would have been futile). Accordingly, even if *Trinko* did not effectively eliminate all Sherman Act causes of action based on a monopolist’s refusal to deal, it raised the bar to a very high level.

**§ 6:13 Operational antitrust issues in an integrated system—Refusals to deal with a health plan—Essential facility issues**

It is foreseeable that an integrated health system could decide not to contract with a particular health plan or not to contract with one health plan on as favorable terms as it deals with another plan. Assuming that contracting decisions are made unilaterally, there should be little or no risk of section 2 liability for the system. A health plan is not (ordinarily) a competitor of a provider of health services, and a provider system cannot extend its market power through a refusal to deal with a health plan. Although such a decision may enhance the system’s profitability (*e.g.*, by avoiding discounts on its services), it will not of necessity enlarge the system’s share of the provider services market and arguably could have the opposite effect.

Further, following *Trinko*, it is clear that the presumption in any case will remain that a health system is free to decide with whom it will do business. Any allegation of monopolistic conduct stemming from a refusal to contract with a health plan would have to offer a credible theory that the system is sacrificing short run profitability for longer-term gain. As long as the system will accept patients on a noncontracted basis (*i.e.*, “at retail”), there would seem to be no credible argument that a decision not to contract with a particular

health plan could be for the purpose of creating or sustaining a monopoly.<sup>1</sup>

However, the above analysis is based on the assumption that any such decision by a health system would be unilateral and not the result of any express or tacit understanding with an unrelated third party payor. Any agreement between a health system and a payor regarding whether the system will do business with another payor, or the terms on which it would do business with another payor, would pose significant antitrust risks

Note also that the analysis is different if the integrated health system includes a provider-sponsored health plan. In that case, the health system is both a supplier to, and competitor of, the independent health plan. Thus, allegations could be made that the system's conduct toward a competing health plan is intended to further the market position of its own health plan.

This, in essence, is an “essential facility” argument.<sup>2</sup> However, in *Trinko*, the Supreme Court made it clear that the alleged withholding of an essential facility must (a)

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**[Section 6:13]**

<sup>1</sup>As noted above, section 2 allegations can arise in circumstances where the subject conduct is directed toward customers (*i.e.*, health plans) or suppliers but only if the intent and result is to injure competitors. It is difficult to imagine a situation in which a health system's refusal to deal with a health plan would directly injure a competitor hospital/health system. In the usual case, such a refusal would create an opportunity for a competitor to acquire incremental business. And even if the system's refusal to contract caused a health plan to withdraw from the market, the patients would remain—and if the competitor hospitals were thereby relieved of discounted service obligations, they would hardly be injured by that result.

<sup>2</sup>The so-called “essential facility” doctrine is a particular subcategory of section 2 theory on refusals to deal. It posits that through monopolistic control of a “facility” (*i.e.*, a means of production or a productive input) that is essential to competition, and through a refusal to make the facility available to competitors on reasonable terms, the defendant destroys or impairs the competitors' ability to compete in the marketplace. The doctrine has its roots in two cases involving concerted refusals to deal that were challenged under section 1 of the Sherman Act. *Associated Press v. U.S.*, 326 U.S. 1, 65 S. Ct. 1416, 89 L. Ed. 2013, 1 Media L. Rep. (BNA) 2269 (1945); *U. S. v. Terminal R. R. Ass'n of St. Louis*, 224 U.S. 383, 32 S. Ct. 507, 56 L. Ed. 810 (1912). Thus, the extension of the doctrine to unilateral refusals to deal has always been theoretically controversial, given that concerted action is more circumscribed under the Sherman Act, and

involve the complete unavailability of the essential facility (*i.e.*, a refusal to make services available to the competing plan's enrollees on an out-of-network basis) and (b) threaten monopolization of the secondary market (*i.e.*, the health plan market). Thus, even if it were assumed that the system's market power could imbue its provider services with an "essential facility" label, there would have to be a realistic future possibility that the system, by withholding access to its facilities, could create a health insurance monopoly for its own health plan. This is an unlikely scenario in most markets.

**§ 6:14 Operational antitrust issues in an integrated system—Conditional contracting—Tying arrangements in managed care contracting**

Integrated systems of physicians and hospitals face potential antitrust challenges based on allegations that enterprise contracting (contracting for both physicians and hospitals together) is an unlawful tying arrangement. A tying arrangement is one in which the sale of one product or service (the "tying product") is conditioned upon the buyer's agreement to purchase a second, different product or service (the "tied product"). The antitrust concern underlying tying arrangements is that if the seller has market power over the tying product, the conditional sale will leverage that power into the tied product market and reduce competition in that market. The concept is similar in nature to an essential facility or monopoly leveraging claim except that monopoly power or a dangerous threat of successful monopolization is not an essential element of the claim.

Tying arrangements implicate section 1 of the Sherman Act. The concerted action for section 1 purposes exists in the sales agreement itself—*i.e.*, the buyer (health plan) is the "unwilling" party to the unlawful agreement. Tying arrangements are potentially of concern to a system with market power because "unreasonable" agreements under section 1

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as noted above, the Sherman Act generally does not require a firm to deal with its competitors.

are generally tested under a less forgiving standard than “predatory” conduct under section 2.<sup>1</sup>

For an unlawful tying arrangement to exist, three substantive conditions must be satisfied. First, the tying and tied products must constitute separate markets and not two components of the same product. This is generally a question of whether there is a demand for the products sold separately and whether it would be efficient for the seller to provide the two products separately.

Second, the sale of the tied product must actually be conditional upon purchase of the tying product. The buyer must be coerced. Hard sales tactics, inequality of bargaining power, and minimum purchase requirements are not sufficient to meet this criterion. As a corollary, if the buyer does not actually purchase the tied product, or if the buyer would have purchased the tied product anyway, no coercion has occurred. Finally, the seller must have market power in the market for the tying product, and this market power must be the source of the seller’s advantage in the tied product market.

Although it is sometimes said that tying arrangements are *per se* unlawful, this statement is not wholly accurate. (If it were, liability would be established merely by proving the existence of a conditional sales agreement, *i.e.*, without regard to the foregoing factors.) Rather, the above factors constitute a truncated rule of reason inquiry and, if proven, establish liability without the necessity of proving adverse competitive effects (assuming the absence of a compelling efficiency justification for the arrangement).

Because market power is an essential element of a claim that a conditional sale constitutes an unlawful tying arrangement, this theory necessarily is relevant to antitrust compliance in any circumstance in which a seller possesses substantial market power or monopoly power. As a vertically integrated enterprise, a health system may face risks that

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**[Section 6:14]**

<sup>1</sup>Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 775, 104 S. Ct. 2731, 81 L. Ed. 2d 628, 1984-2 Trade Cas. (CCH) ¶ 66065 (1984) (Sherman Act “leaves untouched a single firm’s anticompetitive conduct (short of threatened monopolization) that may be indistinguishable in economic effect from the conduct of two firms subject to § 1 liability.”).

an enterprise-wide managed care contracting strategy could be characterized as an unlawful tying arrangement.

A requirement that payors purchase the full line of a system's provider services as a condition of purchasing any provider services (*i.e.*, an all-or-none contracting requirement for the entire enterprise) fits the definition of a conditional sales arrangement because the payor must come to terms with the system for physician services, outpatient diagnostic services, ASC services, etc. as a condition of purchasing, *e.g.*, hospital services. These categories represent distinct product markets, and thus present a degree of antitrust liability risk, depending on the system's market power in some or all of those product lines.

However, reasonable arguments can be made in many cases that a conditional sale of this type is not really a "tie." First, it may be argued that the demand for the various products (or at least some of them) is not truly independent. For example, from a payor's perspective, participating physicians need to have privileges at participating hospitals. Thus, if a payor were to include a system's hospitals in its network, its members would need access to a panel of physicians having privileges at those facilities.<sup>2</sup> Conversely, if a payor wanted specific physicians in its network, it would need to accommodate hospital admissions by those physicians.<sup>3</sup>

More significantly, if a vertically integrated health system truly were functioning as a clinically integrated enterprise, there would be a strong argument that its providers collectively constitute a set of interdependent products rather than a discrete shopping list of medical services. In other words, the system is selling "one" product to payors in the form of an integrated delivery network. In a clinical integration setting, the effectiveness of clinical management depends directly on the operational association of the

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<sup>2</sup>However, the same may not be as true with respect to, *e.g.*, ambulatory surgery centers for which there is a less compelling case for interdependency of demand with hospitals.

<sup>3</sup>Hypothetically, a health plan (or, at least, one with market power) could persuade or coerce physicians to obtain privileges at specific hospitals with which the payor has contracts. However, where the physicians are lawfully employed by a system, this would not be a realistic proposition, as those decisions would be made in the system's economic interest (as the employer) and not in the individual physician's economic interest.



system's physicians with the system's hospitals (and other providers), and the objectives of integration would be defeated if the payor were to purchase services *à la carte*.

To the extent that a system's "products" nevertheless might be deemed separate, the legality of the tie would still depend on whether the system would be deemed to have market power over the tying product (more typically, hospital services) resulting in a coerced purchase of the tied product (*e.g.*, physician services). In tying cases generally, the minimum market share required to sustain a tying allegation is in excess of 30%.<sup>4</sup> In this regard, it should again be noted that courts also may inquire into other factors beyond market share to determine the existence of market power. These include the uniqueness of the tying product, evidence of high costs incurred by purchasers in switching to substitutes for the tying product, evidence of sustained high profitability, evidence of supra-competitive pricing for the tied product, evidence that the seller has the ability to price-discriminate, and/or evidence that purchasers in fact have accepted burdensome terms in order to obtain the tying product.

Of these additional factors, two may be particularly relevant to a large health system. First, although at least one merger case holds that the greater desirability of some hospitals than others to managed care plans does not create a separate market of "anchor" or "marquee" hospitals, older tying cases hold that market power can be inferred not only from the uniqueness of the tying product but also from its greater desirability.<sup>5</sup> Second, it is at least arguable that payors incur high switching costs in making significant changes to their provider networks. That is, once they have

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<sup>4</sup>Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 104 S. Ct. 1551, 80 L. Ed. 2d 2, 1984-1 Trade Cas. (CCH) ¶ 65908 (1984) (implying 30% share insufficient); Brokerage Concepts, Inc. v. U.S. Healthcare, Inc., 140 F.3d 494, R.I.C.O. Bus. Disp. Guide (CCH) P 9458, 1998-1 Trade Cas. (CCH) ¶ 72099 (3d Cir. 1998) (25% share insufficient as a matter of law).

<sup>5</sup>Fortner Enterprises, Inc. v. U.S. Steel Corp., 394 U.S. 495, 89 S. Ct. 1252, 22 L. Ed. 2d 495 (1969); U.S. v. Loew's, Inc., 371 U.S. 38, 83 S. Ct. 97, 9 L. Ed. 2d 11, 135 U.S.P.Q. 201 (1962). Later Supreme Court decisions have discussed product uniqueness but not desirability as a factor in assessing market power, *e.g.*, Eastman Kodak Co. v. Image Technical Services, Inc., 504 U.S. 451, 112 S. Ct. 2072, 119 L. Ed. 2d 265, 1992-1 Trade Cas. (CCH) ¶ 69839 (1992); Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 104 S. Ct. 1551, 80 L. Ed. 2d 2, 1984-1 Trade Cas. (CCH) ¶ 65908 (1984).

built a network around, *e.g.*, the system's hospitals, they may be reluctant to abandon that choice due to the high economic and public relations costs of reconfiguring physician and downstream provider networks, disruption of member care patterns, member confusion and complaints, etc.<sup>6</sup> Thus, to the extent that a payor would not want to purchase provider services in a bundle with a health system's hospitals, it is possible that the payor could argue that one or more factors beyond market share was a source of coercion to buy those other services.

Of course, even if an all-or-nothing enterprise contracting arrangement were deemed to be a presumptively unlawful tying agreement, it is unclear whether a complaining payor would be able to prove damages at the level of certainty required for antitrust liability. Given the nature of managed care networks, an agreement requiring a payor to include a specific system provider would be a source of economic loss only if (a) the inclusion prevented the payor from contracting with a lower-cost alternative (*i.e.*, because either the system or the alternative provider demanded an exclusive arrangement), or (b) the price at the system facility were significantly higher than the price at other facilities in the network such that each insured who used the system facility generated additional cost for the payor.

Thus, antitrust risk may be managed to some degree if an integrated system (i) does not demand an exclusive contract in any such circumstance; (ii) does not condition the contract (in the absence of an objective and procompetitive business rationale) on the payor's agreement to refrain from tiered network structures or, alternatively, to include the system in the preferred tier on terms that otherwise would not entitle it to be so included; and (iii) does not condition the agreement (again, in the absence of an objective and procompetitive business rationale) on the payor's agreement to refrain from carving-out any service provided by the system.

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<sup>6</sup>However, the Third Circuit has held, subsequent to *Kodak*, that high switching costs alone cannot be a basis for finding market power and that it also is necessary in that context to prove the product at issue is, in some fashion, unique. *Queen City Pizza, Inc. v. Domino's Pizza, Inc.*, 124 F.3d 430, 1997-2 Trade Cas. (CCH) ¶ 71909 (3d Cir. 1997).

**§ 6:15 Operational antitrust issues in an integrated system—Conditional contracting—Bundled pricing in managed care contracting**

More recently, there has been increased interest in the legality of so-called “bundling” or multi-product pricing arrangements that involve at least one product or service in which the seller has a monopoly or substantial market power. In these cases, the seller offers a discount arrangement in which the customer will receive substantial discounts on both the monopoly product and a competitive product if the customer agrees to minimum purchasing quotas on both products. The customer is not required to accept this arrangement—the seller will sell either product separately but not at equivalent discounts—hence, this is not a traditional tying arrangement. The customer merely has a strong incentive to purchase both products from the seller.<sup>1</sup>

A competing seller (of the competitive product) may be significantly disadvantaged because in order to be competitive on that product, it must not only meet or beat the first seller’s discount on the competitive product but must also offer an additional discount equal to the discount on the monopoly product that the customer would lose if it purchased the competitive product from the competing seller.

Bundling claims could be implicated in a health system’s enterprise contracting strategies if the system were to require a payor to purchase all providers in the system in order to obtain the maximum discount (or even a reasonable discount) on such services, or, potentially, a situation in which, *e.g.*, a health plan were offered a discount on the system’s “prestige” hospitals only if the plan agreed to

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**[Section 6:15]**

<sup>1</sup>However, some courts have held that a bundled pricing arrangement can constitute the requisite conditional/coerced sale of the tied product provided that the pricing arrangement is such that the bundled purchase is the only realistic economic option for the buyer. *Marts v. Xerox, Inc.*, 77 F.3d 1109, 1996-1 Trade Cas. (CCH) ¶ 71324 (8th Cir. 1996); *Ortho Diagnostic Systems, Inc. v. Abbott Laboratories, Inc.*, 920 F. Supp. 455, 1996-1 Trade Cas. (CCH) ¶ 71362 (S.D. N.Y. 1996), as corrected, (Mar. 15, 1995). Under this theory, the bundle would have to include a true monopoly product that is essential to the purchaser in order for a bundled price to constitute the requisite coercion for a tying arrangement.

include the system's ambulatory surgery centers or physicians in its network. Bundled pricing arrangements have been challenged both as unlawful tying arrangements under section 1 and as unlawful predatory conduct under section 2

The proper standard for analysis of bundling arrangements under the antitrust laws has been a subject of extensive debate but relatively few court decisions. A 2003 decision from the Third Circuit adopted a standard of liability that would seem to condemn many such arrangements.<sup>2</sup> However, a 2007 report of the Antitrust Modernization Commission (AMC) rejected the Third Circuit's approach in favor of a more demanding test for condemnation of bundling arrangements.<sup>3</sup> The AMC's analytical approach, in turn, was reflected (with minor modification) in a more recent opinion from the Ninth Circuit—and that opinion is thought by many to state the prevailing view.<sup>4</sup>

The AMC recommended a three-part test for determining when bundled discounting should be found illegal. Specifically, it recommended that a plaintiff be required to show: (1) that, after allocating the total of all discounts and rebates attributable to the entire bundle of products to the competitive product, the defendant sold the competitive product below its incremental cost of producing the competitive product; (2) the defendant would have the ability (*i.e.*, the market power) to recoup its short-term losses on the competitive product; and (3) the bundled discount or rebate program had (or is likely to have) an adverse effect on competition.

The first two requirements function as “safe harbors” to screen bundled discounts that on their face pose little risk of harm to competition. The AMC believed that the application of this test would bring the case law on bundled discounts into line with the reasoning of the Supreme Court in preda-

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<sup>2</sup>*LePage's Inc. v. 3M*, 324 F.3d 141, 2003-1 Trade Cas. (CCH) ¶ 73989, 61 Fed. R. Evid. Serv. 60 (3d Cir. 2003) (*en banc*). Under *LePage's*, bundled discounts offered by a monopolist are unlawful if they substantially foreclose portions of the market to a competitor that does not provide an equally diverse group of services—and therefore cannot make a comparable offer.

<sup>3</sup>Antitrust Modernization Commission, *Report and Recommendations* (Apr. 2007).

<sup>4</sup>*Cascade Health Solutions v. PeaceHealth*, 515 F.3d 883, 2008-1 Trade Cas. (CCH) ¶ 76030 (9th Cir. 2008).

tory pricing cases (as announced in the *Brooke Group* decision).<sup>5</sup> The third criterion requires a risk of sufficient market foreclosure to support a finding that competition (and hence consumer welfare) has been harmed by the pricing conduct. Such an inquiry is common to all exclusionary practice claims, including tying (at least in some circuits) and exclusive dealing.

Based on the AMC standard, it ordinarily should not be difficult to structure bundled pricing arrangements in a manner that avoids antitrust liability. Moreover, two factors suggest that such claims generally may be difficult to maintain in the context of health plan contracting. First, managed care contracts are generally short-term and in the nature of requirements contracts (*i.e.*, the provider agrees to furnish services to members as needed but does not agree to sell (or require the payor to purchase) any specific quantity of services). Thus, in the absence of express exclusivity, it may be difficult for a competing provider to prove market foreclosure. Second, for essentially the same reason, it may be difficult for a competing provider to prove the requisite competitive injury.

### § 6:16 Operational antitrust issues in an integrated system—Exclusive dealing

Exclusive dealing arrangements are, in a sense, another type of refusal to deal but carry additional implications for antitrust purposes. Notwithstanding the negative tone of the ACO Policy Statement, exclusive contracts are not necessarily or even usually unlawful but can raise antitrust issues when they are employed by a firm with market power.

Traditional antitrust analysis of exclusive contracts under section 1 of the Sherman Act has focused on market foreclosure—the extent to which the contract “ties up” the affected

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<sup>5</sup>*Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 113 S. Ct. 2578, 125 L. Ed. 2d 168, 1993-1 Trade Cas. (CCH) ¶ 70277 (1993). This is considered to be a very difficult standard for a plaintiff to meet.

market (*i.e.*, the market that is the subject of the contract).<sup>1</sup> An exclusive contract in favor of one firm, by definition, denies any other firm access to the particular customer or supplier. As noted above, the general rule of thumb is that a contract must foreclose access to at least 40 percent of the market for competitive issues to arise,<sup>2</sup> but the length of the contract is relevant as well, in the sense that contracts of short duration or that are easily terminable are less likely to create foreclosure problems.<sup>3</sup> An exclusive contract may be defended on the basis of its procompetitive effects, such as assurance of a stable source of supply at a stable price or the stimulation of competition among suppliers.<sup>4</sup>

More recent cases have begun to recognize that competitive effects may extend beyond the primary affected market insofar as exclusive contracting may constitute the type of predatory behavior necessary to sustain a monopoly maintenance claim under section 2. These decisions, as a group, have employed a broader focus on market power and have moved away from a narrower focus on foreclosure. They tend to differentiate exclusive dealing contracts won through aggressive competition from those that are profitable only because of their negative effect on rivals. The cases also have given heightened consideration to proffered efficiency justifications by defendants. The focus on market power in these cases is not a concern with market power in the

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**[Section 6:16]**

<sup>1</sup>*See, e.g.*, *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 104 S. Ct. 1551, 80 L. Ed. 2d 2, 1984-1 Trade Cas. (CCH) ¶ 65908 (1984) (abrogated by, *Illinois Tool Works Inc. v. Independent Ink, Inc.*, 547 U.S. 28, 126 S. Ct. 1281, 164 L. Ed. 2d 26, 77 U.S.P.Q.2d 1801, 2006-1 Trade Cas. (CCH) ¶ 75144 (2006)); *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 81 S. Ct. 623, 5 L. Ed. 2d 580 (1961).

<sup>2</sup>*See, e.g.*, *Satellite Television & Associated Resources, Inc. v. Continental Cablevision of Virginia, Inc.*, 714 F.2d 351, 1983-2 Trade Cas. (CCH) ¶ 65541 (4th Cir. 1983); *U.S. v. Dairymen, Inc.*, 758 F.2d 654, 1985-1 Trade Cas. (CCH) ¶ 66638 (6th Cir. 1985).

<sup>3</sup>*E.g.*, *Roland Machinery Co. v. Dresser Industries, Inc.*, 749 F.2d 380, 1984-2 Trade Cas. (CCH) ¶ 66175, 1985-1 Trade Cas. (CCH) ¶ 66329, 79 A.L.R. Fed. 1 (7th Cir. 1984) (holding that an exclusive agreement with a term of one year or less is presumptively lawful).

<sup>4</sup>*See, e.g.*, *Barry Wright Corp. v. ITT Grinnell Corp.*, 724 F.2d 227, 1984-1 Trade Cas. (CCH) ¶ 65787 (1st Cir. 1983) (well-known case holding that assurance of stable supply justified exclusive contract that foreclosed 50% of the market).

abstract, unrelated to the challenged conduct, but rather reflects a concern that creating or increasing market power through exclusive dealing is the means by which a defendant may increase prices, restrict output, reduce quality, slow innovation, or otherwise harm consumers. The decision in the highly publicized *Microsoft* case is illustrative.<sup>5</sup>

Growth of a health system's market position will increase antitrust risks associated with business conduct that might not raise such issues in the context of a lesser market position. Exclusive payor contracts are typically initiated to gain an advantage in a competitive provider market and usually involve granting the payor a significantly better discount in exchange for the guaranteed patient source. The potential competitive effects are generally quite obvious, in that the contract deprives competitors of in-network access to the same customers. Typically, however, an exclusive contract procured on competitive terms and periodically rebid will not raise significant competitive issues. In that situation, competition for the contract essentially substitutes for competition for the patients, and as long as the contract has a reasonably short term, the market will remain competitive on that basis.

However, antitrust concerns could arise if it appeared that an exclusive contract was obtained simply as an exercise of market power. That is, an exclusive contract obtained for no apparent business purpose other than to increase competitive obstacles for competing providers would be of concern under section 2 if at least some adverse market effects could be shown. As noted above, these effects need not reach the touchstone 40% preclusion level, but on the other hand, there

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<sup>5</sup>U.S. v. Microsoft Corp., 87 F. Supp. 2d 30, 54 U.S.P.Q.2d 1365, 2000-1 Trade Cas. (CCH) ¶ 72839 (D.D.C. 2000), judgment aff'd in part, rev'd in part, 253 F.3d 34, 2001-1 Trade Cas. (CCH) ¶ 73321 (D.C. Cir. 2001). Other recent cases of note include *Omega Environmental, Inc. v. Gilbarco, Inc.*, 127 F.3d 1157, 1997-2 Trade Cas. (CCH) ¶ 71963 (9th Cir. 1997); *CDC Technologies, Inc. v. IDEXX Laboratories, Inc.*, 186 F.3d 74, 1999-2 Trade Cas. (CCH) ¶ 72594 (2d Cir. 1999); *Minnesota Mining and Mfg. Co. v. Appleton Papers, Inc.*, 35 F. Supp. 2d 1138, 50 U.S.P.Q.2d 1091, 1999-1 Trade Cas. (CCH) ¶ 72463, 171 A.L.R. Fed. 691 (D. Minn. 1999); and *PepsiCo, Inc. v. Coca-Cola Co.*, 315 F.3d 101, 2003-1 Trade Cas. (CCH) ¶ 73914 (2d Cir. 2002). All of these decisions involve exclusive distributorship arrangements.

must be some basis to show that price or output in the relevant market has been, or is likely to be, affected.<sup>6</sup>

For an integrated health system, antitrust risk may be minimized to the extent exclusive payor arrangements are limited to health plans that, in aggregate, represent a fairly small proportion of the market, assuming such arrangements reflect competitive benefit to both parties. This would include a better price for the payor than it would receive in the absence of the exclusive arrangement and some reasonable business justification for the health system. It should be assumed that an exclusive contract under which the health system is paid at a nominal discount could be seen presumptively as having been undertaken as an exercise of market power.

Realistically, for health systems with very high market shares, it is difficult to envision significant business benefits that could be obtained through exclusive contracting that it could not obtain on a nonexclusive basis.<sup>7</sup> Unless such benefits can be defined, the system's presumptively better strategy would be to avoid exclusive payor arrangements.

### § 6:17 Will efficiency arguments prevail?

As noted at the outset of this chapter, the objectives of the Affordable Care Act (ACA) and the objectives of the antitrust laws are in tension to the extent that the ACA is stimulating the reorganization of health care delivery systems in ways that promote, if not rely on, provider consolidation. Of course,

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<sup>6</sup>See *PepsiCo, Inc. v. Coca-Cola Co.*, 114 F. Supp. 2d 243, 2000-2 Trade Cas. (CCH) ¶ 73036 (S.D. N.Y. 2000), judgment aff'd, 315 F.3d 101, 2003-1 Trade Cas. (CCH) ¶ 73914 (2d Cir. 2002), holding that a lack of evidence that plaintiff's exclusion from access to one means of fountain syrup delivery resulted in any increase in the defendant's market power (*e.g.*, as shown by higher prices or profit margins) was fatal to the section 2 claim.

<sup>7</sup>See Jacobson, *Exclusive Dealing, "Foreclosure," and Consumer Harm*, 70 Antitrust Law J. 311 (2002) (suggesting that a monopolist would rarely or never have a business need to contract on an exclusive basis). This thinking is reflected in cases such as *U.S. v. Aluminum Co. of America*, 148 F.2d 416, 65 U.S.P.Q. 6 (C.C.A. 2d Cir. 1945) (concerning Alcoa's exclusive contracts with power companies under which they agreed not to supply electricity to any competing producer of aluminum) and *Lorain Journal Co. v. U.S.*, 342 U.S. 143, 72 S. Ct. 181, 96 L. Ed. 162, 1 Media L. Rep. (BNA) 2697 (1951) (concerning newspaper's refusal to accept advertising from companies that also advertised on a "competing" radio station).



the ACA's only direct organizational influence is with respect to Medicare ACOs, but the clear assumption is that ACOs and similarly motivated networks are anticipated to serve the private sector as commercial payors likewise adopt value-based purchasing arrangements and participate in state insurance exchanges and expanded Medicaid managed care programs.<sup>1</sup>

The touchstone principle of health care delivery reform is "alignment." The literature is replete with discussions of strategies to better align the clinical and economic incentives of hospitals and physicians such that overall reductions in costs and utilization are the result of a collaborative effort and inure to the collective benefit of the providers (by sharing rewards and/or better distributing the economic burden of change), as well as patients.

The question that persists (particularly in markets that have little experience with past forms of shared economic risk, such as capitation—which would be most markets) is whether changes in care management and clinical practices can be realized in sufficient time and in sufficient scope to respond effectively to the changing payment environment. In other words, can total care costs be reduced sufficiently to meet the anticipated reductions in public and private payments? For most providers, the answer to this question is unknown.

The corollary unanswered question is whether a strategy that incorporates a significant degree of structural physician integration (acquisition and employment) promises better results than other alignment strategies. Certainly less fully integrated arrangements have worked for some health systems, but some are questioning whether the magnitude of the current economic challenge is greater than the capabilities of those arrangements to drive change. For example, past experience with PHOs has created skepticism as to whether purely contractual network alignment models are sufficiently nimble or stable. Intermediate integration strategies, such as comanagement arrangements, clinical joint ventures, and professional services agreements that incorpo-

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**[Section 6:17]**

<sup>1</sup>As noted, this is an inherent premise of the Agencies' Policy Statement.

rate performance incentives, are capable of providing strong economic alignment. However, particularly for a large health system, dozens or perhaps even hundreds of separate (and separately negotiated) agreements would be necessary to create broad-based alignment with the physician community, and the prospect of managing and periodically renegotiating a large volume of separate business arrangements would seem to be at odds with the goal of streamlined operations.

Certainly, many of the high-functioning examples of integrated clinical delivery are systems that employ all or a majority of their physicians (notably, the physician/clinic-based models such as Mayo Clinic, Geisinger Health System, and Billings Clinic) or organizations in which physicians confine their practices to hospitals that are part of the same overall organizational structure (such as Kaiser Permanente and most academic medical centers).

Thus, it is to be expected that the defense of a future antitrust challenge based on the concentration of physician services within a health system will include the argument that a highly integrated model promotes efficiency and in fact is necessary to achieve the level of efficiency demanded by the particular marketplace.

The FTC and DOJ are skeptical of efficiency arguments. The 2010 revision of the Merger Guidelines largely confirmed that skepticism:<sup>2</sup>

The Agencies credit only those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects . . . . [E]fficiencies projected reasonably and in good faith by the merging firms may not be realized. Therefore, it is incumbent upon the merging firms to substantiate efficiency claims so that the Agencies can verify by reasonable means the likelihood and magnitude of each asserted efficiency, how and when each would be achieved (and any costs of doing so), how each would enhance the merged firm's ability and incentive to compete, and why each would be merger-specific . . . . [E]fficiency claims substantiated by analogous past experience are those most likely to be credited.

In the Agencies' experience, efficiencies are most likely to make a difference in merger analysis when the likely adverse competitive effects, absent the efficiencies, are not great. Efficien-

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<sup>2</sup>Merger Guidelines § 10.

cies almost never justify a merger to monopoly or near-monopoly

Quality improvements are a form of efficiency. However, the Merger Guidelines state that “the agencies consider whether cognizable efficiencies likely would be sufficient to reverse the merger’s potential harm . . . , e.g., by preventing price increases . . . .”<sup>3</sup> This approach gives little credence to benefits in the form of new services or improved quality as it is typically difficult to argue that such nonprice benefits would *prevent* a price increase.

Evidence concerning the results of physician-hospital alignment and clinical integration are conflicting and relate to past periods in which the impetus for change was not as strong as at present. This will make it difficult, at least for the time being, for providers to prospectively defend their integration plans against an antitrust challenge.

Recent studies<sup>4</sup> suggest that, at least in the short term, physician-hospital integration has tended to result in increased costs and prices. There are several reasons for this result. Many (perhaps most) hospital-employed physicians continue to practice in a predominantly fee-for-service environment that has inherent incentives to increase the volume of services delivered. Productivity-based compensation arrangements favored by most hospitals reinforce those incentives. In addition, most payors (including Medicare) pay higher fees for facility-based examinations and procedures than for the same services performed in physician offices. The higher fees are paid not only by health plans but by patients who have deductible and coinsurance obligations. Finally, in some markets, hospital bidding wars for specialists reportedly have resulted in very high levels of compensation for employed physicians, thus driving up hospital costs.

<sup>3</sup>2010 Guidelines § 10.

<sup>4</sup>*See, e.g.*, the following reports and sources cited therein: Burns, L. and M. Pauly, M., “Accountable Care Organizations May Have Difficulty Avoiding The Failures Of Integrated Delivery Networks Of The 1990s,” *Health Affairs* (Nov. 2012); O’Malley, A., A. Bond, and R. Berenson *Rising Hospital Employment of Physicians: Better Quality, Higher Costs?* Issue Brief No. 136 (Center for Studying Health System Change Aug. 2011); Berenson, R., P. Ginsburg, and N. Kemper, “Unchecked Provider Clout in California Foreshadows Challenges to Health Reform,” *Health Affairs*, Vol. 29, No. 4 (Apr. 2010). Casalino, L., et al., “Hospital-Physician Relations: Two Tracks and the Decline of the Voluntary Medical Staff Model,” *Health Affairs*, (Sept.-Oct. 2008).

Health plans in certain markets with high levels of hospital-employed physicians have reported difficulty containing hospital and physician rate increases. This type of leverage is, as discussed, a significant concern of the Agencies.

To the extent there is empirical evidence concerning the clinical “tools” associated with integrated care delivery, it tends to be negative or, at best, mixed. For example, earlier Medicare demonstration projects concluded that care coordination programs did not have an appreciable effect on utilization or health care spending. Most of these projects were undertaken 10 years ago, however. Similarly, evaluations of disease management programs funded by Medicare generally have found that net costs increased in most programs, and there was no widespread evidence of improved compliance with evidence-based care and no evidence of behavioral change by patients. The Medicare pay-for-performance demonstration (conducted 2005–2010) yielded mixed results. Although all participating groups reached program benchmarks on most quality measures, only half generated actual savings.

Conclusions from Medicare demonstrations are not necessarily generalizable to a broader population, and it is also likely that many similar commercial payor initiatives have not resulted in published evaluations. However, evaluations of medical home models undertaken by Group Health, for example, report improvement in prevention and chronic disease management and reduced utilization of hospital emergency departments.

Reports of positive outcomes from integration are largely anecdotal. For example, hospital-employed specialists have been associated with improved access for low-income patients, especially those with Medicaid coverage, whose access historically has been poor. This would make sense in that hospitals, especially tax-exempt hospitals, have community benefit obligations and policies that are extended to their employed physician groups. Similarly, a critical component of population health management is improving access to preventative care, which is perceived to improve for at-risk populations through hospital-employed primary care services. In some cases, hospitals have tied physician integration to capital investment designed to make outpatient care more accessible geographically.

More generally, hospitals report that physician integration has made quality improvement programs more effective and has enabled formal care coordination efforts. Also, by integrating with physicians, hospitals gain access to a wider data set of the community, allowing providers to identify and address areas of need in the population. Finally, integration is associated in many organizations with broader adoption of electronic health records and decision support tools. This likewise makes sense in that “cultural” alignment has been identified as a critical factor in physician adoption and use of hospital information systems.

### § 6:18 Conclusion

There is a certain sense of déjà vu for those who participated in the Clinton-era health reform debates and the 1990’s “integrated delivery system” movement. However, this time around, the structural consolidation aspect of reform is far more pronounced, and that consolidation presents unique antitrust considerations. Vertical merger analysis has been largely dormant for the better part of 30 years, and it will be interesting to see whether the general sense of concern over the growth of integrated health systems evidenced by recent state and federal investigations will actually translate into cognizable antitrust claims. Regardless of whether those claims are pursued, integrated systems will need to remain cognizant that, beyond the formational stages, the acquisition of market power through growth and consolidation changes the antitrust risks associated with ongoing operational decisions.