Thinking Big: Market Power in Consolidating Health Care Markets

Robert W. McCann

Continuing horizontal and vertical integration—both within and outside of health care—is creating a renewed debate over the meaning of market power, and whether the antitrust laws have become too myopic in failing to arrest the potential harms to competition allegedly created by larger and more diversified economic enterprises. Critics argue that the so-called Chicago School of economics set the antitrust laws on a path of diminishing ability to constrain modern-day exercises of market power. This article examines the current debate surrounding the conduct of dominant firms, historical views of that controversy, and some of its implications concerning the exercise of market power by health care organizations, particularly with respect to vertical integration.

I. The State of Horizontal and Vertical Integration in Health Care

That health care organizations are becoming larger and more integrated across geographies and service lines is a well-understood fact. Seventy-seven percent of hospitals with

more than 200 beds are part of a health system, up from 56 percent just 20 years ago. Indeed, only about 300 hospitals in that size category remain independent.[1] Today, the median multi-hospital health system in the United States consists of four hospitals; more than 25 percent of those systems have eight or more hospitals.[2] The continuing growth and expansion of health systems is consistently described as the consequence of a quest for scale, financial stability, and market presence.

System growth also (and increasingly) has vertical dimensions, as health systems become less hospital-centric, develop their own physician groups, and align with post-acute care providers. A recently-reported study conducted by the Physician Advocacy Institute and Avalere found that, in 2016, hospitals owned 29 percent of physician practices in the U.S. and employed 42 percent of all physicians. Between 2012 and 2016, the number of hospital-employed practices increased by 36,000.[3] The trends in physician practice acquisition reflect the perception that hospitals must better align physician networks to reduce medical variation, improve outcomes and successfully deal with performance-based payment reforms.[4]

Similar considerations are driving alignments between hospital systems and post-acute providers. As noted by the American Hospital Association, the increasing proportion of Medicare patients discharged to post-acute settings, combined with the growth of alternative payment models has increased awareness among hospitals of the need to create

---

[1]S. Anderson, C. Regan, and R. McCann, *Standalone Hospitals: Are They Really Dinosaurs?*, THE CHARTIS FORUM (Oct. 31, 2018), *available at* https://www.chartisforum.com/wp-content/uploads/2018/10/WP_FutureOfIndepHospitals-2018-10-31.pdf.

[2]U.S. Agency for Healthcare Research and Quality, COMPENDIUM OF U.S. HEALTH SYSTEMS, 2016 (2017), available at http://www.ahrq.gov/chsp/compendium/index.html.

[3]Physicians Advocacy Institute, *UPDATED PHYSICIAN PRACTICE ACQUISITION STUDY: NATIONAL AND REGIONAL CHANGES IN PHYSICIAN EMPLOYMENT 2012–2016* (March 2018), *available at* http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/2016-PAI-Physician-Employment-Study-Final.pdf.

[4]A. Kacik, "For the first time ever, less than half of physicians are independent," *Modern Healthcare* (May 31, 2017), available at https://www.modernhealthcare.com/article/20170531/NEWS /170539971.

relationships in which data and evidence-based care pathways and can be used to manage post-acute patient placements.[5] Although the majority of hospital-post-acute relationships are networking arrangements rather than common ownership,[6] a recent study found that the percentage of acute care hospitals having common investor ties to the post-acute or hospice sectors increased from 24.6 percent in 2005 to 48.9 percent in 2015.[7] That is, about half of acute care hospitals are controlled by an entity that also owns a significant stake in post-acute or hospice care in the same market.

As the health care industry continues its consolidation, the question inevitably arises as to whether the antitrust laws can effectively police potential exercises of market power.

II. Antitrust as Policy and Politics

To fully consider the issues discussed in this article, it is helpful to briefly digress and consider the antitrust laws as part of the political landscape. Notwithstanding the complex analytics of modern antitrust economics, the antitrust laws have always had a qualitative, political agenda. And today's changing political agenda has the potential to influence and perhaps disrupt current antitrust enforcement policy.

Antitrust practitioners are familiar with the premise that modern antitrust jurisprudence is the progeny of the so-called "Chicago School" of economics, and that the most-referenced explication of that thinking is Judge Robert Bork's book, *The Antitrust Paradox*. As described in that work, the Chicago School sees the central inquiry of the antitrust laws as "consumer welfare," which generally is to

---

[5] American Hospital Association, THE ROLE OF POST-ACUTE CARE IN NEW CARE DELIVERY MODELS (Dec. 2015), *available at* https://www.aha.org/guidereports/2018-03-14-trendwatch-report-role-post-acute-care-new-care-delivery-models.

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

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

be measured by the effects of firm conduct on consumer prices.[8]

But it was not always so.

The legislative history of the Sherman Act makes clear that Congress sought to curb the power of the large business trusts that dominated many facets of commerce in the late nineteenth century, and that the motivations for doing so were not just economic, but political as well. The importance of the Act was described on the floor of Congress in terms of political imperatives—keeping markets free from "autocrats of trade" and eliminating monopolies that were "a menace to republican institutions."[9] Indeed, it has been noted that the period in which the Sherman Act was enacted was in fact one of stable prices, suggesting that the concern of Congress was not simply the redistribution of wealth from consumers to producers, but rather the means by which that redistribution occurred.[10]

Thus, during the first 70 or so years of the Sherman Act, enforcement of the antitrust laws had a distinctly populist bent. Through the 1960's a market structure-based view predominated, in which firm size, industry structure, and

---

[8]R. Bork, THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF (1978). *See also* R. Posner, *The Chicago School of Antitrust Analysis,* 127 U. PA. L. REV. 925 (1979). It has been observed that Judge Bork's arguments actually advocate for the maximization of total welfare (*i.e.*, the maximization of allocative efficiency), which is a different objective than maximizing consumer welfare. *See, e.g.*, the discussion in E. Fox, *The Modernization of Antitrust: A New Equilibrium,* 66 CORNELL L. REV. 1140 (1981). Maximization of total welfare refers to the optimization of both consumer surplus *and* producer surplus. Total welfare maximization considers some forms of wealth transfers from consumers to producers to be acceptable. It has been suggested that Bork's use of the term "consumer welfare" to describe his objectives was, in essence, a marketing strategy to gain broader judicial acceptance of the Chicago School arguments. D. Sokol, *The Transformation of Vertical Restraints: Per Se Illegality, The Rule of Reason, And Per Se Legality*, 79 ANTITRUST L.J. 1003, 1007 n. 18 (2014), *available at* http://scholarship.law.ufl.edu/facultypub/546. One sees this effect in, *e.g.*, Reiter v. Sonotone, 442 U.S. 320, 343 (1979), wherein the Supreme Court stated that Congress designed the Sherman Act as a "consumer welfare prescription," a phrase taken directly from *The Antitrust Paradox*.

[9]21 Cong. Rec. 2457 (statement of Sen. Sherman), 3146 (statement of Sen. Hoar) (1890).

[10]L. M. Kahn, *Amazon's Antitrust Paradox,* 126 YALE L. J. 710, 741 (2017).

concentration levels explained and predicted market dynamics.[11] The behavior of firms in concentrated markets was presumed not just to result in higher prices for consumers, but also to facilitate price-fixing and the creation of impediments to new competition. The potential for economic conflicts of interest also was part of the structural equation, particularly with respect to analysis of vertical arrangements and the threat of foreclosure.[12] The protection of structural market competition also extended to blocking nonhorizontal transactions that were thought to involve the acquisition of potential future competitors.[13]

The Chicago School holds a diametrically opposite view in which market structure is considered to be the effect, not the cause, of market dynamics.[14] It assumes that a market's structure is created by the interplay of independent market forces and the requirements of production—in other words, that markets with rational economic actors seeking to profit-maximize will seek to align in the most efficient structure for the particular market. Contrary behavior, being suboptimal, will be disciplined by competitive forces. In this construct, structural market power is not inherently bad; rather it is only a problem if it leads to higher consumer prices.

---

[11]*E.g.*, U.S. v. Philadelphia Nat'l Bank, 374 U.S. 321, 364–65 (1963), in which the Court found that a merger of the second- and third-largest banks in the Philadelphia market, which would have given the merging parties a 30% share of the market and resulted in the four largest banks controlling approximately 60% of the market, would create a structural presumption of an unlawful reduction in competition.

[12]*E.g.*, Brown Shoe Co. v. United States, 370 U.S. 294 (1962), in which the Court upheld an action to enjoin the acquisition of a large shoe retailer by a major shoe manufacturer, primarily out of concern that the acquisition would give the manufacturer an ability to impede competition in the shoe manufacturing market by restricting its competitors' access to the acquired retail outlets.

[13]*E.g.*, Ford Motor Co. v. United States, 405 U.S. 562, 567–68 (1972), in which Ford Motor Co. was required to divest an acquired equipment manufacturer based upon a finding that, prior to the acquisition, Ford could have entered the equipment manufacturing market, that the threat of Ford's entry was a deterrent to anticompetitive behavior in that market, and that the acquisition eliminated a possibility of further deconcentration of the equipment manufacturing market in the future.

[14]Posner, *supra*, n. 8 at 932; Kahn, *supra*, n. 10 at 719.

Recently, the country has witnessed a resurgence of strong voices from political progressives. Those voices speak specifically to the nature of the social contract between large institutions and society. In the description of one political writer, progressives "focus on using government power to make large institutions play by a set of rules."[15] Certainly, that could be one description of the role of the antitrust laws.

This is not to suggest an endorsement of the progressive view or any political view. Rather, it is to note that recently-reinvigorated debates about the role of the antitrust laws in the modern U.S. economy include views that are decidedly progressive in questioning whether firms can be "too big" and whether large integrated firms should be subjected to a different set of conduct rules. This view can be seen, for example, in the much-discussed 2017 *Yale Law Journal* article by Lina Kahn focused on Amazon's emergence as a horizontally- and vertically-integrated commercial behemoth that has largely escaped antitrust scrutiny.[16]

Kahn's article discusses at length how Amazon, which has expanded from its initial on-line retailing business into operating as a marketing platform, a delivery and logistics network, a payment service, a credit lender, an auction house, a major book publisher, a producer of television shows and films, a fashion designer, a hardware manufacturer, and a leading host of cloud server space, has used its significant size and broad economic presence to crowd out actual and potential competition within the confines of Chicago School antitrust rules. That is, because Amazon continues to offer low prices to consumers (and, indeed, has operated at a loss), the current focus of the antitrust laws on "consumer welfare" finds no concern with Amazon's increasing dominance. Kahn argues that the Chicago School approach will be "too little, too late" if and when Amazon exercises its market power more directly against consumers.

---

[15]D. Sirota, "What's the Difference Between a Liberal and a Progressive?" *HuffPost* (Oct. 19, 2011), available at: https://www.huffingtonpost.com/david-sirota/whats-the-difference-betw_b_9140.html. The progressive view of the social contract between big business and society is clearly illustrated in an oft-cited 2011 campaign speech by now-Sen. Elizabeth Warren, *available at* https://www.cbsnews.com/news/elizabeth-warren-there-is-nobody-in-this-country-who-got-rich-on-his-own/.

[16]Kahn, *supra,* n. 10.

These debates have true implications for health care. Health systems continue to grow horizontally, in many cases expanding into multiple, different geographic markets—conduct generally considered to raise no antitrust concerns. But as we discussed last year in this publication, there is an emerging interest in evaluating so-called "cross-market" price effects—effects putatively created by horizontal mergers of firms in completely separate geographic markets—as potential antitrust violations.[17] Likewise, although vertical integration historically has been viewed favorably in antitrust economics,[18] health care system acquisitions of physician practices unquestionably are a source of potential vertical foreclosure.[19] It seems reasonable to believe that current progressive-conservative political debates may push these questions farther into the open.

III. Section 2 and Enforcement Views Toward Single Firm Conduct

Under § 2 of the Sherman Act, the offense of monopolization is based on two premises: (1) that the defendant possesses "monopoly power" (usually defined by a very high market share) or a "dangerous probability" of acquiring monopoly power; and (2) that the defendant has willfully acquired or maintained that power through improper means (*i.e.*, predatory or "unreasonably exclusionary" conduct).[20] The requisite conduct is generally understood as an act that results or may result in the exclusion of competitors from the market and that does not otherwise result in lower prices, enhanced efficiency, higher output, or product

[17]R.W. McCann and K.M. Vorrasi, *Cross-Market Effects in Hospital Mergers: A Collision of Legal and Economic Theory*, in A. Gosfield, ed., 2018 HEALTH LAW HANDBOOK (Thomson Reuters 2018).

[18]H. Hovenkamp, *Robert Bork and Vertical Integration: Leverage, Foreclosure, and Efficiency*, 79 ANTITRUST L. J. 983, 996 (2014) ("Indeed, today most vertical integration is viewed as economically beneficial and competitively benign.")

[19]*See infra,* nn. 59–68 and accompanying text.

[20]U.S. v. Grinnell Corp., 384 U.S. 563 (1966); Queen City Pizza, Inc. v. Domino's Pizza, Inc., 124 F.3d 430 (3d Cir. 1997).

innovation.[21] That is, the conduct makes sense only because it will drive actual or potential competitors out of the market. The two most significant categories of predatory or unreasonably exclusionary conduct fall under two broad headings: refusals to deal (in various forms) and predatory pricing. Most health care antitrust problems concern the former.[22]

Since the 1980's federal antitrust enforcement has been characterized by a virtual absence of § 2 (and vertical merger) cases. This fact is in many respects a direct consequence of the ascendency of the Chicago School. It has been suggested that the permissiveness of modern § 2 enforcement is due to three factors.[23] The first is a willingness, influenced by Chicago School writing, to accept benign or procompetitive explanations for conduct by dominant firms that was formerly considered suspect. A prime example is the change in predatory pricing analysis, designed to minimize the possibility that aggressive, price-cutting competition would be confused with, and condemned as, anticompetitive behavior.[24]

The second, related factor is the concern that antitrust laws should be applied cautiously to dominant firm conduct that presents a mix of procompetitive and anticompetitive attributes so as to avoid unwarranted, disproportionate, and unavoidable treble damage liability for behavior that either is legitimate or is improper only by a narrow margin.[25]

The third factor, also related, are the concerns that (1)

---

[21]See, *e.g.*, Morgan v. Ponder, 892 F.2d 1355 (8th Cir. 1989).

[22]Also, predatory pricing claims are fundamentally horizontal in nature (*i.e.*, arising between a firm and its direct competitors), as compared to refusals to deal, which are fundamentally vertical in nature (arising between a firm and its customers—who may also be competitors in a related market).

[23]W. Kovacic and M. Winerman, *Competition Policy and the Application of Section 5 of the Federal Trade Commission Act*, 76 ANTITRUST L. J. 929, 937–39 (2010).

[24]*E.g.,* Brooke Group Ltd. v. Brown & Williamson Tobacco Corp., 509 U.S. 209 (1993).

[25]Kovacic and Winerman note that this concern has permeated Section 1 analysis as well, for example, in NYNEX Corp. v. Discon, Inc., 525 U.S. 128, 136–37 (1998) ("To apply the per se rule here . . . would transform cases involving business behavior that is improper for various reasons, say, cases involving nepotism or personal pique, into treble-damages antitrust cases.").

legal rules should be stated with sufficient clarity to permit sensible implementation, especially in private litigation, and (2) that the application of competition rules ought to account for the capability, including the relative capabilities, of the institutions responsible for their implementation. Specifically, older decisions reflect judicial doubts as to the ability of industry regulators to control the conduct of dominant firms. More recent cases, such as the Supreme Court's decision in *Trinko*, reflect a more favorable judicial view of regulatory oversight as a means of controlling dominant firms, and a disinclination to insert judicial oversight into a regulated environment.[26]

Thus, the ability of Section 2 to reach a range of conduct that might in past years have formed the basis of a violation has been constrained by more recent case law.[27] In particular, recent decisions have followed a restrictive view concerning the obligations of a dominant firm to do business with any third party. In health care, these issues can arise when a health system, for example, refuses to contract with a payor, insists that a payor contract with it on an enterprise-wide basis, provides pricing incentives that have the effect of excluding rivals, refuses to allow its employed physicians to practice at a competitor's facilities, or refuses to provide back-up coverage to competing providers.

In this regard, the Supreme Court has narrowed its own holding in *Aspen Skiing* in a manner that makes it extremely difficult to assert that a refusal to deal with a rival constitutes predatory or unreasonably exclusionary behavior.[28] In the same decision, the Supreme Court largely neutered the

---

[26]Verizon Communications, Inc. v. Law Offices of Curtis V. Trinko, LLP, 540 U.S. 398, 412–415 (2004).

[27]The Section 2 issues discussed briefly here are explored in more detail in R. McCann, *Centrality, Competition, and Health Reform: Hospital-Physician Integration and the Antitrust Laws*, in A. Gosfield, ed. 2013 HEALTH LAW HANDBOOK (Thomson Reuters 2013) at 224–240.

[28]*Trinko*, 540 U.S. at 408–410. Aspen Skiing Co. v. *Aspen Highlands Skiing Corp.,* 472 U. S. 585 (1985) suggested that a dominant firm may have a duty to cooperate economically with a rival if the refusal to deal had the effect of maintaining or extending the market power of the dominant firm. In *Trinko*, the Court described *Aspen Skiing* as "at or near the boundary of § 2 liability" and held that liability could only exist if the conduct involved the termination of an existing and otherwise-profitable business relationship involving the sale of a publicly-marketed product or

so-called "essential facility" doctrine, a cause of action under which a dominant firm's refusal to provide access to a necessary resource that it controls is deemed anticompetitive.[29] The ability to allege harm from bundled pricing arrangements has been constrained by the overlay of the Supreme Court's narrow standard for predatory pricing (a direct result of Chicago School thinking).[30]

The state of § 2 is such that the most prominent recent case alleging abuse of market power by a large integrated health care system was brought under § 1 rather than § 2. In 2016, the Department of Justice filed a civil antitrust lawsuit against Atrium Health (then known as Carolinas HealthCare System) alleging that Atrium's requirement that its contracting health plans agree not to steer patients to competing hospitals (*i.e.*, through plan design, narrow network options, etc.) caused a reduction in competition in

---

service, and if the refusal to deal extended to not permitting the competitor to buy the product or service at publicly-offered prices.

[29]*Trinko*, 540 U.S. at 410–412. The Court refused to countenance the cause of action in that case because a federal regulatory scheme required Verizon to provide access to certain interconnection services that were at the heart of the case. Thus, in the Court's view, the essential facilities argument depended on the complete unavailability of the essential facility, which was deemed not to be the case (although the case arose because Verizon in fact had refused to provide access.) But the Court's "unavailability" language has been read as a high bar to assertion of this § 2 theory.

[30]Cascade Health Solutions v. Peace Health, 515 F.3d 883 (9th Cir. 2008); Antitrust Modernization Commission, *Report and Recommendations* (Apr. 2007). An earlier Third Circuit decision is to the contrary. LePage's, Inc. v. 3M Corp., 324 F.3d 141 (3rd Cir. 2003). The Supreme Court's standard for predatory pricing was announced in Brooke Group, Ltd. v. Brown & Williamson Tobacco Corp., 509 U.S. 209 (1993). In order to prevail under a predatory pricing claim, or (following *Peace Health*) on a claim that bundling of facilities or services has the effect of excluding rivals, the plaintiff must show that the arrangement results in below-cost sales by the defendant, and that the defendant will be able to recoup its lost profits in the future. The Chicago School advocated that predatory pricing schemes are economically irrational, rarely tried, and even more rarely successful, and the federal courts adopted that view. See Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 589 (1985), quoting *The Antitrust Paradox* to that effect. The Court in *Matsushita* expressed the concern, frequently stated since, that condemnation of aggressive pricing schemes might suppress, rather than enhance, competition. *Id.* at 594.

the hospital services markets. Atrium is North Carolina's largest healthcare system and one of the largest not-for-profit healthcare systems in the United States. Atrium operates nine general acute-care hospitals in the Charlotte area and owns, manages, or has strategic affiliations with more than 40 other hospitals in the Carolinas.

The Justice Department challenged Atrium's contracts as unreasonable restraints of trade under § 1. As in certain other areas of antitrust law (*e.g.*, tying arrangements), the existence of a contract embodying the disputed conduct provided the fiction that the conduct at issue was "concerted" rather than unilateral, and thus could be challenged under the less demanding standards of liability under § 1.[31] But there is no doubt that Atrium's actions (regardless of lawfulness) were unilateral, and indeed the Justice Department functionally alleged that the contracts represented a monopoly maintenance scheme in its complaint.[32] *Atrium* suggests, nonetheless, that the emphasis in unilateral conduct situations will remain on behavior that can be construed as a § 1 violation.[33]

IV. Vertical Restraints and Antitrust

As the structure and size of health care systems continues

---

[31] *See* Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 775 (1984), holding that because § 1 only prohibits concerted conduct that unreasonably restrains trade, "it 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." The Court explained that Congress, when drafting the Sherman Act, left this intentional gap in the Act's proscription in order to promote the competitive enthusiasm of a single entity. *Id.*

[32] Complaint, *United States of America, et al. v. Charlotte-Mecklenberg Hospital Authority d/b/a Carolinas HealthCare System*, No. 3:16-cv-00311 (June 9, 2016) at ¶ 2 (alleging that CHS (Atrium) has a 50% share of the relevant market) and ¶ 36 ("These steering restrictions have had, and will likely to continue to have, the following substantial anticompetitive effects . . . protecting CHS's market power and enabling CHS to maintain at supracompetitive levels the prices of acute inpatient hospital services.)

[33] The case was settled in late 2018. *See* U.S. Department of Justice Office of Public Affairs, "Atrium Health Agrees to Settle Antitrust Lawsuit and Eliminate Anticompetitive Steering Restrictions" (Nov. 15, 2018), *available at* https://www.justice.gov/opa/pr/atrium-health-agrees-settle-antitrust-lawsuit-and-eliminate-anticompetitive-steering.

to evolve, it seems likely that more emphasis will be given to the state of vertical restraint analysis under § 2, and more so, under § 7 of the Clayton Act. In the area of vertical restraints, the law at present is geared more to addressing the potential adverse consequences of proposed acquisitions than the actual (*i.e.*, post-acquisition) conduct of a vertically-integrated firm.

The principal antitrust concerns arising from vertical integration are twofold. The first is foreclosure, *i.e.*, the possibility that vertical integration by a dominant firm will effectively prevent competitors from entering the market and/or competing successfully. Consider a situation in which a health system that has vertically integrated into physician services effectively controls the flow of patients to a competitor hospital in the same market. Or, conversely, a vertically integrated hospital with market power may disadvantage physicians who compete with its own physician group, *e.g.*, by restricting or denying privileges, discriminating in the assignment of operating room time, etc. Thus, a firm theoretically could exercise market power to effectuate either horizontal or vertical foreclosure.

The second, related concern is leverage—the use of dominance in one market to achieve a competitive advantage in a vertically-related market. The essence of this argument is that a vertically-integrated firm with market power may enjoy an unfair advantage in a related (upstream or downstream) market in which the firm does not otherwise have market power. In health care, the argument was evident in cases from the 1990's alleging that hospitals used their dominance in inpatient services to control downstream (post-acute) referrals, favoring their own post-acute providers over independent providers.[34]

Prior to the 1980's, concern about foreclosure and leveraging were prominent in antitrust analysis of single firm conduct, as the previously-cited *Brown Shoe* and *Ford* decisions illustrated.[35] As the Chicago School influence on antitrust policy became ascendant, prevailing assumptions

---

[34]*See*, *infra* nn. 50–52 and accompanying text.

[35]See, *e.g.*, *Brown Shoe Company v. United States*, *supra*, n. 12; *Ford Motor Co. v. United States*, *supra*, n. 13. In *Brown Shoe*, the Court observed that, "[e]very extended vertical arrangement by its very nature,

about how dominant firms could exercise market power were called into question. Chicago School economists argue that a monopolist in one market cannot—solely by exercising that monopoly power—also earn a monopoly profit in a related, upstream or downstream market. That is, an effort to raise prices in a related, competitive market would lead to reduced sales and lower profits in that market. As Judge Bork reasoned, a manufacturer would not favor its own retail subsidiary unless it was less expensive to do so, in which case the discrimination would create efficiencies that would benefit consumers. Further, he argued, favoring one's own subsidiary would invite competitors to enter the market and compete with the subsidiary.

In 1984, the Department of Justice issued its *Non-Horizontal Merger Guidelines*, which focus almost entirely on the foreclosure effects (as opposed to leverage effects) of vertical integration. The *Guidelines* state that the relevant analysis for federal enforcement in vertical acquisition cases is (1) the degree to which the integration between the two related markets is so extensive that entrants to the primary market would also have to enter the secondary market; (2) the requirement of entry at the secondary level would make entry at the primary level significantly more difficult; and (3) the primary market is concentrated or otherwise unlikely to be competitive following the merger. These criteria set a high bar for enforcement; since the issuance of the *Guidelines*, federal challenges to vertical conduct have been almost nil.

Theoretically, vertical arrangements that threaten competition can be challenged in two ways: (1) if accomplished through acquisition, under § 7 of the Clayton Act, either at their incipiency or at the time the threat to competition becomes apparent;[36] or (2) under § 2 of the Sherman Act at the time the arrangement results in the requisite predatory

---

for at least a time, denies to competitors of the supplier the opportunity to compete for part or all of the trade of the customer-party to the vertical arrangement." 370 U.S. at 324.

[36]Section 7 of the Clayton Act does not apply only prospectively. In 1957, the Supreme Court ruled that a challenge brought in 1949 to a stock acquisition that occurred more than 30 years earlier could proceed under § 7. United States v. E.I. du Pont de Nemours Co. 353 U.S. 586, 597 (1957) The Court ruled that a § 7 challenge may be brought at "any time that an

or "unreasonably exclusionary" conduct. Under the influence of the Chicago School, § 2 has become a more difficult path to remedy potential anticompetitive abuses. Section 7 is more commonly invoked to block transactions of concern prospectively, but it has rarely been invoked to block vertical combinations and has not been used to retroactively break up a vertical combination at any time in recent history.

A. Leveraging

Most instances of leveraging play out as refusals to deal or refusals to deal except on specified terms. Although these situations frequently raise concerns of "fairness," it is a long-established principle of antitrust law that a firm (whether or not a monopolist) has no duty to deal with any other firm.[37] Except within the (now narrower) scope of *Aspen Skiing*, the opportunity to attack a refusal to deal head on is quite limited.[38] And the displacement of populist thinking about the goals of the antitrust laws with the consumer welfare approach of the Chicago School has ended theories that would extend the reach of § 2 in vertical situations. This is best illustrated by the arc of the now-defunct "monopoly leveraging" theory.

Most vertical antitrust problems involve situations in which the firm in question is dominant in one market but faces competition in a related market. For example, a

---

acquisition may be said with reasonable probability to contain a threat that it may lead to a restraint of commerce . . . ." *Id.* at 597. The corollary is that post-acquisition evidence of anticompetitive behavior can be relied upon to prove a violation of Section 7. United States v. General Dynamics Corp. 415 U.S. 486 (1974). *See also* In re Evanston Northwestern Healthcare, No. 9315 (FTC Aug. 6, 2007) (successful post-acquisition challenge to hospital merger occurring in 2000).

[37] *Verizon*, *supra*, n. 26; U.S. v. Colgate & Co., 250 U.S. 300, 39 S. Ct. 465, 63 L. Ed. 992, 7 A.L.R. 443 (1919).

[38] To be sure, one can envision vertical refusals to deal that would be actionable as garden-variety monopoly maintenance claims. For example, a monopolist hospital that also had a monopoly on neurosurgical physician services might be liable under § 2 for refusing to grant privileges to unaffiliated neurosurgeons—provided of course that the hospital lacked a business justification for its refusal (*i.e.*, that it was economically irrational for the hospital to do so). But, most claims alleging abuse of monopoly power by a vertically integrated firm involve secondary markets in which the firm lacks market power, and the allegations are those of leveraging market power in the primary market into the secondary market.

hospital may be a local monopolist of inpatient services, but face competition for outpatient diagnostic services, home care services, etc. Accordingly, a once-predominant theory of liability for vertically-integrated firms was "monopoly leveraging." A quintessential example of the populist approach to antitrust enforcement, the monopoly leveraging theory is based on the proposition that § 2, by implication, prohibits a firm with a high degree of market power in one market from using that market power to gain a "competitive advantage" (*i.e.*, something less than actual or threatened monopolization) in a second, distinct market.[39] The theory had its roots in early Sherman Act cases and its most influential modern exposition in the Second Circuit's 1979 opinion in *Berkey Photo*.[40]

Berkey Photo competed with the market-dominant Eastman Kodak Company to provide photofinishing services, *i.e.*, the conversion of exposed film into finished prints, slides, or movies, and in the manufacture and sales of cameras for amateur photographers. Berkey also bought photofinishing equipment and supplies, including color print paper, from Kodak.

The two firms thus stood in a bi-dimensional relationship in which Kodak was Berkey's competitor in some respects and its supplier in others. In the litigation, Berkey claimed, among other things, that its ability to compete with Kodak in the photofinishing business was impeded by Kodak's abuse of its dominant position in the markets for film and cameras, notwithstanding that Kodak itself was far from dominant in the photofinishing business and had no realistic prospect, let alone a "dangerous probability," of monopolizing that business.

Berkey's argument centered on Kodak's introduction of a

---

[39]If the conduct involved a threat of acquiring an actual monopoly (or the actual acquisition of one), rather than the acquisition of only a competitive advantage, it would be addressable as a potential attempted monopolization (or actual monopolization) claim under Section 2.

[40]Berkey Photo, Inc. v. Eastman Kodak Co., 603 F.2d 263, (2d Cir. 1979) (*rejected by*, Alaska Airlines, Inc. v. United Airlines, Inc., 948 F.2d 536 (9th Cir. 1991)) and (*rejected by*, General Cigar Holdings, Inc. v. Altadis, S.A., 205 F. Supp. 2d 1335 (S.D. Fla. 2002)). The monopoly leveraging theory was subsequently embraced by the Sixth Circuit. Kerasotes Michigan Theatres, Inc. v. National Amusements, Inc., 854 F.2d 135, 11 Fed. R. Serv. 3d 1545 (6th Cir. 1988).

new, purportedly higher-quality color print film (Kodacolor II) simultaneously with the introduction of its small "Pocket Instamatic" camera. These events disrupted the markets in which Kodak and Berkey both participated. The new camera was designed to use only a new, smaller "110" format film. Kodacolor II was designed specifically for the technical requirements of 110 format cameras,[41] and for the first eighteen months after its introduction Kodacolor II was sold only in the 110 format. Kodacolor II film also required a new, higher-temperature developing process, which in turn required specialized developing equipment, which Kodak solely manufactured.

The Pocket Instamatic camera was a major success, rapidly displacing sales of older camera formats, and sales of Kodacolor II film took off accordingly. Kodak enjoyed a significant head start on the market in terms of not just camera and film sales but also in terms of photofinishing for Kodacolor II users. Berkey asserted (among many other allegations) that Kodak's marketing of the new 110 format camera constituted an impermissible leveraging of Kodak's film monopoly into the markets for photofinishing services and equipment.

The Second Circuit sided with Berkey, holding that a firm violates § 2 by using its monopoly power in one market to gain a competitive advantage in another, notwithstanding the absence of an attempt to monopolize the second market. The court found that conclusion to be "an inexorable interpretation of the antitrust laws," going on to state:

> We tolerate the existence of monopoly power, we repeat, only insofar as necessary to preserve competitive incentives and to be fair to the firm that has attained its position innocently. There is no reason to allow the exercise of such power to the detriment of competition, in either the controlled market or any other. ***That the competition in the leveraged market may not be destroyed but merely distorted does not make it more palatable. Social and economic effects of an***

[41]Kodacolor II was designed to produce higher-quality, less grainy prints at higher levels of enlargement, which were necessary given the physically smaller size of the 110 format negatives.

extension of monopoly power militate against such conduct.[42]

The Second Circuit relied, in particular, on the (then) 40-year old Supreme Court ruling in *U.S. v. Griffith*[43], in which a chain of motion picture exhibitors was found to have used its monopoly position in certain geographic markets to extract from distributors exclusive exhibition rights in other localities in which the Griffith chain faced competition. The Second Circuit cited the Supreme Court's very broad rationale in that case that "the use of monopoly power, however lawfully acquired, to foreclose competition, to gain a competitive advantage, or to destroy a competitor, is unlawful."[44]

The Second Circuit further reasoned that leveraging was condemned by the antitrust laws for the same reason that tying arrangements are condemned, citing the Supreme Court's holding in *Northern Pacific Railway v. United States* that the vice of tying arrangement lies in "the use of economic power in one market to restrict competition on the merits in another."[45] The Circuit also reached back to its own *Alcoa* decision, stating "whatever problems of murkiness may plague the Alcoa opinion, on this point it is pellucid. The defendant had employed its monopoly power in the ingot market to impose a price squeeze on the manufacturers of aluminum sheet. Although this court expressly noted that there was no attempt to monopolize the sheet market, it held the challenged practice to be an unlawful exercise of Alcoa's power."[46]

But having made clear its view on monopoly leveraging, the Second Circuit then went on to blur the boundaries of liability: "[A]s we have indicated, a large firm does not violate § 2 simply by reaping the competitive rewards attributable to its efficient size, nor does an integrated business offend the Sherman Act whenever one of its departments benefits from association with a division possessing a monopoly in its

---

[42]603 F.2d at 275 (emphasis added).

[43]United States v. Griffith, 334 U.S. 100 (1948).

[44]*Id.* at 107.

[45]Northern Pacific Railway v. United States, 356 U.S. 1, 11 (1958).

[46]United States v. Aluminum Co. of America, 148 F.2d 416, 438 (2d Cir. 1945) (internal quotations omitted).

own market. So long as we allow a firm to compete in several fields, we must expect it to seek the competitive advantages of its broad-based activity more efficient production, greater ability to develop complementary products, reduced transaction costs, and so forth. These are gains that accrue to any integrated firm, regardless of its market share, and they cannot by themselves be considered uses of monopoly power."[47]

These statements simply begged the question of when the "competitive advantages of broad-based activity" cross the line from efficiency-enhancing conduct to prohibited leveraging of monopoly power. The monopoly leveraging theory as articulated by *Berkey Photo* was a source of controversy for the ensuing fifteen years. While the Sixth Circuit later concurred in the *Berkey Photo* rationale,[48] other circuits declined to extend § 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 § 2, which encompass only monopolization, attempted monopolization, and conspiracy to monopolize.[49]

During this time, monopoly leveraging made its way into health care in cases alleging that hospitals with market power used their position to influence or direct referrals of patients requiring post-acute care, such as home care services or durable medical equipment. Hospital discharge planning staffs were, it was alleged, in a position to ensure that patients went to the hospital's own provider or supplier, to the detriment of independent agencies that were dependent on the market-dominant hospital as a source of patients requiring post-discharge services.

One prominent instance was the *Venice Hospital* litigation,[50] in which a local durable medical equipment (DME) supplier sued Venice Hospital, alleging (among other things)

---

[47]603 F.2d at 276.

[48]*Kerasotes Michigan Theatres, Inc.*, *supra*, n. 40.

[49]*E.g.*, Fineman v. Armstrong World Industries, Inc., 980 F.2d 171, 24 Fed. R. Serv. 3d 162 (3d Cir. 1992); Alaska Airlines, Inc. v. United Airlines, Inc., 948 F.2d 536 (9th Cir. 1991).

[50]Key Enterprises v. Venice Hospital, 703 F. Supp. 1513 (M.D. Fla. 1989), *and opinion upheldreversed,* 919 F.2d 1550 (11th Cir. 1990), *reh'g*

that the hospital violated § 2 by using its monopoly power in the hospital services market to gain an unfair advantage in the DME market in Venice, Florida. Venice Hospital, which had an 80% share of the local inpatient services market, was a partner in a DME joint venture, and nurses employed by the joint venture conducted discharge planning in the hospital for DME services. The joint venture received about 85% of the DME referrals from the hospital.

The jury in the matter ruled for the plaintiff; however, the court entered judgment for the hospital notwithstanding the verdict, concluding that the hospital's behavior was economically rational and could not violate § 2. That ruling was overturned, and the verdict reinstated, by the Eleventh Circuit, which held that the jury had sufficient evidence to conclude that the hospital's practices unreasonably restricted competition by "channeling" patients requiring DME to the joint venture. While a petition for rehearing *en banc* was pending, the plaintiff and the defendants reached a settlement. Subsequently, the decision of the Circuit was vacated and ceased to have any precedential value.

Several copycat cases ensued. In *Advanced Health-care Services*, the Fourth Circuit reversed the dismissal of claims alleging that hospital defendants used their monopoly power in the market for short-term, acute care hospital services with the specific intent of foreclosing competition and gaining an unfair competitive advantage in the DME markets. The court held that the allegations, if proven, could support a finding of liability for monopoly leveraging under Sec. 2 of the Sherman Act.[51] Shortly thereafter, the Fourth Circuit overturned a grant of summary judgment on a monopoly leveraging claim on substantially similar facts, assuming for purposes of remand (but not holding) that monopoly leveraging was a cognizable cause of action under § 2.[52]

Twelve years later, in its *Trinko* decision, the Supreme Court effectively put an end to monopoly leveraging as a the-

---

granted and opinion upheld, 979 F.2d 806 (11th Cir. 1992), *order vacated,* 9 F.3d 893 (11th Cir. 1993).

[51]Advanced Health-care Services, Inc. v. Radford Community Hospital, et al., 910 F.2d 139 (4th Cir. 1990).

[52]M & M Medical Supplies, et al. v. Pleasant Valley Hospital, et al., 981 F. 2d 160 (4th Cir. 1992).

ory of antitrust liability. 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."[53] Following that pronouncement, there was no realistic possibility that a "pure" monopoly leveraging claim, distinct from attempted monopolization (*i.e.*, distinct from credible allegations of a dangerous probability of successful monopolization of a second market), could survive a motion to dismiss.

Although the *Trinko* court did not specifically explain its reasoning on this point, it bears noting that the overall opinion, written by Justice Scalia, paid close attention to the economic concerns of the Chicago School.[54] Rather than condemn the institution of monopoly, the *Trinko* court stated that "[t]he mere possession of monopoly power, and the concomitant charging of monopoly prices, is not only not unlawful; it is an important element of the free-market system. . . . it induces risk taking that produces innovation and economic growth."[55] The Court went on to state, "Firms may acquire monopoly power by establishing an infrastructure that renders them uniquely suited to serve their customers. Compelling such firms to share the source of their advantage is in some tension with the underlying purpose of antitrust law, since it may lessen the incentive for the monopolist, the rival, or both to invest in those economically beneficial facilities."[56]

Finally, reflecting a consistent Chicago School theme, the Court concluded, "Against the slight benefits of antitrust intervention here, we must weigh a realistic assessment of its cost. Under the best of circumstances, applying the requirements of § 2 'can be difficult' because 'the means of illicit exclusion, like the means of legitimate competition, are myriad.' . . . Mistaken inferences and the resulting false

---

[53]*Verizon,* 540 U.S. at 415 n.4.

[54]Of interest, Judge Bork filed a brief on behalf of the Project to Promote Competition and Innovation in the Digital Age as *amicus curiae*.

[55]540 U.S. at 408

[56]*Id.*

condemnations 'are especially costly, because they chill the very conduct the antitrust laws are designed to protect.' The cost of false positives counsels against an undue expansion of § 2 liability."[57]

Thus, legal thinking on vertical restraints has evolved from a broad concern over the prospective ability of large firms to use their upstream or downstream relationships to disadvantage rivals to the wholly different concept that antimonopoly enforcement should be narrowly tailored to ensure that innovation and efficiency are not compromised.

Notably, concerns about the potential harms of downstream referral ("channeling") conduct in health care ultimately were addressed by regulation rather than litigation. As a consequence of *Venice Hospital* and its progeny, the federal government and many states adopted laws to protect patients' rights to choose a downstream provider and to ensure greater transparency in the process. For example, in the Balanced Budget Act of 1997, Congress required Medicare-participating hospitals to provide a list of local, Medicare-certified home health agencies to patients requiring home care services and to disclose whether the hospital has a financial interest in any such home health agency or other entity to which it makes referrals.[58] Of course, today, this type of regulation can be viewed as inconsistent with efforts to encourage providers to develop more clinically efficient delivery networks and accept financial risk, which implies a need to be discriminating in the selection of downstream providers. Free choice regulations also are at tension with more recent Medicare rules imposing financial penalties on hospitals having excessive readmission rates, as those rules likewise create a stake for hospitals in the quality of the downstream providers to which their patients are referred.[59]

B. Section 7 Analysis and Hospital-Physician Integration

Vertical integration by hospitals and health systems into

---

[57] *Id.* at 414 (internal citations omitted).

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

[59] 42 U.S.C. § 1395ww(q).

the physician services market is by no means a recent development, but certainly the trend to employ physicians and acquire physician practices has accelerated with increased interest in payment-for-value, population health management and the Affordable Care Act—in which economic alignment of providers and control over clinical efficiency are considered essential. Although hospital-physician acquisitions, for the most part, traditionally escaped antitrust scrutiny,[60] today these transactions (or at least the larger transactions) often receive attention from the Federal Trade Commission and state attorneys general.[61] The most notable of recent actions was the successful challenge by the FTC and the Idaho Attorney General to the acquisition of a multi-specialty physician group practice (Saltzer Medical Group) by St. Luke's Health System.[62]

The FTC brought the case as a *horizontal* merger challenge under § 7 of the Clayton Act, alleging that the addition of the Salzer primary care physicians (PCPs) to St. Luke's existing stable of PCPs would give St. Luke's a 60 percent share of the relevant primary care services market, which would raise both PCP and ancillary service prices by (1) increasing St. Luke's negotiating leverage with commercial payors; and (2) increasing patient referrals to St. Luke's higher-cost laboratory, radiology, and other ancillary services.[63] This was an interesting argument given that PCP

---

[60]Physician services markets, at least historically, have been thought to have low barriers to entry. Also, the growth of large medical practices often occurs incrementally rather than through major acquisitions. And, of course, growth that occurs strictly through employment (as opposed to acquisition) is beyond the purview of the antitrust laws. Section 6 of the Clayton Act provides that the "labor of a human being is not a commodity or article of commerce." 15 U.S.C. § 17. Section 6 was enacted to immunize labor unions from antitrust scrutiny, but the declaratory effect of Section 6 bars any antitrust claim based solely on the existence of an employment relationship.

[61]Certainly, the enforcement agencies at a minimum are more attentive to the vertical aspects of the horizontal mergers they investigate.

[62]FTC v. St. Luke's Health Sys., Ltd., 2014 WL 525540 (D. Idaho Jan. 24, 2014) *aff'd sub nom* St. Alphonsus Med.l Ctr.—Nampa, Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775 (9th Cir. 2015).

[63]Complaint, FTC v. St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Mar. 26, 2013) at 3–4.

services are far from the largest driver of commercial health insurance premiums (*i.e.*, true consumer costs).[64]

Notably, the FTC did not challenge the acquisition's potential vertical effects in the hospital services market. There is no question that such effects were possible—primary care physicians control a high proportion of patient referrals to hospitals, both directly (for outpatient diagnostic tests and procedures and for the services of hospital-employed specialists) and indirectly (for inpatient admissions).[65] Consequently, a hospital that employs a large share of the PCPs in a local market has a potential advantage over its competitors.

Indeed, this concern was the basis of a separate complaint filed against St. Luke's by St. Alphonsus Medical Center, the only other hospital in Nampa. That complaint alleged that "St. Luke's will gain a near monopoly share in the Nampa, Idaho market for adult primary care physician services market. It will continue its practice of foreclosing virtually all competition for the hospital admissions of the physician practices it acquires."[66] This allegation potentially involved greater consumer harm than a simple rise in the price of primary care services. Nonetheless, the FTC complaint barely

---

[64]Historically, only about 11 percent of the premium of a typical health plan goes to coverage of primary care services, which means that even a 10 percent increase in PCP prices on average would produce only about a one percent rise in insurance premiums. *See, e.g.*, *Capitation, Rate Setting, and Risk Sharing*, *in* UNDERSTANDING HEALTHCARE FINANCIAL MANAGEMENT 627 (Louis C. Gapenski & George H. Pink eds., 5th ed. 2007), *available at* http://www.ache.org/pubs/hap_companion/gapenski_finance/online%20chapter%2020.pdf.

[65]PCPs do not ordinarily admit patients to hospitals for inpatient services but they may direct patients to particular specialists (who have admitting privileges at a particular hospital) or may in some cases direct patients to a hospital's emergency department.

[66]Amended Complaint, *St. Alphonsus Medical Center-Nampa v. St. Luke's Health Sys., Ltd.*, No. 1:12-cv-00560 (D. Idaho Jan. 15, 2013) at 2. The St. Alphonsus complaint went on to detail prior instances in which St. Alphonsus believed that physician practice acquisitions by St. Luke's resulted in a shift of patients to St. Luke's from St. Alphonsus. *See, e.g.*, *id.* at 18–19. St. Alphonsus's case was subsequently consolidated with the FTC's complaint for discovery and trial. *See* Order of Consolidation, St. Luke's Health Sys, Ltd., No. 13-cv-116 (D. Idaho Mar. 19, 2013).

acknowledged this issue[67] and the court's opinion focused exclusively on the acquisition's likely effects on the prices of primary care and ancillary services.

It is likely that, like the Justice Department's decision to challenge Atrium under § 1, the FTC's decision to bring a horizontal case was simple pragmatism. Given the relatively low bar of § 7's standard of liability,[68] demonstrating a likelihood of adverse effects in the primary care market was both feasible and sufficient. However, a case built on adverse effects in the hospital services market might have required walking a fine line between a § 7 allegation of harm to competition, the Chicago School view of vertical integration as efficiency-enhancing, and the Supreme Court's rejection of monopoly leveraging theories under § 2.[69] Given that St. Luke's acquisition of Saltzer could not directly increase its market power in the hospital services market, St. Alphonsus's complaint as to expected adverse effects in that market had clear § 2 (monopoly maintenance or monopoly leveraging) overtones.

C. A Possible Rebirth of Vertical Merger Enforcement?

Although federal antitrust authorities continue to review vertical mergers, challenges remain rare. During the Obama Administration, two very large vertical transactions presenting tangible competitive concerns were cleared with relatively minor constraints imposed on the merging parties. Neither transaction has escaped the concerns that critics raised at the time they were approved. Consequently, the Justice Department is currently pursuing a challenge to another prominent vertical merger through the court of appeals.

Ticketmaster/Live Nation. In 2010, the Justice Depart-

---

[67] *See* FTC Complaint, *supra* note 63, at 3 ("PCPs generally determine what additional care and services their patients need, and refer them to other physicians, labs, or testing facilities accordingly. As St. Luke's own documents show, St. Luke's reaps the benefits of its physician acquisitions in part by relying on those physicians to shift patients to its own facilities.").

[68] 15 U.S.C. § 18 (in which the standard of liability is whether "the effect of such acquisition may be substantially to lessen competition").

[69] *See* n. 53 and accompany text, *supra*.

ment resolved its concerns regarding the merger of Live Nation (the largest concert promotion company in the U.S.) and Ticketmaster (the largest ticketing organization). The settlement allowed the merger to proceed on conditions that Ticketmaster license its primary ticketing software to a competitor, sell off one business unit, and agree not to retaliate against concert venues that use a competing ticket service. Despite the Justice Department's assurance that competition would flourish in spite of the merger, recent investigative reports assert that the dominance of Ticketmaster Live Nation has increased since the merger, no new competitors have had an impact on the ticketing market, and there have been allegations that Live Nation has used its control over the booking of premier live acts to coerce venues to use Ticketmaster as their ticket sales agent.[70]

Comcast/NBC Universal. In 2011, the Justice Department settled its objections to the merger of Comcast and NBC Universal. The transaction raised concerns that Comcast (a cable TV network) would be able to use its control of NBC Universal (a content provider) to disadvantage its cable TV competitors (*i.e.,* by denying them access to NBC Universal content or extracting premium prices for that content). The settlement imposed certain restrictions on Comcast's ability to do so. However, the settlement had a seven-year term, and consequently those restrictions expired, in 2018. Ironically, evidence presented in the AT&T-Time Warner litigation, discussed *infra*, showed that AT&T (which owns Comcast competitor DirectTV) had tangible concerns about, and made contingency plans for, exclusionary conduct by Comcast upon expiration of the settlement conditions.

AT&T/Time Warner. Like Comcast/NBC Universal, the merger between AT&T and Time Warner would bring together a leading provider of pay television services and a leading content provider, and presents the same competitive concerns. The Justice Department, however, declined to permit the merger to go forward on the same conditions as

---

[70]B. Sisario and G. Bowley, *Live Nation Rules Music Ticketing, Some Say With Threats*, N.Y. TIMES (APR. 1, 2018), *available at* https://www.nytimes.com/2018/04/01/arts/music/live-nation-ticketmaster.html.

Comcast/Universal, and filed suit in 2017.[71] The case went to trial and in 2018 the federal district court ruled for the defendants, holding that the government had failed to meet its burden of demonstrating that the merger would impair competition by increasing the merged company's leverage in content negotiations with rival pay TV providers.[72] The court observed that although the threat of a "blackout" (refusal to contract for content) is an acknowledged part of negotiations in the industry, it rarely occurs and is economically irrational for the content provider.[73]

The United States has appealed the decision to the D.C. Circuit, and the case was argued in late 2018. The government has argued that the district court misunderstood the economics of bargaining and, consequently, the dynamics created by the merger.[74] The appeal has not been decided as of this writing.

Nonetheless, it is interesting to consider the fact that leveraging issues—long dormant in federal antitrust analysis—have come back to life, not as § 2 claims, but as § 7 claims. The AT&T case, albeit an isolated instance at this point, would suggest that antitrust authorities are looking away from conduct remedies (settlements such as that in

---

[71]Complaint, United States v. AT&T Inc., et al., No. 1:17-cv-02511, (D.D.C. Nov. 20, 2017). This case constitutes the first litigated federal vertical merger enforcement action in over 40 years.

[72]310 F. Supp. 3d 161, 198–200 (D.D.C. 2018).

[73]*Id.* at 200. Ironically, media reports not long after the court's decision document the growing brinkmanship in pay-TV industry negotiations, and the fact that a number of content providers have "gone dark" on certain networks. *See, e.g.*, B. Fung, "NFL playoff games could go dark on Verizon and Spectrum thanks to disputes with big media companies," *Washington Post* (Dec. 27, 2018), *available at* https://www.washingtonpost.com/technology/2018/12/27/massive-media-company-disputes-could-keep-millions-tv-viewers-watching-football-playoffs/. The article notes, "As more content has come under the ownership umbrella of a shrinking handful of powerful firms—and with many Americans restricted to just a few cable options—companies now undergo bruising, months-long fights over content pricing and terms."

[74]Final, Corrected Brief of Appellant United States of American, United States of America v. AT&T Inc., et al., No. 18-5214 (D.C. Cir. Oct. 18, 2018); Final, Corrected Reply Brief of Appellant United States of American, United States of America v. AT&T Inc. et al., No. 18-5214 (D.C. Cir. Oct. 18, 2018); *see also* Brief of AT&T Inc., *et al.*, United States of America v. AT&T Inc. et al., No. 18-5214 (D.C. Cir. Sept. 20, 2018).

Comcast/NBC Universal) and taking a harsher look at tie-ups of large firms that operate in related markets.

V. Implications for Integration in Health Care

Recent history suggests that regardless of the political temperature, and regardless of which party is in power, health care is one area in which antitrust enforcement will always be vigorous. Nonetheless, the incentives to achieve scale and integration remain strong for health care systems. Thus, there is reason to believe that continued debates over the need for antitrust reform will affect health care enforcement directly.

Critics of current antitrust enforcement policy argue that the policy insufficiently informed about how firms (including health care systems) acquire and exercise market power. There is some research to suggest that the leverage enjoyed by large health systems in fact is not well understood from an antitrust standpoint. For example, a 2015 paper by Lewis and Pflum sought to distinguish, and measure the difference, between the impact created by a change in a hospital's *bargaining position* upon joining a health system (*i.e.*, acquiring structural market leverage by joining a system with other hospitals in the same market) and changes in *bargaining power* created by joining a system *independent* of a change in bargaining position.[75] The authors estimated that, on average, increased bargaining power associated with pure system membership contributed significantly (more than five times) more to a system hospital's markup than was generated as a result of the system's stronger bargaining position. Although the authors (and other researchers) speculate on the exact sources of structural bargaining power derived from system membership (*e.g.*, system hospitals may have access to more skilled or better-informed negotiating teams; large systems may exhibit less risk-averse behavior, *etc.*) the true explanation of these observations remains clouded. And of course, this type of research begs the question as to whether the antitrust laws can—or should—provide a control on the acquisition of non-structural bargaining power.

In regard to vertical integration, this question takes the

---

[75]M. Lewis and K. Pflum, *Diagnosing Hospital System Bargaining Power in Managed Care Networks,* 7 AM. ECON. J. ECON. POL'Y 243 (2015).

form of whether the antitrust laws sufficiently control anticompetitive conflicts of interest and the use dominance in one line of a firm's business to advance another. As health care becomes more of a digital-age enterprise, these issues will become more acute, as the ability to acquire and control data through on-line platforms can create both conflicts of interest and a potential source of leverage in related markets.[76] The over-arching question posed by reformers is whether the antitrust laws can interdict structures that are likely to result in anticompetitive behavior, given that § 2 remedies are weak up to the point where a firm has actually acquired and exercised (or seriously threatens to acquire and is pursuing) monopoly power.

There are few good answers to the questions at this point. Among the possible approaches suggested by a progressive antitrust agenda are:

- Require mandatory (Hart-Scott-Rodino) review for transactions below the size-of-transaction threshold that involve high risks of cross-leverage.
- Create legal presumptions against vertical integration by firms that have reached a high level of dominance. This is the policy thinking underneath the Bank Holding Company Act, for instance.[77]
- Impose public utility-like requirements on large integrated firms, e.g., nondiscriminatory behavior in pricing and service. This was the approach of the Justice Department in the Comcast/NBC Universal settlement.
- Revive the essential facilities doctrine.

Each of these approaches would present significant issues in terms of regulatory line-drawing, not to mention that enforcement would almost certainly require significant additional resources for the federal agencies. While the debate continues, health care providers will likely face the most scrutiny of integration plans in situations that can be viewed through either a horizontal acquisition lens (*e.g.*, acquisition of a cardiology practice by a hospital that already has a cardiology practice) or a § 1 lens (*e.g.*, challenges to payor contracting practices that can be characterized as tying ar-

[76]The issues with on-line platforms are discussed at length in Kahn, *supra*, n. 10.

[77]See discussion in Kahn, *supra* n. 10 at 794–97.

rangements or unreasonable restraints of trade). However, renewed efforts to assert liability in leveraging situations, particularly in acquisitions reviewed under § 7, seem highly probable as systems grow and on-line health care expands.