

PHYSICIANS AND THE ANTITRUST LAWS: THE BIG ISSUES

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There's a lot of talk about health-care reform. But to the extent that we continue to allocate health-care resources primarily through market mechanisms rather than government fiat, the antitrust laws will continue to play an important role in helping ensure that competition aids in controlling prices and promoting high quality, access, choice, and innovation. The federal antitrust-enforcement agencies – the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice – as well as many state attorneys general, not to mention private plaintiffs – have taken an active interest in health-care antitrust issues for over thirty years now, and this is not likely to change. As one FTC commissioner recently emphasized, antitrust enforcement in the health-care sector “is a very important and very active area at the Federal Trade Commission.”² This has important implications, both plus and minus, for physicians.

Because of the plethora of cookie-cutter antitrust enforcement actions the FTC and Antitrust Division have brought against physician-controlled contracting networks such as IPAs, the federal antitrust enforcement agencies have filed more enforcement actions against physicians (or at least against their contracting organizations) than against any other type of health-care provider.³ And the largest number of private treble-damage antitrust suits, by far, has been those filed by physicians against hospitals and other physicians relating to hospital decisions denying or otherwise adversely affecting physician hospital-staff privileges.⁴ So there is no question that health-care attorneys advising physicians and their practices should have a working knowledge of the antitrust laws and how they affect physicians.

It's obviously impossible to discuss all the circumstances in which the antitrust laws apply to physician activity. So after a brief discussion of the possible effects of a

¹ Parts I and IV through VI of this paper are updated and supplemented versions of a paper I prepared for the ABA Health Law Section's Tenth Annual Emerging Issues in Health Care Seminar.

² J. Thomas Rosch, Commissioner, FTC, “Enforcement Strategies in the Health Care Industry” 2, Prepared Remarks Before the ABA Health Law Section Sixth Annual Washington Healthcare Summit (Nov. 17, 2008) [hereinafter Rosch Remarks], <http://www.ftc.gov/speeches/rosch/081117abahealthcaresummit.pdf>.

³ See, e.g., *N. Tex. Specialty Physicians v. FTC*, 528 F.3d 346 (5th Cir. 2008), *petition for cert. filed*, 77 U.S.L.W. 3253 (U.S. Oct. 16, 2008) (No. 08-515).

⁴ A recent example is *Singh v. Mem'l Med. Ctr.*, 536 F. Supp.2d 1244 (D.N.M. 2008).

new administration on health-care antitrust in general, I'll provide an overview of the five areas I think, at present, are the most important to physicians: (1) physician-controlled contracting networks; (2) related to that, contracting-network clinical integration; (3) physician-practice mergers; (4) health-plan mergers; and (6) the general hospital/physician-owned-facility dispute. I'll outline the issues and then briefly discuss some points in their antitrust analysis.

I. A New Administration

At this writing (in early January), most of the antitrust blogs are buzzing about what an Obama administration will mean to antitrust enforcement and to judicial interpretation of the antitrust laws. In truth, no one is sure of the details, but two facts are reasonably clear: Antitrust enforcement will increase, and court decisions, over time, will probably turn somewhat to the left – that is, more aggressive antitrust enforcement and more plaintiff-oriented interpretation of the antitrust laws.⁵

The new administration promises health-care reform, although the form it might take is far from clear. Thus, the role competition will play in a reformed health-care system is unclear, and this means the role the antitrust laws will play is unclear.⁶ But it would be very surprising if reform followed a track in which some form and degree of competition failed to play a major role, and thus it's quite likely that antitrust will continue to be area of law with which health-care attorneys must be familiar.

The Antitrust Division will have a new assistant attorney general in charge of its decisions and operations. The FTC will have one new member who will probably take over as its chairman. Rumors on these appointments are rampant, but, to the best of my knowledge, there is no clear frontrunner for either position (again, as of this writing). What we do know is that President Obama is a strong supporter of aggressive antitrust enforcement. The fullest statement of his positions and intentions is probably his statement to the American Antitrust Institute, itself a left-leaning organization of antitrust practitioners and scholars.⁷ In it, he is very critical of antitrust enforcement during the Bush administration, stating that “[r]egrettably, the current administration has what may be the weakest record of antitrust enforcement by any administration in the last half century.” His evidence, however – that the FTC and Antitrust Division brought fewer

⁵ Cf. *The Politics of the Federal Bench: Obama's Appointments Are Expected to Reshape the U.S. Legal Landscape*, WASH. POST, Dec. 8, 2008, at A1 (in discussing future appointments to the federal circuit courts of appeals, noting that “some experts say that by the end of Obama's term, he and the Democratic Congress will flip the 56 percent majority Republican nominees now exert over those highly influential bodies”).

⁶ Cf. AMERICAN BAR ASSOCIATION ANTITRUST LAW SECTION TRANSITION REPORT 53 (Nov. 2008) [hereinafter ABA TRANSITION REPORT] (“Meaningful health care reform would be a huge development with tremendous implications for competition in the health care sector . . .”), <http://www.abanet.org/antitrust/at-comments/2008/11-08/comments-obamabiden.pdf>.

⁷ Statement of Senator Barack Obama for the American Antitrust Institute, <http://www.antitrustinstitute.org>.

merger challenges during the Bush administration than in the past – seems weak given the necessity to consider a number of variables in addition to merely the number of cases before reaching any conclusion.⁸ In any event, he states explicitly that “I will direct my administration to reinvigorate antitrust enforcement.”

More interesting and specific, Senator Obama singled out health care – and several particular health-care antitrust issues – explicitly in discussing his perception of lax antitrust enforcement and where more aggressive enforcement is needed. For example, he explained:

The consequences of lax enforcement are clear. Take health care, for example. There have been over 400 health care mergers in the last 10 years. The American Medical Association reports that 95% of insurance markets in the United States are now highly concentrated and the number of insurers has fallen by just under 20% since 2000. These changes were supposed to make the industry more efficient, but premiums have skyrocketed, increasing over 87 percent over the past six years.

He also singled out the pharmaceutical industry, particularly those practices by branded pharmaceutical manufacturers that impede the introduction of generic drugs, such as so-called “reverse-payment” agreements:⁹

Americans, for example, spend billions of dollars each year on drugs. Competition from generic manufacturers has the potential to reduce these costs significantly, or at least prevent these costs from ballooning further. An Obama administration will ensure that the law effectively prevents anticompetitive agreements that artificially retard the entry of generic pharmaceuticals into the market, while preserving the incentives to innovate that drive firms to invent life-saving medications.

The Antitrust Division has primary responsibility for antitrust enforcement in the health-plan industry, and it is true, as discussed later, that the Division has not challenged many health-plan mergers or other health-plan conduct besides most-favored-nation provisions in provider agreements, all of which were settled by consent decrees¹⁰ As to pharmaceutical-industry issues, the FTC has primary responsibility. The problem there is

⁸ See ABATRANSITION REPORT, *supra* note 6, at 3:

While DOJ has actively and aggressively prosecuted criminal cartels, there is a perception among some in the bar, academia, and business community of under-enforcement in the merger and civil non-merger areas at DOJ, while other observers have expressed concern about what they perceive as over-enforcement at the FTC Statistical comparisons in a vacuum are not a substitute for thorough review of all an agency’s enforcement decisions

⁹ See, e.g., *In re Tamoxifen Citrate Antitrust Litig.*, 466 F.3d 187 (2d Cir. 2006).

¹⁰ E.g., *United States v. Med. Mut.*, 1999-1 Trade Cas. (CCH) ¶ 72,465 (N.D. Ohio 1999) (consent decree and competitive impact statement).

not that the FTC has failed to file enforcement actions; indeed, it has been extremely active on many pharmaceutical fronts. Rather, for the most part, the courts have refused to find arrangements barring or delaying entry by generic drugs unlawful.¹¹ The solution here, if needed, will be legislation.

Finally, Senator Obama mentioned controlling physician malpractice-insurance rates by repealing the McCarran-Ferguson Act's¹² partial exemption for the business of insurance. He suggests that the exemption has permitted malpractice insurers to fix premium rates, rig insurance bids, and allocate markets. This seems minor. It is true that the McCarran Act would protect insurers from antitrust liability if they fixed premium rates,¹³ but I'm not aware that insurers have done so, and their rates would usually be subject to state insurance-department review at any rate. It's interesting that he blames supposedly high malpractice-insurance rates on insurer cartel arrangement without mentioning any concern with the tort system.

The antitrust laws and antitrust enforcement have always drawn strong bipartisan support from both Democrats and Republicans. In the past, changes in administrations have brought about only minor changes at the margins in antitrust enforcement. I would expect the same in the new administration. Enforcement is likely to increase somewhat; health-care is likely to remain a focus at both federal and state antitrust-enforcement agencies, and that focus may become stronger; and the new administration is likely to appoint judges who, over time, will move antitrust jurisprudence somewhat to the left. Predicting the degree of any of these shifts is impossible; my guess is that they will be noticeable but not substantial.

II. Provider-Controlled Contracting Networks: What Part of No Don't Physicians and Their Attorneys Understand?

Antitrust-enforcement price-fixing actions against provider-controlled contracting networks seem to be a never-ending saga. On December 24 of last year, the FTC filed yet two more antitrust enforcement actions against IPAs, alleging that by negotiating prices on behalf of their members with health plans, they engaged in unlawful price-fixing agreements. In *Independent Physician Associates Medical Group, Inc.*,¹⁴ the FTC sued a 500-member IPA in Modesto, California, alleging that it negotiated fees with various health plans and instigated its members' sending a form termination letter to one plan in an effort to increase reimbursement. In *Boulder Valley Individual Practice*

¹¹ See, e.g., *In re Ciprofloxacin Hydrochloride Antitrust Litig.*, 544 F.3d 1323 (2d Cir. 2008); *Schering-Plough Corp. v. FTC*, 402 F.3d 1056 (11th Cir. 2005).

¹² 15 U.S.C. §§ 1011-15.

¹³ See, e.g., *Slagle v. ITT Hartford*, 102 F.3d 494 (11th Cir. 1996).

¹⁴ File No. 061 0258 (FTC Dec. 24, 2008), <http://www.ftc.gov/opa/2008/12/allcare.shtm>.

Association,¹⁵ the staff sued a 365-physician IPA in Boulder, Colorado, alleging basically the same thing. Proposed consent orders were filed at the same time as the complaints.

Including these actions, the FTC has filed at least 35 enforcement actions against provider-controlled contracting networks since the first of year 2000;¹⁶ indeed, enforcement actions in this genre of case go back at least 25 years to 1983.¹⁷ Only one, the *North Texas Specialty Physicians* case, was actually litigated, and the Fifth Circuit (in a decision at present on petition for certiorari to the Supreme Court) affirmed the FTC's decision that the IPA engaged in unlawful price fixing¹⁸ – more about this later.

If you're a country music fan (and sufficiently old), you may remember a song by Lorrie Morgan entitled "What Part of No Don't You Understand?," which seems to apply here. Why does this problem continue notwithstanding the dedication of a significant percentage of the government's antitrust resources?¹⁹ There are a number of possibilities: (1) bad legal advice, (2) an honest misunderstanding or lack of knowledge about the law, (3) an honest belief that the network is clinically or financially integrated, (4) bad advice from a consultant, or (5) a don't-care, "we'll take the risk," attitude.

¹⁵ File No. 051 0252 (FTC Dec. 24, 2008), <http://www.ftc.gov/os/caselist/05110252/081224boulddedo/pdf>. For an interesting retort to the suit issued by the IPA, see "Statement of Boulder Valley Individual Practice Association in Response to the Announcement of a Proposed Enforcement Action by the Federal Trade Commission" (Dec. 24, 2008), http://www.bvipa.com/4413110_1.pdf. According to the statement, the IPA offered payer three options: (1) if the payer requested it, negotiation of a single contract with the IPA on behalf of its members; (2) a messenger arrangement; and (3) facilitation of direct contracting between the payer and IPA members. Additionally, the IPA noted that its members freely contracted with payers through means other than the IPA.

¹⁶ See Markus H. Meier, Assistant Director & Bradley S. Albert, Deputy Assistant Director, Bureau of Competition, FTC, "Overview of FTC Antitrust Actions in Health Care Services and Products" 10-30 (Sept. 2008), <http://www.ftc.gov/bc/0809hcupdate.pdf>.

¹⁷ See Mich. State Med. Soc'y, 101 F.T.C. 191 (1983).

¹⁸ *N. Tex. Specialty Physicians v. FTC*, 528 F.3d 346 (5th Cir. 2008), *petition for cert. filed*, 77 U.S.L.W. 3253 (U.S. Oct. 18, 2008) (No. 08-515).

¹⁹ Cf. THE NEXT ANTITRUST AGENDA: THE AMERICAN ANTITRUST INSTITUTE'S TRANSITION REPORT ON COMPETITION TO THE PRESIDENT OF THE UNITED STATES 340 (2008) [hereinafter AAI REPORT ON COMPETITION], at <http://www.antitrustinstitute.org/archives/transitionreport.ashx>:

The government has dedicated substantial resources to prosecuting cases involving physician price fixing. But the continued prevalence of enforcement actions suggests that compliance is lacking. An examination of the cases brought by the agencies over the last thirty years reveals that despite repeated prosecution of clear-cut violations of settled antitrust norms, overt cartelization schemes have not disappeared and in fact may have increased in recent years. . . . [M]any of the cases involved situations in which the physician network was operating a "sham" PPO, or was misusing the so-called "messenger model" to disguise an attempt to engage in collective negotiations. . . . The lack of meaningful sanctions has permitted a climate of abuse to fester as illustrated by the fact that dozens of cases involving per se violations lacking any colorable or legitimate integration have been prosecuted in the last five years.

The law here seems clear to me. When a non-integrated or partially integrated organization controlled by otherwise competing sellers acts on behalf of its members in a way that benefits them in their individual capacities, the action results from a horizontal agreement or conspiracy subject to section 1 of the Sherman Act.²⁰ If the organization, such as a provider-controlled contracting network, negotiates prices on behalf of its members, a horizontal price-fixing agreement results. That agreement is per se unlawful unless it is “ancillary” to the network’s operations. The agreement is ancillary if the members have partially, but substantially, integrated their operations in a way likely to achieve significant efficiencies in the delivery of their services and the joint negotiations significantly promote the efficient delivery of those services.²¹ If the organization can posit a plausible argument that the price-fixing agreement is ancillary, the “quick look” rule of reason applies, requiring a more in-depth examination of the network’s claimed efficiencies, possibly including a full-blown rule of reason analysis.²²

Even if the joint negotiations constitute an ancillary restraint, they are still unlawful under full-blown rule-of-reason analysis if the network has market power – i.e., can increase prices simply as a result of aggregating the power of its individual members. Whether a provider-controlled contracting network has market power is generally a function of its “participation percentages” – i.e., the percentage of all physicians in the relevant medical specialty in the relevant geographic market who participate in the network – and whether the network is an “exclusive” or “non-exclusive” network.²³ If the network’s participation percentages are high and it is exclusive in the sense that its members contract only through it (and not, for example, directly with health plans), it likely will have market power and its joint negotiations will be condemned after rule-of-reason analysis.

²⁰ See, e.g., *N. Tex. Specialty Physicians*, 528 F.3d at 356 (“When an organization is controlled by a group of competitors, it is considered to be a conspiracy of its members.”); *Capital Imaging Assocs., P.C. v. Mohawk Valley Med. Assocs., Inc.*, 996 F.2d 537 (2d Cir. 1993) (explaining that an IPA is considered a combination among its members because members are “independent practitioners with separate economic interests”).

²¹ See generally FEDERAL TRADE COMM’N & U.S. DEP’T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS § 3.2 (2000), <http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf>. Several recent decision include particularly helpful discussions of the ancillary-restraints doctrine. See *Major League Baseball Players Ass’n v. Salvino*, 542 F.3d 290 (2d Cir. 2008) (Sotomayor, J., concurring); *In re ATM Antitrust Litig.*, 554 F. Supp.2d 1003 (N.D. Cal. 2008); see also *Texaco, Inc. v. Dagher*, 547 U.S. 1 (2007) (per se rule inapplicable to agreement fixing price of joint-venture product where joint venture completely integrates venturers’ business).

²² See generally *Cal. Dental Ass’n v. FTC*, 526 U.S. 756 (1999); *Polygram Holding Co. v. FTC*, 416 F.3d 29 (D.C. Cir. 2005).

²³ For an explanation of exclusive and non-exclusive networks, see U.S. DEP’T OF JUSTICE & FEDERAL TRADE COMM’N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE Statement 8.A, 8.A.3 (1996) [hereinafter HEALTH CARE STATEMENTS] (“In an ‘exclusive’ venture, the network’s physician participants are restricted in their ability to, or do not in practice, individually contract or affiliate with other network joint ventures or health plans.”), at <http://www.usdoj.gov/atr/public/guidelines/1791.pdf>

If the network functions as a non-exclusive network – e.g., its members are willing to negotiate directly and individually with the health plans and contract if the plans’ offers are sufficient – it’s hard to see the problem. The joint negotiations would seem only to provide health plans with an additional competitive option that reduces the transaction costs of both plans and the network’s members – a type of efficiency many courts have recognized as cognizable.²⁴ And significantly, the mere fact that a health plan can’t sign-up the physicians it needs through direct contracting, even if they are members of the network, is not determinative as long as the physicians decide unilaterally that the plan’s offer is too low and reject it. Nothing in the antitrust laws guarantees that health plans can construct viable provider networks regardless of the level of reimbursement they offer.

Many of the enforcement agencies’ cases against provider-controlled contracting networks have focused on “messed-up messenger models.”²⁵ These are networks that claim to operate as messenger arrangements but engage in some type of activity resulting in the members’ aggregating their market power to raise reimbursement.²⁶ This can occur in a number of ways, but the most common is probably that where the network negotiates an offer with a health plan and *only then* messengers the offer to its members for their individual acceptance or rejection.²⁷

The federal agencies’ health-care antitrust enforcement statements, themselves, speak to this situation, explaining that “[u]se of an intermediary or ‘independent’ third party to convey collectively determined price offers to purchasers or to negotiate agreements with purchasers, or giving to individual providers an opportunity to ‘opt’ into, or out of, such agreements does not negate the existence of an agreement.”²⁸ The network’s negotiation of the offer, itself, constitutes a price-fixing agreement.²⁹

Because the *North Texas Specialty Physicians* case (*NTSP*) is the only litigated provider-controlled contracting network case thus far, it’s worth examining how the court analyzed the issues there. North Texas Specialty Physicians (*NTSP*) is a Fort Worth area

²⁴ E.g., *Major League Baseball Players Ass’n*.

²⁵ See generally Jeff Miles, *Ticking Antitrust Time Bombs: A Message to Messed-Up Messenger Models*, *AHLA HEALTH LAWYERS NEWS*, Nov. 2002, at 5. For an in-depth discussion of messenger model contracting networks, see *AMERICAN BAR ASSOCIATION SECTION OF ANTITRUST LAW, MESSENGER MODEL HANDBOOK* (2008); see also *HEALTH CARE STATEMENTS*, *supra* note 23, Statement 9.C (explaining messenger arrangements).

²⁶ See, e.g. *Health Care Alliance of Laredo*, Dkt. No. C-4158 (FTC Mar. 23, 2006) (consent order), <http://www.ftc.gov/os/caselist/0410097/0410097.htm>.

²⁷ *Id.*

²⁸ *HEALTH CARE STATEMENTS*, *supra* note 23, Statement 6 n.65.

²⁹ This situation is somewhat analogous to that in which competing sellers agree on a “suggested price” or price at which individual price negotiations will begin, conduct which the courts have condemned as a price-fixing agreement. See, e.g. *Plymouth Dealers’ Ass’n v. United States*, 279 F.2d 128 (9th Cir. 1960).

IPA formed, as so many IPAs were, in the 1990s to engage in risk contracting. As interest in risk contracting declined late in the 1990s, NTSP began fee-for-service contracting so that by the time of the FTC proceeding, it had only one risk contract and some twenty fee-for-service contracts.

NTSP's precise contracting methodology is not completely clear from the opinions in the case, but it appears that the FTC was primarily concerned with several forms of NTSP conduct. For example, it polled its members, asking them to provide the lowest prices they were willing to accept from health plans. NTSP would aggregate this information into the mean, median, and mode amounts. It distributed the aggregated information to its members and also used the information to develop a "contract minimum," which it then used to negotiate price offers with health plans. Once the price offer was negotiated, NTSP would messenger the offer, but only if the offer exceeded the NTSP contract minimum, to its members for their individual acceptance or rejection. If, but only if, 50 percent or more of the membership accepted the offer, NTSP would negotiate the remaining terms and conditions of the contract.

In addition, NTSP's participation agreements with its physicians provided that members would not pursue direct contracts with a plan if NTSP were negotiating with it. Once NTSP notified members that it had discontinued negotiating with the plan, they were free to negotiate and contract directly with the plan. The FTC found that this conduct, taken as a whole resulted in horizontal price-fixing agreements. Because, however, the FTC felt there could be plausible procompetitive justifications for the contracting methodology, it applied its "inherently suspect" analysis – i.e., the FTC's version of the quick-look rule of reason – rather than the strict per se rule. Ultimately, however, it found the conduct unlawful.³⁰

The Fifth Circuit agreed. First, as noted above, it found that NTSP's actions resulted from a horizontal agreement because it was an organization controlled by competitors, holding specifically that NTSP's status as a corporation did "not foreclose a

³⁰ See N. Tex. Specialty Physicians, 2005-2 Trade Cas. (CCH) ¶ 75,032, 103,464-65 (FTC 2005), explaining the FTC's "inherently suspect" analysis:

[A]n offense can be described as "inherently suspect" when there is a 'close family resemblance between the suspect practice and another practice that already stands condemned" "[S]uch conduct ordinarily encompasses behavior that [has been held per se unlawful]. At this stage, the focus of the inquiry is on the nature of the restraint rather than on the market effects If the plaintiff is able to make an initial showing that particular conduct meets these strictures, and the defendant makes no effort to advance any procompetitive justification for the conduct, then the case is concluded and the practices are condemned.

A defendant can avoid summary condemnation, however, if it can advance a legitimate justification for the practice. . . . The defendant need only articulate a legitimate justification, and is not obligated to prove the competitive benefits. . . . The proffered justifications, however, must be both cognizable under the antitrust laws and facially plausible.

If a defendant is able to advance a justification that meets both of these requirements – cognizable and plausible – the plaintiff must then make a more detailed showing that the restraints . . . are likely to harm competition.

finding of concerted action by the physicians who constitute, use, and control NTSP.”³¹ Next, the court explained, as the FTC had, that “some of NTSP’s practices bear a very close resemblance to horizontal price fixing,”³² but it, like, the FTC, examined the arrangements under a quick-look rule-of-reason standard. Thus, it assumed the required anticompetitive effect and considered whether there might be offsetting procompetitive justifications such that it was impossible to conclude, absent more examination, that the restraints would have a net anticompetitive effect. To make a long story short, the court concluded that “the net anticompetitive effects of certain of NTSPs practices were obvious. The procompetitive justifications do not plausibly result in a net procompetitive effect or in no effect on competition.”³³ In particular, the court found no connection between NTSP’s claimed procompetitive justifications and its conduct resulting in price fixing conduct: “But NTSP has not cogently articulated how ‘the quality of the professional service that [its] members provide is enhanced by the price restraint.’” In antitrust jargon, the restraints affecting price were not “ancillary” to NTSP’s achievement of efficiencies in delivering care.

The bright side to *NTSP* is that neither the FTC nor the Fifth Circuit applied the strict per se rule to NTSP’s activities. Thus, both the FTC and at least one court of appeals have held that in this context, they are willing to consider – although without applying full-blown rule-of-reason analysis (e.g., proof of relevant markets and market power) – legitimate procompetitive justifications for price-fixing activities, at least where the price restraints support the network’s ability to increase quality or deliver other efficiencies.

To a large extent, the plethora of enforcement actions against physician contracting networks is a result of physician frustration over the disparity in bargaining power between health plans and themselves. Their frustration is quite understandable, especially in light of the plethora of managed-care mergers over the last ten years or so. But whether this disparity results because of health-plan monopsony power or from other causes is debatable, and opinions on this question differ.³⁴ It is only in the former situation that consumers are ultimately injured. And even if health plans do exercise monopsony power, providing physicians with free rein to whatever extent they want to counteract that power by aggregating market power on the seller side (i.e., a “bilateral monopoly”) is far from an ideal solution because it is far from clear that this will result in

³¹ *NTSP*, 528 F.3d at 356.

³² *Id.* at 362.

³³ *Id.* at 363.

³⁴ Compare FEDERAL TRADE COMMISSION & U.S. DEP’T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION Ch. 2 at 21 (2004) [hereinafter FTC-DOJ JOINT REPORT] (“the available evidence does not indicate that there is a monopsony power problem in most health care markets”), http://www.usdoj.gov/atr/public/health_care/204694.pdf with AMERICAN MEDICAL ASSOCIATION, COMPETITION IN HEALTH INSURANCE (2007) (finding that health-plan market concentration is extremely high in most Metropolitan Statistical Areas in the U.S.), <http://www.ama-assn.org/ama1/pub/upload/mm/368/compstudy.pdf>.

a competitive price.³⁵ The FTC has consistently opposed, at both the federal and state levels, efforts by physicians (and other providers) to gain an antitrust exemption for joint negotiations by non-integrated physician groups,³⁶ and there is no reason to believe its position will change in a new administration.

III. Clinical Integration: What Is It and What Does It Do for You?

Any discussion of physician-controlled contracting networks these days naturally segues into a discussion of the potential clinical integration of those networks. If developed and implemented properly, clinical integration can result in contracting-network joint negotiations constituting an ancillary restraint. Importantly (a fact many networks overlook), this does not mean the joint negotiations are lawful; it only means they are subject to rule-of-reason analysis rather than per se condemnation.

Clinical integration is a complex and ambiguous subject, and commentators have urged the FTC to provide additional guidance about the necessary elements.³⁷ But the understandable position of the FTC staff is that it doesn't want to stifle innovation in health-care delivery by attempting to provide a cookie-cutter approach to evading the per se rule against price fixing. Moreover, there is already a good deal of explanation on this subject; the most important are probably the three FTC staff advisory opinions discussing clinical integration and a follow-up letter to one of the opinions,³⁸ and the FTC/Antitrust

³⁵ See generally ROBERT S. PINDYCK & DANIEL L. RUBINFELD, MICROECONOMICS 370 (6th ed. 2005) (explaining that in bilateral monopoly (where the seller has monopoly power and the buyer has monopsony power), the outcome of bargaining is indeterminate, not necessarily resulting in the competitive price).

³⁶ See, e.g., David Wales, Deputy Director, Bureau of Competition, FTC, Prepared Statement of the FTC Before the House Judiciary Committee Concerning H.R. 971, "The Community Pharmacy Fairness Act of 2007 (Oct. 18, 2007) (objecting to federal bill that would permit community pharmacies to jointly negotiate prices with purchasers), <http://www.ftc.gov/os/testimony/p859910pharm.pdf>; FTC Staff Letter to Puerto Rico Treasury & Financial Affairs Committee (Jan. 30, 2008) (objecting to Puerto Rico bill that would permit health-care providers to negotiate collectively with purchasers), *reprinted in* 4 JOHN J. MILES, HEALTH CARE & ANTITRUST LAW App. D121 (Supp. 2008) [hereinafter HCAL].

³⁷ See, e.g., AAI REPORT ON COMPETITION, *supra* note 19, at 341 ("the agencies need to clarify the boundaries of 'clinical integration'"; "Physicians' frustration stems from a lack of clarity on legal requirements for clinical integration, uncertainty about other means to avoid charges of price fixing (such as the messenger model) and the lack of guidance as to whether new payment arrangements, such as pay for performance, will affect their ability to form networks"); ABA TRANSITION REPORT, *supra* note 6, at 55.

³⁸ FTC Staff Advisory Opinion to MedSouth, Inc. (Feb. 19, 2002), <http://www.ftc.gov/bc/adops/medsouth.shtm>; FTC Follow Up to 2002 MedSouth Staff Advisory Opinion (June 18, 2007), <http://www.ftc.gov/bc/adops/070618medsouth.pdf>; FTC Staff Advisory Opinion to Suburban Health Organization (Mar. 28, 2006), <http://www.ftc.gov/os/2006/03/suburbanhealthorganizationstaffadvisoryopinion03282006.pdf>; FTC Staff Advisory Opinion to Greater Rochester Independent Practice Association, Inc. (Sept. 17, 2008), <http://www.ftc.gov/bc/adops/gripa.pdf>.

Division 2004 report on competition in the health care sector.³⁹

Statement 8 of the federal agencies' *Health Care Statements* explains in broad terms that clinical integration can result from "an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."⁴⁰ It then lists characteristics the program might include: "(1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies." Then, "[t]o the extent that agreements on prices to be charged for the integrated provision of services are reasonably necessary to the venture's achievement of efficiencies [the classic definition of an ancillary restraint], they will be evaluated under the rule of reason." Significantly, Statement 8 goes on to explain that "[t]he foregoing are not . . . the only types of arrangements that can evidence sufficient integration to warrant rule of reason analysis."

So synthesizing this, the physicians must integrate their practices through the clinical-integration program in a way likely to achieve significant efficiencies in cost, quality, and/or utilization, *and* the joint negotiation of prices must significantly contribute to their achieving the efficiencies generated by the program.⁴¹ The basic idea is that the physicians work in a *coordinated, collaborative, and interdependent* manner so the whole is greater than its individual parts. The physicians should develop and implement the program themselves. Their hope is that they can not only improve the quality of their aggregate delivery of care but also increase reimbursement – not by aggregating their market power but through offering a higher-quality program for which customers are willing to pay more.

There is no one form of program that constitutes clinical integration for antitrust purposes, but the following characteristics seem, if not important, at least desirable: (1) substantial capital and "sweat equity" contributions by the physicians; (2) careful choice of participating physicians based on their interest in quality and willingness to participate fully in the program; (3) a formal system for the exchange among the physicians of relevant patient medical information; (4) maximization of in-network referrals among the physicians; (5) development and formal issuance by the network of practice protocols

³⁹ FTC-DOJ JOINT REPORT, *supra* note 34, Ch. 5 at 36-41 (2004). For other guidance, *see* Robert F. Leibenluft & Tracy E. Weir, "Clinical Integration: Assessing the Antitrust Issues," in HEALTH LAW HANDBOOK 2004 (A. Gosfield, ed. 2004).

⁴⁰ HEALTH CARE STATEMENTS, *supra* note 23, Statement 8.B.1.

⁴¹ *Cf.* Rosch Speech, *supra* note 2, at 8 ("It is clear that for clinical integration to pass legal muster, there must be proof that (i) the clinical integration has real potential to achieve significant efficiencies in the form of reduced cost/enhanced quality and that (ii) the joint contracting is reasonably needed to achieve those efficiencies.").

covering all specialties represented in the network and agreement among participants to abide by them; (6) development of cost, quality, and utilization network benchmarks or goals reflecting improvement over the status quo; (7) a formal system of reporting and monitoring individual physician and aggregate network compliance with the protocols and achievement of network efficiency benchmarks; (8) identification of “outlying” physicians who fail to apply the protocols or contribute to the network’s goals; (9) development of “corrective action” programs for these physicians; and (10) a formal program for sanctioning habitually non-complaint physicians, including, ultimately, expulsion from the network. Also very worthwhile is some type of financial risk/reward system to provide additional incentive for physicians to both participate in the program and actively pursue its efficiency benchmarks.⁴²

It can be difficult to explain why the joint negotiations are ancillary to the network’s achievement of efficiencies. That the joint negotiations be ancillary to the achievement of efficiencies, rather than the achievement of efficiencies ancillary to the network’s price fixing, is crucial. Commentators and attorneys have posited a number of reasons why joint negotiations support the network’s achievement of efficiencies.⁴³ Perhaps the most valid is the simple fact that for the program to succeed, all participants must participate in all the network’s contracts, and the only way to ensure this is for the network to negotiate contracts on behalf of all its members, while requiring them to participate in all network contracts. Another frequent argument that the FTC rejects (but has some support in the case law)⁴⁴ is that if the physicians can’t negotiate jointly, they won’t participate in the network and the efficiencies it would generate would be lost. But what this seems to say is that unless the physicians can force a price increase through exercising market power as a group, they see no reason to work to improve quality and efficiency. Another argument is that the physicians should be able to negotiate jointly (and force a price increase) to recoup their financial and time investments in the program. But the obvious retort is that it should be up to customers to determine whether the increase in quality is worth a higher price, rather than having the program and higher price crammed down their throats by the network.

If the physicians’ purpose in developing a clinical-integration program is to increase their bargaining leverage to raise prices, the program is probably doomed from the start for at least two reasons: First, if the physicians attain their objective, health plans will complain to the enforcement agencies, and an investigation will ensue. The network’s ability to increase prices in this way is almost a dead giveaway that it has market power and thus flunks rule-of-reason analysis. Second, the participating

⁴² *Id.* at 8-9 (“If a clinical integration program includes a very strong system of rewards and punishment, I personally think it could be successful. But to be on the safe side I have counseled that there be some significant degree of financial integration for a physician group seeking to justify joint contracting on the basis of clinical integration.”).

⁴³ See generally AMERICAN HOSPITAL ASSOCIATION, GUIDANCE FOR CLINICAL INTEGRATION: WORKING PAPER (2007), <http://www.aha.org/aha/content/2007/pdf/070417.pdf>.

⁴⁴ See *Polk Bros., Inc. v. Forest City Enters.*, 776 F.2d 185 (7th Cir. 1985).

physicians will focus on increasing prices rather than improving the delivery of services, and the clinical-integration program will fail.

Physicians contemplating clinical integration should understand that clinical integration is not inexpensive and the development and implementation of a first-class program takes significant time – much more time than the participants expect on the project’s front end. It takes substantial amounts of the physicians’ time and energy, and there is no guarantee of any financial return on the investment. Crucially important is for the physicians to develop a program that customers want to buy. Antitrust problems will arise if the network can force the program on unwilling health plans because the plans can’t obtain the physician services they need elsewhere. Thus, it’s important to meet with potential customers, such as managed-care plans, during the program’s planning stages to obtain their input on program development and ensure customer interest in the program.

IV. Physician-Practice Mergers: A New Area of Antitrust Concern?

Although physicians overwhelmingly continue to practice in solo practices and very small groups, physician-practice mergers into larger groups are a growing phenomenon – primarily for three reasons: (1) efficiencies, (2) greater bargaining power with health plans, and (3) ability under the Stark laws to develop services to which the group may refer patients. Where the merger combines physicians in different medical specialties (or, more technically, different relevant product markets) into a multi-specialty group, or combines those too distant from one another to constitute competitors (that is, in different relevant geographic markets), no antitrust issue typically arises. Most problems arise from single-specialty physician-practice mergers.

Worth emphasizing preliminarily is that there is a dearth of case guidance about the antitrust ramifications of physician-practice mergers. Neither of the federal antitrust enforcement agencies has yet brought a case directly challenging a physician-practice merger. Several state attorneys general, however, have but settled each with a consent order short of dispositive motions or trial.⁴⁵ Moreover, several consent decrees in state-attorney-general challenges to hospital mergers between hospitals’ employing physicians have limited the merging hospitals’ ability to acquire more physicians practicing in the same specialties.⁴⁶

⁴⁵ *E.g.*, *State of Maine v. Maine Heart Surgical Assocs., P.A.*, 1996-2 Trade Cas. (CCH) ¶ 71,653 (Me. Super. Ct. 1996) (consent decree); *State of Maine v. Cardiovascular & Thoracic Assocs., P.A.*, 1992-2 Trade Cas. (CCH) ¶ 69,985 (Me. Super. Ct. 1992) (consent decree).

⁴⁶ *See, e.g.*, *Pa. v. Providence Health Sys., Inc.*, 1994-1 Trade Cas. (CCH) ¶ 70,603 (M.D. Pa. 1994) (consent decree).

The subject also seems to interest the FTC, an interest that is not new.⁴⁷ It has investigated several and has at least one under investigation at the present time. And the Antitrust Division has issued several business review letters discussing physician-practice mergers, concluding that it would challenge some but not others.⁴⁸ Finally, two private plaintiffs have challenged physician-practice mergers. One upheld the transaction, primarily because it found entry barriers into the relevant physician markets low;⁴⁹ the other focused on the antitrust-injury requirement for recovery of damages and did not discuss the merits.⁵⁰

Whether this will become an area of increased scrutiny under the new administration is an open question. On one hand, there seems to be some sympathy with the plight of small practitioners in the face of large managed-care organizations. On the other, there is colorable concern that the effect of these mergers will be to increase health-care costs. The agencies have consistently opposed efforts of physicians and others to gain an antitrust exemption for collective bargaining by individual medical practices with health insurers to “level the playing field,”⁵¹ and physician-practice mergers can have the same effect.

⁴⁷ See Mary Lou Steptoe, Acting Director, Bureau of Competition, FTC, “Current Issues in Health Care Antitrust: Boycotts, Mergers, and Provider Networks,” Prepared Remarks Before the ABA Section of Antitrust Law Spring Meeting (Apr. 5, 1995) [hereinafter Steptoe Remarks] (“A new area of potential antitrust concern is the merger of physician practices.”), reprinted in *HCAL*, supra note 36, App.E54.

⁴⁸ Antitrust Division Business Review Letter to Gastroenterology Associates, Ltd.; GI Associates, P.C.; and Valley Gastroenterologists (Jul. 7, 1997) (Division would probably challenge merger of three gastroenterology groups), <http://www.usdoj.gov/atr/public/busreview/1174.pdf>; Antitrust Division Business Review Letter to CVT Surgical Center and Vascular Surgery Associates of Baton Rouge (Apr. 16, 1997) (Division not likely to challenge merger of two surgery groups), <http://www.usdoj.gov/atr/public/busreview/1099.pdf>; Antitrust Division Business Review Letter to Orthopaedic Associates of Mobile, P.A. and Bone & Joint Center of Mobile (Apr. 16, 1997) (Division not likely to challenge merger of two orthopedic groups), <http://www.usdoj.gov/atr/public/busreview/1098.pdf>; Antitrust Division Business Review Letter to Terrence L. Smith, M.D. (Oct. 17, 1996) (Division not likely to challenge merger of anesthesiology groups), <http://www.usdoj.gov/atr/public/busrev/0954.pdf>; Antitrust Division Business Review Letter to Itasca Clinic and Grand Rapids Medical Associates (Mar. 19, 1996) (Division not likely to challenge merger of two physician-clinic groups), <http://www.usdoj.gov/atr/public/busreview.0626pdf>; Antitrust Division Business Review Letter to Pulmonary Associates, Ltd. and Albuquerque Pulmonary Consultants, P.A. (Oct. 31, 1994) (Division not likely to challenge merger of pulmonologists’ practices), <http://www.usdoj.gov/atr/public/busrev/0797.pdf>; Antitrust Division Business Review Letter to Surgical Associates of Western Connecticut, P.C. and Danbury Surgical Associates (Aug. 28, 1987) (Division likely to challenge merger of two general surgery groups), reprinted in *HCAL*, supra note 36, App. C24.

⁴⁹ *HTI Health Servs., Inc. v. Quorum Health Group, Inc.*, 960 F. Supp. 1104 (S.D. Miss. 1997).

⁵⁰ *Nelson v. Monroe Reg’l Med. Ctr.*, 925 F.2d 1555 (7th Cir. 1991).

⁵¹ See FTC-DOJ JOINT REPORT, supra note 34, Ch. 2 at 18, 21 (“The Agencies have consistently opposed such exemptions because they are likely to harm consumers by increasing costs without improving quality of care.”; “the available evidence does not indicate that there is a monopsony power problem in most health care markets”; “The Agencies believe that antitrust enforcement to prevent the unlawful acquisition or exercise of monopsony power by insurers is a better solution than allowing providers to exercise

When addressing physician-practice mergers and advising physician clients on the subject, two general questions usually arise. One, obviously, is whether the merger would violate the substantive standards of the antitrust laws – most frequently, section 7 of the Clayton Act, which prohibits all forms of mergers or acquisitions that might substantially lessen competition. But a preliminary issue that frequently arises is whether the transaction the physicians propose would result in their becoming a single entity for antitrust purposes – whether the merger is a “real” merger.⁵² This question is crucial because if the transaction fails to result in a single merged entity, the physicians’ post-“merger” negotiations of prices with health plans likely will constitute a per se violation of section 1 of the Sherman Act; they remain separate, competing entities for purposes of the antitrust laws.

Whether the transaction results in a merger and thus a single entity for antitrust purposes depends on the extent to which the physicians *actually* integrate their practices and operate as a single entity would. Physicians typically are very autonomous and independent and often, in proposing a “merger” transaction, they really want to actually integrate their practices as little as possible; they don’t want to work as a whole, or interdependently, with one another. Accordingly, it’s not unusual for them to propose a limited-liability-company or “clinic-without-walls” arrangement where, functionally, they establish a board of managers with relatively little authority over the “merging” practices as a whole, but they otherwise practice separately – precisely as they did prior to the transaction. Indeed, in some situations, the purported merger is nothing more than an office-sharing arrangement.

There is no definitive level of practice integration that sustains a single-entity test. Rather, there are a series of “integration pluses” and “integration minuses” that must be balanced in determining whether the post-merger practice would actually function as a single entity. For example, an “eat-what-you-kill” compensation system and failure to share expenses – that is, failure of the physicians to share profits and losses – are significant minuses but probably not determinative by themselves. On the other hand

countervailing power [by collective negotiations.]”); David Wales, Deputy Director, Bureau of Competition, FTC, Prepared Statement of the FTC Before the House Judiciary Committee Concerning HR 971, “The Community Pharmacy Fairness Act of 2007” (Oct. 18, 2007) (opposing bill that would provide community pharmacists with exemption for collective negotiations “to secure higher fees and more favorable contract terms from health plans”), <http://www.ftc.gov/os/testimony/p859910pharm.pdf>.

⁵² See ABA TRANSITION REPORT, *supra* note 6, at 54:

[T]here has been [an] increasing number of very large consolidations of single specialty physician practices. In some cases, there may be questions as to whether the mergers are real in substance as opposed to just form. In others, the mergers likely create the potential of some significant efficiencies, but also increased market power. Assessing such mergers may raise difficult issues, including product and geographic market definition and entry barriers. So far, there have been few decisions or reported investigations, but it is an area that will likely warrant close attention by the agencies down the road.

integrating the physicians into a single location and centralizing business functions are pluses.⁵³

An example of the problem that can arise was the FTC's 2003 enforcement action against Surgical Specialists of Yakima for negotiating fees on behalf of its physicians.⁵⁴ There, two area general-surgery practices, which included ninety percent of the area's general surgeons, had formed a limited liability company specifically, according to the FTC's complaint,⁵⁵ to "prevent payers from decreasing reimbursement rates." But, the complaint continued, "[t]hese physicians did not . . . want to combine or integrate their practices." Although the practices' employees were paid through the LLC, the LLC assured its physicians that "you will retain management control of you own office including personnel, and all day to day operations as you currently control them." Collections were centralized, but the members billed separately. The complaint alleged that the LLC's "operating agreement was drafted to create the appearance that [the LLC] was operating as single entity, despite the reality that each member physician retained control of his or her individual practice." Patient files remained the property of the individual practices, and the physicians were paid by their individual practices rather than by the LLC. Finally, according to the complaint, "[t]he operating agreement's system allocated income and expenses so that each member's income was independent of the income earned by [the LLC] or any of its individual members."

Although the complaint points out different ways in which the practices were not integrated, it makes no effort to provide any guidance on the degree or types of integration that would have been sufficient for the group to constitute a single entity. But it would seem important that the LLC's board of managers have ultimate control over most all aspects of the practices' operations and for expenses to be shared. The complaint treated the LLC as a non-integrated provider-controlled contracting network and thus its negotiation of prices with health plans as a horizontal price-fixing agreement. This, of course, is unlawful.⁵⁶

Turning to the question of whether the transaction, if resulting in a merger, would violate section 7 of the Clayton Act, several difficult issues frequently arise. First is the definition of the relevant product market, which depends on those types of practitioners whom patients and health plans perceive as reasonably substitutable for one another. All primary-care practitioners might constitute a product market. As to specialists, different medical specialties might constitute separate relevant product markets, but the question

⁵³ For a more detailed discussion of pluses and minuses and this issue in general, *see* Jeff Miles, *The Importance of Integration in Healthcare Antitrust Counseling: Yakima and Susquehanna*, AHLA HEALTH LAWYERS NEWS, Mar. 2004, at 17.

⁵⁴ *Surgical Specialists of Yakima, P.L.L.C.*, 136 F.T.C. 840 (2003) (consent order).

⁵⁵ Available at <http://www.ftc.gov/os/2003/11/031118do0210242.pdf>.

⁵⁶ *See, e.g.* *N. Tex. Specialty Physicians v. FTC*, 528 F.3d 346 (5th Cir. 2008), *petition for cert. filed*, 77 U.S.L.W. 3253 (U.S. Oct. 16, 2008) (No. 08-515).

becomes more complex when different specialties render overlapping types of medical services. For example, should two colon-rectal surgery practices merge, the relevant product market might include not only colon-rectal surgeons but general surgeons doing the same types of procedures as well.⁵⁷ On the other hand, the market for pediatric services would include pediatricians but might not include general family practitioners whose patients include children if health plans cannot substitute family practitioners for pediatricians in their networks.⁵⁸

Even more difficult usually is defining the relevant geographic market because patient-flow information is typically lacking. The merging practices will have information about the area from which they draw their patients – their “service area” – but service areas are not relevant geographic markets.⁵⁹ Rather, one would need patient-flow information from competing practices and information indicating where patients within the service areas could practicably go for comparable services.⁶⁰ Usually, these types of information are impossible for private parties to obtain short of discovery in litigation. Thus, in assessing physician-practice mergers, an educated estimate as to the relevant geographic market is often all that is possible.

Lack of information also makes calculating market shares difficult. If market shares are based on procedures or revenues, those for the merging practices are available, but not those for competing practices. Accordingly, the number of physicians in the different practices is usually used as a surrogate, and a practice’s market share is calculated based on its percentage of all area physicians in the relevant medical specialty. This assumes, however, that all the physicians produce equally,⁶¹ which is rarely the case. Thus, market-share figures can only be estimated (and this estimate is based on an estimate of the relevant geographic market, piling estimate upon estimate). Once this is done, the question becomes whether the merged practice itself has sufficient market power to raise its prices and make the price increase stick or whether the relevant market as a whole is sufficiently concentrated such that the merging practices and their competitors could increase prices through interdependent pricing decisions.⁶²

⁵⁷ See Antitrust Division Business Review Letter to Allied Colon and Rectal Specialists (Jul. 1, 1996), <http://www.usdoj.gov/atr/public/busreview/0703.pdf>.

⁵⁸ See Antitrust Division Business Review Letter to Children’s Healthcare, P.A. (Mar. 1, 1996), <http://www.usdoj.gov/atr/public/busreview/0555.htm>.

⁵⁹ See, e.g., *Gordon v. Lewistown Hosp.*, 423 F.3d 184 (3d Cir. 2005). For an excellent discussion, see HERBERT HOVENKAMP, *FEDERAL ANTITRUST POLICY* § 3.6d at 119-20 (3d ed. 2005).

⁶⁰ See generally *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1961) (explaining that the relevant geographic market is the “market area in which the seller operates, and to which the purchaser can practicably turn for supplies”)

⁶¹ See Steptoe Remarks, *supra* note 47 (explaining that in “calculating concentration levels, we have often begun by counting the number of practicing physicians in the possible product market and treating them as equal producers of output”).

⁶² See *id.*, explaining that in analyzing physician-practice mergers, the FTC considers:

On the other side of the equation, efficiencies from the transactions are an important consideration. Efficiencies from physician-practice mergers tend to be relatively limited, but depend heavily on the medical specialty involved and the degree of integration resulting from the transaction. Thus, to the extent the physicians attempt to minimize the degree of integration, they not only increase the risk of failing to become a single entity, but they limit the most important factor in the antitrust analysis arguing in favor of the transaction – the efficiencies their merger generates.

Although physicians seem hesitant to merge with their colleagues, mergers are probably the most optimal legitimate method for them to improve their position vis a vis large health insurers.⁶³ Given that, given the increase in health-plan market concentration over the last few years, and given physician frustration about the continuing ratcheting down of reimbursement, we are likely to see more and more physician-practice mergers in the near future. Expect some to result in investigations by the FTC, Antitrust Division, and state attorneys general.

V. Health-Plan Mergers: Are the Enforcers Asleep at the Wheel?

Without question, “health-plan markets” (using that term in the lay sense) have become substantially more concentrated over the last ten years or so through mergers. And as noted before, this is a subject that the new administration will likely subject to increased scrutiny, certainly a plus for physicians.

Health-plan mergers can have both “seller-side” and “buyer-side” antitrust ramifications. As to the former, the more concentrated a health-plan market becomes, the

Whether the merged entity can unilaterally achieve market power – the power to raise prices and affect the availability of services – or achieve lessening of competition through coordinated interaction. We examine the views of hospitals, third-party payers, physicians, and others knowledgeable about the particular market. In assessing the likely competitive effects, we are interested in the ability and willingness of third-party payers to switch between provider groups or networks in response to price increases. If third-party payers can contract easily with other provider groups or networks at competitive prices, and can obtain a similar quality and range of services for their enrollees, the merger is less likely to raise competitive concerns. Instances where the non-affiliated physicians charge more, are few in number, offer questionable quality, provide limited services, or have a history of engaging in anticompetitive collusion, are more likely to raise competitive concerns.

⁶³ Cf. Rosch Remarks, *supra* note 2, at 6:

What are the options for competing physicians who wish to collectively negotiate their fees? There are several. First, competing physicians can *merge* their practices into a single entity whereby the physicians are employed by the entity. Aside from financial integration . . . , this may be the best means for physicians to increase efficiencies and negotiate as a group without running afoul of the antitrust laws. There are no price fixing issues associated with physicians in a group practice, because they are no longer competitors, but instead are employed by the same entity. [B]ut [a]n antitrust issue can arise if the market in which the merging physicians compete is already concentrated, so the merger will give the merged entity market power.

more likely it is that a single health plan, or all the plans in the market through interdependent conduct (i.e., oligopolistic tacit collusion), can exercise market power by raising premium prices. As to the buyer side, the fewer the health plans in a market, the more likely it is that one or more can exercise monopsony power – that is, reduce the price they pay for inputs (i.e., provider services) by reducing the amount of those service they purchase.⁶⁴

The Antitrust Division has primary responsibility for antitrust enforcement efforts focusing on health plans and has been criticized for its alleged inactivity in challenging health-plan mergers. Thus far, as discussed below, it has brought three enforcement actions, each resulting in limited divestitures. It has investigated several others and has issued statements explaining its decisions not to challenge two.

An important point that some physicians complaining about this alleged lack of enforcement often overlook is that before a health-plan merger even raises an antitrust issue, the merging plans must be actual (or at least potential) competitors geographically. Many of the largest health-plan mergers have failed this requirement, even though the merging plans involved were mammoth. There is simply nothing the antitrust-enforcement agencies can do about these. A good example is the proposed merger of Highmark, the dominant health plan serving western Pennsylvania, and Independence Blue Cross, the dominant health plan serving eastern Pennsylvania. The Antitrust Division investigated this merger but took no action because the firms do not compete geographically.⁶⁵ Some have argued that even though they are not direct competitors, they are potential competitors and that this should be sufficient for the state department of insurance to reject the transaction. The outcome, at the time of this writing, remains to be seen.⁶⁶

Health-plan mergers typically present a number of complex and very fact-specific issues.⁶⁷ The most difficult might be definition of the relevant product market – in

⁶⁴ See generally *Campfield v. State Farm Mut. Auto Ins. Co.*, 532 F.3d 1111 (5th Cir. 2008). And contrary to the belief of some, a monopsony's ability to pay lower prices for its inputs will not benefit consumers by resulting in lower output prices. For a comprehensive discussion of the economics and law of monopsony, see ROGER D. BLAIR & JEFFREY H. HARRISON, *MONOPSONY: ANTITRUST LAW & ECONOMICS* (1993). Monopsony on the buyer side is the mirror image of monopoly on the seller side and has the same types of resource-misallocation and wealth-redistribution effects. See generally *Weyerhaeuser Co. v. Ross-Simmons Hardwood Lumber Co.*, 549 U.S. 312 (2007).

⁶⁵ See *Justice Department Signs Off on Proposed Highmark-IBC Merger*, PITTSBURGH BUS. TIMES, Jul. 18, 2008, <http://www.pittsburgh.buzjournals.com/pittsburgh/stories/2008/07/14/daily36.html>. Of course, whether the plans are competitors depends on the definition of the relevant geographic market. If that market were state-wide, rather than regional, the plans would be competitors.

⁶⁶ See generally Kris B. Mamula, *Pennsylvania Senate Committee Expected to Recommend Against Highmark-IBC Merger*, PITTSBURGH BUS. TIMES, Nov. 19, 2008, <http://www.pittsburgh.buz.journals.com/pittsburgh/stories/2008/11/17/daily31.htm>.

⁶⁷ For an excellent and relatively comprehensive discussion, see FTC-DOJ JOINT REPORT, *supra* note 34, Ch. 6 at 1-19.

particular, on the seller side, what types of plans the relevant product market includes and whether it includes both private commercial plans and governmental plans. The first question is quite fact specific as the cases demonstrate.

The answer to the question, of course, depends on the degree of substitutability among the different types of plans – HMOs, PPOs, point-of-service, indemnity, and possibly others. Earlier private-plaintiff decisions defining health-plan markets tended to define product markets broadly to include all types of “health care financing.”⁶⁸ But in its health-plan merger enforcement actions, the Antitrust Division has defined product markets more narrowly. For example, in its first challenge of a health-plan merger, Aetna’s acquisition of Prudential’s health-plan business in the Dallas and Houston areas, the Division alleged that the relevant product market was limited to HMO and HMO point-of-service plans, excluding PPO and indemnity plans.⁶⁹ According to the Division, the plans differed in cost and benefit design to the extent that a seller of HMO and HMO point-of-service plans could, hypothetically, profitably raise prices because an insufficient number of HMO and HMO point-of service customers (employers and individuals) would substitute a PPO or indemnity plan.⁷⁰

The Division’s next case, challenging UnitedHealth’s acquisition of PacifiCare in the Tucson area,⁷¹ alleged a relevant product market of all types of commercial insurance, but limited the relevant product market to sales of commercial insurance to small-group employers. Why carve out a market limited to small-group employers? Because, according to the Division, small-group employers, unlike large employers, lack the practical option of self-insuring. Thus, while large employers could easily switch from commercial insurance to a self-funded program if purveyors of commercial insurance attempted to raise prices, small employers could not, and thus commercial insurers could profitably raise prices to them. In that situation, it is perfectly appropriate to carve-out a relevant product market based on the type of customer purchasing exactly the same product as other customers.⁷²

⁶⁸ *E.g.*, *Blue Cross & Blue Shield United v. Marshfield Clinic*, 65 F.3d 1406 (7th Cir. 1995); *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589 (1st Cir. 1993); *Ball Mem’l Hosp., Inc. v. Mut. Hosp. Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986).

⁶⁹ *United States v. Aetna, Inc.*, 1999-2 Trade Cas. (CCH) ¶ 72,730 (N.D. Tex. 1999) (consent order and competitive impact statement).

⁷⁰ Keep in mind that a relevant product market includes only the smallest number of products or services whose price a hypothetical monopolist could raise without losing so many sales that it would have to rescind the price increase because it was not profitable. *See generally* U.S. DEP’T OF JUSTICE & FEDERAL TRADE COMM’N, 1992 MERGER GUIDELINES § 1.11 (1992, as amended 1997) [hereinafter MERGER GUIDELINES], <http://www.usdoj.gov/atr/public/guidelines/hmg.pdf>.

⁷¹ *United States v. UnitedHealth Group, Inc.*, 2006-1 Trade Cas. (CCH) ¶ 75,255 (D.D.C. 2006) (consent decree and competitive impact statement).

⁷² *See* MERGER GUIDELINES, *supra* note 70, § 1.12.

The Division’s final case challenged UnitedHealth’s acquisition of Sierra Health Services’ private-commercial Medicare Advantage business.⁷³ Sierra operated primarily in Nevada and had a very strong presence in the Las Vegas area. The interesting point here is that not only did the government carve-out Medicare from all forms of health insurance, but it went further and alleged that Medicare coordinated-care plans – Medicare Advantage HMO and PPO plans – were in a separate relevant product market from the traditional Medicare fee-for-service plan. According to the Division, because Medicare Advantage plans cost significantly less and provided substantially richer benefits than the Medicare fee-for-service plan, “[a] sufficient number of seniors in the Las Vegas area would not switch away from Medicare Advantage plans to traditional Medicare in the event of a small but significant reduction in plan benefits under the plans, or a small but significant increase in price, to render the benefit decrease or price increase unprofitable.”⁷⁴

The discussion above focuses on the seller-side product-market definition. The Aetna and UnitedHealth/PacifiCare cases also focused on the mergers’ buyer-side effects – that is, the possible monopsony effects on physicians’ selling their services to the merging health plans. In both cases, the Division alleged that the relevant product market constituted the purchase of physicians’ services, regardless of the type of purchaser. In other words, the product market included not only physicians’ services sold to private commercial insurers, but those services sold to governmental programs and private-pay patients as well.⁷⁵ This makes sense. On the buyer side, the relevant product market includes all the reasonably substitutable purchasers to which sellers can turn to sell their services.⁷⁶

As to relevant geographic markets for health plans, the Division has alleged relatively small local markets consisting of Metropolitan Statistical Areas. On the seller

⁷³ United States v. UnitedHealth Group, Inc., 2008-2 Trade Cas. (CCH) ¶ 76,318 (D.D.C. 2008) (consent decree and competitive impact statement).

⁷⁴ *Id.* at 112,206 (Competitive Impact Statement).

⁷⁵ See *UnitedHealth*, 2006-1 Trade Cas. (CCH) at 104,904; *Aetna*, 1999-2 Trade Cas. (CCH) at 86,379 (Competitive Impact Statement); see generally FTC-DOJ JOINT REPORT, *supra* note 34, at Ch. 6 at 15 (“It is possible that public payors (*e.g.*, Medicare and Medicaid) and private payors (*e.g.*, health care insurers) do not compete in output markets, but do compete in the market for the purchase of services from health care providers.”).

⁷⁶ See generally FTC-DOJ JOINT REPORT, *supra* note 34, Ch. 6 at 15 (discussing health-plan relevant markets in the context of buyer market-power issues):

Defining a buyer-side market involves reversing the standard seller-side formula to ask about the extent to which at-risk suppliers will substitute other outlets for their products or services in response to a small but significant and non-transitory *decrease* in price. The crucial consideration in defining monopsony product and geographic markets, therefore, is whether the buyers of the input in the putative market successfully would be able to lower the price they pay for the input or whether, instead, the sellers have sufficient realistic alternatives to allow them to circumvent the price decrease.

side, this is because the scope of the geographic market depends primarily on the plan's network and the geographic scope of a network's services is generally local. Purchasers of health-plan services typically would not purchase a health plan whose network would require extensive patient travel and use of a network located geographically distant from them. Similarly, on the buyer side, health-plan networks located far from the provider's practice do not constitute reasonably substitutable alternatives to which providers might sell their services.

In each case, the merging firms' post-merger market share would have been substantial. In *Aetna*, Aetna's market share as a seller of health insurance in the two alleged relevant geographic markets would have been sixty-three and forty-two percent; information about the case does not disclose Aetna's post-merger share as a purchaser of physicians' services. In the UnitedHealth/Pacific case, the complaint alleged that United's post-merger share would have been about thirty-three percent, which is not overwhelming; but the complaint also alleged that the merging firms were, by far, the largest two firms in the market and that the market was highly concentrated. The post-merger Herfindahl-Hirschman Index (HHI) would have been greater than 2,500 and the merger would have increased the HHI by more than 500.⁷⁷ In the UnitedHealth/Sierra case, the Division alleged that, in the Medicare Advantage market, the transaction would combine UnitedHealth's thirty-four percent share with Sierra's sixty-percent share. The HHI allegedly would have increased by 4,080, from 4,756 to 8,836.⁷⁸

The three health-plan-merger cases brought thus far were terminated by consent decrees – requiring some divestitures but permitting the transactions as a whole to close. No health-plan merger case thus far has been litigated. Thus, guidance in this area remains quite limited. But given the concentrated nature of many health-plan geographic markets and the new administration's interest in this subject, that may change in the near future. This is an area to keep an eye on.

⁷⁷ The HHI is a quantitative measure of market concentration, ranging from almost zero for a relevant market with an almost infinite number of firms to 10,000 for a market with only one firm (a monopoly). To calculate the post-merger HHI, add the market shares of the merging firms and then square that market share and the market share of each other firm in the relevant market. To calculate the HHI increase resulting from the merger, multiply the shares of the merging firms by each other and multiply that product by 2. The MERGER GUIDELINES provide that a merger is rebuttably presumed unlawful if the post-merger HHI would be greater than 1,800 and the merger would increase the HHI by more than 100. MERGER GUIDELINES, *supra* note 70, § 1.5. Although not binding on the courts, the MERGER GUIDELINES are highly influential. *See, e.g.,* Chicago Bridge & Iron Co. v. FTC, 515 F.3d 447 (5th Cir. 2008).

⁷⁸ As noted before, the Antitrust Division has investigated other health-plan mergers without challenge. After concluding two investigations without challenge, the Division issued statements outlining the reasons for its decisions. *See* Background to Closing of Investigation of UnitedHealth Group's Acquisition of Oxford Health Plans (Jul. 20, 2004), http://www.usdoj.gov/atr/public/press_releases/2004/204676.pdf; Department of Justice Antitrust Division Statement on the Closing of its Investigation of Anthem, Inc.'s Acquisition of Wellpoint Health Networks, Inc. (Mar. 9, 2004), http://www.usdoj.gov/atr/press_releases/2004/202738.pdf.

V. Physician-Owned Specialty Hospitals v. General Acute-Care Hospitals (and Vice Versa)

Over the last ten years or so, physicians have increasingly invested in, developed, and operated so-called “single-specialty hospitals,” such as cardiac and orthopedic facilities, that compete directly with the general acute-care hospitals at which the investing physicians frequently have staff privileges to care for patients.⁷⁹ Not surprisingly, it galls the general hospitals that their own staff members would develop these facilities in competition with the general hospital and, at the same time, “free ride” (as the general hospitals claim) off the general hospitals by using their facilities and staff for free.⁸⁰ Accordingly, some general hospitals have taken actions that arguably impede the development and operation of physician-owned facilities. There are many possibilities,⁸¹ but probably the two most common strategies are the general hospitals’ adoption of some type of “loyalty” or “conflict-of-interest” policy, prohibiting physicians with financial interests in competing facilities from obtaining or maintaining staff privileges at the general hospitals, and agreements (which can take many different forms) between general hospitals and health plans that exclude or impede physician-owned facilities from participating in the plans’ networks. These strategies can raise interesting and complex antitrust issues, depending on a plethora of other facts, under both sections 1 and 2 of the Sherman Act.⁸²

The literature on this subject is extensive⁸³ and the policy arguments of both sides well known. The general hospitals argue that:

1. Specialty hospitals usually take the most profitable types of services and patients (for example, cardiac and orthopedic surgery) out of the general hospital, and thus the general hospital loses the funding necessary to pay for services that are unprofitable but that the community needs and demands.

⁷⁹ The issues discussed here can arise when staff members invest in and refer patients to other types of facilities, such as ambulatory surgery centers, that compete against general hospitals.

⁸⁰ See David A. Argue, *An Economic Model of Competition Between General Hospitals and Physician-Owned Specialty Hospitals*, 52 ANTITRUST BULL. 347 (2007).

⁸¹ See generally William E. Berlin, *Antitrust Implications of Competition Between Physician-Owned Facilities and General Hospitals: Competition or Exclusion?*, ABA HEALTH LAW SECTION HEALTH LAWYER, June 2008, at 1.

⁸² 15 U.S.C. §§ 1, 2.

⁸³ Recent examples include Robin Locke Nagle & Elizabeth B. Bradley, *Physician-Owned Specialty Hospitals and Hospital Conflict-of-Interest Policies: Healthy Competition or Business Opportunism?*, in HEALTH LAW HANDBOOK (A. Gosfield ed. 2006); Christine L. White & David Marx, Jr., *Considering the Antitrust Consequences of Full-Service Hospitals’ Strategy for Dealing (or not) with Physician-Owned Specialty Hospitals*, AHLA HEALTH LAWYERS NEWS, June 2008; Mark L. Mattioli, *Economic Credentialing as a Mechanism to Prevent Free-Riding by Physicians: Pro-Competitive Justifications and Practical Considerations*, AHLA MEDSTAFF NEWS, June 2007; Robert A. Berenson, et al., *Hospital-Physician Relations: Cooperation, Competition, or Separation?*, 25 HEALTH AFFAIRS 95 (2006).

2. Specialty hospitals “cherry-pick” patients by serving only those that are well insured, leaving the Medicaid and charity cases to general hospitals.

3. Specialty hospitals are able to undercut the general hospitals on price only because they don’t offer the full range of hospital services that general hospitals do – for example, many have no emergency room.

4. Specialty hospitals take only the uncomplicated cases, leaving the more complex and costly cases to general hospitals and, indeed, transfer costly problem cases to general hospitals.

5. Specialty hospitals drive up the aggregate cost of health care because they result in their owners’ doing more, often unnecessary, procedures.

6. Because the physician-owners profit from referring patients to their specialty hospital, they have a strong economic incentive to refer patients there regardless of whether the patient would receive more appropriate treatment elsewhere.

7. The physician-owners’ ability to refer patients to their own facilities gives them an “unfair competitive advantage” over general hospitals providing the same service.

8. The real reason that physicians invest in specialty hospitals is not to improve quality and patient experience but to increase their income in light of reimbursement cuts by private and public third-party payers.

Supporters of physician-owned single-specialty hospitals retort that:

1. Physician-owned single-specialty hospitals charge lower prices than general hospitals.

2. Specialty hospitals provide higher quality than general hospitals.

3. Specialty hospitals increase competition and thus are unambiguously procompetitive.

4. Specialty hospitals are typically more hassle-free, convenient for patients, and offer a more pleasant ambiance than general hospitals.

5. Physicians invest in and develop specialty hospitals not because of greed but because they provide the physicians with more autonomy to practice as they want, innovate, offer the latest technologies, and schedule procedures more efficiently.

6. Specialty hospitals, through the competitive process, force general hospitals to improve their own facilities, equipment, ambiance, and technologies.

7. Physicians are ethical individuals who would never base their referral decisions on their own economic interests.⁸⁴

From a policy standpoint, the development of physician-owned facilities has presented a quagmire. Congress, through the Stark legislation, has expressed substantial dismay about physician-referral situations in which physicians refer to facilities in which they have an economic interest. The so-called “whole-hospital” exception, however, effectively exempts physician-owned specialty hospitals from Stark. Nevertheless, in 2003, Congress imposed a moratorium on these facilities, banning physician-investors in them from referring Medicare patients for services there. That moratorium extended to June 2005. The policy issue is still not settled, however, as yet more legislation has been proposed that would chill, if not kill, development of more physician-owned hospitals. Indeed, in a recent speech, one FTC commissioner seemed vexed by the policy question.⁸⁵ Likewise, the ABA Section of Antitrust Law has opined that “[t]his is a complicated area, with both sides having credible arguments”; it suggests that the federal antitrust enforcement agencies “could provide some guidance to help shape the application of the antitrust laws to this complex fact pattern.”⁸⁶

Turning to the applicable antitrust principles,⁸⁷ let’s first examine the antitrust ramifications of general-hospital conflict-of-interest policies prohibiting physicians with interests in competing facilities from staff privileges at the general hospital and then examine various forms of exclusionary contracting between general hospitals and health plans.

⁸⁴ In *Heartland Surgical Specialty Hospital, LLC. v. Midwest Division, Inc.*, 527 F. Supp.2d 1257, 1264 (D. Kan. 2007), the court summarized the parties’ positions as follows:

[T]his case ultimately involves the proper place of physician-owned healthcare ventures in the broad landscape of United States healthcare. Both sides insist they solely possess the moral high ground. [Plaintiff] contends that physician ownership yields higher quality care at a lower cost; that physician-owned facilities are better able to react to new ideas and patient needs; and that patients appreciate the convenience of smaller facilities with increased nursing care and patient amenities. Defendants contend that physician-owned healthcare ventures “cherry-pick” the best patients, leaving traditional hospitals with costly obligations such as emergency and uninsured care; that physician-owned healthcare ventures increase the overall cost of healthcare; and that physician-owned facilities are unable to respond to the emergent situations of their patients in the same manner as a general hospital. Neither side can make a colorable argument that the parties’ profits is not a central factor in their dispute.

⁸⁵ See Rosch Remarks, *supra* note 2, at 9, 12 (noting that “[t]his is an area in which I had experience as a litigator when I was in private practice, and I can tell you that the issues involved are complex, with no easy answers” and that “[t]he only firm conclusion I’ve reached is that full service hospitals should not be saddled with the full burden of charity care costs. That is simply not fair. There should be some mechanism to ensure that specialty hospitals carry their share of the burden”).

⁸⁶ ABA TRANSITION REPORT, *supra* note 6, at 56.

⁸⁷ For more in-depth discussions, see *HCAL*, *supra* note 36, Ch. 14A (Supp. 2007); Berlin, *supra* note 81.

In most scenarios, a general hospital's refusal to grant privileges to physicians investing in competing specialty hospitals should not raise a serious antitrust issue. (That's not to say it can never violate the antitrust laws, fails to raise issues under other legal theories, or fails to raise political and business issues for the hospital and medical staff.) In most situations, the policy would result from the unilateral action of the hospital board – i.e., it would not result from an agreement – so section 1 of the Sherman Act would not apply.⁸⁸ Thus, adversely affected physicians would have to allege monopolization⁸⁹ or attempted monopolization⁹⁰ under section 2 of the Sherman Act.

How could the policy significantly harm competition? One possibility is that it might weaken the competitive strength of the excluded physicians in the market for their services: if they can't use the hospital's facilities they might lose patients and thus market share. But there are several, and one overriding, arguments in rebuttal. First, those physicians can use their own facilities and thus remain viable competitors. Second, they may have privileges at other area hospitals not adopting the same type of policy.

But most important, unless the general hospital employs physicians in the same medical specialty as the excluded physicians, the hospital is not a participant in the same relevant product market as the physicians, and thus, as a matter of law, cannot monopolize or attempt to monopolize that market. Decisions espousing the principle that a firm cannot monopolize or attempt to monopolize a market in which it doesn't even compete are legion,⁹¹ and the principle merely reflects common sense. In fact, the conflict-of-interest policy could actually increase competition in this relevant market. Suppose the physicians decide to build their hospital and thus lose their privileges at the general hospital. As a result, the general hospital may have incentive to recruit new physicians in the same specialty to the area, actually increasing competition in the affected physician-services market.

⁸⁸ Unilateral action never violates section 1 of the Sherman Act. *E.g.*, *Fisher v. City of Berkeley*, 475 U.S. 260 (1986).

⁸⁹ Proof of a monopolization violation requires (1) definition of the relevant market (usually); (2) proof of monopoly power (typically a market share of at least 60 or 65 percent, *see United States v. Aluminum Co. of Am.*, 148 F.2d 416 (2d Cir. 1945)); and (3) attainment or maintenance of monopoly power by “exclusionary” or “predatory” conduct. *See generally United States v. Grinnell Corp.*, 384 U.S. 563 (1966). “Predatory conduct” has no uniform definition but, in general, is conduct with a significant exclusionary effect on the defendant's competitors but no legitimate business or procompetitive justification. *See generally Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985); *United States v. Microsoft Corp.*, 253 F.3d 34 (D.C. Cir. 2001) (*per curiam*).

⁹⁰ Proof of an attempted monopolization violation requires (1) definition of the relevant market (usually); (2) a specific intent to monopolize; (3) predatory conduct implementing that intent; and (4) a dangerous probability that, if the conduct were to continue, the defendant would obtain actual monopoly power (typically shown by a market share of at least 45 percent). *Spectrum Sports, Inc. v. McQuillan*, 506 U.S. 447 (1993); *Andrx Pharms., Inc. v. Elan Corp.*, 421 F.3d 1227 (11th Cir. 2005).

⁹¹ *E.g.*, *Novell, Inc. v. Microsoft Corp.*, 505 F.3d 302 (4th Cir. 2007); *Spanish Broad. Sys. v. Clear Channel Commc'ns, Inc.*, 376 F.3d 1065 (11th Cir. 2004); *Little Rock Cardiology Clinic, P.A. v. Baptist Health*, 573 F. Supp.2d 1125 (E.D. Ark. 2008).

What about the relevant market for those hospital services in which the general hospital and specialty hospital would be or are competitors? Arguably, if physicians contemplating investments in a specialty hospital have to choose between investing in the new hospital and losing their privileges, or retaining their privileges at the general hospital and not developing the new facility, they may choose the latter. If so, the specialty hospital may not come to fruition, and thus the policy blocks potential competition. But if the need and profit opportunity are there, why wouldn't someone else come in and develop the facility? And does the general hospital have monopoly power in the relevant market, or is it likely to acquire monopoly power if the new facility goes unbuilt?

Assume so. The question then becomes whether the policy constitutes “predatory conduct” for purposes of section 2. This is a difficult question to answer, primarily because determining whether conduct with exclusionary effects is predatory is one of the most difficult questions in antitrust jurisprudence. Even the Antitrust Division and FTC can't seem to agree on the definition or essential characteristics of predatory conduct.⁹² Courts have formulated numerous definitions with at least slightly different meanings or connotations, but, generally, predatory conduct is conduct with substantial exclusionary effects on competitors but no consumer benefits, procompetitive efficiencies, or “legitimate business justifications.”⁹³ Broadly speaking, it is conduct that is rational business behavior only because it excludes the defendant's competitors from the market.

Assume that the policy does have the requisite exclusionary effect so that the question becomes whether there is any legitimate business justification for it. Unfortunately, the Supreme Court itself has struggled unsuccessfully to determine when, in particular, a firm with market power has a duty to deal with, or help, its competitors. The Court has posited no coherent or consistent analysis.⁹⁴ Nor have the courts provided much guidance for determining what constitutes a legitimate business justification for exclusionary conduct. The general hospital could raise some of the arguments listed before – for example, that output ultimately will fall because it will be forced to discontinue unprofitable services. Or it can argue, as some courts have held, that no

⁹² Compare U.S. DEP'T OF JUSTICE, COMPETITION AND MONOPOLY: SINGLE-FIRM CONDUCT UNDER SECTION 2 OF THE SHERMAN ACT (2008), <http://www.usdoj.gov/atr/public/reports/236681.pdf>., with Statement of Commissioners Harbour, Leibowitz, and Rosch on the Issuance of the Section 2 Report by the Department of Justice, <http://www2.ftc.gov/os/2008/09/080908section2stmt.pdf>. (dissenting from Department of Justice report).

⁹³ See *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 483 (1992) (“liability turns . . . on whether ‘valid business reasons’ can explain [defendant’s] actions”); *Morris Commc’ns Corp. v. PGA Golf Tour, Inc.*, 364 F.3d 1288 (11th Cir. 2004).

⁹⁴ Compare *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985) with *Verizon Commc’ns, Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398 (2004).

competitor must “cut its own throat” by helping its competitors compete against it.⁹⁵ Or it can argue that the prevention of free-riding (that is, its competitors using its facilities to compete against it at no cost) is a legitimate business justification, as several courts have held.⁹⁶ At present, because of a lack of clear guidance from the courts, it simply is not clear what, if any, justifications might be sufficient. And no antitrust decision discusses these issues in any detail in the context of a general-hospital conflict-of-interest policy.

Suppose the physicians go ahead and invest in, develop, and provide services at their facility regardless of the policy, or suppose the general hospital adopts its conflict-of-interest policy after the physicians’ facility is up and running.⁹⁷ In this scenario, it should be difficult for the physicians affected by the policy or the specialty hospital to show that the policy adversely affected competition. The hospital entered the market and is competing.

Interestingly, the FTC and Antitrust Division, in their 2004 report on competition in the health-care sector, expressed little concern about the type of conflict-of-interest policy discussed here. While generally supportive of physician-owned specialty hospitals,⁹⁸ the agencies explained:

Generally speaking, antitrust law does not limit individual hospitals from unilaterally responding to competition . . . by terminating physician admitting privileges If there is specific evidence of anticompetitive conduct by individual hospitals or of hospitals colluding together against efforts to open a [single-specialty hospital] . . . , then the Agencies will aggressively pursue those activities.⁹⁹

The liberal-leaning American Antitrust Institute seems to agree.¹⁰⁰

⁹⁵ *E.g.*, *State of Ill. v. Panhandle E. Pipe Line Co.*, 730 F. Supp. 826, 883 (C.D. Ill. 1990), *aff’d*, 935 F.2d 1469 (7th Cir. 1991); *see also* *Williamson v. Sacred Heart Hosp.*, 1993 WL 543002 (N.D. Fla. May 28, 1993), *aff’d without published opinion*, 41 F.3d 667 (11th Cir. 1994) (opinion reprinted at 1995-1 Trade Cas. (CCH) ¶70,905).

⁹⁶ *See, e.g.*, *Morris Commc’ns*.

⁹⁷ This was the situation in *Little Rock Cardiology Clinic, P.A. v. Baptist Health*, 573 F. Supp.2d 1125 (E.D. Ark. 2008). There, plaintiff physician-investors alleged, among other things, that their cardiac hospital opened in 1997 and that the defendant hospital adopted its conflict-of-interest policy in 2003. The case was dismissed pursuant to Fed. R. Civ. P. 12(b)(6) (now on appeal), so the court did not discuss the merits of the case.

⁹⁸ *Cf.* FTC-DOJ JOINT REPORT, *supra* note 34, Ch. 3 at 27 (“Entry by [single-specialty hospitals] . . . has had a number of beneficial consequences for consumers who receive care from these facilities.”).

⁹⁹ *Id.*

¹⁰⁰ AAI REPORT ON COMPETITION, *supra* note 19, at 343 (“hospitals have the right to engage in economic credentialing (selecting or deselecting doctors for staff privileges based on the doctors’ effect on the hospitals’ costs and quality”).

Thus, the circumstances in which a general hospital's conflict of interest policy will raise significant antitrust issues should be quite limited. This is not to say, however, that the affected physicians will not challenge it, either under the antitrust laws or some state-law contract or tort theory.

Exclusive or exclusionary arrangements between general hospitals and health plans that exclude physician-owned facilities from the health plans' networks can raise very different and more serious antitrust issues, again depending on a host of specific facts. The arrangement can take a number of forms. For example, there may be an exclusive arrangement by which a health plan agrees to purchase the hospital services in question exclusively from the general hospital. Or the agreement may not be exclusive but may still exclude the physician-owned facility from the network – for example, where the health plan agrees to contract for the services with several general hospitals but not with the physician-owned facility. Or the health plan may have a preferred-provider arrangement with the general hospital while the physician-owned facility is “non-preferred,” but still a network, participant. Or there may be a bundled discount arrangement – where the general hospital offers health plans a lower price on all its services if the plans contract with it for all its services, but demands a higher price if the plans include the physician-owned facility. Or there may be an agreement among several competing hospitals and several health plans to exclude the physician-owned facility from the plans' networks.

Where a health plan unilaterally determines those facilities to include and not include in its networks, there is no antitrust issue. Absent an agreement, only section 2 applies; the health plans are not participants in the relevant product market and thus can't monopolize or attempt to monopolize it. But where the arrangement results from an agreement between a health plan and general hospital, section 1 applies, and the arrangement is unlawful if it unreasonably restrains competition.

The precise antitrust analysis that applies depends on the type of arrangement in question. But unless, in addition to the agreement between the health plan and hospital (a vertical agreement), there is an agreement among competing hospitals or competing health plans (i.e., horizontal agreement), a full-blown rule-of-reason analysis always applies. In general, the analysis requires, initially, that the plaintiff physician-owned facility prove the arrangement has a significant anticompetitive effect or that the general hospital has substantial market power in a properly defined relevant market.¹⁰¹ If the plaintiff carries its initial burden, the burden of production or going forward shifts to the defendants to show procompetitive or legitimate justifications for the agreement. If the defendants meet their burden, the burden shifts back to the plaintiff, who bears the burden

¹⁰¹ The plaintiff can meet its initial burden through direct or circumstantial evidence. Direct evidence is evidence that the defendant charged supracompetitive prices or provided sub-competitive quality. Under the circumstantial approach to proving market power, the plaintiff must prove the relevant market, that the defendant has a dominant share of that market, and that significant entry and expansion barriers exist. *See generally* Gordon v. Lewistown Hosp., 423 F.3d 184 (3d Cir. 2005).

of production and the ultimate burden of persuasion to show that the agreement's anticompetitive effects significantly outweigh its procompetitive effects.¹⁰²

The plaintiff's exclusion from a health-plan network typically will injure it (unless it can offset that loss of patients from other sources). But when analyzing any type of exclusionary arrangement such as this, it's crucial to keep in mind one of the most important axioms of antitrust law: that the antitrust laws protect *competition*, not *competitors*.¹⁰³ Thus, the mere fact that a competitor is excluded from the market, competitively weakened, or injured means little by itself. Rather, the ultimate question is whether the agreement significantly decreases market-wide competition. In the case of exclusive contracts or other types of contracts with exclusionary effects, antitrust concern arises when such a large percentage of the contract beneficiary's competitors are excluded from such a large percentage of the market for such a long period of time that the beneficiary may be able to gain or maintain substantial market power, or when the market becomes so concentrated that the remaining competitors may exercise market power jointly.¹⁰⁴ Thus, in analyzing an agreement between a general hospital and health plan that excludes the physician-owned facility from the health-plan's network, the question is whether, as a result of the agreement, the general hospital will obtain or maintain market power in the services offered by the physician-owned facility. Worth keeping in mind also is that exclusionary contracts can also constitute the predatory-conduct element of a section 2 monopolization or attempted monopolization claim.¹⁰⁵

In what circumstances might these effects result from the arrangement? Most important, the arrangement must foreclose the physician-owned facility from a significant percentage of the market – that is, from a substantial percentage of potential patients: this “foreclosure percentage” must be substantial.¹⁰⁶ In general, the foreclosure percentage depends on the market share of the health plan participating in the arrangement; its members are the patients from which the excluded facility is foreclosed. There is no magic or black-letter foreclosure percentage that proves unlawfulness because a number of other variables are relevant as well.¹⁰⁷ But case law suggests that for concern to arise,

¹⁰² Numerous decisions outline this “burden shifting” approach in applying the rule of reason. *See, e.g.*, *Major League Baseball Props., Inc. v. Salvino*, 542 F.3d 290 (2d Cir. 2008); *Nilivar v. Mercy Health Sys.*, 244 Fed. Appx. 690 (6th Cir. 2007); *Geneva Pharms. Tech. Corp. v. Barr Labs.*, 386 F.3d 485 (2d Cir. 2004).

¹⁰³ *E.g.*, *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477 (1977).

¹⁰⁴ For an excellent discussion, *see* Jonathan M. Jacobson, *Exclusive Dealing, “Foreclosure,” and Consumer Harm*, 70 ANTITRUST L.J. 311 (2002); *see also* *Stop & Shop Supermarket Co. v. Blue Cross & Blue Shield*, 373 F.3d 57 (1st Cir. 2004).

¹⁰⁵ *E.g.*, *United States v. Dentsply Int'l, Inc.*, 399 F.3d 181 (3d Cir. 2005).

¹⁰⁶ *E.g.* *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589 (1st Cir. 1993).

¹⁰⁷ These include the percentage of competitors excluded by the arrangement; the arrangement's duration; the contract beneficiary's market power; the existence of other, similar arrangements in the market; and, in particular, procompetitive effects from the arrangement, such as the contract beneficiary's granting the

the foreclosure percentage should be at least thirty or forty percent.¹⁰⁸ And for purposes of assessing the foreclosure percentage, the relevant market, or denominator of the foreclosure-percentage fraction, includes *all* patients – whether their source of payment is commercial insurance, governmental insurance, or their own funds – not just commercially insured patients.¹⁰⁹ Although a high foreclosure percentage is not itself determinative of unlawfulness, the degree of foreclosure from the arrangement is clearly the most important factor, and many courts require proof of a large foreclosure percentage as a threshold requirement before the analysis need proceed to analyze other factors.¹¹⁰

While there are a plethora of antitrust decisions involving exclusive or quasi-exclusive arrangements in general, there are only four in the context of arrangements between general hospitals and health plans excluding physician-owned facilities, and only one of those went to trial. In the most recent case, *Little Rock Cardiology Clinic*,¹¹¹ the physician owners of a cardiac hospital sued the largest hospital in Little Rock and the Blue Cross plan, alleging, among other things, that when the hospital was built, the hospital and Blue Cross conspired to terminate the investing physicians' participation in Blue Cross networks. In dismissing the complaint pursuant to Rule 12(b)(6), the court held that the statute of limitations barred the suit and that the plaintiffs failed to allege plausible relevant product and geographic markets. The court did not need to reach the question of how the effect on competition from the physicians' exclusion from Blue Cross, if any, would be analyzed. The case is on appeal to the Eighth Circuit and, if reversed, may provide some guidance on this issue.

In the *Heartland Surgical Specialty Hospital* case¹¹² a physician-owned surgical-specialty inpatient and outpatient hospital sued a number of competing general hospitals and several health plans alleging horizontal conspiracies among both the hospitals and health plans and vertical conspiracies between the hospitals and health plans to exclude Heartland from participation in the plans' networks. In some cases, the contracts between the hospitals and health plans prohibited the plans from contracting with free-standing facilities; in other cases, the hospitals gave the plans better prices if they excluded these facilities – in some contracts, automatically increasing the hospitals' prices if the health plan admitted free-standing facilities; in yet other cases, the hospitals could veto the addition of new facilities to the plans' networks. The court's decision,

health plan a lower price for some degree of exclusivity. *See generally* Republic Tobacco Co. v. N. Atl. Trading Co., 381 F.2d 717 (7th Cir. 2004); CDC Techs, Inc. v. IDEXX Labs., Inc., 186 F.3d 74 (2d Cir. 1999); Omega Envtl., Inc. v. Gilbarco, Inc., 127 F.3d 1157 (9th Cir. 1997); Paddock Publ'ns, Inc. v. Chicago Tribune Co., 103 F.3d 42 (7th Cir. 1996).

¹⁰⁸ *E.g.*, Theme Promotions, Inc. v. News Am. Mktg. Fsi, 539 F.3d 1046 (9th Cir. 2008); *Stop & Shop*.

¹⁰⁹ *E.g.*, *Stop & Shop*.

¹¹⁰ *See U.S. Healthcare*.

¹¹¹ *Little Rock Cardiology Clinic, P.A. v. Baptist Health*, 573 F. Supp.2d 1125 (E.D. Ark. 2008).

¹¹² *Heartland Surgical Specialty Hosp., LLC v. Midwest Div., Inc.*, 527 F. Supp.2d 1257 (D. Kan. 2007).

however, focused exclusively on the question whether there was sufficient evidence for the plaintiff to avoid summary judgment on the conspiracy question, and the court found there was. Although the opinion does not discuss the alleged agreements' effect on competition, there is some slight suggestion that because the plaintiff alleged horizontal conspiracies not to deal with the surgical hospital, the court would have viewed these as group boycotts and perhaps applied the per se standard of analysis.¹¹³ Because the case settled after denial of defendants' summary-judgment motions on the conspiracy issue, we'll never know.

In the only case actually litigated to judgment (in a bench trial), the *Surgical Center of Hammond* case,¹¹⁴ the plaintiff, a physician-owned ambulatory surgery center, alleged that the defendant general hospital monopolized and attempted to monopolize the outpatient-surgery market by entering into bundled-discount arrangements with managed-care plans. According to the plaintiff, the general hospital entered into contracts by which it would provide greater discounts if the plans designated it as its sole provider of all inpatient and outpatient services. This, the plaintiff alleged, resulted in the general hospital's "leveraging" its market power in the market for inpatient services into the outpatient surgical-facilities market by preventing health-plan members from using the plaintiff's facility. This, the plaintiff claimed, resulted in monopolization and attempted monopolization of the outpatient-surgery market.

The claims failed for a number of reasons. For example, a leveraging claim requires proof of market power in the "upstream" market, here inpatient services. The court, however, rejected plaintiff's definition of the relevant geographic market, negating its market-power claim. But most interesting, plaintiff's economic expert admitted a number of facts which effectively killed the plaintiff's case. He testified, for example, that the general hospital had "'very little ability' to raise prices above competitive levels in the outpatient surgery market" and that "'there are few if any classic barriers to entry into the ambulatory surgical services market.'"¹¹⁵ And as to the exclusionary contracts between the general hospital and health plans, according to the court, plaintiff's expert testified "that it would be reasonable for [defendant] to seek exclusive managed-care contracts as a competitive response to the fact that the physician owners of [plaintiff] have a financial incentive to refer patients to [plaintiff]."¹¹⁶ Case over.

The fullest discussion of exclusionary arrangements between general hospitals and health plans to exclude physician-owned facilities is probably that in *Rome*

¹¹³ *Id.* at 1292 n.22.

¹¹⁴ *Surgical Ctr. of Hammond v. Hosp. Serv. Dist. No. 1*, 2001-1 Trade Cas. (CCH) ¶ 73,215 (E.D. La. 2001), *aff'd*, 309 F.3d 836 (5th Cir. 2002).

¹¹⁵ *Id.* at 89,942.

¹¹⁶ *Id.* at 89,943.

*Ambulatory Surgical Center, LLC v. Rome Memorial Hospital, Inc.*¹¹⁷ There, the plaintiff, a physician-owned ambulatory surgery center, alleged that the defendant general hospital actually drove it out of business and into bankruptcy by a number of tactics, including conspiring with members of its medical staff not to refer patients to the facility, intimidating physicians who did refer to the facility, and entering into exclusive contracts with the two largest health plans for outpatient-surgery services.¹¹⁸ The hospital claimed that it feared the plaintiff would obtain an exclusive contract with one of the health plans, so it sought and obtained one itself in return for granting the health plan lower prices than it would have otherwise given. Initially, the second plan, the area Blue Cross plan, contracted with the plaintiff. Later, however, when plaintiff demanded a rate increase, Blue Cross refused and executed an exclusive contract with the defendant hospital.

Before its exit from the market, the plaintiff took about twenty percent of the defendant's outpatient-surgical volume, and that service began to lose money. Plaintiff's rates were about thirty-five percent below defendant's. When the general hospital entered into its second exclusive contract – that with Blue Cross, which plaintiff claimed was fatal to its existence – the plaintiff filed a twelve-count suit alleging six violations of section 1 (two tying-arrangement claims, an exclusive-dealing agreement claim, a garden-variety restraint-of-competition claim, a market-allocation claim, and a group boycott claim), four violations of section 2 (monopoly leveraging, attempted monopolization, monopolization, and conspiracy to monopolize), and two state-law tortious-interference claims.

Plaintiff's tying claim alleged that the defendant conditioned the sale of its inpatient services on the health plans' contracting exclusively with it for outpatient-surgical services. The court dismissed this claim because the plaintiff failed to adduce any evidence that the defendant *coerced* health plans into exclusive contracts as a condition to their obtaining the hospital's other services.

The court, however, denied the hospital's summary-judgment motion on the plaintiff's exclusive-dealing claim. Applying the rule of reason, the court found that the plaintiff sustained its initial burden of adducing evidence of anticompetitive effects because the plaintiff's outpatient-surgery prices were substantially less than the defendant's, the plaintiff's presence in the market resulted in the health plans' ability to negotiate lower prices with the defendant, and plaintiff's forced exit from the market substantially limited patient choice. As to the foreclosure percentage, it appears that the plaintiff limited the relevant product market to patients insured by private commercial insurance and claimed that within that market, the foreclosure percentage was about sixty-five percent. The defendant did not object to plaintiff's market definition, although it probably should have. As noted before, in a vertical foreclosure case such as this, the relevant product market should include all the plaintiffs' sources of revenue, not merely

¹¹⁷ 349 F. Supp.2d 389 (N.D.N.Y. 2004).

¹¹⁸ The defendant also adopted a medical-staff credentialing policy under which it could consider whether the physician in question competed with the hospital, but it never denied privileges based on the policy.

patients covered by commercial insurance. If the product market were so defined, the foreclosure percentage would have been substantially smaller, perhaps about thirty percent. And the court noted that “[c]ase law supports the proposition that a 40% foreclosure is likely an unreasonable restraint.”¹¹⁹ In any event, the court held that the foreclosure percentage from the contracts was sufficient to raise a jury question whether the restraint on competition was unreasonable.

The court next considered the hospital’s procompetitive justifications for the arrangements, as it must in a rule-of-reason analysis. The hospital posited two: (1) that the exclusive contracts were a legitimate “self-defense” strategy to counteract the ability of plaintiff’s physician-owners to steer patients to their facility (which the plaintiff’s expert in *Surgical Center of Hammond* had testified was “reasonable); and (2) that the contracts increased the hospital’s patient volume, resulting in increased economies of scale. The court appeared to reject the first justification, explaining that there was a “disconnect” between the physicians’ ability to self-refer and the exclusive contracts allegedly used to counteract it.¹²⁰ About the second, the court accepted it conceptually but found that it lacked factual support.¹²¹ The court dismissed the remaining antitrust counts (for reasons not of interest here), except the plaintiff’s conspiracy to monopolize claim.¹²²

As you can see, the law is not well-developed on this issue. But the development of physician-owned facilities and the competitive reactions of general acute-care

¹¹⁹ *Rome Ambulatory Surgical Ctr.*, 349 F. Supp.2d at 410.

¹²⁰ The court explained:

It is difficult to see how exclusive contracting would be considered an appropriate response to the particular behavior defendants claim to be defending against, “cherry picking” or “cream skimming,” and possible “free riding” by the [plaintiff’s] investor physicians. Defendants argue that they would have been permitted to exclude those physicians from hospital privileges altogether. Perhaps, and that may have been a more appropriate response, but it is not a defense to the issue of the exclusive contracts. The logical disconnect in defendants’ arguments is sufficient to raise a question of fact as to its justification.

Id. at 411.

¹²¹ *Id.* (“While the Hospital’s maintaining volume certainly could contribute to beneficial pricing . . . , it is not clear that that is what was intended or what occurred here. Maintaining patient volume is certainly good for the Hospital, but defendants have not conclusively demonstrated that it in any way benefitted competition.”).

¹²² The section 2 conspiracy-to-monopolize violation requires proof of (1) an agreement, (2) specific intent to monopolize, and (3) an overt act in furtherance of that intent. *See Stewart Glass & Mirror Co. v. U.S. Auto Glass Discount Ctrs., Inc.*, 200 F.3d 307 (5th Cir. 2000). Recent decisions also suggest that the plaintiff must prove some adverse effect on competition. *See NYNEX Corp. v. Discon Corp.*, 525 U.S. 128 (1998); *Gregory v. Fort Bridger Rendezvous Ass’n*, 448 F.3d 1195 (10th Cir. 2006). In *Rome*, the court held that based on the evidence, there were genuine disputes of material fact about both the agreement and intent elements.

hospitals, absent legislation banning or limiting these facilities, is clearly an emerging issue in both health-care policy and health-care antitrust law.

Conclusion

The subjects discussed here are only several of those affecting physicians. Others include staff-privilege antitrust suits (which plaintiffs continue to file notwithstanding the Health Care Quality Improvement Act) and exclusive contractual arrangements between hospitals and hospital-based physicians (where the applicable antitrust principles are well-developed), as well as physician joint ventures and hospital/physician joint ventures (where the law is not well-developed). But the subjects discussed here appear to constitute the most important issues likely to affect physicians in the near future.