

3-1-2016

Navigating Through the Fog of Vertical Merger Law: A Guide to Counselling Hospital-Physician Consolidation under the Clayton Act

Thomas L. Greaney

Douglas Ross

Follow this and additional works at: <https://digitalcommons.law.uw.edu/wlr>



Part of the [Antitrust and Trade Regulation Commons](#), and the [Health Law and Policy Commons](#)

Recommended Citation

Thomas L. Greaney & Douglas Ross, *Navigating Through the Fog of Vertical Merger Law: A Guide to Counselling Hospital-Physician Consolidation under the Clayton Act*, 91 Wash. L. Rev. 199 (2016).
Available at: <https://digitalcommons.law.uw.edu/wlr/vol91/iss1/12>

This Article is brought to you for free and open access by the Law Reviews and Journals at UW Law Digital Commons. It has been accepted for inclusion in Washington Law Review by an authorized editor of UW Law Digital Commons. For more information, please contact lawref@uw.edu.

NAVIGATING THROUGH THE FOG OF VERTICAL MERGER LAW: A GUIDE TO COUNSELLING HOSPITAL-PHYSICIAN CONSOLIDATION UNDER THE CLAYTON ACT

Thomas L. Greaney & Douglas Ross*

Abstract: Lawyers assessing legality under the antitrust laws of hospital acquisitions of physician practices face a quandary. The case law is sparse, federal enforcement guidance outdated, and academic input conflicting. Applying these muddled standards in the rapidly-evolving health care sector only magnifies the uncertainty. While most transactions will be competitively neutral or beneficial, rapidly evolving market conditions causing integration between hospitals and physicians present opportunities for consolidations that may harm consumer interests. Indeed, given the highly concentrated structure of many hospital markets in the nation, preemptive acquisitions of physician practices may be a tempting strategy for some to undermine competition. This Article offers guidance by analyzing potential theories of competitive harm and addressing factual elements necessary to establish a violation of antitrust merger law.

INTRODUCTION	200
I. CASE LAW, THEORIES, AND EVIDENCE OF COMPETITIVE HARM	202
A. Vertical Merger Law	202
B. Antitrust Analysis of Physician Acquisitions	206
C. Economic Effects of Physician Acquisitions	212
II. COMPETITIVE EFFECTS OF VERTICAL MERGERS	216
A. Foreclosure	216
1. General Principles	216
2. Foreclosure of PCPs	217
3. Foreclosure in Specialty Physician Markets	222
B. Potential Competition	226
C. Avoidance of Regulation and Similar Strategies	227

* Thomas L. Greaney is a Chester A. Myers Professor of Law and Co-Director of the Center for Health Law Studies, Saint Louis University School of Law. Douglas Ross lectures at the University of Washington School of Law and is a partner with Davis Wright Tremaine LLP, in Seattle, Washington. The authors would like to thank Abigail Wood for research assistance. The participants in the symposium, Healthcare in the 21st Century: The Role of Competition, held at the Seattle University School of Law in September 2016, provided many helpful comments. In particular, Douglas A. Conrad, Professor of Health Services at the University of Washington, provided extensive comments for which the authors are very grateful. This Article is the product of a collaboration between the authors and as such should not be taken as representing the views of each on every point addressed.

D. Increased Bargaining Leverage and Reduced Network Competition	237
III. MITIGATING FACTORS	238
A. Ease of Entry	239
B. The Power Buyer Factor	244
CONCLUSION	251

INTRODUCTION

Lawyers assessing the legality of vertical mergers under antitrust laws face a quandary. The case law is sparse, federal enforcement guidance outdated, and academic input conflicting. Applying these muddled standards in the rapidly-evolving health care sector only magnifies the uncertainty. Yet given the current wave of acquisitions of physician practices by hospitals¹ and the commitment of the federal antitrust agencies to place a high priority on curbing health care consolidation,² many practitioners are struggling to give sound advice as to whether such mergers might run afoul of the Clayton Act.³ This Article seeks to supply guidance on several thorny issues lawyers and courts must confront in this area.

Although the federal antitrust enforcement agencies, the Federal Trade Commission (FTC) and United States Department of Justice (DOJ) (the Agencies), have devoted considerable resources to challenging mergers of acute care hospitals, only recently have physician mergers come under antitrust scrutiny. The increased attention is a natural response to the wholesale changes in provider relationships spurred by health care reform and pressure from commercial payers to encourage providers to accept new forms of reimbursement, manage

1. See Margot Sanger-Katz, *When Hospitals Buy Doctors' Offices, and Patient Fees Soar*, N.Y. TIMES (Feb. 8, 2015), <http://www.nytimes.com/2015/02/07/upshot/medicare-proposal-would-even-out-doctors-pay.html> [<https://perma.cc/BV4D-NAVA>] (describing motives for rapid increase in physician employment and quoting former executive of American College of Cardiology describing the shift as “like a migration of wildebeests”).

2. See Edith Ramirez, Chairwoman, Fed. Trade Comm’n, *Retrospectives at the FTC: Promoting an Antitrust Agenda*, ABA Retrospective Analysis of Agency Determinations in Merger Transactions Symposium (June 28, 2013), http://www.ftc.gov/sites/default/files/documents/public_statements/retrospectives-ftc-promoting-antitrust-agenda/130628aba-antitrust.pdf [<https://perma.cc/WQ5H-2M2G>] (stating there would be “great value in examining more closely the effects of combinations that have a significant vertical element” such as acquisitions of physician practices).

3. Section 7 of the Clayton Act, 15 U.S.C. § 18 (2012), prohibits certain mergers or acquisitions where the effect of the transaction “may be substantially to lessen competition, or to tend to create a monopoly.”

care, and accept financial risk. Organizational changes in response to the legislative impetus to deliver care in a seamless and coordinated manner include accountable care organizations and patient centered medical homes along with a revival of various forms of joint ventures and alliances. Providers have responded by consolidating horizontally; thus, many physicians in small and large practices have merged into single specialty or multispecialty practices, and hospitals that already employ physicians have expanded their ownership of practices.⁴ There has also been a pronounced increase in mergers that, in terms of competitive effect, are purely vertical, i.e., hospitals acquiring physician practices. Because vertical mergers—consolidations joining firms providing different or complementary products or services in the production of a product—are likely to entail efficiency benefits even as they sometimes impair competition, assessments of net competitive effects are inevitably fraught. Moreover, given the probable clinical and administrative efficiencies flowing from integration of health services, evaluations of hospital employment of physicians need to proceed with caution. At the same time, antitrust analyses of possible vertical anticompetitive effects may be warranted based on recent evidence that some acquisitions of physicians' practices by hospitals result in higher physician prices.

The few cases brought by the Agencies and state attorneys general that have proceeded to judgment or settlement all involve horizontal consolidations, usually a hospital expanding its number of employed physicians by acquiring additional practices; one older lawsuit involving a challenge by a rival hospital to a rival's employment of physicians applied a vertical analysis and found plaintiff's case wanting in several respects. While these cases shed light on some issues involved in analyzing a purely vertical merger, many important matters remain unaddressed. Moreover, Agency challenges to vertical mergers have rarely been litigated to a decision,⁵ and the Vertical Merger Guidelines are badly outdated.⁶ Adding to the uncertainty is the fact that new

4. Victoria Stagg Elliott, *Increase in Physician Practice Mergers and Acquisitions Expected to Continue*, AM. MED. NEWS (Aug.14, 2012), www.amednews.com/article/20120814/business/308149997/8/ [<https://perma.cc/L693-W2VV>] (describing physician mergers among large practices and hospitals).

5. The last reported decision involving an agency challenge to a vertical merger was decided by the Second Circuit over thirty-five years ago. *Fruehauf Corp. v. FTC*, 603 F.2d 345 (2d Cir. 1979). The Agencies have filed complaints against several vertical mergers since then but have resolved these by consent orders rather than litigation. See James A. Keyte & Kenneth B. Schwartz, *Getting Vertical Mergers Through the Agencies: "Let's Make a Deal,"* 29 ANTITRUST ABA 10, 17 nn.32–50 (2015); M. Howard Morse, *Vertical Mergers: Recent Learning*, 53 BUS. LAW. 1217, 1226–45 (1998). The Agencies have never filed a case challenging a vertical merger in health care.

6. The 1984 Non-Horizontal Merger Guidelines have received little attention in the courts and

economic learning regarding vertical effects has yet to be incorporated into precedent. Finally, applying antitrust principles in health care is always a tricky undertaking, as market imperfections and the rapid pace of change make predictions predicated on the past unreliable.⁷ Yet lawyers must advise clients, the Agencies need to make sound enforcement decisions, and courts inevitably will chart new territory.

To help penetrate the fog, we examine several issues that are likely to be central to analyzing hospital acquisitions of physician practices under the antitrust laws. In Part I, we review the case law and the economic theories applicable to analyzing vertical mergers. In Part II, we discuss first how allegations of competitive harm through foreclosure should be addressed in the context of acquisitions of primary care practices and specialty groups. We then assess challenges to acquisitions of physician practices under three alternative theories of competitive harm: loss of potential competition, avoidance of regulation, and increased bargaining leverage. Finally, in Part III, we discuss two important mitigating factors likely to be raised by potential defendants: ease of entry and the power buyer factor.

I. CASE LAW, THEORIES, AND EVIDENCE OF COMPETITIVE HARM

A. *Vertical Merger Law*

The early cases addressing vertical mergers following amendments to the Clayton Act were based on the harms flowing from foreclosure. In *Brown Shoe Co. v. United States*,⁸ the Court identified “[t]he primary vice of a vertical merger” as “foreclosing the competitors of either party from a segment of the market”⁹ but neglected to specify the degree of foreclosure or market conditions necessary to prompt condemnation. Responding to *Brown Shoe* and subsequent cases also finding small

focus on harms from reducing the probability of entry and facilitating collusion; The term “foreclosure” does not appear in the Guidelines. 1984 Merger Guidelines, 49 Fed. Reg. 26,823 (June 29, 1984), [www.justice.gov/atr/non-horizontal-merger-guidelines](https://perma.cc/5HGY-HB4Y) [https://perma.cc/5HGY-HB4Y]; see also Keyte & Schwartz, *supra* note 5, at 11 (guidelines provide “only a modicum of insight into how the Agencies currently make enforcement decisions about vertical mergers”).

7. Thomas L. Greaney, *Chicago’s Procrustean Bed: Applying Antitrust in Health Care*, 71 ANTITRUST L.J. 857 (2004); Thomas L. Greaney, *Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law*, 23 AM. J.L. & MED. 191 (1997).

8. 370 U.S. 294 (1962).

9. *Id.* at 323–24.

levels of foreclosure sufficient to invoke the Clayton Act,¹⁰ courts began in the 1970s to qualify the analysis by insisting on evidence of anticompetitive impact beyond mere proof of foreclosure.¹¹ With the ascendancy of Chicago School analysis in the 1980s, vertical merger analysis moved decidedly away from its origins in *Brown Shoe*, as scholars and antitrust officials credited potential efficiencies flowing from improved coordination in pricing, production, and design that can reduce costs and improve product quality.¹² Indeed, some critiques questioned whether competitive harm could ever arise from vertical mergers,¹³ and enforcement efforts all but disappeared.¹⁴ In 1984, the

10. *See, e.g.*, *Ford Motor Co. v. United States*, 405 U.S. 562 (1972) (holding that Ford's acquisition of a spark plug manufacturer violated section 7 of the Clayton Act because it foreclosed other spark plug manufacturers from selling to Ford, which accounted for about ten percent of all spark plug sales); *United States v. Kimberly-Clark Corp.*, 264 F. Supp. 439 (N.D. Cal. 1967) (finding that foreclosure of fourteen percent of the market supported showing of violation of section 7 of the Clayton Act).

11. *See, e.g.*, *Fruehauf Corp. v. FTC*, 603 F.2d 345 (2d Cir. 1979). Herbert Hovenkamp summarizes the flaws of the early foreclosure cases as follows:

The problem with the traditional foreclosure analysis was that it was overly aggressive. First, it condemned mergers where the percentage foreclosure was far too small, often less than 10 percent. Second, it had very little theory about how foreclosure could yield reduced output and higher prices. Foreclosure was largely thought of as an evil for its own sake.

Herbert Hovenkamp, *Post-Chicago Antitrust: A Review and Critique*, 2001 COLUM. BUS. L. REV. 257, 323–24; *see also* Jonathan M. Jacobson, *Exclusive Dealing, Foreclosure, and Consumer Harm*, 70 ANTITRUST L.J. 311, 312 (2002) (noting that in antitrust challenges to exclusive dealing arrangements, which are a form of vertical integration short of merger, “[i]ncreasingly, the courts are focusing on the effect of the challenged arrangement on the defendant’s market power, rather than foreclosure as such”).

12. The “Chicago School of industrial organization economics” has been succinctly described as scholarship that “refuted the dominant structure-conduct-performance paradigm in the 1970s,” while the “Chicago School of antitrust analysis,” which originated with Aaron Director at the University of Chicago and was “developed more fully by Richard Posner, Robert Bork, Frank Easterbrook,” and others, has been described as “transform[ing] antitrust by eliminating or eroding per se illegality of vertical restraints and placing merger analysis on a sounder economic footing.” William H. Page, *Josh Wright’s “Chicago School Papers”: An Overview*, ANTITRUST SOURCE, Apr. 2013, at 5, http://www.americanbar.org/content/dam/aba/publishing/antitrust_source/apr13_papertrail.authcheckdam.pdf [<https://perma.cc/8AR9-MKEC>]. “Post-Chicago antitrust,” in contrast, “has shown that some vertical restraints can reduce efficiency by raising rivals’ costs in certain defined circumstances.” *Id.* Post-Chicago antitrust is associated with a number of academics, including Robert Pitofsky, Steven Salop, Jonathan Baker, and Carl Shapiro. *See, e.g.*, Jonathan B. Baker & Carl Shapiro, *Reinvigorating Horizontal Merger Enforcement*, in *HOW THE CHICAGO SCHOOL OVERSHOT THE MARK: EFFECT OF CONSERVATIVE ECONOMIC ANALYSIS ON U.S. ANTITRUST* 235 (Robert Pitofsky ed., 2008); Robert Pitofsky, *Introduction: Setting the Stage*, in *HOW THE CHICAGO SCHOOL OVERSHOT THE MARK: THE EFFECT OF CONSERVATIVE ECONOMIC ANALYSIS ON U.S. ANTITRUST*, *supra*, at 3, 6; Thomas G. Krattenmaker & Steven C. Salop, *Anticompetitive Exclusion: Raising Rivals’ Costs to Achieve Power Over Price*, 96 YALE L.J. 209 (1986).

13. *See, e.g.*, ROBERT H. BORK, *THE ANTITRUST PARADOX* 225 (1978). *See also* Herbert Hovenkamp’s summation of Robert Bork’s “beguilingly simple” account of the competitive effects

DOJ issued Non-Horizontal Merger Guidelines that identified harms from creating entry barriers and facilitating collusion without mention of foreclosure.¹⁵

Post-Chicago scholarship has moved the pendulum back to some extent. Challenging the claim that “virtually all exclusion claims are chimerical,”¹⁶ economists have demonstrated that under certain conditions exclusionary strategies can profit firms and harm competition.¹⁷ This account identifies risks that “input foreclosure” and “customer foreclosure” can create or enhance market power in upstream (e.g., physician services) markets or downstream (hospital services) markets.¹⁸ Post-Chicagoans qualify foreclosure analysis by requiring

of vertical mergers:

If vertical integration creates efficiencies, then a vertically integrated firm would have cost advantages over unintegrated rivals. [This might] deter entry, but it is not antitrust’s purpose to condemn cost savings. Second, if vertical integration did not create any efficiencies, then it would not impede entry by anyone. Firms that wished to enter at one stage alone could contract with firms at the other stage and be just as efficient as the vertically integrated firm. Third, if vertical integration resulted in higher costs, then vertically integrated firms would decline in favor of unintegrated firms. Fourth, in competitively structured markets vertical integration would lead to self-dealing, but that would do no more than force realignment in purchasing and sale patterns. Bork’s observations were built on an extraordinarily narrow conception of entry barriers. He barely mentioned patents or other intellectual property rights. There was no conception that sunk costs plus risk could facilitate entry deterrence.

Herbert Hovenkamp, *Robert Bork and Vertical Integration: Leverage, Foreclosure, and Efficiency*, SOC. SCI. RESEARCH NETWORK (Oct. 28, 2014), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2272977 [<https://perma.cc/24Q7-EAVV>].

14. See Remarks of J. Thomas Rosch, Comm’r, Fed. Trade Comm’n, *The Challenge of Non-Horizontal Merger Enforcement*, Fordham Competition Law Institute’s 34th Annual Conference on International Antitrust Law & Policy 11–12 (Sept. 27–28, 2007), https://www.ftc.gov/sites/default/files/documents/public_statements/challenge-non-horizontal-merger-enforcement/070927-28non-horizontalmerger_1.pdf [<https://perma.cc/625B-4P6N>] (observing that the constrained view of foreclosure and expansive view of efficiencies led to no litigated merger challenges since the adoption of the Non-Horizontal Merger Guidelines in 1984).

15. 1984 Merger Guidelines, 49 Fed. Reg. 26,823, 26,834 (June 29, 1984).

16. Krattenmaker & Salop, *supra* note 12, at 213–14; Steven C. Salop & Daniel P. Culley, *Potential Competitive Effects of Vertical Mergers: A How-To Guide for Practitioners* 6 (Dec. 8, 2014) (unpublished manuscript), <http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=2404&context=facpub> [<https://perma.cc/6YKF-2HCP>] (“Vertical mergers seldom involve firms that have monopolies protected by prohibitive entry barriers. If there is no monopoly, then there is no single monopoly profit.”).

17. Krattenmaker & Salop, *supra* note 12, at 213–14; Salop & Culley, *supra* note 16, at 6; see also Steven C. Salop, *Economic Analysis of Exclusionary Vertical Conduct: Where Chicago Has Overshot the Mark*, in *HOW THE CHICAGO SCHOOL OVERSHOT THE MARK: THE EFFECT OF CONSERVATIVE ECONOMIC ANALYSIS ON U.S. ANTITRUST*, *supra* note 12, at 141, 142; Michael H. Riordan & Steven C. Salop, *Evaluating Vertical Mergers: A Post-Chicago Approach*, 63 *ANTITRUST L.J.* 513 (1995); Jonathan B. Baker, *Exclusion As a Core Competition Concern* (2013) (Am. Univ. Wash. Coll. of Law, Working Paper No. 279, 2013), http://digitalcommons.wcl.american.edu/facsch_lawrev/279 [<https://perma.cc/SAS3-VMLG>].

18. See Salop & Culley, *supra* note 16, at 13–14 (explaining potential exclusionary effects of

significant foreclosure, identifying criteria for determining whether a particular foreclosure is likely to produce competitive harm, and generally associating “foreclosure” with raising rivals’ costs rather than with outright market exclusion.¹⁹ Thus, analysis turns on the ability of the merging parties to harm consumers by disadvantaging their competitors: “[r]ivals are simply placed in a position where their profit-maximizing price is higher after the merger than it was before. The integrating firm can then raise its own prices as well.”²⁰ Besides exclusionary effects, Post-Chicago analyses have identified other potential harms from vertical mergers, including reducing potential competition, increasing coordinated effects,²¹ enabling evasion of regulation,²² and facilitating harmful price discrimination. As happened in the 1980s, theory has been translated into action, as the Agencies have pursued a number of vertical mergers employing Post-Chicago concepts to inform their analyses.²³

As elsewhere in antitrust law, early foreclosure cases have not been overruled; instead, they are largely ignored. What little guidance can be found must be gleaned from the Agencies’ settlements of cases. Notably, the Agencies have pursued cases in which the merging parties might gain the ability to foreclose competitors from obtaining key inputs by raising their costs, by foreclosing access to customers, and by facilitating

vertical mergers). Under this analysis, foreclosure of necessary inputs for hospital care, such as physician services, can arise from refusals to sell, degradation of quality, or high prices charged to rivals of the merged firm. These tactics confer on the merged firm power to raise its price in its downstream product, hospital services. The merger could lead to customer foreclosure, by which the downstream division of the merged firm reduces or stops purchasing inputs from the other upstream firms, which then can disadvantage those firms and provide the upstream division of the merged firm with the power to raise its price. Alternatively, the downstream division of the merged firm might threaten to refuse to purchase in order to induce the independent input suppliers to raise the prices that they charge to its downstream rivals.

19. Hovenkamp, *supra* note 11, at 323–24.

20. *Id.* at 324.

21. For example, vertical mergers may facilitate coordination in the hospital market by weakening the disruptive behavior of a nonintegrated hospital, a strategy that could be implemented with targeted input foreclosure or threats of foreclosure. *See* Salop & Culley, *supra* note 16, at 25–26.

22. As discussed further in the text, in 2008 the FTC challenged a ten-year, exclusive sublicense for Venofer, a pharmaceutical product produced by Daiichi Sankyo used by dialysis clinics operated by Fresenius Medical Care, which would allow Fresenius to evade Medicare price regulations. Analysis of Agreement Containing Consent Order to Aid Public Comment, Fresenius Med. Care AG & Co. KGaA & Daiichi Sankyo Co., Ltd., No. 081-0146 (F.T.C. Sept. 15, 2008), www.ftc.gov/sites/default/files/documents/cases/2008/09/080915freseniusanal.pdf [<https://perma.cc/SVR4-ZZYA>].

23. *See* Keyte & Schwartz, *supra* note 5, at 12–14 (noting that the Agencies “gradually ramped up vertical merger enforcement” as a result of new economic analysis and citing settlements).

future collusion.²⁴ Indicative of the fact that even anticompetitive vertical mergers usually have plausible claims to create efficiencies, however, the Agencies were willing to resolve these cases by obtaining conduct relief rather than insisting on structural remedies.²⁵ Of course, each case turns on interpretation of market conditions, such as the incentives, probability, and effects of anticipated conduct. While some may question the practicality of Post-Chicago analysis,²⁶ it appears to have inaugurated closer analysis of vertical mergers by the Agencies and evolving economic scholarship aimed at developing econometric tools for predicting anticompetitive effects.²⁷

B. *Antitrust Analysis of Physician Acquisitions*

At the outset, we note that physicians and hospitals are not in a traditional vertical relationship.²⁸ Hospitals do not purchase the services of physicians; instead, they supply facilities for physicians to treat their patients subject to the physicians meeting quality and other standards of the hospital. Under fee-for-service payment, patients or (more often) third-party payers pay hospitals and physicians separately for their services.²⁹ However, a form of exchange takes place: physicians supply patients to hospitals or serve patients in specialty services in return for use of the hospitals' facilities without charge. Moreover, it is clear that

24. *Id.* at 12–13.

25. *See, e.g.*, Competitive Impact Statement, *United States v. Google Inc.*, No. 1:11-cv-00688 (D.D.C. Apr. 8, 2011), <http://www.justice.gov/atr/case-document/file/497671/download> [<https://perma.cc/3SLQ-3KZ8>] (resolving concerns that Google might be able to raise rivals' costs by virtue of acquiring a licensor of valuable software needed by competitors by agreements to license the software for "fair, reasonable and nondiscriminatory terms" for five years and other commitments).

26. *See, e.g.*, Hovenkamp, *supra* note 11, at 325 ("Assessing the overall competitive impact of a vertical merger [under Post-Chicago principles] . . . strains the fact finding abilities of a court, although perhaps not to the breaking point."); John E. Lopatka & Paul E. Godek, *Another Look at Alcoa: Raising Rivals' Costs Does Not Improve the View*, 35 J.L. & ECON. 311 (1992).

27. Serge Moresi & Steven C. Salop, *vGUPPI: Scoring Unilateral Pricing Incentives in Vertical Mergers*, 79 ANTITRUST L.J. 185 (2013).

28. *See* PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION ¶ 1000a (3d ed. 2009) (describing a "vertical merger" as a merger "between a firm selling a particular product or service and a firm that buys that product or service").

29. *See Arizona v. Maricopa Cty. Med. Soc'y*, 457 U.S. 332, 339 n.7 (1982) (explaining fee-for-service payment and contrasting it with fixed, per subscriber payment provided by health maintenance organizations); *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1409–10 (7th Cir. 1995) (explaining incentive of fee-for-service payment is to provide too many services while the incentive of a fixed, per subscriber payment, more often referred to as capitated payment, is to provide too few services).

physicians provide a critical input for hospitals to supply their services. Therefore, a vertical framework is appropriate for antitrust analysis.

The handful of physician merger cases brought by state and federal antitrust enforcers that proceeded to judgment or were settled by consent decree all involve horizontal combinations. As discussed below, with the exception of one suit filed by a private plaintiff almost twenty years ago, no reported cases or advisory opinions address the vertical effects of physician-hospital combinations. Thus far, the Agencies and state attorneys general have gone after relatively easy targets: mergers to near monopoly in well-defined physician services and often in markets with some history of prior consolidation. Nevertheless, these cases do provide precedent and guidance on certain issues highly relevant to cases brought under a vertical theory of harm.

The first Agency challenge to a physician merger, concluded in 2012, involved acquisition of two cardiology groups by the largest hospital system in the Reno, Nevada area.³⁰ Together the acquisitions made the system the employer of eighty-eight percent of the active cardiologists in the market.³¹ The FTC entered a consent order that did not enjoin the merger but rather required the system to release physicians from covenants not to compete.³² In a more recent challenge to a physician merger, also resolved by consent order, the FTC charged that a merger among six small practices that combined nineteen of the twenty-five orthopedists in Berks County, Pennsylvania, was anticompetitive.³³ By the time the agency and the defendants entered into a proposed consent order, however, six orthopedists had left the merged entity, reducing its

30. *In re* Renown Health, No. C-4366 (F.T.C. Dec. 4, 2012), www.ftc.gov/enforcement/cases-proceedings/1110101/renown-health-matter [<https://perma.cc/XF43-C2GU>].

31. Complaint at 19, *In re Renown Health*, No. C-4366 (F.T.C. Aug. 3, 2012), www.ftc.gov/sites/default/files/documents/cases/2012/12/120806renownhealthcmpt.pdf [<https://perma.cc/BDU7-F9HC>].

32. Before commencing the *Renown* litigation, the FTC investigated a proposed acquisition of two cardiology groups constituting sixty percent of cardiologists in the relevant market by Providence Health Care in Spokane, Washington. The investigation was concluded when Providence abandoned the deal and acquired one of the two groups. DAVID A. ETTINGER, HONIGMAN MILLER SCHWARTZ & COHN LLP, CURRENT ANTITRUST ISSUES RELATING TO PHYSICIAN MERGERS, ACQUISITIONS AND COMBINATIONS, https://www.healthlawyers.org/events/programs/materials/documents/phy12/papers/b_ettinger.pdf [<https://perma.cc/WMB7-B3LQ>]; Closing Letter from Donald S. Clark, Sec'y, Fed. Trade Comm'n, to Douglas C. Ross, Esq. (Mar. 21, 2011), www.ftc.gov/enforcement/cases-proceedings/closing-letters/providence-health-services-spokane-cardiology-hearts [<https://perma.cc/4TFF-7DTT>].

33. Keystone Orthopaedic Specialists, LLC, No. 141 0025 (F.T.C. Oct. 21, 2015), <https://www.ftc.gov/enforcement/cases-proceedings/141-0025/keystone-orthopaedic-specialists-llc-orthopaedic-associates> [<https://perma.cc/UVQ8-MNZW>].

share of the market from seventy-six percent to fifty-two percent.³⁴ The FTC consent order required the merged entity and the departing orthopedists to obtain prior approval from the agency before acquiring another practice in the county or hiring an orthopedist who provided services in the county within a year of being hired.³⁵ Together, these cases signal the FTC's heightened concern about physician consolidations and its position that physician specialty services may constitute distinct product markets in localized geographic regions.

In its first litigated case, *Saint Alphonsus Medical Center-Nampa Inc. v. St. Luke's Health System, Ltd. (St. Luke's)*,³⁶ the FTC successfully challenged the acquisition of a physician group by a health system. St. Luke's, which owned hospitals and employed doctors, acquired the largest and most prestigious group of primary care physicians (PCPs) in Nampa, a city approximately twenty miles west of Boise, Idaho, the capital and largest city in the state.³⁷ With its acquisition of Saltzer, St. Luke's added sixteen PCPs to the seven it had previously acquired, giving it approximately an eighty percent share of adult primary care services in Nampa County.³⁸ The acquisition resulted in a post-merger Herfindahl-Hirschman Index (HHI) of 6219, with an increase of 1607.³⁹ Examining the merger as a horizontal combination in the market for adult PCP services in the highly localized geographic market of Nampa, the U.S. Court of Appeals for the Ninth Circuit affirmed a district court's decision that St. Luke's acquisition violated Section 7 of the Clayton Act.⁴⁰ The decision supports the FTC's view that many, perhaps most, physician services markets are local and, in the case of primary care, may be smaller than local hospital markets. The case underscores the now well-established lesson of recent hospital merger cases: internal

34. Analysis of Agreement Containing Consent Order to Aid Public Comment, *Keystone Orthopaedic Specialists, LLC*, F.T.C. No. 141 0025, www.ftc.gov/system/files/documents/cases/151015keystoneanalysis.pdf [<https://perma.cc/F9CL-F44L>].

35. Press Release, Fed. Trade Comm'n, Two Pennsylvania Orthopedic Practices Settle FTC Charges that Merger Harmed Competition and Inflated Prices (Oct. 15, 2015), <https://www.ftc.gov/news-events/press-releases/2015/10/two-pennsylvania-orthopedic-practices-settle-ftc-charges-merger> [<https://perma.cc/F9V2-87TA>].

36. *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd. (St. Luke's)*, 778 F.3d 775 (9th Cir. 2015).

37. *Id.* at 781 (stating that Nampa is twenty miles from Boise); *Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health Sys., Ltd. (St. Luke's)*, Nos. 12-CV-00560-BLW, 13-CV-00116-BLW, 2014 WL 407446, at *3 (D. Idaho Jan. 24, 2014) (finding that Saltzer was "a very prestigious group with a long history"), *aff'd*, 778 F.3d 775 (9th Cir. 2015).

38. *St. Luke's*, 2014 WL 407446, at *3, *8-9.

39. *St. Luke's*, 778 F.3d at 786.

40. *Id.* at 781.

documents and buyer testimony will carry the day even in the face of claims of changing market conditions. Further, on appeal the Ninth Circuit firmly rejected an efficiencies defense predicated on the incentives created by the Affordable Care Act (ACA) to move away from inefficient fee-for-service payments and adopt an integrated delivery model that would provide cost savings and better care.⁴¹ In doing so, it went beyond the district court's finding that the purported quality improvements were not merger specific because integrated delivery could be accomplished through a variety of contractual and joint venture arrangements.⁴² It seemed to question whether efficiencies would ever justify a highly concentrative merger, especially where the justification was premised only on an enhanced ability "to better serve patients" as opposed to lowering the cost of providing care and ultimately lowering prices charged to health plans.⁴³ This holding is unique to the Ninth Circuit and is subject to the criticism that it ignores the need to assess efficiencies in view of their effect on quality-adjusted prices.⁴⁴

State attorneys general have challenged physician mergers on several occasions, all resulting in settlements or abandonment of the

41. *Id.* at 791–92.

42. The district court seemed to acknowledge that the merger had the propensity to improve quality. *St. Luke's*, 2014 WL 407446, at *25 ("In a world that was not governed by the Clayton Act, the best result might be to approve the Acquisition and monitor its outcome to see if the predicted price increases actually occurred. In other words, the Acquisition could serve as a controlled experiment But the Clayton Act is in full force, and it must be enforced. The Act does not give the Court discretion to set it aside to conduct a health care experiment.").

43. *St. Luke's*, 778 F.3d at 791; *id.* at 790 ("We remain skeptical about the efficiencies defense in general and about its scope in particular. It is difficult enough in § 7 cases to predict whether a merger will have future anticompetitive effects without also adding to the judicial balance a prediction of future efficiencies."). The Ninth Circuit went on to quote a passage from *Brown Shoe Co. v. United States*, 370 U.S. 294, 334 (1962), rarely cited favorably elsewhere, that questioned efficiencies: "[c]ongress appreciated that occasional higher costs and prices might result from the maintenance of fragmented industries and markets. It resolved these competing considerations in favor of decentralization." The court also noted that prominent Chicagoans are skeptical of an efficiencies defense. *See, e.g.*, RICHARD A. POSNER, *ANTITRUST LAW* 133 (2d ed. 2001) ("[T]here should be no general defense of efficiency It is rarely feasible to determine by the methods of litigation the effect of a merger on the costs of the firm created by the merger.").

44. John J. Miles, *FTC Notches Yet Another Victory in a Provider Merger Case*, OBER KALER ATTORNEYS AT LAW, HEALTH L. ALERT (2015), <http://www.ober.com/publications/2861-ftc-notches-yet-another-victory-provider-merger-case> [<https://perma.cc/6WM2-RZB8>]. Despite its victory in *St. Luke's*, the FTC has made clear it will continue carefully to examine claims of efficiencies in hospital mergers. *See* discussion *infra* at note 89. And the Agencies' joint Horizontal Merger Guidelines make clear they consider legitimate claims of efficiencies. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, *HORIZONTAL MERGER GUIDELINES* § 10 (2010) [hereinafter 2010 MERGER GUIDELINES], <http://www.justice.gov/atr/horizontal-merger-guidelines-08192010> [<https://perma.cc/BT5R-T4LX>].

acquisition.⁴⁵ A number of these cases have resulted in so-called “conduct remedies” that allow the merger to go forward but require the merged entity to abide by certain restrictions. For example, state decrees have entailed restrictions on raising prices to commercial insurers,⁴⁶ promises that the merged entity will negotiate in “good faith” with health plans;⁴⁷ commitments to tell patients about treatment options outside of the merged entity;⁴⁸ and agreements not to undertake future mergers without notification or consent of the attorney general.⁴⁹ In one noteworthy case, a Massachusetts superior court rejected a proposed settlement by the state Attorney General that imposed restrictions on pricing, bidding with managed care organizations, and future acquisitions of physician practices.⁵⁰

As mentioned earlier, neither the Agencies nor the courts have specifically addressed a physician acquisition as a purely vertical combination. Saint Alphonsus, a rival hospital, and a surgery center, had challenged the St. Luke’s transaction relying on vertical foreclosure theory, arguing that the acquired Saltzer physicians would admit their patients to St. Luke’s, thereby foreclosing competition in the hospital and outpatient surgery markets.⁵¹ Neither the district court nor the court

45. Final Order, *Pennsylvania v. Urology of Cent. Pa., Inc.*, No. 11-01625 (M.D. Pa. Aug. 31, 2011) (merger of five urology practices resulting in group constituting over half the urologists in the relevant market); Consent Decree, *State v. MaineHealth*, No. BCD-CV-11-08 (Me. Super. Ct. 2011), <http://www.maine.gov/tools/whatsnew/attach.php?id=310574&an=1> [<https://perma.cc/EH4G-5SJR>] (acquisition of the largest major cardiology practices in the Portland, Maine, area by a local Hospital); *Minnesota v. Allina Hosps. & Clinics*, No. C6-05-541 (Minn. Dist. Ct. Ramsey Cty. 2005) (Minnesota Attorney General sued Allina Hospital & Clinics to block acquisition of two cardiology groups; complaint alleged Allina already owned area’s largest cardiology group; case settled when acquisitions were abandoned). Maine and Pennsylvania have a history of challenging allegedly anticompetitive physician acquisitions. *Maine v. Me. Heart Surgical Assocs.*, No. CV96-336, 1996 WL 773330 (Me. Super. Ct. July 22, 1996) (combination of four separate practices with nine of the ten cardiothoracic surgeons in Portland challenged by Attorney General; merger permitted under terms of behavioral settlement); *Pennsylvania v. Geisinger Health Sys. Found.*, No. 1:13-cv-02647 (M.D. Pa. Oct. 28, 2013) (acquisition by Geisinger, a health system that employs physicians, of another system that employed physicians was challenged and settled under terms of a behavioral decree that, for two years, relieved departing physicians from any obligation not to compete).

46. See *infra* note 50 and accompanying text.

47. *Urology of Cent. Pa.*, No. 11-01625.

48. *Id.*

49. *Id.*

50. *Commonwealth v. Partners Healthcare Sys., Inc.*, No. SUCv2014-02033-BLS2, 2015 WL 500995, at *4–5 (Mass. Dist. Ct. Jan. 30, 2015).

51. See Plaintiffs’ Joint Pretrial Memorandum at 26–30, *Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke’s Health Sys., Ltd. (St. Luke’s)*, Nos. 12-cv-00560-BLW, 13-CV-00116-BLW, 2014 WL 407446 (D. Idaho Jan. 24, 2014), *aff’d*, 778 F.3d 775 (9th Cir. 2015), <https://www.ftc.gov/>

of appeals decided the vertical claim in light of their decisions to condemn the acquisition under the horizontal theory. The district court nevertheless made findings that were relevant to the private plaintiff's vertical foreclosure theory but that were not relevant to the court's conclusion that the acquisition was unlawful.⁵² This perhaps suggests that even when confronted with a physician merger that raises purely horizontal issues—the aggregation of power in one or more physician services markets—courts are acutely aware of the context when a prominent hospital will control the merging health practices. And to some extent issues can coincide under vertical and horizontal claims. For example, the court made findings to the effect that the substantial bargaining leverage that St. Luke's enjoyed for hospital services prior to the merger would be enhanced.⁵³ Finally, following a trend in antitrust cases involving hospital mergers,⁵⁴ the *St. Luke's* case closely analyzed the merger's effect on the bargaining leverage in the physician services market.⁵⁵

system/files/documents/cases/130910stlukepretrialmemo.pdf [https://perma.cc/GWV9-PTEQ] (the FTC did not join in this claim).

52. Although the district court entered no conclusions on Saint Alphonsus's claim of vertical foreclosure, it entered factual findings that are supportive of the claim. To counter Saint Alphonsus's claim that after the acquisition Saltzer physicians would redirect their patients from Saint Alphonsus to St. Luke's, St. Luke's pointed to the professional service agreements Saltzer physicians signed giving them autonomy to decide where to send their patients. *St. Luke's*, 2014 WL 407446, at *5, *13. The district court was not impressed; noting that after earlier acquisitions, acquired physicians increased their referrals to St. Luke's and decreased referrals to Saint Alphonsus. *Id.* at *13. The court concluded the same likely would occur if the Saltzer physicians were acquired. *Id.* Yet it is unclear what significance the district court attached to this finding. The court examined the effect of the acquisition on competition in only one market: the market for adult primary care physicians in Nampa. The loss of referrals that Saint Alphonsus, a hospital, would suffer is irrelevant to the analysis of harm in that market. It would be highly relevant to an analysis of a claim of anticompetitive vertical foreclosure—but the court did not consider that claim.

53. *Id.* at *13–14.

54. *See, e.g.,* FTC v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1083 (N.D. Ill. 2012) (examining effect of merger in terms of additional bargaining leverage hospitals would acquire in negotiations with managed care organizations). *See generally* Aviv Nevo, Deputy Assistant Att'y Gen., Antitrust Div., U.S. Dep't of Justice, Mergers That Increase Bargaining Leverage, Remarks as Prepared for the Stanford Institute for Economic Policy Research and Cornerstone Research Conference on Antitrust in Highly Innovative Industries (Jan. 22, 2014), <https://www.justice.gov/atr/file/517781/download> [https://perma.cc/427W-H38X].

55. *St. Luke's*, 2014 WL 407446, at *13–14 (finding the merger would give St. Luke's a “dominant bargaining position over health plans in the Nampa market” and concluding it “highly likely that St. Luke's will use its bargaining leverage over health plan payers to receive increased reimbursements that the plans will pass on to consumers in the form of higher health care premiums and higher deductibles”).

C. *Economic Effects of Physician Acquisitions*

Physicians play a central role in their patients' decision making, effectively determining over eighty percent of all personal health care spending.⁵⁶ Moreover, it is well established that physicians exert substantial control over patients' decisions regarding *whether* to receive care and *where* to receive it.⁵⁷ Empirical studies show that physician recommendations play an important role in their patients' choice of hospitals.⁵⁸ With regard to acute hospital care, physicians influence patient choices by making recommendations about the hospitals in which they prefer to provide services or by referring patients to admitting physicians who tend to admit patients to specific hospitals. Although agency relationships strongly influence many consumer decisions, those that are colored by conflicts of interest pose particular problems from the standpoint of evaluating the economic efficiency of market transactions. This section considers whether employment of physicians by hospitals uniformly improves consumer welfare.

It should come as no surprise that hospitals acquiring physician practices expect employee-physicians to refer to their hospitals or to refer to specialists who will do so.⁵⁹ Laws governing self-referrals by physicians, the Federal Anti-Kickback Law⁶⁰ and the Stark Law,⁶¹ afford broad leeway with regard to referrals by employed physicians, and thus provide no significant barrier to meeting these expectations.⁶² Likewise,

56. *Health Care Costs: A Primer*, HENRY J. KAISER FAM. FOUND. (May 1, 2012), <http://kff.org/report-section/health-care-costs-a-primer-2012-report/> [https://perma.cc/PY2Y-SYNT].

57. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, *IMPROVING HEALTH CARE: A DOSE OF COMPETITION* 7 (2004) [hereinafter *IMPROVING HEALTH CARE*], www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf [https://perma.cc/8XMB-4FZF] (observing that “[a] large majority of consumers purchase health care through multiple agents” that included “providers who guide patient choice through referrals and selection of treatments”); Leslie Greenwald et al., *Specialty Versus Community Hospitals: Referrals, Quality, and Community Benefits*, 25 *HEALTH AFF.* 106, 109 (2006) (“[P]hysicians generally drive the decision of which facilities their patients are referred to.”).

58. DELOITTE CTR. FOR HEALTH SOLS., *2011 SURVEY OF HEALTH CARE CONSUMERS IN THE UNITED STATES: KEY FINDINGS, STRATEGIC IMPLICATION* 15 (2011), http://www.statecoverage.org/files/Deloitte_US_CHS_2011ConsumerSurveyinUS_062111.pdf [https://perma.cc/47FM-HSGL].

59. Robert Kocher & Nikhil Sahni, *Hospitals' Race to Employ Physicians—The Logic Behind a Money-Losing Proposition*, 364 *NEW ENG. J. MED.* 1791 (2011).

60. 42 U.S.C. § 1320a-7b (2012).

61. *Id.* § 1395nn.

62. *See id.* § 1395nn(e)(2) (creating an exception under Stark Law for bona fide employment relationships).

antitrust law does not inhibit intra-system referrals.⁶³ Hospitals are often concerned with attempting to gain admissions from doctors who admit to more than one hospital (so-called “splitters”). Acquiring the practices of splitters is seen as the most direct method of securing their loyalty but may disadvantage rival hospitals to which they previously admitted patients.⁶⁴

Yet physician employment has not proved to be an economic bonanza: as a general matter, employment of physicians is a losing proposition. Hospitals lose \$150,000 to \$250,000 per year over the first three years of employing a PCP; losses persist thereafter although hospitals can earn profits based on tests and referrals from the physician’s practice.⁶⁵ The willingness to incur substantial losses in connection with PCP employment lends support to the conclusion that “hospitals are willing to take a loss employing PCPs in order to influence the flow of referrals to specialists who use their facilities.”⁶⁶

63. The litigated antitrust cases are unanimous that referrals within an integrated system are not anticompetitive conduct that would support a violation of section 2 of the Sherman Act. *See, e.g.*, *Four Corners Nephrology Assocs. v. Mercy Med. Ctr. of Durango*, 582 F.3d 1216, 1224 (10th Cir. 2009); *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406 (7th Cir. 1995); *Barry v. Blue Cross of Cal.*, 805 F.2d 871 (9th Cir. 1986); *Park Ave. Radiology Assocs. v. Methodist Health Sys., Inc.*, No. 98-5668 (W.D. Tenn. Nov. 10, 1999). This is consistent with the general principle, set out in *Verizon Communications, Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 411 (2004), that a competitor generally has no duty to deal with a rival. *See also* *Novell, Inc. v. Microsoft Corp.*, 731 F.3d 1064, 1072–76 (10th Cir. 2013) (offering a two-part test for determining if a refusal to deal falls into “a ‘limited exception’ to the general rule of firm independence”).

64. Lawton R. Burns & Ralph W. Muller, *Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration*, 86 MILBANK Q. 375, 390 (2008). This is not to suggest that most acquisitions are motivated by an anticompetitive desire to damage rivals. A hospital may believe the acquisition of physicians is one way to control costs and so better position itself for managed care contracting. As Atul Gawande wrote in an article comparing the very different cost of health care in two similar Texas cities, “[t]he most expensive piece of medical equipment, as the saying goes, is a doctor’s pen. And, as a rule, hospital executives don’t own the pen caps. Doctors do.” Atul Gawande, *The Cost Conundrum: What a Texas Town Can Teach Us About Health Care*, NEW YORKER (June 1, 2009), www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande?currentPage=all [<https://perma.cc/69UK-LJD6>]. A hospital that employs physicians may be better able to influence decisions those physicians make that drive up hospital costs but over which hospitals have no direct control. A decision unnecessarily to extend a hospital stay by one night or to order unneeded tests will not result in additional revenue for a hospital reimbursed on a fixed basis according to the patient’s diagnosis, but it will increase the hospital’s costs. A hospital also may acquire physicians for defensive reasons—if it doesn’t do so, its rivals will, and then it will be on the short end of the splitters’ stick.

65. Kocher & Sahni, *supra* note 59, at 1791. For newly hired PCPs to be profitable, they must generate at least thirty percent more visits; new specialists must generate twenty-five percent more referrals than they do at the outset. *Id.* at 1790–91.

66. *Id.*; *see also* Beth Kutcher, *Making Physicians Pay Off: Hospitals Struggle to Balance Current Costs with Future Benefits of Employing Docs*, MOD. HEALTHCARE (Feb. 22, 2014)

Hospitals may be willing to sustain unprofitable service components for a variety of reasons, e.g., possible benefits flowing from other, related services, mitigation of uncertainties about future market and regulatory changes, and strategic considerations about rivals' responses.⁶⁷

Nor does the evidence yet support the claim that physician employment produces societal benefits, including cost savings or quality improvements.⁶⁸ Many observers assume that such improvements inevitably flow from hierarchical structures.⁶⁹ Not only is economic evidence for this proposition lacking so far, some studies suggest that hospital-physician integration has raised physician costs, hospital prices, and per capita medical spending.⁷⁰ Recent studies examining the relationship between hospital-physician consolidation and performance finds hospital ownership of physician practices (as contrasted with looser forms of contractual integration) to be associated with higher hospital prices and spending.⁷¹ For example, one analysis of physician

<http://www.modernhealthcare.com/article/20140222/MAGAZINE/302229986>
[\[https://perma.cc/F6D9-DBHW\]](https://perma.cc/F6D9-DBHW).

67. See *infra* note 107 (discussing cross subsidization of hospital services).

68. Letter from Acad. Economists to Hon. Janet L. Sanders (July 21, 2014) (on file with *Washington Law Review*) (“[T]here is no convincing evidence to date that combining physicians and hospitals under common ownership tends to result in cost savings.”); see also Lawton Robert Burns et al., *Horizontal and Vertical Integration of Physicians: A Tale of Two Tails*, 15 *ADVANCES HEALTH CARE MGMT.* 39 (2013) (“Research on the effect of integration on physician productivity and hospital profitability has produced *mixed results*.” (emphasis in original)).

69. As Oliver Williamson wrote in *The Vertical Integration of Production: Market Failure Considerations*, 61 *AM. ECON. REV.* 112, 113–14, “the most distinctive advantage of the firm . . . is the wider variety and greater sensitivity of control instruments that are available for enforcing intrafirm in comparison with interfirm activities.” Even more succinctly, “fiat is frequently a more efficient way to settle minor conflicts . . . than is haggling or litigation.” *Id.*

70. See JEFF GOLDSMITH ET AL., *NAT’L ACAD. SOC. INS., INTEGRATED DELIVERY NETWORKS: IN SEARCH OF BENEFITS AND MARKET EFFECTS* (2015) (summarizing literature and analyzing performance of fifteen of the largest integrated delivery systems). But see MARGARET E. GUERIN-CALVERT & JEN A. MAKI, *CTR. FOR HEALTHCARE ECON. & POLICY, HOSPITAL REALIGNMENT: MERGERS OFFER SIGNIFICANT PATIENT AND COMMUNITY BENEFITS* 10 (2014), http://fah.org/upload/documents/FTI_Hospital-Realignment-Mergers-Offer-Significant-Patient-and-Community-Benefits_Report.pdf [<https://perma.cc/59MX-DYAP>] (adding physicians to a system is one way to create an integrated delivery system “to deliver a full spectrum of care to a community”).

71. Laurence C. Baker et al., *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending*, 33 *HEALTH AFF.* 756 (2014) (noting that increases in the market share of hospitals that own physician practices are associated with increases in area prices and spending); see also James C. Robinson & Kelly Miller, *Total Expenditures in Hospital-Owned and Physician-Owned Organizations in California*, 312 *JAMA* 1663 (2014), <http://jama.jamanetwork.com/article.aspx?articleid=1917439> [<https://perma.cc/4NS2-C3SP>] (noting that groups owned by physicians have lower costs than groups owned by hospitals); Hannah T. Naprash et al., *Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices*, *JAMA ONLINE FIRST* (Oct. 19, 2015),

acquisitions by hospitals found that commercial insurers face increases of 13.7% in physician prices with the largest increases occurring when the acquiring hospital has a larger share of its inpatient market.⁷² Moreover, analyses of health system organizations suggest that economic integration historically has failed to generate clinical integration that results in either cost savings or improved efficiency.⁷³ These studies lend support to concerns that certain physician acquisitions may enhance hospital bargaining power and vertical antitrust analysis is warranted. Of course, the historical record of integration predates the introduction of important financial incentives by health reform and changing private insurance contracting practices. Nevertheless, the performance of even highly integrated systems establishing accountable care organizations (ACOs) post-ACA suggests at best a rather slow and winding path to integration producing meaningful improvement in cost and quality.⁷⁴

To summarize, there is ample reason for antitrust enforcers to take a close look at certain hospital acquisitions of physician practices, as excessive consolidation may undermine the cost-saving and quality promoting objectives of a market-driven system. However, economic evidence about both the risks and benefits of hospital-physician

<http://archinte.jamanetwork.com/article.aspx?articleid=2463591> [<https://perma.cc/M4QT-M469>] (noting that higher physician-hospital integration associated with increases in outpatient spending, driven almost entirely by increases in prices). Some older studies also find hospital-physician integration coupled with exclusivity to be associated with increases in prices and little effect on efficiency. See Allison Evans Cuellar & Paul J. Gertler, *Strategic Integration of Hospitals and Physicians*, 25 J. HEALTH ECON. 1 (2006).

72. Cory Capps, David Dranove & Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending* (Inst. for Policy Research, Northwestern Univ., Working Paper No. 15-02, 2015), <http://www.ipr.northwestern.edu/publications/docs/workingpapers/2015/IPR-WP-15-02.pdf> [<https://perma.cc/78ZK-EA2P>]. Notably, the study found that only one-quarter of the price increases were due to increased exploitation of reimbursement rules, as discussed *infra* at notes 150–152 and in the accompanying text.

73. Burns & Muller, *supra* note 64, at 394.

74. Only 29 of 114 ACOs participating in the Medicare Shared Savings Program in its first year achieved savings sufficiently low to earn shared savings. See Brief of Economics Professors as Amici Curiae at 12, *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.* (*St. Luke's*), 778 F.3d 775 (9th Cir. 2015) (No. 14-35173), www.ftc.gov/system/files/documents/cases/140820healthcareeconomistsbrief.pdf [<https://perma.cc/6CPD-WVFP>] (noting that the proportion of ACOs achieving savings relative to the CMS benchmark was “about what one would expect from a random sample of healthcare delivery organizations”). In addition, a significant number of the highly sophisticated integrated systems participating in the Pioneer ACO pilot withdrew from the program. See *From 32 to 19: Three More ACOs Drop Out of Pioneer Program*, ADVISORY BOARD COMPANY (Sept. 26, 2014, 8:49 AM), <https://www.advisory.com/daily-briefing/2014/09/26/from-32-to-19-three-more-acos-drop-out-of-pioneer-program> [<https://perma.cc/D97K-B55S>].

integration is ambiguous, and the legal precedent is limited and does not incorporate recent economic analyses. Below we discuss some of the more vexing issues likely to be encountered in future litigation.

II. COMPETITIVE EFFECTS OF VERTICAL MERGERS

A. *Foreclosure*

1. *General Principles*

As a threshold matter, establishing competitive harm from foreclosure requires that the merged parties will deal exclusively with each other or, under a raising rival's cost variant, will give each other preferential treatment. While some cases suggest that courts might presume that exclusivity or preferential treatment will be the norm after the merger,⁷⁵ it is probably incumbent on plaintiffs to present evidence that physicians will do so in particular cases. Given ethical norms applicable to physicians⁷⁶ and the laws prohibiting self-referrals,⁷⁷ courts are likely to require some proof that employed physicians will not refer or admit patients to other hospitals or refer to physicians associated with rival hospitals absent extraordinary circumstances. This does not seem to present a major hurdle in most cases. It would be the rare case in which a hospital did not expect—and indeed require⁷⁸—its employed physicians to use its facilities and refer to other doctors within its system.

As to the effects of foreclosure, the modern case law insists on more than a showing that rivals will be simply unable to deal with a party to the merger with whom they previously dealt. Because foreclosure resulting from mergers is merely a “structural” phenomenon, evidence

75. *United States v. Kimberly-Clark Corp.*, 264 F. Supp. 439, 448 (N.D. Cal. 1967) (“It is not part of the Government’s burden to show actual foreclosure.”); see also AREEDA & HOVENKAMP, *supra* note 28, ¶ 1004b (“A subsidiary will in all probability deal only with its parent . . .”).

76. See, e.g., *ACP Ethics Manual Sixth Edition*, AM. C. PHYSICIANS, www.acponline.org/running_practice/ethics/manual/manual6th.htm#conflict [<https://perma.cc/4RMD-MAL5>] (last visited Feb. 22, 2016) (discussing financial conflicts of interest and stating, “[p]hysicians must be conscious of all potential influences, and their actions should be guided by patient best interests and appropriate utilization, not by other factors”).

77. Section 1877 of the Social Security Act, also known as the physician self-referral law and commonly referred to as the “Stark Law,” prohibits physicians from referring patients for certain designated health services to entities with which they have financial relationships but includes specific exceptions, including one for employment relationships. 42 U.S.C. § 1395nn (2012). Self-referrals also may implicate the Anti-Kickback Law and state laws. See generally BARRY R. FURROW ET AL., *HEALTH LAW* (3d ed. 2015).

78. See *supra* note 61.

that foreclosure will have anticompetitive effects is needed.⁷⁹ However, the cases vary considerably as to what amount of foreclosure is either probative of harm or establishes a presumption of harm.⁸⁰ While there is some agreement that foreclosure can have no effect in a competitive market,⁸¹ there is no consensus as to whether government guidelines should adopt a market power threshold.⁸²

However, the analysis proposed under “raising rivals’ costs” theory discussed above supplies an economically sound approach to filling the void. Competitive harm can be predicted where a merger narrows the market so that rivals or potential entrants have “inadequate access to low-cost inputs or insufficient sales potential to support production at an efficient scale.”⁸³ Because the ultimate focus of the analysis is the effect on competition, one of two prerequisites must be satisfied to show a hospital acquisition of a physician practice forces rivals to face higher costs: (1) the acquisition must be of such magnitude that rival hospitals cannot gain enough access to needed physician services to achieve sufficient scale (including levels of quality associated with the number and productivity of the physicians acquired), or (2) rival hospitals are relegated to higher-cost or lower-quality physician substitutes.⁸⁴

2. *Foreclosure of PCPs*

As a general matter, allegations that an acquisition of PCPs is anticompetitive present a relatively straightforward scenario for applying

79. See AREEDA & HOVENKAMP, *supra* note 28, ¶ 1004a (“[T]he foreclosure theory has serious weaknesses . . . even when foreclosure has the effect of making it more difficult for one or more existing firms to find inputs or patronage, injury to competition is not obvious and an additional explanation must be supplied.”).

80. Compare *Ash Grove Cement v. FTC*, 577 F.2d 1368, 1371 (9th Cir. 1978) (upholding FTC order of divestiture where shares of the acquiring and the acquired firms in their respective “upstream” and “downstream” markets were thirteen to eighteen percent and eighteen percent respectively), and *Miss. River Corp. v. FTC*, 454 F.2d 1083, 1091–93 (8th Cir. 1972) (condemning an acquisition involving twenty percent foreclosure), with *HTI Health Servs., Inc. v. Quorum Health Grp., Inc.*, 960 F. Supp. 1104 (S.D. Miss. 1997) (finding a substantial foreclosure in small physician specialty markets not anticompetitive), and *infra* notes 90–97 and accompanying text. See also *United States v. Microsoft*, No. CIV. A. 98–1232, 1998 WL 614485 (D.D.C. Sept. 14, 1998) (noting that in the context of exclusive dealing claims, “plaintiffs must establish foreclosure on the order of greater than 40 percent to prevail”).

81. AREEDA & HOVENKAMP, *supra* note 28, ¶ 1004a (“[F]oreclosure has no anticompetitive effect whatsoever in competitive markets and often little effect in oligopolistic markets.”).

82. Salop & Culy, *supra* note 16, at 8–10 (discussing suggestions for safe harbors and presumptions based on concentration data).

83. AREEDA & HOVENKAMP, *supra* note 28, ¶ 1008a.

84. See *id.* ¶ 1008b.

foreclosure analysis. As noted above, PCPs occupy a pivotal position in determining the referral paths for their patients. Moreover, given the widespread adoption by public and private payers of reimbursement methodologies that pay for a continuum of care through bundled payments, capitation, and other methods, the potential for harm from cutting off referrals from PCPs is evident.

Establishing that an acquisition of even a significant number of PCPs will harm competition, however, entails proof of several critical elements. First, there must be clear evidence that the acquisition constitutes a significant proportion of the PCPs available to refer to rival hospitals or that reliance on remaining physicians or new entrants will significantly raise cost or impair quality of rivals. In some circumstances vertical acquisitions merely realign relationships.⁸⁵ Hence, if the employment of some physicians initiates a movement of others to realign with rival hospitals, competitive harm is less likely. A second requirement, usually easily satisfied, is that the employed physicians are likely to change their referral practices so that the acquiring hospital is able to garner significant new business for its secondary and tertiary services. Third, the harm visited on rival hospitals' specialty services must adversely affect consumers. In this connection, proof of increased market power, evidenced by market share statistics and payer testimony regarding changes in bargaining leverage, would be important. However, because evidence supporting such claims is necessarily speculative in a case in which the merger has not been consummated, more compelling evidence might be supplied by a raising rivals' cost analysis. For example, proof that the volume of referrals available post-acquisition would leave rivals below minimum efficient scale or would increase their average costs significantly would be persuasive proof of competitive harm.⁸⁶ Likewise plaintiffs would need to show that the costs of obtaining alternative sources of referrals, such as by inducing new entry by PCPs in a timely fashion, would make such efforts impractical.⁸⁷ Finally, although rarely—if ever—dispositive in litigated horizontal merger cases,⁸⁸ efficiencies that outweigh competitive harms

85. *See id.* ¶ 1004c.

86. A number of related scenarios may also be relevant. For example, fact finders should consider the possibility that the remaining physicians in the market might have incentives to raise their prices either unilaterally or in coordination with each other. *See Salop & Culley, supra* note 16, at 16.

87. *See id.* (suggesting as relevant evidence the “ability of the targeted downstream rivals to substitute to other equally cost-effective input suppliers and the capacity and incentives of those input suppliers, including any impact of any reduced input purchases by the downstream division of the merged firm”).

need to be addressed.⁸⁹

The district court's opinion in *HTI Health Services, Inc. v. Quorum Health Group, Inc.*,⁹⁰ the lone reported case analyzing a physician-hospital alliance as a vertical merger, provided a limited account of the evidence necessary to show competitive harm. Noting that there was “no . . . theoretical basis for evaluating the anticompetitive effects of a vertical merger” comparable to the concentration standards applicable to horizontal mergers, the court framed the inquiry as an evaluation of “structural consequences or economic barriers such as whether the merger ‘forecloses’ competitors of the merging entities from a source of

88. The DOJ 1984 “Non-Horizontal Merger Guidelines” stated that efficiencies are more important in a vertical merger than a horizontal one. 1984 Merger Guidelines, 49 Fed. Reg. 26,823, 26,837 (June 29, 1984) (“The Department will give relatively more weight to expected efficiencies in determining whether to challenge a vertical merger than in determining whether to challenge a horizontal merger.”).

89. Although the Ninth Circuit in *St. Luke's* questioned the existence of an efficiencies defense, FTC officials have continued to state clearly the agency will take claims of efficiencies seriously in merger cases. *See, e.g.*, Edith Ramirez, Chairwoman, Fed. Trade Comm'n, The Horizontal Merger Guidelines Five Years Later, Remarks at the Ninth Annual Global Antitrust Enforcement Symposium, Georgetown University Law Center, Washington, D.C., at 11 (Sept. 29, 2015), https://www.ftc.gov/system/files/documents/public_statements/805441/ramirez_-_georgetown_antitrust_enforcement_symposium_9-29-15.pdf [<https://perma.cc/7CPD-PHAW>] (“In a number of cases, efficiencies have played a role in our decision not to take action against proposed mergers.”); Deborah L. Feinstein, Dir., Bureau of Competition, Fed. Trade Comm'n, *FTC v. Sysco: Old-School Antitrust with Modern Economic Tools*, Remarks at GCR Live, at 8 (Sept. 18, 2015), https://www.ftc.gov/system/files/documents/public_statements/802381/150918gcrspeech.pdf [<https://perma.cc/8EHW-QL79>] (“[S]tudying only litigated cases for guidance on efficiencies presents a skewed sample set, given the very high levels of concentration involved in most litigated cases. . . . [i]n our investigations prior to litigation, we undertake a careful review of efficiencies claims.”); Interview by the Capitol Forum with Julie Brill, Comm'r, Fed. Trade Comm'n, at the ABA's 2015 Antitrust Spring Meeting (Apr. 28, 2015), https://www.ftc.gov/system/files/documents/public_statements/641031/150428capitolforuminterview.pdf [<https://perma.cc/SR8U-PHDS>] (“The federal anti-trust agencies . . . wrote the Horizontal Merger Guidelines . . . I think we will continue to conduct our investigations by doing a very in-depth analysis of the efficiencies arguments.”). Director Feinstein made similar comments specifically referring to health care mergers after the district court issued its decision in *St. Luke's*, saying the FTC will “carefully consider evidence that [a] transaction will benefit consumers through improved quality, new services and/or decreased costs.” Deborah Feinstein, Dir., Bureau of Competition, Fed. Trade Comm'n, *Antitrust Enforcement in Health Care: Proscription, Not Prescription*, Address at the Fifth National Accountable Care Organization Summit, at 2 (June 19, 2014), www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf [<https://perma.cc/6S3C-J4TC>]. The reality for lawyers is that for the foreseeable future, efficiency arguments may have a better reception at the agencies than in the courts. *See generally* Daniel A. Crane, *Rethinking Merger Efficiencies*, 110 MICH. L. REV. 347, 363 (2011) (suggesting that while “efficiencies arguments are seldom dispositive” at the antitrust enforcement agencies, the agencies are “receptive” to them).

90. 960 F. Supp. 1104 (S.D. Miss. 1997).

supply that would otherwise be open to them.”⁹¹ The court announced a truncated standard for analysis, accepting plaintiff’s characterization of its burden as requiring it to show that “[d]efendants [would] have market power in the physician markets and that the hospital market [was] sufficiently concentrated such that it [would be] capable of sustaining competitive injury.”⁹² Plaintiff failed to prove market power in physician markets, however, because of the likelihood of entry⁹³ and the small size of specialty markets.⁹⁴ The court went on to consider whether plaintiff had proven illegality “under the standard analytical framework.”⁹⁵ Significantly, plaintiff failed to convince the court that the acquired medical clinic would redirect its referrals from plaintiff’s hospital to the other hospital in town, which was (indirectly) acquiring the clinic.⁹⁶ Physicians at the Vicksburg Clinic testified they left the choice of hospital to their patients.⁹⁷ The court credited this testimony—perhaps because the Clinic was located on the Vicksburg Medical Center campus and it was much easier for the doctors at the Clinic to see patients there than at the acquiring hospital’s facility. In addition, the acquiring hospital was Catholic and (as is often the case) some number of patients did not want to go to a religiously-affiliated hospital. Finally, the Vicksburg Clinic had no plans to move to the acquiring hospital’s campus and such a move was not practical in the future. As discussed *infra* in Section III.A, the court went on to find that entry was likely to

91. *Id.* at 1112 n.4 (citing *Brown Shoe Co. v. United States*, 370 U.S. 294, 324 (1962)).

92. *Id.* at 1136.

93. *Id.* at 1134–35.

94. In analyzing several specialty markets, the court concluded that where an exceptionally small number of physicians constituted the relevant product market in the region, “it simply defies logic to imagine that federal law requires this Court to enjoin two urologists from working together in a market so small that it might only support two full-time urologists.” *Id.* at 1129 (quoting Judge Posner that doctors in a medical community “too small to support more than a handful of physicians” could not be expected to be “set up in competition with each other”).

95. *Id.* at 1136. The court listed the relevant factors as follows:

[T]he nature and economic purpose of the arrangement; the likelihood and size of any market foreclosure; the extent of concentration of sellers and buyers in the industry; the capital cost required to enter the market; the market share needed by a buyer or seller to achieve a profitable level of production or “scale economy”; the existence of a trend toward vertical concentration or oligopoly in the industry; and whether the merger will eliminate potential competition by one of the merging parties.

Id.

96. The court credited testimony from clinic physicians that they left the choice of hospital to their patients and that it was easier for the doctors to see some patients at plaintiff’s hospital. In addition, it noted that the acquiring hospital was Catholic and some number of patients would prefer not to go to a religiously affiliated hospital. Finally, it added that the clinic had no plans to move to the acquiring hospital’s campus and such a move was not practical in the future. *Id.* at 1137.

97. *Id.* at 1136.

obviate risks of foreclosure. Hence the opinion stops short of the close analysis of competitive effect that would be required under contemporary economic theories.

Although the issue was not reached by the district court, the *St. Luke's* litigation presented an almost paradigmatic illustration of foreclosure resulting from physician employment. Rival hospital Saint Alphonsus and Treasure Valley Hospital, an independent surgery center, contended that St. Luke's ability to redirect referrals and physician affiliations as a result of its acquisition of some eighty percent of the market's PCPs⁹⁸ would "effectively shut out competition" in both the market for general acute care hospital services provided to commercially insured patients and for facility services for orthopedic and general surgery.⁹⁹ Relying on changes in referral practices by previously acquired PCPs and a wealth of internal documents indicating that Saltzer physician referrals to St. Luke's were confidently anticipated,¹⁰⁰ Saint Alphonsus claimed it would lose some forty percent of its patient volume because of changed referral practices by acquired physicians.¹⁰¹ Plaintiffs produced evidence that St. Luke's admitted it planned to further "cripple" a prominent employer's provider network by withdrawing participation of Saltzer physicians.¹⁰² Further, plaintiffs offered evidence that it would be difficult to induce new PCPs to enter the market and in any event it would take years for their practices to "ramp up" so as to provide referrals to plaintiffs' facilities.¹⁰³

This evidence appears to present a strong prima facie case in line with vertical foreclosure precedents. Loss of a significant share of the market

98. The district court calculated the post-merger HHI for PCP services to be 6219 and, as the court of appeals noted, St. Luke's and Saltzer did not challenge that finding on appeal. *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.* (*St. Luke's*), 778 F.3d 775, 786 (9th Cir. 2015).

99. Plaintiffs' Joint Pre-Trial Memorandum at 30, *Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health Sys., Ltd.* (*St. Luke's*), Nos. 12-cv-00560-BLW, 13-CV-00116-BLW, 2014 WL 407446 (D. Idaho Jan. 24, 2014), *aff'd*, 778 F.3d 775 (9th Cir. 2015), www.ftc.gov/system/files/documents/cases/130910stlukepretrialmemo.pdf [<https://perma.cc/GWV9-PTEQ>].

100. For example, one Saltzer physician stated that St. Luke's "declined to allow us autonomy in referring patients," and a consultant for defendants acknowledged "once they are aligned with St. Luke's, there was the expectation that their work would largely . . . go to St. Luke's." *Id.* at 33.

101. *Id.* at 30.

102. *Id.* at 36.

103. *See* Testimony of Dr. Debra Haas-Wilson at 1509, *St. Luke's*, 2014 WL 407446 (Nos. 1:12-cv-00560-BLW, 1:13-CV-00116-BLW), <http://www.ag.idaho.gov/consumerProtection/pendingActions/transcripts/Trial%20Transcript%20-%20Day%209.pdf> [<https://perma.cc/RA8G-CS2J>] (concluding that it would be "very, very unlikely [a rival physician group] could recruit and ramp up to a productive level of practice enough new physicians to replace losses from Saltzer").

to an already dominant rival without alternative means of replacing suppliers (i.e., PCPs) would meet the tests traditionally applied in the courts. Although not thoroughly analyzed in the parties' pleadings or declarations, evidence in the *St. Luke's* case also supported a raising-rival's-cost analysis. For example, plaintiff's expert witness concluded that the substantial foreclosure of possible admissions resulting from steering by eighty-four percent of formerly independent PCPs and eighty-nine percent of formerly independent pediatricians would force plaintiff hospital to reduce its output. This reduction would force it to incur higher average costs, resulting in higher market prices for general acute care hospital services.¹⁰⁴

3. *Foreclosure in Specialty Physician Markets*

Claims that the acquisition of a specialty practice has an anticompetitive vertical effect will be more difficult to prove than claims that an acquisition of PCPs has such an effect. Examination of the particular specialty acquired is important and a plausible theory of harm-to-competition will be critical.

Certain specialists who practice in a hospital—pathologists, radiologists, anesthesiologists, and emergency medicine physicians, for example—rarely have their own patient base. These physicians typically do not influence where patients go for hospitalization. Some, such as pathologists, rarely even see patients. The acquisition by a hospital of a group of such hospital-based physicians is unlikely to have any effect on rival hospitals or on competition.¹⁰⁵

While it might be possible to conjure a plausible vertical theory where the acquisition of other specialists has an anticompetitive effect, cases in which the evidence will support such a claim probably will be rare and must be carefully thought through. Some specialists perform services in hospitals themselves and also refer to other specialists. If one hospital in a two-hospital market acquires a group of cardiologists, for example, a number of factors must be examined in both the market for cardiology

104. Declaration of Debra Haas-Wilson ¶ 93, *St. Luke's*, 2014 WL 407446 (No. 1:12-CV-00560-BLW), 2012 WL 9515607.

105. If a hospital were to acquire a group of hospital-based physicians that provided services to two or more hospitals, and were to prevent its newly employed physicians from offering services at other hospitals, the rival hospitals might be tempted to consider an antitrust claim (or a claim for tortious interference under state law). But, except in unusual circumstances, the likelihood such a claim would succeed is remote. In such cases, courts have found that rivals could hire their own hospital-based physicians and would look to do so in a regional or even national market. See generally *Collins v. Associated Pathologists, Ltd.*, 844 F.2d 473 (7th Cir. 1988).

services and for services for which the cardiologist makes referrals before an anticompetitive effect in the hospital market can be predicted. To begin with cardiology services alone, if the acquiring hospital's rival has no cardiology service, the acquisition is unlikely to have an effect on hospital competition. If the rival offers inpatient heart services, the scope of the possible effect will depend on whether it offers only inpatient services performed by cardiologists, or whether it also offers open heart surgery, which typically is performed by cardiac surgeons. Cardiologists can affect a hospital's competitive position in two ways: first, by admitting their own patients to a hospital for inpatient procedures they perform, and second, by referring their patients to a hospital for procedures (such as open-heart surgery) they do not perform. The acquisition of a group of invasive cardiologists, therefore, could affect a rival hospital by depriving it of both the procedures performed by those cardiologists and by the referrals for open heart surgery made by those cardiologists. Whether either of these effects is anticompetitive will depend on an analysis that mirrors the analysis set out above for establishing that the acquisition of PCPs is anticompetitive. The analysis would begin by establishing the proportion the acquired group accounts for of the market for inpatient cardiology procedures and its share of referrals for open heart surgery. As with PCPs, a plaintiff then must establish that the acquired group previously did a significant amount of business with (or referred a significant amount of business to) the acquiring hospital's rival. Finally, a plaintiff must show the loss of this business will have an impact on competition and consumers.¹⁰⁶

Whether a plaintiff can make such a showing requires a fact-intensive inquiry. To continue with the example in which a hospital acquires a group of cardiologists, even if its rival relied heavily on the acquired group of cardiologists to supply patients to its heart program, the loss of referrals from one specialty group is unlikely to damage the ability of the rival hospital to continue in business at all or prevent it from doing so at an efficient scale, given the typically broad set of service lines offered by most hospitals. When the focus is narrowed to the rival's heart services, it still will be difficult for a plaintiff to establish competitive harm. A rival hospital can more easily respond to the loss of referrals to

106. The acquisition will not give the acquiring hospital the ability to set physician fees for these services at levels higher than those at which the acquired group could have set physician fees before the acquisition. If the group had a monopoly on the provision of professional cardiology services before it was acquired, the hospital's acquisition of the group does not give the hospital any additional ability to raise the group's professional fees. The sole inquiry, therefore, is whether the hospital, by reason of the acquisition, has the ability to increase facility fees associated with the inpatient procedures performed by the acquired group above pre-existing levels.

one service line (here, cardiac services) than it can if it loses referrals across all its service lines (as it might if a group of primary care providers were to be acquired). In evaluating competitive harm in this case, a court would have to assess whether the rival may be able to continue offering cardiac services efficiently but with a smaller complement of providers in which case there would be no apparent consumer injury. A more complicated question arises if the rival chooses to continue providing the services even if it is not efficient (perhaps even if it is losing money) as may be the case if it believes the service is important to its mission.¹⁰⁷ In this circumstance, competitive harm would arise only if the plaintiff could show that the cost increases resulting from reduced scale or other impediments enabled the acquiring hospital to charge supra-competitive prices.

Further, factfinders should be wary of viewing the market through a static lens. Beyond simply making the best of it after it loses referrals from a group of cardiologists acquired by its competitor, the rival hospital for example might be able to respond to the loss of referrals by enhancing its relationships with the remaining independent cardiologists in the community. The rival might do this by investing in equipment important to the delivery of advanced cardiology services, giving cardiologists more control over how heart services are delivered in the

107. A decision to offer a money-losing service cannot be made over and over without putting the hospital out of business, but it is not uncommon for hospitals to offer some services on which they lose money. Some hospitals, especially non-profit and community-based facilities, have long complained that some services their communities need, which may include emergency services, trauma, or psychiatric care, do not generate enough revenue to cover costs. Some evidence exists that some hospitals do provide such money-losing services, at least when they are able to cross-subsidize those services by offering more lucrative services. Guy David et al., *Do Hospitals Cross Subsidize?* (Nat'l Bureau of Econ. Research, Working Paper No. 17300, 2011), <http://www.guy-david.com/pdf/DLHB%2006%202011.pdf> [<https://perma.cc/BV4D-NAVA>]; see also Philip Betbeze, *The Truth About Cross-Subsidization*, HEALTHLEADERS MEDIA (June 2, 2008), <http://healthleadersmedia.com/content/FIN-212643/The-Truth-About-CrossSubsidization##> [<https://perma.cc/7E6A-R6BB>] (“As hospital leaders, you know that you have a multitude of money-losing services that you must provide for patients that are either required by law (emergency services, for example) or can’t easily be eliminated for a variety of reasons (your commitment to improving your community’s health.)”); *Four Corners Nephrology Assocs. V. Mercy Med. Ctr. Of Durango*, 582 F.3d 1216, 1224 (10th Cir. 2009) (holding that a hospital that hired a nephrologist and guaranteed him a salary did not act anticompetitively, despite likelihood “a nephrology practice in Durango would operate at a loss for many years,” because without the salary guarantee the nephrologist would not relocate to Durango and the community would be underserved). Some hospitals may provide a money-losing service simply because they are unable to determine the profitability of particular services. Cost accounting at many hospitals is notoriously imprecise. See, e.g., Gina Kolata, *What Are a Hospital’s Costs? A Utah System Is Trying to Learn*, N.Y. TIMES (Sept. 7, 2015), www.nytimes.com/2015/09/08/health/what-are-a-hospitals-costs-utah-system-is-trying-to-learn.html [<https://perma.cc/UF39-9SNT>].

hospital, and involving cardiologists in leadership roles within the hospital.¹⁰⁸ The rival also could consider recruiting additional cardiologists to the community. In general, it is easier to recruit specialists than PCPs: there is a far greater shortage of PCPs in the United States than there is of most specialists.¹⁰⁹ Ultimately, it is possible that far from harming consumers, the acquisition of a single specialty group may provoke an “outbreak of competition”¹¹⁰ for cardiologists and benefit consumers.¹¹¹

Finally, when a specialty group is acquired, the effect of that acquisition may need to be measured in a broader geographic market than would be the case if an acquisition of primary care providers were at issue. Primary care providers typically draw patients from local geographic markets.¹¹² Some specialists also may draw from local markets, but other specialists draw from much wider geographic areas.¹¹³ If a hospital acquires a group of cardiac surgeons, it is highly likely the relevant geographic market will be far broader than it would have been if the acquisition of a primary care group were at issue.¹¹⁴ Cardiac surgeons may rely on referrals from primary care providers and cardiologists scattered across a broad geographic area, who have a choice of different cardiac centers to which to refer. In such a situation, it is unlikely that an acquisition of a group of cardiac surgeons—even if

108. See generally Sabrina Rodak, *7 Features Cardiologists Look for in Hospital Cardiology Service Lines*, BECKER'S HOSP. REV. (Sept. 27, 2012), www.beckershospitalreview.com/hospital-key-specialties/7-features-cardiologists-look-for-in-hospital-cardiology-service-lines.html [<https://perma.cc/57FG-EH4N>].

109. *Physician Supply and Demand Through 2025: Key Findings*, AM. ASS'N MED. C. (2015), www.aamc.org/download/426260/data/physiciansupplyanddemandthrough2025keyfindings.pdf [<https://perma.cc/37HM-V7TM>].

110. *Brooke Grp. Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 228 (1993).

111. When a hospital acquires a multi-specialty group, the effect may be similar to when a group of primary care physicians is acquired. Different specialists admit patients to different hospital departments. If a large multi-specialty group, cutting across many specialties, is acquired, the loss of these referrals is more likely to have an effect on competing hospitals (although again, a complete review of the market must be undertaken before any conclusions can be reached).

112. See, e.g., *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd. (St. Luke's)*, 778 F.3d 775, 785 (9th Cir. 2015) (“Evidence was presented that insurers generally need local PCPs to market a health care plan . . .”).

113. See, e.g., *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1411 (7th Cir. 1995) (“[T]he physicians employed by the Clinic have a large share of the market for physician services, since, for primary care anyway (an important qualification—people will go a long way for a liver transplant, that market is a local one.”); *United States v. Carilion Health Sys.*, 707 F. Supp. 840 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042 (4th Cir. 1989).

114. *Morgenstern v. Wilson*, 29 F.3d 1291, 1297 (8th Cir. 1994) (noting that the market for cardiac surgery was broad and probably included surgeons in both Omaha and Lincoln, Nebraska, because “patients need travel only fifty-eight miles by main highway” to go from one to the other).

it is the only group in a particular city—will have an effect on competition.

Given these differences, lawyers and courts should approach claims that the acquisition of a single specialty practice is anticompetitive with particular caution.

B. Potential Competition

The Agencies have occasionally raised concerns that vertical mergers would eliminate potential competition in circumstances in which one of the merging parties was the most likely perceived or actual potential entrant into the other's market.¹¹⁵ There are a number of scenarios in which physicians are potential entrants into markets that local hospitals occupy and vice versa. For example, hospitals and physicians often find themselves competing or contemplating entry into ambulatory care markets such as surgicenters and ancillary services. In these situations, a merger that eliminates a likely or perceived likely entrant and that lessens potential competition is cognizable under the Clayton Act, although stringent standards of proof apply.

Predicting competitive harm in such circumstances turns on conventional issues raised under actual or perceived potential competition analyses. These include the existence of market power in the market targeted for entry and whether the presence of the potential entrant on the fringe disciplined pricing in the targeted market (perceived potential competition). Competitive harm also is problematic only if the potential entrant was one of the few firms likely to enter and its entry would have improved competitive performance of the market.¹¹⁶ These are, to be sure, burdensome requirements, which explain why the government rarely relies on potential competition analysis and has been rebuffed in court where it has failed to meet the

115. See, e.g., Competitive Impact Statement, *United States v. Ticketmaster Entm't, Inc.*, No. 1:10-cv-00139 (D.D.C. Jan. 25, 2010), www.justice.gov/atr/cases/t254500/254544.pdf [<https://perma.cc/TV5X-CJQJ>] (suggesting that Ticketmaster and Live Nation were potential entrants into each other's market). The current agency merger guidelines provide little guidance regarding potential competition mergers; however, a more detailed discussion is found in the Agencies' 1984 Guidelines. 1984 Merger Guidelines, 49 Fed. Reg. 26,823, 26,834 (June 29, 1984); see also *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602 (1974).

116. Older Supreme Court precedent recognized the perceived potential competition theory, but the Court has never endorsed actual potential competition analysis. See *Marine Bancorporation*, 418 U.S. at 639. See generally Joseph F. Brodley, *Potential Competition Under the Merger Guidelines*, 71 CALIF. L. REV. 376, 383 n.39 (1983); Dannen Bush & Salvatore Massa, *Rethinking the Potential Competition Doctrine*, 2004 WIS. L. REV. 1035.

exacting standards.¹¹⁷ Nevertheless, given the importance of entry and innovation in highly concentrated markets, antitrust enforcers should be alert to competitive risks from mergers that eliminate a significant source of rivalry in markets for ancillary services or facilities. For example, the acquisition by a hospital of a physician practice that was considering opening an ambulatory surgical center that would have competed with the hospital might give rise to potential competition concerns where the hospital's ambulatory surgery service had market power, the physician group was the only actual potential entrant into the market, and its entry would have improved competition in the market.¹¹⁸ The perceived potential competition analysis would apply where the hospital was viewed by the owners of the physician surgery center as a likely entrant and the center tempered its pricing as a result of that perception.¹¹⁹

Although a litigant's ability to successfully challenge a hospital's acquisition of a physician practice is highly fact-dependent, certain market characteristics may facilitate proof of competitive harm. As a general matter, acute care hospital markets are typically highly concentrated and the number of physicians capable of operating an independent ancillary service in competition with hospitals may be limited. Furthermore, given the strong impetus to integrate service delivery, the escalating acquisition of physician practices may eliminate the limited competition in outpatient facilities in some markets.

C. *Avoidance of Regulation and Similar Strategies*

The DOJ recognized in its 1984 Non-Horizontal Merger Guidelines that vertical mergers "may be used by monopoly public utilities subject to rate regulation as a tool for circumventing that regulation."¹²⁰ The guidelines provide an example: a regulated utility might acquire a supplier of inputs, "sell" the inputs to itself at above market prices, and

117. See, e.g., *FTC v. Steris Corp.*, No. 1:15 CV 1080 (N.D. Ohio Sept. 24, 2015) (refusing to issue preliminary injunction where evidence that acquiring firm was likely actual potential entrant into duopoly market for contract gamma sterilization services).

118. Cf. Letter from Mark J. Horoschak, Assistant Dir., Bureau of Competition, Fed. Trade Comm'n, to Carlos C. Smith & Edward N. Boehm (May 31, 1995) (FTC staff advisory opinion to Erlanger Medical Center and Memorial Hospital examining whether joint venture between two hospitals to open a new obstetrics hospital where one provided obstetrical services and the other did not reduced competition under actual competition analysis and concluding it did not).

119. *Id.* (examining the joint venture under perceived competition analysis and finding insufficient evidence to challenge the proposed arrangement).

120. 1984 Merger Guidelines, 49 Fed. Reg. at 26,834.

then demand the utility's regulator approve an increase in rates charged to consumers on grounds that the utility's costs have increased.¹²¹ The Agencies have used the theory on only a few occasions to challenge acquisitions by utilities.¹²²

In states where hospital rates are regulated, the theory could explain why a hospital might want to acquire a physician group. If rate regulation prevents a hospital from exercising market power, it could evade this constraint by acquiring a physician group and raising rates in the physician market. But only two states regulate rates today.¹²³ It is unlikely, therefore, that evasion of rate regulation explains many physician acquisitions or other transactions by hospitals. Recently, several health care economists have suggested a twist on the theory that may provide a similar motivation for some acquisitions even in states without rate regulation. In hearings the Agencies held in early 2015 examining competition in the health care industry,¹²⁴ Leemore Dafny, an economist and former official at the FTC's Bureau of Economics, suggested that "political restraints" might cause a hospital with market power to set rates below profit maximizing levels:

Suppose in town B, the hospital wants to charge its monopoly price, but there's a mayor who keeps making speeches, or an

121. Areeda and Hovenkamp suggest a similar example: an electric utility that purchases coal to fire its generators might justify higher rates by purchasing a coal company and "selling" itself coal at inflated rates. AREEDA & HOVENKAMP, *supra* note 28, ¶ 1013.

122. See *Entergy Corp.*, 66 Fed. Reg. 9342 (Feb. 7, 2001) (analysis to aid public comment) (where the government charged that following the acquisition of a fifty percent interest in a pipeline, a regulated energy company might pay inflated transportation costs that could be used to justify higher electricity rates); Complaint, *United States v. MCI Commc'ns Corp.*, No. 94-1317 (D.D.C. June 15, 1994), www.justice.gov/atr/case-document/complaint-judgment-and-injunctive-relief [<https://perma.cc/NE86-CNEV>] (the government alleged evasion of rate regulation could follow in the wake of British Telecommunications' acquisition of a minority interest in MCI).

123. These states are Maryland and West Virginia. See ANNA SOMMERS ET AL., NAT'L INST. FOR HEALTH CARE REFORM, ADDRESSING HOSPITAL PRICING LEVERAGE THROUGH REGULATION: STATE RATE SETTING, POLICY ANALYSIS NO. 9 (2012), www.nihcr.org/1t192 [<https://perma.cc/8WUM-HWTW>]. Moreover, the FTC recently questioned the effectiveness of the West Virginia regulatory system to reign in anticompetitive hospital price increases. In its complaint seeking to declare unlawful the proposed merger of the only two hospitals in Huntington, West Virginia, the agency alleges the state's "rate review system would not prevent anticompetitive harm from" the merger because the state regulator "principally reviews and approves (or disapproves) a hospital's list prices, or 'charges,' as opposed to the prices, or 'rates,' negotiated between the hospitals and health plans." Complaint at 3, *Cabell Huntington Hosp., Inc.*, No. 9366 (F.T.C. Nov. 5, 2015), <https://www.ftc.gov/system/files/documents/cases/151106cabellpart3cmpt.pdf> [<https://perma.cc/KH2L-SBAM>].

124. *Examining Health Care Competition*, FED. TRADE COMM'N, www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition [<https://perma.cc/L9YK-2T35>] (last visited Mar. 21, 2016).

attorney general who keeps issuing reports saying that the prices are really much too high and you've got to do something about it.

Well, one thing you could do is acquire the hospital in A, or maybe C, and take your monopoly rents in those markets.¹²⁵

According to Dafny, this situation “has come up with some recent mergers.”¹²⁶

Vistnes and Sarafidis made a similar suggestion in a 2013 article analyzing “cross-market” hospital mergers.¹²⁷ They examined circumstances under which hospitals in different geographic markets might be able to combine and extract higher prices than the hospitals could have obtained without the combination. Traditionally, Vistnes and Sarafidis note, the Agencies have been of the view that combining hospitals in different geographic markets does not affect bargaining leverage or lead to higher prices because competitive circumstances in separate markets are different.¹²⁸ “An exception can arise,” they observe, “if one of the hospitals had significant pre-merger bargaining leverage that, because of regulation *or some other constraint*, could not be exercised.”¹²⁹ In such a case, “a cross-market merger might result in ‘regulatory evasion’ whereby the hospital exercises that bargaining leverage in a different market in which the regulatory (or other) constraints do not exist.”¹³⁰ The “other constraint” could be political pressure as suggested by Dafny, a desire not to tempt states to introduce (or re-introduce) hospital rate regulation,¹³¹ or a concern not to provoke

125. Examining Health Care Competition, Panel on Trends in Provider Consolidation, at 93–94 (Feb. 25, 2015), www.ftc.gov/system/files/documents/public_events/618591/transcript-day2.pdf [<https://perma.cc/UW6D-AB9A>] (emphasis added).

126. *Id.*

127. Gregory Vistnes & Yianis Sarafidis, *Cross-Market Hospital Mergers: A Holistic Approach*, 79 ANTITRUST L.J. 253 (2013). Vistnes, now with an economic consulting firm, previously worked at both the Agencies.

128. Vistnes and Sarafidis question the traditional model, arguing it is possible some cross-market mergers may increase hospitals’ bargaining leverage and so lead to an increase in prices beyond what would have obtained had the merger not occurred. This suggestion is challenged by David A. Argue and Scott D. Stein in their article, *Cross-Market Health Care Provider Mergers: The Next Enforcement Paradigm*, 30 ANTITRUST MAG. 25 (2015). The merits of these competing arguments are beyond the scope of this Article.

129. Vistnes & Sarafidis, *supra* note 127, at 274 n.69 (emphasis added).

130. *Id.*

131. Eight states regulated rates in some part of the 1970s and 1980s: these were Connecticut, Maryland, Massachusetts, New Jersey, New York, Washington, Wisconsin, and West Virginia. SOMMERS ET AL., *supra* note 123, at 2 n.5. “A much larger number relied on voluntary or mandatory participation in some form of budgetary review by a nongovernmental association and voluntary compliance.” *Id.* at 8–9.

the Internal Revenue Service (or state taxing authorities) to question the tax-exempt status of a hospital that raises rates to monopoly levels.¹³²

It is questionable whether the acquisition by one hospital of another hospital or physician group in order to exercise market power that the acquirer already possesses, but is reluctant to exercise, is or should be a matter of *antitrust* concern. The United States Supreme Court cast doubt on the antecedent question—whether evasion of rate regulation can violate the antitrust laws—in *Nynex Corp. v. Discon, Inc.*¹³³ New York Telephone purchased certain services (involving the removal of unneeded switching equipment) from a supplier at inflated prices and received a rebate at the end of the year of some of the overcharge.¹³⁴ The inflated prices were used by New York Telephone’s regulator to set prices the company charged customers for telephone services. A competing supplier, claiming it offered the same removal services for less money, asserted New York Telephone paid the inflated prices “as part of an attempt to defraud local telephone service customers by hoodwinking regulators” and filed an antitrust suit alleging a per se unlawful group boycott.¹³⁵ The Court refused to hold the arrangement subject to the per se rule, and in doing so cast doubt on the notion the agreement was of any antitrust concern at all. The conduct alleged amounted to regulatory fraud¹³⁶ and “hurt consumers by raising telephone service rates.”¹³⁷ But the injury to consumers “flowed not so much from a less competitive market for removal services, as from the exercise of market power that is *lawfully* in the hands of a monopolist . . . combined with a deception . . . that prevented the agency from controlling New York Telephone’s exercise of its monopoly power.”¹³⁸

The Court did not consider whether the conduct might make out a claim under the rule of reason because the only question presented in the

132. The Internal Revenue Service has issued regulations, effective for tax years beginning after December 29, 2015, that detail requirements with which charitable hospitals must comply under section 501I of the Internal Revenue Code to avoid fines or loss of tax-exempt status. These include requirements that hospitals have financial assistance policies for uninsured patients and that they limit the amounts they require patients eligible for such financial assistance to pay. *See* Additional Requirements for Charitable Hospitals, 79 Fed. Reg. 78,954 (Dec. 31, 2014) (to be codified at 26 C.F.R. pts. 1, 53, & 602).

133. 525 U.S. 128 (1998).

134. *Id.* at 131–32.

135. *Id.* at 132.

136. *Id.* at 137.

137. *Id.* at 136.

138. *Id.* (emphasis in original).

petition for certiorari was the propriety of applying the per se rule.¹³⁹ Nonetheless, the Court’s observation that the consumer harm worked by the fraudulent scheme was a “lawful” exercise of its market power suggests, had the question been presented, the Court would have found no violation under the rule of reason either: “cases involving business behavior that is improper for various reasons,” the Court admonished, should not be transformed “into treble-damages antitrust cases.”¹⁴⁰

If, instead of purchasing services from the supplier, New York Telephone had acquired that company, and then raised the internal transfer price at which it obtained those services, the result—increased prices to consumers and “hoodwinking” of regulators—would have been exactly the same. In neither case would consumer harm flow “from a less competitive market.”¹⁴¹ It would make little sense to prohibit the acquisition of the supplier under Section 7 of the Clayton Act if a purchase arrangement with the supplier, producing the same result, is beyond the reach of the Sherman Act. Moreover, the “mere possession of monopoly power, and the concomitant charging of monopoly prices is not . . . unlawful.”¹⁴² It would be odd to prohibit a merger that does not increase market power in any defined market simply because it may provide a company a new opportunity to extract a monopoly rent it had been reluctant to extract before the merger, though it lawfully could have done so.¹⁴³

The FTC used a variant on the evasion-of-rate-regulation theory to challenge a health care transaction in 2008. Fresenius Medical Care, the largest operator of dialysis clinics in the United States, proposed to acquire an exclusive sublicense for the manufacture and supply of Venofer, a drug used to treat iron-deficiency anemia in dialysis patients.¹⁴⁴ Medicare reimbursed dialysis clinics for their use of the drug

139. *Id.* at 140.

140. *Id.* at 137. Earlier, in *Brooke Group Ltd. V. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 232 (1993), the Court made a similar point: “[o]nly if . . . higher prices are a product of nonmarket forces has competition suffered.”

141. *Nynex Corp.*, 525 U.S. at 136.

142. *Verizon Commc’ns Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 407 (2004).

143. If a firm with market power in one market seeks to leverage that power in a second market, it may be engaging in unlawful tying. But it is “superfluous and [an] overdeterrent” to prohibit a merger on that basis. *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke’s Health Sys., Ltd. (St. Luke’s)*, 778 F.3d 775, 787 (9th Cir. 2015) (quoting *AREEDA & HOVENKAMP*, *supra* note 28, ¶ 1144a).

144. Complaint, *Fresenius Med. Care AG & Co. KgaA*, No. 081-0146 (F.T.C. Sept. 15, 2008), <https://www.ftc.gov/sites/default/files/documents/cases/2008/09/080915freseniuscmpt.pdf> [<https://perma.cc/NNN8-JCQS>]; Analysis of Agreement Containing Consent Order to Aid Public Comment, *Fresenius*, No. 081-0146, <https://www.ftc.gov/sites/default/files/documents/cases/>

in an amount equal to the drug manufacturer's average sale price across sales to all users, plus six percent.¹⁴⁵ The FTC asserted acquisition of the license would allow Fresenius to "artificially inflate its internal costs for Venofer."¹⁴⁶ Because Fresenius was a substantial Venofer customer, such a price increase would cause the average sales price to rise. This, in turn, would force Medicare to pay all users—not just Fresenius—more. To resolve the FTC's concerns, the parties agreed to a consent order mandating the Venofer market prices in effect at the time of the acquisition be used to report the average sales prices on which Medicare pegged reimbursement.¹⁴⁷

In its analysis to aid public comment, under the heading "Competitive Effects," the FTC asserted, "[a]fter the transaction, the competitive market will no longer determine the price that Fresenius's clinics will pay for IV iron."¹⁴⁸ The statement is correct, so far as it goes, but does not explain how the harm is an antitrust injury. The higher prices the FTC feared Medicare might pay would come about purely as a result of Medicare's reimbursement rules. If Medicare wanted to change how it reimbursed for the use of Venofer it could do so. In fact, changes in the reimbursement system designed to eliminate the reliance on average sales prices were underway in 2008—and the FTC provided the consent order would expire once those changes were finalized.¹⁴⁹ This provision in the consent order is an implicit acknowledgement that the acquisition did not lessen, or threaten to lessen, *competition* in any market.

The *St. Luke's* litigation presents another example where proof of market power and the oddities of Medicare reimbursement were intertwined, but this time the reviewing court may have improperly rejected evidence of a price increase as irrelevant to the antitrust question when it was highly pertinent. Under the Medicare provider-based billing rules in effect at the time of the litigation, a hospital could

2008/09/080915freseniusanal.pdf [https://perma.cc/M9VC-9ETK].

145. Complaint, *supra* note 144, at 4.

146. *Fresenius Medical Care AG & Co. KgaA, et al., In the Matter of*, FED. TRADE COMM'N, www.ftc.gov/enforcement/cases-proceedings/081-0146/232resenius-medical-care-ag-co-kga-a-et-al-matter [https://perma.cc/EW3R-W67A] (last updated Oct. 21, 2008).

147. The FTC acknowledged that its concern would disappear in 2014, by which date Medicare was required (by the Medicare Improvements for Patients and Providers Act of 2008) to pay for dialysis services, including drugs such as Venofer, with a single, bundled, per patient payment. Analysis of Agreement Containing Consent Order to Aid Public Comment, *supra* note 144, at 3.

148. *Id.*

149. Agreement Containing Consent Order ¶ 10.A, *Fresenius*, No. 081-0146, https://www.ftc.gov/sites/default/files/documents/cases/2008/09/080915freseniusagrmt.pdf [https://perma.cc/V7RC-F3LM].

bill a facility fee, in addition to the professional charge, for procedures performed by a physician in a hospital.¹⁵⁰ If the same procedure were performed in a physician's office or clinic, Medicare did not pay a facility fee. The result was Medicare paid more for certain procedures when performed in a hospital than when performed in a physician's office or clinic. This provided a powerful motivation, completely apart from a desire to increase market power, for hospitals to acquire physician practices.¹⁵¹ If the hospital could license physician offices or clinics as part of the hospital (which could be done under certain conditions, even if the offices or clinics were physically separate from the hospital), then the hospital could charge facility fees for procedures performed there and obtain greater reimbursement from Medicare. As a result of this peculiarity in Medicare reimbursement, once St. Luke's acquired the Saltzer Medical Group, it expected to obtain better reimbursement for certain procedures provided at Saltzer clinics than Saltzer was able to obtain as an independent clinic.¹⁵²

Many commercial payers pattern their payment methodologies after Medicare's reimbursement methodology and so also pay more for some procedures when done in a hospital facility than they would pay if the procedures were done in an independent physician's office or clinic.¹⁵³ Apparently, this was the case in Idaho: internal St. Luke's studies

150. Section 1833(t) of the Social Security Act, ch. 531, 49 Stat. 620 (1935) (codified as amended at 42 U.S.C. § 1395l(t) (2012)), established the system under which most hospitals are reimbursed for services performed in an outpatient department. On November 2, 2015, President Obama signed the Bipartisan Budget Act of 2015 (BBA), Pub. L. No 114-74, 129 Stat. 584, into law. Section 603 of the BBA directs the Centers for Medicare and Medicaid Services (CMS), effective January 1, 2017, not to pay off-campus hospital departments hospital outpatient PPS rates if those departments began billing on or after the date the Act was signed into law. Affected off-campus departments will be paid according to the (generally lower) Medicare Physician Fee Schedule or Ambulatory Surgical Center Payment System.

151. See, e.g., STATE OF CONN. ATT'Y GEN. GEORGE JEPSEN, REPORT OF THE CONNECTICUT ATTORNEY GENERAL CONCERNING HOSPITAL PHYSICIAN PRACTICE ACQUISITIONS AND HOSPITAL-BASED FACILITY FEES 6 (2014) [hereinafter REPORT OF CONN. ATT'Y GEN.], http://www.ct.gov/ag/lib/ag/press_releases/2014/20140416_oag_report_hospitalmdacquisitions_hospitalbasedfacfee.doc200x.pdf [<https://perma.cc/984H-YXN3>] (noting that the trend of vertical acquisition has a compounding effect for consumers: as more previously independent clinics and physicians are acquired by hospitals, more patients are charged hospital facility fees); Kutcher, *supra* note 66.

152. Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health Sys., Ltd. (*St. Luke's*), Nos. 12-CV-00560-BLW, 13-CV-00116-BLW, 2014 WL 407446, at *12 (D. Idaho Jan. 24, 2014), *aff'd*, 778 F.3d 775, (9th Cir. 2015).

153. See Scott Baltic, *Monopolizing Medicine: Why Hospital Consolidation May Increase Healthcare Costs*, MED. ECON. (Feb. 24, 2014), <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/hospital-employment/monopolizing-medicine-why-hospital-consolidation-?page=full> [<https://perma.cc/8XMN-B4M6>].

showed the health system could expect additional reimbursement from commercial payers after the acquisition of Saltzer because those payers, following Medicare's lead, also had contracted to pay facility charges.¹⁵⁴ There was nothing unique about this. Many hospital-physician deals are driven by the peculiarities of Medicare's provider-based billing rules and the tendency of commercial payers to follow these rules in their own payment systems.¹⁵⁵ If St. Luke's would gain no market power from the acquisition of Saltzer, then in the aftermath of the acquisition two things would happen: (1) Medicare would pay more for procedures performed at Saltzer for which a facility fee could be tacked on once Saltzer qualified as a hospital facility, and (2) commercial payers that followed Medicare's reimbursement methodologies would pay more for those procedures as well. The FTC appeared to recognize—unlike in the *Fresenius* case—that increased payments by Medicare are not evidence of market power.¹⁵⁶ The agency argued instead that the increased amounts commercial payers would pay in added facility fees were evidence of market power.¹⁵⁷ The argument was complex. Immediately after the Saltzer acquisition, regardless of whether St. Luke's gained additional market power as a result, commercial payers that were bound contractually to pay facility fees to St. Luke's would find themselves

154. *St. Luke's*, 2014 WL 407446, at *12.

155. The district court, quoting from a study relied on by expert witnesses at trial, noted that “physician reimbursement may be higher for services rendered at hospitals than in physicians’ offices.” *Id.* (quoting BERKELEY FORUM, A NEW VISION FOR CALIFORNIA’S HEALTHCARE SYSTEM: INTEGRATED CARE WITH ALIGNED FINANCIAL INCENTIVES 53 (2013), <https://www.yumpu.com/en/document/view/10509573/a-new-vision-for-californias-healthcare-system> [<https://perma.cc/R58X-PZ93>]). Many other sources have commented on the incentive facility-based reimbursement created for hospitals to acquire physician practices. *See, e.g.*, REPORT OF CONN. ATT’Y GEN., *supra* note 151, at 1–2, 5–7; HEALTHCARE APPRAISERS INC., A REVIEW OF RECENT TRENDS AND TRANSACTIONS 21 (2013), www.healthcareappraisers.com/HTYIR_2013.pdf [<https://perma.cc/73P5-YHEU>]. *See generally* MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 48 (2013), http://medpac.gov/documents/reports/mar13_entirereport.pdf [<https://perma.cc/WZ3B-UZ46>] (noting the shift from physician offices to hospital outpatient departments is “consistent with the financial incentives in the current payment system”).

156. Answering Brief for Plaintiffs/Appellees at 42 n.8, *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke’s Health Sys., Ltd.* (*St. Luke’s*), 778 F.3d 775 (9th Cir. 2014) (No. 14-35173) <https://www.ftc.gov/system/files/documents/cases/140813stlukeansweringbrief.pdf> [<https://perma.cc/TZ33-84LZ>] (“St. Luke’s discussion of provider-based billing under Medicare . . . is irrelevant because Medicare, unlike the private insurance at issue here, does not negotiate reimbursement rates and thus is unaffected by the market power that St. Luke’s gained through the acquisition.”).

157. *Id.* at 43 (“It is precisely St. Luke’s acquisition of market power in the primary-care market that enables it to bargain for increased overall reimbursements that it could not otherwise obtain [in the provision of ancillary services].”).

paying more, simply because St. Luke's could qualify Saltzer locations as part of a hospital and begin to add facility fees to patient bills. But if the Saltzer acquisition did not increase St. Luke's market power in any way, then, at the next opportunity to renegotiate, commercial insurers would have insisted on eliminating those fees.¹⁵⁸

The FTC argued that internal documents showed St. Luke's believed that once commercial payers paid more as a result of newly charged facility fees, "[t]he leverage gained by the Acquisition would give St. Luke's the ability to make these higher rates 'stick' in future contract negotiations."¹⁵⁹ The district court understood the FTC's argument and relied on it for evidence that St. Luke's acquisition of Saltzer would increase the combined system's power in the market for PCP services.¹⁶⁰ The Ninth Circuit, while otherwise affirming the district court's order finding the acquisition unlawful, held that "the ancillary services finding is not supported by the record."¹⁶¹ The Ninth Circuit construed the district court to have held that St. Luke's would use leverage acquired (through the merger with Saltzer) in the market for PCP services improperly to raise prices in the separate market for ancillary services.¹⁶² But the district court made "no findings about St. Luke's' market power in the ancillary services market."¹⁶³ Without such findings, the Ninth Circuit declared, "it is difficult to conclude that the merged entity could easily demand anticompetitive prices for such services."¹⁶⁴ But that was

158. The FTC argued, and apparently St. Luke's agreed, that in practice the health system and commercial payers did not negotiate line-by-line charges for individual items and services, but negotiated "the total amount of money the parties project will be paid for all services covered by the contract." *Id.* at 42. In this case, an insurer facing a system that had added facility fees to its bill without any commensurate increase in market power could insist on removing those fees, or reduce amounts paid for other services—but in no case would the insurer permit the health system to increase its bottom line reimbursement in the next contract cycle.

159. *Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health Sys., Ltd.* (*St. Luke's*), Nos. 12-CV-00560-BLW, 13-CV-00116-BLW, 2014 WL 407446, at *12 (D. Idaho Jan. 24, 2014) (relying on testimony of the St. Luke's economist, David Dranove), *aff'd*, 778 F.3d 775 (9th Cir. 2015).

160. *Id.* at *12, *22; *see also* Memorandum Decision and Order at 3, *St. Luke's*, 2014 WL 407446 ("[I]t appears highly likely that health care costs will rise as the combined entity obtains a dominant market position that will enable it to (1) negotiate higher reimbursement rates from health insurance plans that will be passed on to the consumer, and (2) raise rates for ancillary services (like x-rays) to the higher hospital-billing rates.").

161. *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.* (*St. Luke's*), 778 F.3d 775, 787 (9th Cir. 2015). The error was harmless according to the court of appeals because the lower court's separate finding that the acquisition would increase power in the market for primary care physician services was supported by factual findings.

162. *Id.*

163. *Id.*

164. *Id.* The court also observed that a merger should not be found anticompetitive because the

not the FTC's argument. It was the much simpler argument, which the trial court had credited, that St. Luke's internal documents supplied evidence that the system believed the acquisition of Saltzer would lead to increased power in the primary care market.¹⁶⁵

Unless the nation sees a resurgence of price regulation in health care, few hospitals or health systems will acquire a physician practice to avoid regulation. But the suggestion, made by Dafny, Vistnes, and Sarafidis—that health systems acquire facilities outside their geographic markets, and raise prices there to exploit the market power they already possess but are reluctant to exercise—may provide a motive for some physician practice acquisitions. In light of *Discon* it seems unlikely, however, that an acquisition could be enjoined under the antitrust laws on this basis, even if this motive could be shown. Any post-merger conduct that damaged competition in the second market could be addressed as a tying or bundling issue under sections 1 and 2 of the Sherman Act, as appropriate.¹⁶⁶

Efforts by hospitals or health systems to exploit the labyrinthine architecture of the Medicare system provide even less basis to block an acquisition of a physician practice. Since the passage of the Bipartisan Budget Act¹⁶⁷ on November 2, 2015, hospitals no longer may acquire a physician clinic, qualify it as provider-based, and add a facility fee to the professional fee for procedures performed there.¹⁶⁸ But nothing in Medicare law prevents hospitals that acquired physician clinics before that date from continuing to do so.¹⁶⁹ Moreover, as the FTC's case

newly merged company might be in a position in the future to leverage its market power into a second market. *Id.* (citing AREEDA & HOVENKAMP, *supra* note 28, ¶ 1144a, for the proposition that it is “superfluous and overdeterrent” to condemn a merger because it may have anticompetitive tying effects).

165. Oral argument shows the Ninth Circuit was quite confused about the issue. Oral Argument at 42:00, *St. Luke's*, 778 F.3d 775 (No. 14-35173), www.ca9.uscourts.gov/media/view_video.php?pk_vid=0000006760 [<https://perma.cc/GUX9-8FQV>]. Judge Hurwitz seemed to think a facility fee could be charged by Saltzer doctors only if they took their patients to a St. Luke's hospital (which is not the case) or committed “fraud” by performing procedures at Saltzer clinics and billing a facility fee. This isn't fraud at all: so long as the acquired facility qualifies under the provider-based billing rules, it is exactly what those rules permit.

166. The courts have substantial experience applying the Sherman Act to both tying and bundling arrangements. *See, e.g.*, *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984) (tying anesthesia services to surgical services); *Cascade Health Sols. V. PeaceHealth*, 542 F.3d 668 (9th Cir. 2008) (providing a discounted bundle of primary, secondary, and tertiary services).

167. Bipartisan Budget Act of 2015, Pub. L. No 114-74, 129 Stat. 584.

168. *Id.* § 603, 129 Stat. at 597.

169. In one litigated case, a Washington superior court held imposition of such facility fees do not violate the state's Consumer Protection Act. *Gibson v. Va. Mason Med. Ctr.*, No. 05-2-02198-5SEA (Wash. Super. Ct. Oct. 12, 2006) (order granting in part and denying in part defendant's

against Fresenius over its acquisition of a license for Venofer showed, there are many ways (some of which undoubtedly have yet to be discovered) to game the Medicare system and increase reimbursement. Efforts to exploit Medicare rules to increase reimbursement should be dealt with, if at all, under that regulatory system and not as antitrust matters.

D. Increased Bargaining Leverage and Reduced Network Competition

Economic analyses of provider mergers have begun to emphasize the importance of changes in bargaining leverage as a central measure of the potential competitive effects of mergers. Under the “two-stage” model of provider competition, providers compete for network inclusion in the first stage and for in-network patients in the second stage.¹⁷⁰ Under this framework, the key locus of price competition for healthcare providers is therefore centered on competition among providers for inclusion in insurers’ networks. Competition for inclusion in the network occurs across a number of dimensions including quality and access, although reimbursement rates play a prominent role. Once in the network, providers then compete for patients on non-price dimensions like clinical quality, wait times, and patient satisfaction. Notably, findings of increased bargaining leverage have been a decisive factor in recent hospital merger decisions.¹⁷¹ Analysis of hospital-physician mergers might likewise incorporate analysis of possible increases in bargaining leverage resulting from the combination of complementary services. An important empirical question, therefore, would be whether the changed position of the parties negotiating managed care contracts is enhanced by the combination of the services. For example, the addition of a preferred, “must have” physician practice to a hospital with a strong market position might make it impossible for an insurer to walk away from the combined entity’s “all or nothing” contractual terms.¹⁷² Application of

motion for summary judgment).

170. Cory Capps, David Dranove & Mark Satterthwaite, *Competition and Market Power in Option Demand Markets*, 34 RAND J. ECON. 737 (2003); Robert Town & Greg Vistnes, *Hospital Competition in HMO Networks*, 20 J. HEALTH ECON. 733, 733–52 (2001); Greg Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 ANTITRUST L.J. 671, 672 (2000).

171. *ProMedica Health Sys. Inc. v. FTC*, 749 F.3d 559 (6th Cir. 2014); *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1084 (N.D. Ill. 2012) (“[T]he proposed merger in this case would give the combined entity significant bargaining leverage, which would in turn allow the combined entity to extract higher prices from MCOs.”).

172. See Brief of Amici Curiae Economics Professors in Support of Plaintiffs/Appellees Urging Affirmance, *St. Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke’s Health Sys., Ltd.*, 778 F.3d 775 (9th

this theory would require analysis of insurers' ability to contract for alternative network arrangements and the extent to which the additional leverage is created by the combination of market power in physician and hospital services.¹⁷³

III. MITIGATING FACTORS

The preceding Part offered a roadmap for evaluating whether the effect of a vertical physician/hospital merger may be substantially to lessen competition in violation of section 7 of the Clayton Act. As is undoubtedly apparent, the trail is marked by numerous diverging paths and cases will turn on specific facts and circumstances unique to every market. Even when a plaintiff successfully navigates the course the journey is not over, as a host of factors may undercut the claim that a particular vertical merger is likely to be anticompetitive. We discuss two of the most important factors below: ease of entry and countervailing power.¹⁷⁴

Cir. 2015) (No. 14-35173) ("From the provider-insurer bargaining model that characterizes the first stage of competition, it follows that the total reimbursements paid by an insurer to a provider organization will depend on that organization's combined bargaining leverage across all services it supplies to enrollees.").

173. Studies indicating that hospital employment of physicians correlates with higher costs and prices. *See supra* notes 69–71 (suggesting that mergers strengthen the bargaining position of the combined entity).

174. In the context of a horizontal merger, the Agencies argue that analysis in "Section 7 claims [proceeds] under a burden-shifting framework" under which plaintiff "can establish a presumption of liability by . . . showing that the transaction will lead to undue concentration in the relevant market." *Polypore Int'l, Inc.*, 150 F.T.C. 586, 599–600 (2010), *aff'd*, 686 F.3d 1208 (11th Cir. 2012). Once the plaintiff does so, the burden shifts to defendants to "produce evidence showing that the plaintiff's evidence paints an inaccurate picture of the merger's likely competitive effects." *Id.* This is the so-called "Philadelphia National Bank" presumption, originating in the Supreme Court's holding that once a plaintiff in a horizontal merger case has shown the merger will result in "a firm controlling an undue percentage share of the relevant market, and result[] in a significant increase in the concentration of firms in that market," the burden shifts to defendants to come forward with evidence that mitigates the claim of anticompetitive harm. *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 363 (1963). Though the burden of production may shift, at all times the burden of persuasion remains on the plaintiff. *United States v. Baker Hughes Inc.*, 908 F.2d 981, 982–83 (D.C. Cir. 1990). To be precise, therefore, in a horizontal merger case, ease of entry and other factors on which defendants may wish to introduce evidence are not "defenses" but represent avenues a defendant may take to undercut or vitiate the notion that the market shares and structure in a particular case necessarily lead to a finding of market power. The "Philadelphia National Bank" presumption is explored at length in a series of essays prepared for a symposium held at New York University School of Law on the occasion of the decision's fiftieth anniversary. The papers are published in 80 *ANTITRUST L.J.* 189 (2015). In a vertical merger, where no similar market structure presumption applies, it is even clearer that the burden of persuasion that the merger is anticompetitive rests at all times on the plaintiff.

A. *Ease of Entry*

Ease of entry has been held to trump inferences of market power from concentration data in a number of antitrust cases.¹⁷⁵ Following significant setbacks in litigation,¹⁷⁶ the DOJ, joined for the first time by the FTC, issued extensively revised Merger Guidelines in 1992 to clarify the standards deemed necessary to merit obviating other indicia of the potential exercise of market power.¹⁷⁷ Supported by economic analysis of strategic considerations guiding entry decisions and efficacy,¹⁷⁸ the Agencies adopted a tri-partite formula for evaluating entry in merger cases: entry need be “timely, likely, and sufficient” to assure that a market would perform competitively despite high concentration resulting from a merger.¹⁷⁹ “Timeliness” was set, somewhat arbitrarily, at two years, presumably based on the premise that predictions of longer term entry are speculative and that the Clayton Act should not condone extended periods of harm to consumers. A finding of “likelihood” would depend on evaluation of sunk expenditures, scale of entry, and post-entry prices. “Sufficiency” turns on the closeness of potential substitutes in differentiated products, limitations on entrants’ capabilities or reputation, and entry at the “scale and strength of one of the merging firms” in order to replace the lost competition from the acquisition.¹⁸⁰ The revised guidelines have been successful in clarifying the standard to be applied and a number of courts have adopted the framework.¹⁸¹ At the

175. As the Agencies explain in the current Horizontal Merger Guidelines, a “merger is not likely to enhance market power if entry into the market is so easy that the merged firm and its remaining rivals in the market, either unilaterally or collectively, could not profitably raise price or otherwise reduce competition compared to the level that would prevail in the absence of the merger.” 2010 MERGER GUIDELINES, *supra* note 44, § 9.

176. *United States v. Syufy Enters.*, 903 F.2d 659 (9th Cir. 1990); *Baker Hughes Inc.*, 908 F.2d 981; *United States v. Waste Mgmt., Inc.*, 743 F.2d 976, 983–84 (2d Cir. 1984).

177. U.S. DEP’T. OF JUSTICE & FED. TRADE COMM’N, HORIZONTAL MERGER GUIDELINES (1992), <https://www.ftc.gov/sites/default/files/attachments/merger-review/hmg.pdf> [<https://perma.cc/B8NB-SFZ6>].

178. Professor Jonathan Baker summarizes the strategic approach to understanding entry as follows: “if entry requires sunk expenditures (irreversible investments), and incumbents would be expected to react quickly to cut price in response to entry, entry may be deterred even if the pre-entry price exceeds competitive levels. This may occur because the prospective entrant, recognizing the prospect of post-entry competition, will not expect to earn a contribution margin (revenues less variable costs) adequate to cover its own sunk costs.” Jonathan B. Baker, *Responding to Developments in Economics and the Courts: Entry in the Merger Guidelines*, 71 ANTITRUST L.J. 189, 194 (2003).

179. 2010 MERGER GUIDELINES, *supra* note 44, § 9.

180. *Id.*

181. Baker, *supra* note 178, at 201–02.

same time, critics have noted that applying the principles is hardly a straightforward task, particularly with regard to likelihood¹⁸² and factors such as “minimum viable scale” and “sales opportunity,” which, although seemingly precise, prove elusive in litigation.¹⁸³

The two reported cases dealing with ease of entry in the context of physician mergers reached different conclusions. In *HTI Health Services, Inc. v. Quorum Health Group, Inc.*,¹⁸⁴ the district court rejected a private plaintiff’s challenge to a merger despite finding that the acquisition would result in the acquiring hospital attaining what it conceded were “staggering” market shares in several distinct product markets: eighty percent PCP services; one hundred percent in general surgery and urology; and sixty-seven percent in otolaryngology.¹⁸⁵ Notwithstanding these very large post-merger market shares, the court upheld the merger because it believed that entry barriers into the primary care market were not significant and that the rival hospital would not face obstacles in recruiting physicians.¹⁸⁶ As to specialty practices, the court found that “if there is any arguable monopoly here at all, it is a ‘natural monopoly.’”¹⁸⁷

The *HTI Health Services* court relied on a variety of factors to reach its conclusion regarding entry barriers. First, it concluded that the primary care market had “not reached the point of saturation” and there was “high demand” for these services.¹⁸⁸ While acknowledging testimony of a physician recruiter who described problems that he encountered recruiting physicians to Vicksburg, in particular, and to Mississippi, in general, based in part on “negative perceptions and stereotypes about Mississippi,” the court also noted past successes in

182. An FTC Commissioner suggested that likelihood decisions should be guided by evidence of the history or nonhistory of entry and whether “special circumstances” limit the predictive value of history. See Thomas B. Leary, *The Essential Stability of Merger Policy in the United States*, 70 ANTITRUST L.J. 105, 121 n.70 (2002). As many have pointed out however, the absence of entry can be indicative of competitive market conditions rather than entry barriers, and past entry may reflect monopolistic pricing. Janusz A. Ordovery & Daniel M. Wall, *Proving Entry Barriers: A Practical Guide to the Economics of New Entry*, ANTITRUST, Winter 1988, at 12, 13.

183. Baker, *supra* note 178, at 204.

184. 960 F. Supp. 1104, 1128 (S.D. Miss. 1997).

185. *Id.* (“At first blush, the market share percentages in this case, which range from 67% to 100%, are staggering.”).

186. *Id.* at 1135.

187. *Id.* at 1128 (citing *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1412 (7th Cir. 1995)) (stating that employing all twelve physicians “might be considered a ‘natural monopolist’ . . . because the market is too small to support more than a single firm”).

188. *Id.* at 1134.

recruiting PCPs.¹⁸⁹ As to the timeliness of entry, it observed that hospitals in the area often guarantee the income of new physicians and seemed to conclude that, given exigent circumstances, financial inducements would hasten entry.¹⁹⁰ While not explicitly invoking ease of entry with respect to specialty service markets, the court noted that actual and potential competition from nearby surgeons outside the geographic market might act as a “competitive check” on the exercise of market power.¹⁹¹

By contrast, the *St. Luke’s* district court’s application of the Merger Guidelines standard—framing the question as whether entry would prove “timely, likely, and sufficient in its magnitude, character and scope to deter or counteract the competitive effects” of the proposed transaction—found the entry defense wanting.¹⁹² Its application of the standard rested primarily on three factual findings: the disinclination of young doctors to live in the relevant market, past difficulties in recruiting physicians, and the time required for newly minted physicians to “ramp up” in practice and earn a reputation sufficient to compete with established practices.¹⁹³ These findings, the court concluded, “demonstrated how difficult it is to recruit primary care physicians into [the relevant market], and how difficult it is for new primary care physicians to open an office, hire staff, earn a reputation, and develop a practice with the quality to compete with St. Luke’s/Saltzer.”¹⁹⁴ The court concluded St. Luke’s had not carried its burden of proving that entry was likely and would be timely.¹⁹⁵

Much evidence, albeit not specifically cited by the court, underlies these findings. For example, hospital plaintiffs’ expert Dr. Haas-Wilson closely examined the trajectory of primary care practice experience and concluded that even if new physicians were to enter the market, it would likely take two or more years to ramp up to average levels of

189. *Id.* at 1135.

190. *Id.*

191. *Id.* at 1130.

192. *Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke’s Health Sys., Ltd.* (*St. Luke’s*), Nos. 12-CV-00560-BLW, 13-CV-00116-BLW, 2014 WL 407446, at *19, *23 (D. Idaho Jan. 24, 2014) (citing 2010 MERGER GUIDELINES, *supra* note 44, § 9), *aff’d*, 778 F.3d 775 (9th Cir. 2015). The district court’s holding on entry issues was not contested on appeal. *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke’s Health Sys., Ltd.* (*St. Luke’s*), 778 F.3d at 786.

193. *St. Luke’s*, 778 F.3d at 791. Expert testimony detailed the delays inherent in “ramping up” a new practice.

194. *St. Luke’s*, 2014 WL 407446, at *22.

195. *Id.* at *23.

productivity.¹⁹⁶ To reach this conclusion, she examined the productivity ramp up of eight full-time physicians newly hired by the Saltzer group. In their first two years, newly hired physicians were below the twenty-fifth percentile of productivity, benchmarked against other PCPs in the region.¹⁹⁷ In addition, Dr. Haas-Wilson cited studies of patient loyalty¹⁹⁸ and concluded that patients' reluctance to change physicians "made it difficult for new entrants to ramp up their practices" and difficult for incumbents "to grow their practices by recruiting new physicians from outside the market."¹⁹⁹

Notably, the district court did not address the sufficiency of entry. In this connection, the parties had sparred over the extent and scope of entry. Defendant's expert argued that "the entire Saltzer practice need not be replicated by entry or expansion,"²⁰⁰ while plaintiffs responded that high fixed costs of entry and the need to establish reputation undermined contentions that entrants would replace the lost competition resulting from the acquisition.²⁰¹ The court's reluctance to address the issue is not surprising and probably reflects the inherent uncertainty surrounding the many issues that would inform a judgment as to whether a prospective entrant would ultimately make a difference. Hence, courts are more likely to turn to the somewhat more tractable questions of timeliness and likelihood of entry.

In sum, the case law and Merger Guidelines require accumulating considerable evidence about the resources and capabilities required to effectively replace an acquired physician practice and the conditions that might impair effective competition. Entry analysis in decided cases has focused on likelihood and timeliness: courts understandably tend to shy away from the even more speculative enterprise of evaluating sufficiency of yet-to-be specified entrants. Data on physician shortages, medical school enrollments, and education subsidies can give courts useful information. Finding probative evidence on the willingness of physicians to locate in geographic areas or affiliate with specific hospitals necessarily involves a mixture of opinion evidence from

196. Declaration of Debra Haas-Wilson, *supra* note 104, ¶ 79.

197. *Id.* ¶ 128.

198. See Scott MacStravic, *Patient Loyalty to Physicians: Attitudes and Behavior*, 10 J. HOSP. MARKETING 51, 51 (1995) (defining patient loyalty as the "tendency to use the same physician consistently," and the "willingness to overcome barriers to go to one's preferred physician").

199. Declaration of Debra Haas-Wilson, *supra* note 104, ¶ 54.

200. Declaration of David A. Argue ¶ 69, *St. Luke's*, 2014 WL 407446 (Nos. 12-cv-00560-CWD, 13-CV-00116-BLW).

201. Answering Brief for Plaintiffs/Appellees, *supra* note 156, at 25.

credible sources, such as physician recruitment experts, and of past experience in a given market. However, the latter illustrates a key problem in entry analysis in all antitrust cases that is even more starkly apparent in evaluating health care mergers: what weight should courts assign to historical evidence? One must question how much light past experience sheds on the evidentiary issues raised in entry analysis given the tumultuous changes in delivery and payment currently underway.²⁰²

Next we examine several of the factual issues relevant to entry analysis that are likely to arise in the foreclosure scenarios described above. In analyzing the effect of potential entry on the competitive effects of a hospital-physician merger, the central focus will be on evaluating whether rival hospitals that are subject to risk of foreclosure have the capability to recruit and support replacement physicians and whether that recruitment will make a difference. As discussed above, many issues raised regarding the likelihood of recruiting primary care physicians, as explored in the *St. Luke's* case, are market specific—e.g., the attractiveness of the local market, the history of past recruitment efforts, and overall demand conditions. Also relevant are data on the supply conditions. That is, do shortages of entry-level physicians in particular specialty markets and especially in family practice service markets make recruitment especially difficult?²⁰³ In this connection, courts need to gather evidence probative of future supply conditions, as the dynamic conditions of health delivery may make reliance on historical patterns problematic. As to the timeliness and sufficiency of entry, a careful examination of the obstacles new physicians face to build their practices will be required. In the context of an acquisition of specialist physicians, a key issue will be whether the loss of specialists so disrupts rival hospitals' referrals as to place extraordinary constraints on keeping their departments operating even for a short time. Uncertainty as to viability of the department and the need to recruit and train physicians rapidly may reduce the chances that entry will be timely

202. Compare *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 56 (D.D.C. 1998) (noting that the “history of entry into the relevant market is a central factor in assessing the likelihood of entry in the future”), and 2010 MERGER GUIDELINES, *supra* note 44, § 9 (“Recent examples of entry, whether successful or unsuccessful, generally provide the starting point for identifying the elements of practical entry efforts.”), with *Ordovery & Wall*, *supra* note 182, at 13 (questioning reliability of historical evidence of entry or non-entry).

203. See, e.g., *Physician Supply and Demand Through 2025: Key Findings*, *supra* note 109 (estimating total shortfall of physicians between 12,500 and 31,000 primary care physicians and 38,300 and 63,700 non-primary care physicians); IHS INC., THE COMPLEXITIES OF PHYSICIAN SUPPLY AND DEMAND: PROJECTIONS FROM 2013 TO 2025 (2015), www.aamc.org/download/426242/data/ihsreportdownload.pdf [<https://perma.cc/W3LU-WY59>].

or sufficient. Also complicating the analysis is the rapid change underway in payment and delivery. For example, strong market pressures to integrate delivery, e.g., through the formation of accountable care organizations, may change the minimum scale needed to provide specialty services at the hospital.²⁰⁴ Finally, the acquisition of a multispecialty group may raise special issues in the context of entry analysis. For example, the acquisition of a “must have” physician group might chill the willingness of physicians to enter the market.²⁰⁵ In addition, the need to replace physicians quickly in multiple specialties may increase the costs of recruitment. Finally, given integration into larger systems, is the market creating bigger, new “natural monopolies”?²⁰⁶

B. *The Power Buyer Factor*

In evaluating a merger of sellers of a product or services, courts may take into account the size, sophistication, and bargaining leverage of buyers in their markets. Typically such phenomena are considered “mitigating factors” that reduce concerns based on concentration data. With respect to mergers in oligopolistic markets, the analysis holds that successful collusion among sellers is less likely when purchases are “lumpy” and when buyers are large and sophisticated because sellers have greater incentive to “cheat” on any collusive arrangement to obtain a significant piece of business.²⁰⁷ Another premise, likely applicable in

204. See Jeff Goldsmith, *Accountable Care Organizations: The Case for Flexible Partnerships Between Health Plans and Providers*, 30 HEALTH AFF. 32, 35 (2011) (describing pressures in ACOs to redistribute income from high earning specialists).

205. Courts have recognized that consumers may highly value certain providers so that the inclusion of those providers in an insurer’s network is vital to the marketability of the insurer’s health plans. For example, in the *St. Luke’s* case, the district court found that the largest health plan in Idaho, Blue Cross of Idaho, considered the acquired physician group “to be a must have provider for Blue Cross” in the relevant market. *Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke’s Health Sys., Ltd. (St. Luke’s)*, Nos. 12-CV-00560-BLW, 13-CV-00116-BLW, 2014 WL 407446, at *9 (D. Idaho Jan. 24, 2014).

206. Judge Posner concluded that a medical community was “too small to support more than a handful of physicians”:

If an entire county has only 12 physicians, one can hardly expect or want them to set up in competition with each other. We live in the age of technology and specialization in medical services. *Physicians practice in groups, in alliances, in networks, utilizing expensive equipment and support.* Twelve physicians competing in a county would be competing to provide horse-and-buggy medicine.

Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic, 65 F.3d 1406, 1412 (7th Cir. 1995) (emphasis added).

207. See *Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1391 (7th Cir. 1986) (“[C]oncentration of the buying side . . . does inhibit collusion. The bigger a buyer is, the more easily and lucratively a

vertical foreclosure cases, is that large buyers are better equipped to monitor price and quality in the sellers' market and use their leverage to negotiate more favorable terms. The potential exercise of "countervailing power" by large buyers (insurance companies and employers) might mitigate the risks of supracompetitive pricing by vertically integrated hospitals.

The Agencies offer a rather constrained acceptance of the power buyer factor, framing the issue as follows:

The Agencies consider the possibility that powerful buyers may constrain the ability of the merging parties to raise prices. This can occur, for example, if powerful buyers have the ability and incentive to vertically integrate upstream or sponsor entry, or if the conduct or presence of large buyers undermines coordinated effects. However, the Agencies do not presume that the presence of powerful buyers alone forestalls adverse competitive effects flowing from the merger. Even buyers that can negotiate favorable terms may be harmed by an increase in market power. The Agencies examine the choices available to powerful buyers and how those choices likely would change due to the merger. Normally, a merger that eliminates a supplier whose presence contributed significantly to a buyer's negotiating leverage will harm that buyer.²⁰⁸

The Agencies also have expressed considerable skepticism about the relevance of large buyers in speeches,²⁰⁹ litigation,²¹⁰ and in their "Dose of Competition" report.²¹¹ At the same time the DOJ occasionally has passed on highly concentrative mergers based in part on its analysis of

member of the cartel can cheat on his fellows; for with a single transaction, he may be able to increase his sales and hence profits dramatically.").

208. 2010 MERGER GUIDELINES, *supra* note 44, § 8.

209. *See, e.g.*, KEVIN J. ARQUIT, FED. TRADE COMM'N, GROUP BUYING AND ANTITRUST (1992) (expressing opinion that the "power buyer defense" is not applicable in hospital merger cases); STEVEN C. SUNSHINE, U.S. DEP'T OF JUSTICE, MARKET-BASED REFORMS OF HEALTH CARE DELIVERY: WHERE DOES ANTITRUST FIT IN? (1995) ("[W]e often hear from merging parties that the transaction is needed to balance the hospital's power against the growing power of managed care. We typically don't credit arguments of countervailing power. We are skeptical that monopsony power wielded by managed care providers is likely to have serious welfare effects since demand for in-patient service may be quite inelastic."); Mary Lou Steptoe, *The Power-Buyer Defense in Merger Cases*, 61 ANTITRUST L.J. 493 (1993) (where the author, the Deputy Director of the FTC's Bureau of Competition, argued that the power buyer doctrine "would now profit from a period of pause and reflection").

210. *See, e.g.*, *United States v. Baker Hughes Inc.*, 908 F.2d 981 (D.C. Cir. 1990).

211. IMPROVING HEALTH CARE, *supra* note 57, at 1, 21.

offsetting buyer power.²¹²

While a number of cases cite the presence of powerful or sophisticated buyers as a factor reducing the likelihood that the merging parties will exercise market power,²¹³ the phenomenon has not by itself been decisive in rebutting the presumption of illegality based on concentration and market share data.²¹⁴ Courts rarely explain the basis for concluding that the risk of competitive harm is lessened other than to note that buyers negotiate with multiple bidders or have monitored changes in price in the past.²¹⁵ Another consideration that is seldom invoked is the question of whether there are small buyers who are unable to negotiate favorable prices. In such circumstances the small buyer can be the victim of price discrimination, which in turn can increase the market power of the power buyer.²¹⁶ In addition, courts do not always distinguish between the rationales based on the sophistication of the large buyer and monopsony power. The Areeda-Hovenkamp treatise argues persuasively that the former should rarely affect the competitive analysis because merger analysis presumes “ordinary knowledge and sophistication”—which is usually present in markets for intermediate services such as insurance—and the difficulty in calculating degrees of

212. The Antitrust Division explained its decision not to challenge Whirlpool Corporation’s acquisition of Maytag Corporation, noting that “the large retailers through which the majority of [the merging parties] appliances are sold—Sears, Lowe’s, The Home Depot and Best Buy—have alternatives available to help them resist an attempt by the merged entity to raise prices.” Press Release, U.S. Dep’t of Justice, Department of Justice Antitrust Division Statement on the Closing of Its Investigation of Whirlpool’s Acquisition of Maytag (Mar. 29, 2006), http://www.justice.gov/archive/atr/public/press_releases/2006/215326.htm [<https://perma.cc/RK27-AS4X>]; Steven Pearlstein, *Arguments for Whirlpool-Maytag Merger Don’t Wash*, WASH. POST (Feb. 22, 2006), <http://www.washingtonpost.com/wp-dyn/content/article/2006/02/21/AR2006022101670.html> [<https://perma.cc/HF7X-GCBN>] (noting that the existence of large buyers weighed on the decision to allow the merger to go forward).

213. See, e.g., *Baker Hughes Inc.*, 908 F.2d 981 (citing existence of large and sophisticated buyers as one factor reducing risk of competitive harm); *United States v. Country Lake Foods, Inc.*, 754 F. Supp. 669, 675 (D. Minn. 1990) (noting that the merger of dairies was less likely to harm consumers because the food distributor market was even more concentrated). *But cf.* *Chi. Bridge & Iron Co. v. FTC*, 534 F.3d 410 (5th Cir. 2008) (finding that despite the presence of large buyers, the court doubted that the new entry would obviate competitive risks). In several non-merger cases buyer power has been a significant factor in the court’s analysis.

214. AREEDA & HOVENKAMP, *supra* note 28, ¶ 943c (stating that “very few or perhaps no cases have turned on” the sophistication or power of buyers).

215. *Country Lake Foods, Inc.*, 754 F. Supp. at 673 (noting that purchasers were “sensitive to and monitor changes in fluid milk prices”).

216. See AREEDA & HOVENKAMP, *supra* note 28, ¶ 943b (“[A] common consequence of large-buyer bargaining pressure is likely to be recurrent and more or less systematic price discrimination in which large buyers obtain lower prices than smaller buyers, but adverse price effects on small buyers alone is sufficient to invoke § 7’s prohibitions.”).

sophistication.²¹⁷ Even if there are no small, vulnerable customers, the Areeda-Hovenkamp treatise recommends that courts and enforcement agencies ignore buyer power as a mitigating factor in a merger of sellers unless the circumstances are exceptional.²¹⁸ The treatise justifies this view on intractable measurement problems and notes “powerful buyers might find it more profitable to share in their suppliers’ excess profits rather than trying to get supply prices down to competitive levels.”²¹⁹

Several courts have considered the countervailing power of payers and managers of employer health plans in evaluating horizontal hospital mergers. In *FTC v. Freeman Hospital*,²²⁰ for example, the district court was impressed with the sophistication of HMOs, insurers, and large employers. In *FTC v. Tenet Health Care Corp.*,²²¹ the Eighth Circuit observed (albeit with disapproval) the growing influence of managed care in the market. Other courts examining hospital mergers have questioned the significance of an insurer’s countervailing power.²²² Notably, the former group of cases neglected to consider whether smaller, less sophisticated hospitals would be harmed and as a result the merger would force higher prices to them.²²³ Most recently, a court found the preference of consumers for choice of area hospitals and the increased bargaining leverage resulting from the merger negated the possibility of large managed care organizations exercising

217. *Id.* ¶ 943a, at 249.

218. *Id.* ¶ 943b, at 253 (“We conclude that it would be inappropriate to give formal recognition to buyer concentration and related factors in the ordinary run of merger cases.”).

219. *Id.*

220. 911 F. Supp. 1213 (W.D. Mo.), *aff’d*, 69 F.3d 260 (8th Cir. 1995).

221. 186 F.3d 1045, 1054 (8th Cir. 1999) (finding the lower court should have considered reductions in quality caused by managed care purchasers of hospital services and quoting Judge Posner’s dictum in *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406, 1410 (7th Cir. 1995), that “the HMO’s incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible”).

222. The district court in *FTC v. Universal Health, Inc.*, 938 F.2d 1206, 1213 (11th Cir. 1991), questioned whether despite their size, large insurers could resist consumer demand for inclusion of certain hospitals in their networks:

The insurance companies in this market, however, are not truly large buyers; rather, they are third-party payors acting on behalf of individuals, the ultimate consumers. These insurance companies, as a practical matter, could not refuse to reimburse their subscribers because the prices in the relevant market were too high; rather, they would, as always, reimburse their subscribers for necessary medical services and, if the prices remained high, they would pass these increased costs on to the individual consumers.

223. AREEDA & HOVENKAMP, *supra* note 28, ¶ 943c (questioning the application of power buyer analysis in *Freeman* and concluding that “conclusion[s] about large health insurer buyers should mitigate in favor of legality only if it could additionally be shown that the hospital is unable to price-discriminate against smaller buyers”).

countervailing power.²²⁴ In *In re ProMedica Health System, Inc.*,²²⁵ the FTC closely analyzed the relative bargaining leverage of the insurers and the merging hospitals using econometric analysis of willingness-to-pay and other indicia of consumer preferences and concluded that the balance would tip decisively in favor of the hospitals.²²⁶

Scholars who, contrary to the position taken by the Areeda-Hovenkamp treatise, advocate a closer look at the effect of power buyers, suggest that courts should attempt to distinguish situations in which buyers may exercise “countervailing power” to counteract seller monopolies or oligopolies from the case of monopsony.²²⁷ Given economic studies suggesting that insurers with market power tend to pay lower prices to hospitals, the approach recommended would be to closely examine the likelihood that price concessions would occur and whether they would benefit consumers.²²⁸ By this analysis, fact finders would need to unpack several distinct issues: (1) whether price concessions result from “countervailing power”—the bargaining pressures applied to hospitals with market power under threat of exclusion from the insurer’s network, or instead are the result of the insurer’s exercise of monopsony power;²²⁹ (2) whether the exercise of

224. *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1084 (N.D. Ill. 2012) (“Given the current norms and expectations of Rockford area consumers, the proposed merger in this case would give the combined entity significant bargaining leverage, which would in turn allow the combined entity to extract higher prices from MCOs.”).

225. No. 101-0167 (F.T.C. Mar. 28, 2012), *aff’d*, *ProMedica Health Sys. v. FTC*, 749 F.3d 559 (6th Cir. 2014).

226. *Id.* (citing economic evidence that commercially-insured patients placed 28% more value on having in-network access to the dominant merging hospital than on having in-network access to its remaining rival and the merger had increased by fifty-eight percent the value that commercially-insured patients place on having in-network access to the merged entity).

227. John Kirkwood argues:

[I]f . . . there are relatively few input suppliers, each with significant market power and each with a constant or downward-sloping marginal cost curve, the buyer could not exert monopsony power but may be able to exert countervailing power, with procompetitive consequences. If a substantial buyer can wield countervailing power against monopolistic, oligopolistic, or monopolistically competitive suppliers, it can force their prices closer to the competitive level and benefit both efficiency and consumer welfare.

John B. Kirkwood, *Powerful Buyers and Merger Enforcement*, 92 B.U. L. REV. 1485, 1500–01 (2012).

228. See, e.g., Glenn A. Melnick et al., *The Increased Concentration of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices*, 30 HEALTH AFF. 1728 (2011); Asako S. Moriya et al., *Hospital Prices and Market Structure in the Hospital and Insurance Industries*, 5 HEALTH ECON. POL’Y & L. 459 (2010).

229. John B. Kirkwood, *Buyer Power and Healthcare Prices*, 91 WASH. L. REV. 253, 261 n.34 (2016) (defining monopsony power as “the kind of power that a dominant buyer exerts against small, *competitive* suppliers” while countervailing power “is the kind of power that a substantial buyer exercises against suppliers *with market power*” and explaining the difference “is significant”

countervailing power will result in consumer harm notwithstanding its tendency to lower provider prices; and (3) whether savings caused by countervailing power will be passed on to consumers.²³⁰

This rather complex analytic route is driven by the fact that consumer harm may result under *both* the “countervailing power” and monopsony scenarios. There is little question that the exercise of monopsony power visits harm on consumers. Artificially low prices decrease the welfare of upstream suppliers and generally reduce consumer welfare.²³¹ However, in a variety of “countervailing power” situations, consumer welfare may also be harmed. For example, the merged firm may coerce or induce its suppliers to raise the costs of its remaining rivals, enabling the merged firm to increase prices in downstream markets, or may extract price cuts from suppliers that induce them to increase prices to other buyers, thus allowing the merged firm to raise its own prices.²³² Even if downstream prices fall as the merged firm takes share from its smaller rivals, their destruction may deprive consumers of choices they preferred and depress overall consumer welfare. Further, the merged firm may take advantage of its preferred cost status to enjoy the “quiet life” and become less efficient and innovative.²³³

One additional complication: it may be difficult to predict whether countervailing power will actually be exercised or will be successful. The merging parties and a large supplier have ample incentives to divide monopoly profits available in their markets.²³⁴ Experience with

because monopsony power is “generally harmful, and countervailing power usually—but not always—[is] beneficial”).

230. For example, Professor Kirkwood has suggested that antitrust reviews of mergers of insurance companies should turn on a careful factual inquiry as to whether the provider and insurance markets are competitive. Insurer buyer power, he argues, will harm consumers where it enables the insurer to pay low prices to “small, powerless providers” or where the cost savings from bargaining (i.e., the “countervailing power” scenario) are not passed on to consumers because of the insurer’s excessive market power. *Id.* at 279.

231. *See, e.g.,* Roger D. Blair & Jeffrey L. Harrison, *Antitrust Policy and Monopsony*, 76 CORNELL L. REV. 297, 339 (1991) (“[L]ower input prices resulting from the exercise of monopsony power do *not* ultimately translate into lower prices to the monopsonist’s customers and increased overall consumer welfare.”); Kirkwood, *supra* note 227.

232. *See* Krattenmaker & Salop, *supra* note 12, at 230–31. *See generally* Kirkwood, *supra* note 227, at 1537–57 (describing countervailing power scenarios that may result in consumer harm).

233. The “quiet life” hypothesis suggests that firms with monopoly power may choose to incur inefficiencies rather than reap monopoly rents. *See* Michael Koetter et al., *Enjoying the Quiet Life Under Deregulation? Evidence from Adjusted Lerner Indices for U.S. Banks*, 94 REV. ECON. & STAT. 462 (2012).

234. AREEDA & HOVENKAMP, *supra* note 28, ¶ 943b (“[P]owerful buyers might find it more profitable to share in their suppliers’ excess profits rather than trying to get supply prices down to competitive levels.”).

dominant insurer/dominant hospital cooperation in health care markets suggests that such scenarios are possible. For example, in *West Penn Allegheny Health System, Inc. v. UPMC*,²³⁵ the plaintiff alleged that Highmark, the dominant health insurer in the Pittsburgh area, and UPMC, the leading hospital system, conspired to protect each other from competition and to undertake measures designed to harm UPMC's rival hospital in exchange for UPMC limiting competition to Highmark in the insurance market.²³⁶ Likewise, insurers in many markets have entered into "most favored nations agreements" with hospitals that reward hospitals for contractual commitments not to grant discounts to rival payers.²³⁷ In a number of other instances, providers and insurers have found it in their mutual interest to enter into exclusionary agreements that injure rivals of the provider.²³⁸

In sum, the case law does not present a clear roadmap for applying power buyer considerations and applying a full-blown economic inquiry presents severe problems of administrability in litigation. We believe that the uncertainty that attends predictions of hard-nosed negotiations between buyers and sellers favors a cautious approach. The Areeda-Hovenkamp analysis suggesting that courts should approach claims of mitigation from buyer power with skepticism is therefore warranted. Situations in which there are small rivals that would be unable to exercise buyer power and in which price discrimination is possible are particularly inappropriate for applying a power buyer offset. Courts

235. 627 F.3d 85 (3d Cir. 2010).

236. See also Allen Bombardierie, *A Handshake that Made Healthcare History*, BOS. GLOBE (Dec. 28, 2008), www.boston.com/news/local/massachusetts/articles/2008/12/28/a_handshake_that_made_healthcare_history/ [<https://perma.cc/JBQ3-NFBK>] (reporting agreement between dominant insurer, Blue Cross Blue Shield of Massachusetts, and dominant hospital system Partners Health Care, pursuant to which Blue Cross agreed to give Partners higher levels of reimbursement, in exchange for Partners' promise that it would demand the same rate increases from other payers).

237. See, e.g., *United States v. Blue Cross Blue Shield of Mich.*, 809 F. Supp. 2d 665, 665, 668 (E.D. Mich. 2011) (denying motion to dismiss in case alleging dominant health insurer used anticompetitive "most favored nation" (MFN) clauses in its contracts with hospital providers to foreclose competition in health insurance market while also increasing hospitals' reimbursement). The case was dismissed as moot after the Michigan legislature adopted legislation prohibiting MFN agreements. Order of Dismissal Without Prejudice, *Blue Cross Blue Shield of Mich.*, 809 F. Supp. 665 (E.D. Mich. 2011) (No. 2:10-cv-14155-DPH-MKM).

238. See *Heartland Surgical Specialty Hosp., LLC v. Midwest Div., Inc.*, 527 F. Supp. 2d 1257, 1266, 1325 (D. Kan. 2007) (denying summary judgment in case involving alleged conspiracy between combination of hospitals accounting for seventy-four percent of local market and insurers accounting for ninety percent of managed care contracts to prevent new specialty hospital from obtaining managed care contracts); *Texas v. Mem'l Hermann Healthcare Sys.*, No. 2009-04609 (Tex. Dist. Ct. Jan. 26, 2009) (settling antitrust claims that largest hospital system in Houston discouraged commercial insurers from contracting with rival hospitals by threats of termination or demands for large increases in reimbursement).

should also examine the history and proclivity of buyers and sellers in markets to engage in cooperative bargaining as another factor militating against recognition of the offset.

CONCLUSION

Rapidly evolving market conditions are spurring an increasing number of acquisitions by hospitals and health systems of provider groups. Yet courts and practitioners analyzing such transactions are entering largely uncharted territory. The vertical merger guidelines, written in 1984, are obsolete and provide little help for practitioners or courts seeking to analyze such acquisitions three decades on. The Agencies have filed no enforcement actions challenging vertical health care provider mergers. Although the Agencies have left open the possibility they will do so in the future, the FTC passed up the most recent opportunity to do so. In the recently concluded *St. Luke's* litigation, the private plaintiff pursued such a theory, but the FTC ignored it. Perhaps as a result, so did the trial and appellate courts.

Many—probably most—vertical transactions that courts and practitioners confront are competitively neutral or even beneficial. But some consolidations may harm consumer interests. Acquisitions of physician practices may be a strategy that some hospitals and systems use to undermine competition. At the same time, the history of antitrust law in health care is replete with meritless private lawsuits—such as those challenging hospital denials of staff privileges²³⁹—that likely deterred efficient reordering of hospital-physician arrangements. We offer the foregoing analysis and benchmarks in the hopes that courts and antitrust enforcers proceed, but with caution, in this important area.

239. See FURROW ET AL., *supra* note 77.