

**SELECTED ANTITRUST DEVELOPMENTS  
IN HEALTH CARE**

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This paper reviews selected developments in antitrust health care. While the paper surveys some of the more important such developments since the last conference in May 2010, the principal focus is on matters that have taken place over the last year. The paper reviews developments in health care antitrust enforcement in Section I, developments in private litigation in Section II and concludes in Section III with a discussion of the agencies' guidelines, issued last year, on accountable care organizations.<sup>1</sup>

## I. GOVERNMENT ACTIVITIES

The last two years have been among the busiest ever at the federal antitrust enforcement agencies with respect to health care matters and in particular mergers.

### A. Hospital Mergers

#### 1. FTC Wins a Hospital Merger on the Road: District Court Enjoins Rockford Merger<sup>2</sup>

In early April a federal court handed the FTC a win in a hospital merger being fought on the same battleground as the Department of Justice fought a hospital merger case nearly a quarter of a century ago: Rockford, Illinois.<sup>3</sup> The court enjoined OSF Healthcare System's proposed acquisition of Rockford Health System pending an administrative trial scheduled for later in the month. Judge Kapala of the Northern District of Illinois had "no trouble" finding that a combined OSF and Rockford would control an undue share of the market for acute care services in an area encompassing a 30-minute drive time around Rockford.

Rockford, a non-profit health care system, owns Rockford Memorial Hospital which is located in Rockford, Illinois. OSF, a health care system with several acute care hospitals throughout Illinois, owns St. Anthony Medical Center, another hospital in Rockford. St. Anthony's and Rockford Memorial compete with each other and with SwedishAmerican.

OSF's proposed acquisition of Rockford would combine the two hospitals and their physicians to form OSF Northern Region, a new health care system. The two non-profit systems entered an affiliation agreement in early 2011. The Illinois Health Facilities and Services Review Board approved the acquisition in May 2011, when it granted a Certificate of Exemption to OSF. The FTC parted ways with the State of Illinois and filed an administrative complaint against both systems in November 2011.<sup>4</sup> The complaint alleged the acquisition would create a dominant health system that would control 64% of the market for general acute care inpatient services and

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<sup>1</sup> The authors would like to thank Charles Wright and Ryan Gist of Davis Wright Tremaine who authored numerous member alerts for the AHLA Antitrust Practice Group on which many of these summaries are based.

<sup>2</sup> *FTC v. OSF Healthcare System and Rockford Health System*, No. 3:11-cv-50344 (N.D. Ill. April 5, 2012) available at [www.ftc.gov/os/caselist/1110102/120505rockfordmemo.pdf](http://www.ftc.gov/os/caselist/1110102/120505rockfordmemo.pdf)

<sup>3</sup> *United States v. Rockford Memorial Corp.*, 898 F.2d 1278 (7th Cir. 1990).

<sup>4</sup> *In the Matter of OSF Healthcare System and Rockford Health System*, FTC Docket No. 9349 (Nov. 17, 2011) available at [www.ftc.gov/os/adjpro/d9349/111118rockfordcmpt.pdf](http://www.ftc.gov/os/adjpro/d9349/111118rockfordcmpt.pdf)

would combine two of the three primary care physician groups in the area accounting for 37% of the relevant physician market.

The FTC simultaneously moved to enjoin the acquisition in federal court for the Northern District of Illinois. The agency expressed concern in a press release that the acquisition would end “decades of competition between the defendants’ hospitals,” leading to “significantly higher costs that would be passed on to employers and to health care consumers in Rockford.”<sup>5</sup>

At the hearing on the requested injunction, FTC witnesses testified the acquisition would create a single system with nearly 65% of the market for general acute care inpatient services within a thirty-minute drive from Rockford. The “three to two” merger would, the FTC claimed, result in “a significant increase in the concentration of firms” in the market leading to an increased danger of collusion.

The court agreed and enjoined the acquisition. The court rejected the two systems’ argument that SwedishAmerican, the remaining competitor and current market leader, would constrain any market power a combined OSF and Rockford might have. The court also expressed skepticism that – given the recent failures of single-hospital insurance networks in Rockford – insurance companies could defeat post-merger price increases by refusing to contract with a combined OSF and Rockford.

While taking pains not to express any opinion on the ultimate merits of the claim, the court observed “the FTC’s likelihood of success on its claim involving the [primary care physician] market is distinctly lower than its claim involving the [general acute care inpatient] market.” The post-merger market shares in the physician market would be lower than in the inpatient market, barriers to entry are lower, and payors have more bargaining leverage.

OSF and Rockford argued that the merger would reduce costs and increase the quality of care available to Rockford residents in a number of ways. Although Judge Kapala commended the two systems for “having the desirable goals of improving patient quality of care,” he found the touted the efficiencies and improvements from the merger either were too speculative to rebut the FTC’s case or could be realized even without the acquisition.

## **2. FTC Wins a Hospital Merger at Home: Commissioners Stop Toledo Hospitals From Forming Powerhouse<sup>6</sup>**

In a widely anticipated decision following a contested hearing before an administrative law judge, the Federal Trade Commission in late March blocked ProMedica Health System’s acquisition of St. Luke’s Hospital in Toledo. The FTC found the acquisition would likely result in higher health care costs for patients, employers, and employees, in violation of Section 7 of the Clayton Act. The FTC ordered ProMedica to sell St. Luke’s to a willing buyer for no minimum price. ProMedica has vowed to appeal to the Sixth Circuit Court of Appeals.

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<sup>5</sup> “FTC Challenges OSF Healthcare System Proposed Acquisition of Rockford Health System as Anticompetitive,” (Nov. 18, 2011) available at [www.ftc.gov/opa/2011/11/rockford.shtm](http://www.ftc.gov/opa/2011/11/rockford.shtm).

<sup>6</sup> *In the Matter of ProMedica Health System, Inc.*, FTC Docket No. 9346 (March 28, 2012) available at [www.ftc.gov/os/adjpro/d9346/120328promedicabrillopinion.pdf](http://www.ftc.gov/os/adjpro/d9346/120328promedicabrillopinion.pdf)

ProMedica Health System is an integrated health care delivery system that owns three general acute care hospitals in Lucas County, Ohio (where Toledo is located). ProMedica also owns a health insurance company that operates in Lucas County. Evidence at trial showed the ProMedica hospitals enjoy the highest reimbursement rates in Lucas County.

St. Luke's is a stand-alone, community hospital in Toledo's suburbs. St. Luke's had the lowest reimbursement rates in the market and for years it had been losing money. In February 2010, Moody's downgraded its bond rating to two steps above junk-bond status. St. Luke's argued at trial that its operating expenses and looming capital needs could deplete its reserves by 2013.

Toledo's per capita bed ratio is higher than the national average. In addition to ProMedica and St. Luke's, the Mercy system operates three hospitals in Toledo and the University of Toledo operates a teaching hospital there. Toledo's economy lags the national average, with unemployment peaking in 2010 at over 13%.

Faced with these economics, St. Luke's sought shelter in the arms of a better-financed merger partner. In May 2010, St. Luke's and ProMedica signed a Joinder Agreement. The FTC opened an investigation in July of that year.

In January 2011, the FTC simultaneously issued an administrative complaint against the proposed merger and filed suit in federal district court, seeking an injunction that would keep the hospitals from integrating pending the outcome of the administrative hearing. A federal judge granted a preliminary injunction in March 2011. The parties then litigated the case before an administrative law judge in a hearing that included over 2,600 exhibits, testimony from 34 witnesses, and 7,955 pages of hearing transcripts.

In December 2011, the ALJ issued his initial decision concluding the transaction was likely to substantially lessen competition in violation of Section 7 of the Clayton Act. ProMedica and the FTC's Complaint Counsel both appealed separate aspects of that decision to the full Commission.

Commissioner Julie Brill wrote the opinion on behalf of three of the Commission's four members. Commissioner Thomas Rosch concurred in the result, but not in all of the majority's reasoning.<sup>7</sup> The primary points of contention involved the relevant product market and the trial staff's reliance on expert econometric analysis.

The majority's analysis began with an extended discussion of the relevant product market. At the administrative hearing, ProMedica argued the relevant product market should be the cluster of general acute care services provided by hospitals, without differentiation. Complaint Counsel argued the product market should exclude tertiary services (which St. Luke's generally does not offer), and that there should be a separate analysis of the market for obstetrical services. The ALJ agreed with ProMedica and analyzed the market for all general acute care services. The

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<sup>7</sup> *In the Matter of ProMedica Health System, Inc.*, FTC Docket No. 9346 (March 28, 2012) (concurring opinion of Commissioner Thomas Rosch) available at [www.ftc.gov/os/adjpro/d9346/120328promedicaroschopinion.pdf](http://www.ftc.gov/os/adjpro/d9346/120328promedicaroschopinion.pdf).

trial staff appealed that portion of the ruling. Commissioner Brill's majority opinion reversed the ALJ on this issue.

The majority first found the product market should not include tertiary services, given that St. Luke's does not provide such services. As a result, the merger could not affect competition for such services: "Absent an overlap or potential overlap involving a given service line, there is no substantial lessening of competition, and, thus, no need to include the service in the relevant product market." The majority also reasoned that including tertiary service in the market might "obscure the analysis of competitive effects," given that patients might be willing to travel farther for such services and thus expand the geographic market accordingly.

Commissioner Rosch disagreed and would have included tertiary services in the market definition, in accordance with the FTC's approach in its *Evanston Northwestern Healthcare Corp.* decision from 2007.<sup>8</sup>

In the end, however, this debate had little practical effect: both the majority and Commissioner Rosch agreed with the ALJ that the competitive effects would be the same with or without the inclusion of tertiary services.

The majority then found evidence of a separate market for obstetrical services. That evidence included the fact that "no other services are interchangeable with OB services;" "obstetrics is recognized as a separate field of medicine with distinct providers of OB services;" the hospitals themselves "track OB services market shares separately from [general acute care] inpatient services;" at least one other hospital in the market did not provide OB services; and insurers separately negotiate reimbursement rates for OB services. For the majority, these "practical indicia" warranted examination of a separate market.

Again, Commissioner Rosch disagreed. Because OB services are already included in the cluster of general acute care services, Rosch reasoned, examining a separate market would be redundant. He found no judicial precedent for the majority's approach and concluded by warning the majority against "'gerrymandering' the relevant product market so as to make it more susceptible to a structural presumption of liability."

Turning to that structural presumption, the full Commission (joined by Commissioner Rosch) easily found a likelihood of competitive harm by examining market shares and concentration levels. The Commission found those data "exceed the thresholds for presumptive illegality provided in the 2010 Horizontal Merger Guidelines and the case law." Indeed, ProMedica did not dispute that presumption. As a result, the burden shifted to ProMedica "to cast doubt on the accuracy of the Government's evidence as predictive of future anticompetitive effects." The Commission rejected ProMedica's efforts.

ProMedica's primary effort at rebuttal focused on St. Luke's economic health. ProMedica faced a daunting challenge: as the FTC noted, courts have concluded that "financial weakness, while

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<sup>8</sup> *In the Matter of* Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc., FTC Docket No. 9315, File No. 011 0234 (2007) available at [www.ftc.gov/os/adjpro/d9315/index.shtm](http://www.ftc.gov/os/adjpro/d9315/index.shtm)

perhaps relevant in some cases, is probably the weakest ground of all for justifying a merger, and certainly cannot be the primary justification for permitting one.” Nor did the evidence help that task. The Commission found St. Luke’s was actually turning its finances around in the year or so preceding the Joinder Agreement: it had hired a new CEO, it had begun implementing a new strategic plan, it had seen an increase in patient volumes, and by August 2010 it had realized a positive operating margin (albeit \$7,000). The Commission concluded ProMedica “has not shown that St. Luke’s financial condition so reduces its competitive significance as to undermine Complaint Counsel’s prima facie case.” Its “weakened competitor” evidence fell “far short of what the courts have demanded.”

The full Commission then surveyed evidence buttressing the structural presumption of illegality. Perhaps most problematically, every insurer testified that “the Joinder would further increase ProMedica’s bargaining leverage, thereby leading to even higher rates,” and that the remaining hospitals in the market would not be sufficient substitutes in the insurers’ opinions. The FTC did not discredit these opinions as biased, as ProMedica had argued.

Perhaps equally problematic were St. Luke’s internal documents, which the Commission found predicted increased reimbursement rates for St. Luke’s through enhanced bargaining leverage with insurers. Among other things, the documents noted the ProMedica affiliation could “harm the community by forcing higher hospital rates on them,” and allow St. Luke’s to “force high rates on employers and insurance companies.”

The Commission then turned to the economic evidence the parties presented at trial. The FTC’s economist predicted rates at St. Luke’s would increase to supra-competitive levels as a result of the transaction. Finding ProMedica to be St. Luke’s next-best substitute, the Commission agreed. The expert’s prediction of a price increase at ProMedica’s hospitals was not as clear-cut. The evidence showed St. Luke’s is not ProMedica’s closest substitute; instead, most ProMedica patients would choose to go to one of the Mercy hospitals after ProMedica. Nonetheless, the FTC’s economist constructed an econometric model that attempted to calculate insurers’ “willingness to pay” to include the various hospitals in their networks. From those calculations, the expert then predicted price increases of 16.2 percent in the aggregate, with prices rising 38 percent at St. Luke’s and 10.75 percent at ProMedica’s legacy hospitals. ProMedica and its economist strongly disputed the soundness of these conclusions. Nonetheless, the majority concluded this analysis “provides confirming evidence for the conclusion that the increased bargaining leverage created by the Joinder will lead to higher prices.”

Commissioner Rosch saved his strongest criticism for the majority’s reliance on this merger simulation evidence. First, he attacked the evidence as legally inappropriate, because St. Luke’s was not ProMedica’s next best substitute. As a result, he claimed, this evidence did not meet the courts’ test that “customers accounting for a ‘significant share of sales’ in the market must view the merger parties as each other’s closest substitutes.” Second, Commissioner Rosch attacked the reliability of the econometric evidence, noting critics “have charged that such studies always predict a price increase if there is any degree of substitution between the merging parties’ products.” In other words, such evidence can lead to false positives in assessing competitive impact, regardless of the actual substitution between the merging parties. Finally, Commissioner Rosch found the economic evidence unnecessary, both in this case and generally:

[T]he Commission has tried to persuade staff of the virtues of “telling a story” predominantly out of the mouths of the parties and their documents. This is how the top-flight plaintiff’s lawyers try their cases. We have much to learn from them. The Commission should be reluctant to focus attention instead on economic models especially when the Commission has devoted so much time and effort to insisting that staff focus on the real world as contrasted with the theoretical world.

Finally, the Commission rejected ProMedica’s evidence that insurers or other competitors might be able to constrain the combined entity from raising its prices. The Commission credited evidence that the insurers could not steer their customers to competitors and the other hospitals could not reposition themselves to capture market share from ProMedica/St. Luke’s.

As it had argued to the ALJ, ProMedica argued to the full Commission that if there were a violation the appropriate remedy would be to permit the Joinder but require separate, walled-off bargaining units for the ProMedica hospitals and for St. Luke’s. ProMedica argued this arrangement, which the FTC approved in the *Evanston* case, would allow St. Luke’s to gain financial stability while preventing any perceived anticompetitive effects. Like the ALJ, the Commission rejected this argument and instead concluded that structural remedies like divestiture are preferred once the FTC has found an illegal merger. The Commission noted a conduct remedy was appropriate in *Evanston* only because the parties had merged seven years before the FTC’s final decision and unscrambling the eggs would be nearly impossible, or at least very expensive. The Commission concluded the ProMedica/St. Luke’s joinder was not such an omelet, in large part because the parties had entered a hold separate agreement that the district court had extended with its preliminary injunction.

Alternatively, ProMedica argued it should not be forced to sell St. Luke’s but should be permitted simply to spin it off as an independent entity. The Commission disagreed, stating its order was broad enough to permit ProMedica to sell St. Luke’s to its previously independent parent and thus restore its status as an independent hospital.

### **3. That’s “Al-benny” to you: 11th Circuit Court Dismisses the FTC’s Challenge to Georgia Hospital Merger Under State Action Doctrine; FTC Files for Certiorari to the Supreme Court<sup>9</sup>**

In a ruling issued late in 2011, the Court of Appeals for the Eleventh Circuit dealt a serious blow to the Federal Trade Commission’s effort to reign in the ability of hospitals to use the state action doctrine to protect otherwise anticompetitive mergers and acquisitions from attack under the antitrust laws. The FTC responded by filing a cert petition in late March 2012 with the Supreme Court.<sup>10</sup>

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<sup>9</sup> Federal Trade Commission v. Phoebe Putney Health System, Inc., 663 F.3d 1369 (11th Cir. Aug. 9, 2011).

<sup>10</sup> Federal Trade Commission v. Phoebe Putney Health System, Inc. *Petition for Writ of Certiorari* (March 23, 2012) available at <http://www.ftc.gov/opa/2012/03/phoebeputney.shtm>.

The appellate court affirmed the dismissal, under the state action doctrine, of the FTC's complaint against the acquisition by Phoebe Putney Health System of Palmyra Park Hospital. The ruling immunizes from antitrust attack the consolidation of the only two acute care hospitals in a six-county region of rural southwestern Georgia.

For many years, the state-created Hospital Authority of Albany-Douglas County owned and operated Phoebe Putney Memorial Hospital in Albany, Georgia. In 1991, Phoebe Putney Health System and its subsidiary Phoebe Putney Memorial Hospital, Inc. – both nonprofit corporations created by the Authority – have leased Memorial Hospital from the Authority and operated the hospital semi-independently from the Authority.

Memorial Hospital's only competitor in a six-county geographic market was Palmyra Park Hospital, owned and operated by HCA, Inc. Between them, the two hospitals account for over 85% of acute care in their geographic market.

In April 2011, the Authority approved a plan by which it would acquire Palmyra Park Hospital. The Authority proposed to fund the acquisition with money provided by Phoebe Putney Health System, and then lease Palmyra Park back to the system or a subsidiary. The FTC attacked the structure of this transaction as a "strawman" designed for no reason other than to bring the transaction within the immunity of the state action doctrine.

The FTC sought to enjoin the transaction in federal court shortly after the Authority approved the deal. The agency claimed the deal would substantially lessen competition in the market for acute care hospital services in southwestern Georgia.

The hospitals moved to dismiss the complaint, asserting the transaction was immune from the antitrust laws under the state action doctrine. The district court agreed and dismissed the complaint with prejudice. The FTC sought an expedited appeal, and the Eleventh Circuit temporarily enjoined the transaction pending the outcome of that appeal.

Under the state action doctrine, courts consider whether state law authorizes the challenged conduct and whether state law "has clearly articulated a state policy authorizing anticompetitive conduct." The key inquiry under this standard is whether "anticompetitive conduct is a 'foreseeable result' of the legislation," that is, whether the anticompetitive conduct could be "reasonably anticipated" at the time of passage of the legislation. The Eleventh Circuit found both prongs of the standard were met.

Notably, the court assumed the merger would create a monopoly for acute care.

The court first surveyed the broad powers the Georgia legislature granted to public hospital authorities under the Georgia Hospital Authorities Law, passed in 1941. Through both expressly enumerated powers and a catch-all "necessary powers" clause in the statute, the court concluded "the Authority can in effect deploy any power a private corporation could in its stead," as well as deploy powers a private corporation could not (such as pricing its services below cost and making up the difference through tax revenues). Most importantly, the law expressly permits public hospital authorities to acquire other hospitals and to lease its hospitals to others for operation.



The court then reasoned it was foreseeable this broad grant of power to hospital authorities could have an effect on competition. According to the court, the economic realities of rural hospital districts made obvious the anticompetitive effects of hospital acquisitions within those districts:

[T]he Georgia legislature must have anticipated anticompetitive harm when it authorized hospital acquisitions by the authorities. It defies imagination to suppose the legislature could have believed that every geographic market in Georgia was so replete with hospitals that authorizing acquisitions by the authorities could have no serious anticompetitive consequences. The legislature could hardly have thought that Georgia's more rural markets could support so many hospitals that acquisitions by an authority would not harm competition.

The court did not rely on legislative history or contemporaneous market studies from the time of passage of the Hospital Authorities Law. Instead, the court reasoned that if a rural hospital district in 1941 was authorized to acquire a hospital within its district, the effect on competition should have been obvious to the legislature.

In so ruling, the court declined to consider the FTC's "strawman" argument. As it had done before the district court, the FTC urged the Eleventh Circuit to find that the structure of the transaction did not involve any genuine state action, but that the Authority simply provided a rubber stamp of a private transaction.

Following the Supreme Court's decision in *City of Columbia v. Omni Outdoor Advertising, Inc.*,<sup>11</sup> the Eleventh Circuit declined to "deconstruct the governmental process or probe the official intent to determine whether the government's decision-making process has been usurped by private parties." Supreme Court precedent requires courts to take government approval at face value when considering the state-action doctrine, and not "look behind governmental actions for perceived conspiracies to restrain trade."

## **B. Payor Mergers**

### **1. Advantage DOJ: Humana Agrees to Spin off Medicare Assets as Price of Acquiring Competitor<sup>12</sup>**

The Antitrust Division of the Department of Justice announced in late March 2012 a proposed consent decree that would require Humana Inc. and Arcadian Management Services Inc. to divest assets relating to Arcadian's Medicare Advantage business in parts of Arizona, Arkansas, Louisiana, Oklahoma and Texas in order for Humana to proceed with its acquisition of Arcadian.

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<sup>11</sup> 499 U.S. 365 (1991).

<sup>12</sup> *United States v. Humana Inc. and Arcadian Management Services*, (D.D.C. March 28, 2012) available at [www.justice.gov/atr/cases/humana.html](http://www.justice.gov/atr/cases/humana.html).

The Division claimed without the divestitures Medicare beneficiaries would likely have faced higher prices, fewer choices and lower quality options in the market for Medicare Advantage plans.

According to the complaint the Division filed simultaneously with the proposed consent decree, Humana and Arcadian are two of the few significant sellers of Medicare Advantage plans in 45 of counties and parishes in the five states where the divestitures will occur. The Division asserted the transaction would have created a combined company controlling between 40% and 100% of the Medicare Advantage health insurance market in these areas.

To avoid the perceived anticompetitive effects, Humana must promptly divest the Medicare Advantage plans in a slightly broader area of 51 counties and parishes to companies approved by the Division. The Division noted the divestitures encompassed a broader area than the 45 counties and parishes identified as presenting competitive concerns “to facilitate the divestiture of the plans” and to “make those plans more administrable.”

The proposed consent decree would require buyers of the divested Medicare Advantage plans contract with substantially all of the health care providers included in the Humana and Arcadian plans at substantially the same rates.

## **C. Other Mergers**

### **1. No Benefit to Enforcement: FTC Passes on PBM Merger<sup>13</sup>**

By a three-to-one vote, the Federal Trade Commission opted to close its investigation of the acquisition proposed by Medco Health Solutions of Express Scripts, Inc. The three commissioners in the majority found that the merged entity, despite enjoying a market share of at least 40% in the broadest possible market, nonetheless would be unlikely to raise prices unilaterally, to collude with others, or to exercise monopsony power when negotiating drug dispensing fees with pharmacists.

Medco and Express Scripts are pharmacy benefit managers. PBMs are third party administrators of prescription drug programs. They process and pay prescription drug claims, maintain drug formularies, contract with pharmacies, and negotiate discounts with manufacturers.

The Commission rejected the possibility that the acquisition might have an anticompetitive effect in the market for the provision of PBM services to health care benefit plan sponsors, including employers and unions. The Commission called this market “moderately concentrated,” with at least ten significant competitors. The merged company would have a share of this market, wrote the Commission, of just over 40%.

“Medco and Express Scripts are not particularly close competitors” in this market, wrote the Commission majority. Medco focuses on large employers while Express Scripts historically has

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<sup>13</sup> Statement of the Federal Trade Commission Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts, Inc., FTC File No. 111-0210 (April 2, 2012) available at [www.ftc.gov/os/2012/04/120402expressmedcostatement.pdf](http://www.ftc.gov/os/2012/04/120402expressmedcostatement.pdf).

targeted middle market plan sponsors and health plans. Interviews with customers and internal documents confirmed the conclusion that the two companies were not close competitors. CVS Caremark, along with Express Scripts and Medco, one of the “big three” in the PBM market, has provided robust competition to each of the merging parties. In fact, the Commission wrote, CVS Caremark was the closest competitor to each of Express Scripts and Medco. The Commission also noted that health plan owned and standalone PBMs have become stronger competitive threats over the last several years. Moreover, despite initial concerns that the big three PBMs might have a cost advantage over smaller companies, the Commission found the cost data submitted by PBMs did not support that conclusion.

“Ultimately,” the Commission concluded “the evidence fails to demonstrate that the transaction is likely to produce unilateral anticompetitive effects.” The Commission then turned to consider whether the merger may increase the likelihood that PBMs might collude, tacitly or explicitly, to raise price following the transaction.

The Commission concluded that the merger was unlikely to increase the possibility of anticompetitive collusion because coordination requires firms be able to reach agreements and monitor adherence to them. But because PBM contracts contain numerous pricing components and bids are rarely released, pricing terms for PBM services “are complicated and difficult to compare” and coordinated effects among PBMs would be difficult.

The Commission considered as well whether, as a result of the transaction, PBMs might be in a better position to allocate customers or refrain from bidding aggressively on each other’s business. Again the Commission concluded this was unlikely. The success of CVS Caremark in the marketplace suggested to the Commission that this company, in particular, will find it profitable to continue to compete vigorously rather than “pull its punches and participate in a coordinated allocation of customers.” The smaller, independent PBMs and PBMs owned by health plaintiffs also would have little incentive to collude because they have invested substantially in additional capacity and therefore need to grow.

Finally, the Commission turned to the question of whether the merger might permit the new firm to exercise monopsony power when it negotiates dispensing fees with retail pharmacies. The Commission found no such risk. The most significant factor on which the Commission relied to reach this result was market share. The merged firm would have a “smaller share of retail pharmacies’ sales – approximately 29% – than is ordinarily considered necessary for the exercise of monopsony power.” Moreover, the Commission wrote, “PBM size does not correlate to reimbursement rates paid to retail pharmacies.” The Commission concluded that savings in dispensing fees likely would be passed through to PBM customers. As a result, the transaction could lower health care costs.

The Commission also considered and rejected the notion that the merger might lead to anticompetitive effects with respect to specialty drugs. Apparently, some opponents of the transaction argued the new firm would be in a better position to demand exclusive distribution arrangements from manufacturers of such drugs. But the specialty pharmacy market, the Commission found, is substantially less concentrated than the overall market for PBM services. Dozens of specialty pharmacies operate in the specialty market.

Significantly, manufacturers of specialty drugs indicated that they seek exclusive distribution arrangements on occasion. The fact the manufacturers seek these, rather than the PBM, would suggest the arrangements are efficient and not anticompetitive.

The Commission concluded that the high market shares of the merging parties “do not accurately reflect the current competitive environment and are not an accurate indicator of the likely effects of the merger on competition and consumers.” This finding is significant because it underlines the basic antitrust point that while large market shares may signal a merger is anticompetitive, they are not conclusive evidence on this point.

Commissioner Julie Brill dissented from the decision.<sup>14</sup> In her view the acquisition violated Section 7 of the Clayton Act and Section 5 of the Federal Trade Commission Act. She wrote the merger would produce a “duopoly with few efficiencies in a market with high entry barriers.” Express Scripts is the country’s largest PBM with 90 million covered lives and Medco is the third largest with 65 million covered lives. CVS Caremark, with 85 million covered lives, is the second largest company. “After the merger,” wrote Commissioner Brill, “the merged entity will be over five times larger than the third largest firm.” According to Commissioner Brill, a market could be defined for “large commercial employers,” and in this market the merger would increase the Herfindahl-Hirschman Index (HHI) over 1,300 points taking the concentration level from 2,760 to 4,063.

Commissioner Brill argued that whether the relevant market were limited to the top 100 or the top 300 employers, or even the entire employer market, the new firm would have a 45% market share and the big three would have almost three-quarters of the market. In these markets, wrote Commissioner Brill, the HHI would also increase significantly by almost 1,000 points.

The Commissioner commented that she felt “some discomfort about unilateral effects from this merger.” In the arena of coordinated effects, however, she felt more strongly the merger “this merger creates an appreciable danger of anticompetitive effects.” To bolster her conclusions the Commissioner relied on statements made by Express Scripts’ and Medco’s CEOs. The majority took note of the same evidence in its opinion, commenting these statements were “ambiguous.”

The Commission investigation of the merger took eight months, resulted in the production of millions of pages of documents, and involved over 200 interviews of market participants by Commission staff.

## **2. FTC Sniffs, OmniCare Sneezes<sup>15</sup>**

OmniCare Inc. announced on February 21, 2012, that it had abandoned its effort to acquire rival PharMerica Corp. The decision came in the wake of an Federal Trade Commission challenge to the proposed deal between the two long term care pharmacy companies. The FTC had charged

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<sup>14</sup> Dissenting Statement of Commissioner Julie Brill FTC File No. 111-0210 (April 2, 2012) available at [www.ftc.gov/speeches/brill/120402medcobrillstatement.pdf](http://www.ftc.gov/speeches/brill/120402medcobrillstatement.pdf).

<sup>15</sup> *In the Matter of Omnicare, Inc.*, FTC Docket No. 9352, File No. 111 0239 (Order Dismissing Complaint, Feb. 23, 2012) available at [www.ftc.gov/os/adjpro/d9352/120223omnicareorder.pdf](http://www.ftc.gov/os/adjpro/d9352/120223omnicareorder.pdf).

their combination would lead to increased prices for prescription drugs sold to Medicare Part D participants living in skilled nursing facilities (so-called “SNFs”).

Residents in a SNF typically receive their prescription drugs from a long term care pharmacy located within the facility. Omnicare and PharMerica, who own and operate long term care pharmacies throughout the United States, contract with nursing facilities to provide pharmacy services. Many nursing facility residents offset the cost of their medication by participating in the federal government’s prescription drug insurance program under Medicare Part D. The Centers for Medicare & Medicaid Services require that health plans offering Part D insurance have contracts with long term care pharmacies to ensure health plan customers have convenient access to prescription drugs.

Omnicare made an unsolicited bid in September 2011 to acquire the outstanding shares of PharMerica, its primary competitor. PharMerica’s chief executive officer publically opposed the deal, valued at approximately \$760 million.

The FTC sued to block the proposed acquisition on January 27, 2012. A merger between the two, according to the agency, would “combine the largest and only two national long term care pharmacies in the country.” The FTC claimed that a combined Omnicare/PharMerica would serve nearly 60% of all licensed SNF beds in the United States and would become a must-have for Part D health plans seeking to meet CMS’ “convenient access” requirement. This would enable the company to increase prescription drug prices to what the FTC called, in its press release, the “fragile population” of SNF residents.

In its statement announcing the abandonment of the transaction, Omnicare wrote, “While we continue to strongly disagree with the FTC’s decision to seek to block the proposed transaction, we do not believe it is prudent to invest significant time and money in a lawsuit at this time.”

The company revealed it had offered to enter into a consent agreement with the FTC that would require divestitures, but apparently the agency did not consider the proposal sufficient to resolve its competitive concerns.

### **3. Lab Experiment Explodes: FTC Challenge to LabCorp Acquisition of California Rival Rebuffed<sup>16</sup>**

In early 2011, a federal judge in California denied the FTC’s request for a preliminary injunction that would have stopped the acquisition by LabCorp in California of Westcliff Medical Laboratories, Inc. pending resolution of FTC’s administrative complaint against the parties. Unable to stop the acquisition before the matter could be heard in an administrative proceeding, the FTC dropped its suit.

LabCorp – the second largest independent clinical laboratory company in the United States – announced in May 2010 it had agreed to purchase the assets of Westcliff, the third largest

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<sup>16</sup> Federal Trade Commission v. Laboratory Corporation of America and Laboratory Corporation of America Holdings, Case No. 8:10-cv-01873-AG-MLG (C.D. Cal. 2011) materials available at <http://www.ftc.gov/os/caselist/1010152/index.shtm>.

clinical laboratory in California, with operations focused primarily in Orange County. LabCorp agreed to pay \$57.5 million to buy Westcliffe, which meant that the acquisition was not reportable to the federal enforcement agencies under the Hart-Scott-Rodino Act.

Nonetheless, the FTC moved to investigate. In a hold-separate agreement, the parties agreed not to consummate the acquisition until 30 days after they had certified compliance with the CID. With the hold-separate agreement set to expire in early December 2010, the FTC acted at the end of November. The agency simultaneously filed an administrative complaint, alleging the acquisition would violate Section 7 of the Clayton Act and Section 5 of the FTC Act, and a complaint in federal court, seeking injunctive relief that would have extended the hold-separate agreement through the completion of the FTC's investigative hearing.

The court denied FTC's requested injunction despite the favorable standard for obtaining injunctive relief under § 13(b) of the FTC Act. Under that statute, the FTC does not have to make a showing of irreparable harm, as private litigants must to obtain injunctive relief. Instead, the FTC need show only a likelihood of success on the merits and the equities balance in favor of injunctive relief.

The court concluded that the FTC did not make either showing. The court made multiple factual findings supporting its conclusion that the FTC had not demonstrated it was likely to succeed on the merits.

- The court rejected the FTC's product market definition. The FTC would have treated capitated and fee-for-service clinical laboratory services as separate products. The court found as a matter of fact, and concluded as a matter of law, the methods by which consumers and payers pay for services do not define the product at issue, in this case clinical laboratory services.
- The court noted that FTC Commissioner J. Thomas Rosch had dissented from issuing the complaint in this matter. Commissioner Rosch called the product market definition in the complaint "misleading" because it turned on the means of payment, not the product being offered. The court found expansion of the product market to include all clinical laboratory services, regardless of the type of payment, "dramatically expands the number of competitors in the market and reduces LabCorp's and Westcliff's market shares significantly."
- The court appeared to reject the FTC's geographic market definition (which would have limited the market to Southern California), suggesting in its findings that the market might be statewide and that such expansion also would reduce the companies' combined market shares.
- The court made several findings suggesting low barriers to entry would preclude any anticompetitive effects as a result of the acquisition. Several competitors had begun providing clinical laboratory services in Southern California in recent years. The court even turned the FTC's product market against the agency and found that Westcliff itself had begun competing for capitated contracts in recent years and had become an effective competitor in a relatively short time. The court concluded that even if there were some

likelihood of anticompetitive concentration as a result of the acquisition, the low barriers to entry would effectively dilute that concentration.

- The court found several merger-specific efficiencies. The defendants presented evidence that clinical laboratories are high fixed-cost businesses and therefore increased volumes would allow LabCorp to offer lower capitated rates to purchasers. The court also noted evidence suggesting the acquisition would produce \$22 million in efficiencies through cost and supply savings. Defendants' expert estimated that those efficiencies would result in \$2.3 million in annual savings to consumers. The court made separate findings in support of its conclusion that balancing the equities "strongly favors defendants."
- The court again noted the efficiencies to be gained from the acquisition, and concluded reduced cost to consumers is the type of "public interest" most relevant to balancing the equities.
- The court paid particular attention to the length of time the injunction would likely remain in place pending the conclusion of the hearing on the merits. The court made specific findings about the length of the FTC administrative hearings, and found that despite efforts at reform, "that process remains a long, drawn-out ordeal." In the court's opinion, such delay would be particularly inequitable for the defendants given they could not receive compensation for the delay in the event they ultimately prevailed on the merits.
- Westcliff (renamed LabWest) had been losing money since the announcement of the acquisition. The court seemed particularly troubled by the "real possibility that a preliminary injunction here would financially devastate or destroy LabWest."
- Finally, the court found divestiture remained a possibility in the event the FTC prevailed on the merits.

As a result of all these factors, the equities favoring denial of the injunction "heavily outweighed" any minimal likelihood of success by the FTC.

The FTC immediately appealed the decision to the Ninth Circuit and simultaneously requested a stay pending appeal. On February 25, 2011, the district court denied the FTC's request for a stay. The Ninth Circuit also denied the FTC's request for a stay.

In March, the FTC withdrew its appeal. The FTC also agreed to postpone, but not dismiss the underlying administrative action. In the meantime, LabCorp and Westcliff remained free to integrate their operations.

Commissioner Julie Brill dissented from the Commission's decision. Brill identified three issues she believed the appeal would resolve notwithstanding the mootness of the injunction. First, Brill believed the district court ignored internal evidence of the parties' intention to raise prices after the merger. Given the prominent role such evidence plays in the agencies' new Horizontal Merger Guidelines, Brill wanted to give the court of appeals the opportunity to determine the effect of such evidence on requests for injunctive relief. Second, the dissent claimed the district

court had valued the parties' private interests over the "public equities" that injunctive relief by FTC is intended to protect. Third, Brill noted "pre-integration relief is often far more likely to remedy competitive problems than post-integration divestiture," and wanted the Ninth Circuit to make this clear.

Perhaps most significantly, Brill would have persevered with the appeal because "vigorous antitrust enforcement" will help contain rising health care costs. In Brill's view, "an appeal in this case is worth the expenditure of resources because of the industry in which it arises."

In April 2011, the FTC withdrew its administrative complaint, finding that further adjudication would not serve the public interest.

#### **4. No Standing Ovation: Court Affirms Dismissal of FTC's Claims in Pharma Merger<sup>17</sup>**

In August 2011, the Eighth Circuit Court of Appeals affirmed the judgment a district court entered against the FTC and the Minnesota Attorney General after the agencies challenged the purchase by pharmaceutical company Lundbeck Inc. of a drug that gave it control of the only two drugs approved for treatment of potentially deadly congenital heart defect affecting low-birth weight premature infants. The court held the FTC had not supported its proposed product market, a fatal flaw in its proof during the bench trial.

There are only two treatments for the heart defect, known as patent ductus arteriosus (PDA): pharmacological treatment or surgical ligation if pharmacological intervention fails. Lundbeck (through its predecessor, Ovation) acquired one of the approved drugs (Indocin IV) in 2005. It acquired the other (NeoProfen) in 2006. Within two years, Lundbeck raised the price of Indocin twenty-fold (from nearly \$78 to more than \$1,614 per treatment), and introduced NeoProfen to market at a similarly high price.

The FTC challenged Lundbeck's acquisition of NeoProfen, arguing this foreclosed competition. The agency sought to prove Lundbeck had obtained a monopoly by acquiring the only two drugs approved for pharmacological intervention of PDA, and had exercised its monopoly power by raising prices precipitously. The court of appeals, however, affirmed the district court's finding that FTC failed to meet its burden to prove the relevant product market.

The trial court had relied primarily on the testimony of neonatologists, who are responsible for choosing which drug to use to treat PDA. The trial court found the neonatologists were not sensitive to the price of the drugs, because they were not the purchasers of the drug. As a result, the court found that the FTC failed to show demand substitution – i.e., that consumers would shift from one drug to the other in response to changes in their relative cost. "[A]n increase in the price of Indocin IV would not drive a hospital to purchase NeoProfen, and vice versa."

Although the FTC argued the district court erred in ignoring the role hospitals played in the purchasing decisions, the court of appeals nonetheless affirmed the district court's findings

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<sup>17</sup> FTC v. Lundbeck, Inc., 650 F.3d 1236 (8th Cir. August 19, 2011).



because “[t]he FTC offers no evidence that hospitals would disregard the preferences of the neonatologists and make purchasing decisions based on price.” The appellate court also noted that the district court gave little weight to the functional equivalency of the two drugs and to internal Lundbeck documents suggesting Indocin and NeoProfen are in the same market.

One judge wrote, in a concurring opinion, “the standard of review carries the day in this case as it does in so many others.” This judge, however, found it “perplexing” the district court would place so much weight on the testimony of prescribing doctors who did not have to pay for the drugs they ordered. “In an antitrust case, it seems odd to define a product market based upon the actions of actors who eschew rational economic considerations.” But the court of appeals reviewed the district court’s consideration of the evidence under the “clearly erroneous standard,” and whether the court of appeals would have come to the same conclusion was “irrelevant.”

## **5. Footprint Shrinks: FTC Requires Divestiture of Psychiatric Facilities in Delaware, Puerto Rico and Las Vegas<sup>18</sup>**

In April 2011, the FTC entered a consent decree conditioning the acquisition of Psychiatric Solutions, Inc. by Universal Health Services, Inc. on the divestiture of 15 psychiatric facilities in Delaware, Puerto Rico, and Las Vegas.

Psychiatric Solutions and UHS agreed to merge in May 2010. UHS owns or operates 25 general acute care hospitals and 102 behavioral health facilities in across the nation. PSI operates 94 inpatient behavioral health facilities.

The FTC argued in the complaint accompanying the consent agreement that the acquisition would merge the two largest providers of acute inpatient psychiatric services in the Delaware, Puerto Rico, and metropolitan Las Vegas, NV markets. Acute inpatient psychiatric services is defined as “inpatient psychiatric services for the diagnosis, treatment, and care of patients deemed, due to an acute psychiatric condition, to be a threat to themselves or others or are unable to perform basic life functions.”

### **D. FTC Enforcement Actions**

#### **1. Through Clenched Teeth: FTC Rules against North Carolina Dental Board<sup>19</sup>**

Affirming a decision issued by an administrative law judge, the Federal Trade Commission held that the North Carolina Board of Dental Examiners violated Section 5 of the FTC Act when it acted to prevent non-dentists from providing teeth-whitening services in North Carolina.

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<sup>18</sup> *In the Matter of Alan B. Miller; Universal Health Services, Inc., and Psychiatric Solutions, Inc.*, FTC Docket No. C-4309, File No. 101 0142, available at <http://www.ftc.gov/os/caselist/1010142/index.shtm>.

<sup>19</sup> *In the Matter of The North Carolina Board of Dental Examiners*, FTC Docket No. 9343, File No. 081-0133, available at <http://www.ftc.gov/os/adjpro/d9343/index.shtm>.

The FTC complaint charged the Board colluded “to exclude non-dentists from competing with dentists in the provisions of teeth-whitening services.” The eight-member Board, six of whom are dentists, had declared that when non-dentists provided teeth-whitening services they were engaged in the unauthorized practice of dentistry.

The Board filed a motion before the FTC to dismiss the complaint on grounds it was immune from antitrust attack under the state action doctrine. The FTC denied the motion. The Commission held that active state supervision requires a proper demonstration that the Board was both “fiscally disinterested and politically accountable” because a majority of its members were market participants. When the Board failed to demonstrate this supervision the FTC held it was not entitled to antitrust immunity.

The Board then sought to enlist a federal district court in its efforts to block the FTC’s administrative proceeding. The court refused to do so and the matter proceeded to trial before an administrative law judge.

The ALJ found the board’s members were had an economic interest in the matter and that their actions reduced competition by reducing sales of teeth-whitening products, causing non-dentist providers to leave the market, and limiting choices available to consumers. The judge rejected all claims that the restrictions were justified by procompetitive efficiencies. The Board had argued its ban protected the public from insufficiently qualified tooth whiteners.

On appeal, the Commission agreed with the ALJ and found the Board’s actions violated the FTC Act. The Commission rejected the board’s claim that its individual members were not separate actors, holding they were actual or potential competitors and thus liable for anticompetitive collusion. Using a “quick look” approach, the Commission dismissed the Board’s claimed efficiencies. The Commission said the claim that the restraint would improve public health and safety was not cognizable under the Sherman Act but that even if it was, no scientific evidence supported the claim.

The Board is now seeking review in the Fourth Circuit.

## **2. Yellow Dogs: FTC Enters Consent Decree with Amarillo Physicians<sup>20</sup>**

In May 2011, the FTC announced it had entered yet another consent decree with yet another physician group that allegedly was bargaining collectively with payors. As with prior consent decrees, the proposed order would prohibit the provider network from negotiating on behalf of its members, with exceptions for contracting on a capitated basis and for entering into “qualified risk-sharing” or “qualified clinically integrated” joint arrangements, as defined in the order.

Southwest Health Alliances Inc., d/b/a BSA Provider Network, is a physician-hospital organization located in Amarillo, TX. BSA included twenty-five hospitals, a handful of

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<sup>20</sup> *In the Matter of Southwest Health Alliances, Inc., doing business as BSA Provider Network, a Texas corporation*, FTC File No. 091 0013, available at [www.ftc.gov/os/caselist/0910013/index.shtm](http://www.ftc.gov/os/caselist/0910013/index.shtm).

employed physicians, and multiple independent physician practices with approximately 900 members, including approximately 300 primary care physicians.

BSA operated lawful “messenger model” negotiations on behalf of its members, but its members continued to sell their services independently on a fee-for-service basis, and so were not financially integrated.

The complaint alleged that BSA unlawfully deviated from the messenger model when it negotiated independently with its members to set a fee schedule that it then used as a signaling device as to whether members should accept or reject payors’ offers. BSA also allegedly renegotiated prices collectively on behalf of its members that were originally set independently (and lawfully) through the messenger model. Finally, the FTC alleged BSA unilaterally raised prices in a joint fee schedule – set through a lawful “reverse messenger” model – without independently asking its members the price at which they would accept offers. Because the IPA members were not integrated clinically or financially, the FTC claimed their actions were nothing more than horizontal price fixing.

### **3. Gopher It: FTC Enters Consent Decree with Minnesota Physicians<sup>21</sup>**

In June 2010, the FTC announced a consent decree with the Minnesota Rural Health Cooperative, a group representing most of the hospitals and 50% of the primary care physicians in southwestern Minnesota. The MRHC required that its board of directors negotiate on behalf of all its members, it used coercive tactics in negotiations with payers, and it obtained higher reimbursement rates than comparable providers and more favorable payment methods. The group entered into the usual stipulations in the consent order.

## **E. DOJ Enforcement Actions**

### **1. Sacrificing the Firstborn: Department of Justice and State of Montana Object<sup>22</sup>**

A group of hospitals in Montana that started a health plan to compete with the dominant payor in that state agreed to divest the health plan’s commercial insurance business to resolve a lawsuit filed by the U.S. Department of Justice and the Montana Attorney General’s Office. The antitrust enforcers claimed the hospitals violated antitrust laws when they entered into an agreement with Blue Cross Blue Shield of Montana (BCBS) that hamstrung the ability of the hospitals’ own health plan to compete.

The Department and Montana Attorney General filed a complaint on November 8, 2011, in federal court in Montana against BCBS, the state’s largest health insurer, New West Health

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<sup>21</sup> *In the matter of Minnesota Rural Health Cooperative*, FTC File No. 051 0199 (June 18, 2010) available at [www.ftc.gov/os/caselist/0510199/index.shtm](http://www.ftc.gov/os/caselist/0510199/index.shtm).

<sup>22</sup> *United States and State of Montana v. Blue Cross and Blue Shield of Montana, Inc., Billings Clinic, Bozeman Deaconess Health Services, Inc., Community Medical Center, Inc., New West Health Services, Inc., Northern Montana Health Care, Inc., and St. Peter’s Hospital*, No.1:11-cv-00123-RFC (D. Montana) available at [www.justice.gov/atr/cases/bcbsmnw.html](http://www.justice.gov/atr/cases/bcbsmnw.html).

Services, Inc., a non-profit, provider-sponsored health plan that has become the Montana's third largest insurer, and five of the six hospitals that formed New West.

The Department and Attorney General filed a proposed stipulated judgment on the same day. If the judgment is approved by the court, New West must sell its commercial insurance to PacificSource Health Plans of Oregon.

The complaint alleges that after the hospitals founded New West in 1996, the company became a vigorous competitor in the offering of health insurance in Montana. BCBS reduced its prices in order to maintain its competitive position. Despite this competition, the complaint alleges, BCBS retained a market share of between 43% and 75% in the commercial insurance markets in the cities where New West's hospital owners operate. The complaint states New West's share did not exceed 12% in those markets.

Against this background, the Department and Attorney General charged BCBS agreed to pay the hospitals \$26 million if they purchased health insurance for their employer group health plan from BCBS, rather than from New West. BCBS also promised the hospitals two seats on the BCBS board of directors if the hospitals did not "own or belong to an entity that competes" with BCBS in the sale of commercial health insurance.

One of New West's hospital owners operates in Great Falls, Montana's third largest city, and already used BCBS for its employees, independent of the agreement prompting DOJ's investigation. That hospital was not named a defendant in the case.

The complaint alleges separate product markets for group and individual health insurance coverage, but analyzes concentration and effects in an undifferentiated market for "commercial insurance." According to the complaint, New West was the "only significant competitor" in the geographic areas covered by the agreement.

The Department of Justice and Attorney General asserted the agreement between BCBS and the hospitals was likely to eliminate New West as a viable competitor in the sale of commercial health insurance. The complaint identifies three factors that would have caused New West to exit the market for commercial health insurance in the five geographic regions where the hospitals are located:

- First, the complaint alleges the agreement would remove the owners' direct support for New West. The hospitals are some of the largest employers in their respective markets. Moving their employees from New West to BCBS would eliminate one-third of New West's enrollees while simultaneously increasing BCBS's already substantial market shares. Similarly, the complaint alleges the payment and the seats on BCBS's board would reduce the hospitals' incentives to win commercial business for New West.
- Second, the complaint alleges the agreement would lead to the perception that New West was failing because its owners had abandoned it, thus speeding its demise by encouraging other employers to stop purchasing insurance from New West. Indeed, according to the complaint, several employers switched from New West to BCBS after the deal was announced.

- Third, the complaint avers the agreement would create a barrier to new insurers entering the market for commercial insurance. All hospitals had to participate for the agreement to be effective; if one hospital did not move its employees to BCBS, none of the hospitals would receive the payment. The exclusive arrangement between these large employers in four of the largest cities in Montana (Billings, Bozeman, Missoula and Helena) and BCBS, according to the complaint, would make it difficult for any new health insurers to enter the market.

The proposed stipulated judgment filed by the Department and Attorney General is notable for the relief it provides. The antitrust enforcers did not propose to block the hospitals from transferring their employees to BCBS, or from sitting on the BCBS board nor, presumably, from making the \$26 million payment. Instead, if the judgment becomes final, New West will be required to divest its commercial insurance business to another insurer, PacificSource. The stated purpose of the proposed relief is to give PacificSource an opportunity to become a viable competitor in the sale of health care in Montana.

New West's divested assets include both fully insured commercial products and administrative services contracts, but do not include its Medicare Advantage contracts. New West also will commit its executives to exercise their best efforts to maintain New West as a viable business with a sufficient number of enrollees during the divestment period, and it will establish an incentive pool to promote those efforts. Divestiture must occur within 30 days of filing the complaint.

The judgment will provide PacificSource with an established network of providers. The hospital defendants have agreed to contract with PacificSource for three years "on terms that are substantially similar to their existing contractual terms with New West." Similarly, New West also must lease its provider network to PacificSource for a period of three years. New West and the hospital defendants must provide support to PacificSource during the transition period.

The judgment limits the contracting activities of BCBS. The insurer must give the Department and Attorney General 30 days' notice of any exclusive deals with insurance brokers or health care providers, as well as 30 days' notice of any most favored nation clauses entered with providers. This notice period would allow either government agency to issue a civil investigative demand or challenge the provisions. These requirements last for six years.

## **2. Out of Favor: Court Sustains DOJ's Complaint against Michigan BCBS<sup>23</sup>**

In June 2011, a federal judge in Michigan denied Blue Cross Blue Shield of Michigan's motion to dismiss a lawsuit filed by the U.S. Department of Justice and the Michigan Attorney General challenging Blue Cross's use of most-favored nations clauses in its contracts with hospitals. The opinion flatly rejected every argument Blue Cross advanced.

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<sup>23</sup> United States v. Blue Cross Blue Shield of Michigan, No, 2:10-14155-DPH-MKM (filed Oct. 18, 2010) available at [http://www.justice.gov/atr/public/press\\_releases/2010/263227.htm](http://www.justice.gov/atr/public/press_releases/2010/263227.htm).

DOJ's suit against Blue Cross challenges two types of "MFN clauses": "MFN-plus" clauses that guarantee Blue Cross discounts from hospital charges greater than those afforded any of its competitors, and the more common "equal-to" clauses that guarantee Blue Cross discounts in an amount at least as great as provided to any of its competitors. DOJ alleged these clauses prevent Blue Cross's competitors from entering the various localized markets for health insurance in Michigan and thereby keep prices higher than they otherwise would be without the clauses.

For example, the complaint alleged an MFN-plus clause in Blue Cross's contract with the only tertiary care hospital in Michigan's Upper Peninsula required the hospital to charge competing insurers at least 23% more than it charged Blue Cross, thereby insulating the Upper Peninsula insurance market from competition.

Blue Cross responded to the complaint with a motion to dismiss.

Blue Cross argued that DOJ had not alleged product and geographic markets with sufficient specificity. The court disagreed. The court found that the complaint plausibly alleged product markets in commercial group health insurance and commercial individual health insurance, and concluded that the complaint need not include detailed allegations about the two markets, participants within those markets, or the products those participants offer. Turning to the allegations of geographic markets, the court rejected Blue Cross's argument that the markets were national based on the national availability of capital. Instead, the court concluded, the complaint plausibly alleged local markets because employers and insureds cannot practicably turn to insurers who do not offer local providers in their networks. The court found the complaint's reliance on statistical data (such as metropolitan statistical areas) sufficient to state plausible geographic markets at the pleading stage.

The court found no fault with the complaint's allegations of market power and anticompetitive effects. Surveying allegations that Blue Cross had between 40% and 80% market share in the various markets alleged and that Blue Cross had successfully excluded competitors, as well as Blue Cross's own admission that it is the "dominant provider" in Michigan, the court found the allegations of market power were plausible.

Turning to the possible effects of that power, the court declined to balance the possible procompetitive benefits of MFNs at the pleading stage, and focused instead on the complaint's allegations that the MFN clauses had raised competitors' costs, increased premiums, and increased the costs of insurance to employers and consumers. In its analysis of effects, the court focused primarily on the MFN-plus clauses, noting that those clauses required Blue Cross's competitors to pay substantially more for healthcare in certain markets than did Blue Cross. Finally, the court noted that the plausibility of possible harm from the MFN clauses because of the alleged exclusion of competitors from certain markets. Again, the court pointed to an example of exclusion arising from the alleged operation of an MFN-plus clause with Marquette Hospital in Michigan's Upper Peninsula. The court's analysis suggests it was most troubled by the effect of the MFN-plus clauses, particularly in rural markets.

The court then addressed several defenses asserted by Blue Cross, and rejected them all. The court first disposed of Blue Cross's argument that its clauses were exempt from the antitrust laws

under Michigan’s Antitrust Reform Act. That Act exempts healthcare transactions, including insurance transactions, “when the transaction or conduct is to reduce the cost of healthcare and is permitted by the [insurance] commissioner.” Because the complaint alleged that the effect of the MFN clauses was to increase cost, and because Blue Cross could not submit contrary evidence on a motion to dismiss, the court concluded Blue Cross had not established its entitlement to exemption.

The court then rejected a similar argument that Blue Cross is entitled to immunity under the state action doctrine. Blue Cross argued a Michigan law regulating nonprofit healthcare corporations provided the express legislative intention to displace competition and the active supervision necessary to confer state action immunity on private entities. The court disagreed. The court found no intent to displace competition in Michigan’s Nonprofit Healthcare Corporation Reform Act and instead found the Act’s purpose is “to secure for all the people of this state . . . the opportunity for access to healthcare services at a fair and reasonable price.” The court found no intent to discourage competition between insurers or to shift the costs of healthcare between insurers. The court also found no evidence that the Michigan Insurance Commissioner actively supervised the conduct at issue by reviewing and approving Blue Cross’s contracts or the MFN clauses within them.

The court declined to abstain from considering the complaint because it found there was no likelihood that the insurance commissioner would in fact review Blue Cross’s MFN clauses.

Blue Cross sought interlocutory review but this was denied by the Sixth Circuit.<sup>24</sup> Blue Cross now is seeking review *en banc*.

### **3. The One and Only Section 2 Case: DOJ Challenges Hospital Monopolist in Wichita Falls, Texas<sup>25</sup>**

In the only case brought under Section 2 of the Sherman Act since the Obama administration came to office, the Antitrust Division (along with the State of Texas) sued a hospital in Wichita Falls, Texas, for monopolization.

The complaint, filed in February 2011, alleged that the hospital, United Regional Health Care System, monopolized the markets for general acute care inpatient hospital services and outpatient surgical services. The agencies and the hospital entered into a consent decree settling the charges at the same time the complaint was filed.

The crux of the government attack was the contract terms United Regional had extracted from commercial payors.

United Regional is a 369-bed acute-care hospital and Level III trauma center. United Regional was formed in October 1997 by the merger of Wichita General Hospital and Bethania Regional

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<sup>24</sup> Nos. 11-1984/2279 (6th Cir. Feb. 23, 2012).

<sup>25</sup> *United States v. United Regional Health Care System*, Case No.: 7:11-cv-00030-O (September 29, 2012) available at <http://www.justice.gov/atr/cases/unitedregional.html>.

Health Care Center, the only two general acute-care hospitals in Wichita Falls at the time. The parties had obtained an exemption from the Texas legislature to consummate the transaction.

The only other hospital in Wichita Falls is Kell West Regional Hospital, a 41-bed, general acute care hospital that opened in January 1999. Kell West does not offer cardiac surgery or obstetrics. There are two other hospitals in the Wichita Falls MSA. Electra Memorial Hospital is a 22-bed hospital in Electra, more than 30 miles west of the city of Wichita Falls. Clay County Memorial Hospital is a 25-bed hospital in Henrietta, more than 15 miles east of Wichita Falls. According to the DOJ's complaint, both Electra Memorial and Clay County Memorial offer a narrower range of inpatient and outpatient surgical services than either United Regional or Kell West.

The government alleged United Regional had market shares giving it monopoly power in two product markets: (1) a 90% share of general acute-care inpatient hospital services; and (2) a 65% share of outpatient surgical services. Further, according to the government, commercial payors consider United Regional a "must have" hospital in their networks because it is the largest hospital and the only provider of certain services such as cardiac surgery, obstetrics, and high-level trauma cases.

The fact of high market shares, however, is not what drove the government's investigation. Instead, the government focused on the "exclusionary contracts" United Regional entered into with payors that, according to DOJ, "effectively prevent insurers from contracting with United Regional's competitors." The government charged United Regional financially punished payors if they included other hospitals or surgical centers in their networks. United Regional provided higher discounts off billed charges for exclusivity within the payor's network, and a much lower discount if the payor added other hospitals or outpatient surgical providers to its network. The government alleged that the penalty for adding an additional hospital or outpatient surgical provider to a payor's network ranged from 13% to 27%.

Relying on testimony from payors, the government alleged United Regional charged monopoly prices. One payor reported payments for inpatient hospital services in Wichita Falls were at least 50% higher than comparable Texas cities. Another payor estimated United Regional's negotiated rates were 70% more than hospitals in the Dallas-Fort Worth area. The government also pointed to evidence that United Regional's reimbursement rate for inpatient stays was 70% higher than its closest competitor, Kell West.

The consent decree prohibits United Regional from conditioning prices or discounts to commercial payors on whether those payors contract with other providers. The decree also prohibits United Regional from preventing payors from entering into agreements with its competitors or taking any retaliatory action from doing so.

#### **4. Step On It: DOJ Enters Consent Decree with Idaho Orthopedists<sup>26</sup>**

In May 2010, DOJ announced a consent decree with Orthopedists in the Boise, Idaho area. The complaint alleges that competing physicians had conspired to refuse to treat patients covered by

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<sup>26</sup> United States v. Idaho Orthopedic Society, No. 10-268-SEJL (D. Idaho Aug. 30, 2010) (final judgment) available at [www.justice.gov/atr/cases/idortho.htm](http://www.justice.gov/atr/cases/idortho.htm).



Idaho's workers' compensation system in an effort to increase reimbursement from that system. This classic group boycott restricted the supply of orthopedic services and increased the price of those services. The physicians also entered the usual stipulations with the FTC.

## **F. Federal Policy Activities**

### **1. FTC: Hospital Mergers Do Not Increase Quality<sup>27</sup>**

In November 2010, FTC economists released an analysis of the effects on clinical quality of the acquisition of Highland Park Hospital by Evanston Northwestern Healthcare in 2000. The study found "little evidence that the merger improved quality" at Highland Park.

The economists used a "difference-in-differences" analysis of risk-adjusted mortality and complication rates for a number of clinical conditions. Such an analysis compares the difference in outcomes between the merged parties and a control group before the merger with the difference in outcomes between the merged parties and a control group after the merger. The economists studied quality outcomes in four categories according to the claims made by the hospitals during the FTC's challenge to the merger: (1) cardiac surgery and interventional cardiology; (2) advantages of teaching hospitals; (3) nursing-sensitive indicators; and (4) obstetrics.

### **2. Massachusetts AG: Hospital Mergers Lead to Higher Prices<sup>28</sup>**

In response to a legislative directive, the Massachusetts Attorney General submitted a report to the Legislature in 2010 that asserted an "unequivocal 'no'" to the "threshold question ... whether we can expect the existing health care market in Massachusetts to successfully contain health care costs." The study surveyed the Massachusetts health care marketplace and concluded:

- Prices paid by health insurers to hospitals and physician groups vary significantly within the same geographic area and among providers offering similar levels of service.
- Price variations are not correlated to quality of care, the sickness of the population or complexity of the services provided, the extent to which a provider cares for a large portion of patients on Medicare or Medicaid, or whether a provider is an academic teaching or research facility.

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<sup>27</sup> A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare, Patrick S. Romano, David J. Balan, Working paper No. 307 (November 2010) available at [www.ftc.gov/be/workpapers/wp307.pdf](http://www.ftc.gov/be/workpapers/wp307.pdf).

<sup>28</sup> Office of Attorney General Martha Coakley, *Examination of Health Care Cost Trends and Cost Drivers*, (March 16, 2010); Thomas M. O'Brien, Office of Attorney General Martha Coakley, Letter to Brent Henry at Partners HealthCare System, Inc. (June 25, 2010) available at [www.mass.gov/ago/docs/healthcare/final-report-w-cover-appendices-glossary.pdf](http://www.mass.gov/ago/docs/healthcare/final-report-w-cover-appendices-glossary.pdf). See also Robert A. Berenson, Paul B. Ginsburg, and Nicole Kemper, *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, Health Affairs, Vol. 29, No. 4, April 2010.

- Price variations are not adequately explained by differences in hospital costs of delivering similar services at similar facilities.
- Instead, price variations are correlated to market leverage (measured as the relative market position of a provider compared to similar providers in a geographic region).
- And global payment methods don't help rein in costs: variation in total medical expenses on a per member per month basis is not correlated to the methodology used to pay for health care. Sometimes total medical expenses are higher for risk-sharing providers than for providers paid on a fee-for-service basis.
- Higher priced hospitals are gaining market share at the expense of lower priced hospitals, which are losing volume.

### 3. Hospitals: Mergers Do *Not* Lead to Higher Prices<sup>29</sup>

In March 2011, economists not affiliated with the FTC concluded that differences in hospital prices are attributable primarily to hospital expenses, not market power, as the Massachusetts study discussed above suggested. The study was sponsored by the American Hospital Association.<sup>30</sup>

Examining historical data, the study concludes that costs are the primary driver of hospital prices. And the primary component of hospital costs, the economists assert, are labor costs, including “salaries and benefits for physicians, nurses, technicians, and numerous other personnel.” The study notes that capital investments, such as investments in technology, have contributed to the rise in hospital prices as well. Over the past decade, “hospital revenues closely tracked cost increases, each increasing by roughly 5% per year.” From the data, the authors conclude, “revenues are closely tracking costs, and . . . costs are key factors driving hospital price increases.”

The authors also report empirical analyses of factors explaining price differences among hospitals. Those analyses included studies of published literature discussing hospital price, as well as an econometric evaluation of price differences. From these analyses, the authors identify objectively verifiable factors that account for differences in hospital prices: “factors such as case mix, regional costs, hospital characteristics, resource utilization, characteristics of the population, and other factors explain a very large proportion – up to 72% of the differences in hospital prices for non-Medicare services across the U.S., and a large proportion of the variability in Medicare and all-payor prices.”

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<sup>29</sup> *Assessment of Cost Trends and Price Differences for U. S. Hospitals*, Compass Lexecon (March 2011) available at <http://aharesourcecenter.wordpress.com/2011/03/09/hospital-cost-drivers-market-power-and-pricing-relationship-to-hospital-prices/>; see also *A Critique of Recent Publications on Provider Market Power* Compass Lexecon (October 4, 2010) available at [www.aha.org/content/00-10/100410-critique-report.pdf](http://www.aha.org/content/00-10/100410-critique-report.pdf).

<sup>30</sup> See <http://aharesourcecenter.wordpress.com/2011/03/09/hospital-cost-drivers-market-power-and-pricing-relationship-to-hospital-prices/>.

While the authors concede they could not account for all factors contributing to price differences, they nonetheless conclude market power is not likely among those factors: “as a matter of economics, it is incorrect that any residual price differences reflect some form of inefficiency or market power.”

By focusing on cost and eliminating “automatic” correlations between market power and price differentials, the authors suggest their research makes the case for increased efficiencies: “the research demonstrates a link between improving care coordination, cost reduction, and lower prices.”

#### **4. FTC Bureau of Competition: Legislation that Reduces Competition Is Bad**

The FTC was busy on the legislative front, providing comments regarding numerous state proposals that might reduce competition in health care:

- The FTC wrote the Maine Board of Dental Examiners (November 2011) arguing that x-ray restrictions imposed on independent practice dental hygienists proposed as part of a pilot test program designed to provide dental services to underserved areas of Maine would lessen competition and reduce the effectiveness of the program.<sup>31</sup>
- The FTC voiced concerns about New York legislation (August 2011) that would reduce the availability of mail order pharmacies.<sup>32</sup>
- The FTC condemned proposed legislation in Texas (May 2011) that would insulate “healthcare collaboratives” from federal and state antitrust laws, and similar legislation in Connecticut (June 2011) that would exempt health care cooperatives from the antitrust laws.<sup>33</sup>
- The FTC encouraged Florida (March 2011) and Texas (May 2011) to approve legislation that would make it easier for APRNs to practice in the state.<sup>34</sup>
- The FTC warned the Mississippi House of Representatives (March 2011) that proposed legislation moving regulation of pharmacy benefit managers from the

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<sup>31</sup> FTC Letter to Teneale E. Johnson (Nov. 16, 2011) available at [www.healthlawyers.org/Members/PracticeGroups/Antitrust/emailalerts/Documents/111214mainedental.pdf](http://www.healthlawyers.org/Members/PracticeGroups/Antitrust/emailalerts/Documents/111214mainedental.pdf).

<sup>32</sup> FTC Letter to Hon. James L. Seward (August 8, 2011) available at [www.ftc.gov/os/2011/08/110808healthcarecomment.pdf](http://www.ftc.gov/os/2011/08/110808healthcarecomment.pdf).

<sup>33</sup> FTC Letter to Representative Elliott Naishtat (May 18, 2011) available at [www.ftc.gov/os/2011/05/1105texashealthcare.pdf](http://www.ftc.gov/os/2011/05/1105texashealthcare.pdf); [www.ftc.gov/os/2011/06/110608chc.pdf](http://www.ftc.gov/os/2011/06/110608chc.pdf).

<sup>34</sup> FTC Letter to Hon. Daphne Campbell (May 11, 2011) available at [www.ftc.gov/os/2011/03/V110004campbell-florida.pdf](http://www.ftc.gov/os/2011/03/V110004campbell-florida.pdf); FTC Letter to Hon. Rodney Ellis and Hon. Royce West (May 11, 2011) [www.ftc.gov/os/2011/05/V110007texasaprn.pdf](http://www.ftc.gov/os/2011/05/V110007texasaprn.pdf).

Office of the Insurance Commissioner to the authority of a Pharmacy Board composed of pharmacists might reduce competition and increase drug prices.<sup>35</sup>

- The FTC urged Alabama (November 2010) and Tennessee (September 2011) to reject rules and legislation that would restrict the practice of pain management to physicians, thereby excluding CRNAs from practice.<sup>36</sup>

## **G. State Activities**

### **1. New York, New York: No Market For You<sup>37</sup>**

A very long time ago (2005) two health insurance carriers, Group Health Incorporated (“GHI”), and HIP Foundation/Health Insurance Plan of Greater New York (together, “HIP”), announced a merger and their intent to convert from nonprofit to for-profit status. After the Department of Justice and New York’s attorney general decided not to challenge the merger, the City of New York sued to permanently enjoin the merger under federal and state antitrust laws.

GHI’s and HIP’s plans cover a vast majority of the employees in the City’s health benefits program and the City’s concern focused on the risk that the merger of the carriers would reduce competition, with the result of higher health insurance premiums being paid by the City.

The City unsuccessfully sought a temporary restraining order and the merger was consummated. Discovery ensued. Years passed. In December, 2009, Defendants moved for summary judgment arguing that market alleged by the city – a “low-cost municipal health benefits market” that included only those insurance plans that are inexpensive and that the City selects for inclusion in the Health Benefits Program – is legally insufficient. Days before its opposition papers were due, the City sought to amend its complaint to include all health benefits plans operating in downstate New York. The City also sought to base its claim on the “Upward Pricing Pressure” test, which analyzes the effect of a merger on the merged firm’s pricing incentives. The City contended that the Upward Pricing Pressure test could establish the anticompetitive effect of the merger without the need to define a relevant market. Agreeing that an alleged market based on the city’s preferences, and that ignores the market of insurance providers that compete for the city’s business, is inconsistent with established precedent requiring a test of interchangeability and cross-elasticity of demand, the trial court granted the summary judgment motion and denied leave to amend.

GHI and HIP also argued that the city could not demonstrate a relevant antitrust injury because any increased premiums would result from the carriers’ conversion to for-profit entities, not from their merger.

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<sup>35</sup> FTC Letter to Honorable Mark Formby (March 22, 2011) available at [www.ftc.gov/os/2011/03/110322mississippipbm.pdf](http://www.ftc.gov/os/2011/03/110322mississippipbm.pdf).

<sup>36</sup> FTC Letter to Patricia E. Shaner (November 3, 2010) available at [www.ftc.gov/os/2010/11/101109alabamabrdme.pdf](http://www.ftc.gov/os/2010/11/101109alabamabrdme.pdf); FTC Letter to Hon. Gary Odom (September 28, 2011) available at [www.ftc.gov/os/2011/10/V11001tennesseebill.pdf](http://www.ftc.gov/os/2011/10/V11001tennesseebill.pdf).

<sup>37</sup> City of New York v. Group Health Inc., 649 F.3d 151 (2d Cir. August 18, 2011).

The Second Circuit affirmed the district court. While not finding the lateness of the amendment to be evidence of bad faith, it did not think it was an abuse of discretion for the district court to find that this delay, together with the prejudice that would result from the amendment, warranted denial of the City's motion to amend. The Second Circuit also agreed with the district court's rejection of the "Upward Pricing Pressure" test noting that the City failed to explain how the test can substitute for a definition of the relevant market in the pleadings. Whether or not the Upward Pricing Pressure test could be admissible evidence of impaired competition is irrelevant to the adequacy of the pleadings, the court concluded.

## **2. Pennsylvania AG: Urology Merger Could Lead to Higher Prices<sup>38</sup>**

In August 2011, the Pennsylvania Attorney General's Office filed a complaint and simultaneously entered a consent decree against a group of urologists in the Harrisburg area who merged their practices in 2005. The complaint and decree are notable for several reasons: (1) the action is another reminder that enforcement agencies may investigate and take action years after a merger occurs; (2) the decree imposes various restrictions on the urologists' negotiations and referrals; and (3) neither the U.S. Department of Justice nor the Federal Trade Commission participated in the consent decree.

In November 2005, five independent urology practices in the Harrisburg area merged into a single practice, Urology of Central Pennsylvania Inc. That merger brought 13 of the 22 urologists practicing in a 20-mile radius of Harrisburg into a single practice. The complaint alleges UCPA enjoyed an 84% market share. With resulting annual revenues of approximately \$7 million, the merger sailed under the Hart-Scott-Rodino radar.

But an investigation by the Pennsylvania AG ensued into the urology group's post-merger conduct. Whether that investigation uncovered evidence of actual, supracompetitive price increases as a result of the merger is unclear. The complaint alleges the group's "urologists were able to collectively bargain with area health plans to obtain increases in reimbursement rates for urology services and ancillary services," but does not include details of any price increases. The complaint does not allege any particular percentage increases or whether such increases impacted all payors. Elsewhere, the complaint merely alleges the group had the "increased ability and incentive" to raise its prices – again, without any specific allegations of actual price increases.

Apart from actual or perhaps possible price increases, the complaint expresses concern about changes in the urologists' service offerings and referral patterns. For example, the complaint alleges that as a result of the merger, the group hired its own radiation oncologist and referred its patients in-house for radiation services instead of to area radiation oncology centers, which experienced "a dramatic decline in the number of referrals of prostate cancer patients." The complaint also alleges that postmerger the urologists opened their own prostate cancer center and expanded their output of technologies like robotic surgery, while performing fewer (less-expensive) brachytherapy procedures.

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<sup>38</sup> Pennsylvania v. Urology of Central Pennsylvania, Inc., et al., Civil Action No. 1:11-cv-01625-JEJ (M.D. Pa. August 31, 2011).

The consent decree's "public interest determination" does not discuss whether the state considered breaking up UCPA, although state and federal officials have noted the difficulty in "demerging" physician practices. Instead, the AG extracted several behavioral modifications from the urologists.

### **3. Pennsylvania AG: Hospital Merger Could Lead to Higher Prices<sup>39</sup>**

In July 2011, the Pennsylvania Attorney General announced it had entered into a consent decree imposing conditions on the merger of two central Pennsylvania hospitals. The accompanying complaint alleges that the two competing hospitals together controlled 60% of the market for primary and secondary acute-care hospital services in Northumberland County in central Pennsylvania.

The complaint alleges the merger would have left Medicare Advantage Plans doing business in Northumberland County with only one option for acute care services. This allegedly would have presented a problem because the plans predominantly serve senior citizen consumers who "have less physical ability to travel and often have less income to pay for travel costs than other consumers."

The complaint also alleges the merger would harm competition for physician services by preventing independent physicians from obtaining staff privileges at the surviving entity. This was a concern because the acquiring hospital was a closed staff model, while the target was an open staff model.

Simultaneously with the filing of the complaint, the parties entered a consent decree permitting the merger to proceed on several conditions. The decree addresses the Attorney General's allegations regarding Medicare Advantage Plans by requiring the acquiring hospital to permit plans with existing contracts at the target's facilities to extend the contracts for three years from the date of closing, at prices adjusted annually. Regarding competition for physician services, the decree requires the system to allow independent physicians to maintain staff privileges at the target's facilities after the merger, and bars the system from requiring that these physicians practice exclusively at its facilities.

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<sup>39</sup> Pennsylvania v. Geisinger Medical Center and Shamokin Area Community Hospital, No. 344-MD (Pa. Commonwealth Court).

## II. PRIVATE LITIGATION

### A. Exclusionary Conduct Cases

#### 1. Still Breathing: Section 1 Claims Against Heart and Lung Center Survive while Section 2 Claims Expire<sup>40</sup>

A federal district court denied a motion to dismiss Deborah Heart and Lung Center's Section 1 claims that competing hospitals conspired to exclude it from the emergency cardiac procedures market but granted Deborah's motion to dismiss its Section 2 claim in late December 2011.

Deborah is a nationally-renowned specialty hospital in Burlington County, New Jersey. Defendants are Virtua Health, Inc. which operated three hospitals in the area; Presbyterian Medical Center of the University of Pennsylvania Health System and related entities; and the Cardiology Group, P.A.(CGPA) a group of cardiologists performing services at local hospitals.

At the time of the suit, Virtua Memorial Hospital operated the principal emergency room in Deborah's market and transferred all patients needing cardiac procedures to nearby hospitals including Deborah. Deborah asserted that Virtua entered into a conspiracy with other defendants to exclude it from the market for critical, advanced cardiac interventional procedures and that the conspiracy was intended to permit the Virtua defendants to monopolize the market for emergent/primary angioplasties. The alleged scheme consisted of two interlocking written agreements: first, between the Virtua and CGPA, making CPGA the exclusive provider of cardiology services at Virtua Memorial; and second, between CGPA and the Penn defendants, making the Penn defendants the exclusive recommended referral of CGPA. Deborah characterized these agreements as the building blocks of the larger conspiracies to exclude Deborah from receiving transfers from the Virtua, drive it out of the market, and allow Virtua to monopolize the emergency procedures market.

Addressing standing, the court found Deborah had plausibly alleged that defendants had conspired to harm Deborah causing harm in the form of lost patient revenues, and further that Deborah's loss of revenues from its exclusion is among the types of harm the antitrust laws were designed to prevent.

Relying on direct and circumstantial evidence, the court held plaintiff adequately pled concerted action to exclude Deborah from receiving patient transfer from the Virtua. As direct evidence, the court cited two interlocking written agreements: first, between the Virtua and CGPA, making CPGA the exclusive provider of cardiology services at Virtua and, second, between CGPA and the Penn Defendants, making the Penn Defendants the exclusive recommended referral of CGPA. Circumstantial evidence included "the powerful shift in the Virtua Defendants' transfer pattern"; the fact that the shift in patients needing emergency procedures was made despite increased medical risks and costs; "coercive conduct" by defendants to prevent patients from exercising their choice of hospital "in the face of a statutory obligation to allow that very choice"; and the defendants' dissemination and discussion of "leakage reports" tracking patient

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<sup>40</sup> Deborah Heart and Lung Center v. Penn Presbyterian Medical Center, Civil No. 11-1290 (RMB) (D.N.J. Dec. 30, 2011).

referrals to other hospitals. Further buttressing the court's conclusion was an email by CGPA's president concerning the possibility of Deborah being driven out of business which hypothesized that that process could be accelerated by no longer transferring certain cardiac patients there. Adding to the mix was defendants' view that Deborah's exit would enhance the possibility that Virtua might be awarded a Certificate of Need to perform additional cardiac interventional procedures.

Turning to whether Deborah had plausibly alleged adverse, anticompetitive effects, the court observed that its allegations of direct anticompetitive effects obviated the need to assess whether plaintiff adequately alleged market power. While finding Deborah's allegations of supracompetitive pricing "too conclusory to be credited," the court was satisfied by allegations of: (1) higher prices through co-pays and related expenses and increased transportation costs, particularly helicopter transport costs; (2) reduced quality of care as through allegations that the increased transport time may cause adverse medical outcomes; and (3) the loss of consumer choice in cases where patients request to be transferred to Deborah but are denied.

Notably, Deborah is one of only three hospitals in the United States that are legally exempt from collecting insurance co-pays and deductibles from patients. However, the court refused to accept defendants' argument that lower costs at Deborah were attributable to this "regulatory anomaly" and not competition. Further, the court rejected defendants' argument that they have no "duty to cooperate" under the antitrust laws, reasoning that the essence of plaintiff's claim rests on the harmful effects on consumers from its exclusion. Finally, the court was satisfied that plaintiff had adequately pled the "rough contours of the marketplace for both elective and emergency procedures" – the former being a marketplace in southern New Jersey and Philadelphia with the latter being a more restricted geographic market, which excludes Philadelphia. The court found the pleading plausible in light of the need for patients needing emergency treatment to receive more rapid care and the alleged greater transport time in transit to Philadelphia.

On the other hand, Deborah's Section 2 claim failed to survive because it had not plausibly alleged that the conspirators had a specific intent to enable Virtua to monopolize the market. While holding that a dangerous probability of success is not a required element of a conspiracy to monopolize claim, the court observed that likelihood of success may be significant to addressing whether the defendants had the specific intent to monopolize the relevant market.

Several facts undermined plaintiff's allegation of specific intent. At the time the conspiracy occurred, Virtua had (at most) very limited ability to perform any of the emergency procedures. Moreover any future ability to perform these procedures was constrained by the need to obtain a Certificate of Need from the state. Furthermore, Virtua faced robust competition from at least two other hospitals besides Deborah. Given these market conditions, the court found it implausible that the defendants would have had the requisite intent to achieve successful monopolization of the emergency services market by Virtua.



## 2. Claims Barred: Bard Wins<sup>41</sup>

The Eighth Circuit affirmed the dismissal of two Missouri hospitals' claims against C.R. Bard Inc. in June 2011. The court held the hospitals were attacking share-based discounts, which are not unlawful in the Eighth Circuit.

Bard manufactures and sells various types of urological catheters. The hospitals brought claims against Bard on behalf of themselves and all direct purchasers of Bard urological catheters whose purchases were governed by contracts between Bard and various group purchasing organizations and integrated delivery networks. The plaintiffs claimed that Bard has a monopoly in the urological catheter market, and that it has maintained its monopoly through exclusionary contracts with these purchasing organizations that foreclose competition and result in overcharges for hospital purchasers. The contracts at issue included "share-based discounts" that "gave hospitals discounts for committing to purchase specified percentages of their catheter needs from Bard."

The district court certified the matter as a class action in September 2010. The parties subsequently moved for summary judgment, which the district court granted.

## 3. Menage a Trois: Highmark Swaps UPMC for West Penn<sup>42</sup>

As the baseball season gets underway, Pittsburgh Pirates fans once again have little to look forward to.<sup>43</sup> But steel city denizens seeking alternative entertainment could do worse than pay close attention to the soap opera involving Pittsburgh's two leading health care systems and western Pennsylvania's largest health care insurer.

The story so far: the University of Pittsburgh Medical Center (#1 in Pittsburgh hospital market share) battles Highmark, Inc., a Blue Cross and Blue Shield plan and the area's largest payer. Then, UPMC rethinks its approach and cozies up to Highmark, outraging West Penn Allegheny (#2 in the hospital market) in the process. West Penn sues UPMC and Highmark. The lawsuit is tossed by a district court. The court of appeals reverses and sends the parties back to the start line. But then West Penn dismisses its lawsuit. Why? Highmark has jilted UPMC and announced merger plans with ... West Penn. UPMC reacts with predictable outrage.<sup>44</sup> DOJ issues a (rare) public closing statement in April explaining why it decided not to oppose the merger. The insurance commissioner, meanwhile, promises hearings on the deal.<sup>45</sup>

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<sup>41</sup> SE Mo. Hosp. v. C.R. Bard, Inc., 642 F.3d 608 (8th Cir. 2011).

<sup>42</sup> West Penn Allegheny Health Sys., Inc. v. UPMC, 627 F.3d 85 (3rd Cir. 2010).

<sup>43</sup> See, e.g., "Pittsburgh Pirates MLB 2012 Predictions," Betfirms.com available at [http://www.youtube.com/watch?v=f\\_Kr4euJ9Fo](http://www.youtube.com/watch?v=f_Kr4euJ9Fo).

<sup>44</sup> See UPMC Statement (November 30, 2011) available at [www.upmc.com/mediarelations/newsreleases/2011/pages/jar-statement-before-the-pennsylvania-senate-banking-and-insurance-committee.aspx](http://www.upmc.com/mediarelations/newsreleases/2011/pages/jar-statement-before-the-pennsylvania-senate-banking-and-insurance-committee.aspx).

<sup>45</sup> "State hearings on Highmark-West Penn merger set for April," Pittsburgh Tribune-Review (March 3, 2012) available at [www.pittsburghlive.com/x/pittsburghtrib/business/s\\_784609.html#ixzz1rbQfwYSV](http://www.pittsburghlive.com/x/pittsburghtrib/business/s_784609.html#ixzz1rbQfwYSV).

Developments over the coming summer promise to be unpredictable. The Pirates? Not so much.<sup>46</sup>

West Penn Allegheny Health System (according to the complaint it filed in the now-dismissed litigation) is the second largest hospital system in the Pittsburgh area, with a market share of approximately 23% of hospital services. UPMC enjoys market share of approximately 55% of hospital services. West Penn and UPMC are the only competitors for tertiary and quaternary care. Highmark, Inc., a Blue Cross and Blue Shield plan serving markets in Pennsylvania and West Virginia, is the dominant health insurer in the region, with between 60% and 80% of the market for commercial insurance.

West Penn alleged that UPMC was “obsessed” with driving West Penn out of business. Thus, according to the complaint, beginning in approximately 2002, UPMC and Highmark abandoned a previous course of mutual hostility and began conspiring to protect each other’s market shares and inflate each other’s profits. West Penn alleged that UPMC refused to enter into provider agreements with Highmark’s rivals, thereby leveraging the health system’s “must-have” status to foreclose entry into the regional commercial health insurance market.

In return, Highmark allegedly paid UPMC supracompetitive reimbursement rates, provided financial support to UPMC in the form of grants and low-interest loans that it denied to West Penn (after having provided such support to West Penn in the past), and artificially depressed West Penn’s reimbursement rates. West Penn also alleged that UPMC agreed to shrink its own captive insurer, UPMC Health Plan – Highmark’s main competitor – in exchange for Highmark eliminating its low-cost insurance product. According to West Penn, this quid pro quo lasted for five years and resulted in increased health insurance premiums charged to consumers and supracompetitive profits for UPMC and Highmark.

West Penn claimed that UPMC’s “obsession” extended beyond conspiracy and led to unilateral acts taken solely for the purpose of harming West Penn. For years, UPMC allegedly raided West Penn’s (and other hospitals’) key physicians, not because UPMC needed or could even use those physicians profitably, but because hiring them away, even at “bloated” salaries, would keep them and their referrals from West Penn.

UPMC purportedly also pressured community hospitals into forming joint ventures with UPMC, key features of which were exclusive agreements with UPMC for those hospitals’ referrals.

Finally, West Penn alleged that UPMC went so far as to issue false statements about West Penn’s financial health in order to discourage investors from purchasing West Penn bonds.

The district court dismissed all counts set forth in the complaint. As to West Penn’s claim that UPMC and Highmark had conspired to restrain trade in violation of Section 1 of the Sherman Act, the court found insufficient allegations of an agreement. As to West Penn’s claim that UPMC unilaterally had attempted to monopolize the market for hospital services in violation of

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<sup>46</sup> “Phillies Beat Pirates 1-0 in 2012 Season Home Opener,” [wpxi.com](http://www.wpxi.com/news/news/local/pirates-looking-improve-2012-season-gets-under-way/nMKX6/) (April 5, 2012)

Section 2 of the Sherman Act, the court found insufficient allegations of anticompetitive conduct. The Third Circuit reversed on all points.

Addressing West Penn's allegations of conspiracy, the court of appeals found allegations of direct evidence of an agreement between UPMC and Highmark. The court noted that West Penn alleged, with specificity, that when West Penn had asked Highmark to refinance a loan Highmark had given to West Penn, Highmark declined by stating it would violate Highmark's "agreement" with UPMC, which agreement Highmark allegedly admitted was "probably" illegal. The court further noted that Highmark allegedly admitted West Penn's reimbursement rates were too low, but that Highmark could not raise them because that would violate its "agreement" with UPMC. Finally, the complaint alleged that UPMC's CEO had stated to a meeting of UPMC employees that UPMC had agreed to shrink its captive insurer in exchange for Highmark's elimination of its low-cost product. The court held these allegations were sufficient to survive a motion to dismiss.

The question of antitrust injury was closer. Maintaining some dramatic tension, the court of appeals first rejected West Penn's argument that it was injured as a result of Highmark's decision to eliminate its low-cost insurance product, which in turn reduced competition and increased health insurance premiums. This argument failed because West Penn does not participate in the health insurance market as a consumer or competitor but as a supplier, and "a supplier does not suffer an antitrust injury when competition is reduced in the downstream market in which it sells goods or services." Building the drama (if only slightly), the court then rejected West Penn's argument that Highmark's refusal to refinance its loan caused it antitrust injury. The court noted that Highmark was hardly the only source of capital and that West Penn did, in fact, turn to other lenders to refinance its debt.

The Third Circuit found an antitrust injury, however, in the reduced reimbursement rates Highmark paid to West Penn as a result of the alleged conspiracy. The court noted that had Highmark acted independently in negotiating lower reimbursement rates with West Penn, Highmark's actions likely would not have offended the Sherman Act. Yet because the complaint alleged that Highmark agreed with UPMC to use its monopsony power to hinder West Penn's ability to compete with UPMC, in exchange for UPMC taking steps to insulate Highmark from increased competition, the lower reimbursement rates Highmark paid to West Penn was sufficient antitrust injury. In addition to noting the potential for diminished quality and availability of hospital services that could result from the reduced payment rates, the complaint alleged that Highmark did not pass its savings on to its members in the form of lower premiums, but instead kept the savings for itself; and, in any event, such an agreement is simply anticompetitive and therefore the harm flowing from it was antitrust injury.

Turning to West Penn's Section 2 claim, the court noted that UPMC's conduct, "taken as a whole," was sufficiently anticompetitive to survive a motion to dismiss. The court noted the following allegations: UPMC had engaged in a conspiracy with UPMC to drive West Penn out of business; "UPMC hired employees away from West Penn by paying them bloated salaries," even when it did not need those employees and in some cases lost money on them; UPMC had strong-armed community hospitals into entering joint ventures that required exclusive referrals to UPMC; and UPMC had made false statements to West Penn's potential investors, causing "West Penn to pay artificially inflated financing costs on its debt." Taken as a whole, the court

concluded, these allegations plausibly suggested UPMC had competed “on some basis other than the merits.”

The Third Circuit’s decision noted that the alleged conspiracy between UPMC and Highmark came to an end in 2007, when the Antitrust Division of the Department of Justice began investigating the relationship between UPMC and Highmark. Notably, in testimony before Congress two days after the Third Circuit’s decision, Sharis Pozen, then Chief of Staff at the Antitrust Division warned that one of its top enforcement priorities is “to carefully scrutinize and continue to challenge exclusionary practices by dominant firms ... that substantially increase the cost of entry or expansion” in health insurance markets.<sup>47</sup> She noted the Division will be targeting “most-favored nations clauses, exclusive contracts, or similar arrangements between insurers and significant providers that reduce the ability or incentive of providers to negotiate discounts with aggressive insurance entrants.”

The United States Supreme Court denied UPMC’s petition for certiorari in October 2011. That, however, was not the end of the saga. That same month, as noted above, Highmark and West Penn announced merger plans (with Highmark stating it would invest \$475 million in West Penn). Not surprisingly, West Penn dismissed its complaint against Highmark.

In April the Antitrust Division took the relatively unusual step of issuing a closing statement, explaining why it had determined not to oppose the transaction.<sup>48</sup> The Division asserted the affiliation “holds the promise of bringing increased competition to western Pennsylvania’s health care markets by providing [West Penn] with a significant infusion of capital” and by increasing the incentives for market participants to compete.

The Division noted that the consolidation is a vertical one, as neither Highmark nor West Penn compete in each other’s product markets. “Vertical agreements,” the Division stated, “can reduce competition by limiting entry or expansion by third parties.” But such effects were not foreseen by the Division here. The agency noted that Highmark was not likely to sponsor expansion by a hospital network other than West Penn “because there is no other significant network with which Highmark could partner.

In addition, West Penn “on its own likely would not have promoted entry or expansion by other health insurers” because it had tried previously to sponsor entry by national insurers “and largely failed.” Moreover, the affiliation, in the Division’s view, is not likely to reduce West Penn’s “incentive to offer competitive rates to insurers other than Highmark because [West Penn] has strong incentives to increase its patient volume.”

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<sup>47</sup> Statement of Sharis A. Pozen, Chief of Staff, Antitrust Division, Before the Subcommittee on Antitrust, Competition Policy and Consumer Rights Committee of the Judiciary, United States Senate, “Antitrust Laws and their Effects on Healthcare Providers, Insurers and Patients” (December 1, 2010), available at [www.justice.gov/atr/public/testimony/264672.pdf](http://www.justice.gov/atr/public/testimony/264672.pdf).

<sup>48</sup> “Statement of the Department of Justice’s Antitrust Division on Its Decision to Close Its Investigation of Highmark’s Affiliation Agreement with West Penn Allegheny Health System,” (April 10, 2012) available at [www.justice.gov/opa/pr/2012/April/12-at-439.html](http://www.justice.gov/opa/pr/2012/April/12-at-439.html).

While the federal antitrust review has ended, as of the date this paper was prepared the insurance commissioner's review had not yet been completed. The date when the happy couple may tie the knot remains uncertain.

#### **4. Standup Guys: Federal Jury Awards \$35 Million to Upright MRI Providers**

A federal jury in the Eastern District of New York returned a verdict in November 2010 in favor of plaintiff radiologists who were excluded from CareCore's preferred provider network, in violation of the Sherman Act. After a two week trial, the jury awarded plaintiffs \$11.3 million dollars in damages, which was trebled to nearly \$35 million.<sup>49</sup> In September 2011, the trial judge denied CareCore's post-trial motions to vacate the jury's award.

Defendant CareCore offers radiology benefits management services to health insurers, offering risk contracts for managing the care of members' outpatient radiology needs. Plaintiffs were radiologists who provided "upright MRIs," which are MRIs taken in a standing or sitting position instead of lying down. Plaintiffs claimed they were excluded from CareCore's network, which acted as a "gatekeeper" in denying plaintiffs access to some of the largest health insurance networks in New York. Plaintiffs claimed CareCore excluded them from its networks in order to protect CareCore's owners (also radiologists) from competition from the allegedly superior upright MRI procedures.

#### **B. Antitrust Potpourri: Indirect Purchasers, Noerr, Gun Jumping**

##### **1. No Antitrust Injury: Tying White Blood Cells to Red Blood Cells Doesn't Hurt Hospital<sup>50</sup>**

The dismissal of a Pennsylvania hospital's complaint against pharmaceutical company Amgen was affirmed by the Third Circuit in June 2011 because the hospital was an "indirect purchaser" and thus had not sustained "antitrust injury."

The hospital claimed Amgen had conditioned discounts for its white blood cell growth factor drugs on the purchase of its red blood cell growth factor drugs. Amgen has a monopoly in the market for white blood cell drugs, but faces real competition in the market for red blood cell drugs. The hospital asserted the discounts on the white blood cell drugs made it economically irrational to turn down the red blood cell drugs in favor of cheaper alternatives.

However, because the hospital purchases all the drugs through a middleman, the district court dismissed the hospital's claims as it was an indirect purchaser. The court of appeals affirmed.

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<sup>49</sup> Stand-up MRI of the Bronx P.C. v. CareCore National, LLC, No. 08-cv-2954 (E.D.N.Y. Nov. 30, 2010).

<sup>50</sup> Warren Gen'l Hosp. v. Amgen, Inc., 643 F.3d 77 (3rd Cir. 2011).

## **2. Say What You Will: *Noerr* Protects It<sup>51</sup>**

In May 2011, the Seventh Circuit upheld the dismissal of one hospital's antitrust claims against a competitor under the *Noerr-Pennington* doctrine.

The Mercatus Group LLC had partnered with Evanston Northwestern Healthcare to construct a new physician center in the village of Lake Bluff, Illinois. Nearby Lake Forest Hospital recognized the project as a competitive threat and campaigned to persuade the Lake Bluff Village Board to deny approvals necessary for construction to proceed. Among other actions, the hospital lobbied board members individually and at board meetings and launched a public relations campaign encouraging others to do the same.

After the village board denied Mercatus' application, Mercatus sued Lake Forest Hospital. Mercatus alleged that the hospital violated Section 2 of the Sherman Act by misrepresenting the detrimental impact of the physician center on the price and availability of care during its campaign.

The district court granted summary judgment in favor of Lake Forest Hospital. It held the *Noerr-Pennington* doctrine, which protects petitioning activity from antitrust liability, immunized any misrepresentations the hospital may have made to the village board or to the general public. The court of appeals affirmed.

## **3. Shooting Blanks: Gun Jumping Claim Loses at the Seventh Circuit<sup>52</sup>**

The Seventh Circuit in January 2011 rejected claims by institutional pharmacy Omnicare challenging pre-merger planning and information exchanges between two health insurers, UnitedHealth Group and PacifiCare Health Systems.

The federal merger rules promulgated under the Hart-Scott-Rodino pre-merger notification statute prohibit parties to a planned merger from transferring beneficial control a company to its merger partner before the HSR waiting period expires. The practice frequently is referred to as "gun jumping."

In 2005, United and PacifiCare each were negotiating reimbursement contracts with Omnicare, the nation's largest institutional pharmacy, which provides pharmaceutical services to long-term care facilities like nursing homes. At the same time, United and PacifiCare were planning to merge and, as a result, were exchanging information as part of due diligence and preparing for post-merger operations.

Before the merger closed, United and Omnicare negotiated an agreement on terms favorable to Omnicare, while PacifiCare was able to obtain favorable concessions from Omnicare. Shortly after the merger closed, United abandoned its Omnicare contract and joined PacifiCare's

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<sup>51</sup> *Mercatus Group LLC v. Lake Forest Hosp.*, 641 F.3d 834 (7th Cir. 2011).

<sup>52</sup> *Omnicare, Inc. v. UnitedHealth Group, Inc.*, 629 F.3d 697 (7th Cir. 2011).

contract. Omnicare sued, claiming that the insurers had coordinated their approaches with Omnicare to ensure that one of them was able to make a deal for a lower reimbursement rate.

Omnicare's claims turned on evidence of pre-merger conspiracy between the insurers. Without direct evidence of an agreement between the two, Omnicare pointed to circumstantial evidence. The district court granted the insurers' motion for summary judgment, finding a lack of evidence of improper coordination.

The court of appeals affirmed, holding the evidence of conspiracy was "ambiguous." Because the evidence was equally consistent with either conspiracy or independent action, Omnicare had to produce evidence excluding the possibility of independent action on the part of the insurers. Omnicare failed to carry its burden. The court concluded, in fact, the inference of conspiracy was less reasonable than the inference of independent action. Without evidence of an agreement, Omnicare's claims could not survive summary judgment.

### **C. Private Litigation Following Public Enforcement**

#### **1. Out of Favor: Michigan Court Dismisses Claims against Blue Cross Blue Shield<sup>53</sup>**

Issuing not one but two decisions, a federal district judge in Detroit dismissed claims made by the City of Pontiac, Michigan, against Blue Cross Blue Shield of Michigan arising out of its use of most-favored-nations clauses in its contracts with hospitals. The rulings dismiss only one of several class actions pending against BCBS over the MFN clauses, and have no effect on the Department of Justice's case (reported above) against BCBS.

In October 2010, the department of Justice and the Michigan Attorney General filed suit against BCBS, alleging that its use of MFN clauses had excluded competing health insurers from the market and had driven up the cost of insurance to employers and individuals. Numerous private lawsuits followed.

The City of Pontiac filed a complaint on behalf of persons who did not purchase their health insurance directly from BCBS. Instead, the City was self-insured and used BCBS only as a third-party administrator. Its theory was that the MFN clauses caused hospitals to raise their prices for all services sold to self-insured entities like the city: the MFN clauses set a cost floor that resulted in higher premiums for the city and its employees. Pontiac sued BCBS as well as 22 hospitals it accused of conspiring to raise prices.

The district judge before whom all of the BCBS cases are pending issued two orders dismissing Pontiac's claims on March 30. First, the court dismissed the city's claims against BCBS. Second, the court dismissed the city's claims against the hospitals.

The city alleged only per se violations of Section 1 of the Sherman Act. Per se violations describe that set of agreements among horizontal competitors that are so pernicious that courts

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<sup>53</sup> City of Pontiac v. Blue Cross Blue Shield of Michigan, No. 11-10276 (E.D. Mich., March 30, 2012).

need not examine their competitive effects in order to condemn them. But the court found BCBS and the hospitals have a vertical relationship in the market, not a horizontal relationship as competitors, and therefore per se condemnation was not an option.

While the hospitals are horizontal competitors, Pontiac nowhere alleged an agreement between them, an essential element in a Section 1 claim. Although the city argued in its briefing the court might infer an agreement, it failed to make any such allegations in the document that mattered – the complaint. The court searched the city’s complaint for allegations that might support a rule of reason claim, but found none.

The court also found implausible the city’s allegations that the hospitals and BCBS were unjustly enriched by payments by the city.

## **2. The Beat Goes on: Class Certification Revived in Evanston<sup>54</sup>**

The saga of the Evanston, Illinois, hospital market continues. The background: three hospitals in suburban Chicago merged on January 1, 2000. In 2004, the FTC took the unusual step of challenging that merger retroactively. In 2005, an FTC administrative law judge held that the merger violated section 7 of the Clayton Act and ordered the merger to be dissolved. The record contained substantial evidence that the merged entity, Northshore, had raised prices substantially after consummating the merger; indeed defendants’ own expert ultimately acknowledged price increased at least nine or ten percent above competitive prices. In 2007, the full FTC upheld the finding on liability, but reversed the remedy and ordered only a controversial “conduct” remedy (separate contracting) instead of a “structural” remedy (divestiture).

Private litigation soon followed. In 2007, plaintiffs sued Evanston Northwest in a putative class action, claiming that the merger had caused them to pay too much for their health care at the three hospitals. Plaintiff sought to certify a class of consumers who bought health care services directly from any Northshore entity between 2000 and 2008.

In April 2010, a federal district judge in Chicago denied plaintiffs’ motion for class certification, holding that the plaintiffs could not prove “antitrust impact,” that is, causal injury, on a uniform basis across the proposed class.<sup>55</sup> Plaintiffs certainly tried: the decision turned on a battle of two expert economists who spent a lot of time (and no doubt money) developing and critiquing economic models for proving impact on a class-wide basis.<sup>56</sup> The court concluded that the plaintiffs’ expert’s methodology for calculating the amount price increases resulting from the exercise of market power would not permit class-wide proof of antitrust injury in the form of higher prices. In order to work as a class-wide proof, the court reasoned, this methodology required proof that defendant raised its prices at uniform rates affecting all class members to the

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<sup>54</sup> *Messner v. Northshore University HealthSystem*, 7th Cir., No. 10-2514, 1/13/12).

<sup>55</sup> *In re Evanston NW Healthcare Corp. Antitrust Litig.*, 268 F.R.D. 56 (N.D. Ill. Apr. 12, 2010).

<sup>56</sup> The Seventh Circuit explained the vigorous contest over class certification: “In light of the FTC’s findings that the merger had violated the law and enabled Northshore to raise its prices at least nine or ten percent above competitive prices, it is understandable that Northshore put up a determined opposition to class certification.”



same degree. Because the court found price increases were not uniform, the court concluded that the plaintiffs could not show predominance.

Noting the importance of the issue for “for private antitrust enforcement, particularly with respect to hospitals and health care providers with complex pricing systems,” the Seventh Circuit granted the petition for interlocutory appeal. It found the district court’s conclusion that a lack of uniform price increases required denial of class certification was erroneous as a matter of both fact and law, and hence an abuse of discretion. First, it found that the trial court failed to determine whether the defense expert’s report used to attack plaintiff’s method of common proof was admissible pursuant to Fed.R.Evid. 702 and *Daubert*.<sup>57</sup> Noting that the defendants’ expert’s report and testimony were important to an issue decisive for certification, the expert’s testimony was “critical” under Seventh Circuit precedent<sup>58</sup> and hence the court needed to rule conclusively on plaintiff’s challenge to her opinions before it turned to the merits of plaintiffs’ motion for class certification.

The court then went on to analyze whether common issues predominate among the putative class. It found that the trial court failed to apply the correct standard under Rule 23, which the court explained as examining only whether common questions represent a significant aspect of the case and can be resolved for all class members in a single adjudication. Plaintiffs need not prove antitrust impact at this stage, it concluded, only that antitrust impact is capable of proof at trial through evidence common to the class. The court noted that plaintiff’s economic expert claimed that he could use common evidence – the post-merger price increases Northshore negotiated with insurers – to show that all or most of the insurers and individuals who received coverage through those insurers suffered some antitrust injury as a result of the merger. “That was all that was necessary to show predominance for purposes of Rule 23(b)(3),” the court concluded. The fact that some members of the proposed class were not injured (*e.g.*, Blue Cross Blue Shield of Illinois, the largest putative class member, allegedly suffered no injury) or are immune from price increases was of no moment. “All of this is at best an argument that some class members’ claims will fail on the merits if and when damages are decided,” the court explained.

#### **D. Nurse cases**

##### **1. Working Overtime: No Agreement, No Case<sup>59</sup>**

Plaintiffs, acting on behalf of themselves and a class of nurses and technical care specialists, alleged that the Hospital Association of Southern California and several member hospitals conspired to depress nurse wages throughout Southern California in violation of California’s antitrust statute, the Cartwright Act. Their claim asserted that defendants entered into a secret agreement to lower the hourly wage rate of nurses by 15 percent in order to offset the effects of a California law (AB 60) that reinstated mandatory overtime pay. Putting in its own overtime, the California Court of Appeal parsed the record on summary judgment and affirmed the trial court’s

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<sup>57</sup> *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993).

<sup>58</sup> *American Honda Motor Co. v. Allen*, 600 F.3d 813, 815-16 (7th Cir. 2010).

<sup>59</sup> *Zumbowicz and Gordon v. Hospital Association of Southern California*, No. B215633 (November 16, 2010, Court of Appeals of California, Second District).

dismissal of the case based on plaintiffs' failure to identify sufficient evidence of an agreement to depress wages.

After observing that "many nurses preferred the option of a 12-hour shift because it allowed them to take more days off or pick up additional shifts at different hospitals," the appellate court explained that several hospitals had decided to implement a 15 percent "equivalency pay reduction" in the hourly pay rate for nurses who worked a 12-hour shift in order to "provide nurses the same amount of compensation for a 12-hour shift that they had received prior to the passage of the new law."

Under Cartwright Act precedent, plaintiffs may demonstrate "illegal concerted action based on consciously parallel behavior" by showing (1) that the defendants' behavior was parallel; (2) that the defendants were conscious of each other's conduct and that this awareness was an element in their decision-making process; and (3) certain "plus factors." The court found plaintiffs' evidence on all three factors wanting.

The court reviewed three categories of evidence proffered by plaintiffs in support of their claim: (1) testimony and documentary evidence from non-defendant hospitals indicating that they had participated in association-sponsored meetings and phone calls regarding AB 60 where some hospital administrators had revealed that they intended to adopt equivalency pay reductions, (2) a memo the hospital association sent to its members stating that the "safest course" was to adopt an equivalency pay reduction, and (3) testimony from a non-defendant hospital administrator stating that hospitals that did not adopt equivalency pay reductions would have a competitive advantage in recruiting and retaining nurses over hospitals that did impose such a reduction.

First, the court found defendants' behavior was not sufficiently "parallel" given that of the 18 hospitals operated by the seven defendants, only one hospital mandated an equivalency pay reduction "that adjusted the straight time base hourly rate of pay for ... 12 hour shift registered nurses," while nine other hospitals permitted nurses to vote on whether they preferred to convert to 8 hour shifts and retain their level of hourly base pay, or, alternatively, retain 12 hour shifts with an equivalency pay reduction, and the remaining eight hospitals did not adopt an equivalency pay reduction of any kind. Evidence that hospitals purportedly urged each other to adopt equivalency pay reductions did not support the claim that the actions undertaken were "parallel," especially where so many hospitals did not so act.

Second, plaintiffs offered testimony from non-defendant witnesses stating that they participated in association-hosted conferences and phone calls wherein competitors discussed potential responses to the new law and an association memo that purportedly encouraged member hospitals to adopt equivalency pay reductions. The court held that even if this evidence demonstrated that defendants were "conscious" of each other's conduct, plaintiffs had failed to satisfy the second prong of the inquiry, i.e. that the "awareness was an element in the Defendants' decisional process."

Finally the court was not satisfied that plaintiff had established the "plus factors" necessary to survive summary judgment. As to the most important factor, whether the conduct was contrary to defendants' economic self interest if acting alone, evidence that an administrator of a non-defendant hospitals thought so was not enough. While acknowledging the existence of a nursing

shortage in California, the court stressed plaintiffs' failure to introduce any expert testimony or statistical evidence suggesting that nurses would actually behave in the manner they suggested. It regarded as insufficient the testimony of "a single lay witness" supporting this claim as it merely repeated an "economic truism" that ignored crucial economic factors such as the fact that hospitals were not paying their nurses the same base hourly wage.

The court also found a strong economic motive for each hospital to independently adopt the equivalency pay reduction in the increased cost associated with overtime pay. Further undermining plaintiffs' case was the absence of evidence indicating that the ten defendant hospitals that did impose equivalency pay reductions suffered a competitive disadvantage in retaining nurses in comparison to the eight defendant hospitals that did not impose such reductions. Also lacking was "any evidence indicating that the hospital industry, or the market for hospital nurses, is oligopolistic in nature and therefore conducive to price fixing."

As to the plus factor the court called "traditional evidence of a conspiracy," there was plenty: (1) various HASC-hosted meetings and phone calls during which hospital administrators discussed potential responses to AB 60; (2) a memo circulated by HASC that refers to equivalency pay reductions as "the safest course," and (3) other statements and documents demonstrating that hospitals were collectively discussing AB 60 and aware of competitors' planned response to AB 60. Again, the court found the evidence wanting. While acknowledging that the meetings were intended to "discuss strategies on how to deal with [AB 60]," the court was more impressed with testimony that some participants came away believing that only a minority would adopt the equivalency pay reduction option and it was plausible that "the hospitals met to educate themselves on the various ways an entity might respond to AB 60's requirements, and then used that information to independently decide which option was best for their institution." The court went on to find the "safest course" memo and seemingly damning statements from hospital representatives about "getting together" to resolve the issue as subject to multiple interpretations.

## **2. Arizona Temporary Nurse Cases Settled**

In September 2010, the Arizona Hospital Association settled a class action with temporary nurses for \$22 million. The settlement arose out of the association's nurse registry program. That program began wisely enough as a clearinghouse for vetting the credentials of nurses traveling to Arizona for temporary work during the winter months. But over the years, the registry branched out into pricing data and eventually became a vehicle through which the hospitals allegedly suppressed the wages of traveling nurses.

In 2007, the Department of Justice announced a settlement with the association enjoining it from continuing to engage in any price-related behavior.<sup>60</sup> Private litigation followed and a federal judge ultimately certified the matter as a class action (although the certification order was limited to per diem nurses, not traveling nurses). Nonetheless, the pressures of class certification led the association and defendant hospitals to settle for a significant amount of money.

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<sup>60</sup> United States v. Arizona Hospital and HealthCare Association, No. CV07-1030-PHX (September 12, 2007) available at <http://www.justice.gov/atr/cases/azhha.htm>.

### III. HEALTH CARE REFORM AND ANTITRUST: ACOS

The federal antitrust agencies issued the final statement of their antitrust enforcement policy regarding Accountable Care Organizations participating in Medicare's Shared Savings Program on October 20, 2011.<sup>61</sup>

The statement departs in two significant ways from the proposed statement released in March 2011 by the Federal Trade Commission and the Department of Justice's Antitrust Division.

First, and most significantly, the agencies will not require any ACO to submit to mandatory review by the antitrust agencies as a condition to entry into the Shared Savings Program. The statement issued in March proposed to require review for ACOs combining providers with shares of 50% or more in overlapping services within their primary service areas (PSAs).

Second, the guidance in the final statement applies to "all collaborations among otherwise independent providers and provider groups that are eligible and intend, or have been approved, to participate in the Medicare Shared Savings Program." The earlier statement proposed to limit applicability to collaborations formed after March 23, 2010 (the date the Patient Protection and Affordable Care Act was enacted).

The final policy statement, issued on the same day CMS issued its final rule on ACOs, confirms the federal antitrust enforcement agencies will apply the so-called "rule of reason" to combinations of providers meeting CMS eligibility criteria for ACOs participating in the Shared Savings Program rather than the considerably more harsh "per se" rule of illegality reserved for provider collaborations that do not involve significant financial or clinical integration.

ACOs with groups of providers who offer common services that cumulatively account for no more than 30% of those services within their PSAs fall within a "safety zone." Such ACOs "are highly unlikely to raise significant competitive concerns." Therefore, the agencies state, they will not challenge these ACOs under the antitrust laws, "absent extraordinary circumstances."

ACOs that do not qualify for the safety zone "may be procompetitive and legal." But, "not all ACOs are likely to benefit consumers." According to the final policy statement, "under certain conditions ACOs could reduce competition and harm consumers through higher prices or lower quality of care."

The effect of the final policy statement is to place the responsibility squarely on the shoulders of each ACO and its antitrust advisors to determine the legality under the antitrust laws of ACOs that fall outside the safety zone. Newly formed ACOs that want guidance from the antitrust agencies may request a statement as to the agencies' assessment of the ACO's likely competitive effects through an expedited, 90-day review process detailed in the policy statement. No ACO is required to obtain such input, however, before applying for entry to the Shared Savings Program and commencing operations. ACOs that choose to skip a review by the antitrust agencies are

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<sup>61</sup> Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (October 28, 2011) available at [www.ftc.gov/os/fedreg/2011/10/111020aco.pdf](http://www.ftc.gov/os/fedreg/2011/10/111020aco.pdf).

provided with advice on how to operate so as to minimize the possibility of a later antitrust enforcement action.

### *Applicability of the Policy Statement*

The policy statement applies to “collaborations among otherwise independent providers and provider groups that are eligible and intend, or have been approved, to participate in the Shared Savings Program.” The agencies recognize many ACOs will provide services to commercially insured patients as well. The policy statement provides a framework under which the agencies will analyze CMS-qualified ACOs when they provide services in the commercial market.

The policy statement does not apply to single, integrated entities, nor does it apply to mergers.

### *“Rule of Reason” Treatment for Price Negotiations by Qualifying ACOs with Commercial Payors*

Under standard antitrust principles, otherwise competing providers who jointly negotiate contracts with commercial payors are fixing prices in violation of Section 1 of the Sherman Act, unless the providers are either clinically or financially “integrated.” In antitrust jargon, such joint negotiations are a “per se” violation of Section 1. In the event the providers are “integrated,” however, their collaboration is judged under the more lenient “rule of reason.” As the agencies explain in the final policy statement, a rule of reason analysis examines both the efficiencies that flow from the collaboration and its anticompetitive effects. The arrangement is unlawful only if, on balance, the likely anticompetitive effects outweigh the efficiencies.

The antitrust agencies have provided a great deal of advice elsewhere on what constitutes sufficient financial or clinical integration to escape per se treatment and bring an arrangement under the rule of reason. In particular, the “[Statements of Antitrust Enforcement Policy in Health Care](#),” issued by the two federal antitrust agencies in 1996, provide detailed guidance on how providers might integrate.<sup>62</sup> Both the Federal Trade Commission and the Department of Justice have issued advice letters that discuss adequate financial or clinical integration in specific factual circumstances. Speeches from enforcement officials and various agency reports have further illuminated the criteria the agencies consider to determine when integration is present.

While the criteria by which financial integration is judged are broadly understood and have caused little controversy, the same cannot be said about clinical integration. Until now, the antitrust agencies have resisted setting out specific criteria required to establish clinical integration. Instead, in the years since the issuance of the 1996 antitrust enforcement advice, the

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<sup>62</sup> Examples of sharing financial risk include accepting capitation or setting a fee schedule with a substantial risk withhold. Clinical integration is evidenced by the implementation by a network of an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and the creation of a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. Networks that are clinically integrated may set prices jointly, so long as such price setting is reasonably necessary to achieve promised efficiencies.

FTC has issued a number of staff advice letters explaining what does, and does not, qualify as clinical integration sufficient to permit joint price setting.

In an important departure from this history, the policy statement provides that ACOs participating in the Medicare Shared Savings Program will be presumed to be clinically integrated (and so able to negotiate prices with commercial payors without running afoul of the antitrust laws) as long as they comply with the CMS eligibility criteria for participation in the Shared Savings Program and participate in that program. Such ACOs also must employ in their commercial business “the same governance and leadership structures and the same clinical and administrative processes” used to qualify for and participate in the Shared Savings Program.

The antitrust agencies have deferred to CMS in this area because they consider CMS’s eligibility criteria to be “broadly consistent with the indicia of clinical integration” traditionally employed by the antitrust enforcers.

Therefore, so long as an ACO participates in the Shared Services Program and keeps the same governance and clinical structures in place as existed at the time of CMS’s approval of the ACO’s application for participation in that program, the ACO’s negotiations with commercial payors will not be considered by the antitrust agencies as per se violations of the antitrust laws.

#### *Calculation of Shares for Determining the Applicability of the Safety Zone*

The policy statement establishes an antitrust “safety zone” for ACOs in the Shared Service Program when shares of overlapping providers do not exceed 30%. ACOs falling within this safety zone are assured that “absent extraordinary circumstances” the agencies “will not challenge” either their formation or their operation.

If an ACO wishes to establish that it qualifies for the safety zone it must engage in a detailed share calculation. To conduct the required share analysis, the ACO first must determine which services are provided by two or more competing providers (or groups of providers) in the ACO. The ACO then must calculate, for each such “common service,” the share all the ACO’s providers hold of that service within each provider’s PSA.”

For example, if an ACO were to include two otherwise independent groups of cardiologists, the PSA for each group would be separately determined. Then the combined shares of both groups would be calculated within each of the two PSAs.

The guidelines borrow the CMS definition of a PSA as the lowest number of zip codes from which the provider draws a least 75% of its patients for a particular service.

In order to perform these calculations:

- Physician services are defined by a physician’s specialty, as defined by the Medicare Specialty Code (“MSC”);
- Hospital inpatient services are identified by Major Diagnostic Categories (“MDCs”);

- Outpatient services are defined by categories to be identified by CMS.

Shares will be calculated for hospital inpatient services by using all-payor discharge data for the relevant MDCs when they exist at a state level. Physician shares will be calculated using Medicare fee-for-service allowed charges. Outpatient services will be measured by Medicare fee-for-service payment data for hospitals and fee-for-services allowed charges for ambulatory surgery centers. If available, an ACO can use state-level, all-payor discharge data instead. For services rarely used by Medicare beneficiaries, such as pediatrics, obstetrics and neonatal care, ACO applicants are directed to use “other available data” to determine shares.

An appendix to the Policy Statement provides detailed examples of share calculations.

### *The 30% Safety Zone*

A safety zone applies to an ACO that combines providers with shares of no more than 30% in any common service (i.e., any overlapping service line) in each PSA where an ACO provider of such service is found.

If an ACO includes hospitals or ASCs, those facilities must be “non-exclusive” to the ACO to fall within the safety zone. This means a hospital or ASC must retain the ability to contract or affiliate with other payors or ACOs or the protection of the safety zone is lost.

- Rural Hospitals. An ACO may include “Rural Hospitals” on a non-exclusive basis and still qualify for the safety zone even if the shares for common hospital services exceed 30%. A Rural Hospital is defined as a Sole Community Hospital or Critical Access Hospital under CMS regulations, or any other acute care hospital in a rural area that has no more than 50 beds and is located at least 35 miles from another hospital.

The safety zone for physicians applies regardless of whether they contract with the ACO on an exclusive basis or not – unless the physicians fall within either the “rural exception” or “dominant participant limitation,” in which case they must contract on a non-exclusive basis to take advantage of the safety zone.

- Rural exception for physicians. An ACO in a rural area that has more than a 30% share within a PSA may still qualify for the safety zone if that share is the result of including no more than one physician or pre-existing physician group practice, per specialty, from a rural area. The physician or group, however, must be included on a non-exclusive basis to qualify for the safety zone. The agencies borrow the definition of rural areas developed by the Health Research Center at the University of Washington.
- Dominant Provider Limitation. If a provider with a share greater than 50% is included in an ACO, the ACO will still qualify for the safety zone if the provider is non-exclusive to the ACO and no other providers of the same service are included. The ACO also may not require a commercial payor to contract exclusively with it.

Except as set forth in the rural exception and the dominant provider limitation, an ACO could require its physicians to provide their services on an exclusive basis, and still qualify for the safety zone, so long as the 30% thresholds are not exceeded.

To qualify for the safety zone, unless the rural exception applies, an ACO could not exceed 30% in any of the service lines in which it combined competing providers. While failing to qualify for the safety zone would not mean the ACO had run afoul of antitrust law, falling outside the safety zone could impose additional administrative burdens, as discussed below.

### *Guidelines for ACOs outside the Safety Zone*

ACOs that fall outside the 30% safety zone “may be procompetitive and lawful.” Such ACOs, however, remain exposed to possible antitrust challenge by the enforcement agencies. The risk of such a challenge will rise with the market power held by an ACO. The policy statement does not give specific guidance as to when an ACO with a share or shares above 30% may violate the antitrust laws. Nonetheless, the agencies do provide guidance as to how such ACOs may reduce competitive concerns.

The policy statement identifies four types of conduct ACOs “with high PSA shares or other possible indicia of market power” should consider avoiding to minimize the likelihood of an antitrust challenge. Such ACOs should not:

- 1) Prevent or discourage commercial payors from steering patients to certain providers through “anti-steering,” “anti-tiering,” “guaranteed inclusion,” “most favored nation,” or other similar contractual provisions.
- 2) Tie sales of the ACO’s services to a commercial payor’s purchase of other services from providers outside the ACO.
- 3) Contract on an exclusive basis with ACO participants. There is no exception for primary care physicians.<sup>63</sup>
- 4) Restrict a commercial payor’s ability to share cost, quality, efficiency, and performance information with its enrollees.

Regardless of the ACO’s market shares, the Agencies warn that its operations should not facilitate price-fixing or other collusion among competing participants in the sale of their services outside of the ACO. For example, the ACO should implement firewalls or other safeguards to prevent improper exchanges of competitively sensitive information among non-integrated participants, such as the prices participating providers accept when contracting with payers outside the ACO.

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<sup>63</sup> The policy statement notes that while CMS “requires the physician practice through which physicians bill for primary care services and to which Medicare beneficiaries are assigned to contract exclusively with one ACO for the purposes of beneficiary assignment, CMS does not require either those individual physicians or physician practices to contract exclusively through the same ACO for the purposes of providing services to private health plans’ enrollees.”



### *Voluntary Antitrust Review by the Agencies*

Any “newly formed” ACO may seek, on an “expedited” basis, antitrust review from the enforcement agencies. A newly formed ACO is one that, as of March 23, 2010, had not signed or negotiated contracts with a commercial payor, and had not participated in the Shared Savings Program.

An ACO that wants a review must inform the FTC and DOJ it wants a review, using a form available on the agencies’ website. The agencies then decide which agency will conduct that review and inform the ACO. The ACO then must submit certain identified information to that agency. The required information includes: (1) the application and supporting documents submitted to CMS for participation in the Shared Savings Program; (2) documents discussing the ACO’s business strategies or plans to compete in the Medicare and commercial markets, including the ACO’s impact on quality or price; (3) documents discussing competition among ACO participants and in markets to be served by the ACO; and (4) information sufficient to show the common services offered by two or more ACO members, and the share calculations by PSA for those services, “or other data that show the current competitive significance of the ACO or ACO participants.”

Within 90 days of receiving “all” the required information, the reviewing agency will inform the ACO that the group’s formation and operation “does not likely raise competitive concerns,” “potentially raises competitive concerns,” or “likely raises competitive concerns.” The agency may condition a finding that the ACO does not likely raise competitive concerns on agreement by the ACO to take certain prescribed steps to remedy concerns raised by the agency.

All request letters and responses will be public documents. The two antitrust agencies also will establish a joint working group “to collaborate and discuss issues arising out of the ACO reviews.”

### *Observations*

- No mandatory reporting. Unlike the proposed policy statement issued in March, the final statement does not require any ACO to submit anything to the antitrust enforcement agencies. This means antitrust enforcement in this area is consistent with antitrust enforcement philosophy generally: parties may form and operate a collaborative venture without first seeking permission from the government. But if they violate the antitrust laws they may be the subject of an enforcement action by those agencies.
- PSAs are not antitrust relevant markets. The policy statement expressly notes a PSA is not necessarily equivalent to a relevant geographic market used in traditional antitrust analysis and it nowhere states the calculations providers make will result in “market shares.” (The statement is careful to use the word “shares,” without the modifier “market,” throughout.) Nonetheless, for the purposes of the Shared Savings Program, the policy statement in effect considers PSAs as proxies for antitrust relevant geographic markets. As a matter of antitrust law, however, a PSA at best is only a rough approximation of a relevant geographic market. At worst it bears no resemblance at all to

a relevant geographic market, and market analysis based on PSAs can yield incorrect antitrust conclusions.<sup>64</sup>

- Data Limitations. The share calculations necessarily are limited to available data. The antitrust agencies recognize that many states collect and publish all-payer discharge data that permit, when hospital services are at issue, share calculations based on these data. But similar data generally are not available for physician services. Accordingly the statement discusses the use of Medicare data for physicians and outpatient services. But this necessarily produces shares based on Medicare revenues. Not all physicians in the same specialty see Medicare patients, however, and of those who do, not all do so in equal proportions. Consequently, share calculations based on Medicare data may be either higher or lower than calculations based on all-payer data – which, the agencies acknowledge, is preferable to Medicare data. Incomplete data (such as Medicare reimbursement data only) may lead to incorrect conclusions.
- Safety Zones Do Not Provide Antitrust Immunity. While an ACO that applies for antitrust review and receives a letter from an antitrust agency indicating that the ACO is not likely to raise competitive concerns may proceed safe in the knowledge that the federal antitrust agencies will not prosecute it (so long as it does not substantially change the manner in which it does business), it will have no such protection from private litigants. Similarly, if an ACO falls within the 30% “safety zone,” this protects it only from an enforcement action by the agencies. Private parties would be free to sue the ACO.
- Uncertainty for ACOs that Are Not Qualified by CMS. If an ACO is structured in a way that falls within the safety zone described in the policy statement, but the ACO chooses not to qualify under the Medicare Shared Savings Program and instead focuses on commercial business, it is not clear whether the antitrust enforcement agencies would scrutinize it under the guidelines set forth in the policy statement or under more traditional antitrust principles.
- Different Criteria for Clinical Integration? The effect of the deferral by the antitrust agencies to CMS to determine when otherwise competing providers are clinically integrated is uncertain. Despite the hopeful claims in the policy statement that CMS’s eligibility criteria “are broadly consistent with the indicia of clinical integration” and that organizations meeting the CMS criteria are “reasonably likely to be bona fide

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<sup>64</sup> Courts, antitrust commentators and enforcers repeatedly have warned against confusing the area from which a seller obtains its customers with a relevant geographic market. “[A] court would often be mistaken to conclude that a seller’s ‘trade area,’ or the area from which it currently draws its customers, constitutes a relevant geographic market. In fact, the ‘trade area’ and the ‘relevant market’ are precisely reverse concepts.” *Bathke v. Casey’s General Stores, Inc.*, 64 F.3d 340, 346 (8th Cir. 1995) (quoting H. Hovenkamp, *FEDERAL ANTITRUST POLICY* § 3.6d, at 113-14); *Federal Trade Commission v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995); see also *Antitrust Issues Raised by Rural, Health Care Networks*, R. Leibenluft, Assistant Director, Health Care, Federal Trade Commission (February 20, 1998) (emphasis in original) available at [www.ftc.gov/bc/ruralsp.shtm](http://www.ftc.gov/bc/ruralsp.shtm).

organizations” intended to improve quality and reduce costs, it remains to be seen whether, in practice, CMS’s criteria are more lenient than those the agencies would have used to test clinical integration. The possibility that CMS’s criteria will be different from – and more relaxed than – those applied until now by the antitrust agencies is a real one.

- Information to Be Provided and the 90-Day Review Period. The Policy Statement promises an expedited 90-day review for an ACO applying for a letter indicating the enforcement intentions of the antitrust agencies. ACOs expecting to hear definitively from an antitrust agency 90 days after they submit their applications must take great care to provide what can be a burdensome and complex amount of data in advance. Whether the agencies have sufficient staff to follow through on the promise of expedited review remains to be seen, especially as the volume – and complexity – of ACO voluntary requests is unknown and difficult to predict. Nonetheless, the burden on the agencies clearly will not be as great as it would have been had they required review of ACOs with shares over particular thresholds.