XV. ANTITRUST IN THE HEALTH CARE SECTOR

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A. Overview

This chapter is an opportunity for students to apply the concepts addressed elsewhere in the book, but at a deeper level and in the context of a sector that accounts for a very large share of antitrust activity on the part of government enforcers and private plaintiffs. The topics chosen illustrate some of the nuances in applying antitrust law in the real world and show how the application of antitrust principles has evolved over time. The chapter also raises important policy questions regarding how to apply antitrust to a sector that is rife with market failures, including what tools and approaches (including regulation) could be used to make such markets work better.

Our particular focus here is on those parts of the health care sector involving *health care providers*, which primarily include physicians and hospitals, and how they have organized and conducted themselves, including in particular in negotiating contracts with *health care payers,* which primarily include commercial health plans, for the services furnished by the providers to members of the health plans.

Section B presents crucial background on how the health care sector has evolved over the past 50 years. The commercially insured population, and to a lesser extent patients in government programs such as Medicare and Medicaid, depend heavily on competition to control health care costs and assure quality. But, as the section will explain, many factors cause market failures in health care delivery. The sector has grown increasingly concentrated in recent years, despite active antitrust enforcement. While there has always been substantial skepticism about how well competition can ever work in health care, in recent years even greater attention has been given to whether more regulatory oversight is needed and, if so, how such government intervention can be undertaken without further distorting market competition.

Sections C and D address three different ways that health care providers have sought to adapt to changing market conditions, with a particular focus on how they could address health plans which, beginning in the late 1970s, adopted much more aggressive tactics in negotiating contracts to limit both the cost (i.e. reimbursement rates) and the quantity (i.e. utilization) of health care services.

- Section C.1 describes how physicians in independent practices reacted to such initiatives by seeking to negotiate collectively with health plans, the antitrust enforcement actions that considered such collective action to be *per se* illegal, and how over time a path developed that permitted a more nuanced consideration under the Rule of Reason for physician collaborations that involved economic integration promising substantial efficiencies.

- Section C.2 addresses how the courts have analyzed attempts by providers, in this case hospitals, to form joint ventures that fall short of a full merger. This section discusses three cases which address whether such JVs resulted in a single entity that would not be subject to Section 1 challenge under *Copperweld*—and which resulted in three different conclusions.

- Section D turns to mergers, with a particular emphasis on hospital mergers, and drills down on how efficiencies in provider mergers have been assessed by the agencies and the courts. The section also discusses aspects of physician practice and health plan mergers. The case law illustrates how the types of evidence and economic approaches that courts have relied on have evolved over time, resulting in periods when the merging parties often prevailed in court, and other times when the government ran impressive winning streaks.

Sections E and F focus on matters that are often addressed under Section 2 of the Sherman Act (although they may also be considered under Section 1 as well).

- Section E addresses contracting practices of dominant health systems or health plans, a subject that frequently has been litigated because in many geographic markets a health system or plan arguably has a dominant share, opening the door to greater scrutiny of its conduct.

- Section F addresses some of the issues raised by the exclusion of providers from hospitals or health plan networks. This is another common source of litigation although, as we will see, in most (but not all) cases, plaintiffs have fared poorly. Courts reason that if hospitals or networks are to work well, they must be able to exclude entities whose quality or costs they consider to be unacceptable.

Section G concludes the chapter with a discussion of attempts to incorporate more regulatory oversight over the health care sector, including the use of "Certificates-of-Need," which are designed to avoid what is perceived as *wasteful* competition, and so-called "Certificates of Public Advantage," which purport to displace competition altogether under the state action doctrine. In recent years, several states have instituted COPAs, drawing strong opposition from the FTC. The agency is undertaking a multi-year study of their effects. In addition, many states are instituting increasingly extensive regulatory reviews of mergers and acquisitions addressing not only competition issues, but issues that arguably are outside the purview of the antitrust laws.

While this chapter covers a great deal, it is not exhaustive. We omit entirely the part of the health care sector that involves the research, manufacture, sale and distribution of drugs and devices. This too, has been the subject of a tremendous amount of antitrust litigation and raises a multitude of questions involving such things as the intersection of antitrust and intellectual property law, the role of government (primarily through the FDA) in determining who can enter the market under the Hatch–Waxman Act and other provisions that grant exclusivity in certain circumstances, how Noerr–Pennington should apply to certain conduct aimed at government proceedings, and the complex role played by pharmacy benefit managers and drug distributers in determining the price of and access to drugs. Many of these issues are addressed elsewhere in this book, such as in Chapters IX (covering Noerr–Pennington) and X (Antitrust and Intellectual Property).

In considering the issues addressed here involving health care providers and payers, students may find several general sources to be particularly helpful. Two are overviews of antitrust law as applied to health care aimed at practitioners.[1] A third is a website called "The Source on Health Care Price and Competition," which is project of the UC College of Law in San Francisco.[2] It contains both a wealth of background materials, as well as current updates on new developments.

B. Setting the Stage: The U.S. Health Care System

When we get sick, we rely on our health care system to help. Typically, we go to our local doctor, get care in a clinic, use the nearest emergency room, fill a prescription, get an X-ray or an MRI, enter a hospital, or seek care from an alternative provider. Today, over 6,000 hospitals, and about one million physicians,[3] provide care in the U.S. The health care sector accounts for about ten percent of total employment. The result of this activity is a national health care bill for 2024 that likely exceeded $5 trillion and approached one-fifth of the U.S. gross domestic product.

In 1890, when the Sherman Act became law, the picture was radically different. American health care cost little—and delivered little. The transition from providing care at home to providing care at hospitals was underway, but many Americans never so much as entered a hospital. The notion that germs caused disease had gained widespread acceptance only a few decades before 1890. This scientific breakthrough laid the groundwork for substantial advances

[1] ABA Section of Antitrust Law, ANTITRUST HEALTH CARE HANDBOOK (5th ed. 2022); C. White, S Brau, & D. Marx, Jr., ANTITRUST AND HEALTH CARE: A COMPREHENSIVE GUIDE (2d Edition) (2017).

[2] *See Restriction of All-or-Nothing Provisions in Provider Contracts*, The Source on Healthcare Price & Competition, https://sourceonhealthcare.org/ (last visited Aug. 28, 2024).

[3] Statista reported 1.1 million physicians as of January 2024. *Total Number of Active Physicians in the U.S., as of January 2024, by State*, Statista, https://www.statista.com/statistics/186269/total-active-physicians-in-the-us/ (Jan. 2024). The U.S. Bureau of Labor Statistics reported 933,000 physicians as of 2022. *Spotlight on Statistics, Employment in the 25 Largest Health Care Occupations, 2022*, https://www.bls.gov/spotlight/2023/healthcare-occupations-in-2022/home.htm#:~:text=Altogether%2C%20employment%20in%20the%20top,Created%20with%20Highcharts%2010.3 (last visited Aug. 28, 2024).

in treatment of widespread diseases in the early twentieth century, as researchers gained insights in how to treat tuberculosis, measles, scarlet fever, and syphilis, among other scourges. But most medical innovations we take for granted today were, in 1890, still decades—or a century or more—in the future.

As care became more sophisticated, so did our medical care system. Hospitals began to specialize, with some offering basic care and others concentrating on specific services. Charity hospitals that provided care for the indigent in the 19th century gave way to government, or private, not-for-profit hospitals. Investor-owned, for-profit hospitals entered the mix. Physicians in solo practice joined colleagues in small practices, then over time formed ever larger groups or became employees of hospitals or regional or even national health care organizations. Local pharmacies joined chain pharmacies. And all the while, as the health care system grew and became more complex, legal oversight of health care accelerated.

To the extent Americans received health care in 1890, they typically paid for it directly, if they paid at all. Prepaid insurance was a novel concept. And yet, in 1912, when Theodore Roosevelt (often associated in the popular imagination with the early days of the antitrust project[4]) ran for the presidency for a second time, on the Bull Moose Party platform, he called for universal health care coverage. But Teddy Roosevelt didn't win the election and the proposal died with his Party.

Two decades later, President Franklin Roosevelt included universal health care in the forerunner to the Social Security Act of 1935—but the provision was dropped from the bill Congress ultimately enacted. Meanwhile, for the first time, health insurance was made available to a few groups, such as schoolteachers in Dallas who, in 1929, obtained prepaid inpatient hospital care from Baylor University Hospital.[5] Blue Cross plans, organized by hospitals, and Blue Shield plans, organized by physicians, provided rudimentary hospital or physician insurance. The 1930s saw the birth of employer-sponsored, comprehensive health coverage when Henry J. Kaiser, a California industrialist, contracted to build an aqueduct from the Colorado River to Los Angeles and, (later) the Grand Coulee Dam. Dr. Sidney Garfield, a young physician who had difficulty finding work during the Great Depression, organized a prepaid medical plan for Kaiser's workers that offered both hospital and physician care. Dr Garfield focused not just on caring for workers when they were sick or injured, but on preventive health care as well. Today's health maintenance organizations (and in particular, the Kaiser-Permanente HMO) grew from these foundations.

During the Second World War, the federal government introduced wage and price controls, prohibiting employers from granting large wage increases. But the War Labor Board determined that employer payments for employee health insurance were not taxable wages to the employee. This decision spurred employers to offer health coverage as a way to attract and retain scarce workers. And it created a bias—still in place today—where health care benefits, on a dollar-for-dollar basis, are more valuable to workers than pay. After the war ended in 1945, health insurance became a common employee benefit offered by larger employers to their workforces. Efforts to provide comprehensive public coverage continued, but continued to fail as well. In 1946, Congress rebuffed President Truman's call for national health care coverage, electing instead to pass the Hill-Burton Act, which funded substantial hospital construction across the country.

1965 saw the nation adopt the most fundamental and consequential health care reform in U.S. history when an overwhelmingly Democratic Congress, at President Lyndon Johnson's urging, enacted the Medicare and Medicaid programs. The programs were—and remain today—quite different in structure. Medicare provided hospital and physician coverage, funded by the federal government but administered by private health insurers (mostly Blue Cross or Blue Shield plans), to the aged (over 65), blind, and disabled. Medicaid was structured very differently. The program built on existing support some states had in place (funded by state and local taxes) to provide health care to certain

[4] *See supra,* Ch. I, Section E. 2.

[5] The discussion in this paragraph is drawn in part from Paul Starr, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 295–301 (2d ed. 2017) and Michael Morrisey, HEALTH INSURANCE Ch. 1, 6 (3d ed. 2020), https://account.ache.org/iweb/upload/Morrisey2253_Chapter_1-3b5f4e08.pdf.

categories of low-income people. Congress chose to support these existing programs rather than replace them with federal funding. The resulting state-federal partnership increased coverage, expanded funding, and assisted in paying for long-term nursing home care. States electing to opt into the program received federal dollars to supplement state funds, as long as they followed certain federal requirements. Most states took advantage of the opportunity, although a few remained outside the program for decades. (Arizona did not implement Medicaid until 1982.)

The Affordable Care Act of 2010, enacted during President Barrack Obama's administration, is undoubtedly the most consequential health care financing reform since the Medicare and Medicaid programs were created. While a full description of the statute, popularly known as "Obamacare," is beyond the scope of this chapter, a significant goal was to increase health care coverage by (i) further expanding eligibility for the Medicaid program, (ii) mandating the provision of commercial insurance by larger employers, and (iii) creating markets, known as health care exchanges, where people who remained uninsured could purchase affordable coverage with a federal subsidy that varied according to income. The ACA had the effect of reducing the total proportion of uninsured Americans from 16% of the population in 2010 (the year the reform was enacted) to about seven percent in 2023.

Over the century that has passed since the time when few Americans obtained even rudimentary commercial insurance, private payment systems have expanded to cover many more people and have become far more complex as well. Historically, health care providers sent their bills directly to patients. Insurers then would "reimburse" insurance subscribers for some, or all, of the fees charged. This evolved into the so-called "third-party" payment system where insurers contracted to pay providers an amount that did not exceed the insurer's fee schedule for services rendered to the insurers' subscribers. Providers agreed to accept these amounts as payments in full and not bill subscribers for any balance in excess of the amount allowed by the fee schedule. The insurer then paid the agreed amounts directly to the provider (minus any co-insurance, co-payment, or deductible amount that was the responsibility of the subscriber).

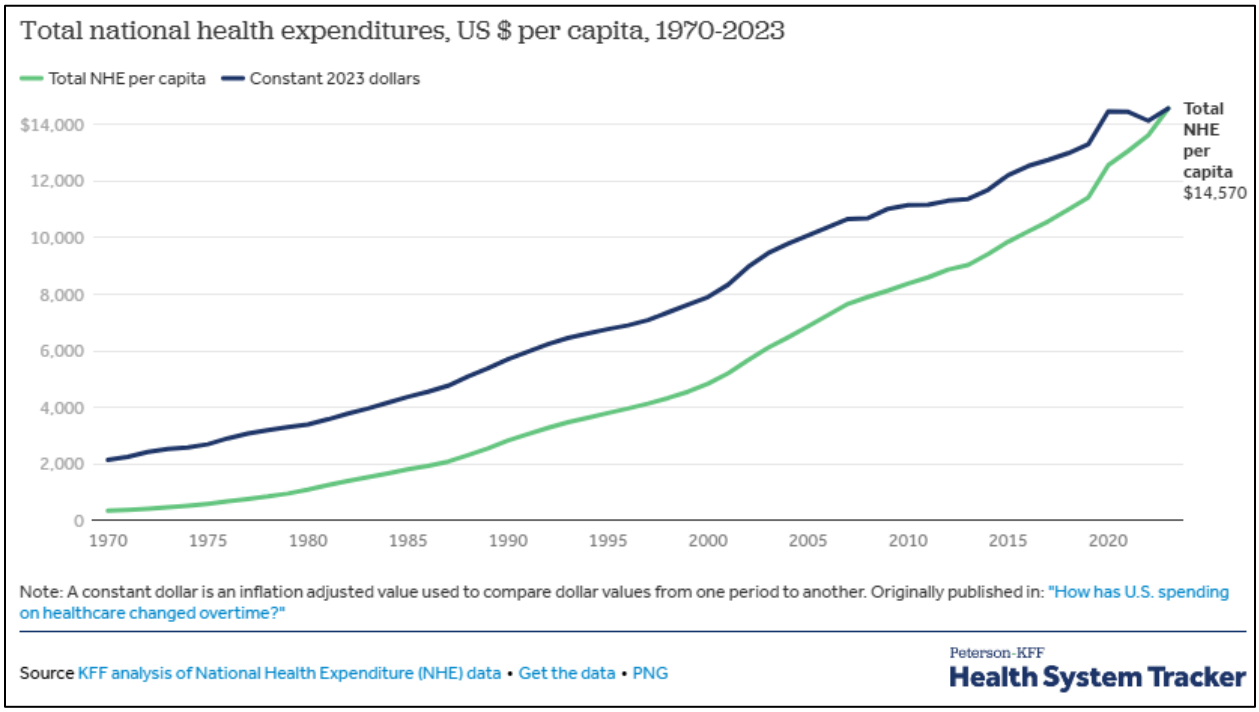
When Medicare first stepped in to pay on behalf of its beneficiaries, the program required hospitals to complete an annual cost report. Based on these reports, Medicare generally paid hospitals for the percentage of their costs accounted for by Medicare patients. Physicians were reimbursed based on their usual or customary charges (within prescribed limits). Many state Medicaid programs followed the Medicare model as well, although often with lower caps on payments. But, because increases in costs or charges led to higher payments, the Medicare and Medicaid payment systems provided no incentive for hospitals or physicians to constrain costs. In the 1980s, Medicare began experimenting with new payment systems to end or even reverse this incentive. These systems provided pre-determined lump sum payments to hospitals for specific types of stays or visits (with inpatient services classified by "diagnostic related groups" and outpatient services classified by type of visit). These "prospective" payments were intended to promote cost control. Payments of fixed amounts for particular diagnoses put hospitals and outpatient providers at risk of loss if they didn't control costs, while providing an upside (more profit) if they did. Medicare also switched to paying physicians based on a government-developed fee schedule that was not indexed to increases in physician charges. Private insurers copied and sometimes refined these methods, providing more incentive for providers to control their costs.

While these prospective payment systems changed incentives, health care costs still increased rapidly, leaving state and federal programs struggling to pay the health care bill. To cap risk to government programs, both state and federal governments began to promote managed care plans for Medicare and Medicaid beneficiaries. In these plans the government pays a private health plan a predetermined amount for each Medicare or Medicaid enrollee who receives coverage through that plan. Plans are responsible for enrolling and paying providers. If a plan delivers required coverage for less than the amount the government pays, it pockets the difference. If the plan spends more, it is responsible for the shortfall. Private insurers also experimented with this model of "capitation" payment (so named because it involves a payment per enrollee, or "per capita").

While the reliance on managed care plans may have muted cost increases in some years, the overall trajectory for health care costs has far outpaced inflation. A comparison of where the nation stood in 1970, just five years after the

two blockbuster federal programs were created, and today illustrates this. In constant (inflation-adjusted) U.S. dollars, national health expenditures in 1970 amounted to $435 billion. By 2022, total expenditures had increased tenfold to $4.465 trillion. (And as noted above, expenditures were projected to exceed $5 trillion in 2024.) Yet the population increased only about 58% in the same period. Over the period through 2022, as the following chart shows, spending per person (again in constant dollars) increased from a modest $2,072 to $13,493—so, in 2022, health care expenditures per person were about six and one-half times higher than they had been in 1970.

Figure 1: National Per Capita Health Expenditure



Source: KFF-Peterson Health System Tracker, https://www.healthsystemtracker.org/indicator/spending/per-capita-spending/

To put these amounts into further perspective, total national health expenditures in 1970 amounted to 6.9% of the U.S. gross domestic product. By 2022, health expenditures accounted for 17.3% of GDP—and even surged close to 20% in 2020, the first year of the recent pandemic, before receding to pre-pandemic levels two years later.

To some extent, these increases aren't surprising. Today there is more—and better—health care to purchase than there was in 1970. We should expect to pay more for health care today than we did then. And undeniably we receive a great deal more health care of value today than we did in 1970. A (very) few examples of advances since 1970 include stem cell therapy; significant advances in immunotherapies; MRI imaging (and even more advanced forms of imaging); genetic markers for Huntington's and other inherited diseases; developments in transplants of kidneys and other organs making these treatments widespread, effective, and much safer; and the promise of personalized medicine. Our ability to cope with common diseases has increased tremendously. Many forms of cancer were far more deadly in 1970 than they are today because scientific advances in cancer care have dramatically prolonged and saved lives.[6]

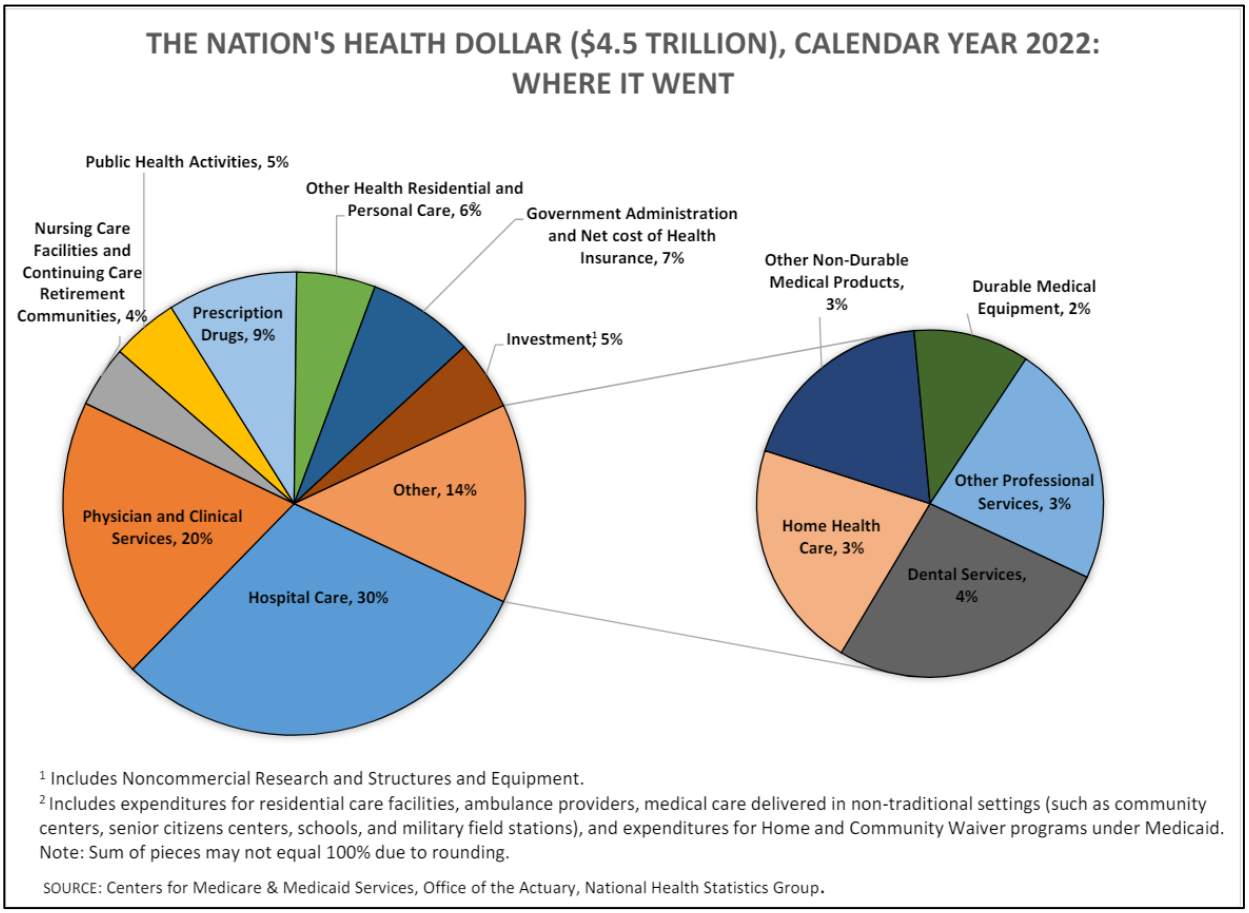
[6] Two examples: The survival rate for patients with leukemia has almost doubled since 1975, from 34 percent to 66 percent. The chances of surviving non-Hodgkin lymphoma and kidney cancer have each more than doubled (from 47 to 74 percent in the former case and 50 to 77 percent in the latter). https://www.healthsystemtracker.org/chart-collection/how-has-the-quality-of-the-u-s-healthcare-system-changed-over-time/#Percentage%20of%20adults%20reporting%20that%20their%20general%20health%20was%20fair%20or%20poor,%20by%20sex%20and%20race/ethnicity,%202011%20and%202017.

But the U.S. has long been notorious for spending far more than other developed countries in the world on health care without achieving better results for its residents. The gap in spending is not minor: the U.S. spends almost twice as much, per capita, as do Austria, Belgium, Canada, France, Germany, Netherlands, Sweden, Switzerland, and the U.K., grouped together. At the same time, broad measures of health outcomes favor these other nations, not the United States. Life expectancy in the U.S. in 2022, was 77.5 years. In the comparable countries just mentioned it was 82.2 years—and in none of these countries did it dip below 80.7 years. Infant mortality rates are higher in the U.S. than in any of the same basket of comparable countries. Life expectancy and infant mortality, of course, are affected by many public health and demographic factors beyond the direct control of the health care system, so they may not be the best measures to assess the efficacy of our health care spending. Mortality rates for the leading causes of death provide a measure that arguably better indicates the effect of care interventions on health. Here the picture is more mixed. A 2015 comparison between the U.S. and OECD countries suggested that "[a]mong the major causes of death, the U.S. ha[d] lower than average mortality rates for cancers and higher than average rates in the other categories relative to comparable OECD countries."

If we are to improve results in the U.S., perhaps we should incentivize providers to provide "quality" care and preventive services. An immediate problem presents itself. Historically the health care system has focused on measuring services and procedures, not "quality," which is much harder to assess. To help address this deficiency, Medicare, Medicaid, and commercial insurers have introduced many quality markers that can be used to increase or diminish payments made to providers. Managed care plans, which receive per capita payments, should already have some incentive to ensure their subscribers receive quality care. But many of these incentives work well only if a plan can expect a subscriber to remain enrolled for several years so it can recoup the upfront expense.

Where does all this money go? Fully one-half of U.S. national health care expenditures go to paying hospitals and physicians: in 2022, 30% of every health care dollar was paid to hospitals and 20% to physicians. Prescription drug spending, which is seen by much of the public as a primary cause of rising health care costs, in fact accounts for only nine percent of total national health care expenditures. The many slices of the spending pie are shown in the chart below.

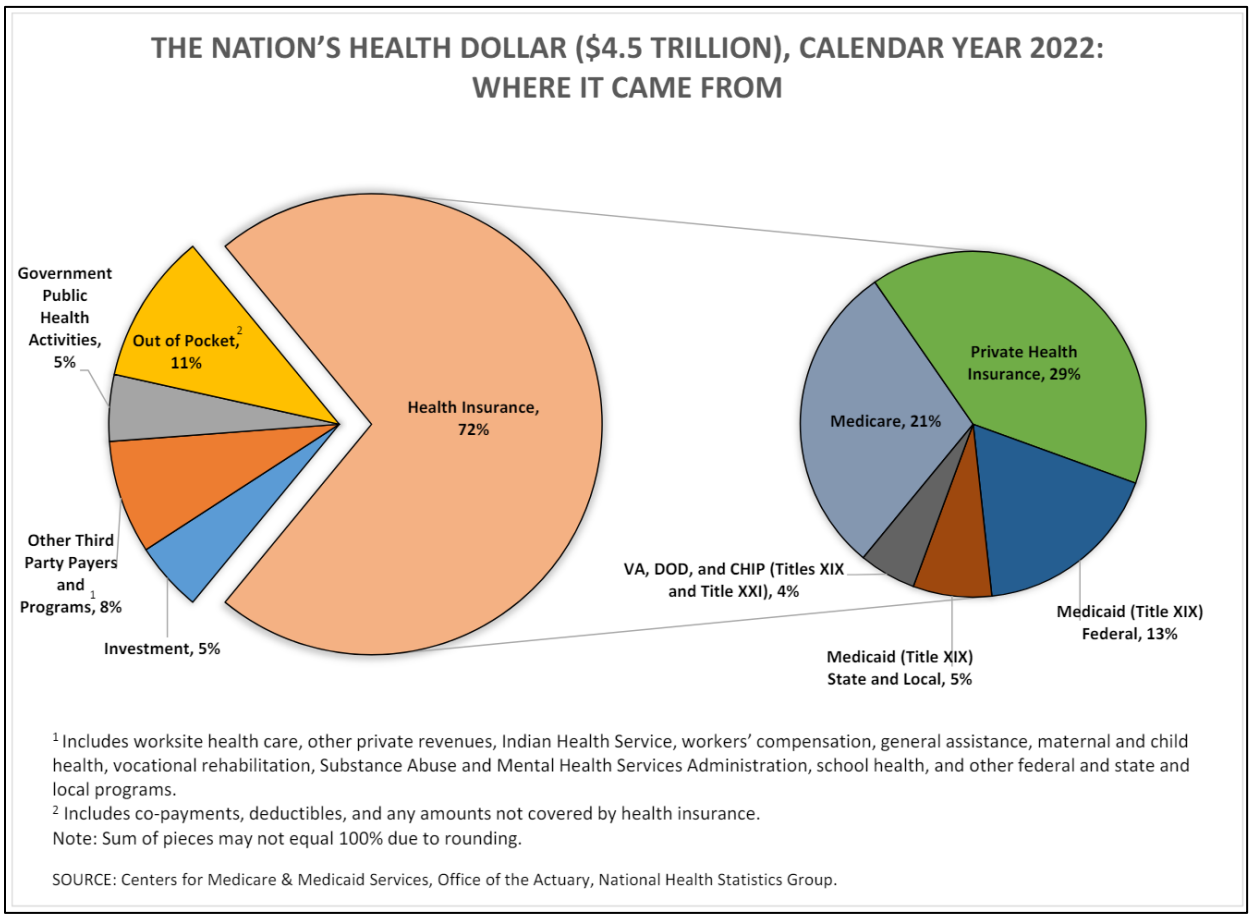
Figure 2: National Health Care Spending



Source: Nations' Health Dollar: Where It Came From, Where It Went, CMS.gov, chart, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.

Where does all this money come from? The most important sources that pay the nation's health care bill have been identified already—commercial insurance, Medicare, and Medicaid. Almost three-quarters of our health care spending is funded by such insurance. (See the next diagram.) Commercial insurance foots almost 30% of the total bill while government spending (Medicare, Medicaid, and other government programs) accounts for over 40%. Individual patients pay a little over 10% directly for co-payments, deductibles, and amounts not covered by health insurance.

Figure 3: Sources of Funding for Health Care



Source: Nations' Health Dollar: Where It Came From, Where It Went, CMS.gov, chart, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.

The large percentage of the nation's health care bill paid for by government programs masks what is an increasingly serious problem: Medicare and Medicaid now reimburse many providers less than the actual cost of providing the care covered by those programs. The non-partisan Medicare Payment Advisory Committee (MedPAC) found that across inpatient, outpatient and certain other service lines, hospitals reimbursed under Medicare's prospective payment system (*i.e.* the vast majority of all hospitals in the U.S.) saw their Medicare margins decline in 2022 "to a record low of -11.6 percent," when taking pandemic relief funds into account, and even further, to -12.7 percent, when these one-time payments were excluded.[7] The American Hospital Association states that in 2020, hospitals received only 84 cents for every dollar spent providing care to Medicare patients and 88 cents for care provided to Medicaid patients. The result, arguably, forces hospitals (and physicians who suffer from similar underpayment) to demand more from commercial payers or—in the case of physicians—to reduce the number of Medicare and Medicaid patients they see, or even stop seeing them altogether.[8] These shortfalls from government programs have important implications for

[7] MEDPAC REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY xvi (Mar. 2024), https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf. These negative margins have persisted for years. According to Kaiser Family Foundation's review of MedPAC reports, negative margins across all hospitals date back to at least 2010. *How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature*, Fig. 6, KFF, (Apr. 15, 2020),https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/.

[8] The counterargument is that hospitals simply charge private payers what the market will bear and are not shifting costs to make up for Medicare losses. *How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature*, nn.91–114. *See also* Austin B. Frackt, *How Much Do Hospitals Shift Costs: A Review of the Evidence*, 89 Milbank Q. 90 (Mar. 2011),

antitrust enforcement. Most antitrust challenges to conduct or mergers of providers focus on the potential impact on rates paid by commercial insurers. But providers argue that because of inadequate government payment rates, the only way they can survive is by increasing revenues from the shrinking share of patients covered by commercial health insurance. This has engendered the response that the government rates could be viable if providers were more efficient and more restrained in their spending.

Two other features of American health care deserve mention before we dive into the antitrust issues faced in this unique industry: the not-for-profit status of many health care providers and unique barriers to entry in this field.

Not-for-Profit Entities

Only 36 percent of U.S. hospitals are for-profit entities. Nearly half of all hospitals are private, not-for-profit organizations, and another 15 percent are government owned. But these shares actually understate the importance of the nation's non-profit hospitals. Because for-profit hospitals tend to be smaller, with fewer beds than not-for-profit and government hospitals, the non-profit sector (private not-for-profit and government hospitals together) account for almost three-quarters of all hospital beds in the U.S. Given the importance of non-profit health care, and the assumption many hold that non-profits have different goals and motives than for-profits, it's a fair question to ask whether it makes sense to apply the antitrust laws in unvarnished form to non-profit hospitals.

In an early hospital merger case (1990), Judge Posner confronted the claim, advanced by the two merging non-profit hospitals, that a post-merger increase in their market share—even if it conferred market power—would not translate into higher prices for consumers, because non-profits don't seek to maximize profits.[9] After remarking that if this were so, then "the Supreme Court was wrong in *National Collegiate Athletic Ass'n v. Board of Regents* . . . to reject an implicit exemption of nonprofit enterprises from the antitrust laws," Judge Posner rejected the argument. The claim, as Judge Posner saw it, was supported only by "conjectures . . . and other will o' the wisps." "It is regrettable," he wrote, "that antitrust cases are decided on the basis of theoretical guesses as to what particular market-structure characteristics portend for competition." He urged that "more effort [be] put into studying the actual effect of concentration on price in the hospital industry."

Seven years later, in *FTC v. Butterworth Health Corp.*, a district court judge rejected the FTC's challenge to a non-profit hospital merger in Grand Rapids, Michigan, asserting that defendants had answered Judge Posner's challenge by supplying studies and evidence that mergers of non-profit hospitals were associated with *lower* rather than higher hospital prices.[10] The court echoed defendants' expert in suggesting that the explanation for this perhaps counterintuitive phenomenon might be that a non-profit hospital board, made up of "the very people who depend on it for service" (such as community members and local business owners), had "no rational economic incentive" to raise prices even if it had increased market power.

The *Butterworth* decision has been heavily criticized.[11] In the years following the decision, economists at the FTC and elsewhere published empirical studies showing that nonprofit hospitals raise prices following mergers just as for-profits do.[12] In a highly-regarded report both federal antitrust enforcement agencies issued in 2004, describing and analyzing

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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160596/#:~:text=On%20average%2C%20about%2020%25%20of,share%20of%20for%2Dprofit%20hospitals.

[9] U.S. v. Rockford Memorial Corp., 898 F.2d 1278, 1285–86 (7th Cir. 1990).

[10] 946 F. Supp. 1285, 1295 (W.D. Mich. 1996), aff'd 121 F.3d 708 (6th Cir. 1997). The district court relied on a study published by the defendants' expert (William Lynk) of California hospitals and another he undertook, of Michigan hospitals, to equip him to testify in the Grand Rapids merger. Both studies came to the same result: that higher concentration is associated with lower nonprofit hospital prices.

[11] *See*, *e.g.*, Barak D. Richman, *Antitrust and Nonprofit Hospital Mergers: A Return to Basics*, 156 U. Penn. L. Rev. 121 (2007); Thomas Greany, Antitrust and Hospital Mergers: Does the Nonprofit Form Affect Competitive Substance? 31 J. Health Pol., Pol'y & Law 511, 519 (2006), https://scholarship.law.slu.edu/cgi/viewcontent.cgi?article=1573&context=faculty.

[12] *See*, *e.g.*, Vita & Sacher, *supra*, at 31 (after a merger of two nonprofits in Watsonville, California, the merged hospital and its only remaining competitor, itself a nonprofit, both raised prices); Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter–Summit Transaction*, 18 Int'l J. Econ. Bus. 65, 79 (2011), http://www.tandfonline.com/doi/full/10.1080/13571516.2011.542956 ("[o]ur

the application of antitrust to the health care sector, the agencies wrote that "[m]ost studies of the relationship between competition and hospital prices have found that high hospital concentration is associated with increased prices, regardless of whether the hospitals are for-profit or nonprofit."[13] The report concluded, "[t]he best available evidence shows that the pricing behavior of nonprofits when they achieve market power does not systematically differ from that of for-profits. The nonprofit status of a hospital should not be considered in determining whether a proposed hospital merger violates the antitrust laws."[14] The research and report seem to have been effective: no court since *Butterworth* has held that mergers of nonprofit hospitals should be judged differently than other hospital mergers because of their organizational status.

Interestingly, the FTC recently has raised the question as to whether the corporate structure of certain entities—in this case, those owned by private equity firms—may cause them to have different incentives which could be relevant to the likelihood of harm caused by their acquisition or competitive strategies.[15] One concern is that private equity firms may be so focused on short-term profits that they engage in "flip and strip" tactics whereby they use large amounts of debt to acquire companies, and then drastically reduce staff and other services to reap short-term profits at the expense of patient care and quality.

Barriers to Entry

The health care industry is replete with barriers to entry. Virtually every health care professional must be licensed to practice by a state regulatory authority. These barriers have an obvious public safety justification. Not so with "certificate of need" (CON) statutes on the books in 30 or more states in the U.S. These statutes prevent a provider from offering certain health care services without permission from a state authority. So, for example, in the State of Washington, no hospital, hospice care center, nursing home, ambulatory service center, home health agency or kidney dialysis center may be opened (or, often, expanded) unless the State's Department of Health approves.[16] Typically, approval is withheld unless the Department determines there is a "need" for the additional services. And competitors have the ability (which they often exercise vigorously) to intervene in the CON process to urge the agency not to grant the application.[17] If the agency grants the CON regardless, the competitor often may litigate in state court arguing the CON was improperly granted.

Not surprisingly, the federal antitrust enforcement agencies oppose CON laws. In the 2004 *Dose of Competition* report, the FTC (joined by DOJ) commented that while CON laws once were thought to control costs (by preventing creation of supposedly unneeded services), "there is considerable evidence that they can actually drive up prices by fostering anticompetitive barriers to entry."[18] The argument in favor of CON laws to address an "arms race" in health care expansion may have been stronger when they were first adopted in the 1960s and '70s, when generous government subsidies and reimbursement provided strong incentives to add health care capacity regardless of market need, but

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results demonstrate that nonprofit hospitals may still raise price quite substantially after they merge. This suggests that mergers involving nonprofit hospitals should perhaps attract as much antitrust scrutiny as other hospital mergers.").

[13] IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Executive Summary 15, DOJ & FTC (July 2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf. The FTC issued a statement in 2023 that "cautions" against reliance on this report, although the caution seemed largely to be focused on the discussion in the report on the pharmacy benefit manager (PBM) industry. *See* Statement Concerning Reliance on Prior PBM-Related Advocacy Statements and Reports That No Longer Reflect Current Market Realities, 5, FTC (July 20, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/CLEANPBMStatement7182023%28OPPFinalRevisionsnoon%29.pdf.

[14] Improving Health Care: Dose of Competition, Executive Summary, *supra* at 27. *See also* Ch. 4, *supra*, at 30–33 ("[T]he best available evidence indicates that nonprofits exploit market power when given the opportunity to do so. Accordingly, the profit/nonprofit status of the merging hospitals should not be considered a factor in predicting whether a hospital merger is likely to be anticompetitive.").

[15] *See*, *e.g.*, Remarks by Chair Lina M. Khan As Prepared for Delivery at Private Capital, Public Impact Workshop on Private Equity in Healthcare, FTC (March 5, 2024), https://www.ftc.gov/system/files/ftc_gov/pdf/2024.03.05-chair-khan-remarks-at-the-private-capital-public-impact-workshop-on-private-equity-in-healthcare.pdf.

[16] *See* Ch. 70.38 RCW.

[17] *See*, *e.g.*, Kottle v. Northwest Kidney Centers, 146 F.3d 1056 (9th Cir. 1998).

[18] IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Ch. 8, *supra*, at 2.

this is no longer the case. Moreover, other means of cost control appear to be more effective and pose less significant competitive concerns."[19] For years the FTC (sometimes, again, joined by DOJ) has submitted comments to state legislators urging they repeal existing CON laws and not adopt new ones.[20] This is one issue on which Republican and Democratic members of the Commission have largely agreed.[21]

Exercise: Who's the buyer? The seller?

Antitrust analysis relies heavily on determining who the buyers and sellers are in an alleged relevant market. This is important for assessing the likely competitive effects of a merger or conduct—i.e., who might be harmed and how. And buyers and sellers are a crucial source of information and evidence in investigating and litigating an antitrust matter. In many markets it is not hard to determine who are the buyers and sellers, and to understand how buyers make decisions about their purchasing decisions, including the cost and quality trade-offs in turning to alternative sellers. But often it can be much more challenging to identify buyers and sellers in the health care context. Read through the facts below—how would you answer the questions that follow?

Joanie is a lawyer at the Washington, D.C., law firm of Dewey Cheatham & Howe, through which she has health insurance with the Good Samaritan Health Plan. On a weekend hike at Old Rag, she falls and twists her knee. She is driven home by her friend and goes to GW Hospital where she is seen by an emergency department doctor who takes an x-ray and determines that because she has not fractured any bones she can go home but also prescribes a painkiller, which she obtains at the local CVS pharmacy. The next day, she sees Dr. Strongarm, an orthopedist at the Washington Orthopedic Group, who refers her to the Washington Radiology Clinic for an MRI. After obtaining a reading from the radiologist at WRC, Dr. Strongarm tells Joanie that she needs to have a staged ligament reconstruction which would require an inpatient procedure. Dr. Strongarm has hospital privileges at GW Hospital, which is where he performs the procedure the following day. After a 6-month recovery period, including the use of crutches, various prescription and over-the-counter pain medicines, and extensive physical therapy, Joanie fully recovers from her injury.

Joanie received a number of items and services in connection with her hiking mishap, including the following:

1. GW Hospital ED services
2. GW ED doctor services
3. ED X-ray
4. Prescription painkillers
5. Dr. Strongarm's professional services
6. WRC MRI
7. WRC radiologist services
8. GW Hospital orthopedic services
9. Crutches
10. Over-the-counter painkillers

[19] *Id.*.

[20] *See*, *e.g.*, Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Carolina House Bill 3250, (Jan. 11, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-certificate-need-laws-south-carolina-house-bill-3250/160111ftc-doj-sclaw.pdf.

[21] *See*, *e.g.*, Maureen K. Ohlhausen, *Certificate of Need Laws: A Prescription for Higher Costs*, 30 Antitrust 50 (Fall 2015), https://www.ftc.gov/system/files/documents/public_statements/896453/1512fall15-ohlhausenc.pdf.

11. PT services

For each of the above, consider the following:

- Who was the customer?
- Who paid for the item/service?
- Who decided to buy the item/service? What alternatives were available or considered?
- Did cost or quality affect the decision to buy the item or service? What information did the buyer have about cost or quality?
- Did competition affect the price or quality of the service? How?

C. Collective Activity by Providers

Hospitals, physicians, and other providers collaborate to an unusual extent in the health care industry. Some of this raises no antitrust concerns at all: a group of researchers collaborating on discovering a cure for cancer or a hospital association working on improving safety standards among its members should have little to fear from the antitrust laws. But competing providers collaborate frequently on other matters, including negotiations with health insurers (or "payers," in industry argot). This collaboration, rare in other industries but common in health care, raises antitrust issues that must be carefully navigated if the providers involved want to avoid lengthy and expensive antitrust litigation, treble damage awards—and even, perhaps, imprisonment.

In this Section we first examine physician interaction with payers and then turn to collaboration among hospitals and health systems.

1. Provider Collaboration: Physician Joint Negotiations with Health Plans

Antitrust scrutiny of physician interactions with health plans warrants attention for several reasons. First, it has been a major focus of government enforcement efforts for the past 50 years. Second, these efforts have resulted in several Supreme Court decisions that have clarified how the Sherman Act should be applied to concerted activities among competitors. The importance of these precedents extends far beyond the health care sector. Third, without this antitrust scrutiny, it is doubtful that health plans would have been able to rely on the tools they use today to manage health care costs. Finally, government initiatives in health care illustrate how the antitrust agencies—outside the litigation context—provide guidance to an industry on how to apply antitrust laws to complex situations.

As we discussed above, private health insurance was not widespread in the United States before the Second World War. While employers began to offer health insurance widely in the decades after the war, until the 1980s most health plans did not play an active role in seeking to control physician costs or monitor quality. Rather, health plans usually indemnified enrollees for a portion of the physician costs they incurred, typically determined by fee schedules the plans developed based on the "usual, customary and reasonable" fees charged by physicians in a local community. A few prepaid health plans were exceptions to this paradigm. These organizations included early health management organizations (HMOs) such as the Kaiser Permanente Group in California and the Group Health Association of

Washington, D.C., which took on most of the financial risk of the health care services to be provided their members.[22] Similar efforts elsewhere were few.

Indemnity reimbursement proved ineffective in controlling the principal drivers of health care costs: utilization (*i.e.*, the quantity of services provided) and price. The reasons are obvious. Indemnity plans simply paid whatever the provider charged for whatever services were provided. Efforts to limit charges to the usual, customary, and reasonable rate in the community (by stipulating, for example, that an insurer would not pay above the 80th or 90th percentile charge for a particular service) did little to stem inflation in health care prices.

As a result, health plans in the 1980s began to turn to "managed care" models which relied on two key features. First, health plans began to closely monitor and control consumption of health care goods and services by, for example, requiring pre-approval by the plan of certain procedures, or retroactively disallowing coverage of services the plan did not view as medically necessary. Second, health plans sought to control prices through selectively contracting with more limited networks of physicians (sometimes called "preferred provider organizations," or PPOs) who were willing to accept lower reimbursement rates in return for greater access to the health plan's members.

Not surprisingly, many physicians were not pleased with these initiatives. They considered health plan clinical oversight to be burdensome, poorly informed, and generally to interfere with their ability to exercise clinical judgment and provide the highest quality care to their patients. Physicians viewed selective contracting as resulting in unacceptably low reimbursement rates. They felt they were playing on an unlevel field on which physicians, typically in solo or small group practices, were unable to negotiate meaningfully with health plans that had far greater financial resources and clout.

In response, providers organized to negotiate fee levels, to refuse to deal with certain health plan requests, or to boycott managed care altogether. Some of the ways physicians reacted to managed care have been addressed in cases highlighted earlier in this casebook. For example:

- In *FTC v. Indiana Federation of Dentists,* 476 U.S. 447 (1986), dentists in Indiana agreed not to provide X-rays requested by insurers to assist in their review of dental claims. The Supreme Court, applying what has been identified as a "quick look" analysis, condemned such collective action.[23]
- In *Arizona v. Maricopa County Medical Society,* 457 U.S. 332 (1982), the Supreme Court held that physicians who agreed on a maximum fee schedule in negotiations with health plans had engaged in *per se* illegal price-fixing.[24] (This is an important case to review now—see the Casenote in Chapter V.)

Following these cases, the FTC brought a number of enforcement actions against physicians who allegedly had entered into agreements either not to contract with managed care plans at all, or to do so only through collective negotiations. In these cases, the FTC typically alleged that the physicians had not integrated their practices at all or, if the agency conceded some integration had taken place, it argued that minimal integration did not excuse physician joint conduct. All but one of these cases settled, typically with injunctions requiring the physicians not to engage in such conduct in the future.[25]

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[22] These early efforts were strongly opposed by organized medicine, including the American Medical Association, which sought to prevent its members from being employed by or otherwise working with certain prepaid health plans. One such boycott, aimed at Group Health Association, Inc. in Washington D.C., resulted in a successful criminal prosecution. *See* AMA v. United States, 317 U.S. 510 (1943).

[23] *See supra* Chapter V.

[24] *Id.*

[25] For summaries of cases brought by the Federal Trade Commission, see, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS 7–44, FTC, Bureau of Competition, Health Care Division (April 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/2022.04.08%20Overview%20Healthcare%20%28final%29.pdf. The one exception which resulted in a litigated case in which the FTC prevailed involved North Texas Specialty Physicians, discussed *infra*.

DOJ staff also investigated provider groups that engaged in joint negotiations the agency believed should be condemned not just as *per se* illegal, but as criminal conduct. This effort achieved mixed results, at best. DOJ's first prosecution, *United States v. Alston*, involved a group of about 50 dentists in Tucson, Arizona, who, after meeting in one dentist's office, agreed to send an identical letter to various health plans requesting higher copayment fees.[26] Subsequently the plans agreed to the requested fee schedule. The case against three of the ringleaders was tried before a jury, which returned guilty verdicts against all defendants. The district court judge overturned the verdicts, however, granting an acquittal for two of the defendants and ordering a new trial for the third.

On appeal, the Ninth Circuit affirmed, in an opinion authored by Judge Alex Kozinski, finding that the district court had not abused its discretion. The court went out of its way to note this was the first criminal prosecution of health care professionals in half a century and directed, on remand, the district court to consider jury instructions suitable to the unique circumstances presented. The message was clear: obtaining a conviction of health care professionals before a jury, even in circumstances that would clearly constitute *per se* illegal activity, would be very challenging. With one minor exception, also in the 1990s, DOJ has not brought another criminal prosecution alleging physician price-fixing since.[27]

Physician advocates sought relief from what they viewed as heavy-handed antitrust enforcement that ignored the imbalance in negotiating power physicians believed they suffered with health plans. One approach, which would allow physicians to collectively negotiate with plans, had been suggested by the Supreme Court in *Maricopa* decision itself. Recall that the doctors who joined the foundations maintained their separate practices, along with their separate fee schedules. But the doctors agreed (through the foundations) to set a maximum rate above which no doctor could bill an insurer with which the foundation contracted and they agreed not to "balance bill" patients for the amount by which a treating physician's fee might exceed the maximum. By a 4–3 vote, the Supreme Court held the agreement setting a maximum rate was *per se* unlawful price fixing in violation of Section 1.

But, in an important paragraph at the end of the majority opinion, Justice Stevens indicated that physicians—while maintaining separate practices—might still enter into arrangements that could escape *per se* condemnation under Section 1:

> The foundations are not analogous to partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit. In such joint ventures, the partnership is regarded as a single firm competing with other sellers in the market. If a [group of doctors] offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price fixing agreement among the doctors would be perfectly proper."[28]

By this language the Court acknowledged that competing physicians could lawfully join together in an organization and contract with one or more insurers (or health plans) at rates agreed upon by the doctors, so long as they were taking and sharing risk of loss and the opportunity for profit.

What are the mechanics of taking and sharing risk?

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[26] United States v. Alston, 974 F.2d 1206 (9th Cir 1992).

[27] DOJ filed a one count information in 1995 against an optometric association for conspiring with unnamed co-conspirators to fix prices of eye examinations in central Texas. United States v. Lake Country Optometric Soc'y, (W-95-CR-114, 12/15/95). The association pled guilty and was fined $75,000. *See Summary of Antitrust Division Health Care Cases (Since August 25, 1983)*, at 15, DOJ (July 13, 1999), https://www.justice.gov/sites/default/files/atr/legacy/2007/08/14/0000_0.pdf. DOJ's Antitrust Division didn't bring another criminal case of any sort in health care until 2020, when it charged two oncology clinics in Florida with allocating markets in Florida. Leading Cancer Treatment Center Admits to Antitrust Crime and Agrees to Pay $100 Million Criminal Penalty, Office of Public Affairs, DOJ (Apr. 30, 2020), https://www.justice.gov/opa/pr/leading-cancer-treatment-center-admits-antitrust-crime-and-agrees-pay-100-million-criminal. Although the Division has brought several criminal cases since then, such as the Jindal case charging wage-fixing by health care businesses (discussed in Ch. V), it has not brought a case since 1995 charging criminal price fixing by providers.

[28] 457 U.S. at 356.

Typically, a health plan bears the risk that the amount it collects in premiums on behalf of its members might not cover the cost of providing those members with medically necessary care. Suppose a group of otherwise competing physicians form an organization (let's call it an independent practice association, or "IPA") that offers a health plan the opportunity to shift to the physicians some or all of the financial risk the plan bears. The physicians could assume this risk by agreeing to deliver care to the plan's members in exchange for a lump sum payment. This payment typically is set as a certain amount per member, per month. (In industry jargon, a payment "PMPM.") Now the IPA, not the health plan, bears the risk that the cost of providing all necessary care to the plan's members exceeds the amount paid on behalf of those members for their health coverage.

Why would physicians form an IPA and take this risk? Because there is also a possibility of financial reward. If the IPA is able to deliver necessary care for less than the PMPM, the cost savings accrue to the IPA. What are the consequences of the shift in risk? Before the shift, physicians individually billed the health plan for their services on a fee-for-service basis. The incentives in this situation are to compete for patients, to raise rates, and to provide more services for which fees can be charged. After financial risk shifts to a group of physicians, they no longer are simply competitors with an incentive to raise prices and overutilize, but rather are engaged in a joint venture in which they have incentives to work together, monitor overutilization, and improve their collective performance for the benefit of patients. Accordingly, there is the potential that their collaboration may have significant procompetitive benefits, and therefore should not be condemned at the outset as *per se* illegal.

In the 1990s, the FTC and DOJ agreed that efforts among competing providers to take and share risk could escape the *per se* condemnation of *Maricopa*. The agencies issued a set of "Statements of Antitrust Enforcement Policy in Health Care" in 1996, that explained how the agencies would apply the antitrust laws in nine specific situations.[29] The eighth of the nine statements, excerpted below, addressed "physician network joint ventures." The statement (which was effective until its withdrawal in 2023, see box after the excerpt), explained the importance of financial (and clinical) integration to a proper antitrust analysis, and set forth "safety zones" for financially-integrated networks that did not exceed certain share thresholds in the relevant geographic market.[30]

Statement of Department of Justice and Federal Trade Commission Enforcement Policy on Physician Network Joint Ventures

[1] In recent years, health plans and other purchasers of health care services have developed a variety of managed care programs that seek to reduce the costs and assure the quality of health care services. Many physicians and physician groups have organized physician network joint ventures, such as individual practice associations ("IPAs"), preferred provider organizations ("PPOs"), and other arrangements to market their services to these plans. Typically, such networks contract with the plans to provide physician services to plan subscribers at predetermined prices, and the physician participants in the networks agree to controls aimed at containing costs and assuring the appropriate and efficient provision of high quality physician services. By developing and implementing mechanisms that encourage physicians to collaborate in practicing efficiently as part of the network, many physician network joint ventures promise significant procompetitive benefits for consumers of health care services. [. . .]

[29] The process whereby the FTC and DOJ collaborated on drafting the *Statements* is discussed in an oral history recording of antitrust enforcers who were involved in that effort, as well as other developments in health antitrust. *See Milestones In AHLA and Health Law Interviews: Evolution of Government Antitrust Enforcement in Healthcare*, Am. Health L. Ass'n (Apr. 11, 2019, May 6, 2019); *Milestones In AHLA and Health Law Interviews:* Use and Rise of the FCA and Healthcare Fraud Enforcement, Am. Health L. Ass'n (Oct. 2, 2019, Oct. 29, 2019, Nov. 14, 2019); *Milestones In AHLA and Health Law Interviews: Evolution of the Appeals Process*, Am. Health L. Ass'n (June 11, 2019, Nov. 13, 2019), https://www.americanhealthlaw.org/about-ahla/a-history-of-excellence/milestones-in-ahla-and-health-law-interviews. The 1996 Statements were revisions of prior versions of the statements that were released in 1993 and 1994.

[30] STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, U.S. Dep't Just. & Fed. Trade Comm'n (Aug. 1996), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf.

[2] As used in this statement, a physician network joint venture is a physician-controlled venture in which the network's physician participants collectively agree on prices or price-related terms and jointly market their services. [. . .]

[3] . . . participants in a physician network joint venture [may] share substantial financial risk in providing all the services that are jointly priced through the network. . . . [S]uch risk sharing is [not] a desired end in itself, but . . . normally is a clear and reliable indicator that a physician network involves sufficient integration by its physician participants to achieve significant efficiencies. Risk sharing provides incentives for the physicians to cooperate in controlling costs and improving quality by managing the provision of services by network physicians.

[4] The following are examples of some types of arrangements through which participants in a physician network joint venture can share substantial financial risk:

> (1) agreement by the venture to provide services to a health plan at a "capitated" rate;
>
> (2) agreement by the venture to provide designated services or classes of services to a health plan for a predetermined percentage of premium or revenue from the plan;
>
> (3) use by the venture of significant financial incentives for its physician participants, as a group, to achieve specified cost-containment goals. Two methods by which the venture can accomplish this are:
>
> > (a) withholding from all physician participants in the network a substantial amount of the compensation due to them, with distribution of that amount to the physician participants based on group performance in meeting the cost-containment goals of the network as a whole; or
> >
> > (b) establishing overall cost or utilization targets for the network as a whole, with the network's physician participants subject to subsequent substantial financial rewards or penalties based on group performance in meeting the targets; and
>
> (4) agreement by the venture to provide a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialties offering a complementary mix of services, for a fixed, predetermined payment, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors.

[5] The Agencies recognize that new types of risk-sharing arrangements may develop. The preceding examples do not foreclose consideration of other arrangements through which the participants in a physician network joint venture may share substantial financial risk in the provision of medical services through the network. [. . .]

1. Determining When Agreements Among Physicians In A Physician Network Joint Venture Are Analyzed Under The Rule Of Reason

[6] Antitrust law treats naked agreements among competitors that fix prices or allocate markets as per se illegal. Where competitors economically integrate in a joint venture, however, such agreements, if reasonably necessary to accomplish the procompetitive benefits of the integration, are analyzed under the rule of reason. In accord with general antitrust principles, physician network joint ventures will be analyzed under the rule of reason, and will not be viewed as per se illegal, if the physicians' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be per se illegal) by the network physicians are reasonably necessary to realize those efficiencies.

[7] Where the participants in a physician network joint venture have agreed to share substantial financial risk as defined [above in] this policy statement, their risk-sharing arrangement generally establishes both an overall efficiency goal for the venture and the incentives for the physicians to meet that goal. The setting of price is integral to the venture's use of such an arrangement and therefore warrants evaluation under the rule of reason.

[8] Physician network joint ventures that do not involve the sharing of substantial financial risk may also involve sufficient integration to demonstrate that the venture is likely to produce significant efficiencies. Such integration can be evidenced by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.

[9] The foregoing are not, however, the only types of arrangements that can evidence sufficient integration to warrant rule of reason analysis, and the Agencies will consider other arrangements that also may evidence such integration. However, in all cases, the Agencies' analysis will focus on substance, rather than form, in assessing a network's likelihood of producing significant efficiencies. To the extent that agreements on prices to be charged for the integrated provision of services are reasonably necessary to the venture's achievement of efficiencies, they will be evaluated under the rule of reason.

[10] In contrast to integrated physician network joint ventures, such as these discussed above, there have been arrangements among physicians that have taken the form of networks, but which in purpose or effect were little more than efforts by their participants to prevent or impede competitive forces from operating in the market. These arrangements are not likely to produce significant procompetitive efficiencies. Such arrangements have been, and will continue to be, treated as unlawful conspiracies or cartels, whose price agreements are per se illegal.

[11] Determining that an arrangement is merely a vehicle to fix prices or engage in naked anticompetitive conduct is a factual inquiry that must be done on a case-by-case basis to determine the arrangement's true nature and likely competitive effects. However, a variety of factors may tend to corroborate a network's anticompetitive nature, including: statements evidencing anticompetitive purpose; a recent history of anticompetitive behavior or collusion in the market, including efforts to obstruct or undermine the development of managed care; obvious anticompetitive structure of the network (e.g., a network comprising a very high percentage of local area physicians, whose participation in the network is exclusive, without any plausible business or efficiency justification); the absence of any mechanisms with the potential for generating significant efficiencies or otherwise increasing competition through the network; the presence of anticompetitive collateral agreements; and the absence of mechanisms to prevent the network's operation from having anticompetitive spillover effects outside the network.

Withdrawal of the 1996 Health Care Statements

The *Statements of Antitrust Enforcement Policy in Health Care*, issued in 1996 by DOJ and the FTC, covered nine areas, including hospital mergers, certain types of joint ventures, information sharing, joint purchasing, and network joint ventures among physicians and other providers. Most statements included "antitrust safety zones," which described "conduct that the Agencies will not challenge under the antitrust laws, absent extraordinary circumstances." Statement 8 above, for example, included a safety zone for physician network joint ventures with no more than 20% or 30% of the physicians in a relevant market, the percentage depending on whether the network was "exclusive" or not. (An exclusive network was defined as one through which member physicians did all their contracting; if physicians retained the ability to contract outside the network then the network was "nonexclusive.") The agencies also emphasized that arrangements falling outside the safety zones were not necessarily unlawful.

The statements were well received by health care lawyers and industry participants. While the safety zones generally were considered cautious, the statements provided useful guidance on how to analyze more ambitious arrangements that fell outside the safety zones. Many antitrust lawyers advising industries outside health care also came to rely on certain of the statements as well. In particular, Statement 6, which covered provider participation in exchanges of price and cost information, was widely influential in non-health care industries. Statement 6 established a safety zone for an exchange of price and cost information that was administered by a third-party and sought data that was at least

three months old and was provided by at least five providers (no one of which could account for more than 25% of a particular statistic). All information disseminated had to be "sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider."

In 2023, first DOJ, and then the FTC (by a 3–0 vote), withdrew the statements. DOJ called the statements "outdated," asserting that as a result of significant changes in the healthcare landscape, "the statements are overly permissive on certain subjects, such as information sharing, and no longer serve their intended purposes of providing encompassing guidance to the public on relevant healthcare competition issues in today's environment."[31] Unfortunately, the agencies gave no further explanation for the withdrawal and did not indicate which parts of the Statements were outdated and which, if any, might still accurately reflect agency policy. Some believe that what most troubled the agencies were parts of the Statements that provided for "safety zones," especially with respect to information exchanges and to mergers involving very small hospitals. Statement 8, concerning physician joint arrangements and discussed in the text above, probably continues to be consistent with agency policy, but this is unconfirmed.

No replacement statements have been issued and there is no indication any will be. The result, some critics have suggested, is to "reintroduce[] uncertainty in several areas in which the health-care industry had relied on the guidance."[32]

The FTC supplemented Statement 8 by providing guidance in the form of a series of Staff Advisory Opinions in response to requests from physician groups that were planning various arrangements that would involve joint negotiations with health plans.[33] Among other things, these Advisory Opinions described arrangements that relied on "clinical integration" without substantial financial risk-sharing. The reason to exclude these arrangements from *per se* treatment was that clinically integrated physicians would engage in a variety of joint activities that would help them control utilization and assure quality. So long as joint negotiations were "ancillary," *i.e.*, reasonably necessary, to the success of these efficiency-enhancing activities, such negotiations were to be judged under the rule of reason.

The Advisory Opinions process provided guidance to address the commonly asked question of "how much integration is enough" to warrant rule of reason treatment and what rationale was acceptable to FTC staff as a basis of concluding that the conduct was ancillary to achieving the potential benefits. Importantly, both the requests for Advisory Opinions (including detailed information about the planned arrangements), and the FTC staff's analyses,[34] were made available to the public, thereby providing roadmaps to the FTC's approach to such issues.

The 2002 Advisory Opinion Request concerning MedSouth, Inc., a physician group in Denver, Colorado, was the first dealing with a clinically integrated arrangement that had no financial risk-sharing whatsoever.

FTC, Advisory Opinion to Miles re MedSouth, Inc. (2002)[35]

Dear Mr. Miles:

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[31] Justice Department Withdraws Outdated Enforcement Policy Statements, Off. of Pub. Aff., U.S. Dep't of Just. (Feb. 3, 2023), https://www.justice.gov/opa/pr/justice-department-withdraws-outdated-enforcement-policy-statements; Federal Trade Commission Withdraws Health Care Enforcement Policy Statements, F.T.C. (July 14, 2023) https://www.ftc.gov/news-events/news/press-releases/2023/07/federal-trade-commission-withdraws-health-care-enforcement-policy-statements.

[32] Susan Feigin Harris, Carsten Reichel, Gerald Stein, *Axing Health-Care Antitrust Safety Zones will Impact Transactions*, Bloomberg L. (Feb. 21, 2023), https://news.bloomberglaw.com/us-law-week/axing-health-care-antitrust-safety-zones-will-impact-transactions.

[33] Further information from the FTC about its Advisory Opinion process as it relates to health care matters can be found at *Guidance From Staff of the Bureau of Competition's Health Care Division on Requesting and Obtaining an Advisory Opinion*, F.T.C. (Oct. 2015), https://www.ftc.gov/system/files/attachments/competition-advisory-opinions/advisoryopinionguidance-hc_updated_links_oct2015.pdf.

[34] To give you a sense of the kind of info that backs up a request for an Advisory Opinion, here is a link to additional information that was given to the FTC staff by lawyers seeking an advisory opinion in another request involving a clinically integrated arrangement. Incoming Request for Advisory Opinion Filed by Christi Braun regarding TriState Health Partners, Inc., F.T.C. (July 9, 2007), http://www.ftc.gov/sites/default/files/documents/advisory-opinions/tristate-health-partners-inc./090413requesttristate.pdf.

[35] *Advisory Opinion to Miles*, F.T.C. (Feb. 19, 2002), https://www.ftc.gov/legal-library/browse/advisory-opinions/advisory-opinion-miles-02-19-02.

[1] You have requested an advisory opinion relating to the proposal of MedSouth, Inc., a physician independent practice association located in Denver, Colorado, to integrate partially its member physicians' practices in the ways discussed below, and to enter into contracts with third-party payers for the sale of those physicians' services on a fee-for-service basis. Specifically, you request a statement whether the Commission staff would recommend a challenge to the proposed activities as a violation of Section 5 of the Federal Trade Commission Act.

[2] Based on the information you provided as well as our independent inquiry, we have concluded that *per se* analysis would not be appropriate in evaluating MedSouth's proposed course of conduct, including its proposed joint negotiation of payer contracts. The program you have described appears to involve partial integration among MedSouth physicians that has the potential to increase the quality and reduce the cost of medical care that the physicians provide to patients. In addition, we have concluded that the joint contracting appears to be sufficiently related to, and reasonably necessary for, the achievement of the potential benefits to be regarded as ancillary to the operation of the venture.

[3] In the context of an advisory opinion, which by definition involves prospective analysis of proposed conduct, we do not have the kind of evidence on the magnitude of the efficiencies that will be produced, or on the extent to which competition in the market will be restrained, that is necessary to reach a conclusion about the overall competitive effect of the venture. We cannot predict at this juncture to what extent the program -- which is still being developed—actually will achieve the efficiencies that MedSouth anticipates. There is evidence that MedSouth's current physician members may collectively possess the ability to exercise significant market power. We do not know, however, how many members MedSouth will have when the joint negotiation is undertaken, or to what extent MedSouth members would attempt to coordinate their contracting behavior outside the IPA or otherwise engage in practices that impair competition unreasonably. For purposes of this advisory opinion, we accept your representation that MedSouth will operate as a non-exclusive network, so that its participating physicians will be available to contract with payers individually. On balance, therefore, we have concluded that we would not recommend at this time that the Commission bring an enforcement action against MedSouth if it engages in the proposed conduct. As long as MedSouth's physician members actually are available and willing to contract individually with payers who prefer not to contract with the network, at prices that do not reflect the aggregate power of the group, or its membership is at a level where the network physicians are unable to exercise significant market power, implementation of the arrangement is not likely to endanger competition unreasonably. We will, however, closely monitor MedSouth's activities, and will recommend that the Commission take appropriate action if the proposed conduct appears to result in actual anticompetitive effects.

Description

MedSouth

[4] MedSouth is an independent practice association (IPA) that includes competing primary care and specialist physicians who practice in the "South Denver/Arapahoe County" area of Denver, Colorado. It is a for-profit corporation owned by the physician practices of its members. All MedSouth physicians have a practice location in South Denver, and staff privileges at one of the three hospitals located in that area.

[5] As we understand the facts based on the information you have submitted, MedSouth currently includes approximately 432 physicians in 216 practices. One hundred one of the physicians are primary care practitioners (PCPs) (family practitioners, general internists, and pediatricians); and 331 are specialists in 39 specialties and subspecialties. In general, the specialists in MedSouth are those to whom MedSouth PCPs most frequently refer. Until the year 2000, MedSouth had capitated risk contracts with payers that required most referrals to be made to other physicians in MedSouth. The referral patterns established under those contracts largely have continued. MedSouth estimates that its PCPs make 90% to 95% of their referrals to specialty physicians in MedSouth. MedSouth's specialists, however, also receive a large number of referrals from doctors outside the IPA.

[6] MedSouth expects that a number of its current members will terminate their membership in the organization before it fully implements the proposed program and attempts to negotiate contracts, so that it will represent fewer physicians in negotiations with payers than currently are members. The IPA is not currently accepting new member practices, and it does not intend to do so in the future, except perhaps in practice areas where it has no or few members and has a definite need for the services in question. It does permit physicians who join practices whose members already are MedSouth participants to become participating physicians, but few practices have taken on new members recently.

[7] Contractual relationships between physicians and payers in the Denver area have undergone significant change in the past several years. Beginning in 1998 or 1999, Denver physicians established a number of financially-integrated IPAs that entered into capitated contracts with local HMOs. Many of these groups experienced significant financial difficulties under those contracts, and a number of the organizations declared bankruptcy. In the wake of this experience, payers and most physician groups, including MedSouth, terminated their capitated contracts. Some MedSouth physicians, however, wish to continue to practice on a partially-integrated basis with other members of the IPA.

The Proposed Integration Program

[8] MedSouth proposes to implement a program that it believes will result in lower costs, higher quality, and more efficient delivery of its members' services. MedSouth has not yet placed the program into operation, or engaged in negotiation or contracting with insurance plans concerning the provision of physician services under the program. The essential features of the program, however, have been determined, and MedSouth has developed or is in the process of developing its various components. According to your letter, the proposed program has three major goals:

[9] 1. to integrate the provision of primary and specialty services so they are delivered in a coordinated fashion; 2. to integrate these coordinated physician services with a clinical resource management program that involves sharing of patient clinical information, development and implementation of practice protocols, and oversight and reporting of physicians' performance relative to preestablished benchmarks, so as to improve patient outcomes, decrease use of physician resources, and provide MedSouth with a competitive advantage with respect to other physician practices in the area; and 3. to offer payers a network in which all physicians have agreed to participate and in which the physicians will work together to improve care and to compete with other physicians and physician groups.

[10] MedSouth's physicians and its consultants, in conjunction with a health care information technology service provider and a national clinical laboratory company, have worked for over a year to develop the proposed program. It will have two major parts: (1) a web-based electronic clinical data record system that will permit MedSouth physicians to access and share clinical information relating to their patients; and (2) the adoption and implementation of clinical practice guidelines and performance goals relating to the quality and appropriate use of services provided by MedSouth physicians. All physicians contracting through MedSouth will be required to participate in these activities. With these systems, MedSouth believes it will be able to improve and standardize members' treatment of specific diagnoses and their fulfillment of standards of care; reduce medical errors and improve patient care outcomes; permit its members to provide their services more efficiently and to reduce the aggregate long-term cost of physician services; and demonstrate to payers, employers, and others that the integrated and coordinated delivery of services by primary care and specialist physicians can improve the quality and delivery of physician services. [. . .] {*Eds.: The omitted paragraphs describe the program in greater detail.*}

Negotiation of Contracts

[11] MedSouth proposes to offer the medical services of its participating members pursuant to this program to commercial third-party payers, and to negotiate and execute contracts under which MedSouth members would provide services to health plan enrollees. Thus, the IPA will seek to negotiate price and other contract terms on behalf of physician members of the network. It will retain a consultant to develop fee proposals for use in contract negotiations

and, if necessary, to gather information from MedSouth physicians. The consultant will not disclose competitively sensitive information received from MedSouth physicians to other physicians in the network. ....

[12] While MedSouth seeks to offer its members' services to payers as a package, you represent that it is intended to be, and will actually be, a non-exclusive network…

Analysis

Form of Analysis

[14] The first question to be addressed is how MedSouth's proposed negotiation of fee-for-service contracts on behalf of its participating physicians should be analyzed. The information sharing and guidelines activities that MedSouth proposes to undertake, by themselves, are not inherently anticompetitive. Agreement by a group of physicians jointly to adopt an electronic patient record system that permits them more easily to communicate and share information about their patients, or to adopt and promote adherence to recognized, evidence-based practice guidelines or clinical protocols, would not normally raise serious concerns about anticompetitive effects.

[15] Standing alone, however, joint negotiation of price terms by non-integrated, competing physicians would constitute an agreement among the physicians not to compete on price, and would be illegal *per se*. *Per se* treatment is inappropriate, however, and more elaborate analysis under the rule of reason is warranted, when the joint negotiation of price is reasonably related to an efficiency-enhancing integration of the participants' economic activity and is reasonably necessary to achieve the procompetitive benefits of that integration. How detailed that analysis should be depends, of course, on the circumstances. As the Supreme Court has ruled, truncated analysis under the rule of reason may be appropriate in some cases.

[16] Efficiency-enhancing integration typically involves joint performance of one or more business functions of the participants in a way that potentially benefits consumers by expanding output, reducing price, or enhancing quality, service or innovation, and that could not reasonably be achieved by the participants individually. The integration must likely generate procompetitive benefits that enhance the participants' ability or incentives to compete, and thus offset any anticompetitive tendencies of the arrangement. Joint negotiation of prices is not "reasonably necessary" if the participants could achieve an equivalent or comparable efficiency-enhancing integration through practical means that provide significantly less restriction on competition.

[17] We conclude that MedSouth's overall proposed course of conduct, as described in the information you have supplied, should not be accorded *per se* treatment. The program in which MedSouth proposes to engage appears to be capable of creating substantial partial integration of the participating physicians' practices, and to have the potential to produce efficiencies in the form of higher quality or reduced costs for patient care services rendered by network physicians. More elaborate analysis under the rule of reason, therefore, is warranted.

Integration and Likely Efficiencies

[18] Taken as whole, the proposed program is designed to facilitate and increase communication and cooperation among MedSouth physicians, both in the treatment of individual patients and in modifying the regular practice patterns of members of the IPA. The collective development and implementation of the protocols and benchmarks has the potential to create significant integration and interdependence among the physicians in their rendering of medical services. The physicians have pooled their resources and expertise to identify common standards of care. Through their agreement to abide by those standards, the physicians have subjected themselves, to some extent, to the collective judgment of the group with respect to their patterns of practice; and they have agreed to make themselves individually and collectively accountable for their performance by making information about their achievement of goals, which are linked to those standards, available to customers. . . .

The Relationship of Joint Contracting to the Production of Efficiencies

[19] The extent to which collective negotiation of prices is ancillary to this integration is a crucial question. Generally speaking, an agreement is ancillary to a competitor collaboration to the extent that it is subordinate to and reasonably necessary to accomplish the goals of the integration, unless the parties could have achieved similar efficiencies by practical, significantly less restrictive means. It may be possible to develop an arrangement, apart from payment for the professional services of the network physicians, under which those physicians could be appropriately compensated for the costs entailed in providing programs of the type MedSouth intends to undertake. In this instance, however, we conclude that the price agreement embodied in joint negotiation of contracts for services to be provided subject to the entire proposed program appears to be reasonably related to the integration among MedSouth members, and reasonably necessary for MedSouth to achieve the procompetitive benefits it seeks.

[20] In order to establish and maintain the on-going collaboration and interdependence among physicians from which the projected efficiencies flow, the doctors need to be able to rely on the participation of other members of the group in the network and its activities on a continuing basis. This does not appear to be possible if contracting for the sale of services is done individually. The price for professional services rendered under health plan contracts needs to be established, and if it is done through individual negotiation and contracting, then no one can count on the full participation of the group's members. Whatever value the program has for consumers, beyond what would result from individual doctors computerizing their records and determining to follow particular guidelines, is significantly dependent on the doctors being able to function as a group within which patients are commonly referred. In the absence of the group being able to assure continuing participation of its members in its contracts, some of the benefits are likely to go unrealized.

[21] In addition, joint contracting may permit the network to allocate the returns among members of the network in a way that creates incentives for the physicians to make appropriate investments of time and effort in setting up and implementing the proposed program. According to your letter, it is important for MedSouth to be able to assure that the rewards from the program flow to the doctors in an equitable manner, so that some are not able to charge disproportionately high prices relative to other members, and thereby capture an excessive proportion of the value of the network's programs. . . .

Competitive Effects

[22] The fundamental concern of antitrust analysis is whether a given arrangement may have a substantial anticompetitive effect and, if so, whether that potential effect is offset by any procompetitive efficiencies resulting from the conduct. The central question is whether, taking into account both potential procompetitive and anticompetitive effects, the arrangement is likely to harm competition by increasing the ability or incentive of the participants to raise price above—or reduce output, quality, service, or innovation below— the level that likely would prevail in the absence of the agreement. The ability and incentive of the participants to compete individually with one another and with their joint undertaking is an important part of the analysis.

[23] Because the proposed program is yet to be implemented, it appears to be impossible at this point to predict the magnitude of anticompetitive or procompetitive effects that will flow from its actual operation. You were not able to obtain reliable information that would allow us to determine with any precision the relevant geographic markets for the services to be delivered through the network. However, the information available to us indicates that the MedSouth membership as presently constituted likely would be able to exercise significant market power, and thus to extract higher prices, if the doctors coordinate their actions outside the integrated group.

[24] MedSouth currently has a large number of participating doctors who are concentrated in a distinct area of the city. In a number of specialties, they constitute half or more of the physicians with admitting privileges at the three hospitals in south Denver. Of particular significance with respect to the needs of local health plans that contract for physician services, MedSouth contains a substantial proportion of the internists and family practitioners in the south Denver area. For example, MedSouth's current members are 51% of the internists and 33% of the family practitioners at Swedish Hospital, and from 50% to 100% of the specialists in 19 other practice areas at that hospital

(allergy/immunology, cardiology, endocrinology, hematology/oncology, infectious disease, nephrology, neurology, oncology, pulmonary medicine, radiology, rheumatology, hand surgery, neurosurgery, pathology, podiatric surgery, urology, vascular surgery, pediatric cardiology, and pediatric neurology). They are 44% of the family practice physicians and 48% of the internists at the two Adventist hospitals, and from 50% to 100% of the specialists in 21 other fields at those two hospitals (allergy, cardiology, cardiovascular surgery, endocrinology, gastroenterology, gynecology. infectious diseases, nephrology, neurology, neurosurgery, oncology, otolaryngology, otology, pathology, podiatry, pulmonology, radiation oncology, radiology, rheumatology, hand surgery, and urology). As noted above, however, we do not know how many of these physicians will remain members of MedSouth after the venture is launched. A significant decrease in the number of MedSouth participating physicians would lessen the risk of anticompetitive harm . . .

[25] In spite of MedSouth's explicit policy of "nonexclusivity," MedSouth members may have the incentive and the ability to agree not to contract independently of the venture. They have incentives to seek higher fees to recoup their investments in developing and implementing the proposed program. Negotiation of fee-for-service rates for the group will involve identification of price levels that could become the focal point for collusion on individual contracts. To the extent that the program creates greater communication and interdependence among the doctors, the easier it likely would be for them to coordinate their activities. Particularly in light of the doctors' existing referral arrangements, MedSouth members may be able to discipline members of the IPA who might be inclined to break ranks and contract independently. We cannot conclude with certainty that MedSouth's physicians actually will contract outside the IPA; nor can we conclude, at this early stage, that MedSouth's operation will restrict competition unreasonably. MedSouth plans to take steps to ensure that its physicians will in fact be available to contract independently with health plans. We recognize, further, that MedSouth physicians apparently did contract with health plans individually at prevailing market prices when the IPA's capitated contracts were terminated. We assume for purposes of this advisory opinion that your representations regarding the availability of MedSouth members to contract individually with health plans at competitive rates is accurate and will be borne out by the members' actual conduct.

[26] In addition, we cannot now determine the extent to which the group will achieve the efficiencies that it expects. We are aware, however, that electronic record keeping and prescribing, and the application of evidence-based practice guidelines to regular clinical practice, are widely seen as potentially effective ways to increase the quality and efficiency of medical care. These practices may reduce errors, reduce the use of ineffective or counterproductive treatments, and increase the use of interventions that have been shown to be effective. We recognize the intention of MedSouth's leadership to achieve the goals they have established for the network, and the potential value of the means they have chosen to employ.

[27] The information we have obtained in analyzing physician markets suggests that, in actual practice, it is often difficult to change physicians' established patterns of practice. Doing so does not result simply from the adoption of guidelines and benchmarks. Rather, the effectiveness of such programs depends upon a number of intangible factors, including the degree of commitment to the process by the members of the group and the effectiveness of its leadership. To change practice patterns requires an ongoing commitment of time, effort, and expertise, and it can be difficult to accomplish even when there are significant external incentives to do so. The experience of other physician groups indicates that it is harder to achieve implementation of this type of program in a large group, in the absence of direct financial risk relating to achievement of network goals, or where the physicians are not already closely connected to one another, and that each physician needs to have a significant number of patients subject to the system before it has an actual impact on his or her practice patterns.

[28] The ultimate conclusion we draw in this advisory opinion turns in substantial measure on your representations concerning MedSouth's determination and ability to overcome these challenges. MedSouth has established efficiency goals and developed concrete plans to achieve them. We think a conclusion at this stage that MedSouth is unlikely to achieve the efficiencies it seeks is unwarranted. Nonetheless, the extent to which efficiencies actually are achieved would be an important factor in assessing the overall competitive effects of the proposed conduct.

Conclusions

[29] We conclude, on balance, that the proposed program appears to have the potential to improve the quality and effectiveness of health care services that are delivered to patients, and thus to provide important benefits to consumers. Given the prospective nature of the analysis inherent in an advisory opinion, we do not have any direct evidence of either efficiencies or competitive effects. Based on all the factors discussed above, we have concluded that we would not recommend a challenge to MedSouth fully implementing the program and then offering it to payers on a collective basis. As long as doctors are, in fact, willing to deal individually on competitive terms with payers who do not want the package product, as you represent will be the case, significant anticompetitive effects appear unlikely. If final physician participation in the group is significantly smaller than MedSouth's current membership, significant anticompetitive effects, likewise, may be unlikely. If, however, MedSouth's member physicians are able to use collective power to force payers to contract with the network or to pay higher prices, then absent evidence that substantial efficiency benefits outweighed likely anticompetitive effects, we likely would recommend that the Commission bring an enforcement action. As your letter recognizes, members of the network face an increased antitrust risk to the extent that they do not actually agree to contract with health plans independent of the network and at competitive prices, either when a payer prefers as an initial matter not to purchase the group product or when it has done so and then desires to return to individual contracting. Of course, concerted refusal by some or all of MedSouth's members to deal with payers outside of the IPA would appear to be unrelated to the joint venture presented in your request, and, thus, to be illegal *per se*. This office will monitor MedSouth's operations and the behavior of its physician members for indications that the proposed conduct is resulting in significant anticompetitive effects. . . .

Sincerely yours,

Jeffrey W. Brennan
Assistant Director

* * *

FTC staff issued several other Advisory Opinions in the 2000s providing additional gloss to the analysis in *MedSouth*. These were all favorable, with one exception: a request from Suburban Health Organization, Inc. ("SHO").[36] SHO functioned as a "super physician-hospital organization ("PHO")" composed of several PHOs (seven were affiliated with separate local hospitals and one with a multi-facility health system) operating in a suburban ring around Indianapolis. Each PHO employed primary care physicians. While there was minimal overlap across the hospitals' 192 employed primary care physicians, SHO made no claim that their member physicians were not competitors. SHO sought an advisory opinion with respect to its plan to negotiate fees for the physicians.

FTC staff declined to issue a favorable opinion, concluding instead that the proposed arrangement did not involve the type of interdependence *across* physicians in the various PHOs that was the hallmark of successful clinically integrated programs and that SHO had not provided a rationale for why it needed joint negotiations to achieve its legitimate goals. Because the physicians were employed by their respective hospitals, FTC staff noted, each of the separate PHOs already had the ability to ensure that its physicians complied with programs to improve their performance.

The Pros, Cons, and Pitfalls of Agency Informal Guidance

The most forceful and direct way in which the antitrust agencies can communicate their enforcement agendas and seek to shape antitrust law is by successfully bringing cases. But there are drawbacks to relying solely on successful litigation. Such an approach is largely reactive—enforcers can only prosecute conduct that occurs and about which they are aware. And cases can be messy things, often involving complicated fact scenarios from which it may be difficult to draw clear conclusions. Litigation is also time-consuming and resource-intensive. Judges may be unpredictable.

[36] Advisory Opinion concerning Suburban Health Organization, F.T.C. (2006), https://www.ftc.gov/sites/default/files/documents/advisory-opinions/suburban-health-organization/suburbanhealthorganizationstaffadvisoryopinion03282006.pdf.

Most have little antitrust background and there are substantial risks that courts will not find for the agency, or that they will issue opinions that muddy the waters rather than provide clear guidance for market participants and their counsel.

Enforcers have several tools at their disposal other than litigation to make their views known. The health care sector, more than any other sector of the economy, has been the subject of a broad range of such initiatives since the 1980s. One reason is that the application of antitrust to health care was relatively new and physicians (and their counsel) had little experience with respect to antitrust sensitivities in this sector; indeed forty or more years ago many physicians believed—or at least hoped—that antitrust either would not apply or would apply more leniently to their profession.[37]

Second, both physicians and hospitals were well-organized politically, and strenuously lobbied Congress and state legislatures for antitrust exemptions in response to the new scrutiny to which they were being subjected. They argued that antitrust enforcers did not understand how health care markets worked and that traditional antitrust law should not apply in light of the professional nature of health care services, the non-profit structure of many entities, the power of health plans, and a host of other reasons. Thus, for example, legislation that would have exempted joint negotiations by physicians with health plans was considered by Congress and many states throughout the 1990s.[38] In response to such threats, the agencies wished to assure legislators that they did, in fact, understand health care markets and were furnishing helpful guidance to health care providers.

This guidance took several forms. Senior agency officials gave periodic speeches describing their views on antitrust concerns raised by provider conduct and outlining how providers could avoid antitrust risks in structuring and implementing their arrangements. For example, in a 1997 speech, FTC Chair Robert Pitofksy specifically addressed arguments that physicians should be able to join together to "level the playing field" with dominant health plans. More than 25 years later it still reads well.[39]

The FTC, through its Advisory Opinions, and the DOJ, through its similar Business Review Letters, issued public responses to specific requests for advice, taking great pains to explain their analytical approaches. As discussed above, in 1996, the FTC and DOJ issued a set of *Joint Statements on Antitrust Enforcement Policy in Health Care* (drafts of which had been issued in 1993 and 1994). The Statements were a direct and deliberate attempt to mollify Congressional concerns that the Agencies were uninformed about health care and that providers faced uncertainty as to how they could conduct their activities without antitrust challenge.

To this day, these have been the only Guidelines the agencies have issued targeted at a specific industry sector. Providing such informal guidance enables the agencies to be much more expansive and nimble in how they communicate to the public in general and the antitrust bar more specifically. Guidelines satisfy demands for

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[37] This belief may have been inadvertently spurred, in part, by the same decision that otherwise sounded the death knell for the claim that the professions were beyond the reach of the antitrust laws. In Goldfarb v. Virginia State Bar, 421 U. S. 773, 788 n.17 (1975), the Supreme Court stated that the "public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently." But in *Maricopa* seven years later the Court rejected the notion that physician agreements on price should not be subjected to the *per se* rule because physicians (as opposed to other participants in any other industry in the U.S. economy) were doing the price fixing.

[38] The Quality Health-Care Coalition Act of 2000 (QHCCA) was passed by the House of Representatives in the 106th Congress, but did not reach the floor of the Senate. It would have enabled health-care professionals to negotiate jointly with non-federally affiliated health plans concerning "the terms of any contract under which the professionals provide health care items or services for which benefits are provided under such plans." H.R. 1304, 106th Cong., JOINT NEGOTIATION BY HEALTH-CARE PROFESSIONALS: H.R. 1304, QUALITY HEALTH-CARE COALITION ACT OF 2000, Cong. Rsch. Ser. Rep. for Cong. (July 17, 2000), https://www.everycrsreport.com/files/20000717_RS20410_fd05e534251277417aec286b51411767406c00f8.pdf.

[39] *See* Robert Pitofsky, *Thoughts on 'Leveling the Playing Field' in Health Care Markets*, F.T.C. (Feb. 13, 1997), https://www.ftc.gov/news-events/news/speeches/thoughts-leveling-playing-field-health-care-markets. The practice of highlighting an administration's particular enforcement direction in health care through speechmaking continues to the present. FTC Chair Lina Khan, for example, spoke to the AMA in early 2024 to announce the FTC plans to investigate "corporate decision-makers" and "middlemen" who "can have an outsized say in how you do your jobs as physicians, and more broadly, in the type of care that patients receive." *See Remarks by Chair Lina M. Khan As Prepared for Delivery American Medical Association National Advocacy Conference*, F.T.C. (Feb. 13, 2024), https://www.ftc.gov/system/files/ftc_gov/pdf/remarks-chair-khan-ama-national-advocacy-conference.pdf.

transparency and can provide clear guardrails that antitrust counsel can use in advising clients, although it should be noted that they are not regulations, and need not meet the notice and comment and other requirements of the Administrative Procedure Act. While this guidance doesn't have the force of law, it may be instructive to courts when similar issues come before them. And guidelines require relatively few resources to develop.

There are drawbacks, however, to informal agency guidance. First, guidance runs the risk of tying the hands of enforcers in future cases in unintended and unanticipated ways. And it may be used by parties outside the context in which it was provided.

Second, antitrust officials typically have viewed themselves as "enforcers" who prosecute parties who have violated the antitrust laws, not as "regulators" who prescribe what conduct should or should not be taken.[40] Antitrust guidelines run the risk of being perceived as regulations and they may direct market participants in ways that may be more restrictive than warranted, especially with respect to "safety zones" that necessarily must be drafted very conservatively.

So, for example, in drafting the discussion in Statement 8 regarding the factors that might be considered in assessing whether a physician arrangement is sufficiently integrated, agency staff were careful to describe the factors conceptually, in very general terms, notwithstanding repeated requests from the provider community for greater specificity. Staff was concerned that not only did they lack the knowledge to detail what particular elements must be included in an arrangement, but that whatever details they did suggest might be rigorously adhered to even when they may not have been effective or practical. To ameliorate this, the Statements presented more detailed guidance in the form of hypotheticals, which can be used to illustrate principles.

A third drawback of agency guidance is it can be withdrawn easily as administrations change, potentially resulting in uncertainty for private parties. And, indeed, as explained above, in 2023 the agencies rescinded their support for the 1996 Statements.

NOTES

1) The FTC *MedSouth* Advisory Opinion was intended not only to give advice to the requestors, but also to provide guidance to the public more generally on how the FTC analyzes provider networks. In what ways does it go beyond Statement 8 in doing so?

2) Providers who seek antitrust advice regarding clinical integration often raise certain practical questions, including those listed below. Give some thought as to how you would respond in light of the guidance that the antitrust agencies provided in the *Policy Statements* and Advisory Opinions that we have discussed:

   a. How much clinical integration is enough to allow for joint negotiations?
   b. Are there particular numbers and scope of coverage requirements for the clinical protocols?
   c. Can the hospital fund a physician clinical integration program?
   d. Can employed and independent physicians be clinically integrated?
   e. Can single-specialty physician networks be clinically integrated?
   f. Should payers play any role in the early development of the program?
   g. When can joint negotiations begin?
   h. How important is evidence of cost and quality gains?
   i. What are the risks of including too many, or too few, providers?
   j. Must the clinically integrated network be non-exclusive?
   k. What if prices go up?
   l. What if payers are not supportive?
   m. Should a clinically integrated network seek an advisory review from the antitrust agencies?

[40] Typically does not mean always: the FTC under Chair Khan issued a rule banning noncompetes in employment. As of early 2025, a district court has enjoined the rule and it is not being enforced. *See* "FTC Announces Rule Banning Noncompetes," (April 23, 2024) https://www.ftc.gov/news-events/news/press-releases/2024/04/ftc-announces-rule-banning-noncompetes.

n. Will the agencies provide any guidance short of a formal opinion?

3) Some physicians tried to find ways to deal collectively with health plans without having to integrate financially or clinically—and without running afoul of the *per se* rule. One approach to thread this needle was the so-called "messenger model," whereby physicians would retain an agent to poll them as to what minimum fee levels each individually found acceptable and then to "messenger" such information to a health plan. The health plan would send back to each physician (through the messenger) any contracts it was willing to offer. Each physician then would make an independent decision to accept or reject each contract offer; physicians would not be given any information by the messenger regarding what other physicians had communicated or decided.

4) Proponents of messenger models argued that without an agreement on price or collective action, no *per se* violation of Section 1 was possible. While the FTC accepted, in theory, the notion that this approach (if carefully adhered to) would minimize antitrust concerns, in practice messenger models proved unwieldy. Many physicians groups were subject to FTC investigations and challenges because the physicians employed a "messed up messenger model" in which the messenger had facilitated information exchanges among the physicians about their fees, refused to messenger what were considered "unacceptable" proposals, or otherwise facilitated what might be viewed as joint price negotiations among physicians.[41] While most of these matters were resolved through a settlement, one challenge, involving the North Texas Specialty Physicians in Fort Worth, Texas, was litigated, with the Fifth Circuit upholding the FTC's decision.

North Texas Specialty Physicians v. FTC

528 F.3d 346 (5th Cir. 2008)

Judge Owen.

[1] . . . NTSP is an organization of independent physicians and physician groups principally located in Tarrant County, which includes the city of Fort Worth, although physicians from seven other Texas counties are affiliated with NTSP. NTSP's size has varied. It had approximately 575 members in 2003 and 480 members in April 2004. As of 2003, NTSP was comprised of practitioners in 26 medical specialties but also included some primary care physicians. The ALJ found, and NTSP does not dispute, that in Tarrant County NTSP specialists were a large percentage of the practitioners within a specialty, for example 80 percent in pulmonary disease, 59 percent in cardiovascular disease, and 69 percent in urology. Many NTSP physicians compete with one another. All physicians pay a fee upon joining NTSP and elect representatives from their ranks to serve on its eight-member Board of Directors.

[2] When it formed in 1995, NTSP's original business model was to assemble physician groups and negotiate contracts between these groups and "payors," such as insurance companies, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and partially or fully self-insured employers. These contracts were on a flat fee-per-patient basis and were termed "risk" contracts (also known as "capitation" contracts) because the physician groups bore the risk of profit and loss, based on how efficiently they could provide medical care for the fixed fee per patient during the term of a contract. However, payors' interest in risk contracts declined, and by 2001, NTSP's board began to focus on assisting physicians in negotiating "non-risk" contracts. A non-risk contract is a fee-for-service arrangement between the payor and the physician. The non-risk model was more successful, and at the time of the proceedings before the FTC, NTSP had approximately twenty non-risk contracts and only one risk contract. The FTC found that about one-half of NTSP's physicians participate in the risk contract. Only NTSP's activities with regard to non-risk contracts are at issue. The FTC has not challenged any of NTSP's conduct with regard to risk contracts.

[3] In facilitating non-risk contracts, NTSP and each of its physicians executed Physician Participation Agreements. Those provide that if NTSP enters into an agreement with a payor to disseminate non-risk offers, NTSP will send or

[41] Jeff Miles, *Ticking Antitrust Time Bombs: A Message to Messed-Up Messenger Models*, AHLA Health Law. News, Nov. 2002, at 5.

"messenger" all of those offers to physicians, who are free to accept or reject them. If more than 50% of the NTSP physicians agree to accept a non-risk offer, NTSP will proceed to negotiate a contract for the physicians. The Physician Participation Agreements contemplate that physicians will not individually pursue a payor offer unless and until they are notified by NTSP that it has permanently discontinued negotiations with that payor. However, the physicians' relationship with NTSP is not exclusive. If NTSP is not negotiating with a payor or if NTSP has an agreement with a payor that does not cover particular services that a physician seeks to provide, a physician may deal directly with that payor or indirectly through participation in other independent physician associations.

[4] NTSP polls its physicians on an annual basis, asking the minimum rate each would accept in a non-risk contract. NTSP uses the poll responses to calculate the mean, median, and mode of the minimum acceptable fees identified by its physicians. Based on these calculations, NTSP determines a minimum contract fee that it utilizes when negotiating managed care contracts on behalf of its participants. NTSP contends that the poll assists it in determining whether a non-risk offer is likely to attract a majority of its participating physicians, and accordingly, it only messengers non-risk contracts that offer at least the minimum fee calculated from the polls.

[5] NTSP reports the mean, median, and mode from the polls to its participating physicians and explains to participating physicians that "NTSP polls its affiliates and membership to establish Contracted Minimums." In conducting the poll each year, NTSP reminds physicians of the results of the previous year's poll. [. . .]

[6] The FTC's ultimate conclusion was that the "activities [of NTSP], taken as a whole, amount to horizontal price fixing which is unrelated to any procompetitive efficiencies." In deciding "whether NTSP's conduct amounts to a restraint of trade," the Commission said that it would first "look at the factual evidence to determine whether the conduct amounts to price fixing, and is thus illegal absent a cognizable and plausible justification." In Part A below we consider "the theoretical basis for the anticompetitive effects" of NTSP's conduct and whether "the effects actually are anticompetitive." We consider in Part B whether NTSP's proffered justifications might plausibly be thought to have net procompetitive effects.

[7] The first challenged restraint the FTC examined was polls of participating physicians that NTSP conducted. NTSP asked each physician what minimum rate or fee he or she would be willing to accept during the coming year. The FTC found as factual matters that NTSP then reported the mean, median, and mode of the responses to all affiliated physicians, and those physicians were aware that NTSP would determine a minimum fee for its negotiations with payors from the poll responses. NTSP also reminded its physicians of the prior poll's results in soliciting each physician to state the minimum fee he or she would accept during the upcoming year. The FTC reasonably concluded that the "physicians anticipated that any individual response would help to raise or lower the average fee for the group—an average that NTSP would then use in negotiating with payors."

[8] The written Physician Participation Agreement NTSP had with each physician obligated the physician to refrain from pursuing an offer from a payor if NTSP was in negotiations with that payor. This either foreclosed or delayed negotiations between those payors and physicians who were willing to accept a fee lower than the minimum fee determined by NTSP and used in its negotiations with payors. If NTSP was successful in obtaining a contract with a payor, it is logical to conclude that the fees to which NTSP agreed would be higher than the minimum fees that many of its participating physicians were willing to accept and had indicated in their polling responses they were willing to accept. The FTC relied on an expert's conclusions that "the NTSP minimum reimbursement rates were higher than what some physicians were actually willing to accept, and that negotiation of a minimum price offer has the effect of raising the prices that 'low end' physicians would otherwise earn, without reducing the price that 'high end' physicians would receive" because the "high end" physicians could "opt out." These conclusions are logical and are supported by the record. If NTSP did not consummate a contract with a payor in its negotiations, then that payor's ability to bargain directly with physicians was delayed. Payors' patients in need of medical services did not have access to NTSP physicians while negotiations were ongoing, and accordingly, the number of competing physicians was reduced.

[9] NTSP disputes the FTC's construction of the Participating Physician Agreements with physicians, contending that those contracts do not require physicians to await notice from NTSP that negotiations with a payor have ceased before a physician may negotiate directly with that payor. The contracts do not support this argument. Section 2 of the physician agreement deals with payor offers. It provides in subsection 2.1 that "NTSP shall have the right to receive all Payor Offers made to NTSP or Physician," and the physician is obligated to "promptly forward such Payor Offer to NTSP for further handling." There is an exception for offers that are to extend or renew an existing contract between the physician and the payor. Otherwise, it is only if NTSP rejects a payor offer that a physician has "the right to pursue such Payor Offer on its own behalf." The agreements have a "non-exclusivity" clause, but it reiterates that physicians may not negotiate directly with payors concerning services covered by a payor offer or an existing NTSP agreement. The non-exclusivity clause recognizes that physicians may contract with other physician groups, but only "[s]ubject to Section 2" of the NTSP agreement.

[10] NTSP asserts that even if we agree with the FTC's construction of the physician agreements, there is no evidence that any physician actually refused to negotiate with a payor while NTSP negotiations with that payor were ongoing. The FTC found to the contrary, and there is evidence from payors that physicians declined to negotiate because they had designated NTSP as their bargaining agent.

[11] NTSP points out that only 34 percent of its physicians responded to its polls. The FTC concluded, however, that the fact that poll results were disclosed to all NTSP physicians, regardless of whether they responded to the poll, encouraged physicians "to reject price offers below the minimum fees indicated." It is not obvious that this is the case as to all physicians affiliated with NTSP. Physicians who had expressed an unwillingness to contract at fees below NTSP's minimum might not have been influenced by learning of NTSP's minimum negotiating fee. Those physicians may have rejected price offers below NTSP's minimum in any event. But it is obvious that the practice of reporting poll results encouraged other physicians to reject offers that equaled the fee they reported in the poll as the minimum they would have accepted if the offered fee was less than the minimum fee calculated by NTSP. Armed with knowledge from NTSP's polling, those physicians would also be encouraged to hold out for a fee equal to or even less than NTSP's minimum fee but greater than the fee they were willing to accept at the time they responded to the poll.

[12] The FTC further found that "NTSP actively encouraged [physicians] to reject the offers" below the minimum fees indicated in the polls. That finding is supported by the record and is evidence of concerted action to fix prices.

[13] The record evidence supports the FTC's factual finding that NTSP "regularly informed payors that its physicians had established minimum fees for NTSP-payor agreements, identified the fee minimums, and stated that NTSP would not enter into or forward to any of its physicians payor offers that were below the minimums." There was evidence that after receiving this information, payors attempted to deal directly with individual physicians but were told by those physicians that they must negotiate with NTSP. The logical tendency of this practice, coupled with the physicians' agreement to refrain from negotiating with payors, was at a minimum to delay direct negotiations between payors and physicians, including physicians willing to accept fees lower than the minimum used by NTSP. This added significant transaction costs to offers below NTSP's minimum. A payor wishing to achieve a contract below that minimum would have to submit its offer to NTSP, negotiate with NTSP, and wait until NTSP communicated to physicians that negotiations were unsuccessful, before being able to negotiate with physicians directly. Accordingly, even though NTSP could not bind physicians to particular contracts, its practices interfered with payors seeking lower fees. NTSP's practices also narrowed patients' choices of physicians.

[14] The FTC additionally found, based on the record evidence, that although the Participating Physician Agreements require NTSP to deliver certain payor offers to physicians, NTSP in fact "rejects and does not deliver any contract that falls below its minimum reimbursement schedule." This prevented or at least delayed offers less than NTSP's minimum fee from reaching physicians.

[15] The agreements NTSP had with physicians further "contain[ ] provisions whereby 50 percent of NTSP's membership must approve the reimbursement proposal of a payor before an offer is 'messengered' by NTSP to the

physicians for actual opt-in/out [on an individual basis] of the proposed contracts." This provision allows NTSP to counter payor rate proposals on direction from at least 50 percent of its physicians. The FTC concluded that

> NTSP is able to exert collective bargaining power and hence fix prices because NTSP does not messenger contracts below its minimum reimbursement schedule. Instead it rejects the contracts outright on behalf of its physicians and NTSP's collective bargaining leverage is thus exerted before its physicians even have a chance to opt in or out of a contract."

[16] Here again, it is obvious that when NTSP is successful in negotiating with a payor, the fees in those contracts would tend to be higher than fees many participating physicians otherwise would have been willing to accept, since a significant number of physicians had previously indicated in polling they would be willing to accept less than the mean, median, or mode on which NTSP's minimum negotiating fee was determined.

[17] Another challenged practice is NTSP's use of powers of attorney from its physicians. The FTC found that in negotiations with Aetna, NTSP sent Aetna a list of 180 physicians who had executed powers of attorney appointing NTSP as the bargaining agent for any direct contracting with Aetna. Aetna officials testified that they understood this as a message that the physicians would not negotiate directly, and Aetna concluded there was no practical alternative other than to deal with NTSP.

[18] NTSP contends that the powers of attorney only authorized NTSP to act "in any lawful way." However, in obtaining the powers of attorney, NTSP advised physicians that it would pursue a contract "that meets or exceeds the fee schedule minimums set by the NTSP membership." NTSP did in fact negotiate with payors on behalf of physicians regarding the fees that would be paid.

[19] The FTC further concluded that NTSP had engaged in concerted withdrawals and refusals to deal except on collective terms. The FTC pointed to NTSP's termination of contracts United Healthcare Services, Inc. had with physicians when NTSP was dissatisfied with negotiations. The ALJ's findings in this regard and the facts in the record reflect that United then attempted to negotiate directly with NTSP physicians, they refused, and United ultimately offered NTSP higher reimbursement rates.

[20] In another instance cited by the FTC, the ALJ's findings and facts in the record reflect that NTSP had a contract with Cigna that applied to physicians who were specialists. NTSP demanded that its primary care physicians be permitted to "participate" in this contract. Cigna already had contracts with most of these primary care physicians at lower rates. NTSP threatened contract termination if its demands were not met, and to avoid losing the participation of NTSP's specialists, Cigna agreed to NTSP's demands.

[21] At several points in its briefing, NTSP stresses that the FTC and the ALJ found that NTSP did not receive higher rates than those that other physicians and physician groups were already receiving. The FTC addressed this fact, saying "[w]e agree that higher physician rates, by themselves, are of no antitrust significance," but the Commission concluded that "this case is about a concerted effort by NTSP's participating physicians to increase their bargaining power." We agree that proof of higher fees for NTSP physicians is not necessary in this case. As the Supreme Court explained in FTC v. Indiana Federation of Dentists, if a practice "is likely enough to disrupt the proper functioning of the price-setting mechanism of the market it may be condemned even absent proof that it resulted in higher prices." In that case dentists had agreed not to send dental x-rays to their patients' insurance companies for use in benefits determinations. The Supreme Court held this was an unfair method of competition in violation of section 5 of the Federal Trade Commission Act. NTSP's challenged practices erect barriers between payors and physicians who would otherwise be willing to negotiate directly with those payors. It also erects obstacles to price communications between payors and physicians. The Commission concluded, and we agree, that NTSP engaged in concerted action to increase its bargaining power. The fact that there is no evidence in the record that NTSP obtained higher prices for its physicians than other physicians received does not foreclose a determination that NTSP's practices had anticompetitive effects.

[22] The other side of the equation, however, is the procompetitive effects, if any, that NTSP's challenged business practices generated. We turn to those.

[23] After concluding that NTSP's challenged conduct had anticompetitive effects, the FTC proceeded to examine NTSP's justifications. Although the general thrust of NTSP's arguments regarding "spillover" benefits has some facial plausibility, closer examination of the underpinnings of the justification reveals significant gaps in logic.

[24] The FTC first considered the polling of physicians. The Commission reasoned, and we agree, that NTSP's argument that its polls permitted it to determine when spillover efficiencies from risk contracts to non-risk contracts were likely to occur did not withstand scrutiny. Of the 34 percent of NTSP physicians responding to the poll, only 55 percent were physicians who participated in NTSP's risk contract. Accordingly, the mean, median, and mode that NTSP determined and used to negotiate with payors was based on minimum acceptable fees from non-risk as well as risk panel physicians. These polling results would not be a particularly effective tool to determine the fee that would attract a majority of NTSP's risk panel physicians, particularly since NTSP did not know which poll responses came from risk as distinguished from non-risk panel physicians. This undercuts a logical nexus to claimed efficiencies and thus the plausibility of the proffered procompetitive effects.

[25] The Commission also recognized that it was not evident how physicians who enter only non-risk contracts could achieve spillover efficiencies from NTSP's risk contract, and NTSP did not offer an explanation. As the FTC correctly noted, "[t]his is a non-trivial point, because non-risk physicians make up half of NTSP's members." This means that half of NTSP physicians had no experience in teamwork with NTSP physicians on the risk panel. Additionally, NTSP had only one risk contract, and it was a small part of NTSP's business. The FTC made further observations supported by the evidence:

[26] NTSP does not even explain why its risk panel physicians will have the incentive to apply the quality and cost control techniques they utilize on risk patients to any non-risk patients they may have. NTSP has not provided any financial incentive for them to do so, and it does nothing to promote compliance with whatever techniques have been learned under risk contracts. NTSP does not employ the processes it uses to monitor and control the quality and utilization of services provided under its risk contracts to patient care provided under non-risk contracts.

[27] NTSP argues that it did offer some empirical evidence but that the Commission "ignored" it. There is some evidence in the record of spillover effects from the risk contract to non-risk panels, and there is evidence that NTSP physicians perform as well or better than non-NTSP groups. For example, an NTSP expert opined that there is some reason to believe that "what NTSP learns in its risk contracting accrues to the benefit of payors even in the nonrisk setting" and that there are "palpable and real," "beneficial" effects from NTSP's business model. NTSP's expert pointed out that patient data created in a risk setting is available to physicians treating similar patients under a non-risk contract, "disease management and patient education programs" have benefits that spill over to treatment of patients under non-risk contracts, and NTSP's website allows patients and potential payors to see performance and quality data for NTSP and other Dallas or Fort Worth area physicians.

[28] We assume that all of the foregoing is factually correct. But, as the FTC importantly noted, NTSP "does not address how [its] nebulous 'teamwork' efficiencies are dependent on its price-fixing activities." NTSP has no theory as to how its proffered procompetitive effects, which we will assume are higher quality healthcare provided by teamwork and shared experiences over time, result from or are in any way connected to (1) communicating the polling results regarding fees to all NTSP physicians, (2) encouraging NTSP physicians to reject payor offers below the minimum fees NTSP calculated from the polls, or (3) using collective bargaining power to demand higher fees for physicians who are already under contract with a payor.

[29] We recognize that the Supreme Court has said that the "public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently." But NTSP has not cogently articulated how "the quality of the professional service that [its] members provide is enhanced by the price restraint."

[30] NTSP offered three other "justifications" for its challenged conduct. The first is that it had "no legal obligation to participate in, messenger, or facilitate a payor's contract offer," and as "a collection of individuals" the group had the right to vote among themselves "not to involve" the group in a contract. NTSP argues that it did not have a significant market share and "that even a monopolist has a right to refuse to deal." This is re-argument of issues relating to an agreement and concerted action, which we have addressed earlier.

[31] The second justification NTSP offers is that it "need[ed] to avoid expending scarce resources in analyzing, messengering, and participating in contracts of interest to relatively few of the physicians." We do not disagree that this is a permissible goal, but this does not justify the challenged methods NTSP used to achieve that goal.

[32] The third justification was "the avoidance of legally or medically risky situations" and that NTSP was "surely justified in refusing to sign payor contracts that present these problems." These are certainly permissible goals. But again, none of these concerns had any bearing on the methods NTSP used in an attempt to obtain higher fees than its physicians might otherwise have been offered.

[33] One of NTSP's chief complaints is that it was not permitted to develop a fuller record, based on additional empirical evidence. However, it does not assert that the additional empirical evidence it desired to develop would have shown a nexus between better or market-priced medical care and the need for NTSP to engage in the specific activities that we conclude are anticompetitive, which include (1) the communication of the mean, median, and mode results from the polling regarding fees, in combination with (2) foreclosing or delaying direct negotiations between payors and physicians; (3) urging physicians to reject fee offers from payors; and (4) using collective bargaining power to demand higher fees for physicians who were already under contract at a lower fee.

[34] In sum, based on the record in this case, we conclude that "the experience of the market has been so clear, or necessarily will be, that a confident conclusion about the principal tendency" of NTSP's challenged practices follows from the "look" the FTC conducted in this case, even though that "look" was less than a full-blown market analysis. "[T]he inquiry mandated by the Rule of Reason is whether the challenged agreement is one that promotes competition or one that suppresses competition." NTSP's proffered procompetitive effects do not meet the "might plausibly be thought to have a net procompetitive effect, or possibly no effect at all on competition" threshold. The Commission's determination that NTSP's conduct, taken as a whole, amounted to horizontal price-fixing that is unrelated to procompetitive efficiencies is supported by the law and substantial evidence.

* * *

Physician joint negotiations garnered much less attention from the enforcement agencies after the 2000s. While the same antitrust issues still can arise, several reasons may explain why such conduct now is less of an enforcement focus.

First, the guidance provided from the agencies and reinforced by counsel eventually filtered down to most physicians (and their counsel), so they are aware of the potential risks posed by joint negotiations absent requisite financial or clinical integration.

Second, government and private health plans have promoted the use of "accountable care organizations" ("ACO"s) whereby physicians are eligible to receive financial bonuses if they are able to meet certain cost and quality benchmarks with respect to providing care to a defined group of patients. To have a successful ACO, physicians need to engage in the type of financial and clinical integration that the FTC and DOJ recognized would allow their joint negotiations to avoid *per se* condemnation. In short, instead of developing arrangements simply to satisfy the antitrust enforcers but for which there may have been little market demand and even less enthusiasm, physicians began to create their own approaches to meet specific incentives offered by payers. These are more effective (for if they are not, they will be replaced) and incidentally help them to survive antitrust scrutiny.[42]

[42] In 2011, the DOJ and FTC issued a joint statement regarding ACOs that participated in the Medicare program. Accountable Care Organizations, F.T.C., https://www.ftc.gov/advice-guidance/competition-guidance/industry-guidance/competition-health-care-

Finally, there simply are fewer independent physicians in the United States. By one measure, three-quarters of all physicians owned their own practices in 1983.[43] This share declined to about 60% in 2012, and to under half in 2022.[44] At the same time, what independent physician practices remained were in practices that were increasing in size. The result is there are fewer independent physicians who need to engage in joint negotiations, so such antitrust issues are less prevalent. On the other hand, acquisitions of physician groups by health systems, health plans, and private equity, as well as mergers of physician groups, create their own antitrust concerns, as will be discussed below in Section D.

NOTES

1) For a critique of antitrust enforcement efforts involving efforts by physicians to jointly negotiate with health plans (arguing that these efforts have been at times too lax or forgiving), *see* Thomas Greaney, *Thirty Years of Solicitude: Antitrust Law and Physician Cartels*, 7 Hous. J. Health L. & Pol'y 189–226, 189 (2007).

2. Provider Collaboration: When Are Collaborating Providers Subject to the Rule of Reason? When is a Single Entity Formed?

While it has been common for otherwise competing physicians to come together to negotiate jointly with health plans using some of the mechanisms described above, hospitals, health systems, and other providers also frequently wish to collaborate in arrangements that fall short of a complete merger or acquisition. Sometimes the parties might prefer a complete merger, but differences in mission or structure preclude it. A non-Catholic system considering a merger with a Catholic system, for example, may seek an arrangement short of merger to avoid the restrictions that could follow if it were to operate under the Ethical and Religious Directives for Catholic Health Care.[45] At the same time, the Catholic system may worry that too close an association with a secular system could jeopardize the former's Catholic identity.[46] Or, a private, not-for-profit, tax-exempt hospital and a governmental hospital may want to combine but realize their different legal structures make a merger or acquisition difficult.

Possible merger partners may also just want some time to "live together" before tying the knot. An established physician group whose leadership has determined it should join with a health care system may want to go slowly at first, taking time to assure its physicians that the cultural shift that will occur when the group affiliates with the system can be managed successfully. Similarly, two hospital systems that have long been rivals may wish to explore ways of collaborating closely before deciding to merge completely.

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marketplace/accountable-care-organizations (last visited Sept. 3, 2024). Among other things, the guidance indicated the agencies would view such ACOs as sufficiently integrated to warrant rule of reason treatment if they employed similar mechanisms when contracting with commercial health plans as they did when working with Medicare; the guidelines also established several narrow "safety zones" where ACOs were unlikely to have market power, and identified several types of contracting provisions, such as "anti-tiering and anti-steering" clauses (which we discuss later in this chapter) that could raise antitrust concerns. The agencies withdrew the ACO statement in 2023 at the same time as they withdrew the 1996 Statements on Antitrust Enforcement Policy in Health Care.

[43] Carol K. Kane, *Policy Research Perspectives: Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership* at 6, Am. Med. Ass'n (2015), https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/health-policy/prp-practice-arrangement-2015.pdf.

[44] Carol K. Kane, *Policy Research Perspectives: Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022* at 1, Am. Med. Ass'n (2023), https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf.

[45] ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES, U.S. Conf. of Cath. Bishops (sixth ed. 2018) https://www.usccb.org/resources/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06_0.pdf. The ERDs, as they often are called, limit the ability to provide services that non-Catholic systems often provide or at least facilitate, including, for example, abortions, tubal ligations, and assisted suicide.

[46] In 2010, the Bishop for the Diocese of Phoenix, decreed that St. Joseph's Hospital, then part of Catholic Healthcare West, could no longer be considered Catholic because it had "not addressed in an adequate manner the scandal caused by" an abortion performed at the hospital. *Phoenix Bishop Removes Hospital's Catholic Status*, Nat'l Cath. Rep. (Dec. 21, 2010), https://www.ncronline.org/news/phoenix-bishop-removes-hospitals-catholic-status#:~:text=photo%2FNancy%20Wiechec)-,Bishop%20Thomas%20J.,year%20was%20a%20direct%20abortion. The hospital nonetheless remains part of Dignity Health (the successor to CHW).

In instances like these, the parties may want to integrate some, but not all, of their assets or operations and cede some, but not all, of their independence to the combined operation. The parties may, or may not, see such an arrangement as a step towards the final goal of merger. They may make such an arrangement temporary or permanent and add escape hatches that are easy or difficult to access.

While for-profit entities also may have reasons to explore joint ventures before fully merging, the unusual dynamics of non-profit health systems run by community boards and physician groups accustomed to independence have resulted in more interest in experimenting with arrangements short of a full merger in the health care sector than is generally the case in other industries.

If the parties have combined substantial operations and shed much of their independence, can their collaboration be considered tantamount to a merger? The answer to this question is important. Recall that when parties combine into a single entity, Section 1 of the Sherman Act does not apply to that entity's subsequent conduct because the statute reaches only *agreements* in restraint of trade, and an entity cannot enter into unlawful antitrust agreements with itself. Recall also, as the Supreme Court explained in *Copperweld*, that "[c]oncerted activity subject to § 1 is judged more sternly than unilateral activity under § 2."[47] So knowing whether conduct will be subject to Section 1 of the Sherman Act, or just to Section 2, may be outcome determinative of antitrust liability.

It's important to understand that if two health care entities enter into a collaborative venture that is tantamount to a single entity—so that the subsequent conduct of that venture will escape review under Section 1—the parties have *not* avoided antitrust scrutiny completely. The *formation* of their venture is subject to Section 1 of the Sherman Act and, possibly, to Section 7 of the Clayton Act as well. And the *conduct* of the venture after formation is subject to Section 2 of the Sherman Act.

Let's take an example: suppose the CEOs of two competing hospitals meet in a restaurant one evening and agree on a fee schedule at which they will offer their services to patients and insurers. This is a naked restraint in violation of Section 1, subject to condemnation under the *per se* rule. In fact, if the Department of Justice learns of the meeting, the agency might prosecute the agreement as a felony. But if the same hospitals merge, no antitrust issue is raised when the combined entity later sets the prices at which it offers its services. Section 1 doesn't apply to a single entity and, so long as there is no predatory pricing, Section 2 has nothing to say about the entity's prices either—even if the combined operation has monopoly power (remember *Trinko*[48]).

But what if our hospitals *partially* integrate? What if they form an organization through which they do some, but not all, of their business and create real efficiencies for insurers and patients? Agreements on competitive terms that are ancillary to the integration still will be subject to scrutiny under Sherman Act Section 1, but under the rule of reason and not the *per se* rule.[49] We can see now that when a group of hospitals (or any competing players in a health care market) act together, there are, broadly speaking, at least *four* possible antitrust rules that could apply to their conduct: (i) the *per se* rule under Section 1; (ii) the rule of reason under Section 1, (iii) monopolization standards under Section 2;[50] and (4) if the parties' conduct involves an acquisition or merger, Section 7 of the Clayton Act. If antitrust were the only issue (of course it never is), the providers might wish to form a single entity, subject only to Sherman Act Section 2 (and Section 7 of the Clayton Act with respect to its formation), and escape the lower liability tripwire (and possible criminal consequences) of Section 1. But if the parties don't integrate sufficiently to escape Section 1 altogether, they still may want to integrate sufficiently to avoid *per se* condemnation under that provision: far better to face the sweet music of Section 1's rule of reason than the martial beat of the *per se* rule.

[47] Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 768 (1984).

[48] Verizon Commc'ns Inc. v. Law Offices of Curtis V. Trinko, LLP, 540 U.S. 398 (2004).

[49] You may want to re-read the discussion of *Addyston Pipe* in Chapter IV.

[50] Not to complicate things too much, but of course intermediate scrutiny is also possible.

Putting aside issues involving mergers or acquisition under the Clayton Act, which are addressed below at Section D.1., you should have two questions in mind now: how much integration is enough to move conduct by separate actors out from under the *per se* rule to the rule of reason? And how much more integration is required to avoid Section 1 entirely? Physicians, hospitals, insurers, and other health care players enter into what seems an inexhaustible number of collaborative permutations and combinations.[51] The discussion in the preceding section (Section C.1.) on joint negotiations by physicians with health plans (and the discussion in Chapter V) help answer the first question. The materials that follow help answer the second—although, as you will see when you read about the litigation involving the *Medical Center at Elizabeth Place*, both questions can be implicated in one litigation.

New York v. Saint Francis Hospital

94 F. Supp. 2d 399 (S.D.N.Y. 2000)

Judge Conner.

{*Eds.*: *St. Francis Hospital and Vassar Brothers Hospital, not-for-profit hospitals in Poughkeepsie, N.Y., formed Mid- Hudson Health and, through Mid-Hudson, allocated between them which hospital would provide which services and at what rates. The New York Attorney General sued, claiming a violation of Section 1 of the Sherman Act and New York's antitrust law, the Donnelly Act. On cross-motions for summary judgment the district court granted the state's motion and denied the hospitals' motion.*}

[1] [. . .] St. Francis, a 295-bed hospital . . . is affiliated with the Roman Catholic Church and must comply with the Ethical and Religious Directive for Catholic Health Care Facilities approved by the Archdiocese of New York. Vassar, a 315-bed hospital . . . is not church-affiliated. The hospitals have different bond financing sources which cannot be commingled.

[2] In the 1980s, the hospitals began to experience financial difficulties resulting from increased competition from neighboring hospitals. In an internal memorandum regarding the defendants' application to establish Mid-Hudson, the state Department of Health (the "DOH") found that services in the two hospitals began to deteriorate in the mid to late-1980s . . .

{*Eds.: The court then described the state's certificate of need ("CON") law. St. Francis and Vassar had each independently sought DOH approval for a CON to operate a cardiac catheterization laboratory at their respective hospitals but these applications were denied. The DOH instead urged both hospitals to jointly operate just one cath lab at one of their hospitals. Soon after, the hospitals submitted a CON to provide three services jointly: a cath lab at Vassar, a fixed-site magnetic resonance imaging unit at St. Francis, and a mobile lithotripsy unit at St. Francis. Mid-Hudson was issued an operating certificate (in 1994) for the three services involved. At the same time, the hospitals also sought and received approval to establish a joint venture, Mid-Hudson Medical Center, licensed as a hospital under state law. Mid-Hudson would not have a physical facility or staff but would be "empowered with shared operational and management authority for new clinical services for each of the sponsoring hospitals." The court also explained that new legislation, effective January 1, 1997, relied on competition to replace the prior regulatory regime that involved close state regulation of hospital rates. Leading up to the implementation of the new approach, the Department received complaints from several payers about the hospitals' refusal to engage in independent negotiations.*}

[3] In January 1995, defendants entered into an agreement ... in which the parties state that:

> [Vassar] and [St. Francis] originally caused [Mid-Hudson] to be formed to carry out the intent of [Vassar] and [St. Francis] to jointly own and operate, directly or indirectly, and to delegate to [Mid-Hudson] direct control of the three clinical services described in the original Certificate of Need application. . . . Since that time the parties have deemed it in their best interests to expand

[51] Some commentators have called joint ventures that bring competitors (usually hospitals) together sufficiently to escape Section 1 scrutiny, without actually completing a merger or acquisition, "virtual" mergers. *See*, *e.g.*, Mark Botti, *Comments on the Antitrust Aspects of Hospital Virtual Mergers*, Health Care Task Force, Antitrust Division, Dep't of Just. (presented at the American Health Lawyers Meeting, San Diego, Cal., July 1, 1998), https://www.justice.gov/atr/speech/comments-antitrust-aspects-hospital-virtual-mergers.

> the delegation of authority to [Mid-Hudson] in order to more closely integrate Vassar Brothers and St. Francis to carry on further activities to eliminate costly duplication of services. . . .

[4] Defendants agreed not to compete with Mid-Hudson, nor with one another, for the provision of "the same or substantially similar services." The 1995 Agreement also states that the hospitals will "unify substantially all hospital operations, including creating a single parent board, merging medical staffs into [Mid-Hudson], combining development and control over clinical services and integrating administrative services." Despite the 1995 Agreement, Defendants state that the hospitals continue to duplicate some services. For example, Vassar continues to provide orthopedic surgery, although "they're not investing in the resources to bring it to a different level of service as St. Francis is. . . ." [One deponent testified that] the hospitals have not to this date substantially unified their operations, created a single parent board, nor merged their medical staffs.

[5] Defendants expressly told the DOH that they were not merging. In the establishment CON application, defendants state that "[e]ach hospital will remain a financially independent structure and will retain all governance responsibilities not specifically given to the new corporation." [. . .]

DISCUSSION [. . .]

III. Per se Analysis

[6] [. . .] In the case at bar, defendants have fixed prices by jointly agreeing on the terms and rates they will charge for many of the services they provide. Defendants appointed Marianne Muise [a St. Francis employee] to negotiate on their behalf starting in 1997, the first year that New York State law allowed hospitals to negotiate such contracts. The fact defendants' contract terms are negotiated with insurers rather than set unilaterally does not save defendants from per se liability. The Supreme Court has found that "[a]ny combination which tampers with price structures is engaged in an unlawful activity." *Socony Vacuum*, 310 U.S. at 221 . . .

[7] . . . Defendants are the only hospitals in Poughkeepsie. Pursuant to their joint negotiating strategy, defendants essentially have an opportunity to unilaterally determine a range of prices acceptable to them, much like the maximum fee schedules established by the *Maricopa* defendants. By using Mid-Hudson as their common and exclusive agent to negotiate with insurers, defendants have prevented determination of the rates and terms of the services they provide by free competition alone. Defendants concede as much. Defendants' chief negotiator, Marianne Muise, admits in her deposition that from the time Mid-Hudson was established, competition between defendants for the business of third-party payers was eliminated:

> Q: So from the beginning of Mid-Hudson, there was no competition between the hospitals for the business of third-party payers?
>
> A: I don't believe so, no.

[8] [. . .] Defendants urge that Rule of Reason analysis is appropriate because their collaboration has created "efficiencies and benefits." However, none of the proffered efficiencies relate to the joint negotiations themselves. Defendants highlight: the reduction of duplication of services; elimination of competition for equipment and personnel; the ability to offer services in Poughkeepsie that defendants allege could not otherwise exist; cost savings through joint purchasing; joint professional training and public education; and standardized protocols. Many of these "efficiencies" are tantamount to the elimination of free competition. For example, eliminating the duplication of services is simply another way of stating that defendants have allocated the market for services among themselves. Their argument rests on the impermissible premise "that competition itself is unreasonable." *National Society of Professional Engineers*, 435 U.S. at 696.

[9] . . . For the reasons stated above, the State's motion for summary judgment as to per se liability with respect to defendants' joint negotiations with third party payers is granted.

{*Eds.: The court then found that the hospitals "engaged in an ongoing horizontal arrangement to divide the market for healthcare services in Poughkeepsie" and that this also was a* per se *violation of Section 1, relying in part on* United States v. Topco, *405 U.S. 596 (1972) and* Palmer v. BRG of Georgia, Inc., *498 U.S. 46 (1990).*} [. . .]

C. *Defendants' Arguments Against Per se Treatment*

[10] Defendants argue that Mid-Hudson and its member hospitals represent a unique entity and that Rule of Reason analysis applies to their activities for the following reasons: (1) Mid-Hudson is a joint venture; (2) the state was involved in the creation of Mid-Hudson; (3) the challenged restraints are ancillary to a legitimate business transaction; (4) the judiciary has no experience with an entity such as Mid-Hudson; (5) defendants are non-profit organizations; (6) the U.S. Department of Justice and the State reviewed plans for a "virtual merger" of defendants in 1995 and did not object to it; (7) the community supports defendants' plan; and (8) the complaining managed care companies are guilty of "inequitable conduct". . . . We find each of these arguments unavailing.

[10] First, as a matter of law, joint ventures have no immunity from the antitrust laws. *National Collegiate Athletic Ass'n v. Board of Regents of the University of Oklahoma,* 468 U.S. 85 (1984) *("NCAA").* Cases in which joint ventures whose anticompetitive activities otherwise would have been subjected to per se treatment but were reviewed under the Rule of Reason are those in which "horizontal restraints on competition are essential if the product is to be available at all." 468 U.S. at 101.Thus, in *NCAA,* the Supreme Court recognized: "What the NCAA and its member institutions market in this case is competition itself—contests between competing institutions. Of course, this would be completely ineffective if there were no rules on which the competitors agreed to create and define the competition to be marketed." *Id.* In an earlier decision, *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.,* 441 U.S. 1 (1979), the Supreme Court ruled that a blanket license fee for use of copyrighted musical compositions set by agencies was not per se illegal as it "accompanies the integration of sales, monitoring, and enforcement against unauthorized copyright use." 441 U.S. at 20. The Court found that the blanket license, which took the place of individual bargaining with copyright holders, was "to some extent, a different product." 441 U.S. at 22.

[11] Here, the provision of hospital services is not dependent upon restraints on competition as in league sports, nor can it be said that defendants have created essentially a new product. Restraining competition is not a necessary condition of the provision of health care services. The hospitals argue that market and customer allocation and joint negotiations have allowed the hospitals to provide services at "an ever increasing level of expertise and specialization" and in a more cost-effective manner. . . . However, claims of improved quality of service do not shield price-fixing and market allocation activities from per se treatment. *See Maricopa,* 457 U.S. at 351 (1982) (finding that "[t]hose claims of enhanced competition are so unlikely to prove significant in any particular case that we adhere to the rule of law that is justified in its general application."). In this case, the claimed procompetitive benefits of defendants' activities relate to the Poughkeepsie hospitals' provision of a full panoply of services to allow them to compete with other hospitals in the region. However, their activities clearly limit choice for local consumers who desire health care close to home and their joint negotiations with third-party payers are likely to ultimately result in increased prices to some of these consumers.

[12] [. . .] Defendants' argument that the challenged restraints are ancillary to an otherwise legitimate business endeavor is similarly unavailing. Defendants claim that "[t]he challenged restraints . . . have contributed to the success of [Mid-Hudson] by making possible new and enhanced services and a formula for sharing revenue from these services." . . . As stated above, the new services could be offered independently of the challenged restraints. Defendants' argument boils down to an assertion that competition would result in financial hardship on defendants. The Supreme Court has found that "the Rule of Reason does not support a defense based on the assumption that competition itself is unreasonable." *National Society of Professional Engineers,* 435 U.S. at 696.

[13] Defendants also claim that this Court should apply the Rule of Reason to their activities because of a lack of judicial experience with the industry. Certainly an Article 28 hospital without a physical plant or medical staff of its own is a novel creation. However, the courts have had substantial experience with the type of restraints challenged

here. The fact these restraints arose in the context of a new form of Article 28 hospital does not alter the analysis. In *Maricopa,* the Supreme Court was "unpersuaded by the argument that we should not apply the per se rule in this case because the judiciary has little experience in the health care industry." The Court reiterated the finding in *Socony-Vacuum* that "[w]hatever may be its peculiar problems and characteristics, the Sherman Act, in so far as price-fixing agreements are concerned, establishes one uniform rule applicable to all industries alike."

[14] Defendants also point to their non-profit status to support their position. However, the Supreme Court has made it clear that the antitrust laws are applicable to non-profit organizations. *See, e.g., NCAA,* 468 U.S. at 101 (1984); *Goldfarb v. Virginia State Bar,* 421 U.S. 773, 786–87 (1975). Nor is this Court compelled to apply the Rule of Reason because the United States Department of Justice and the State Attorney General's Office reviewed a proposed "virtual merger" of the two hospitals in 1995 and failed to object. Certainly courts have considered, among many other factors, a favorable review of the challenged activities by antitrust prosecutors in making a determination whether the restraints are anticompetitive. For example, in *Westchester Radiological Associates,* this court noted that the Department of Justice had found that the buying scheme at issue promoted cost containment. 707 F. Supp. at 714. In *NCAA,* Justice White, writing in dissent, pointed out that the Antitrust Division of the Department of Justice had taken the 1951–53 television plans, which were similar to those at issue in the 1980s, "under study" and failed to object to them until that lawsuit was initiated. 468 U.S. at 125 n.1 (White, J., dissenting). Nonetheless, we hesitate to place too much importance on the failure of prosecutors to object to a plan for a "virtual merger" in 1995 when the State was still pervasively regulating the health care industry. Furthermore, the record is unclear as to why these agencies failed to object, and we will not engage in speculation.

[15] Finally, defendants claim that community support for defendants' operations and the alleged inequitable conduct of the complaining managed care companies suggest rejection of per se treatment. First, the Supreme Court has made clear that anticompetitive activities such as price fixing cannot be justified by the good intentions of the parties engaged in the scheme. *Socony-Vacuum,* 310 U.S. at 221–22. "Whatever may be its peculiar problems and characteristics, the Sherman Act, so far as price-fixing agreements are concerned, establishes one uniform rule applicable to all industries alike." *Id.*; *see also NCAA,* 468 U.S. at 101 n.23 ("[I]t is . . . well settled that good motives will not validate an otherwise anticompetitive practice."). Although defendants' actions may be applauded by some members of the community, the antitrust laws were written pursuant to a firmly-held belief that free competition ultimately enures to the benefit of consumers. The remedy here may lie with the legislature.

[16] As the Supreme Court stated in *Maricopa:*

> Our adherence to the per se rule is grounded not only on economic prediction, judicial convenience, and business certainty, but also on a recognition of the respective roles of the judiciary and the Congress in regulating the economy. Given its generality, our enforcement of the Sherman Act has required the Court to provide much of its substantive content. By articulating the rules of law with some clarity and by adhering to rules that are justified in their general application, however, we enhance the legislative prerogative to amend the law.

[17] [. . .] For the reasons stated above, we deny defendants' motion for summary judgment, which asks us to rule that their conduct is subject to Rule of Reason analysis. As stated above, the State's motion for summary judgment on the issue of liability is granted. [. . .]

NOTES

1) Who made the decisions as to which services would be offered at the two hospitals? If your answer is Mid-Hudson, who controlled the decisions made by Mid-Hudson? Was there a so-called "single entity" here, or were separate competitors making the decisions as to what they would offer?

2) The hospitals had plans to "unify substantially all hospital operations, including creating a single parent board, merging medical staffs into [Mid-Hudson], combining development and control over clinical services and

integrating administrative services." The court observes, however, that they didn't carry through on these plans. Had they done so, might the decision have been different? Why or why not? What is the significance of the hospital's statement that each will "remain a financially independent . . . and will retain all governance responsibilities not specifically given to the new corporation"?

3) Would this case have been decided any differently after *American Needle* (discussed above in Chapter IV)?

4) The court wrote, in the language excerpted above, that "the new services could be offered independently of the challenged restraints." If this was so, then perhaps the application of the *per se* rule followed logically: the agreement not to compete between the hospitals was not reasonably necessary to provide the new services. But elsewhere in its decision (in language not excerpted above) the court took note of the hospitals' arguments that their collaboration "has brought to the Mid-Hudson Valley high technology, tertiary, health care services, which otherwise would not have been available without their cooperation" and responded, "[t]his may be the case" but still found that the *per se* rule was appropriate. Do you agree?

5) The court wrote that *Topco* "unequivocally" required application of the *per se* rule "to horizontal market allocations in the absence of a determination that the restraints were necessary to make the product available at all." Is this a correct reading of the law after *BMI*? Is it consistent with the approach taken by DOJ and the FTC in 2000 when they issued the *Antitrust Guidelines for Collaborations Among Competitors* (discussed above in Chapter V)? Section 3.2 of the Guidelines states if "participants in an efficiency-enhancing integration of economic activity enter into an agreement that is reasonably related to the integration and reasonably necessary to achieve its procompetitive benefits, the Agencies analyze the agreement under the rule of reason, even if it is of a type that might otherwise be considered *per se* illegal." The *Guidelines* explain, "[a]n agreement may be 'reasonably necessary' without being essential."

6) In 2003, three years after the district court decision in *New York v. St. Francis*, a district court in Pennsylvania considered a joint venture that included three hospitals (controlled by two different health care systems) in Lycoming County, Pennsylvania. Two of the hospitals, Muncy Valley Hospital and Divine Providence Hospital, were part of the Providence Health System Foundation ("PHS"). The third, Williamsport Hospital Medical Center, was a subsidiary of North Central Pennsylvania Health System ("NCPHS"). The two parent systems formed a third organization, the Susquehanna Regional Healthcare Alliance d/b/a Susquehanna Health System, to operate the three hospitals. HealthAmerica, a managed care plan, sued, asserting that the defendants had conspired to fix health care prices. On cross-motions for summary judgment the court ruled for defendants, finding they were sufficiently integrated that no "contract, combination . . . or conspiracy" among them was possible.

HealthAmerica Pennsylvania v. Susquehanna Health System

278 F. Supp. 2d 423 (M.D. Pa. 2003)

Judge Conner {*Eds.: note this is a different Judge Conner than the judge in the previous extract!*}.

[1] [. . .] PHS and NCPHS are the [Susquehanna] Alliance's sole corporate members. . . . The Board of Directors of Susquehanna Alliance consists of eighteen directors. North Central Pennsylvania Health System nominates and elects nine directors. At least five of those directors must be persons serving on the Board of Directors of Williamsport Hospital. NCPHS retains the power to remove, with or without cause, any Alliance director elected by NCPHS. The Providence Health System nominates and elects nine directors to the board. At least five of those directors must be members of the Board of Directors of either Divine Providence Hospital or Muncy Valley Hospital. PHS retains the power to remove, with or without cause, any Alliance director elected by PHS. The bylaws of Susquehanna Alliance, state that "[t]he act of a majority of the Directors present in person or by proxy at any meeting at which a quorum is present shall be the act of the Board unless a greater proportion is required by law or by the Articles of Incorporation or by these Bylaws."

Pre-Transaction Events

[2] Prior to formation of the Alliance, Williamsport and Divine Providence hospitals were competitors. At that time, the defendant hospitals offered the same services, with the exception of open heart surgery, available only at the Williamsport Hospital, and radiation oncology and dialysis services, available only at Divine Providence Hospital.

[3] On March 9, 1994, defendants submitted a presentation describing the proposed formation of Susquehanna Alliance to the Pennsylvania Office of the Attorney General and the United States Department of Justice. The presentation stated:

> The Alliance will not result in a "merger" or "consolidation" of the hospitals or in an acquisition of assets. *PHS . . . as well as NCPHS, believe it important for PHS to retain its Catholic identity and mission, which might be lost if the two systems were to consolidate. The Alliance, however, will have responsibility for most economic decisions affecting the hospitals' activities, and the Alliance hospitals will compete as one entity*. For antitrust analytical purposes, the Alliances' formation should be examined as an "acquisition."
>
> The Alliance's market share, in any reasonably defined relevant geographic market, will be high. Entry barriers also are high because of certificate-of-need laws. . . . Other factors indicate, however, that on balance, the Alliance's effect on competition will be procompetitive rather than anticompetitive.

[4] . . . The factors cited included the reconfiguration and consolidation of many services creating efficiencies and reducing costs, passing cost savings on to consumers, the existence of significant competition, and the formation of a business advisory committee. The concluding paragraph of the presentation stated:

> The Alliance's efficiencies and service reconfiguration plans clearly would save significant costs; and they would be implemented. The more difficult question is whether those savings would be passed on to purchasers of hospital services—employers and payers. Given the present actual fringe competition, the likely growth of Geisinger, the likely power of both Geisinger and Blue Cross, and the safeguards built into the Alliance through employer input and monitoring, we believe that they will. Those closest to the scene, who have been pressuring the hospitals to integrate for years and are best positioned to answer this question—businesses that will pay the bills—strongly believe so. So should the Antitrust Division and Pennsylvania Office of Attorney General.

[5] The Pennsylvania Attorney General's Office filed a complaint on May 24, 1994 challenging the proposed formation of the Susquehanna Alliance. *Commonwealth of Pennsylvania v. Providence Health System, Inc. and North Central Pennsylvania Health System*, Civil Action No. 4:CV-94-772 (M.D. Pa. 1994) (the "1994 Action"). The Commonwealth of Pennsylvania, PHS and NCPHS immediately entered into a Final Judgment on May 24, 1994 (hereinafter the "Consent Decree") in the 1994 Action. By express terms of the Consent Decree, the Attorney General authorized the formation of the Susquehanna Alliance in exchange for various conditions and restrictions on the new entity's operations and pricing as set forth below.

The Alliance Agreement

[6] In June, 1994, approximately one month after entry of the Consent Decree, North Central Pennsylvania Health System and Providence Health System, Inc., together with their affiliates , formed the Susquehanna Alliance. After the June 1994 Alliance Agreement, NCPHS and PHS, and their Affiliates ceased being competitors. The Alliance Agreement provides that Susquehanna Alliance has

> the authority and responsibility for the management and operation of the NCPHS Affiliates and the PHS Affiliates, but not NCPHS or PHS, including the establishment of overall policy,

> oversight of the management, long range planning, coordination of managed care plans, and responsibility for programs and services and a unified budget.

[7] The Alliance Agreement further provides that the Boards of Directors of the respective PHS and NCPHS Affiliates retain authority and responsibility for mission and values, governance, credentialing, medical staff issues and quality assurance of the Affiliates.

[8] The Alliance Agreement contemplates that the parties will share equally in the financial risks and rewards of the joinder. Each party to the Alliance Agreement retains "its respective separate legal identity and the ownership of all of its assets, real and personal, tangible and intangible, and shall continue to be governed by its respective Board of Directors subject to Section III" of the Alliance Agreement. Section III of the Alliance Agreement relates to consolidation of services, service reconfigurations, and compliance with the Consent Decree.

[9] An Affiliate must seek approval of Susquehanna Alliance before it acquires, purchases, sells, leases or otherwise transfers any property. No Affiliate may incur any capital indebtedness unless expressly authorized by the Alliance. Absent express authorization, NCPHS and PHS may not merge, consolidate, reorganize or enter into any joint venture, management or alliance agreement that would affect autonomy or governance with any entity not a party to the Alliance Agreement. Under the Alliance Agreement, no party may terminate any program or service or initiate any program or service without the prior approval of the Chief Executive Officer or the Board of Directors of Susquehanna Alliance.

The Consent Decree

[10] The Consent Decree has a ten (10) year term which will expire on May 24, 2004. Through June 30, 1999, the Consent Decree required the defendants to achieve certain savings from increased efficiency and to pass those savings on to consumers or other purchasers of health care services in the form of low-cost or no cost health care programs for the community or by reducing prices or by limiting actual price increases for the existing services. The five year period during which the defendants were specifically required to pass on efficiencies ended July 1, 1999.

[11 Defendants complied with the provisions of the Consent Decree regarding the amount of savings to be achieved as well as the amount to be passed on to the community through fiscal year 1999. The Attorney General determined that as of July 1, 1999, Susquehanna Alliance saved over $105,000,000 and returned $117,000,000 to the community.

The Susquehanna Alliance: Post Transaction Events

[12] On May 2, 1996, NCPHS, PHS and Susquehanna Alliance executed a "Second Amendment" to the Alliance Agreement for the purpose of merging their two physician groups, HERF and GHS, respectively, to become Susquehanna Physician Services. Effective July 1, 1996, Susquehanna Physician Services became a wholly owned subsidiary of Susquehanna Alliance. ¶ 66.

[13] . . . Although Susquehanna Physician Services employs the largest number of primary care physicians in the county, it represents less than a majority of the total number of primary care physicians in Lycoming County.

Management and Operation

[14] As a result of the creation of Susquehanna Alliance, the medical staffs of Divine Providence and Williamsport merged. {*Eds.: The court then describes the division of services among the three hospitals.*}

[15] . . . Each individual hospital has its own audited financial statement which is included in the combined audited financial statements for Susquehanna Alliance. Each hospital must approve the revenues and expenses relating to that hospital as part of the Alliance budgeting process.

[16] The defendant hospitals share, among other things, one risk manager, one facilities manager, one chief nursing officer, one human resources department, one set of human resources policies, one pension plan, one defined

contribution plan, one § 403(b) plan, one vice-president of human resources, one set of administrative policies, one compliance officer, one manager for each separate clinic department, one operating budget, one capital budget, and one health insurance program. Susquehanna Alliance centralizes and performs marketing functions on behalf of all Affiliates. The Alliance also handles all personnel matters. Susquehanna Alliance technically employs the staff at each of the Affiliates, including the three hospitals, but the funding for the workers' salaries and pension benefits comes from the individual hospitals.

[17] The Alliance purchases one medical malpractice, one commercial, one property and one vehicle insurance policy on behalf of the three defendant hospitals. Williamsport Hospital and the Divine Providence/Muncy Valley hospitals have separate bond obligations. Although not technically obligated under bond covenants to do so, the parties have transferred cash to each other to ensure that the other is not in default of bond covenants. [. . .]

{*Eds.: The court describes how the Alliance set common charges for all its hospitals and contracted for services with HealthAmerica on the hospitals' behalf.*}

IV. Discussion

[18] HealthAmerica alleges various conspiracies and agreements in restraint of trade under Section 1 of the Sherman Act. . . .

[19] Due to their similarity, Counts I and V will be discussed together. Both Count I and Count V charge defendants with antitrust liability based on conduct wholly internal within the Alliance.

[20] In Count I, plaintiffs' claim that defendants' joint negotiation of hospital rates offered to managed care plans constitutes *per se* illegal price fixing. . . .

[21] In Count V, plaintiffs allege:

> The defendants' insistence that physician services offered by the defendants be negotiated through the Susquehanna Regional Healthcare Alliance, that hospital services offered by the defendants be negotiated through that organizations and that hospital services and physician services offered by the defendants be negotiated together through the same organization, constitutes an illegal *per se* boycott, or other illegal refusal to deal as an unreasonable restraint of trade in the markets for hospital services and the market for physician services in violation of Section 1. . . .

[22] Defendants contend that the Alliance and its component parts have integrated to such a degree that they constitute a single entity, legally incapable of conspiring or otherwise engaging in concerted action under *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984), and its progeny. HealthAmerica asserts that *Copperweld* is inapplicable because the Alliance is nothing more than a joint operating arrangement created by separate and independent hospital systems.

[23] In *Copperweld*, the Supreme Court held that a corporation and its wholly-owned subsidiary constitute a single entity incapable of conspiring for purposes of Section 1. The *Copperweld* Court recognized that the "Sherman Act contains a "basic distinction between concerted and independent action," Copperweld, 467 U.S. at 767 (quoting *Monsanto Co. v. Spray Rite Service Corp.*, 465 U.S. 752, 761 (1984)), which is necessary to a proper understanding of the terms "contract, combination . . . or conspiracy" in Section 1. *Copperweld*, 467 U.S. at 769. "[B]ecause it is sometimes difficult to distinguish robust competition from conduct with long-run anti-competitive effects, Congress authorized Sherman Act scrutiny of single firms only when they pose a danger of monopolization." *Id.* at 768.

[24] In contrast, concerted action "inherently is fraught with anticompetitive risk. It deprives the marketplace of the independent centers of decisionmaking that competition assumes and demands." *Copperweld*, 467 U.S. at 768-69. Therefore, concerted action in restraint of trade need not rise to the level of monopoly; Section 1 prohibits any level of concerted action in restraint of trade.

[25] The Supreme Court clarified this dichotomy in the context of a single entity, stating that

> it is perfectly plain that an internal "agreement to implement a single, unitary firm's policies does not raise the antitrust dangers that [Section] 1 was designed to police. The officers of a single firm are *not separate economic actors pursuing separate economic interests*, so agreements among them do not suddenly bring together economic power that was previously pursuing divergent goals.

[26] . . . The Court found that this reasoning applies equally to agreements made between a corporate parent and its wholly owned subsidiary and held that a parent and its subsidiary constitute a single entity for purposes of Section 1 liability.

[27] Although it explicitly limited its holding to the facts presented (i.e. a corporate parent and its wholly owned subsidiary), the *Copperweld* Court stated that "substance, not form, should determine whether a separately incorporated entity is capable of conspiring under § 1." 467 U.S. at 773 n.21. The Court's rationale included the following:

> (1) corporate parents and their wholly owned subsidiaries have "complete unity of interest";
>
> (2) "their objectives are common, not disparate"; and
>
> (3) their actions are "guided or determined not by two separate consciousnesses, but one.

[28] Federal courts have used the corporate *Copperweld* factors and the "substance, not form" mantra to extend *Copperweld* to situations other than that of parents and wholly owned subsidiaries, such as sibling subsidiaries under the same parent corporation. Certain courts have applied *Copperweld* to corporations sharing no common corporate ownership whatever. For example, the Ninth Circuit has applied Copperweld principles to an arrangement between franchisors and franchisees. *See Williams v. Nevada*, 999 F.2d 445 (9th Cir. 1993). The district court in *Williams* concluded:

> [f]or two separate corporations to act as a single entity, it is not necessary that one be owned, wholly or in part, by the other corporation. The presence of a parent and subsidiary relationship is not an essential element. The emphasis is properly placed upon the commonality of interest of the corporations and the degree of control exercised by the dominant corporation.

[29] In a case decided immediately after *Copperweld*, the Fifth Circuit extended the *Copperweld* doctrine to two corporations which were outwardly unrelated, but commonly controlled. *Century Oil Tool, Inc. v. Production Specialties, Inc.*, 737 F.2d 1316 (5th Cir. 1984). In *Century Oil Tool*, three men each owned 30%, 30% and 40%, respectively, of each of the two defendant corporations and each served as officers and directors of both corporations. The Fifth Circuit observed:

> When the three joined forces they considered but for tax reasons rejected a formal merger of the two corporations. Given Copperweld, we see no relevant difference between a corporation wholly owned by another corporation, two corporations wholly owned by a third corporation or two corporations wholly owned by three persons who together manage all affairs of the two corporations. A contract between them does not join formerly distinct economic units. In reality, they have always had "a unity of purpose or a common design."

[30] . . . The court finds that defendants' corporate structure does not prohibit a finding of single entity status. Therefore, the court will evaluate the facts of this case, in light of the guidance provided by the Supreme Court, to determine whether defendants constitute a single entity legally incapable of concerted action under *Copperweld*.

[31] The court notes that Count I does not challenge the validity of the defendant hospitals' joinder through the Alliance agreement; it only challenges the subsequent act of joint-pricing. Likewise, Count V only challenges the manner in which the Alliance negotiates contracts. Thus, the threshold inquiry for the court is whether Susquehanna

Alliance and the defendant hospitals constitute a single entity legally incapable of conspiring to fix prices for managed care organizations.

[32] Susquehanna Alliance enjoys substantial and significant control over the defendant hospitals. The Alliance has sole authority for the management of the defendant hospitals, including establishment of overall policy, coordination of programs and services and the preparation and implementation of a unified budget. "Susquehanna Alliance's prior approval is needed before any Affiliate acquires, purchases, sells, leases, or otherwise transfers any property." The hospitals cannot "incur any capital indebtedness not previously authorized by Susquehanna Alliance." In addition, the hospitals have merged their medical staffs and most workers are employees of Susquehanna Alliance. While the hospitals technically have separate bond covenants, they work together to ensure that each meets the requirements of its own bond covenant.

[33] In sum, substantial authority is centralized in the Alliance and it is readily apparent that defendants' actions are guided "not by two separate corporate consciousnesses, but one." *Copperweld*, 467 U.S. at 771. The defendants share common objectives and have complete unity of interests.

[34] Although the organizational form employed here is unique, the court finds that the Alliance functions as a single entity. Defendants' composition is akin to a corporate parent (Susquehanna Alliance) and its subsidiaries (the hospitals and Affiliates). When defendants act, they "do not suddenly bring together economic power that was previously pursuing divergent goals." *Copperweld*, 467 U.S. at 769. Indeed, under the Alliance Agreement, the defendant hospitals are helpless to act without the approval of Susquehanna Alliance. Decisions, therefore, are not the product of conspiracy; they are the product of Susquehanna Alliance's exercise of authority.

[35] HealthAmerica relies heavily on the case *New York ex rel. Spitzer v. Saint Francis Hospital*, 94 F. Supp. 2d 399 (S.D.N.Y. 2000), to support its antitrust claims. While *Saint Francis* appears similar, a closer examination reveals material factual differences between it and the present case. The defendant hospitals in *Saint Francis* operated under a facially similar joinder, but their agreement concerned only certain services within the two hospitals. The key distinction between the two cases is that the hospitals in *Saint Francis* remained independent decisionmakers, while the defendant hospitals in the instant case are controlled by a single decisionmaker, Susquehanna Alliance.

[36] The Alliance is the source from which all major decisions and policies emanate. The defendant hospitals may not buy, sell or lease property without the Alliance's approval. The Alliance employs all medical staff at each of the defendant hospitals under a centralized system of human resources. The defendants share, inter alia:

> one risk manager, one facilities manager, one chief nursing officer, one human resources department, one set of human resources policies, one pension plan, one defined contribution plan, one § 403(b) plan, one vice-president of human resources, one set of administrative policies, one compliance officer, one manager for each separate clinic department, . . . one capital budget, and one health insurance program.

[37] On behalf of all of the hospitals, Susquehanna Alliance purchases a single medical malpractice insurance policy, as well as, "one commercial, one property, and one vehicle insurance policy." This degree of integration was specifically contemplated and authorized by the Commonwealth of Pennsylvania through the Consent Decree.

[38] Not only did the Susquehanna Alliance hospitals integrate their internal operations, they hold themselves out to the public as a single entity under a centralized marketing arrangement. At some point between 2010 and 2015, the defendants will merge their facilities within a single building and, thus, complete their integration.

[39] In stark contrast to defendants' substantial integration, the New York State Department of Health ("DOH") authorized the *Saint Francis* defendants to merge only three of their numerous services. The *Saint Francis* defendants never actually "unified their operations, created a single parent board, nor merged their medical staffs." Indeed, the

defendants in Saint Francis never shared a common decisionmaker. Rather, Vassar and St. Francis hospitals, acting through their respective boards of directors, pursued their own interests. For example, Vassar Hospital,

> in conjunction with another hospital, not St. Francis, completed a one million-dollar clinic in Kingston and has entered into a joint venture agreement with Northern Dutchess Community Hospital.

[40] In addition, the *Saint Francis* hospitals never claimed that they constituted a single entity. They argued only that they were engaged in a joint venture subject to rule of reason antitrust analysis. Thus, the *Saint Francis* court did not evaluate the facts under the *Copperweld* doctrine.

[41] The threshold similarity of corporate structures in *Saint Francis* and the present case provides an excellent example of why the Supreme Court found that "substance, not form, should determine whether a separately incorporated entity is capable of conspiring under § 1." *Copperweld*, 467 U.S. at 773 n. 21. HealthAmerica's reliance on Francis is misplaced. Under *Copperweld*, the defendants constitute a single entity incapable of concerted action.

[42] HealthAmerica argues, in the alternative, that *Copperweld* does not immunize the Alliance; it simply changes the standard of analysis of the Alliance's conduct from "*per se*" to "rule of reason." The court disagrees. A finding that *Copperweld* applies is a finding that defendants' conduct is unilateral, not concerted, action. Section 1 simply does not apply to the unilateral conduct of an organization like the Alliance which functions as a single entity. . . . HealthAmerica could have challenged the creation of the Alliance under Section 1, however, it did not. Defendants are entitled to judgment as a matter of law on Counts I and V.

NOTES

1) On what basis did the district court in *Susquehanna* distinguish *St. Francis*? Do you find this convincing? Would *American Needle* (discussed above in Chapter IV) change the result in this case in any way?

2) The court noted that "between 2010 and 2015, the defendants will merge their facilities within a single building and, thus, complete their integration." In fact, in 2016, Susquehanna went further than this: it merged with the University of Pittsburgh Medical Center.[52] The Department of Justice took no action. Why do you suppose it did not act?

U.S. Department of Justice and FTC, Antitrust Guidelines for Collaborations Among Competitors (2000)

"In order to compete in modern markets, competitors sometimes need to collaborate." This is the first sentence in what sometimes are called the *"Joint Venture Guidelines*,"[53] issued by DOJ and the FTC a quarter century ago—and which still are in place, unlike the health care guidelines discussed above (issued in 1996 and withdrawn in 2023). The *Joint Venture Guidelines* set forth the framework the agencies use to analyze antitrust issues raised by collaborations among competitors and to distinguish between collaborations that are anticompetitive and those that are "not only benign but procompetitive."

The general principles for evaluating such collaborations are set forth above, in Chapter V. You should re-read those now. You will see that Section 3 of the *Guidelines* provides a framework for determining when a collaboration is subject to the *per se* rule or the rule of reason—and the *Guidelines* explain how to perform the appropriate analysis.

The *Guidelines* also observe that "competitive effects from competitor collaborations may differ from those of mergers" because mergers (unlike collaborations) "completely end competition among the merging parties." (Section 1.3) On

[52] *Susquehanna Health, UPMC Merge*, The Express (Oct. 21, 2016), https://www.lockhaven.com/news/local-news/2016/10/susquehanna-health-upmc-merge/.

[53] This is how the DOJ website describes the guidelines. *Joint Venture Guidelines*, Antitrust Div., Dep't of Just. (updated July 29, 2015), https://www.justice.gov/atr/joint-venture-guidelines.

the other hand, "participants in a collaboration typically remain potential competitors, even if they are not actual competitors for certain purposes (*e.g.*, R&D) during the collaboration. The potential for future competition between participants in a collaboration requires antitrust scrutiny different from that required for mergers."

But, the *Guidelines* observe, in the same section, that "in some cases, competitor collaborations have competitive effects identical to those that would arise if the participants merged in whole or in part." And when is that? The *Guidelines* explain: "The Agencies treat a competitor collaboration as a horizontal merger in a relevant market and analyze the collaboration pursuant to the *Horizontal Merger Guidelines* if appropriate, which ordinarily is when: (a) the participants are competitors in that relevant market; (b) the formation of the collaboration involves an efficiency enhancing integration of economic activity in the relevant market; (c) the integration eliminates all competition among the participants in the relevant market; and (d) the collaboration does not terminate within a sufficiently limited period by its own specific and express terms."

Note: On December 11, 2024, the FTC and DOJ jointly withdrew the 2000 Joint Venture Guidelines*, asserting these "no longer provide reliable guidance about how enforcers assess the legality of collaborations involving competitors."*[54] *The withdrawal statement gave no guidance to lawyers and business to replace the rescinded* Guidelines*. Instead the withdrawal statement simply "encourage[d]" "[b]usinesses considering collaboration with competitors . . . to review the relevant statutes and caselaw to assess whether a collaboration would violate the law." The withdrawal came after the November 2024 election and just a little over a month before the Biden administration left office. The vote to withdraw the guidelines at the FTC was 3-2 with the two Republican appointees in the minority. It remains to be seen whether the second Trump administration will take any action to reinstate or revise the* Guidelines*. At the time of writing (June 2025) they have not yet done so.*

St. Francis and *Susquehanna* were decided before the Supreme Court's decision in *American Needle.* As you will see in the next case, decided after *American Needle,* courts still are wrestling with how to evaluate whether multiple hospitals have formed a single entity that would immunize them from Section 1 attack, and what factors are relevant to that assessment.

The Medical Center at Elizabeth Place, LLC v. Atrium Health System,

817 F.3d 934 (6th Cir. 2016)

Judge Merritt.

[1] Section 1 of the Sherman Act broadly prohibits "combinations in restraint of trade." Plaintiff claims that defendants conspired to deny it access to managed care contracts that plaintiff needed to compete in the hospital market in Dayton, Ohio. The question in this case is whether defendants, four previously independent hospitals now operating as a hospital "network" under the name "Premier Health Partners," is a "combination" subject to liability under § 1 of the Sherman Act, or whether it should be characterized as a single entity competing in the marketplace for hospital services in the Dayton area. The four hospitals entered into a joint operating agreement that merged[2] some of their healthcare functions, but retained control of others, and they continued to compete with each other. The district court held that the Premier group was a single entity and dismissed this antitrust case on summary judgment without adjudicating the question of whether the behavior of the Premier group of hospitals constitutes impermissible anticompetitive conduct. We disagree and reverse and remand for further proceedings under the Sherman Act.

I. Background

[2] Plaintiff, The Medical Center at Elizabeth Place, opened in 2006 and operates a 26-bed, for-profit, physician-owned hospital in Dayton, Ohio. Plaintiff specializes in acute-care surgical services. Its competitors for surgical patients

[54] Justice Department and Federal Trade Commission Withdraw Guidelines for Collaboration Among Competitors," F.T.C. (Dec. 11, 2024) https://www.ftc.gov/system/files/ftc_gov/pdf/v250000collaborationguidelineswithdrawalstatement.pdf

[2] A merger was not possible because one of the hospitals, Catholic Health Initiatives, Inc., was prohibited from joining a non-Catholic entity.

in the Dayton market include the defendant hospitals. Defendant Premier Health Partners was formed in 1995 when two Dayton-area hospitals entered into a joint operating agreement. Over the next 13 years, several additional hospital corporations in the area entered into Premier's joint operating agreement. Premier Health Partners, through the joint operating agreement, operates four hospitals: Good Samaritan Hospital, Miami Valley Hospital, Atrium Medical Center, and Upper Valley Medical Center. . . . Premier is not a hospital, does not provide any health care itself, and has no assets of its own. Instead, Premier handles much of the financial business of the hospitals through the joint operating agreement, including negotiating managed-care contracts with insurance carriers. The defendant hospitals share revenues and losses through an agreed-upon formula set forth in the joint operating agreement, but each defendant maintains separate ownership of its assets. Defendant hospitals file separate tax returns and other corporate forms and documents filed with the government.

[3] Plaintiff claims that the hospital defendants are not a single entity, but instead a group of hospitals capable of concerted action to keep plaintiff from competing in the market. Plaintiff offers proof that the group engaged in concerted action in three principal ways: (1) to coerce commercial health insurers that collectively represent at least 70% of the insured consumers in Dayton to refuse to negotiate contracts for managed care with plaintiff and to otherwise deny it access to their networks, thereby depriving plaintiff of the ability to serve a large segment of the Dayton consumer market; (2) by threatening punitive financial consequences to physicians who affiliated with plaintiff, including terminating leases that physicians had with defendant hospitals for office space or terminating or evicting physicians already leasing from defendant facilities, and threatening to withhold referrals; and (3) by compelling physicians, either through threats of punitive measures or through financial incentives, to refuse to admit their patients to plaintiff hospital.

[4] The question cannot be answered in the abstract as to whether a joint venture like the one here constitutes a single entity incapable of conspiring with itself in an anticompetitive manner, or whether, instead, it becomes a vehicle to facilitate separate entities to conspire illegally to restrain trade. In *American Needle, Inc. v. National Football League*, 560 U.S. 183, 203 n.10 (2010), the Supreme Court relied on Justice Brandeis's multi-factored test in *Board of Trade of Chicago v. United States*, 246 U.S. 231, 238 (1918), to determine whether a joint venture constitutes a "combination" under Section 1:

> The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. *To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint is imposed; the nature of the restraint and its effect, actual or probable.* The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation or the reverse; *but because knowledge of intent may help the court to interpret facts and to predict consequences*.

[5] (Emphasis added.)[5] The summary judgment record leaves little doubt on the question of the intent of the network to prevent plaintiff hospital from entering the Dayton healthcare market. The deposition of the eventual head of

[5] Our dissenting colleague does not agree that this statement from Justice Brandeis in American Needle is relevant because it discusses facts relating to defendants' intent, history, and coercive behavior. The objection is strange because Justice Brandeis's admonition is quoted at length in a case where the issue was whether the defendant was a single entity. Surely if the Supreme Court had thought that Justice Brandeis's factors concerning conduct and intent were irrelevant, it would not have said they were relevant and directed lower courts to consider them. We understand that, at least on paper, the joint venture agreement, written by defendants themselves, aims to legitimate the cartel. But further factual determination is required to resolve whether the neutral words of the agreement belie the true aim of defendants' association. We are tasked with looking at the evidence before us, which includes evidence of defendants' unveiled threats to plaintiff and the words of defendants' employees and agents concerning their views on the nature of the relationship among defendants. *See Freeman v. San Diego Ass'n of Realtors,* 322 F.3d 1133, 1150 (9th Cir. 2003) ("Defendants sabotage their theory by their own admissions. . . . Rarely do antitrust defendants serve up their own heads on so shiny a silver platter."). Our colleague's refusal to consider anything other than the joint venture agreement is tantamount to repealing Section 1 of the Sherman Act by allowing the cartel members themselves to write up the only facts to be considered.

plaintiff hospital contains the following testimony about a phone conversation he had with Thomas Arquilla, Executive Vice President of the Premier group of hospitals, one afternoon before the plaintiff hospital opened:

> The conversation started with him asking me the question, John, I understand that you are an investor in this new Regent Hospital [plaintiff hospital]. And I said yes, Tom, that's true. I also understand that you are the chairman of the board of the hospital. Is that true? I said yes, it's true. He said I want you to know that you are the enemy and that this is war, and you are not going to open this hospital. I replied to him are you going to kick me off of staff at Miami Valley Hospital? And he said John, I'm not going to tell you what we are going to do to you, but there are many things that we can do to you, and we are going to do them. I said Tom, are you going to blow the facility up? And he laughed, and he said I already told you, John, there's lots of things that we can do to you, and we are going to do them. You are not going to open this hospital. He then went on to say that our facility would suck off good paying patients, that we were going to be cherry pickers, and that we would suck off good patients.

[6] [. . .] *American Needle* sets out the framework we are to follow in deciding the "single entity" versus "concerted activity" question at issue in this appeal. Based on defendants' stated intent to keep plaintiff out of the Dayton market, the evidence of coercive conduct threatening both physicians and insurance companies with financial loss if they did business with plaintiff, evidence of continued actual and self-proclaimed competition among the defendant hospitals, and evidence that the defendant hospitals' business operations are not entirely unitary, we conclude that there is a genuine issue of material fact as to whether the defendant hospitals' network constitutes a single entity or concerted action among competitors for purposes of Section 1 of the Sherman Act.

II. Analysis

[7] The Sherman Antitrust Act is based on an often-difficult distinction between concerted and independent, unilateral action. Concerted activity is scrutinized more closely than unilateral behavior because "'[c]oncerted activity inherently is fraught with anticompetitive risk' insofar as it 'deprives the marketplace of independent centers of decisionmaking that competition assumes and demands.'" *Am. Needle*, 560 U.S. at 190 (quoting *Copperweld Corp. v. Indep. Tube Corp.*, 467 U.S. 752, 768-69 (1984)). Specifically, Section 1 regulates concerted activity between two or more entities, outlawing "[e]very contract, combination . . . or conspiracy, in restraint of trade," 15 U.S.C. § 1, a provision that has subsequently been limited to target only "unreasonable" restraints of trade. To prevail on a claim under § 1, a plaintiff must prove: (1) a contract, combination, or conspiracy; (2) producing adverse, anticompetitive effects in the relevant market; and (3) resulting in injury. . . . This appeal looks only at the element addressed by the district court, which is the first element: whether defendants' conduct is the result of two or more entities acting in concert or whether defendants, based on their participation in the joint operating agreement, function as a single entity in the market place. Our analysis is guided by *American Needle*, which sets out the standard to apply in distinguishing concerted from unilateral action.

[8] [. . .] Applying *American Needle* to examine the relationship among the defendant hospitals pursuant to the joint operating agreement, we come to the same conclusion. Like the joint venture in *American Needle*, the joint operating agreement brings together "independent centers of decisionmaking" that "remain separately controlled, potential competitors with economic interests that are distinct" and thus are capable of concerted action. . . .

[9] [. . .] *American Needle* directs us to look at a number of factors when determining whether multiple parties joined together in a joint venture are functioning as a single entity for purposes of Section 1 of the Sherman Act. We first look to the actual conduct of the parties to the joint venture: "We have long held that concerted activity does not turn simply on whether the parties involved are legally distinct entities. Instead, we have eschewed formalistic distinctions in favor of a functional consideration of how the parties involved in the alleged anticompetitive conduct actually operate." 560 U.S. at 191 (emphasis added). The Court went on to say that in looking at how the parties actually operate, "we have repeatedly found instances in which members of a legally single entity violated § 1 when the entity was controlled by a group of competitors and served, in essence, as a vehicle for ongoing concerted activity." *Id.* . . .

[10] The stated intent on the part of the defendants to engage in coercive behavior, as well as conduct providing evidence of that intent, is demonstrated by the conversation recited above between the CEO of plaintiff and the Executive Vice President of Premier, in which the Premier official stated his intention to keep plaintiff from entering the Dayton healthcare market. The record also contains evidence, through letters and emails, that physicians who collaborated with plaintiff in any way lost their leases for office space in properties owned by defendants and were threatened with loss of treating privileges at defendant hospitals.

Boycott by Health Insurance Companies

[11] Another example of alleged conduct indicating possible anticompetitive intent on the part of defendants arises from evidence that insurance companies were refusing to deal with plaintiff at the behest of defendant hospitals. Defendant hospitals each executed separate managed-care contracts with each insurance company. Plaintiff offered evidence that defendant hospitals each individually executed managed-care contracts with the insurance companies that contained language prohibiting the insurer from also contracting with plaintiff by including an explicit restriction on the insurer's ability to add a new hospital to its network. . . . Access to managed-care contracts offered by insurers is crucial to a hospital's financial success. The managed-care contracts with insurers provide the hospital with the volume (patients who are covered by the insurers) that is necessary to survive. If a hospital cannot contract with a number of insurers, or at least several insurers with large numbers of insureds, it is unlikely to admit enough patients, and it is only through patients that the hospital generates revenue. Hospitals generally seek to become "in-network" or "preferred" providers for a number of insurers, often accepting lower rates from the insurance companies in exchange for a higher volume of patients. In this case, the forming of the joint venture, bringing the defendant hospitals under the umbrella of Premier Health Partners, facilitated negotiation with insurers for managed-care contracts. The Federal Trade Commission and the Antitrust Division of the Justice Department recognize that "collaboration that eliminates or reduces price competition or allows providers to gain increased bargaining leverage with [insurers] raises significant antitrust concerns." Deborah L. Feinstein, Director, Bureau of Competition, Federal Trade Commission, Antitrust Enforcement in Health Care: Proscription, not Prescription, at 2, Address at the Fifth National Accountable Care Organization Summit (June 19, 2014). In this address, Director Feinstein also noted that "management contracts whereby one hospital manages another hospital with which it also competes may raise concerns similar to horizontal acquisitions." *Id.* at 9.

[12] Negotiating contracts that explicitly exclude the insurers' ability to contract with other parties is anticompetitive on its face and normally serves no proper business function [. . .]

The Joint Operating Agreement

[13] *American Needle* also looked to other factors in addition to actual conduct, examining the nature of the business relationship among defendants, focusing on whether that relationship remains that of separate, competing entities or whether there is a single center of decisionmaking. As noted above, Premier owns no assets and it does not provide any healthcare services. Like the joint venture under scrutiny in *American Needle*, Premier is a separate corporate entity with its own management structure, including a CEO and a Board of Directors, some of whom are employees of the individual defendant hospitals. The joint operating agreement provides for certain management functions to be carried out by Premier on behalf of the defendant hospitals. Premier's duties under the joint operating agreement are an attempt to achieve efficiencies in billing and collecting payments, managing physicians and physician groups, property management and other similar duties. *American Needle* emphasized that it is not dispositive that the parties to the joint venture have organized and created a legally separate entity that centralizes certain management functions. The Court stated that an "ongoing § 1 violation cannot evade § 1 scrutiny simply by giving the ongoing violation a name and label. 'Perhaps every agreement and combination in restraint of trade could be so labeled.'" *Am. Needle*, 560 U.S. at 197 (quoting *Timken Roller Bearing*, 341 U.S. at 598). The joint operating agreement provides for some degree of unitary management, but questions remain as to whether "their general corporate actions are guided or determined by separate corporate consciousnesses." *Id.* at 196 . . . .

[14] The Premier joint operating agreement also provides for sharing revenue pursuant to an agreed upon formula. But, if the fact that potential competitors shared in profits or losses from a venture meant that the venture was immune from § 1, then any cartel "could evade the antitrust laws simply by creating a 'joint venture' to serve as the exclusive seller of their competing products." *Major League Baseball Props., Inc. v. Salvino, Inc.*, 542 F.3d 290, 335 (2d Cir. 2008) (Sotomayor, J., concurring in judgment). Indeed, a joint venture with a single management structure is generally a better way to operate a cartel because it decreases the risk that a party to an illegal agreement will defect from that agreement. But, competitors "cannot simply get around" antitrust liability by acting "through a third-party intermediary or joint venture." *Am. Needle*, 560 U.S. at 201 (internal quotations omitted). Although joining together to carry out certain functions, defendant hospitals remain separate legal entities, each with their own assets, filing their own tax returns and maintaining a separate corporate identity with its own CEO and Board of Directors. The record also demonstrates that defendant hospitals compete with each other for physicians and patients, with each defendant hospital continuing to market certain hospital services to the public. Each of the defendant hospitals makes material independent decisions concerning their respective medical operations that are not managed by Premier, including staffing decisions and medical strategies concerning patient care.

[15] Like the NFL teams in *American Needle*, each defendant hospital holds its own assets. Thus, the defendant hospitals only "partially" unite their economic interests, and they continue to have distinct, potentially competing interests. See *Am. Needle*, 560 U.S. at 198. Any joint venture involves multiple sources of economic power cooperating to produce a product or provide a service. The benefits of cooperation do not transform concerted action into unilateral action that puts the joint venture beyond the reach of § 1. As the Court noted, "Apart from their agreement to cooperate in exploiting those assets, . . . there would be nothing to prevent each of those teams from making its own market decisions . . . ." *Id.* at 200. Here, the defendant hospitals clearly did not completely align their interests, economic or otherwise. The defendant hospitals continue to function more or less as independent and competing hospitals that entered into the joint operating agreement largely to derive the benefit of conforming certain business practices to a uniform standard. The evidence shows that the joint venture under Premier's management is composed of individual hospitals that are separately incorporated, hold their assets separately, and compete with each other for patients. Like the NFL teams, each defendant hospital "is a substantial, independently owned" business that is "guided [by a] 'separate corporate consciousness[ ].'" *Id.* at 196 (quoting *Copperweld*, 467 U.S. at 771).

Defendant Hospitals Continue to Compete

[16] The record also provides evidence that defendant hospitals continue to view themselves not as a single entity, but as competitors in the market. Defendants made statements to the public, among themselves and to a consultant hired by Premier, that demonstrate that they view themselves as separate entities. In 2010, Premier retained H*Works Consulting to help it devise a strategic five-year plan (2010–2015). One aspect of the study was to analyze the role of Premier and its relationship to its constituent elements, the defendant hospitals. As part of the process, 44 of defendants' "executives and key stakeholders" were interviewed by H*Works on a number of topics, including the integration of defendant hospitals. Pearce Fleming of H*Works conducted all of the interviews of defendants' executives, including Premier's Board of Trustees, the top level executives at Premier, and senior management from all the defendant hospitals. Fleming took contemporaneous notes of each interview, generating 11 sets of handwritten notes.

[17] Based on these statements by defendants' top administrators, H*Works made a number of findings, including the following: "[Premier] partners do not collaborate or act as a system today, more often [Premier] partners find themselves competing with each other;" "[Premier] does not have an identity as a collaborative group, rather act as a confederacy that collaborates in a few areas (*i.e.*, supplies, financing/access to capital, electronic medical records);" "[Premier] does not think of itself as integrated organization;" and "[Premier] Partners compete with each other for market share." H*Works Consulting, Key Interview Findings, at 8 (Apr. 2010). Specific statements from the interviews include: Premier is a "confederation of autonomous organizations" that cooperate in certain areas; "[t]he brand is the hospital, not [Premier];" defendant hospitals "do their own thing and act in their own self interest above that of [Premier];" and the joint venture structure was "designed to keep everyone separate." H*Works Consulting Interview

Statements at 2-5 (Apr. 2010). The H*Works findings and interview statements set forth in its reports to Premier provide evidence that defendant hospitals uniformly agree that the they are driven to pursue individual hospital goals even after entering into the joint venture. [. . .]

III. Conclusion

[18] The gravamen of plaintiff's complaint is that in creating a joint venture, defendants colluded to keep plaintiff from competing in the Dayton hospital market through a number of avenues. The evidence of emails, letters, and the statements elicited by the consultant, together with the lack of shared assets by the defendants, raises a genuine issue of material fact as to whether defendant hospitals have "separate" corporate consciences or whether they should be considered a single entity for purposes of the antitrust laws. All of these facts suggest that defendant hospitals are actually competitors attempting to eliminate another competitor through concerted action. When viewing the record in the light most favorable to plaintiff, a reasonable juror might conclude that, aside from a business relationship pursuant to the joint operating agreement, defendant hospitals maintained separate identities and acted more like competitors than one unit. . . .

[19] Because plaintiff presented evidence of conduct and business operations that raise the possibility of concerted action among defendant hospitals, the question remains upon remand whether hospitals that had previously pursued their own interests separately, and that continue to seem to compete, combined unlawfully to restrain competition.

[20] For the foregoing reasons, the judgment of the district court is reversed, and the case is remanded for further proceedings consistent with this opinion.

Judge Griffin, dissenting.

[21] To succeed on a § 1 claim under the Sherman Antitrust Act, a plaintiff must establish that the defendants: "(1) participated in an agreement that (2) unreasonably restrained trade in the relevant market." Because § 1 "does not reach conduct that is wholly unilateral," *Copperweld Corp. v. Indep. Tube Corp.*, 467 U.S. 752, 768 (1984) (internal quotation marks omitted), proving the first element involves a threshold showing that the defendants are separate entities capable of concerted action. That is the only question before us: "whether defendants . . . should be characterized as a single entity." (Majority opinion.)

[22] The test we apply to determine single-entity status is from *American Needle* and *Copperweld*: whether the defendants are "separate economic actors pursuing separate economic interests," such that their agreement "'deprives the marketplace of independent centers of decisionmaking,' . . . and thus of actual or potential competition." *Am. Needle, Inc. v. Nat'l Football League*, 560 U.S. 183, 195 (2010) (quoting *Copperweld*, 467 U.S. at 769).

[23] My colleagues begin not with *American Needle* and *Copperweld*, but with the "rule of reason" as articulated in *Board of Trade of Chicago v. United* States, 246 U.S. 231 (1918)—a test that may come into play only for the second part of the inquiry—*i.e.*, in determining whether the agreement itself constitutes an "unreasonable restraint" on trade. See *Am. Needle*, 560 U.S. at 203 ("[T]he restraint must be judged according to the flexible Rule of Reason.") (footnote omitted) Reaching this issue is premature. Because of its ruling that defendants are a single entity for § 1 purposes, the district court never considered whether defendants "participated in [any] agreement," much less an agreement to restrain trade unreasonably. Citing the rule of reason seems all the more misplaced here, where plaintiff alleges that defendants' conduct constitutes a *per se* violation of § 1, not a violation under the "flexible Rule of Reason." *Am. Needle*, 560 U.S. at 203.

[24] The majority's misapplication of *American Needle* is problematic. Invoking the rule of reason steers focus to defendants' intent to avoid competition with plaintiff and away from the relevant question: whether, under the terms of their Joint Operating Agreement (JOA), defendant hospitals and their joint operating company, Premier Health Partners (Premier), share "a complete unity of interest," *Copperweld*, 467 U.S. at 771, and represent a single center of

decisionmaking. I conclude they do. Thus, I would affirm summary judgment in favor of defendants and respectfully dissent.

[25] [. . .] Whether two legally separate entities constitute a single actor depends upon commonality of interest, not corporate formality. Thus, "although a parent corporation and its wholly owned subsidiary are 'separate' for the purposes of incorporation or formal title, they are controlled by a single center of decisionmaking and they control a single aggregation of economic power. Joint conduct by two such entities does not 'depriv[e] the marketplace of independent centers of decisionmaking.'" *Am. Needle*, 560 U.S. at 194 (quoting *Copperweld*, 467 U.S. at 769).

[26] The Supreme Court reiterated the substance-over-form analysis in *American Needle*. [. . .]

[27] As the majority states, *American Needle* "eschewed formalistic distinctions in favor of a functional consideration of how the parties involved in the alleged anticompetitive conduct actually operate." *Am. Needle*, 560 U.S. at 191. Guided by the rule of reason, my colleagues interpret this directive to mean that we should ask how defendants "actually operate" with regard to plaintiff—specifically, their intent to keep plaintiff out of the market as expressed through apparent threats by Premier's executives and the boycott defendants allegedly arranged among the insurance companies. This view is flawed. Defendants' intent to exclude others from the market is irrelevant to determining whether defendants themselves constitute a single entity. To resolve that question, we should consider how defendants "actually operate" amongst each other.

[28] *American Needle* asks if "the [anticompetitive] agreement joins together independent centers of decisionmaking" between the defendant entities. Defendant hospitals were independent centers of decisionmaking before forming Premier as their joint operating company, but the question here is whether that independence survived the creation of the joint venture; whether, when acting through Premier, defendants are "pursuing the common interests of the whole," or whether each defendant has a remaining, independent economic interest, such that it could be "pursuing the interests of [the] corporation itself," even in the course of taking joint action. What matters then is whether defendants remain in competition with each other, not whether they intend to ward off competition with a third party. The Supreme Court's reasoning makes this point plain:

> Agreements made within a firm can constitute concerted action covered by § 1 when the parties to the agreement act on interests separate from those of the firm itself . . . .
>
> For that reason, decisions by the NFLP regarding the teams' separately owned intellectual property constitute concerted action. Thirty-two teams operating independently through the vehicle of the NFLP are not like components of a single firm that act to maximize the firm's profits. The teams remain separately controlled, potential competitors with economic interests that are distinct from NFLP's financial well-being. Unlike typical decisions by corporate shareholders, NFLP licensing decisions effectively require the assent of more than a mere majority of shareholders. And each team's decision reflects not only an interest in NFLP's profits but also an interest in the team's individual profits.

[29] . . . Defendants' wish to avoid competing with plaintiff tells us nothing about whether defendant hospitals are themselves "potential competitors with economic interests that are distinct from [Premier's] financial well-being" as a whole.

[30] The best evidence of how Premier and the defendant hospitals "actually operate" is the parties' JOA. The majority concedes that the JOA vests Premier with control over the hospitals' "management functions," but insists—without discussion of the agreement's terms—that "questions remain" as to whether defendants are guided by a single corporate consciousness. Review of the JOA should resolve those questions. From the outset, the JOA identifies corporate unification as an overarching goal: "The vision of the Parties is to create and operate the JOC [joint operating company] Network as a multi-entity, integrated health care delivery system for the Miami Valley Region that is positioned for the future and not simply a continuation of the large JOC Hospitals."

[31] Executing on that vision, the agreement creates a "unity of interest" among defendant hospitals by establishing a system of shared income:

- The JOA provides that its financial arrangements are intended to promote the functioning of Premier and defendant hospitals as an "integrated health system."
- Defendants' net incomes are totaled each year into a single "network net income," to be allocated to the parties based on predetermined percentages in the JOA.
- Defendants also share losses according to the same predetermined percentages.

[32] Most importantly, the allocation of network net income is not linked to any individual hospital's revenue or profitability. For example, defendant MedAmerica Health Systems is entitled to 55.35% of the network net income under the JOA. Because defendants' revenues are combined in totaling the network net income, MedAmerica receives 55.35% of the profit earned from a patient regardless of whether that patient is treated at Atrium Health System, Samaritan Health Partners, Catholic Health Initiatives, UVMC, or MedAmerica's own facility. Unlike the NFL teams in *American Needle*, who maintained "economic interests . . . distinct from NFLP's financial well-being," no single hospital has any incentive to become more profitable by attracting more patients than the other. The majority is therefore incorrect to say "defendant hospitals compete with each other for . . . patients." They do not.

[33] To be sure, revenue sharing is not dispositive of single-entity status. Competitors cannot side-step antitrust liability merely by sharing revenue through a joint venture. "If the fact that potential competitors shared in profits or losses from a venture meant that the venture was immune from § 1, then any cartel 'could evade the antitrust law simply by creating a "joint venture" to serve as the exclusive seller of their competing products.'" *Am. Needle*, 560 U.S. at 201 (quoting *Major League Baseball Props., Inc. v. Salvino, Inc.*, 542 F.3d 290, 335 (2d Cir. 2008) (Sotomayor, J., concurring in judgment)).

[34] But defendants' integration is not limited to profits and losses on a balance sheet. The JOA grants Premier significant operational authority over each defendant hospital. In particular:

- It designates Premier as the "operator" for all health system activities and requires Premier to coordinate and have authority over all of those activities. Premier has general authority to operate and manage the operations of the health system activities of all defendants.
- Defendant hospitals' CEOs report to Premier's COO.
- Each defendant's management reports to Premier's executives, and Premier's system vice presidents and senior vice presidents serve at the top of each department throughout the system.
- Premier has integrated a number of system management functions among defendant hospitals, such as managed care and legal functions, into single departments for the entire system.
- The JOA grants Premier authority and control over defendants' strategic plans, budgets, and business plans.
- The JOA requires Premier to develop and oversee the implementation of a strategic plan for all system activities, and each defendant must comply with and implement the strategic plan. 2 Additionally, defendants' counsel represented at oral argument that Premier sets prices for all hospital services performed by physician-employees, ensuring that each hospital charges the same price for the same service.
- It also requires Premier to develop annual capital expenditure and operating budgets for the system, and each defendant must adopt and implement the budget approved for it by Premier.
- Premier's CEO has the power to remove each defendant hospital's CEO.
- Premier controls defendant hospitals' material debt incurrence and negotiates and manages their relationships with insurance companies.

[35] Although each defendant hospital retains its separate corporate existence, along with the right to amend or repeal their corporate governing documents, the JOA requires them to "take all corporate action . . . as required to implement" Premier's authority. Defendants are also prohibited from modifying corporate documents in a manner inconsistent with the JOA without prior approval. To the extent defendant hospitals' corporate documents conflict with the JOA, the JOA controls.

[36] The majority's reply that "defendant hospitals remain separate legal entities . . . [each] filing their own tax returns and maintaining a separate corporate identity with its own CEO and Board of Directors" is beside the point. Finding an issue of fact on these grounds elevates form over substance. "[T]he question is not whether the defendant is a legally single entity or has a single name"; rather, the question is one of functional reality. *Am. Needle*, 560 U.S. at 195. And the functional reality is that the JOA unifies defendant hospitals under Premier's flagship. [. . .]

[37] Defendants' alleged conduct in this case, if proven at trial, is indeed anticompetitive. But the Sherman Act does not proscribe unreasonable restraints on trade by a single entity; "it leaves untouched a single firm's anticompetitive conduct (short of threatened monopolization) that may be indistinguishable in economic effect from the conduct of two firms subject to § 1 liability." *Copperweld*, 467 U.S. at 775. "Congress left this 'gap'" purposefully, "for eminently sound reasons." *Id.* A prohibition against independent action "that merely restrains trade . . . could deter perfectly competitive conduct by firms that are fearful of litigation costs and judicial error." *Am. Needle*, 560 U.S. at 190 n.2. Regardless of their intent to keep plaintiff out of the market, defendants have demonstrated a complete unity of interest and a single center of decisionmaking. "Unless we second-guess the judgment of Congress to limit § 1 to concerted conduct," *Copperweld*, 467 U.S. at 776, we are without authority to check them.

[38] For these reasons, I respectfully dissent. I would affirm the judgment of the district court.

NOTES

1) Who got the single entity analysis right in *The Medical Center at Elizabeth Place*: the majority or the dissent?

2) Is the majority correct that in order to resolve the single entity question a court must "resolve whether the neutral words of the agreement belie the true aim of defendants' association" (see footnote 5)?

3) Suppose that 200 miles away from Dayton, there is another town that exactly replicates Dayton. Suppose the facts in that town replicate the facts here (so, there is a joint venture among four hospitals that excludes a fifth, etc.) except that in this second town, no threats have been made against the excluded hospital, no consultant was hired to review the venture and write a report, no damning emails exist, etc. All we have are the facts of what the JOA says and how the parties operate. Would the majority here come to a different conclusion on the single entity status? Should it? If so, does this make sense?

4) Look again at the list of facts marshalled by the dissent to show integration. If you were advising two hospitals or health systems that wanted to form a joint venture short of a complete merger, what more would you advise them to do? Or would you think that the list should be enough (at least for hospitals outside the Sixth Circuit)?

The Sixth Circuit in *The Medical Center at Elizabeth Place* held that the four hospitals forming the Premier network (by then known as Atrium Health—hence the case name) had not shown on summary judgment that they integrated sufficiently to escape the reach of Section 1. But the question whether the joint venture's conduct should be judged under Section 1's *per se* rule, the rule of reason, or perhaps an intermediate "quick look," was not addressed in that decision. This issue became the centerpiece of the litigation when the case returned to the district court for a curious reason: when The Medical Center at Elizabeth Place filed its original antitrust complaint it pled just one claim, that Premier (and its constituent hospitals) committed a *per se* violation of Section 1. Plaintiff did not plead, in the alternative, a rule of reason violation.

After the case returned to the district court, defendants filed another motion for summary judgment but this time on different grounds from the single entity argument. Defendants asserted that even if they hadn't integrated enough to

form a single entity and escape review altogether under Section 1, they had integrated enough to show plausible procompetitive effects that took their conduct outside the *per se* rule (and into the rule of reason). This motion was denied by the same district court judge who had granted the earlier motion that was appealed to the Sixth Circuit. But shortly before trial, the judge recused himself and the case was re-assigned to a new district court judge who, on what amounted to a motion for reconsideration, *granted* defendants' summary judgment motion. This time it was plaintiff's turn to appeal to the Sixth Circuit. Another panel of that court was selected (the panel did not include any of the judges who participated in the first decision) and this panel *affirmed* the district court's grant of summary judgment.

The Sixth Circuit held "when *conduct* of . . . [a] joint venture is challenged, the relationship of the challenged conduct to the joint venture is analyzed to see if the conduct is reasonably related to the joint venture's procompetitive features (and therefore should be judged under the rule of reason), or is a naked restraint lurking beneath the veneer of a legitimate joint venture (and therefore deserves *per se* condemnation)."[55] The court of appeals held, relying on precedent from a majority of circuit courts outside the Sixth Circuit (which had not ruled on the matter before) and on then-Judge Sotomayor's concurring opinion in a Second Circuit case, that "[u]nder the ancillary restraints doctrine, a challenged restraint need not be essential, but rather only 'reasonably ancillary to the legitimate cooperative aspects of the venture.'"[56]

NOTES

1) Why might The Medical Center at Elizabeth Place have pled only a *per se* claim under Section 1? Did its lawyers make a mistake? Or might there be strategic or cost reasons for limiting an antitrust complaint just to a *per se* claim and not add a rule of reason claim?

What threat did The Medical Center at Elizabeth Place pose to the Premier hospitals?

The decision set forth above shows that the Premier hospitals harbored deep concerns about The Medical Center at Elizabeth Place. Why? How could a 26-bed specialty hospital possibly threaten the Premier hospitals' business model?

The Sixth Circuit shone some light on this issue in the course of its second opinion, affirming summary judgment for Premier and its hospital members. The court quoted from a letter physicians affiliated with the defendants wrote to other physicians in the Dayton market: "There is currently widespread opposition among not-for-profit community hospitals across the country toward physician owned inpatients [sic] hospitals such as this. The physician investors are doing so for reasons of profitability. MVH and GSH [two of the Premier hospitals] offer the range of services and the quality of care necessary to enable surgeons to care for their patients. A physician owned specialty hospital will take the better-insured and more profitable patients away from Premier (along with ancillary services), leaving our local hospitals with only the more complex and underinsured patients."

This concern, often referred to as "cherry picking," is repeated in other health care contexts. For example, some defenders of the certificate of need process say that forcing hospitals to obtain a CON before they can operate in a community will allow state authorities to block specialty hospitals that offer only cardiology services, or orthopedic services, for example, to siphon off the "better-insured and more profitable patients" from the hospitals that see it as their mission to provide all services to their community and that take the uninsured and underinsured along with commercially insured patients.

Some economists criticize the cherry picking argument, asserting that a specialty hospital will simply increase competition (albeit for a segment of all patients) and this benefits those patients (and their insurers). They recognize that full-service community hospitals often have no choice but to provide services below their cost (because patients are uninsured or because government payers do not reimburse enough) but argue the better policy solution is to

[55] The Medical Center at Elizabeth Place, LLC v. Atrium Health System, 922 F.3d 713, 724 (6th Cir. April 25, 2019).

[56] Major League Baseball Properties v. Salvino, 542 F.3d 290, 340 n.11.

increase coverage and government reimbursement rates, not engage in what amounts to cross subsidizing by one set of patients of another.

D. Mergers

1. Hospital Mergers

Antitrust review of hospital mergers has been one of the most visible enforcement priorities of government enforcers for decades. This is not surprising. Hospitals tend to be the focal point for the provision of complex health services, and this has remained the case even as an increasing number of health care services are being furnished in an outpatient setting. Hospitals are often the largest employers in a community, and a hospital merger or acquisition affects not only where and how services are furnished, but also the local job market and in some cases a community's identity and vibrancy. Because of the costs of hospital construction and the challenges of obtaining regulatory approval for a new facility, entry barriers are typically very high. Hospital mergers also often involve firms that are struggling financially, raising difficult questions as to whether a merger will create an entity whose large scope and scale will lead to better health care services and access. Hospital merger analysis is made more complex by the not-for-profit nature of the large majority of hospitals, raising questions as to whether they may not behave as typical profit-maximizing firms; by the fact that 50–70% of a typical hospital's revenue is based on administered prices from Medicare, Medicaid and other government sources that are not determined by competition (and would not be affected by a merger); and, in some cases, by state oversight of the prices, quality and access of hospital services.

All of these issues have had a role in hospital merger review, and have resulted in a string of cases that are both fascinating and unique. But in most litigated cases the determinative issue has been how the courts have defined the relevant geographic market—and this analysis has changed markedly over time. How market definition has evolved has lessons that extend far beyond health antitrust and illustrate the role economic analysis has played in antitrust litigation, including increasing reliance on more sophisticated economic modeling. And it raises questions as to whether judges fully understand conflicting models and the limits of such models in predicting competitive harm.

Over the last several decades, consolidation among U.S. hospitals has occurred at a rapid rate. Approximately 40% of all U.S. hospitals belonged to a system in 1980. Forty years later, in 2021, the proportion had doubled, to 80%.[57] Throughout this period hospitals merged, were acquired, or otherwise consolidated into systems (both large and small). These mergers did not avoid the antitrust spotlight: in the 1980s and 1990s, both the FTC and DOJ investigated and brought cases to prevent mergers the agencies considered anticompetitive. The agencies' record in those years was mixed—the agencies won some and lost some. Starting in 1994, however, the government went on a seven-year losing streak. The FTC lost five cases during this period, the DOJ lost two, and in 2001, the State of California entered the fray and notched the final loss in the streak on its own.

After California's loss, the federal agencies hit the pause button on hospital merger challenges. DOJ didn't bring another hospital merger case until it filed an unusual case in 2021 (and it hasn't filed one since).[58] The FTC took a different tack. Instead of abandoning the field, in 2002 the agency launched its "Hospital Merger Retrospectives Project" to better understand competition in hospital markets—and to figure out why the government had lost so

[57] *Table 89. Hospitals, Beds, and Occupancy Rates, by Type of Ownership and Size of Hospital: United States, Selected Years 1975–2015*, Ctr. Dis. Cont. (2017), https://www.cdc.gov/nchs/data/hus/2017/089.pdf. *See also* Lawrence Casalino, *Health Systems—The Present and the Future*, 329 JAMA 293 (Jan. 24-31, 2023), https://bookcafe.yuntsg.com/ueditor/jsp/upload/file/20230207/1675729896717052505.pdf; *see also* Karyn Schwartz, Eric Lopez, Matthew Rae, & Tricia Neuman, *What We Know about Provider Consolidation*, KFF (Sept. 2, 2020), https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/.

[58] In 2020, DOJ filed an action claiming that Geisinger Health's acquisition of a 30% interest in a community hospital was anticompetitive. The case was resolved the following year by entry of a consent order capping Geisinger's interest at 7.5%. U.S. v Geisinger Health and Evangelical Community Hospital, No. 4:20-cv-01383-MWB (M.D. Pa. 2021).

many cases.[59] Economists at the FTC studied several hospital mergers that the agency had not challenged to determine whether the mergers had increased prices; the FTC later published the results of four of their reviews.[60] FTC enforcers also examined cases they had brought and lost, drawing various lessons as to what had gone wrong. In some cases the agency had failed to secure the support of local authorities (usually the state's Attorney General). In other cases, district courts claimed the nonprofit status of the merging hospitals meant they were unlikely, even if they gained market power, to exploit it. But across almost all the losses, the enforcers concluded, there was one consistency: courts had drawn very broad geographic markets in which the merging parties had small shares. The FTC could not blame this result entirely on the courts because the agency itself had acquiesced in the use of a methodology (the so-called "Elzinga–Hogarty" test) that typically led to expansive markets.

During the retrospective project the FTC identified a merger that had not been challenged when it occurred but which, the FTC believed, based on post-merger evidence, had resulted in an anticompetitive post-merger price increase: the acquisition, in 2000, by Evanston Northwestern Healthcare Corporation (owner of two hospitals in the northern Chicago suburbs) of Highland Park Hospital (a solo facility in the same area). The FTC issued an administrative complaint in 2004, seeking to declare that merger unlawful. The agency won this litigation, albeit before its own administrative law judge, and then, on appeal, before the Commission itself.[61]

After the win in the Evanston Northwestern–Highland Park merger, the FTC was off to the races. In twenty years of litigation after it filed the Evanston Northwestern case in 2004, the FTC has won or favorably settled all but two of its cases.[62] The chart below depicts this history in visual terms:[63]

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[59] *See generally* Joseph Farrell, Paul A. Pautler & Michael G. Vita, *Economics at the FTC: Retrospective Merger Analysis with a Focus on Hospitals* at 10, Fed. Trade Comm'n (2009), https://www.ftc.gov/sites/default/files/documents/reports/economics-ftc-retrospective-merger-analysis-focus-hospitals/farrelletal_rio2009.pdf; Deborah Haas-Wilson & Christopher Garmon, Hospital Mergers and Competitive Effects: Two Retrospective Analyses, 18 Int'l J. of the Econ. of Bus. 17 (Feb. 2011), https://www.smith.edu/sites/default/files/media/Faculty/Haas-Wilson_Hospital-Mergers-and-Competitive-Effects.pdf.

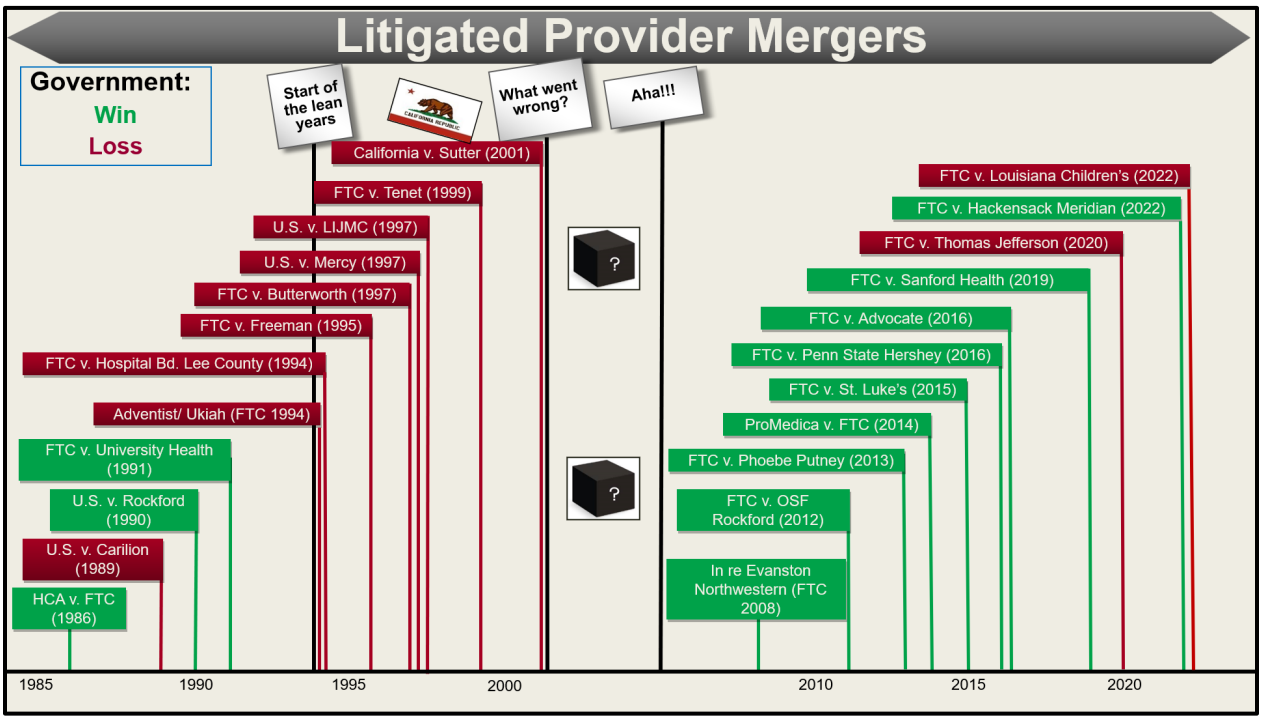
[60] *See* David A. Argue, *Looking for Anticompetitive Price Effects: FTC's Retrospective Studies of Hospital Mergers*, Am. Health Law. (May 2009), https://ei.com/wp-content/uploads/downloadables/argue_price_effects.pdf.

[61] The losing hospitals did not pursue an appeal to a court of appeals. Why not? Perhaps because the Commission refused to order divestiture of the acquired hospital, as requested by staff. Instead (as explained in Chapter VIII) the Commission ordered the merged hospitals to accommodate any health plan that wished to negotiate separately with Evanston and Highland Park. So the result of the litigation may have been a "win–win" of sorts: the FTC got a win on liability: the merger was unlawful. But the hospitals got a win on their business objective: the merger was completed and not undone. If the hospitals viewed the matter this way, an appeal to a federal court of appeals was superfluous—and risked imposition of a worse remedy.

[62] FTC v. Thomas Jefferson Univ., 505 F. Supp. 3d 522, 527 (E.D. Pa. 2020) was the sole loss.

[63] The chart shows only cases that produced a litigated result in court or before the FTC's administrative tribunal. The cases, shown in the order they appear on the chart, are: Hosp. Corp. of Am. v. FTC, 807 F.2d 1381 (7th Cir. 1986); United States v. Carilion Health Sys., 707 F. Supp. 840 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042 (4th Cir. 1989); United States v. Rockford Mem'l Corp., 898 F.2d 1278 (7th Cir. 1990); FTC v. Univ. Health, 938 F.2d 1206 (11th Cir. 1991); Adventist Health Sys./West, 117 F.T.C. 224 (1994); FTC v. Hosp. Bd. of Directors, Lee County, 38 F.3d 1184 (11th Cir. 1994); FTC v. Freeman Hosp., 69 F.3d 260 (8th Cir. 1995); FTC v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd per curiam*, 121 F.3d 708 (6th Cir. 1997); United States v. Mercy Health Servs., 902 F. Supp. 968 (N.D. Iowa 1995), *vacated on other grounds*, 107 F.3d 632 (8th Cir. 1997); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121 (E.D.N.Y. 1997); FTC v. Tenet Health Care, 186 F.3d 1045 (8th Cir. 1999); California v. Sutter Health Sys., 130 F. Supp. 2d 1109 (N.D. Cal. 2001); In the Matter of Evanston Northwestern Healthcare Corp., 40-47, 67-70, FTC Docket No. 9315 (2007) (Aug. 6, opinion on merger), (April 29, 2008) (opinion on remedy); FTC v. OSF Healthcare Sys., 852 F. Supp. 2d (N.D. Ill. 2012); FTC v. Phoebe Putney Health Sys., Inc., 568 U.S. 216 (2013); ProMedica Health Sys., Inc. v. FTC, 749 F.3d 559 (6th Cir. 2014); Saint Alphonsus Medical Center-Nampa, Inc. v. St. Luke's Health System, 778 F. 3d 775 (9th Cir. 2015) (the FTC was co-plaintiff in this case with Saint Alphonsus and other parties); FTC v. Penn State Hershey Medical Ctr., 838 F.33d 327 (3rd Cir. 2016); FTC v. Advocate Health Care Network, (7th Cir. 2016); FTC v. Sanford Health, 926 F.3d 959 (8th Cir. 2019); FTC v. Thomas Jefferson Univ., 505 F. Supp. 3d 522 (E.D. Pa. 2020); FTC v. Hackensack Meridian Health, Inc., 30 F.4th 160 (3rd Cir. 2022); Louisiana Children's Medical Center v. Attorney General of the United States, No. CV 23-1305, 2023 WL 6293887 (E.D. La. Sept. 27, 2023). Not shown here are cases that were settled before any action by a court or an FTC administrative judge and cases where the parties abandoned the merger after a complaint was filed but before any further litigation. Also not shown is an unusual case the FTC litigated in 2024 in North Carolina. The agency filed a Part 3 administrative complaint and a federal action seeking a preliminary injunction to block the proposed acquisition by Novant Health of two hospitals in central North Carolina from Community Health Systems until the FTC's administrative process was completed. A district court denied the FTC's motion for the injunction, finding the FTC was unlikely to succeed in proving the acquisitions were anticompetitive under Section 7 of the Clayton Act. Federal Trade Commission v. Novant Health, Inc. et al, No. 5:2024cv00028 - Document 227 (W.D.N.C. June 5, 2024). The FTC appealed to the Fourth Circuit and sought an injunction from that

Figure 4: Results of FTC Hospital Merger Litigations (1985–2022)



To understand what the FTC did to turn losses into victories, we start with one of the losses in the 1990s. The FTC sought a preliminary injunction to block the merger of two hospitals in Joplin, Missouri. The district court denied the motion and the FTC appealed to the Eighth Circuit. Although the Eighth Circuit showed the FTC more respect than had the district court (read on!), it came to the same conclusion: the injunction was denied.

FTC v. Freeman Hospital

69 F.3d 260 (8th Cir. 1995)

Judge Beam.

[. . .]

I. Background

[1] The city of Joplin, Missouri, a community of approximately 40,000 people, is located in the southwest corner of Missouri near the confluence of four states. Joplin is situated just five miles from the Kansas state line, forty miles from the northwest corner of Arkansas, and twelve miles from the northeast corner of Oklahoma. Joplin is also located within a few hours of several larger metropolitan centers, including Kansas City, Missouri, Springfield, Missouri, and Tulsa, Oklahoma.

[2] Joplin is currently home to three general acute care hospitals. The largest of these hospitals is St. John's Regional Medical Center, a nonprofit, allopathic hospital with 331 beds. The other two hospitals are significantly smaller. Freeman Hospital, also a nonprofit allopathic institution, houses 158 beds. Oak Hill Hospital is a 96-bed hospital and

court pending appeal. When that court (on a 2-1 vote) granted the requested injunction, the parties abandoned the deal. FTC v. Novant Health, Inc., No. 24-1526 (4th Cir. June 18, 2024). On an unopposed motion by the FTC, the court of appeals a week later vacated the district court decision and dismissed the appeal as moot.

the only hospital in Joplin with an osteopathic, rather than an allopathic, orientation. Surrounding Joplin are several smaller communities, many of which have their own acute care hospitals ranging from eighteen to 161 beds.

[3] In February 1994, Freeman Hospital and Oak Hill Hospital (the Hospitals) agreed to consolidate their assets and form a new nonprofit organization, Health SouthWest Alliance of Missouri, Inc. Oak Hill had been experiencing financial difficulties, and its trustees believed a merger with Freeman would strengthen Oak Hill's financial standing and enable it to better compete in a changing health care market. . . .

[4] . . . [After an investigation] the FTC filed a complaint alleging that the Hospitals' consolidation would lessen competition for acute care inpatient hospital services in the Joplin area. Pursuant to Section 13(b) of the Federal Trade Commission Act (FTC Act), 15 U.S.C. § 53(b), the FTC sought a temporary restraining order and a preliminary injunction to enjoin the Hospitals from merging pending an administrative determination of whether the merger would violate Section 7 of the Clayton Act.

[5] The following day, the parties appeared and presented arguments to the district court on the FTC's request for a temporary restraining order. After hearing the arguments, the district court orally denied the motion for a temporary restraining order, stating:

> I'm denying the TRO because based upon the pleadings filed here, I don't feel that the Federal Trade Commission has shown sufficient factual basis that they are entitled to a TRO. . . . I don't think you've got any business being in here. I don't see how the Federal Trade Commission can claim there is lack of competition when there [are] four or five hospitals in the area, and reducing it by one is not going to wipe out competition.
>
> . . .
>
> It looks to me like Washington D.C. once again thinks they know better what's going on in southwest Missouri. I think they ought to stay in D.C.

[6] . . . On February 28, 1995, without holding an additional evidentiary hearing, the district court issued a written order reiterating its oral denial of the temporary restraining order and denying, in addition, the FTC's application for a preliminary injunction.

[7] By order of March 1, 1995, in the midst of various procedural maneuvers, this court considered the FTC's notice of appeal of the district court's decision. We noted that the district court had not held an evidentiary hearing on the issue of the preliminary injunction, and declined to address the substantive issues raised by the parties without a fully developed record. Accordingly, we entered a stay order, retained jurisdiction of the appeal and remanded the matter to the district court for an evidentiary hearing.

[8] On March 23 and 24, 1995, the district court held an evidentiary hearing to determine whether to grant the FTC's requested preliminary injunction. Each side was permitted to present three witnesses and offer additional deposition testimony and exhibits. A voluminous record resulted, in which the parties attempted to establish the Hospitals' area of competition and to predict the competitive effects of the proposed merger.

[9] At this hearing, both sides relied heavily on expert testimony. Dr. Keith Leffler, an economist at the University of Washington, appeared for the FTC. Dr. Leffler testified that the Hospitals were part of a market for acute care inpatient hospital services which encompassed Joplin, Missouri, and areas located within a twenty-seven-mile radius of the city. To reach this conclusion, Dr. Leffler applied the Elzinga-Hogarty test, a method devised by professors of economics Kenneth G. Elzinga and Thomas F. Hogarty to analyze patterns of consumer origin and destination and to identify relevant competitors of the merging entities. *See United States v. Rockford Memorial Corp.*, 717 F. Supp. 1251, 1266 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990).

[10] The first prong of the Elzinga–Hogarty test requires a determination of the merging hospitals' "service area," the area from which they attract their patients. To determine the service area, Dr. Leffler examined the zip codes of patients discharged from the three hospitals in Joplin. After accounting for approximately eighty percent of the patient population at those hospitals, he arranged them in order of distance from Joplin and developed a preliminary map of the service area. Within that area were other hospitals, and Dr. Leffler performed the same analysis for those hospitals to complete a map of the collective service area of all the hospitals.

[11] The second step in the Elzinga-Hogarty test requires an analysis of where patients within the collective service area currently go to receive their health care. In undertaking this analysis, Dr. Leffler again used patient zip code information and determined that approximately ninety percent of hospital admissions of people residing in the proposed service area were admissions to hospitals within the service area.

[12] Relying on his test results and statements of various market participants regarding the nature of the health care market in southwest Missouri, Dr. Leffler delineated his geographic market spanning twenty-seven miles in every direction from Joplin, Missouri, and encompassing seven acute care facilities. To this market, Dr. Leffler applied the Herfindahl-Hirschmann Index (HHI), an economic index designed to provide a numerical measure of concentration in a given market. Dr. Leffler found that within his proposed market the HHI indicated a highly concentrated industry which presumptively raises antitrust concerns.

[13] The Hospitals' expert, Dr. William Lynk, presented a much different picture of the geographic market in which the Hospitals compete. Dr. Lynk also performed the first prong of the Elzinga–Hogarty test to determine the Hospitals' "service area," but his method differed from Dr. Leffler's approach in two important respects. First, Dr. Lynk used a ninety percent inclusion criterion to account for a greater percentage of patient business. Second, he arranged the zip codes contributing patients to the service area not by distance from Joplin but by economic importance to the hospitals, defined in terms of number of patients contributed.

[14] Dr. Lynk did not complete the second prong of the Elzinga–Hogarty analysis, as it was his opinion that an accurate picture of where patients in the service area seek health care could only be presented with admission data from all four states in the area. Unfortunately, complete admission data was available only from Missouri and not from Oklahoma, Arkansas, or Kansas. Dr. Lynk testified that the absence of complete data from these states rendered a reliable analysis of patient outflow impossible. To substitute for the second component of the Elzinga–Hogarty test, Dr. Lynk applied principles of geographic proximity, reasoning that if patients from communities surrounding Joplin would travel to Joplin for their health care, they could as easily drive that same distance to another town if Joplin's health care costs rose.

[15] Dr. Lynk's finalized market consisted of a thirteen-county area which included seventeen hospitals located up to fifty-four miles from Joplin. In this area, he determined that the market share owned by Health SouthWest Alliance would be no cause for antitrust concern.

[16] Both sides also presented the testimony of individuals familiar with Joplin's health care market and with the proposed merger. That testimony focused on current perceptions of the geographic market in which the merging hospitals compete and on the lingering interest of other health care companies in acquiring and maintaining Oak Hill Hospital as a competitor in the Joplin area. [. . .]

II. Discussion

A. FTC Authority Over Nonprofit Hospitals

{Eds.: The court rejected the merging hospitals' argument that the FTC lacked jurisdiction to challenge a merger of not-for-profit hospitals. Section 7 of the Clayton Act provides, "no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person ... where ... the effect of such acquisition may be substantially to lessen competition . . . ." The hospitals argued they were not subject to FTC jurisdiction (and therefore not subject to an FTC action enforcing the Clayton Act) because the FTC

Act excludes from the FTC's jurisdiction "nonprofit corporations." The court, acting consistently with earlier decisions in the Seventh and Eleventh Circuits, rejected the argument, holding the FTC's jurisdiction to enforce the Clayton Act is determined by Section 11 of that Act (not the FTC Act)—and Section 11 provides no exemption for not-for-profit entities.}

[. . .]

C. The Merits

[17] . . . Section 13(b) of the Federal Trade Commission Act, under which the FTC seeks relief, provides that a preliminary injunction may be granted "[u]pon a proper showing that, weighing the equities and considering the [18] Commission's likelihood of ultimate success, such action would be in the public interest." Thus, the district court was charged with making two separate inquiries, one examining the likelihood that the FTC would ultimately succeed on the merits of its antitrust action and one addressing the competing equities advanced by the parties. We address each issue in turn.

1. Likelihood of Success on the Merits

[18] . . . The FTC's task in proving a Section 7 case, and thus in showing likely success in a preliminary injunction proceeding, is twofold. The FTC must present evidence of (1) a relevant market within which (2) the effect of the acquisition in question may be to substantially lessen competition. . . .

a. The Relevant Market

[19] The determination of the relevant market is a "necessary predicate" to a finding of a Clayton Act violation. *United States v. E.I. du Pont de Nemours Co.*, 353 U.S. 586, 593 . . . (1957). Without a well-defined relevant market, an examination of a transaction's competitive effects is without context or meaning. [. . .]

[20] A relevant market consists of two separate components: a product market and a geographic market. *See Morgenstern v. Wilson*, 29 F.3d 1291, 1296 (8th Cir. 1994). The parties agree that the product market in this case consists of "acute care inpatient hospital services." The parties possess widely divergent views, however, of the geographic market within which the merging hospitals compete. As noted earlier, the FTC has proposed a geographic market which includes Joplin, Missouri, and areas spanning twenty-seven miles in all directions from Joplin. The Hospitals, on the other hand, have proposed a thirteen-county market including communities over fifty miles from Joplin.

[21] We need not fully resolve this conflict at this juncture, for . . . it is the FTC's burden to identify a geographic market within which a challenged transaction raises "serious, substantial, difficult and doubtful" questions of antitrust concern. *See, e.g., Morgenstern*, 29 F.3d at 1296. A geographic market is that geographic area "to which consumers can practically turn for alternative sources of the product and in which the antitrust defendants face competition." *Id.* In order to meet its burden, the FTC is required to present evidence addressing the critical question of where consumers of acute care inpatient hospital services could practicably turn for alternative sources of the product should the Hospitals' merger be consummated and Joplin hospital prices become anti-competitive. The FTC has failed to produce such evidence.

[22] Two recent cases show the importance of adequately discerning practicable alternatives for consumers of the relevant product. In *Morgenstern*, a cardiac surgeon brought suit under the Sherman Antitrust Act alleging that members of the Nebraska Heart Institute monopolized the market for cardiac surgery in Lincoln, Nebraska. Morgenstern proposed a geographic market including Lincoln and twenty-six counties located up to 200 miles from Lincoln but excluding Omaha, Nebraska. *Id.* That market was based largely on expert testimony detailing the residences of cardiac surgery patients in the Lincoln and Omaha heart surgery programs and demonstrating the counties that supplied patients to each program. *Id.* In rejecting Morgenstern's proposed market in favor of a market including Omaha, we noted that the record addressed only where Nebraska residents actually went, as opposed to where they could practicably go, for cardiac surgery services. *Id.* We held that Morgenstern's failure to present evidence on practicable alternatives for cardiac surgery patients was fatal to his case.

[{*Eds.: Discussion of the second case,* Bathke v. Casey's General Stores, Inc., 64 F.3d 340 (8th Cir. 1995)*, is omitted.*}

[23] [. . .] In this case, the district court held that, like the plaintiff in *Morgenstern* . . . the FTC failed to produce sufficient evidence on the crucial aspect of the geographic market: where consumers of acute care inpatient hospital services could practicably turn for alternative sources of that product. After reviewing the extensive record in this case, we cannot say the district court's holding on this issue constitutes an abuse of discretion. The evidence produced by the FTC to support its geographic market consisted primarily of Dr. Leffler's Elzinga–Hogarty analysis of zip code data illustrating current patient flow into and out of the three Joplin hospitals and hospitals located within a twenty-seven-mile radius of Joplin. This analysis gives a static, rather than a dynamic, picture of the acute care market in Joplin and the surrounding areas. Even if we did not credit the concerns Dr. Lynk raised about the completeness and correctness of Dr. Leffler's analysis, we would still be forced to conclude that the Elzinga–Hogarty analysis presented in this case did not, by itself, address the decisive question of where consumers could practicably go for alternative sources of acute care inpatient hospital services. Simply put, Dr. Leffler's theory provided no insight into the future effects of the allegedly anti-competitive merger of the Hospitals.

[24] The FTC argues, however, that the evidence it presented to establish the appropriate geographic market consisted of far more than Dr. Leffler's testimony. The FTC submitted the statements of various market participants to address the question of where consumers would likely go if the merger was consummated. The majority of these participants testified that even if Joplin health care prices increased after the merger due to collusion between the remaining Joplin hospitals, few patients currently traveling to Joplin for care would travel instead to hospitals located outside the FTC's proposed geographic market. The FTC asserts that the district court abused its discretion in discounting the importance of this evidence to defining the relevant market.

[25] We agree that testimony of market participants is relevant to a determination of a proper geographic market, and recognized the importance of exploring their perceptions in *Morgenstern*. . . . [T]he views of market participants [however] are not always sufficient to establish a relevant market, especially when their testimony fails to specifically address the practicable choices available to consumers. [. . .]

[26] . . . The testimony from market participants in this case . . . spoke mainly to current competitor perceptions and current consumer habits and not to the crucial question of where consumers could practicably go to seek alternative acute care inpatient hospital services should Freeman Hospital and Oak Hill Hospital merge.

[27] The testimony that most closely addressed the question of where patients could practicably turn for alternative sources of acute care inpatient hospital services was the testimony of health care administrators from hospitals located both at the margins of and outside of the FTC's proposed geographic market. Several of these administrators testified that patients in their area who travel to Joplin for health care go mainly because the Joplin hospitals provide services which are not otherwise available in their local hospitals. The FTC claims that this testimony establishes differences in the quality and range of services available in Joplin from those available at many of the hospitals in Dr. Lynk's proposed geographic market. These differences, the FTC argues, undercut Dr. Lynk's assertions that the hospitals in his thirteen-county market are competitors of the Joplin hospitals merely because of their geographic proximity to Joplin and the communities which supply patients to Joplin hospitals. Taking this analysis further, the FTC borrows a page from the Seventh Circuit's opinion in *Rockford Memorial*, arguing that it would be "ridiculous" to assume that Joplin residents, in particular, "will be searching out small, obscure hospitals in remote rural areas" if prices charged by the postmerger Joplin hospitals rise above competitive levels. *Rockford Memorial*, 898 F.2d at 1285.

[28] For two reasons, we find no clear error by the district court in refusing to fully credit this testimony and hold that it adequately established acute care consumers' practicable alternatives. First, we have searched the record and have been unable to find significant economic or statistical data which supports the assertions of the health care providers and the FTC regarding quality and range of services. . . .

[29] Second, placing too much emphasis on the allegedly superior range of services available at Joplin hospitals could ultimately lead to a blurring of the product market. If, as the FTC urges, patients from areas extending beyond the

FTC's market come to the three Joplin hospitals to receive specialized, sophisticated services, those services may begin to define a separate product market. Focusing on more specialized care may mean that hospitals in larger cities in the four-state area, such as Springfield, Missouri; Kansas City, Missouri; or Tulsa, Oklahoma, become viable competitive alternatives to hospitals in Joplin. ... Nevertheless, it is not necessary for us to decide at this time what percentage of patients the outlying hospitals must be capable of accommodating before they may be included within the geographic market. We hold only that it was not clearly erroneous for the district court to hold that the testimonial evidence of the market participants did not sufficiently demonstrate where consumers could practicably turn for alternative sources of acute care inpatient hospital services.

[30] In summary, the FTC's expert testimony addressed only the question of where patients currently go, rather than where they could practicably go, for acute care inpatient services. The bulk of the testimony from market participants suffered from a similar defect . . . We therefore hold that the district court did not abuse its discretion when it determined that the FTC had failed to meet its burden of establishing the relevant geographic market.

b. Anticompetitive Effects

[31] The FTC advances several arguments regarding the alleged anticompetitive effects of the Hospitals' merger on the market for acute care inpatient hospital services. . . . We have already stated, however, that identification of a relevant market is a "necessary predicate" to a successful challenge under the Clayton Act and thus to establishing a likelihood of ultimate success for preliminary injunction purposes. Because our resolution of this issue is dispositive, we need not reach the other issues presented on appeal.

2. Balance of the Equities

{*Eds.: The court held the balance of the equities did not favor the FTC, largely because the agency had failed to carry its burden to show a substantial threat to competition.*}

[32] The FTC further alleges that the district court's opinion may have been driven by its personal bias against the FTC and the work of administrative agencies in general. We are disturbed any time a district court expresses personal opinions regarding the parties or their motives during a formal judicial proceeding, and we agree that the district court was injudicious in its remarks about the FTC. Our affirmance of the district court's ultimate decision is in no way intended to express our approval of such a practice. Nevertheless, there is nothing in the district court's remarks which suggests "such a high degree of favoritism or antagonism as to make fair judgment impossible." *Liteky v. United States*, 510 U.S. 540, 555, (1994). While we do not condone the district court's comments, we have reviewed the record and the district court's opinion and find no clear error or abuse of discretion.

III. Conclusion

[33] The district court did not err in holding that the FTC had failed to carry its burden of showing a likelihood of success on the merits of its antitrust action or in holding that the balance of the equities favors denying a preliminary injunction. We therefore affirm the district court's order denying the FTC an injunction, dissolve our order of March 15, 1995, and deny as moot all other pending motions.

NOTES

1) The court gave short shrift to the testimony of market participants in *Freeman*. Yet the Horizontal Merger Guidelines in place at the time (like those that followed, including the 2023 Merger Guidelines in Section 4.1) stated that this kind of testimony can be useful in merger cases. Why did the court fail to credit this testimony? What testimony from market participants might the court have considered more probative? In this regard, refer to the *Oracle* decision in the mergers chapter.

2) In this case the FTC sued; the State of Missouri was not involved. After the merger retrospective review was over and the FTC resumed bringing cases against hospital mergers, the agency almost always lined up the state attorney general for the state within which it was litigating as a co-plaintiff. Can you see why?

3) The merging hospitals in Joplin were not-for-profit hospitals. The district court thought this relevant, arguing that a "private nonprofit hospital that is sponsored and directed by the local community is similar to a consumer cooperative." How so? "It is highly unlikely that a cooperative will arbitrarily raise prices merely to earn higher profits because the owners of such an organization are also its consumers." Ultimately the district court's decision didn't turn on this observation. But, as noted above, a year later another district court considered the nonprofit status of two merging hospitals of critical importance. In *Federal Trade Commission v. Butterworth Health Corp.*, 646 F. Supp. 1285 (W.D. Mich. 1996) a district court refused the FTC's motion to enjoin a merger of two not-for-profit hospitals in Grand Rapids, Michigan, relying in part on an article and testimony from an expert economist, Dr. William Lynk (the same economist who testified for the hospitals in Joplin). The court in Butterworth concluded that "nonprofit hospitals operate differently in highly-concentrated markets than do profit-maximizing firms." The hospitals' boards were made up "of community business leaders who have a direct stake in maintaining high quality, low cost hospital services" and so would resist raising prices after the merger just because they might be able to do so as a result of additional market power." Do you agree?

4) How should a court react if a hospital merger between two not-for-profit hospitals will lead to a substantial increase in market power, but the boards of the merging hospitals make a promise to freeze charges for three years and then promise to raise them at no more than the rate of hospital inflation for four more years? The merging hospitals in *Butterworth* made such a commitment and offered to enter into a consent decree making the commitment legally binding. The FTC objected to the commitment as unenforceable, illusory, and inadequate. But the court was impressed: after acknowledging it is difficult to "provide failsafe assurances to the community," the court wrote that "it bespeaks a serious commitment by defendants[,] a commitment to which they can be held accountable[,] to refrain from exercising market power in ways injurious to the consuming public."

5) The FTC loss in Joplin was not the last government loss before the FTC conducted its retrospective analysis of why the government was losing cases; that distinction was claimed by the State of California when it challenged the Sutter Health System's acquisition of a hospital in Oakland not far from another Sutter hospital in neighboring Berkeley.[64] Relying not just on the Joplin case but also on decisions in other hospital merger cases tried in the 1990s,[65] the Sutter court used the Elzinga–Hogarty test to define a very broad relevant geographic market. The district court in *Sutter* even poked fun at the State's notion that the geographic market should be narrowly confined to the East Bay area, repeating in its decision a comment hospital counsel made at trial that "[i]f you believe the plaintiff's market, you would believe that Conestoga wagons are still being used today, that no one ever goes over the hills because the hills are too high and you have to build a boat to take you across the Bay."[66]

   The *Sutter* case, however, represented the high water mark for the use of the Elzinga–Hogarty test to draw broad geographic markets. As part of the FTC's retrospective hospital merger review several years later, as noted already, lawyers and economists at the agency came to believe that the large geographic markets defined by courts of that era didn't reflect commercial realities. They concluded that the test—which led to these broad markets—was flawed and should be scrapped. In the Evanston Northwestern–Highland Park merger the Commission affirmed the ALJ's holding that the merger was unlawful and explained in detail the problem with applying the test to

[64] California v. Sutter Health System, 130 F. Supp. 2d 1109 (N.D. Cal. 2001).

[65] *See*, *e.g.*, FTC v. Tenet Healthcare Corp., 17 F. Supp. 2d 937 (E.D. Mo. 1998), *rev'd on other grounds*, 186 F.3d 1045 (8th Cir. 1999) (merger of two hospitals in Polar Bluff, Missouri); FTC v. Freeman Hosp., 911 F. Supp. 1213, *aff'd*, 69 F.3d 260, 264–65 (8th Cir. 1995); United States v. Mercy Health Servs., 902 F. Supp. 968, 978 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997) (merger of only two hospitals in Dubuque, Iowa).

[66] *Sutter*, 130 F. Supp. 2d at 1132.

hospital markets. And who was the star witness on whom the Commission relied to discredit the value of Elzinga–Hogarty in hospital cases? Dr. Elzinga himself.[67]

Opinion of the Commission, In the Matter of Evanston Northwestern Healthcare Corporation

FTC Docket No. 9315, 2007 WL 2286195 (F.T.C. Aug. 6, 2007)

Chairman Majoras.

{*Eds.: The bulk of this 91-page opinion is omitted.*}

[1] . . .[R]espondent argues that patient flow data undermine the ALJ's conclusion that the triangle formed by the three ENH hospitals [the two owned by Evanston Northwestern and Highland Park Hospital] is a relevant geographic market and that the ALJ erred by not considering such data. As the name suggests, patient flow data provide information about where patients travel to obtain hospital services. Respondent claims that in the context of "an 80% service area," Evanston had more patient overlap with Northwestern Memorial, Rush North Shore, Advocate Lutheran General, St. Francis, and Weiss than with Highland Park. In addition, respondent maintains that there was at least as great an overlap before the merger between Highland Park and Advocate Lutheran General or Lake Forest as between Evanston and Highland Park.

[2] A number of courts have considered patient flow data when they have defined the geographic market. In particular, they have applied the Elzinga–Hogarty ("E–H") test to patient flow information as a proxy test to determine whether a firm could exercise market power in a potential geographic market. *See California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1072 (N.D. Cal. 2002); *FTC v. Tenet Healthcare Corp.*, 17 F. Supp. 2d 937 (E.D. Mo. 1998), *rev'd on other grounds*, 186 F.3d 1045 (8th Cir. 1999); *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, *aff'd*, 69 F.3d 260, 264–65 (8th Cir. 1995); *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 978 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997).

[3] The E–H test was devised by professors Kenneth G. Elzinga and Thomas F. Hogarty to help to delineate geographic markets, specifically in the coal and beer industries. The objective of the E-H test is to "measure[] the accuracy of a [potential] market delineation by determining the amount of either imports into or exports from a tentative market." *United States v. Country Lake Foods, Inc.*, 754 F. Supp. 669, 672 n.2 (D. Minn. 1990). The test's underlying assumption is that if an area has significant exports outside of the area or imports into the area, then that area is not a relevant geographic market because it is unlikely that a dominant firm within the area could exercise market power.

[4] At trial, Professor Elzinga testified that the E-H test was not an appropriate method to define geographic markets in the hospital sector because of two related problems, which he termed the "silent majority fallacy" and the "payor problem." The silent majority fallacy is the false assumption that patients who travel to a distant hospital to obtain care significantly constrain the prices that the closer hospital charges to patients who will not travel to other hospitals. Elzinga testified that for the most part, patient decisions do not have such a constraining effect because their choices of hospitals largely are based not on price but on other factors, such as location and the preferences of their physician. He explained that

> [p]eople who travel outside their home turf for hospital services usually do so [because] . . . [t]here's some particular service or amenity that they associate with that distant hospital that's important to them, or they may have family who lives some distance away and they travel to that hospital. People who consume . . . hospital services close to home typically are there either because their doctor places them at that hospital or, for purposes of their own convenience or the

[67] Tom Campbell, Defending Hospital Mergers after the FTC's Unorthodox Challenge to the Evanston Northwestern-Highland Park Transaction, 16 Annals of Health L., 10 (Summer 2007), https://lawecommons.luc.edu/cgi/viewcontent.cgi?article=1147&context=annals.

> convenience of their family, it is very important for them to be hospitalized close to home. So, unlike products like coal and beer that will move about in response to the market signals . . . prices change and beer gets shipped to a different location – here, the prices of hospital services do not drive most people to change the location of where they consume hospital services.[68]

[5] Further reducing the effect of prices on patients' hospital choices is that patients rarely pay directly the full cost of hospital services. Insurance companies pay the large majority of hospital costs in most instances from revenues obtained through a broad base of employer and employee-paid premiums and deductibles. Consequently, when a hospital raises its prices, the increase often is spread out over a broad number of employers and members, many of whom will never use the hospital. Even if an MCO tries to steer patients toward less costly hospitals through "tiering" of co-payments, the price effect often is diluted because the co-payments often do not cover the difference between the total costs of the expensive hospital and those of other, less costly hospitals. Consequently, there is little reason to infer from some residents' choice of a more distant hospital that others would do likewise in response to a price increase from a closer hospital.

[6] Put more formally, the workings of the third-party payor system in the United States are such that rarely do patients fully internalize the benefits and costs of their decision to purchase a medical product or service. This lack of internalization is what Elzinga termed the "payor problem":

> [T]here's a wedge between the consumption of the service and the person who decides where the service will be consumed and then some other party actually paying for the service, and consequently, the usual market analysis of goods and services . . . in response to price incentives really doesn't fit. And so it follows in my view that looking at the flow of patients really doesn't help you define the contours of a relevant geographic market area[] because the patients who are moving are not necessarily moving in response to price incentives.

[7] Elzinga concluded that because "the ability of particular hospitals to raise prices is not disciplined or thwarted by the travel patterns" of patients, using patient flow data is uninformative about whether it would be profitable for merging hospitals to raise prices, and that the application of the E–H test to patient flow data would identify overly broad geographic markets.

[8] We find Elzinga's testimony to be persuasive. . . . Nonetheless, there is some merit to respondent's argument that the ALJ erred in holding that patient flow data are always irrelevant to determining the relevant geographic market. MCO demand for hospital services is partially a derived demand based on patient preferences, and the percentage of patients in a given area who use a hospital can, in certain circumstances, provide some rough indication of MCO preferences when they form a network. Ultimately, however, we believe that we should view patient flow with a high degree of caution because of the silent majority fallacy and payor problem and, at best, we should use it as one potentially very rough benchmark in the context of evaluating other types of evidence. A robust application of the hypothetical monopolist methodology is almost certain to produce a more reliable determination of the geographic market than is analysis of patient flow data.

[9] In this case, even assuming that respondent's description of the patient flow information is correct, it provides no sound basis to alter our conclusion that the merger resulted in ENH's ability to exercise market power or that the triangle formed by the ENH hospitals is a relevant geographic market. For the reasons that Professor Elzinga explained, that Evanston and Highland Park may have had a greater patient flow overlap with certain other hospitals

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[68] *See also* Cory Capps, *Cross-Market Mergers: Theories and Limiting Principles*, Competition Pol'y Int'l (May 31, 2023), https://www.pymnts.com/cpi-posts/cross-market-mergers-theories-of-harm-and-limiting-principles/, ("Given the propensity of some patients to travel substantial distances for care, [the Elzinga–Hogarty] standard has led to large market boundaries and, consequently, permissive merger rulings. Our results indicate that this may be a serious error. . . . Many patients, especially those with conditions that are relatively straightforward to treat, have a strong preference to go to a convenient, nearby hospital. These preferences give hospitals with no nearby competitors a strong bargaining position.").

than they did with each other is not inconsistent with the conclusion that the combination of Evanston and Highland Park enabled the merged entity to exercise market power. To the contrary, here the record reflects that the merger did just that, and, consequently, that the relevant geographic market is narrower than the patient flow data might suggest.

* * *

And with that, Elzinga-Hogarty's relevance in hospital merger cases ended. But what took its place?

FTC v. Penn State Hershey Medical Center

838 F.3d 327 (3d Cir. 2016)

Judge Fisher.

[1] At issue in this case is the proposed merger of the two largest hospitals in the Harrisburg, Pennsylvania area: Penn State Hershey Medical Center and PinnacleHealth System. The Federal Trade Commission ("FTC") opposes their merger and filed an administrative complaint alleging that it violates Section 7 of the Clayton Act because it is likely to substantially lessen competition. In order to maintain the status quo and prevent the parties from merging before the administrative adjudication could occur, the FTC, joined by the Commonwealth of Pennsylvania, filed suit in the Middle District of Pennsylvania under Section 13(b) of the Federal Trade Commission Act ("FTC Act") and Section 16 of the Clayton Act, which authorize the FTC and the Commonwealth, respectively, to seek a preliminary injunction pending the outcome of the FTC's adjudication on the merits. The District Court denied the FTC and the Commonwealth's motion for a preliminary injunction, holding that they did not properly define the relevant geographic market—a necessary prerequisite to determining whether a proposed combination is sufficiently likely to be anticompetitive as to warrant injunctive relief. For the reasons that follow, we will reverse. We will also remand the case and direct the District Court to enter the preliminary injunction requested by the FTC and the Commonwealth.

I. Background

A. Factual Background

[2] Penn State Hershey Medical Center ("Hershey") is a leading academic medical center and the primary teaching hospital of the Penn State College of Medicine. It is located in Hershey, and it offers 551 beds and employs more than 800 physicians, many of whom are highly specialized. Hershey offers all levels of care, but it specializes in more complex, specialized services that are unavailable at most other hospitals. Because of its advanced services, Hershey draws patients from a broad area both inside and outside Dauphin County.

[3] PinnacleHealth System ("Pinnacle") is a health system with three hospital campuses—two located in Harrisburg in Dauphin County, and the third located in Mechanicsburg in Cumberland County. It focuses on cost-effective primary and secondary services and offers only a limited range of more complex services. It employs fewer than 300 physicians and provides 646 beds.

[4] In June 2014, Hershey and Pinnacle (collectively, the "Hospitals") signed a letter of intent for the proposed merger. Their respective boards subsequently approved the merger in March 2015. The following month, the Hospitals notified the FTC of their proposed merger and, in May 2015, executed a "Strategic Affiliation Agreement."

B. Procedural History

[5] After receiving notification of the proposed merger, the FTC began investigating the combination. Following the investigation, on December 7, 2015, the FTC filed an administrative complaint alleging that the merger violates Section 7 of the Clayton Act. On December 9, 2015, the FTC and the Commonwealth of Pennsylvania (collectively, the "Government") filed suit in the Middle District of Pennsylvania. Invoking Section 13(b) of the FTC

Act, 15 U.S.C. § 53(b) , and Section 16 of the Clayton Act, 15 U.S.C. § 26 , the Government sought a preliminary injunction pending resolution of the FTC's administrative adjudication. In its complaint, the Government alleged that the Hospitals' merger would substantially lessen competition in the market for general acute care services sold to commercial insurers in the Harrisburg, Pennsylvania market. According to the Government, the combined Hospitals would control 76% of the market in Harrisburg.

[6] The District Court conducted expedited discovery and held five days of evidentiary hearings. During the hearings, the District Court heard testimony from sixteen witnesses and admitted thousands of pages of exhibits into evidence.

[7] Following the hearings, the District Court denied the Government's request for a preliminary injunction on the basis that the Government had failed to meet its burden to properly define the relevant geographic market. Without a properly defined relevant geographic market, the District Court held there was no way to determine whether the proposed merger was likely to be anticompetitive. Thus, the Government could not show a likelihood of success on the merits, and its failure to properly define the relevant geographic market was fatal to its motion. The District Court also analyzed what it called "equities," which it held supported denying the injunction request. The Government timely appealed. [. . .]

IV. Analysis

[8] The Government alleges that the proposed merger of Hershey and Pinnacle violates Section 7 of the Clayton Act. In order to prevent the parties from merging until the FTC can conduct an administrative adjudication on the merits to determine whether the merger violates Section 7, the Government seeks a preliminary injunction under Section 13(b) of the FTC Act.

[9] Section 13(b) of the FTC Act empowers the FTC to file suit in the federal district courts and seek a preliminary injunction to prevent a merger pending a FTC administrative adjudication "[w]henever the Commission has reason to believe that a corporation is violating, or is about to violate, Section 7 of the Clayton Act." *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 714 (D.C. Cir. 2001) (quoting FTC v. Staples, Inc., 970 F. Supp. 1066, 1070 (D.D.C. 1997)); see 15 U.S.C. § 53(b).

[10] A district court may issue a preliminary injunction "[u]pon a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest." 15 U.S.C. § 53(b). The public interest standard is not the same as the traditional equity standard for injunctive relief. Under Section 13(b), we first consider the FTC's likelihood of success on the merits and then weigh the equities to determine whether a preliminary injunction would be in the public interest. *FTC v. University Health, Inc.*, 938 F.2d 1206, 1217–18 (11th Cir. 1991).

A. Likelihood of Success on the Merits

[11] We first consider the FTC's likelihood of success on the merits. In its administrative adjudication, the FTC must show that the proposed merger violates Section 7 of the Clayton Act. Section 7 bars mergers whose effect "may be substantially to lessen competition, or to tend to create a monopoly." "Congress used the words 'may be substantially to lessen competition' . . . to indicate that its concern was with probabilities, not certainties," *Brown Shoe*, 370 U.S. at 323 , rendering Section 7 's definition of antitrust liability "relatively expansive." *California v. Am. Stores Co.*, 495 U.S. 271, 284 (1990). At this stage, "[t]he FTC is not required to establish that the proposed merger would in fact violate section 7 of the Clayton Act." *H.J. Heinz*, 246 F.3d at 714. Accordingly, "[a] certainty, even a high probability, need not be shown," and any "doubts are to be resolved against the transaction." *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 906 (7th Cir. 1989).

[12] We assess Section 7 claims under a burden-shifting framework. First, the Government must establish a prima facie case that the merger is anticompetitive. If the Government establishes a prima facie case, the burden then shifts to the Hospitals to rebut it. If the Hospitals successfully rebut the Government's prima facie case, "the burden of

production shifts back to the Government and merges with the ultimate burden of persuasion, which is incumbent on the Government at all times." *St. Alphonsus*, 778 F.3d at 783 . . . .

[13] To establish a prima facie case, the Government must (1) propose the proper relevant market and (2) show that the effect of the merger in that market is likely to be anticompetitive.

1. Relevant Market

[14] "Determination of the relevant product and geographic markets is 'a necessary predicate' to deciding whether a merger contravenes the Clayton Act." *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 618 (1974) (quoting *United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586, 593 (1957)). "Without a well-defined relevant market," an examination of the merger's competitive effects would be "without context or meaning." *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995). The relevant market is defined in terms of two components: the product market and the geographic market. *Id.*; *see Brown Shoe*, 370 U.S. at 324.

a. Relevant Product Market

[15] There is no dispute as to the relevant product market. The District Court found, and the parties stipulated, that the relevant product market is general acute care ("GAC") services sold to commercial payors. GAC services comprise a number of "medical and surgical services that require an overnight hospital stay." Though the parties agree as to the relevant product market, the Hospitals strongly dispute the relevant geographic market put forth by the Government.

b. Relevant Geographic Market

[16] The relevant geographic market "is that area in which a potential buyer may rationally look for the goods or services he seeks." *Gordon*, 423 F.3d at 212. Determined within the specific context of each case, a market's geographic scope must "correspond to the commercial realities of the industry" being considered and "be economically significant." *Brown Shoe*, 370 U.S. at 336–37 (footnote and internal quotation marks omitted). The plaintiff (here, the Government) bears the burden of establishing the relevant geographic market. *St. Alphonsus*, 778 F.3d at 784.

[17] A common method employed by courts and the FTC to determine the relevant geographic market is the hypothetical monopolist test. Under the Horizontal Merger Guidelines issued by the U.S. Department of Justice's Antitrust Division and the FTC, if a hypothetical monopolist could impose a small but significant non-transitory increase in price ("SSNIP") in the proposed market, the market is properly defined. Merger Guidelines, § 4, at 7–8. If, however, consumers would respond to a SSNIP by purchasing the product from outside the proposed market, thereby making the SSNIP unprofitable, the proposed market definition is too narrow. Important for our purposes, both the Government and the Hospitals agree that this test should govern the instant appeal.

[18] The Government argues, as it did before the District Court, that the relevant geographic market is the "Harrisburg area." More specifically, the four counties encompassing and immediately surrounding Harrisburg, Pennsylvania: Dauphin, Cumberland, Lebanon, and Perry counties.

[19] The District Court rejected the Government's proposed geographic market. It first observed that 43.5% of Hershey's patients—11,260 people—travel to Hershey from outside the four-county area, which "strongly indicate[d] that the FTC had created a geographic market that [was] too narrow because it does not appropriately account for where the Hospitals, particularly Hershey, draw their business." Second, it held that the nineteen hospitals within a sixty-five-minute drive of Harrisburg "would readily offer consumers an alternative" to accepting a SSNIP. . . . The failure to propose the proper relevant geographic market was fatal to the Government's motion, and the District Court denied the preliminary injunction request.

[20] We conclude that the District Court erred in both its formulation and its application of the proper legal test. Although the District Court correctly identified the hypothetical monopolist test, its decision reflects neither the proper

formulation nor the correct application of that test. We find . . . errors in the District Court's analysis. First, by relying almost exclusively on the number of patients that enter the proposed market, the District Court's analysis more closely aligns with a discredited economic theory, not the hypothetical monopolist test. Second, the District Court focused on the likely response of patients to a price increase, completely neglecting any mention of the likely response of insurers. [. . .]

i. Formulation of the Legal Test

[21] In formulating the legal standard for the relevant geographic market, the District Court relied primarily on the Eighth Circuit's decision in *Little Rock Cardiology*, 591 F.3d 591. According to the District Court, to determine the geographic market, a court must apply a two-part test. First, it must determine "the market area in which the seller operates, its trade area." Second, it "must then determine whether a plaintiff has alleged a geographic market in which only a small percentage of purchasers have alternative suppliers to whom they could practicably turn in the event that a defendant supplier's anticompetitive actions result in a price increase." Under the District Court's inquiry, the "end goal" of the relevant geographic market analysis is "to delineate a geographic area where, in the medical setting, few patients leave . . . and few patients enter."

[22] This formulation of the relevant geographic market test is inconsistent with the hypothetical monopolist test. Rather, it is one-half of a different test utilized in non-healthcare markets to define the relevant geographic market: the Elzinga–Hogarty test. The Elzinga–Hogarty test consists of two separate measurements: first, the number of customers who come from outside the proposed market to purchase goods and services from inside of it, and, second, the number of customers who reside inside the market but leave that market to purchase goods and services.

[23] The Elzinga–Hogarty test was once the preferred method to analyze the relevant geographic market and was employed by many courts. *See, e.g.*, *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1120–24 (N.D. Cal. 2001); *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1217–21 (W.D. Mo.), *aff'd*, 69 F.3d 260 (8th Cir. 1995); *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1266–78 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990). But subsequent empirical research demonstrated that utilizing patient flow data to determine the relevant geographic market resulted in overbroad markets with respect to hospitals. Professor Elzinga himself testified before the FTC that this method "was not an appropriate method to define geographic markets in the hospital sector." *In re Evanston Northwestern Healthcare Corp.*, 2007 FTC LEXIS 210, 2007 WL 2286195, at *64 (F.T.C. Aug. 6, 2007).

[24] The Hospitals dispute that the District Court's formulation of the relevant geographic market standard is the Elzinga–Hogarty test. The District Court's opinion does not specifically name or address Elzinga-Hogarty; neither does the Eighth Circuit's opinion in *Little Rock Cardiology*. But Little Rock Cardiology's statement that the market is one in which "'few' patients leave . . . and 'few' patients enter," 591 F.3d at 598 (alteration in original), is a direct quote from *Rockford Memorial*, 717 F. Supp. at 1267.

[25] In *Rockford Memorial*, the Northern District of Illinois, after observing that, "[i]deally, an area should be delineated where 'few' patients leave an area and 'few' patients enter an area to obtain hospital services," immediately outlined a step-by-step methodology put forward by the defendants' expert "to implement the Elzinga–Hogarty test." This methodology proceeded as follows: first, determine the merging hospitals' service area; second, determine the collective service area of all hospitals located within the merging hospitals' service area (this area satisfies the "little out from inside" test); finally, determine the area containing those hospitals that supply 90% of all the business that comes from patients residing in the collective service area (this area satisfies the "little in from outside" test).

[26] The standard articulated by the District Court in this case parallels the standard from *Rockford Memorial*, which the *Rockford Memorial* court acknowledged was based on Elzinga–Hogarty. And the District Court's analysis here proceeded in accordance with the way it articulated the standard. Consistent with this "few patients leave ... and few patients enter" test, the District Court relied primarily on the fact that 43.5% of Hershey's patients travel from outside of the Harrisburg area (the Government's proposed geographic market) in order to receive GAC services. This number is a measure of patient inflows—one of the two primary measurements relevant to the Elzinga–Hogarty analysis.

[27] As the amici curiae Economics Professors[3] have persuasively demonstrated, patient flow data—such as the 43.5% number emphasized by the District Court—is particularly unhelpful in hospital merger cases because of two problems: the "silent majority fallacy" and the "payor problem." "The silent majority fallacy is the false assumption that patients who travel to a distant hospital to obtain care significantly constrain the prices that the closer hospital charges to patients who will not travel to other hospitals." *Evanston Northwestern*, 2007 FTC LEXIS 210, 2007 WL 2286195, at *64 (citing testimony of Professor Elzinga). The constraining effect is non-existent because patient decisions are based mostly on non-price factors, such as location or quality of services. This fallacy is particularly salient here, where the District Court relied almost exclusively on the fact that Hershey attracts many patients from outside of the Harrisburg area. In deciding that patients who travel to Hershey would turn to other hospitals outside of Harrisburg if the merger gave rise to higher prices, the District Court did not consider that Hershey is a leading academic medical center that provides highly complex medical services. We are skeptical that patients who travel to Hershey for these complex services would turn to other hospitals in the area.

[28] Although the District Court did not employ strict cutoffs to determine whether too many patients enter or leave the proposed market, the silent majority fallacy renders the test employed by the District Court unreliable even in the absence of precise thresholds. In other words, the inadequacy of using patient flow data to determine the geographic market does not depend on whether the District Court used an exact percentage or whether it used a more flexible approach: relying solely on patient flow data is not consistent with the hypothetical monopolist test.

[29] Moreover, even assuming that relying strictly on patient flow data is consistent with the hypothetical monopolist test, the District Court did not consider the other half of the equation: patient outflows. The Government presented undisputed evidence that 91% of patients who live in Harrisburg receive GAC services in the Harrisburg area. Such a high number of patients who do not travel long distances for healthcare supports the Government's contention that GAC services are inherently local and that, in turn, payors would not be able to market a healthcare plan to Harrisburg-area residents that did not include Harrisburg-area hospitals. Although the District Court was not required to cite every piece of evidence it received, or even on which it relied, citing only patient inflows and ignoring patient outflows creates a misleading picture of the relevant geographic market.

ii. Likely Response of Payors

[30] The next problem with utilizing patient flow data—the payor problem—underscores the second error committed by the District Court. By utilizing patient flow data as its primary evidence that the relevant market was too narrow, the District Court failed to properly account for the likely response of insurers in the face of a SSNIP. In fact, it completely neglected any mention of the insurers in the healthcare market. This incorrect focus reflects a misunderstanding of the "commercial realities" of the healthcare market. *Brown Shoe*, 370 U.S. at 336.

[31] As the FTC and several courts have recognized, the healthcare market is represented by a two-stage model of competition. *See St. Alphonsus*, 778 F.3d at 784 n.10 (calling the two-stage model the "accepted model"). In the first stage, hospitals compete to be included in an insurance plan's hospital network. In the second stage, hospitals compete to attract individual members of an insurer's plan. Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 Antitrust L.J. 671, 672 (2000). Patients are largely insensitive to healthcare prices because they utilize insurance, which covers the majority of their healthcare costs. Because of this, our analysis must focus, at least in part, on the payors who will feel the impact of any price increase. *Id.* at 682, 692.

[32] The Hospitals argue that there is no fundamental difference between analyzing the likely response of consumers through the patient or the payor perspective. We disagree. Patients are relevant to the analysis, especially to the extent that their behavior affects the relative bargaining positions of insurers and hospitals as they negotiate rates. But patients,

[3] *Amici* are a group of 36 economics professors—including Professor Elzinga—who argue that the District Court engaged in faulty economic reasoning, particularly with regard to geographic market definition.

in large part, do not feel the impact of price increases.[6] Insurers do. And they are the ones who negotiate directly with the hospitals to determine both reimbursement rates and the hospitals that will be included in their networks.

[33] Imagine that a hospital raised the cost of a procedure from $1,000 to $2,000. The patient who utilizes health insurance will still have the same out-of-pocket costs before and after the price increase. It is the insurer who will bear the immediate impact of that price increase. Not until the insurer passes that cost on to the patient in the form of higher premiums will the patient feel the impact of that price increase. And even then, the cost will be spread among many insured patients; it will not be felt solely by the patient who receives the higher-priced procedure. This is the commercial reality of the healthcare market as it exists today.

[34] Thus, consistent with the mandate to determine the relevant geographic market taking into account the commercial realities of the specific industry involved, *Brown Shoe*, 370 U.S. at 336, when we apply the hypothetical monopolist test, we must also do so through the lens of the insurers: if enough insurers, in the face of a small but significant non-transitory price increase, would avoid the price increase by looking to hospitals outside the proposed geographic market, then the market is too narrow. This view has been confirmed by several courts. *E.g., St. Alphonsus*, 778 F.3d at 784 & n.10; *see also FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069 , 1083-85 (N.D. Ill. 2012) (concluding that managed care organizations will not be an effective constraint on the ability of the merged entity to use its market power to raise prices). It is also consistent with the FTC's view. In re *ProMedica Health Sys.*, 2012 FTC LEXIS 60, 2012 WL 1155392 , at *1-10, *23 n.28 (F.T.C. Mar. 28, 2012), *adopted as modified*, 2012 FTC LEXIS 293, 2012 WL 2450574 (F.T.C. June 25, 2012). It was error for the District Court to completely disregard the role that insurers play in the healthcare market.

[35] We do not mean to suggest that, in the healthcare context, considering the effect of a price increase on patients constitutes error standing alone. Patients, of course, are relevant. For instance, an antitrust defendant may be able to demonstrate that enough patients would buy a health plan marketed to them with no in-network hospital in the proposed geographic market. It would necessarily follow that those patients who purchased the health plan would have to turn to hospitals outside the relevant market (lest they pay significant out-of-pocket costs for an out-of-network hospital). In this scenario, patient response is clearly important, but it is not important with respect to patients' response to the price increase demanded by the post-merger Hospitals. The District Court here did not address this correlated behavior. And although it is possible that this scenario could play out in some healthcare market, to assume that it would in Harrisburg defies the payors' testimony. The payors repeatedly said that they could not successfully market a plan in the Harrisburg area without Hershey and Pinnacle. In fact, one payor that attempted to do just that (with Holy Spirit, a Harrisburg-area hospital, no less) lost half of its membership. That is to say nothing about whether payors would be able to successfully market a plan without any Harrisburg-area hospital, which is the less burdensome question the Government was tasked with answering under the hypothetical monopolist test. [. . .]

[36] These errors together render the District Court's analysis economically unsound and not reflective of the commercial reality of the healthcare market. In recent years, economists have concluded that the use of patient flow data does not accurately portray the relevant geographic market in the hospital merger context. Instead, economists have proposed, and the FTC has implemented, the hypothetical monopolist test. The realities of the healthcare market—in which payors negotiate prices for GAC services and will therefore feel the impact of any price increase—dictate that we consider the payors in our analysis. The District Court did not properly formulate the hypothetical monopolist test, nor did it properly apply that test. Because our antitrust analysis must be consistent with the evolution of economic understanding, *Kimble*, 135 S. Ct. at 2412-13 , and must be tied to the commercial realities of the specific

[6] The Hospitals put forth evidence that patients are becomingly increasingly sensitive to prices. We do not disagree. But despite the increasing sensitivity of patients to pricing—*e.g.*, through high-deductible plans, coinsurance, and tiered networks—the majority of patients do not feel the impact of the price of a specific procedure or at a specific hospital. The Hospitals' own study showed that only 2% of respondents considered out-of-pocket costs in choosing a hospital. Moreover, the Hospitals have not drawn our attention to any specific evidence about the use of health plans that would result in price sensitivity to patients.

industry at issue, *Brown Shoe*, 370 U.S. at 336 , we hold that the District Court committed legal error in failing to properly formulate and apply the hypothetical monopolist test.

[37] We emphasize, however, that our holding is narrow. We are not suggesting that the hypothetical monopolist test is the only test that the district courts may use in determining whether the Government has met its burden to properly define the relevant geographic market. In our case, the District Court, the Hospitals, and the Government all agreed that the hypothetical monopolist test was the proper standard to apply. The District Court identified the standard and purported to apply it. But in doing so, it incorrectly defined and misapplied that standard. This was error.

iv. The Government Has Properly Defined the Relevant Geographic Market

[38] Our conclusion that the District Court incorrectly formulated and misapplied the proper standard does not end the inquiry. We must still determine whether the Government has met its burden to properly define the relevant geographic market. We conclude that it has.

[39] The Government presented extensive evidence showing that insurers would have no choice but to accept a price increase from a combined Hershey/Pinnacle in lieu of excluding the Hospitals from their networks. First, two of Central Pennsylvania's largest insurers—Payor A and Payor B—testified that they could not successfully market a network to employers without including at least one of the Hospitals. Payor A's representative stated in his deposition that "[y]ou wouldn't have a whole lot of choice" if Hershey and Pinnacle raised their prices following a merger and there was no price agreement; that "there would be no network without" a combined Hershey and Pinnacle; and that the combined entity would have more bargaining leverage. He estimated that the insurer would lose half of its membership in Dauphin County if they tried to market a plan that excluded Pinnacle and Hershey.

[40] He further testified that the insurer previously used the possibility of creating a network that included only Holy Spirit and Hershey in the Harrisburg market in order to get Pinnacle to accept lower prices. According to him, insurers used the separate existence of Pinnacle and Hershey at the bargaining table: in order to resist a large price increase from Pinnacle, Payor A threatened to form a network with Holy Spirit and Hershey, excluding Pinnacle. After making this threat, Payor A and Pinnacle were able to come to an agreement that included only modest rate increases. The representative conceded that, without the ability to create a network with Hershey, this threat would not have been credible—Payor A could not have threatened to form a network with only Holy Spirit. This is strong evidence that the separate existence of Pinnacle and Hershey constrains prices.

[41] A representative from a second large insurer, Payor B, also expressed concerns that the Hospitals would control greater than 50% of the market and would have too much leverage. He testified that the insurer would need to market a combined Hershey/Pinnacle in its network in order to be marketable. Employers in the area similarly stated that they would have a difficult time marketing a health plan without the Hospitals after the merger.

[42] The results of one natural experiment also support the insurer's testimony. From 2000 until 2014, Payor E was able to market a viable network in Harrisburg that included only Holy Spirit and Pinnacle but did not include Hershey. In August 2014, Pinnacle terminated its agreement with Payor E. After losing Pinnacle from its network, Payor E negotiated substantial discounts with Holy Spirit and large hospitals in York and Lancaster counties and was able to offer plans at a substantial discount. Despite being priced much lower than its competitors, Payor E lost half its members, who switched to other health plans. Brokers informed the Payor E representative that it no longer had a viable network without Pinnacle, and even in the face of substantial discounts for Payor E's health plan, patients were willing to pay more to other insurers for health plans that included Hershey or Pinnacle.

[43] Finally, payors testified that they consider the Harrisburg area a distinct market and do not consider hospitals in other areas, such as York or Lancaster counties, to be suitable alternatives.

[44] The Hospitals argue that the payors have enough bargaining leverage that they would be able to defeat a SSNIP. In the Hospitals' view, the payors, which supply patients to the Hospitals, can threaten to exclude the Hospitals from

their network; this would in turn cause the Hospitals to lose significant numbers of patients. Such a loss would render the SSNIP unprofitable and therefore does not satisfy the hypothetical monopolist test. No one disputes that the parties both have bargaining leverage when negotiating reimbursement rates. The question here, however, is whether the merger will cause such a significant increase in the Hospitals' bargaining leverage that they will be able to profitably impose a SSNIP and, in the face of demand for the SSNIP, whether the payors will be forced to accept it. In other words, whatever leverage the payors will have after the merger, they have that leverage now. The Government's evidence shows that the increase in the Hospitals' bargaining leverage as a result of the merger will allow the post-merger combined Hershey/Pinnacle to profitably impose a SSNIP on payors.

[45] All of the aforementioned evidence answered an even narrower question than the one presented: the Government was not required to show that payors would accept a price increase rather than excluding the merged Hershey/Pinnacle entity from their networks; it was required to show only that payors would accept a price increase rather than excluding all of the hospitals in the Harrisburg area. That is the inquiry under the hypothetical monopolist test. Considering the evidence put forth by the Government, we conclude that the Government has met its burden to properly define the relevant geographic market. It is the four-county Harrisburg area.

2. Prima Facie Case

[46] "Once the relevant geographic market is determined, a prima facie case is established if the plaintiff proves that the merger will probably lead to anticompetitive effects in that market." *St. Alphonsus*, 778 F.3d at 785. Market concentration is a useful indicator of the likely competitive, or anticompetitive, effects of a merger. Merger Guidelines, § 5.3, at 18; *see also H.J. Heinz*, 246 F.3d at 715–16 ("Increases in concentration above certain levels are thought to raise a likelihood of interdependent anticompetitive conduct." (internal quotation marks and alterations omitted)).

[47] Market concentration is measured by the Herfindahl–Hirschman Index ("HHI"). The HHI is calculated by summing the squares of the individual firms' market shares. In determining whether the HHI demonstrates a high market concentration, we consider both the post-merger HHI number and the increase in the HHI resulting from the merger. Merger Guidelines, § 5.3, at 18–19. A post-merger market with a HHI above 2,500 is classified as "highly concentrated," and a merger that increases the HHI by more than 200 points is "presumed to be likely to enhance market power." *Id.* § 5.3, at 19. The Government can establish a prima facie case simply by showing a high market concentration based on HHI numbers. See *St. Alphonsus*, 778 F.3d at 788 ("The extremely high HHI on its own establishes the prima facie case."); *H.J. Heinz*, 246 F.3d at 716 ("Sufficiently large HHI figures establish the FTC's prima facie case that a merger is anti-competitive.").

[48] The Government put forth undisputed evidence that the post-merger HHI is 5,984—more than twice that of a highly concentrated market. The increase in HHI is 2,582—well beyond the 200-point increase that is presumed likely to enhance market power. These numbers, the accuracy of which the Hospitals conceded at oral argument, are significantly higher than post-merger HHIs and HHI increases that other courts have deemed presumptively anticompetitive. *See ProMedica Health Sys., Inc.* v. FTC, 749 F.3d 559, 568 (6th Cir. 2014) (post-merger HHI of 4,391 and HHI increase of 1,078 was presumptively anticompetitive); H.J. *Heinz*, 246 F.3d at 716 (post-merger HHI of 4,775 and HHI increase of 510 was presumptively anticompetitive). Furthermore, the Government has alleged that the post-merger combined Hershey/Pinnacle will control 76% of the market in Harrisburg. Together, these numbers demonstrate that the merger is presumptively anticompetitive. [. . .]

V. Conclusion

[49] We therefore conclude that, after determining the Government's likelihood of success and weighing the equities, a preliminary injunction would be in the public interest. Accordingly, we will reverse the District Court's denial of the Government's motion for a preliminary injunction. We will also remand the case and direct the District Court to preliminarily enjoin the proposed merger between Hershey and Pinnacle pending the outcome of the FTC's administrative adjudication.

* * *

As Judge Fisher noted at paragraph 31 of the opinion excerpted above, antitrust enforcers and courts now recognize what is called a "two-stage model of competition" when considering how hospitals and other providers generally compete for commercially-insured patients.

In the first stage, providers compete to be included in the health plan's network. While providers may need to meet certain minimum levels of quality to be included in the network, this competition is mostly based on price—*i.e.*, health plans will try to exclude from their networks those providers whose rates they consider are too high. In this stage, the focus is squarely on what alternatives a health plan can turn to if it excludes a particular provider. The antitrust implications are straightforward—if there are few alternatives, the provider can exercise market power and raise prices; similarly, a merger that eliminates a significant alternative will likely raise price.

The second stage involves competition among providers who are in-network to be selected by the patient (or his physician). Here, the competition is much more based on quality (or perceived quality as determined by the patient/physician).

The above is a bit of an over-simplification. In competing to be in-network, a provider's perceived quality will affect how much the health plan is willing to pay, so there is some element of quality competition in the first-stage. And in the second-stage, health plans can use steering and tiering (see discussion below) to give members a financial incentive to use in-network providers who have lower rates. But the "two-stage competition model is a useful paradigm in helping to identity how competition plays out in many health care markets, and in particular, what kind of competitive effects might be in play and where to find such evidence.

A recent FTC hospital merger loss: the Jefferson/Einstein Merger

While the FTC in recent years has generally prevailed in its hospital merger litigation, its winning streak ended in 2020, when its challenge a proposed merger of two non-profit health systems in the Philadelphia area failed.[69] The systems were Thomas Jefferson University, with 14 hospitals and 2,885 licensed beds, and Albert Einstein Healthcare Network, with two general acute care hospitals and 741 beds.

The FTC litigation strategy sought to build on a game plan that had an unblemished record of success in this century. In some ways, the Philadelphia market resembles that of Chicago, where the FTC had prevailed in its 2016 challenge to a merger between the Advocate Heath and NorthShore systems.[70] Both mergers involved transactions in large metropolitan areas in which there were many hospitals, including hospitals close by the merging systems. But the FTC expert in the Advocate case was able to point to econometric evidence, in particular diversion ratios (see discussion in Chapter VIII) which supported a very narrow geographic market that satisfied the Hypothetical Monopolist Test and which caused the merger to be presumptively illegal under the 2010 Merger Guidelines. In addition, the FTC had recently prevailed in the *Penn State/Hershey* case (discussed above) in the Third Circuit (where any appeal of the Jefferson/Einstein would be lodged) that gave short shrift to the use of patient flow data to show expansive geographic markets and also was very skeptical of efficiencies as a defense to an otherwise anticompetitive transaction. The FTC was joined in that challenge by the Pennsylvania Attorney General, thereby demonstrating local concerns over the proposed merger.

The FTC expert in *Jefferson/Einstein* found very narrow geographic markets using econometric evidence similar to that used in the Advocate challenge and the FTC presented testimony from several payers, including the dominant health plan, Independence Blue Cross (IBC) that the merger would result in higher prices. But this testimony proved

[69] FTC v. Thomas Jefferson Univ., 505 F. Supp. 3d 522 (E.D. Pa. 2020).

[70] *See* FTC v. Advocate Health Care Network, (7th Cir. 2016) in which the Court of Appeals reversed the district court's initial ruling denying the FTC's motion for a preliminary injunction, finding that the lower court had failed to sufficiently focus on the area of effective competition in the alleged geographic market and had not fully assessed what choices were meaningful alternatives to the merging parties for insurers seeking to develop a viable hospital network. On remand, the District Court ruled in favor of the FTC.

unpersuasive to District Court Judge Gerald Pappert, a former Pennsylvania Attorney General and current Philadelphia resident, who expressed surprise that the government failed to include PennMedicine in its narrowly constructed geographic markets, despite PennMedicine's obvious presence throughout the Philadelphia area and testimony that established it as Jefferson Health's closest competitor. In addition, Einstein was struggling financially, with a declining commercially-insured patient population—its main campus in northern Philadelphia was a "safety-net" hospital where more than 87% of its patients were government-insured. To Judge Pappert, the FTC's alleged market relied too much on patient preferences, as opposed to those of insurers, and failed to conform to the "commercial realities" of the market. While acknowledging the value of economic evidence, he observed that "geographic market determination is not merely a 'statistical exercise' looking for a hypothetical monopolist that can impose a SSNIP." He refused to rely on adverse testimony from insurers finding their testimony mixed or not well-supported, noting that IBC, in particular, had motives other than antitrust concerns in opposing a transaction that would enable Jefferson to control a health plan that would be a more potent competitor to IBC's health plan business.

Judge Pappert's opinion relied heavily on his assessment of the witnesses who testified at trial and hued closely to the Third Circuit's guidance in *PennState/Hershey*. These factors may have convinced the FTC and the Pennsylvania Attorney General not to appeal the decision.

The case is instructive for several reasons. It illustrates that while econometric evidence can be very important, it may not carry the day if it is inconsistent with other facts on the ground—the so-called "commercial realities" that can be adduced from the testimony of market participants. Such testimony will be subject to intense examination. Recent cases have emphasized the paramount importance of considering how a proposed transaction will affect the ability of health plans to control costs when constructing their provider networks. Accordingly, health plan testimony will be center stage. But as this case illustrates, a court will inquire into not only the evidence supporting a health plan's views, but also into whether the plan may have non-antitrust concerns in opposing a transaction. As vertical integration grows among both health systems and health plans, many plans will no longer simply be purchasers of hospital services, but also their potential or actual competitors, thus making it that much more difficult to unravel the underlying basis for their testimony. Finally, at trial Einstein presented itself as a financially struggling institution that primarily served government or under-insured patients. Jefferson was the only system that was willing and able to combine with Einstein so as to ensure its long-term future. And finally, the government's case largely ignored PennMedicine, which had a strong presence throughout the Philadelphia area, even though it did not have a facility in the narrowly-drawn FTC geographic market. These "commercial realities" are ignored at the government's peril, especially before a judge who lives in the community and knows it well.

Pushing the Envelope: Enforcement involving cross-market and private equity transactions

Recently concerns have been raised about certain kinds of health care transactions that traditionally have not been challenged because they involve neither horizontal mergers involving close competitors nor vertical mergers involving firms that operate in different stages of the supply chain. These concerns have been prompted by health plans who have complained that the transactions have resulted in higher prices or lower quality, as well as some evidence from academics supporting such claims. The challenge here, assuming that these adverse effects are real and can be linked to the transactions, is identifying the mechanism causing such effects and establishing that it can be traced to a reduction in competition that can be framed as an antitrust law violation.

Cross-market mergers. For many years health plans have complained that in some cases health systems have been able to negotiate higher prices after they acquire providers even where the acquisitions are in geographic markets that do not substantially overlap with their existing facilities. Such "cross-market" transactions raise both conceptual

and legal issues.[71] If the acquirer and target are in different geographic markets, the transaction would not result in an increase in market concentration or the elimination of a close competitor that would be the basis for a traditional horizontal merger challenge; nor would they typically involve the sort of relationships that could underlie concerns about vertical mergers. Nevertheless, some economic studies seemed to support that certain cross-market mergers did, indeed, result in higher prices to health plans.[72] Note that for "higher prices" to be an adverse effect, one would first want to account for any quality improvements that might explain such increases, *i.e.*, the concern here as in mergers generally is with increases in "quality-adjusted prices."

Various mechanisms have been proposed that could explain the adverse effects. One explanation is that the transaction brings a "change-in-control" whereby the target is now controlled by an acquirer that either is a more effective or more aggressive negotiator with health plans.[73] Arguably, however, this mechanism does not involve a reduction in competition that would violate the antitrust laws; nor does it require that the target or the acquirer be in close proximity to each other, or that either have market power. A second explanation is traditional tying, *i.e.*, that the acquirer has market power which it has not fully exploited, and that it can exploit that market power by raising the target's prices.[74] While this is a traditional antitrust theory, tying cases are not easy to prove, and challenging a merger on the theory that it could potentially result in anticompetitive tying might be viewed as particularly speculative. A third mechanism involves the presence of "common customers," which could occur where employers or health plans wish to have both the merging hospitals in their networks, even though the hospitals are in different geographic markets. In such cases, some economists have posited that the merged entity would have greater leverage when negotiating rates with health plans since they could threaten to create more "holes" in the provider network than would occur pre-merger. It has been suggested that several conditions must be satisfied for this mechanism to work, including that there be a sufficient volume of common customers, that the merging hospitals be not too far from each other (*e.g.*, less than 90 minutes apart) or perhaps in the same state, and that at least one or perhaps both hospitals have some degree of market power.

The FTC has not brought a hospital challenge solely on the basis of a cross-market theory, although in recent years it has raised such concerns in the course of several hospital merger investigations. The California Attorney General relied on such a theory in imposing conditions on several transactions involving hospitals that have little patient overlap.[75]

Private Equity Transactions. A second type of health care transaction that has been garnering increasing attention involves acquisitions by private equity firms. Some studies have suggested that such transactions result in higher prices and lower quality.[76] Opponents claim that private equity owners may have the incentive to more aggressively seek short-term profits, causing them to take on debt, raise prices, and reduce staffing ratios and needed supplies and equipment. In March 2024, the FTC held a workshop on private equity in health care, at the outset of which FTC Chairman Lina Khan described a range of concerns involving private equity acquisitions of health care

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[71] *See* Jaime S. King, Alexandra Montague, Daniel Arnold, & Thomas L. Greaney, Antitrust's Healthcare Conundrum: Cross-Market Mergers and the Rise of System Power, 74 Hastings L. J. 1057 (2023),,; Cory Capps, *Cross-Market Mergers: Theories and Limiting Principles*, Competition Pol'y Int'l (May 31, 2023), https://www.pymnts.com/cpi-posts/cross-market-mergers-theories-of-harm-and-limiting-principles/; Matthew B. Perry & Michael J. Adler, *Antitrust Enforcement Policy for Crossmarket Health Care Mergers Legal Theories, Limiting Principles and Practical Considerations*, 83 Antitrust L. J. 483 (2020).

[72] *See* articles cited in preceding footnote.

[73] A similar argument was made by the defendants (and rejected by the Commission as a factual matter) in the Evanston Northwestern-Highland Park merger. *See* In the Matter of Evanston Northwestern Healthcare Corporation, 40-47, 67-70, FTC Docket No. 9315 (Aug. 6, 2007) (discussion of "learning-about-demand" theory advanced by the merging parties).

[74] Thomas L. Greaney & Douglas Ross, *Navigating Through the Fog of Vertical Merger Law: A Guide to Counselling Hospital-Physical Consolidation under the Clayton Act* 91 Wash. L. Rev 199, 227–238 (2016) (explaining theory and questioning whether it should be an antitrust concern).

[75] *See* discussion in King et al at 1067-68.

[76] *See, e.g.*, Anaeze C. Offodile II, Marcelo Cerullo, Mohini Bindal, Jose Alejandro Rauh-Hain, & Vivian Ho, *Private Equity Investments In Health Care: An Overview Of Hospital And Health System Leveraged Buyouts, 2003–17,* 40 Health Affairs 719 (May 2021); Sneha Kannan, Joseph Dov Bruch, & Zurui Song, *Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition*, 330 JAMA 2365 (2023), https://jamanetwork.com/journals/jama/fullarticle/2813379?guestAccessKey=e0cef9be-d55c-4bcf-8892-412af8f24355&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfl&utm_term=122623; Joseph D. Bruch et al., *Evaluating Trends in Private Equity Ownership and Impacts on Health Outcomes, Costs, and Quality: Systematic Review*, 382 BMJ e075244 (2023), https://doi.org/10.1136/bmj-2023-075244.

providers.[77] At the hearing, the FTC, along with DOJ and HHS, issued a Request for Information seeking information about such transactions.[78]

Some private equity transactions may involve roll-ups whereby the PE firm acquires a series of health care providers in the same geographic market, so that in the aggregate the transaction results in an increase in market power. Such acquisitions are subject to Clayton Act Section 7 under traditional antitrust principles, as reflected in Section 2.8 of the revised *Horizontal Merger Guidelines*. In other cases, however, where the change in conduct is due entirely to the fact that the PE firm is embarking on a different business strategy and there is no change in market structure, it will be more difficult to establish that there is reduction in competition that is actionable under the antitrust laws.

In fall 2023, the FTC brought a challenge that implicates both cross-market and private equity transactions. The case involves the acquisition by U.S. Anesthesia Partners of a number of anesthesiology practices in Texas.[79] Also named were various entities affiliated with Welsh Carson, Anderson and Stowe, a PE firm that founded USAP and had various ownership stakes in USAP over the year. The FTC alleges relevant geographic markets in Houston, Dallas, and Austin, and to the extent the case is confined to those areas, it reflects a traditional antitrust challenge. But the complaint also refers to price increases in other parts of Texas, as well as USAP's market share and dominance throughout the state. In so doing, it could implicate cross-market theories of harm. In addition, the complaint highlights Welsh Carson's strategy in forming USAP and "rolling up" a series of acquisitions. In so doing, it has been viewed as an initial FTC salvo against PE firms, and as a harbinger of increased agency scrutiny and potential actions against such firms.[80]

2. Efficiencies in Hospital Mergers

Chapter VIII, Section D.1. described the approach antitrust enforcers and courts have generally applied in considering whether the potential efficiencies arising from a proposed merger might outweigh the merger's likely anticompetitive efforts. The Supreme Court has not weighed in on this issue for decades, and recent lower court decisions—to the extent they acknowledge that efficiencies are relevant—are generally skeptical of such claims, applying the high bar of the 2010 *Horizontal Merger Guidelines* (which is retained in the 2023 Guidelines) that, at a minimum, efficiencies must be merger-specific, verifiable, and cognizable to be credited. The 3d Circuit's treatment of efficiency claims in *FTC v. Penn State Hershey Medical Center,* which we first encountered in the preceding section, is typical.

FTC v. Penn State Hershey Medical Center

838 F.3d 327 (3d Cir. 2016)

Judge Fisher.

[. . .]

[1] Once the Government has established a prima facie case that the merger may substantially lessen competition, the burden shifts to the Hospitals to rebut the Government's prima facie case. In order to rebut the prima facie case, the

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[77] *Remarks by Chair Lina M. Khan As Prepared for Delivery Private Capital, Public Impact Workshop on Private Equity in Healthcare*, March 5, 2024, https://www.ftc.gov/system/files/ftc_gov/pdf/2024.03.05-chair-khan-remarks-at-the-private-capital-public-impact-workshop-on-private-equity-in-healthcare.pdf.

[78] *See Request for Information on Consolidation in Health Care Markets*, Docket No. ATR 102, Dep't of Just., Dep't Health & Hum Serv., F.T.C. (Feb. 29, 2024), https://www.ftc.gov/system/files/ftc_gov/pdf/FTC-2024-0022-0001-Request-for-Information-on-Consolidation-in-health-care-markets.pdf.

[79] FTC v US Anesthesia Practices, Welsh Carson et al., (W.D Texas 2023), Complaint, https://www.ftc.gov/system/files/ftc_gov/pdf/2010031usapcomplaintpublic.pdf.

[80] *See, e.g.*, Peter Guryan, Preston Miller & Karen Kazmerzak**,** *FTC's Health Co. Suit Indicates Agency's Private Equity Focus*, Law360 (Oct 6, 2023), https://www.law360.com/articles/1729114/ftc-s-health-co-suit-indicates-agency-s-private-equity-focus. In May 2024, a district court granted Welsh Carson's motion to dismiss, holding that allegations the private equity firm, which owned only a minority interest in USAP, profited from USAP's wrongful acts were insufficient to state a claim that the firm was violating antitrust law. Federal Trade Commission v. U.S. Anesthesia Partners, Inc. et al., No. 4:23-CV-03560 (S.D. Tex. May 13, 2024), https://law.justia.com/cases/federal/district-courts/texas/txsdce/4:2023cv03560/1935515/146/.

Hospitals must show either that the combination would not have anticompetitive effects or that the anticompetitive effects of the merger will be offset by extraordinary efficiencies resulting from the merger. *See H.J. Heinz*, 246 F.3d at 718–25. The Hospitals present two efficiencies-based defenses. First, they put forth considerable evidence in an attempt to show that the merger will produce procompetitive effects, including relieving Hershey's capacity constraints and allowing Hershey to avoid construction of an expensive bed tower that would save $277 million—savings which could be passed on to patients. Second, the Hospitals claim that the merger will enhance their efforts to engage in risk-based contracting. And finally, in addition to their efficiencies defense, the Hospitals argue that, because of repositioning by other hospitals in the area, the merger will not have anticompetitive effects.

[2] We note at the outset that we have never formally adopted the efficiencies defense. Neither has the Supreme Court. Contrary to endorsing such a defense, the Supreme Court has instead, on three occasions, cast doubt on its availability. First, in *Brown Shoe*, the Supreme Court, though acknowledging that mergers may sometimes produce benefits that flow to consumers, reasoned that "Congress appreciated that occasional higher costs and prices might result from the maintenance of fragmented industries and markets. It resolved these competing considerations in favor of decentralization." 370 U.S. at 344, 82 S.Ct. 1502. Next, in *Philadelphia National Bank*, the Supreme Court made clear that a merger the effect of which "may be substantially to lessen competition" is not saved because, on some ultimate reckoning of social or economic debits and credits, it may be deemed beneficial. . . . Congress determined to preserve our traditionally competitive economy. It therefore proscribed anticompetitive mergers, the benign and the malignant alike, fully aware, we must assume, that some price might have to be paid. Finally, in *FTC v. Procter & Gamble Co*., 386 U.S. 568, 87 S.Ct. 1224, 18 L.Ed.2d 303 (1967), the Supreme Court cautioned that "[p]ossible economies cannot be used as a defense to illegality." *Id*. at 580, 87 S.Ct. 1224.

[3] Based on this language and on the Clayton Act's silence on the issue, we are skeptical that such an efficiencies defense even exists. Nevertheless, other courts of appeals have held that the efficiencies defense is cognizable. *E.g*., *Univ. Health*, 938 F.2d at 1222 ("We think . . . that an efficiency defense to the government's prima facie case in section 7 challenges is appropriate in certain circumstances."). And still others have analyzed the efficiencies to determine whether they might overcome the presumption of illegality. *See St. Alphonsus*, 778 F.3d at 788–92 (expressing skepticism that the defense exists but nevertheless addressing it); *H.J. Heinz*, 246 F.3d at 720 (acknowledging that the Supreme Court has never "sanctioned the use of the efficiencies defense," but noting that "the trend among lower courts is to recognize the defense"); *see also ProMedica Health*, 749 F.3d 559, 571 (6th Cir. 2014) (recognizing that merging parties often put forth the efficiencies defense). The FTC's Merger Guidelines also recognize the defense. *See* Merger Guidelines, § 10, at 30 ("The Agencies will not challenge a merger if cognizable efficiencies are of a character and magnitude such that the merger is not likely to be anticompetitive in any relevant market."). Because we conclude that the Hospitals cannot clearly show that their claimed efficiencies will offset any anticompetitive effects of the merger, we need not decide whether to adopt or reject the efficiencies defense. However, because the District Court concluded otherwise, we address the requirements of the efficiencies defense and each of the Hospitals' claimed benefits in turn.

[4] Those courts of appeals to recognize the defense have articulated several requirements, which are also found in the Merger Guidelines. In order to be cognizable, the efficiencies must, first, offset the anticompetitive concerns in highly concentrated markets. *See St. Alphonsus*, 778 F.3d at 790. Second, the efficiencies must be "merger specific," *id.*—meaning, "they must be efficiencies that cannot be achieved by either company alone." *H.J. Heinz*, 246 F.3d at 722. Otherwise, "the merger's . . . benefits [could] be achieved without the concomitant loss of a competitor." Id. Third, the efficiencies "must be verifiable, not speculative," St. Alphonsus, 778 F.3d at 791; they "must be shown in what economists label 'real' terms." *Univ. Health,* 938 F.2d at 1223 (quoting Procter & Gamble, 386 U.S. at 604, 87 S.Ct. 1224 (Harlan, J., concurring)). Finally, the efficiencies must not arise from anticompetitive reductions in output or service. Merger Guidelines, § 10, at 30.

[5] Remaining cognizant that the "language of the Clayton Act must be the linchpin of any efficiencies defense," and that the Clayton Act speaks in terms of "competition," we must emphasize that "a successful efficiencies defense requires proof that a merger is not, despite the existence of a prima facie case, anticompetitive." *St. Alphonsus*, 778 F.3d

at 790. The presumption of illegality may be overcome only where the defendants "demonstrate that the intended acquisition would result in significant economies and that these economies ultimately would benefit competition and, hence, consumers." *Univ. Health*, 938 F.2d at 1223.

[6] Efficiencies are not the same as equities. In assessing whether a preliminary injunction may issue in a Section 7 case, a court must always weigh the equities as part of its determination that granting the injunction would be in the public interest. This essential step is expressly required by Section 13(b) of the FTC Act: "Upon a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest . . . a preliminary injunction may be granted. . . ." 15 U.S.C. § 53(b) (emphasis added). The efficiencies defense, on the other hand, is a means to show that any anticompetitive effects of the merger will be offset by efficiencies that will ultimately benefit consumers. It is not mentioned in Section 7 of the Clayton Act, nor is it part of the standard for granting a preliminary injunction.

[7] Some of the considerations may overlap, but they are properly viewed as distinct inquiries, in part, because of the rigorous standard that applies to efficiencies, which must be merger specific, verifiable, and must not arise from any anticompetitive reduction in output or service. And importantly, the efficiencies defense, because it is aimed at rebutting the Government's prima facie case that the merger is anticompetitive, must "demonstrate that the prima facie case portrays inaccurately the merger's probable effects on competition." *St. Alphonsus*, 778 F.3d at 790 (internal quotation marks and alterations omitted). The District Court analyzed several claimed efficiencies and concluded that they weigh in favor of denying the preliminary injunction. But it did not address whether those claimed efficiencies meet the demanding scrutiny that the efficiencies defense requires.

[8] Our review of the Hospitals' claimed efficiencies leads us to conclude that they are insufficient to rebut the presumption of anticompetitiveness. With respect to the Hospitals' capacity constraints and capital savings claims, the District Court found that the merger will alleviate Hershey's capacity constraints because, upon consummating the merger, Hershey will immediately be able to transfer patients to Pinnacle. The District Court also credited the testimony of Hershey CEO Craig Hillemeier that, because Hershey will transfer patients to Pinnacle, it can avoid constructing a new planned bed tower aimed at providing additional beds at Hershey, resulting in capital savings of nearly $277 million.

[9] The parties dispute whether capital savings can constitute efficiencies. *Compare FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1300–01 (W.D. Mich. 1996) (capital savings are cognizable efficiencies), *with FTC v. ProMedica Health Sys., Inc.*, No. 3:11–cv–47, 2011 WL 1219281, at *36–37 (N.D. Ohio Mar. 29, 2011) (capital savings are not cognizable efficiencies). We turn to the Merger Guidelines in answering this question. As the Merger Guidelines explain, competition is what "usually spurs firms to achieve efficiencies internally." Merger Guidelines, § 10, at 29. One of the rationales for recognizing the efficiencies defense is that a merger may produce efficiencies that "result in lower prices, improved quality, enhanced service, or new products." *Id.* Thus, although capital savings, in and of themselves, would not be cognizable efficiencies, we can foresee that an antitrust defendant could demonstrate that its avoidance of capital expenditures would benefit the public by, for example, lowering prices or improving the quality of its services. In such a case, so long as the capital savings result in some tangible, verifiable benefit to consumers, capital savings may play a role in our efficiencies analysis.

[10] Our recognition that capital savings are cognizable efficiencies does not decide this issue, however, because even if capital savings are efficiencies, they must nonetheless be verifiable and must not result in any anticompetitive reduction in output. It is on these requirements that the Hospitals' efficiencies claim fails. As an initial matter, we are bound to accept the District Court's findings of fact unless they are clearly erroneous. And, as the District Court observed, we do not second guess the business judgments of Hershey's able executives. We do, however, require that the Hospitals provide clear evidence showing that the merger will result in efficiencies that will offset the anticompetitive effects and ultimately benefit consumers. First, the evidence is ambiguous at best that Hershey needed to construct a 100-bed tower to alleviate its capacity constraints. The Hospitals' own efficiencies analysis shows that Hershey needs only thirteen additional beds in order to operate at 85% capacity, which is a hospital's optimal

occupancy rate. App. 18; Corrected Reply Br. 28 n.18. Second, Hershey's ability to forego building the 100-bed tower is a reduction in output. The Merger Guidelines expressly indicate that the FTC will not consider efficiencies that "arise from anticompetitive reductions in output or service." Merger Guidelines, § 10, at 30.

[11] Even if we were to agree with the Hospitals that their ability to forego building a new 100-bed tower as a result of the merger is a cognizable efficiency that is verified, merger specific, and did not arise from any anticompetitive reduction in output, we cannot overlook that the HHI numbers here eclipse any others we have identified in similar cases. They render this combination not only presumptively anticompetitive, but so likely to be anticompetitive that "extraordinarily great cognizable efficiencies [are] necessary to prevent the merger from being anticompetitive." *Id.* § 10, at 31. This high standard is not met here—nor, we note, has this high standard been met by any proposed efficiencies considered by a court of appeals.

[12] Second, the Hospitals claim that the merger will enhance their efforts to engage in risk-based contracting. Risk-based contracting is an alternative payment model to the traditional fee-for-service model in which healthcare providers bear some of the financial risk and upside in the cost of treatment. The Hospitals' expert testified that large systems that control the entire continuum of care are better suited to risk-based contracting, partly because they are able to spread out the financial risk involved. The Government disputes that a system as large as the combined Hershey/Pinnacle system has any advantages over a smaller, albeit still large, healthcare system. The District Court seemingly agreed with the Government that both Pinnacle and Hershey are capable of independently operating under the risk-based contracting model. But it found that the merger will be beneficial to the Hospitals' ability to engage in risk-based contracting, which in turn will allow Hershey "to continue to use its revenue to operate its College of Medicine and draw high-quality medical students and professors into the region."

[13] Irrespective of whatever benefits the merger may bestow upon the Hospitals in increasing their ability to engage in risk-based contracting, the Hospitals must demonstrate that such a benefit would ultimately be passed on to consumers. It is not clear from the record how this would be so beyond the mere assertion that it would save the Hospitals money and such savings would be passed on to consumers. We cannot credit the District Court's observation that, because of the benefits to risk-based contracting, Hershey will be able to continue to use its revenue to operate its College of Medicine and draw high-quality medical students and professors to Hershey. An efficiencies analysis requires more than speculative assurances that a benefit enjoyed by the Hospitals will also be enjoyed by the public. It is similarly unclear how this ability to engage in risk-based contracting will counteract any of the anticompetitive effects of the merger. Finally, the District Court's finding that both Pinnacle and Hershey are capable of independently engaging in risk-based contracting contravenes its conclusion that this is a cognizable efficiency because the benefit is not merger specific. *See H.J. Heinz*, 246 F.3d at 722 (the efficiencies must not be achievable by either company alone; otherwise, the merger's benefits could be achieved without the loss of a competitor). . .

* * *

Efficiency claims in hospital mergers are often particularly difficult to establish for several reasons. Such mergers typically will result in some savings in so-called "back office" administrative operations and supply purchasing, but under agency guidelines these are often given limited consideration as efficiencies. Hospitals generally can obtain the benefit of volume purchasing through group purchasing organizations ("GPO"s), achieve administrative savings through the employment of "best practices" suggested by outside consultants, or manage their claims processing and related payment functions by contracting with outside vendors. Accordingly, these projected savings would be discounted as not merger-specific.

Potentially greater benefits might be achieved through combining clinical service lines, thereby eliminating duplication and obtaining better results through the experience and best practices gained by pooling patient volumes and expertise. However, such claims also face serious obstacles. The best opportunities for combining clinical service lines occur where hospitals are geographically close and provide relatively similar services. But since those are situations where the hospitals are also most likely to be each other's closest competitors, the magnitude of the potential adverse

competitive effects may be great. And if the clinical services are not in immediate proximity, enforcers might argue, as they did in *Penn State,* that eliminating overlaps constitutes a non-cognizable efficiency because it reduces overall output. Enforcers may be concerned that cost reductions that stem from achieving economies in staffing may also reflect an increase in hospital market power in labor markets.

Moreover, recent scholarship has cast some doubt regarding the track record of merging hospitals in achieving their planned efficiencies.[81]

Another challenge facing hospitals attempting to rely on an efficiencies defense is that, as a practical matter, the merging parties often have not had the opportunity to engage in the type of detailed planning required to underpin the kind of analysis that could withstand scrutiny under the *Guidelines.* Even if the hospitals have considered at a high level the possible benefits of a combination, they are competitors until a transaction is closed and so must be circumspect—for both antitrust compliance and business reasons—about sharing competitively sensitive information. In addition, those merger plans that may provide the most significant benefits also are likely to involve the greatest disruption, including the loss of jobs or the consolidation of services in particular locations. Accordingly, the merging parties may wish to delay such planning until post-closing.

Finally, to the extent that courts have recognized an "efficiencies defense," it is based on the rationale that efficiencies can be considered only because they may result in making the merged entity a better competitor, and thereby balance some of the possible anticompetitive effects stemming from the consolidation. But most hospitals, in considering a possible merger, are not looking primarily through the antitrust lens to consider whether the transaction will benefit competition. Rather, they may be focusing on such things as whether the merger will enable more coordinated care, improve quality, provide better patient care, or expand access for the under-served.

While hospital lawyers can seek to recast such benefits as enabling the merged entity to better compete in the relevant market, this is not the way that many hospital executives, or even courts, might initially view them. The Ninth Circuit illustrated this disparity when it dismissed benefits that St. Luke's Health System claimed would result from its acquisition of a large primary care clinic in Nampa, Idaho. These benefits included access to a better electronic medical record system and greater coordinated care. After expressing skepticism about the efficiencies defense generally, the court opined:

> It is not enough that the merger would allow St. Luke's to better serve its patients. The Clayton Act focuses on competition, and the claimed efficiencies therefore must show that the prediction of anticompetitive effects from the prima facie case is inaccurate . . . . [E]ven if we assume that the claimed efficiencies were merger-specific, the defense would nonetheless fail. At most, the district court concluded that the St. Luke's might provide better service to patients after the merger. That is a laudable goal, but the Clayton Act does not excuse mergers that lessen competition or create monopolies simply because the merged entity can improve its operations."

Saint Alphonsus Medical Center-Nampa, Inc. v. St. Luke's Health System, 778 F. 3d 775, 792 (9th Cir. 2015).

Notwithstanding the above, in most hospital merger investigations the hospitals present at least some form of efficiency defense, even with the realization that they may have slim chances of meeting all the stringent criteria of the *Horizontal Merger Guidelines.* Their goal, at least in close cases, is to persuade agency enforcers that: (1) there are enough potential benefits stemming from the transaction to justify the agency's exercise of its prosecutorial discretion in not challenging the deal; or (2) such purported benefits may significantly increase the litigation risks for a successful agency challenge, especially before a local judge who may be sympathetic to the merging hospitals. As with mergers in other industries, claimed efficiencies will not overcome what otherwise appear to be very significant adverse competitive effects.

[81] *See supra* Chapter VIII.

3. Insurer Mergers

Hospitals and physicians frequently complain that the enforcement agencies focus on provider mergers and ignore mergers of health insurers that aggregate buying power to the disadvantage of providers who must negotiate with health plans. The facts suggest a more nuanced conclusion. DOJ's Antitrust Division has investigated many mergers of health insurers over the years and, while it has let some mergers through without opposition, it has filed suit against others, resolving these cases with a consent decree or—as in two mergers in 2016–2017, that would have significantly consolidated the insurer market—with litigated wins in federal court.

Notice, before we continue, that DOJ, rather than the FTC, is the usual enforcer of the Clayton Act where insurer mergers are concerned. As we saw above, it's the other way around with respect to provider mergers—the FTC, not DOJ, typically brings those cases. Starting around the turn of this century, when DOJ all but abandoned its pursuit of hospital mergers, the agencies effectively split the merger market between them through the clearance process the agencies use to decide which agency will review a merger after a Hart-Scott-Rodino notice is filed.[82]

Between 2005 and 2012, DOJ filed suit challenging three insurer mergers and in each case obtained significant divestitures as a condition of allowing the mergers to proceed. The cases were:

- 2005: UnitedHealth's proposed acquisition of PacifiCare Health Systems, an insurer doing business primarily in the far west. DOJ entered a settlement that permitted the merger to close on certain conditions, including the divestiture of aspects of PacifiCare's business in Arizona and Colorado.[83]

- 2008: UnitedHealth's proposed acquisition of Sierra Health, the largest health insurer in the Las Vegas, Nevada, area. A settlement allowed the merger to proceed only after Sierra divested its Medicare Advantage business in the Las Vegas area.[84]

- 2012: Humana's proposed acquisition of Arcadian Management Services, an insurer providing Medicare Advantage plans in 15 states. The transaction was completed only after the parties divested parts of their Medicare Advantage business in five states (Arizona, Arkansas, Louisiana, Oklahoma, and Texas) where they overlapped.[85]

In 2015, two blockbuster insurer mergers were publicly announced: on July 2 that year, Aetna agreed to buy Humana. Three weeks later, on July 23, Anthem agreed to buy Cigna. The four companies were the four largest commercial insurers in the United States behind the largest, UnitedHealthcare. So, if the deals had been completed, the top five commercial health insurers would have consolidated, almost overnight, into three firms. In its complaint against the Anthem-Cigna deal, DOJ described a "bidding frenzy" leading up to the two mergers in which all five of the nation's largest insurers participated, in various combinations. "In a two-month period, Anthem made several bids for Cigna;

[82] In fact, in 2002, the FTC and DOJ entered into an actual agreement that would have allocated the review of provider health care mergers to the FTC and insurance mergers to DOJ. DOJ and FTC Announce New Clearance Procedures for Antitrust Matters, Dep't of Just. (March 5, 2002), https://www.justice.gov/archive/atr/public/press_releases/2002/10171.htm. After the chairman of the Senate Commerce, Justice and State Appropriations Subcommittee expressed his opposition to the agreement, DOJ withdrew from it. Statement by Charles A. James Regarding DOJ/FTC Clearance Agreement, Dep't of Just. (May 2, 2002), https://www.justice.gov/archive/opa/pr/2002/May/02_ag_302.htm. But although the official agreement was no more, and each agency avers it could and might investigate both kinds of mergers, the *de facto* split described in the text has continued in the clearance process the agencies use to allocate mergers between them.

[83] U.S. v. UnitedHealth Group, Inc. and PacifiCare Health Systems, Inc., No. 1:05CV02436 (D.D.C. Dec. 5, 2005). Pleadings available at https://www.justice.gov/atr/case/us-v-unitedhealth-group-inc-and-pacificare-health-systems-inc.

[84] U.S. v. UnitedHealth Group, Inc. and Sierra Health Services, Inc., No. 1:08-CV-00322 (D.D.C. Feb. 25, 2008). Pleadings available at https://www.justice.gov/atr/case/us-v-unitedhealth-group-inc-and-sierra-health-services-inc.

[85] U.S. v. Humana Inc. and Arcadian Management Services, Inc., No. 12-CV-00464 (D.D.C. March 27, 2012). Pleadings available at https://www.justice.gov/atr/case/us-v-humana-inc-and-arcadian-management-services-inc.

Cigna made two bids for Humana; UnitedHealthcare made bids for Aetna and Cigna; and Aetna made a bid for Humana."[86]

DOJ investigated both transactions and, on the same day in July 2016, filed complaints to stop both. The two cases went to trial in November before different judges in the district court for the District of Columbia. For several weeks the two trials proceeded simultaneously. Ultimately the government won each case. Only one case, the *Anthem/Cigna* merger, was appealed to the Court of Appeals for the D.C. Circuit. That court affirmed the lower court's judgment. But the similarities between the two cases ends with the simultaneous trials. Each case proceeded at trial on a very different theory. We briefly describe the cases here.

CASENOTE: United States v. Anthem, Inc. (Anthem/Cigna)

855 F.3d 345 (D.C. Cir. 2017)

DOJ, joined by 11 states and the District of Columbia, made three arguments in its effort to block Anthem's acquisition of Cigna under Section 7 of the Clayton Act. Anthem had an exclusive license to operate under the Blue Cross Blue Shield brand in all, or parts, of 14 states and it competed with Cigna in most of those states. The governments argued that the merger would substantially lessen competition (i) in the market for the sale of health insurance to "national accounts" in the 14 states and in United States as a whole, (ii) in the market for the sale of health insurance to large group employers in 35 specified local markets, and (iii) in the market for the purchase of services from providers in the same 35 local markets.

After a six-week trial, the district court found the merger likely would be anticompetitive in the sale of health insurance to national accounts in the 14 states, as well as in the market for the sale of health insurance to large group employers in Richmond, Virginia. "National" accounts were defined as employers purchasing health insurance for more than 5,000 employees in more than one state. The court found DOJ had successfully defined a national accounts market that included both fully insured plans and "administrative services only" plans. In the latter, a self-insured employer purchases certain services from a health insurance company, such as claims adjudication, and pays for access to the insurer's provider network at rates the insurer has negotiated.

The district court found the merger would increase the HHI in the 14 states' national accounts market by over 500 points, to 3000. The merger also would reduce the number of health insurers in this market from four to three (of the five largest commercial insurers, the court found, all but Humana participated in this particular market).

In Richmond, Virginia, the government claimed Anthem and Cigna were the two largest health insurance competitors with a combined share between 64% and 78%. The district court credited some of the defense criticisms of the relevant geographic market but ultimately found that "[e]ven if the data [the defense economist] used for his calculations was not perfect, the resulting market share figures were sufficiently large . . . to be unaffected by minor discrepancies."

Anthem appealed the adverse judgment primarily on grounds that the district court failed to credit substantial efficiencies (claimed to amount to $2.4 billion). But, in the opinion excerpted in Chapter VIII, a split Court of Appeals (Judge Kavanaugh dissenting) rejected the argument and affirmed the district court judgment.

CASENOTE: United States v. Aetna Inc. (Aetna/Humana)

240 F. Supp. 3d 1 (D.D.C. 2017)

[86] U.S. and Plaintiff States v. Anthem, Inc., and Cigna Corp., Case 1:16-cv-01493, Complaint at Par. 13 (D.D.C. Jul7 21, 2016), https://www.justice.gov/atr/file/903111/dl?inline.

The case DOJ and nine states brought against the Aetna/Humana merger proceeded on a very different theory. The governments' focus was on the Medicare Advantage ("MA") market and on the individual commercial health insurance plans offered on public exchanges created in the wake of the Affordable Care Act. The district court found the merger unlawful in MA markets in 364 counties identified in the complaint and in individual commercial health insurance plans offered on public exchanges in three counties.

Medicare coverage—as offered by the federal government to the aged, blind, and disabled—promises coverage of hospital services (through "Part A"), physician services ("Part B"), and prescription drug services ("Part D").[87] Part B coverage is offered in return for payment of an income-adjusted premium. Part D drug services are offered, at the beneficiary's option, for an additional premium. Medicare coverage is not comprehensive; it exposes beneficiaries to gaps in its coverage. Medicare doesn't offer vision, dental or hearing benefits. There are no limits on out-of-pocket costs that might be incurred under Part A or Part B. To insure against these gaps in coverage, many (but far from all) Medicare enrollees purchase separate Medicare Supplement plans from commercial insurers.

Beginning in 1997, an alternative to this complicated patchwork system of coverage was authorized by Congress: Medicare Advantage (or, as it was initially called, Medicare Part C). Commercial insurance companies offer MA Plans. These insurers receive payment from the federal government on a fixed, per member per month basis for every Medicare beneficiary who opts out of "original" Medicare and into an MA plan. MA insurers calculate that they can offer more services (*e.g.*, they often offer vision, dental and other benefits—these sometimes include amenities such as fitness club memberships), guarantee enrollees a cap on out-of-pocket expenses, and earn a margin, in exchange for the capitated amount they are paid for Medicare beneficiaries who enroll with them. To control costs, MA insurers typically offer a narrower network of providers than available through original Medicare.[88]

As of June 2016, just before DOJ filed its action to enjoin the Aetna/Humana merger, 69 percent of Medicare enrollees received healthcare coverage through original Medicare, while 31 percent were enrolled in MA plans.[89] Humana was "atop the Medicare Advantage market," while Aetna followed in fourth place—although, as the district court noted, Aetna was growing rapidly in the MA market. The merging companies, however, hotly denied there was an "MA market," arguing instead that original Medicare and MA plans were all part of the same market.

The court disagreed, finding that MA was a separate market. The court accepted that MA and original Medicare are functionally the same (they both provide statutorily required coverage to eligible Medicare beneficiaries) but noted that this did not answer the question whether the products were reasonably interchangeable in the eyes of consumers. The court noted the functional differences between the two programs described above (*i.e.*, the broader coverage MA plans usually afford, the cap on out-of-pocket expenses built into MA plans, and so on.) The companies themselves treated original Medicare and MA differently. Internal documents showed both Aetna and Humana promoted their MA plans as superior to original Medicare. And both companies reported the financial results of their MA businesses separate from Medicare Supplement plans they sold. Both maintained separate business units, with the bulk of the relevant employees in these units dedicated either to Medicare Advantage or Medicare Supplement plans. In one internal document, an Aetna executive referred to Medicare Advantage and Medicare Supplement plans as "apples and oranges."

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[87] This discussion is drawn from Douglas Ross & David Maas, *A Market All Its Own: Medicare Advantage as a Separate Product Market in the DOJ's Case against the Aetna-Humana Merger*, 28 Rsch. in L. & Econ. 123, Healthcare Antitrust, Settlements, and the Federal Trade Commission (August 2018), https://www.dwt.com/-/media/files/publications/2018/08/coauthor-a-market-all-its-own-medicare-advantage-a/files/082018rossmaasa-market-all-its-own/fileattachment/082018rossmaasa-market-all-its-own.pdf.

[88] More detail on the differences between original Medicare and MA is available on Medicare's website. *Compare Original Medicare & Medicare Advantage*, Medicare.gov, https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage (last visited Sept. 5, 2024).

[89] MA enrollment has continued to grow and in 2023, for the first time, more Medicare beneficiaries (51%) were enrolled in an MA plan than were enrolled in original Medicare. Nancy Ochieng et al., *Medicare Advantage in 2023: Enrollment Update and Key Trends*, KFF (Aug. 9, 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/.

The court also looked at the evidence of enrollee switching. This showed that more than 80% of the time, when MA enrollees left their plans, they switched to another MA plan rather than to original Medicare. This strong tendency to switch from one MA product to another was true regardless of whether the enrollee changed plans in response to premium increases or because their initial MA plan was cancelled. These "durable preferences" for MA, the court found, meant little switching from MA to original Medicare would occur in the event of a small but significant increase in price (a SSNIP—see Chapter VIII) in MA prices.

Finally, the court also considered econometric evidence. But as each party presented an economist, and as the two economists came to exactly opposite conclusions, the judge did what trial judges in antitrust cases often do—viewed the economists as largely offsetting each other and relied on what he had heard from the witnesses and seen in the documents to arrive at his conclusion that MA constituted a separate market. And once the court defined the market this narrowly, the case was over because, "based on its significant HHI scores, the Aetna-Humana merger is presumptively unlawful in all 364 complaint counties."[90]

E. Dominant Health System Contracting Practices

Many health care markets today are heavily concentrated and marked by little competition. A widely cited study, published in 2016, found that the hospital HHI in 90 percent of all metropolitan statistical areas (MSAs) in the United States was over 2,500; nearly 60 percent of all MSAs had an HHI at that level for specialist physicians; and about 57 percent of the MSAs showed insurer concentration at that level.[91] Other studies suggest, not surprisingly, that concentration levels have increased since then.[92] A year after the report was published, three noted health care economists (including a former Director of the FTC's Bureau of Economics) wrote, "[m]any areas of the country are dominated by one or two large hospital systems with no close competitors."[93] And these areas were not just rural markets, where sparse population makes robust competition unlikely. The authors observed that a single health care system dominates in many urban areas too, such as in "Boston (Partners), Cleveland (Cleveland Clinic and University Hospital), Pittsburgh (UPMC), and San Francisco (Sutter)." A monopoly in health care, like a monopoly in any other industry, can be expected to lead to higher prices, lower output, and less innovation.[94] So it's important to protect and nurture what competition may exist in a market dominated by a single health system if any hope of more robust competition in the future is to be preserved. But in health care, as in all industries, there is an ever-present danger that "once a firm has obtained a dominant position it often engages in anticompetitive practices in order to maintain it."[95]

What practices might a dominant health system (or dominant insurer) employ if it wants to fend off competitors? To the extent a health system—dominant or otherwise—lowers costs, expands services to meet need, introduces innovative ways to improve health outcomes, or conducts research to develop better treatments, it likely will be harder for its rivals to compete. But as we learned in Chapter VII (and notwithstanding Judge Hand's pronouncements to the contrary in *Alcoa*[96]), this conduct is encouraged by the antitrust laws, not discouraged. As we saw in that chapter,

[90] U.S. v. Aetna, Inc., 240 F. Supp. 3d. 1, 47 (D.D.C. 2017).

[91] Brent D. Fulton, *Health Care Market Concentration Trends In The United States: Evidence And Policy Response*, 36 Health Affairs 1533–1534 (Sept. 2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0556. One limitation of this study, of course, is that an MSA may not coincide with a relevant geographic market.

[92] *See, e.g.*, Jose R. Guardado, *Competition in Hospital Markets, 2013–2021*, Am. Med. Ass'n, Policy Research Perspectives, https://www.ama-assn.org/system/files/prp-competition-in-hospital-markets.pdf.

[93] Martin Gaynor et al., MAKING MARKETS WORK 7 (2017), https://www.brookings.edu/wp-content/uploads/2017/04/gaynor-et-al-final-report-v11.pdf. Gaynor was Director of the Bureau of Economics during the Obama administration and recently accepted a position as Special Advisor to the Assistant Attorney General for Antitrust.

[94] *Id.*

[95] *Id.*

[96] United States v. Aluminum Co. of America et al., 148 F.2d 416 (2d Cir. 1945).

practices that draw antitrust opprobrium are those that exclude competition by suppressing the ability or incentive of rivals to compete.

What kinds of exclusionary practices might we see from a dominant health care system? We have seen one example already: in Chapter VI we read DOJ's complaint in *United States v. Blue Cross Blue Shield of Michigan* which alleged that the dominant health plan in Michigan used most favored-nations-clauses with hospitals to make it harder for other insurers to enter the market or grow, and thereby lessened the prospect that the dominant plan would face aggressive competition in the future. What other contracting practices might accomplish similar goals?

- **"All-or-nothing" contracting.** A single health care system may have multiple hospitals; multiple non-hospital facilities such as ambulatory surgery centers (where outpatient surgery is done with no overnight stay), imaging centers (providing services such as X-rays, MRIs, and CT scans), and medical office buildings offering services from physician and non-physician providers; and many employed physicians, often organized in separate physician groups under the system's umbrella. Such a system may require that a health plan that wants to contract with one hospital must contract with all the system's provider components. Requiring that a plan take "all" the system's providers if it wants any of them is "all-or-nothing" contracting. Frequently systems do something similar with some, but not all, of their provider components. A system might, for example, require that a health plan that wants to contract with a hospital in one market also contract with the system's physicians in that market. Although this isn't literally "all-or-nothing" contracting, the same dynamics are in play. The antitrust theory most often invoked to try to limit such contracting is tying law.

- **Anti-steering provision.** Health plans typically offer products with multiple hospitals, physicians, and other providers. The plan will have negotiated different contracts with the various providers, and some will have negotiated higher reimbursement from the plan than others. The plan might then "steer" its members to the lower cost providers by imposing higher out-of-pocket costs (*i.e.*, higher co-insurance or copay amounts) on plan members who choose the more expensive providers. An "anti-steering" provision in a contract prohibits creating such incentives. The dominant system, for example, might negotiate higher rates from a health plan than the plan pays other providers and then, through an anti-steering provision, prohibit the plan from incentivizing members to visit the lower cost providers.

- **Anti-tiering provision.** This is closely related to an anti-steering provision. Health plans may create two or more "tiers" of providers, grouping the lowest cost (or most efficient) providers in one tier, for example, and the higher cost (or less efficient) providers in another—and then imposing higher out-of-pocket costs on members who choose providers in the second tier. An anti-tiering provision could prohibit this, or could simply require that the dominant system be placed in the tier with the lowest member costs, even if that system is more expensive than other providers with which the plan has contracted.

Health care is not the only industry where such contracting practices might be employed by dominant firms in an effort to reduce competitive threats. The Apple e-books and *Ohio v. American Express* cases showed that MFNs and anti-steering efforts are employed in many different industries. But perhaps because so many health care markets are marked by dominant firms, potentially abusive contracting practices have attracted particular attention in this industry. And such scrutiny has been fueled by health plans who believe that "steering" and "tiering" are two of the limited options that are available to help address the market power that can be exercised by a dominant health system.

Contracting practices by dominant health care firms have resulted in some well-known litigation—but, so far, few opinions that provide much guidance as to when such contracting practices are, or are not, lawful. In the discussion that follows we discuss first the Department of Justice's litigation against Charlotte Mecklenberg Hospital Authority and then the saga, only recently concluded after more than a decade of litigation, involving the Sutter Health System in northern California. In both cases dominant hospital systems were accused of a variety of contracting practices allegedly adopted to entrench their position and exclude competition.

1. United States v. Charlotte Mecklenberg Hospital Authority

In 2016, DOJ sued the Charlotte-Mecklenburg Hospital Authority, claiming it used "anti-steering" language in its contracts with insurers to protect its position as "the dominant hospital system in the Charlotte [North Carolina] area, with approximately a 50 percent share of the relevant market."[97] The Hospital Authority moved for judgment on the pleadings—inviting the court to enter judgment for it on the basis of the allegations in DOJ's complaint. The court denied the motion, saying little more than because the rule of reason applied, discovery was needed before the court could fully evaluate the effect of the anti-steering provisions.[98]

Because the parties settled soon after the Hospital Authority's motion was denied, the court never issued an opinion on summary judgment or after trial on the lawfulness of the anti-steering provisions in the Hospital Authority's contracts. Nonetheless, the parties' briefs on the motion do a good job of laying out the arguments for and against anti-steering (and anti-tiering) provisions. We start with excerpts from the Hospital Authority's brief moving for judgment in its favor and explaining why, in its view, the anti-steering provisions were procompetitive.

Defendant's Memorandum in Support of Motion for Judgment on the Pleadings, United States v. Charlotte Mecklenburg Hospital Authority

Case No. 3:16-cv-00311, 2016 WL 4584960 (W.D.N.C. filed Aug. 8, 2016)

[1] The [Charlotte-Mecklenburg] Hospital Authority extends significant discounts to insurance companies in order to gain in-network status. By participating in an insurance company's network, the Hospital Authority is effectively assured of serving a substantial portion of the insurer's members. Patient volume is critical to the Hospital Authority (and any other full-service health system) because of high fixed costs in the form of buildings, equipment and employees and because it operates many of its facilities around-the-clock. By serving a larger patient population, the Hospital Authority can achieve economies of scale and can effectively improve quality and lower its costs of providing services. As part of the contract negotiation process, the Hospital Authority makes projections about the patient population it is likely to serve and the range of services likely to be provided under a given contract. The magnitude of the overall price discount that the Hospital Authority offers an insurer is based, in part, on such projections. Generally, insurance companies with larger memberships tend to receive deeper overall discounts.

[2] Once the Hospital Authority secures in-network status, it competes vigorously with other health systems to attract the insurer's members. It does so by, among other things, offering a broader range of services than its competitors and making continual capital investments in clinical programs and technology. Absent contractual protections, an insurer could unilaterally destroy the value of the contract by selectively steering its members away from the Hospital Authority after both parties have agreed to the discounted rates. In that scenario, the insurer would receive the full benefit of the overall discount while the Hospital Authority would likely derive insufficient revenue from the contract to support or expand its clinical programs and outreach to the community as a whole. Such a scenario would be financially disastrous for the Hospital Authority and, ultimately, harmful to all the patients the Hospital Authority serves, including those who use its facilities as the safety net healthcare provider in the community.

[3] To mitigate this risk, the Hospital Authority has negotiated provisions with the large insurers to deter the selective steering of patients away from it once a contract has been executed. Without some modicum of contractual protection, the Hospital Authority would have little incentive to offer the overall discounted prices that insurance companies have come to expect. As such, the provisions in question—which the governments flatly characterize as anticompetitive—are, in fact, essential to price competition. Indeed, as recently explained by a former chief antitrust economist for the Department of Justice, these provisions serve to undergird the essential economics of the bargain, for "the provider

[97] Complaint, United States v. Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas HealthCare System, Case No. 3:16-cv-00311-RJC-DCK (June 9, 2016), https://www.justice.gov/atr/file/867111/dl?inline.

[98] Order, United States v. The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Healthcare System, No. 3:16-cv-00311-RJC-DCK (March 30, 2017).

needs the referrals from one service to the other. If you take away broken legs, then somehow that impacts referrals into more fancy orthopedic services. The provider needs scale in order to keep average costs down. And if you take away some part of the business, then the rest of the business has to cover that same set of fixed costs." And, as explained by another expert panelist at the government-sponsored workshop on healthcare competition:

> . . . [A]s a provider going into [a] narrow network, . . . let's say I'm willing to drop my rates, but I'm anticipating a certain increase in volume. I probably want to be sure that there won't be other members of the network who, unbeknownst to me, are getting incentives to drive patients who have signed up for that network to get care there that's going to throw off my rate and volume projections. *So this is an area, perhaps, where a surgical use of anti-steering or prevention of carve-outs could actually be pro-competitive, in the sense of enticing a provider to come into a arrow network, accept a certain cut in rates, and have some validity to their volume projections.* [. . .]

* * *

After the Hospital Authority made its motion, DOJ responded. (As you read, note that DOJ calls the Charlotte-Mecklenburg Hospital Authority the "Carolinas Healthcare System" or just "CHS".)

Plaintiffs' Opposition to Defendant's Rule 12(c) Motion for Judgment on the Pleadings, United States v. Charlotte Mecklenburg Hospital Authority

Case No. 3:16-cv-00311, (W.D.N.C. filed Aug. 31, 2016)

[1] The United States and the State of North Carolina brought this antitrust action to protect Charlotte healthcare consumers from the higher prices and other anticompetitive harm that result from Defendant Carolinas Healthcare System's ("CHS") imposition of contractual restrictions on steering. The contract terms effectively shield CHS—which controls about half of the market for the sale of general acute care inpatient hospital services in the Charlotte area—from having to compete on price and quality with its rivals. The Court should deny CHS's motion for judgment on the pleadings because the Complaint's detailed allegations about the anticompetitive nature and effects of CHS's contractual provisions more than plausibly state that the restrictions unreasonably restrain competition in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1. [. . .]

CHS's Interference with the Competitive Process is Actual Competitive Harm

[2] Courts recognize that protecting the competitive process is a principal objective of the antitrust laws. *See, e.g., Geneva Pharms. Tech. Corp. v. Barr Labs. Inc.*, 386 F.3d 485, 489 (2d Cir. 2004) ("The antitrust laws . . . safeguard consumers by protecting the competitive process."); *Morrison v. Murray Biscuit Co.*, 797 F.2d 1430, 1437 (7th Cir. 1986) (Posner, J.) ("The purpose of antitrust law, at least as articulated in the modern cases, is to protect the competitive process as a means of promoting economic efficiency.").

[3] Courts also recognize that harm to the competitive process amounts to an anticompetitive effect. *See, e.g., FTC v. Ind. Fed'n of Dentists*, 476 U.S. 447, 460-62 (1986) (holding that "disrupt[ing] the proper functioning of the price-setting mechanism of the market" is an anticompetitive effect) . . . .

The Competitive Process is Grounded in Firms Having the Freedom to Steer Consumers

[4] Steering is a normal and important part of competition. Sellers constantly try to steer buyers toward their products. Those efforts can take a variety of forms—such as offering lower prices, additional features, or a greater variety of choices—but they all involve providing buyers with the information they need to make their own decisions about which seller to choose. Buyers reward sellers offering the most compelling products with additional sales and punish those with inferior products with fewer sales. This open and vigorous competition pushes all sellers to improve their offerings to the benefit of consumers.

[5] In most markets in the American economy, the individual deciding to buy a product or service is the same one who must pay for it. Healthcare service markets diverge from that standard model. Patients choose the service but do not (typically apart from a co-payment) directly pay for it; the patient's insurance company does that. Health insurers' outlays therefore are determined by the purchasing decisions of their enrollees, who are not sensitive to the differences in providers' prices. Insurers have the incentive and ability to reduce their costs by steering consumers to lower-cost and higher-quality healthcare providers. When consumers respond to insurer steering, higher-cost providers will likely lose business to lower-cost providers, thus creating incentives for higher-cost providers to lower their costs. Consumers will benefit not only from the financial incentives that insurers use to steer them to low-cost providers, but also from lower premiums, lower out-of-pocket expenses, and (in the case of Charlotte employers who self-fund their employee's healthcare benefits) lower direct costs that are made possible through steering.

[. . .]

The Complaint Alleges How CHS's Steering Restrictions Interfere with the Competitive Process

[6] The Complaint alleges that steering can facilitate price and quality competition among healthcare providers, so that consumers can save money and obtain the highest quality heathcare. Some common methods of steering include health plan designs that allow a consumer to pay "lower out-of-pocket costs" for using "top tier" providers that "offer better value healthcare services," and others that allow consumers to pay "lower premiums" in exchange for accessing a narrow network of providers. Insurers provide these financial incentives to consumers who select these types of plans in order to steer them towards providers that are as "efficient as possible," "maintain low prices, and offer high quality and innovative services." Healthcare providers want to participate in these types of plans because they "increase[ ] patient volume."

[7] But CHS's steering restrictions limit the four insurers that cover more than 85% of commercially-insured Charlotte residents from offering, among other things, both "tiered networks that feature hospitals that compete with CHS in the top tiers" and "narrow networks that include only CHS's competitors." As a result, "CHS's competitors have less incentive to remain lower priced." Consequently, insurers pay higher prices and Charlotte consumers "incur higher out-of-pocket costs for their healthcare." . . .

[8] . . . Plaintiffs here challenge steering restrictions that block insurers from steering their customers to use lower-cost health care providers.

NOTES

1) It's common for a health insurer to offer multiple benefit plans in a single market. An insurer might offer a benefit plan that includes all providers in the community and a narrow network benefit plan with few providers. Typically the second product is less expensive than the first because the second likely excludes high-cost providers—and also because when providers may be willing to cut their rates even further to be included in a narrow network plan. (Do you understand why?) You will notice from the DOJ brief that the government didn't just object to anti-steering and anti-tiering provisions that were designed to stop health plans from incentivizing their members to choose the lower cost providers in a multi-provider health product, but also to prevent health plans from offering products built around a network of providers that excluded the Hospital Authority altogether.

2) After the district court denied the Hospital Authority's motion for judgment on the pleadings, the parties settled.[99] They agreed to entry of a stipulated final judgment by which the Authority promised (among other things) that it would not require any insurer to include it in the most-preferred tier of the insurer's benefit plans—with an exception: "Defendant may enter into a contract with an Insurer that provides Defendant with the right to participate in the most-preferred tier of a Benefit Plan under the same terms and conditions as any other Charlotte

[99] Atrium Health Agrees to Settle Antitrust Lawsuit and Eliminate Anticompetitive Steering Restrictions, Dep't of Just. (Nov. 15, 2018) https://www.justice.gov/opa/pr/atrium-health-agrees-settle-antitrust-lawsuit-and-eliminate-anticompetitive-steering. Carolinas Health System had taken the name "Atrium" after the litigation was underway.

Area Provider, provided that if Defendant declines to participate in the most-preferred tier of that Benefit Plan, then Defendant must participate in that Benefit Plan on terms and conditions that are substantially the same as any terms and conditions of any then-existing broad-network Benefit Plan . . . in which Defendant participates with that Insurer."[100] Why is this exception included in the settlement? What is the reason for the proviso?

3) Another provision of the stipulated final judgment states: "For any Co-Branded Plan or Narrow Network in which Defendant is the most-prominently featured Provider, Defendant may restrict steerage within that Co-Branded Plan or Narrow Network. For example, Defendant may restrict an Insurer from including at inception or later adding other Providers to any (i) Narrow Network in which Defendant is the most-prominently featured Provider, or (ii) any Co-Branded Plan."[101] Why do you think this was included? Why isn't this fatal to the relief the government was trying to get in the settlement?

4) Interestingly, the FTC and DOJ have flirted with using an uncharacteristic regulatory approach in addressing steering and tiering conduct. In 2011, the agencies were concerned that the as a result of certain provisions in the Affordable Care Act, many health systems would create "accountable care organizations" or "ACOs" that would contract on behalf of large numbers of local physicians and the hospitals. Anticipating such rapid and significant reactions (which ultimately in fact did not occur), the agencies and the Centers for Medicare and Medicaid Services ("CMS") initially proposed that before CMS would approve a Medicare ACO the arrangement would first need to obtain approval from the antitrust agencies. This proposed foray by the agencies into the heart of a regulatory review was ultimately dropped, but the agencies did provide guidance regarding ACO formation, including "safety zones" for ACOs that met certain requirements. In presenting these safety zones, the agencies discussed at some length their concerns about certain "disfavored" contracting practices by dominant health systems, including anti-tiering and anti-steering. *See* FTC/DOJ ACO statements regarding disfavored contracting practices, https://www.govinfo.gov/content/pkg/FR-2011-10-28/pdf/2011-27944.pdf at 67030. (These guidelines were rescinded recently along with the 1996 *Health Care Policy Statements*, as discussed above).

5) Ultimately, because the final rule did not require antitrust approval before granting Medicare ACO status and the ACO safety zones were generally ignored because they were so cumbersome and difficult to meet, the agency pronouncements about "disfavored" contracting practices had less direct impact than some had predicted. But they serve to illustrate how the antitrust enforcers can use mechanisms other than bringing cases to seek to curb what they believe is anticompetitive conduct in areas where the law is uncertain and litigation risk is high.

6) Some state legislatures have considered adopting anti-steering and anti-tiering legislation. Texas adopted a statute in 2023 that prohibits clauses in contracts that restrict the ability of an insurer to encourage (or steer) enrollees to certain providers and that restrict insurers from placing providers in copay or coinsurance tiers.[102] Connecticut adopted a similar bill the same year. Other states, including California and Washington, have considered but not adopted such bills.[103]

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[100] Proposed Final Judgment ¶ IV.B.3, Atrium Health Agrees to Settle Antitrust Lawsuit and Eliminate Anticompetitive Steering Restrictions, Dep't of Just. (Nov. 15, 2018), https://www.justice.gov/opa/pr/atrium-health-agrees-settle-antitrust-lawsuit-and-eliminate-anticompetitive-steering.

[101] *Id.*, ¶ V.B.

[102] Texas H.B. 711 (2023), https://capitol.texas.gov/BillLookup/History.aspx?LegSess=88R&Bill=HB711.

[103] Michael Friedrich, *State Policy Win Snapshot: Texas and Connecticut Fight Anti-Competitive Hospital Practices*, Arnold Ventures (Jan. 4, 2024), https://www.arnoldventures.org/stories/state-policy-win-snapshot-texas-and-connecticut-fight-anti-competitive-hospital-practices#:~:text=Through%20anti%2Dtiering%20and%20anti,up%20costs%20for%20all%20beneficiaries. The National Academy for State Health Policy (an organization primarily of state regulators) has drafted a *Model Act to Address Anticompetitive Terms in Health Insurance Contracts*, NASHIP Blog (Apr. 12, 2021), https://nashp.org/nashp-model-act-to-address-anticompetitive-terms-in-health-insurance-contracts/.

7) Bundling is another tactic dominant firms may use to increase or extend their market power. Bundling is discussed in Chapter VII, as is *Cascade Health Solutions v. PeaceHealth*,[104] the leading health care involving bundling claims in health care.

2. The *Sutter Health* Saga

Recall from the earlier discussion on mergers that California's Attorney General, in 2000, sought unsuccessfully to block Sutter Health's acquisition of a hospital in Oakland that competed directly with a Sutter hospital in Berkeley. (This defeat capped the seven-loss, hospital-merger losing streak government enforcers suffered and led to the FTC's merger retrospective.) In the course of that litigation, Sutter argued—and the district court agreed—that "[w]hen faced with price increases, there are numerous mechanisms through which health plans can discipline hospitals." The court continued:

> The simplest, but rarely used, is to exclude hospitals from the plans' provider networks. The primary mechanism by which MCOs [managed care organizations] and IPAs keep prices low is through the "steering" of patients. In managing their patients' illnesses, physicians are often responsible for deciding the components to be used in providing treatment, including the hospitals to which their patients are admitted. In steering, MCOs or IPAs provide incentives to or direct physicians to refer their patients to certain hospitals. Such incentives may include direct financial incentives as well as more general risk-sharing arrangements that reward physicians for providing care in the most cost-effective environment. When faced with rising prices, MCOs can attempt to steer patients to lower cost health care providers and away from the hospital imposing a price increase, thereby pressuring the hospital to eliminate the price increase. As one witness who has been on both sides of the table explained, "there is a discipline going both ways" because "we need them, but simultaneously they need us."
>
> Hospitals, in general, have high fixed costs, both in terms of the physical plant and equipment as well as the high cost of maintaining a highly skilled staff. At the same time, their profit margins are thin. Steering has been quite effective in disciplining prices because hospitals are sensitive to declines in volume. This is especially true of high-value specialty services such as cardiac care, neurosurgery, and oncology, due to the large capital commitments required for such programs and their higher profit margins.[105]

After completing the acquisition of another hospital in the East Bay area, Sutter continued to grow throughout northern California. Today it is one of the largest health systems in the state, with over two dozen hospitals, many other health care facilities (such as ambulatory surgery centers) and a roster of thousands of physicians in various medical foundations under Sutter's control.[106] With continued growth came more antitrust scrutiny. By 2010, Sutter was drawing the attention of patient advocacy groups claiming, for example, that Sutter "can dictate higher prices . . . because it has a lock on certain markets."[107] In a *Wall Street Journal* article in 2012, discussing acquisition of physician practices by health care systems, Sutter was singled out for a physician practice acquisition that caused an immediate 140% jump in rates for those physicians.[108] A year later the *New York Times* ran an article with the headline, "As Hospital Prices Soar, a Single Stitch Tops $500," using Sutter as a target to highlight rising hospital prices.[109]

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[104] Cascade Health Solutions v. PeaceHealth, 515 F.3d 883 (9th Cir. 2008).

[105] California v. Sutter Health System, 130 F. Supp. 2d 1109, 1131 (N.D. Cal. 2001).

[106] California has a strong "corporate practice of medicine" doctrine that forbids corporations from employing physicians. So, instead of hiring physicians, hospitals typically fund and indirectly control so-called medical foundations (provided for by California statute) that themselves employ physicians. Pamela Martin & Anne Nevelle, THE CORPORATE PRACTICE OF MEDICINE IN A CHANGING HEALTHCARE ENVIRONMENT 2, (Cal. Rsch. Bureau, Apr. 2016), https://www.library.ca.gov/wp-content/uploads/crb-reports/CRB_CPM_Final.pdf.

[107] Jordan Rau, *As Hospital System Expands, Patient Advocates Worry*, NPR., Nov. 20, 2010.

[108] Anna Wilde Matthews, *Same Doctor Visit, Double the Cost*, Wall St. J., Aug. 27, 2012, https://www.wsj.com/articles/SB10000872396390443713704577601113671007448.

[109] Elizabeth Rosenthal, *As Hospital Prices Soar, a Single Stitch Tops $500*, N.Y. Times, Dec. 3, 2013.

That same year, 2012, Sutter was sued in the first of what became three cases alleging that its contracting practices with payers violated antitrust law.[110] The first complaint was filed in federal court on behalf of a putative class (later certified) of individuals and employers who obtained commercial health insurance alleging claims under both the Sherman Act and California's Cartwright Act. The next case was filed two years later in state court, under the Cartwright Act, on behalf of a class of self-funded payers. Finally, in 2018, the California Attorney General filed an action, also in state court and making similar claims under state law. The two state court cases were soon consolidated before settling (as described below) in 2020.

Plaintiffs in all cases complained that Sutter contracted with payers on an "all or nothing" basis, refused to allow payers to steer patients to lower cost providers, and insisted that Sutter facilities always be in the network tier with the lowest out-of-pocket costs. These allegations were packaged into a number of different antitrust claims in the federal and state court cases: unlawful tying in violation of Section 1 of the Sherman Act and California's Cartwright Act, monopolization, under Section 2 of the Sherman Act and the Cartwright Act , and vertical price tampering in violation of the Cartwright Act. While the Cartwright Act and the Sherman Act are similar, there are differences (not discussed here) as well.

Settlement of the State Court Cases

With the California Attorney General and an army of plaintiffs' lawyers on the attack, Sutter careened toward what promised to be an expensive and lengthy trial with massive stakes. Plaintiffs' damages expert was expected to testify that Sutter's conduct caused $980 million in damages—which, after trebling, and adding plaintiffs' attorneys fees, could expose Sutter to a judgment of over $3 billion. But on the eve of trial, the parties settled. The key components were as follows:

- $575 million cash payment by Sutter to plaintiffs.
- A multifaceted injunction (a) restricting Sutter's conduct in contracting with payers and (b) forcing Sutter to undertake certain conduct to keep costs down, and quality and access up.
    - Sutter was enjoined from all-or-nothing contracting and required to permit payers and employers to exclude some (but not all) of its facilities from their networks. Sutter also promised to make a number of its facilities in less competitive markets, like rural hospitals and its Berkeley hospital, available to payers and employers.
    - Sutter was permitted to require a bundle of its providers be included in a network together if it can meet certain clinical integration criteria.
    - Sutter was enjoined from using anti-steering provisions that prohibit payers or employers from steering patients to other hospitals.
    - Sutter's rates for out-of-network services were capped.
- Sutter was subjected to a compliance monitor for at least 10 years.

The Federal Court Case against Sutter

Meanwhile the first-filed federal court case languished in litigation limbo. Over the course of a decade the initial complaint was dismissed by the district court and reinstated by the Ninth Circuit, multiple additional amended

[110] Sidibe et al. v. Sutter Health, No. 3-12-cv-04854, 333 F.R.D. 463 (N.D. Cal. 2019).

complaints were filed, a class was certified, and summary judgment was granted on several but not all claims.[111] The case finally proceeded to trial in early 2022—and, after a month-long trial, the jury found for Sutter.

Although the complaint had pled claims under the Sherman Act and the Cartwright Act, the case went to trial only under the Cartwright Act claims because plaintiffs sought damages only under those claims. The parties stipulated that after a jury verdict the court could decide whether to enter injunctive relief under that statute and the Sherman Act.

The jury was asked a series of questions. By answering two of the questions in the negative Sutter won and the jury did not have to answer any further questions on the jury form. One of the two questions asked whether Sutter had used its alleged market power to tie its hospitals together and so force insurers to include all Sutter hospitals in a network if the insurers wanted any of them (the "all-or-nothing" claim). The second asked whether Sutter had forced insurers to agree to contract terms that prevented steering patients to non-Sutter hospitals (the "anti-steering" claim). As noted, the jury answered "no" to each question. Because juries don't write opinions explaining their votes, we don't know what persuaded the jurors to find as they did. However, one observer commenting on the trial discussed the evidence the jury heard that may explain the outcome:

> On the issue of whether Sutter tied some hospitals to others when negotiating with insurers, the jury heard testimony that Sutter turned down narrow-network health plan products which offer some but not all its hospitals on an in-network basis. It also heard that Sutter charged higher "non-par" (non-participation) rates for hospitals that insurers tried to carve out of their health plan products. On the other hand, the jury also heard testimony to the effect that some health plan products did, in fact, offer only a subset of Sutter's hospitals in-network.
>
> On anti-steering, some testimony suggested that Sutter would not agree to contracts placing it in a health plan's less preferred "second tier" that imposes higher cost-sharing obligations on members. Other testimony, however, suggested this was justified by the discounted rates insurers receive from Sutter in exchange for directing a steady volume of patients to its hospitals. (A similar argument was made to justify the non-par rates.)
>
> Sutter also sought to help its cause by putting forth testimony tending to show that engaging in systemwide contracting and avoiding narrow-network health plans was intended to avoid patient confusion about out-of-pocket costs and to help support coordination of care across its health care system. Testimony also suggested that Sutter's contracting practices may have been a way to protect the benefit of its bargain with the insurers against the risk of changes to its network participation status midway through a contract period.[112]

But Sutter's victory was temporary. In mid–2024, by a 2–1 vote, the Ninth Circuit reversed, holding the magistrate judge who conducted the trial erred in her jury instructions and excluded evidence improperly.[113] The opinion sheds little light on Sutter's contested practices because the lawfulness of those practices was not directly at issue on appeal (as it might have been had the jury ruled against Sutter). The case was remanded to the trial court for a new trial. In April 2025, on the eve of trial, Sutter threw in the towel, agreeing to pay $228 million to settle the federal litigation.[114]

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[111] Amy Y. Gu, *[Case Brief] Sidibe v. Sutter Health: The Oldest Chapter in the Sutter Antitrust Saga Sees New Light for Class Plaintiffs*, Source on Healthcare (May 17, 2021), https://sourceonhealthcare.org/case-brief-sidibe-v-sutter-health-the-oldest-chapter-in-the-sutter-antitrust-saga-sees-new-light-for-class-plaintiffs/.

[112] Kaj Rozga, *Legal Gray Area Remains for Payer Contracting Practices Despite Sutter Health's Big Win in Landmark Antitrust Trial*, Am. Health L. Ass'n, Antitrust Practice Group Bull. (April 27, 2022), https://www.americanhealthlaw.org/content-library/publications/bulletins/5f866da4-dba6-46fd-be07-d917150e2a32/legal-gray-area-remains-for-payer-contracting-prac?Token=f5c259ed-b1ad-409d-97d6-9cbfedfc5b2f.

[113] *Sidibe v. Sutter Health*, 103 F.4th 675 (9th Cir. 2024).

[114] Mike Scarcella, "California's Sutter Health agrees to pay $228 million to settle antitrust lawsuit," Reuters (April 28, 2025) https://www.reuters.com/legal/government/californias-sutter-health-agrees-pay-228-million-settle-antitrust-lawsuit-2025-04-28/#:~:text=California's%20Sutter%20Health%20agrees%20to%20pay%20$228%20million%20to%20settle%20antitrust%20lawsuit,-

The result, for those seeking clarity on the legality of anti-steering and anti-tiering practices? No such clarity is to be found in this result, despite 13 years of litigation.[115]

NOTES

1) How could the results in the two cases be so different? Sutter didn't "lose" the state case, but it did agree to an onerous settlement. Yet it won a clean jury verdict in the federal case. Two lawyers who represented plaintiffs in the state case (one with a law firm that represented the private plaintiffs, the other with the Office of the California Attorney General) have suggested that while "[t]he cases appear to have much in common on the surface . . . [b]eneath the surface . . . the cases had meaningful differences."[116] There were some differences in how the plaintiffs in each case presented their theories that all-or-nothing contracting was unlawful tying, for example.[117] In addition, the state court judge had permitted evidence that the federal judge precluded. "As a result, the state plaintiffs were free to argue an important point: In 2001, Sutter persuaded a federal judge to *approve* a merger based on pro-competitive tools, then undermined those very tools through its anticompetitive conduct."[118]

3. A Final Word on MFN Clauses

One of the first sightings of an MFN occurred in Judge Posner's decision in *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406, 1415 (7th Cir. 1995), *as amended on denial of reh'g,* (Oct. 13, 1995).[119] A large physician clinic contracted with community (non-employee) physicians for coverage the clinic did not provide. The clinic refused to pay these physicians more than the physicians charged other patients. Judge Posner, writing for the Seventh Circuit, rejected the claim that the MFNs were anticompetitive, characterizing them instead as "standard devices by which buyers try to bargain for low prices, by getting the seller to agree to treat them as favorably as any of their other customers. The Clinic did this to minimize the cost of these physicians to it, and that is the sort of conduct that the antitrust laws seek to encourage." When Blue Cross moved for reconsideration of the Seventh Circuit's decision, DOJ and the FTC (neither of which were parties to the case) filed an amicus brief protesting that the court's language overlooked the possibility that MFNs can be used anticompetitively.[120] The court denied the motion but did reissue its decision adding a sentence acknowledging DOJ's concern while simultaneously dismissing it: "Perhaps, as the Department of Justice believes, these clauses are misused to anticompetitive ends in some cases; but there is no evidence of that in this case."

By%20Mike%20Scarcella&text=April%2028%20(Reuters)%20%2D%20California's,artificially%20driving%20up%20insurance%20premiums.

115 The settlement of the *Sidibe v. Sutter* case disappointed those who hoped that, one day, admittedly still far in the future, the fabled case of *Jarndyce v. Jarndyce* might tumble from its presumptive position as the longest running legal dispute of all time. See C. Dickens, Bleak House (1853).

116 Daniel Bird, Emilio Varanini, "Deciphering Sutter Health's State-Court Settlement and Federal-Court Win in Parallel Antitrust Cases," Health Affairs (May 10, 2022) https://www.healthaffairs.org/content/forefront/deciphering-sutter-health-s-state-court-settlement-and-federal-court-win-parallel

117 "The state case alleged that Sutter used systemwide contracting to condition the participation in insurer networks of some of its hospitals and providers with market power on the participation of its other hospitals and providers for which there were alternatives. The federal case involved a more rigid theory where plaintiffs had to define specific markets and show how Sutter forcibly linked those specific markets in which Sutter hospitals had market power with other specific markets in which Sutter's market power was absent." Id.

118 Id. "In addition, the state plaintiffs unearthed evidence that in 2015—a year after the lawsuit was filed—Sutter destroyed nearly 200 boxes of documents dating from 1995 to 2005. While evidence of that destruction would have been fiercely litigated in the state trial, the federal judge prevented the jury from hearing anything about it." Id.

119 The case is a complicated one and today is mostly remembered for two things: its holding—that HMOs don't constitute a market separate from other forms of commercial health care coverage, and Judge Posner's dry observation that "from a short-term financial standpoint ... the HMO's incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible." *Blue Cross Blue Shield v. Marshfield Clinic*, 65 F.3d 1406, 1410 (7th Cir. 1995)

120 Kevin McDonald, "The *Marshfield Clinic* Case: The Sound of a Broken Record," 5 Annals of Health L. 1, 5 (1996) https://lawecommons.luc.edu/annals/vol5/iss1/3/

While there are a number of health care cases law involving MFNs, there are few decisions in this area. Those decided on the merits favor defendants.

- In the 1980s, the First Circuit held that a dominant insurer did not violate Section 2 when it imposed MFNs on providers to ensure the insurer got the providers' best prices. The MFN wasn't anticompetitive because it helped the insurer obtain lower costs and attract more members. *Kartell v. Blue Shield of Massachusetts, Inc*., 749 F.2d 922, 929 (1st Cir. 1984).

- Five years later, the First Circuit reprised its *Kartell* decision in *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island*, 883 F.2d 1101, 1110 (1st Cir. 1989) ("a policy of insisting on a supplier's lowest price—assuming that the price is not predatory or below the supplier's incremental cost—tends to further competition on the merits and, as matter of law is not exclusionary").

The few cases that favor plaintiffs are hardly conclusive.

- In 1990, the Tenth Circuit briefly addressed MFNs in a decision upholding a finding of monopolization in violation of Section 2. But the decision doesn't give plaintiffs seeking to argue MFNs are anticompetitive much purchase. While the plaintiff claimed MFNs the defendant insurer had entered into with providers were anticompetitive, the court made no such finding, referring to the MFNs only to support the conclusion that the insurer had monopoly power (otherwise the providers wouldn't have agreed to these clauses).[121]

MFNs are discussed in Chapter V (the Apple ebooks case) and Chapter VI (the *Michigan Blue Cross Blue Shield* case). These are important issues and we only omit them here because they already are included in the casebook.

F. Exclusion of Providers

Health care entities frequently exclude providers from their organizations. A medical staff may refuse to admit a particular physician or may move to revoke a physician's staff membership. An independent practice association or other provider network might turn down an applicant. An insurer might decline to add more providers to its network. A provider may be excluded for reasons of high cost, low quality—or for other reasons altogether. An IPA or insurer may decide it has representation in a specialty, or in a geographic area, and doesn't want more providers from that specialty or area.

While an exclusion on the basis of quality or cost may seem the easiest to defend, most antitrust claims made by providers excluded from a network or entity fail. But the stakes in these cases are high. A physician losing his medical staff membership may find it all but impossible to retain his practice; a provider excluded from an important insurer's network may lose access to many commercially insured patients constituting a substantial part of her practice. Because the financial stakes are substantial—and because sometimes some very substantial egos have been bruised—such exclusions historically have been the source of a large amount of private antitrust litigation and remain an issue that requires informed antirust counseling to manage litigation risk. And, of course, the principles discussed in this section are not confined to health care: exclusions and foreclosure are a frequent focus of antitrust litigation in many industry sectors.

Hospital Medical Staffs

The medical staff of a hospital consists of the physicians, dentists, and other licensed providers who attend to patients while they are in the hospital. Historically, the medical staff of a community hospital consisted of professionals (mostly physicians) who were not employees of the hospital but maintained their own practices in the community. A physician

[121] Reazin v. Blue Cross Blue Shield of Kansas, 899 F.2d 951, 971 n.30 (10th Cir. 1990). *See also U.S. v. Delta Dental of Rhode Island*, 943 F. Supp. 172 (D.R.I. 1996) (denying motion to dismiss); *U.S. v. Delta Dental of Rhode Island*, 1997 WL 527669 (D.R.I. 1997) (consent decree).

who wishes to apply for medical staff membership typically also applies for certain "privileges" to practice in the areas of her expertise. So, for example, a cardiologist may apply for privileges in cardiology that will allow her to admit, evaluate, diagnose, and treat individuals with heart diseases and cardiac conditions.

Medical staff arrangements historically did not involve compensation between the hospital and the physicians. Both sides benefited: physicians had access to the facilities needed to provide more complex care than they could furnish in their offices, and hospitals (which were separately paid for the facility services they furnished) needed physicians both to provide patient referrals to them, and furnish the professional services need to care for patients admitted to their facilities. Today, with the increasing numbers of physicians who are employed by hospitals, the typical medical staff of a hospital will consist of a mix of community practitioners, as well as employed physicians who are paid by the hospital.

The hospital medical staff typically is organized and has bylaws that set out the application process for membership and privileges, specifies categories of the medical staff (such as active, consulting, and courtesy membership), provides for a medical executive committee and various other committees, and (either in the bylaws or a separate document) provides a fair hearing process for individuals whose applications are denied and for those members of the staff who (usually after an investigation, which also is provided for in the bylaws) face discipline which may result in the suspension or withdrawal of some or all privileges and, possibly, medical staff membership.

Not surprisingly, individuals involved in privileges decisions include physicians, and often physicians who are in the same specialty as, and arguably competitors, of the applicant. And often plaintiffs can allege that access to the hospital's medical staff is essential for them to compete. As the following cases illustrate, this scenario can provide a basis for antitrust claims that underlying the denial of privileges was an attempt to limit competition.

Oltz v. St. Peter's Community Hospital

861 F.2d 1440 (9th Cir. 1988)

Judge Hug.

[1] This case concerns a Sherman Act Sec. 1 claim for damages from an unlawful conspiracy among anesthesia service providers and the local hospital to enter an exclusive dealing contract and eliminate competition. By special verdict in a bifurcated trial, the jury found the defendant hospital liable and awarded damages of $421,831. The district court denied the hospital's motion for judgment notwithstanding the verdict or for a new trial on the issue of liability. . . .

FACTUAL BACKGROUND

[2] Defendant St. Peter's Community Hospital ("St. Peter's") is one of two hospitals in Helena, one of Montana's smaller cities. St. Peter's, however, is the only hospital in the area open to the general public and equipped to perform general surgery. At trial, the parties stipulated that St. Peter's enjoys a market share of 84% of general surgical services in Helena.

[3] Plaintiff Tafford E. Oltz and his wife are registered nurse anesthetists. A nurse anesthetist does not have the broad and extensive medical education that is required for an M.D. anesthesiologist; however, nurse anesthetists are clinically qualified to provide certain anesthesia services under the supervision of the M.D. performing the surgery. Thus, nurse anesthetists may provide anesthesia services in direct competition with M.D. anesthesiologists.

[4] In late 1974, Mr. and Mrs. Oltz were living in Bozeman, Montana. At the invitation of St. Peter's, Mr. Oltz began administering anesthesia at St. Peter's in Helena pursuant to a written billing agreement. Under the agreement, Mr. Oltz submitted his bills to St. Peter's, rather than to the patient, and received 90 percent of his billings as full payment directly from St. Peter's. The agreement expressly provided that Mr. Oltz was an independent contractor and not an employee of the hospital. The agreement was automatically renewable each month until one of the parties gave written notice of termination.

[5] When Mr. Oltz began at St. Peter's, three M.D. anesthesiologists were also administering anesthesia there. Mr. Oltz, however, performed as a free lance anesthetist, administering anesthesia under the clinical supervision of the operating surgeon or obstetrician. Mr. and Mrs. Oltz moved from Bozeman to Helena in early 1977. During this time, Mrs. Oltz was practicing as a nurse anesthetist in communities outside of Helena.

[6] By early 1978, the number of M.D. anesthesiologists with hospital privileges at St. Peter's had risen to four. Evidence at trial revealed that Mr. Oltz and the anesthesiologists were in direct competition for many of the cases at St. Peter's. Mr. Oltz' popularity among the surgical staff had grown so that some doctors, particularly obstetricians, preferred his services. For example, Mr. Oltz administered lumbar epidural anesthesia, a type of spinal anesthesia commonly used to assist women in childbirth, which some of the anesthesiologists were reluctant to perform. Moreover, Mr. Oltz charged $9.30 per anesthesia unit, while the anesthesiologists charged $14 per unit.

[7] The dispute over Mr. Oltz' independent billing status became divisive among the general medical staff, and some of the anesthesiologists began threatening to leave the hospital. On March 30, 1978, St. Peter's organized the Department of Anesthesia. The anesthesiologists comprised the department's membership. During department meetings in the presence of Howard Purcell, Jr., the administrator at St. Peter's, the department discussed termination of Mr. Oltz' billing contract. They also drafted policies encouraging supervision by anesthesiologists of all anesthesia administered at St. Peter's, removed Mr. Oltz from the anesthesia call schedule, and declined administrative as opposed to clinical supervision of Mr. Oltz' practice at St. Peter's.

[8] On September 14, 1978, the anesthesiologists wrote to Purcell and demanded that the hospital terminate the billing contract with Mr. Oltz. The anesthesiologists forwarded copies of their demand to the chief of staff and to the St. Peter's Board of Trustees. The board discussed the demand and referred the matter to a joint conference committee of the medical staff. The anesthesiologists presented a report to the joint committee, outlining the impact of nurse anesthetists on anesthesiologist incomes.

[9] Near December 28, 1978, Purcell telephoned Mr. Oltz and informed him the billing contract was terminated. After receiving correspondence from Mr. Oltz' attorney and the antitrust section of the Montana Attorney General's office, however, the board of trustees rescinded the termination. The board submitted the matter to an ad hoc committee of medical staff, directing them to recommend a resolution in compliance with the standards of the Joint Commission on Accreditation of Hospitals ("JCAH") regarding supervision of nurse anesthetists.

[10] The ad hoc committee recommended that St. Peter's institute supervision of all nurse anesthetists by anesthesiologists but "grandfather" Oltz' free lance position as an exception to the policy. The committee further recommended placing Oltz within the administrative supervision of the department of anesthesia while leaving his clinical supervision to the operating surgeons. Upon inquiry, the committee received confirmation from JCAH personnel that such supervision would satisfy JCAH standards. The medical staff, including the anesthesiologists, voiced approval of the recommendation, and the committee submitted the recommendation to the board of trustees.

[11] Even though they had approved the recommendation, at least three of the four anesthesiologists continued to openly discuss plans of leaving St. Peter's. On April 9 and 11, 1979, the Board of Trustees met to discuss the committee's recommendation. The Board minutes indicate that the board rejected the recommendation, in part, because the anesthesiologists were threatening to leave. Instead, the board decided to offer an exclusive contract for anesthesia services.

[12] St. Peter's advertised nationally for proposals from anesthesiologists to enter an exclusive contract. St. Peter's received proposals from various groups of doctors but ultimately awarded the contract to an association formed by three of the four anesthesiologists already in Helena. On April 29, 1980, Purcell wrote Mr. Oltz that the exclusive contract would commence and Oltz' billing contract would terminate on July 14, 1980.

[13] Following the termination, the anesthesiologists at St. Peter's offered Mr. Oltz a salaried position as an employee in their association but under their clinical supervision. The salary offered to Mr. Oltz was $40,000. Mr. Oltz rejected

the offer and advertised nationally for employment. Ultimately, Mr. Oltz and his wife accepted positions on the University of Iowa faculty, and Mr. Oltz eventually became chief nurse anesthetist at a regional medical center of the university. After Mr. Oltz' departure from St. Peter's, each of the anesthesiologists in Helena experienced increased annual earnings by 40 to 50%.

PROCEDURAL HISTORY

[14] Mr. Oltz sued St. Peter's and the four anesthesiologists under section one of the Sherman Act. The four doctors settled, paying $462,500, and the case was dismissed as to them. The case against St. Peter's proceeded to a bifurcated jury trial on a theory of conspiracy to boycott and exclude competition. The jury found liability by special verdict.

[15] Before the trial on damages, the district court ruled in limine to exclude evidence of Mrs. Oltz' earnings after 1980. The jury then awarded Mr. Oltz $212,182 damages for loss of income to the date of trial and $209,649 damages for loss of future income.

[16] St. Peter's moved for judgment notwithstanding the verdict or for a new trial on the issue of liability. The district court denied the motions but *sua sponte* ordered a new trial on damages. Oltz v. St. Peter's Community Hosp., 656 F. Supp. 760, 765 (D. Mont. 1987). The district court found that the damages awarded were excessive and that the court had caused the excess by erroneously excluding evidence of Mrs. Oltz' income after 1980. *Id.* at 764–65.

[17] Both parties sought our permission to appeal the district court's post-verdict ruling under 28 U.S.C. § 1292(b). We granted permission, and the parties perfected appeals pursuant to Fed. R. App. P. 5(d).

ISSUES PRESENTED

[18] St. Peter's appeal from the jury verdict on liability and Oltz' appeal from the order granting a new trial on damages raise four issues that we must decide:

(1) whether the district court improperly removed from the jury the factual determination of the relevant market;

(2) whether the duration and purpose of the exclusive contract between St. Peter's and several M.D. anesthesiologists preclude a finding of intent to injure competition;

(3) whether the jury properly concluded that St. Peter's was capable of conspiring with its medical staff under Sherman Act Sec. 1; and

(4) whether the district court abused its discretion by ordering a new trial on damages.

DISCUSSION

[19] By its terms, section one of the Sherman Act prohibits " [e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade." 15 U.S.C. § 1 (1982). The Supreme Court, however, has long recognized that section one was intended to prohibit only those restraints that unreasonably restrain competition. Ordinarily, whether particular concerted conduct unreasonably restrains competition is determined under a "rule of reason" analysis, which is a case-by-case study in which "the fact finder weighs all of the circumstances of a case." Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36, 49 (1977). In contrast, the Court has identified certain discrete categories of restraints so manifestly anticompetitive in nature that they are illegal *per se*, dispensing with the need for case-by-case evaluation. Id. at 50 . The district court instructed the jury to evaluate Oltz' claim against St. Peter's exclusively under the rule of reason.

[20] Our traditional framework for analyzing a rule of reason claim under section one of the Sherman Act is well settled and easily summarized. A section one claimant must initially prove three elements: (1) an agreement or conspiracy among two or more persons or distinct business entities; (2) by which the persons or entities intend to harm or restrain competition; and (3) which actually injures competition. . . . After the claimant has proven that the conspiracy harmed competition, the fact finder must balance the restraint and any justifications or pro-competitive

effects of the restraint in order to determine whether the restraint is unreasonable. . . . This balancing process requires a thorough examination into all the surrounding circumstances.

[21] Each of the three issues raised by St. Peter's appeal corresponds to one of the initial elements of proof in a rule of reason case. We address each one in reverse order.

[22] St. Peter's urges us to find an utter failure of proof on the issue of injury to competition because the district court incorrectly defined the relevant product and geographic market. In particular, St. Peter's objects to the district court's instruction that the jury should evaluate the impact of the conspiracy on "competition among providers of anesthesia services in the Helena area." St. Peter's maintains that market relevance presents a factual question and that the instruction improperly decided the question as a matter of law.

[23] Reduced to its essence, St. Peter's position is that the district court erroneously directed a verdict as to the relevant market . . .

[24] Proving injury to competition in a rule of reason case almost uniformly requires a claimant to prove the relevant market and to show the effects upon competition within that market. . . . Defining the relevant market is a factual inquiry ordinarily reserved for the jury. . . .

[25] We agree with St. Peter's that the district court decided the relevant market issue as a matter of law. The court confined the jury's evaluation to Helena as the relevant geographic area of competition and anesthesia services as the relevant product. According to St. Peter's, however, the relevant geographic area extends throughout the nation, and the relevant product consists of the providers of anesthesia services whom hospitals seek to attract to their facilities. St. Peter's contends that unrebutted evidence established that Oltz sought new work and St. Peter's solicited bids for an exclusive anesthesia contract by advertising in nationally circulated publications. St. Peter's maintains this evidence would substantially support a factual finding that the relevant market is broader than the market for anesthesia services in Helena, invalidating the district court's directed verdict on that issue.

[26] St. Peter's arguments seek to cast the search for the market in this case as a choice between the local market for patient services and the broader job market for anesthesia service positions. Such a choice is entirely unnecessary. The M.D. anesthesiologists, the hospital, and Oltz operated in both markets. Thus, the exclusive arrangement potentially affected both markets, and both were relevant to the search for competitive harm. Even if we accept St. Peter's contention that the job market was national and competition in it suffered no injury, the analysis could not have ended there. An evaluation of the impact on competition in the patient market for anesthesia service was required.

[27] Through its instruction, the district court confined the jury's search for competitive harm in the patient services market to the Helena area. The conclusion that Helena was the relevant geographic market for assessing such harm is inescapable. St. Peter's enjoyed the overwhelming majority of the market for general surgery. As a result, an anesthesia service provider desiring to serve that market had to work at St. Peter's. More importantly, there was no evidence that patients could effectively turn outside of St. Peter's for alternate sources of anesthesia services. There was also no evidence of any other service that was a reasonable substitute for anesthesia services in terms of use and cross-elasticity of demand. Accordingly, we conclude that anesthesia services and the Helena area framed the appropriate product and geographic components of a relevant market in which the jury could assess injury to competition. [. . .]

[28] . . . St. Peter's arrangement with the M.D. anesthesiologists potentially affected two different segments of the economy. One segment was the market in which anesthesia service providers compete for staff privileges at hospitals; the other was the patient market for anesthesia services. Consideration of the impact of the exclusive contract on competition does not require acceptance of one segment as the relevant market and rejection of the other. Rather . . . , a showing of injury to competition in either market suffices for the rule of reason.

[29] St. Peter's also relies on *Collins v. Associated Pathologists, Ltd.* in arguing that anesthesia service providers and not anesthesia services constitute the relevant product. 844 F.2d 473 (7th Cir. 1988). In *Collins*, the court held that pathologists and not pathology services were the relevant market for analyzing the competitive effect of an exclusive contract for pathology privileges at the defendant hospital. *Id.* at 478. The court affirmed dismissal of the Sherman Act Sec. 1 claims because the excluded plaintiff could show no significant effect upon the market in which pathologists compete for jobs. The court rejected pathology services as a relevant product because no evidence showed a demand for such services that was separate from the demand for hospital services in general.

[30] Unlike the situation in *Collins*, the evidence at trial revealed a demand for individual anesthesia service providers. Indeed, some surgeons and obstetricians actually preferred Oltz over the M.D. anesthesiologists for certain anesthetic procedures. The district court was justified in finding that such services constitute a relevant product market in which the jury should evaluate competitive harm.

[31] Our conclusion that the district court correctly limited the jury's search for competitive harm to the patient market in Helena is compelled by still another reason. Defining the market is not the aim of antitrust law; it merely aids the search for competitive injury. Once defined, the relevant market demarcates "objective benchmarks" for separating reasonable and unreasonable restraints. *See Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 53 n.21 (1977). It requires the claimant to demonstrate harm to the economy beyond the claimants' own injury. *Aydin Corp. v. Loral Corp.*, 718 F.2d 897, 902 (9th Cir. 1983) (citing *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977). In so doing, market definition furthers antitrust policy: the protection of competitive processes and not individual competitors. *Gough*, 585 F.2d at 386. But the failure to pinpoint precisely the relevant market through detailed market analysis is not uniformly fatal to a claim under Sherman Act Sec. 1. *F.T.C. v. Indiana Fed'n of Dentists*, 476 U.S. 447, 460 (1986).

[32] Because market definition and market power are merely tools designed to uncover competitive harm, proof of "actual detrimental effects, such as a reduction of output, can obviate the need ... [for] elaborate market analysis." *Id.* at 460–61, 106 S. Ct. at 2018–19. For example, in *Indiana Fed'n*, member dentists in several cities collectively withheld dental x-rays from dental insurers seeking to evaluate patients' claims for benefits. The F.T.C. found that the policy violated section one of the Sherman Act and issued a cease and desist order under section five of the F.T.C. Act. The dentists challenged the F.T.C. order for a lack of specific findings concerning the definition of the market in which competition was unreasonably restrained. The Supreme Court affirmed the order because the F.T.C. had found actual adverse effects on competition in those areas where the federation dentists predominated. The Court concluded that this finding of actual harm to competition, when "viewed in light of the reality that markets for dental services tend to be relatively localized, [was] legally sufficient to support a finding that the challenged restraint was unreasonable even in the absence of elaborate market analysis." *Id.* at 461, 106 S. Ct. at 2019.

[33] The reasoning of *Indiana Fed'n* is applicable to the challenged restraint in this case. St. Peter's and the M.D. anesthesiologists faced no appreciable competition in serving the surgical and anesthesiological needs of the Helena area. By special verdict, the jury found that the exclusive anesthesia contract and the termination of Oltz had actual detrimental effects on competition among anesthesia service providers in that area. The evidence amply supports that finding. Some patients and surgeons who preferred the services of Oltz were hindered from obtaining them. Furthermore, the price of anesthesia services and the incomes of the M.D. anesthesiologists rose dramatically because of the challenged restraint. Given that the ability to raise price and to exclude competition are hallmarks of market power, the finding of actual harm to competition suffices under Sherman Act Sec. 1 even in the absence of extended market analysis.

[34] St. Peter's next seeks a judgment notwithstanding the verdict, arguing that the exclusive contract was short in duration and served a legitimate business purpose and that Oltz' billing contract was terminable at will. . . .

[35] In support of this argument, St. Peter's has cited us several authorities that have denied relief for exclusive staffing arrangements at hospitals. These authorities recognize that exclusive arrangements generally permit hospitals to

control the identity, number and quality of persons who work there. *See, e.g., Konik v. Champlain Valley Physicians Hosp. Medical Center*, 733 F.2d 1007, 1014–15 (2d Cir.); *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346, 1353–54 (7th Cir. 1982). St. Peter's even asserts that no reported decision has upheld Sherman Act liability against a hospital because of an exclusive staffing arrangement. Furthermore, St. Peter's forecasts that its liability will mean no hospital in a small rural community could ever negotiate an exclusive contract with a group of anesthesiologists without running afoul of the antitrust laws.

[36] St. Peter's argument is flawed in at least two respects. First, the argument ignores one-half of the conspiracy about which the jury received evidence. Ample evidence supports Oltz' claim that the M.D. anesthesiologists and St. Peter's conspired to terminate his billing contract as well as to enter the exclusive contract. Thus, the jury could justifiably have concluded that the goal was, at least partially, the elimination of Oltz as a direct competitor of the anesthesiologists. Such a goal would furnish the necessary intent for a section one claim.

[37] Second, the assertion that no rural hospital could lawfully grant an exclusive contract if St. Peter's is now liable is clearly overstated. The rule of reason requires an evaluation of each challenged restraint in light of the special circumstances involved. That the analysis will differ from case to case is the essence of the rule. As noted above, the conspiracy St. Peter's joined involved more than the establishment of an exclusive contract. The absence of a goal to remove Oltz and reduce the competition for the patients whom he served would have dramatically altered the outcome of this case. Our decision, therefore, cannot be read as establishing any rule applicable to other situations involving rural hospitals engaged in exclusive contracts for staff privileges. The legality of those arrangements will depend on their individual case merit.

[38] The final issue raised by St. Peter's concerns the jury's finding that St. Peter's conspired with the anesthesiologists. St. Peter's maintains it lacks the capacity to conspire with the anesthesiologists as a matter of law. Although " [t]he nature of an entity and its ability to combine or conspire in violation of Sec. 1 is [ordinarily] a fact question," *Los Angeles Memorial Coliseum*, 726 F.2d at 1387, St. Peter's urges us to adopt a rule of law that hospitals cannot conspire with their medical staff. Accordingly, we face a question of law and our review is de novo. *United States v. McConney*, 728 F.2d 1195, 1201 (9th Cir.) (*en banc*) (1984).

[39] The phrase "contract, combination, or conspiracy" limits application of the Sherman Act to concerted conduct by more than one person or single entity. *The Jeanery, Inc. v. James Jeans, Inc.*, 849 F.2d 1148, 1152 (9th Cir. 1988). Unilateral conduct by a single entity does not implicate Sherman Act Sec. 1 regardless of the magnitude of the restraint on competition; only section two covers unilateral conduct. *Id.* (citing *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 767 (1984)). In *Copperweld*, the Supreme Court concluded "officers or employees of the same firm do not provide the plurality of actors imperative for a Sec. 1 conspiracy." 467 U.S. at 769. "The officers of a single firm are not separate economic actors pursuing separate economic interests, so agreements among them do not suddenly bring together economic power that was previously pursuing divergent goals." *Id.* Thus, no dangers against which section one was designed to protect can arise. *Id.*

[40] In holding a hospital legally incapable of conspiring with its medical staff under Sherman Act Sec. 1, some courts have relied on the rule that a corporation cannot conspire with its officers and directors. *See Weiss v. York Hosp.*, 745 F.2d 786, 814-17 (3d Cir. 1984); *Potters Medical Center v. City Hosp. Ass'n*, 800 F.2d 568, 573 (6th Cir. 1986). The Eleventh Circuit, however, has rejected the analogy. *Bolt v. Halifax Hosp. Medical Center*, 851 F.2d 1273, 1280 (11th Cir. 1988). In *Bolt*, a physician whose staff privileges were revoked alleged a conspiracy in violation of Sherman Act Sec. 1 among the hospital and the members of the medical staff who conducted the peer review that caused his termination.. The court reasoned that the hospital and each member of the medical staff were legally separate entities. Their relationship, therefore, differed from the relationship between a corporation and its officers or employees, whose acts more frequently fall within the scope of their agency.

[41] We find *Bolt* persuasive. Although the M.D. anesthesiologists may have been the agents of St. Peter's for some purposes, their interests were not as wed as the ties between a corporation and its officers or employees. St. Peter's did

not pay the anesthesiologists a salary; they billed the patients they served directly. The anesthesiologists were independent contractors pursuing their personal economic interests when they pressured St. Peter's to eliminate Oltz as a direct competitor. Those interests were sufficiently independent so that the collaborated conduct between the anesthesiologists and St. Peter's coalesced economic power previously directed at disparate goals.

[42] St. Peter's relies on *Weiss v. York Hosp.* in arguing that St. Peter's could not conspire with the anesthesiologists because they were too closely related to manifest bilateral conduct under Sherman Act Sec. 1. 745 F.2d 786 (3d Cir. 1984). *Weiss*, however, is readily distinguishable. There, an osteopath who was denied staff privileges alleged a conspiracy among the entire medical staff and the hospital. "The medical staff was empowered to make staff privilege decisions on behalf of the hospital." As a result, the court reasoned that the staff, as an entity, acted for the hospital like an officer would have acted for a corporation. This relationship precluded a finding of conspiracy.

[43] Unlike the staff in *Weiss*, the M.D. anesthesiologists were not empowered to act for St. Peter's. The board of trustees held the power to terminate Oltz and award the exclusive contract. Therefore, the anesthesiologists were not acting like an officer in relation to the corporation, and St. Peter's had the capacity to conspire with them.

[44] Arguing in the alternative, St. Peter's maintains the evidence of conspiracy does not support the verdict. . . .

[45] Because direct evidence of concerted action in violation of antitrust laws is so rare, the Supreme Court has traditionally granted fact finders some latitude to find collusion or conspiracy from parallel conduct and inferences drawn from the circumstances. *See American Tobacco Co. v. United States*, 328 U.S. 781 (1946). Such latitude is not without limits, and courts have fashioned various tests designed to limit the permissible situations justifying inferences of conspiratorial conduct. *E.g.*, *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752, 764 (1984) (the evidence must tend to exclude the possibility of independent rather than collusive action) . . . .

[46] Relying on these authorities, St. Peter's contends that Oltz offered no evidence of a motivation for St. Peter's to enter the conspiracy and no evidence of conduct by St. Peter's against its own independent economic interest. But, contrary to St. Peter's contention, the jury did not need to infer conspiracy from circumstantial evidence. As the district court found below, ample direct evidence of collusion was offered to the jury. Oltz and the anesthesiologists feuded for a substantial period, and in 1979, all the anesthesiologists threatened to leave unless Oltz' status as a free-lance operator ended. Minutes of the Board of Trustees indicate that the board knew about the threat and feared the quality of the hospital might deteriorate as a result. From such evidence, the jury justifiably could have concluded that the trustees knew of and submitted to pressure from the anesthesiologists, thereby joining the conspiracy.

[. . .]

CONCLUSION

[47] St. Peter's has presented no grounds for reversal of the jury's verdict on liability. The district court did not improperly define the relevant market, and St. Peter's did not lack capacity to conspire with the M.D. anesthesiologists. Moreover, ample evidence supports the jury findings of conspiracy, intent, and injury to competition. . . .

AFFIRMED AND REMANDED.

Oksanen v. Page Memorial Hosp.

945 F.2d 646 (4th Cir. 1991)

Judge Wilkinson.

[1] Appellant Dr. Owen D. Oksanen contends that the Sherman Antitrust Act was violated when the medical staff of Page Memorial Hospital allegedly conspired amongst itself and with the hospital's Board of Trustees to revoke Oksanen's staff privileges. Whether such conspiracies are cognizable under federal antitrust law has significant

implications for the nation's health care system because the peer review process that Oksanen challenges has become an important element of hospital governance.

[2] In our view, the Board of Trustees and the medical staff of Page Memorial comprised a single entity during the peer review process. Because an entity cannot conspire with itself, the Board and the staff lacked the capacity to conspire. *See Copperweld Corp. v. Independence Tube Corp.,* 467 U.S. 752 (1984). While the members of a medical staff may have the capacity to conspire among themselves, such a conspiracy did not occur in this case. We likewise affirm the district court's dismissal of Oksanen's other claims and its refusal to cloak in federal antitrust law what is in essence a workplace dispute.

[3] Upon completing a residency program in 1978, Dr. Owen D. Oksanen began practicing family medicine in Luray, Virginia. Luray is located in Page County, a county of approximately 18,000 residents. In 1979, Oksanen received full medical staff privileges at the sole hospital in Page County, the fifty-four bed Page Memorial Hospital.

[4] This hospital, like many others, has an organizational structure with three components. First, the Board of Trustees operates as the hospital's governing body with final decisionmaking authority on issues affecting the hospital. Second, day to day management of the hospital is vested in a hospital administrator. In this case, John S. Berry was the administrator responsible for supervising the hospital's staff of nurses, laboratory personnel, and other providers of services. Third, the physicians at the hospital are organized as a medical staff. Dr. Oksanen became a member of the staff by virtue of being granted staff privileges. Other members of the medical staff included Dr. Ancheta who primarily practiced general surgery, Dr. Horng who was also a surgeon, Dr. Holsinger a family practitioner, and Dr. Dale who was admitted to the staff in August of 1983 and practiced as an internist.

[5] Page Memorial itself does not directly employ the physicians on the medical staff, but rather provides a facility for physicians to treat those of their patients who need hospital care. The hospital encourages physicians to seek staff privileges by providing staff members with office space and allowances for expenses. As part of the medical staff's relationship with the hospital, it engages in a process known as peer review. During peer review, the members of the medical staff make recommendations to the Board on whether physicians meet the standards for practicing medicine at the hospital in the first instance and on whether a physician will be able to continue practicing once he or she has been accorded staff privileges.

[6] Almost immediately after the medical staff granted privileges to Oksanen the complaints about his conduct began. For example, in October 1979, administrator Berry wrote to Oksanen questioning his attitude toward the use of laboratory facilities and the treatment of laboratory personnel. The chronicle of complaints pertaining to Oksanen's abusive attitude mounted over time. Oksanen reportedly addressed or referred to hospital employees and third party professional reviewers with profanity. In another incident, this time in the emergency room, he termed the mother of a young patient a "red neck from Stanley." Many of Oksanen's outbursts were made publicly and disrupted hospital operations. One nurse who worked with him commented that he "has a volatile personality and you just don't know when it's going to erupt."

[7] Oksanen contends that the friction which developed at the hospital could not be attributed to him alone. He responds that his actions simply reflected his concern with the quality of patient care at the hospital. For instance, he states that he questioned whether Drs. Horng and Ancheta recognized the appropriate limitations on their surgical abilities. As a result, he began referring his patients to other hospitals where he contended they would receive a better quality of care. Oksanen also claims that his poor relationship with Dr. Holsinger stemmed from his earlier refusal to accept a position in Dr. Holsinger's office.

[8] Unfortunately, relations between Oksanen and other members of the hospital and medical staffs only worsened over time. In May of 1983, Oksanen publicly reprimanded a nurse and her supervisor for allegedly providing poor care to his patients. When the nurses attempted to respond, Oksanen refused to discuss the matter, threw down his charts, and left the area. Oksanen's actions spurred hospital administrator Berry to request that the medical staff, in

accordance with Medical Staff Bylaws, investigate the incident. The medical staff declined, however, to take disciplinary action against Oksanen.

[9] Oksanen's involvement in another incident, however, did motivate the hospital to take action against him. In response to a letter to all physicians from the President of the Board seeking a harmonious working environment, Oksanen wrote the Board that its letter was "demeaning [and] insulting." Oksanen further indicated that he would not cooperate with the Board's efforts unless the Board retracted its letter and a Trustee personally retrieved the letter from his office. The Board of Trustees discussed Oksanen's response at its July 12, 1983 meeting. Dr. Holsinger, the only physician who also served on the Board, was absent from the meeting. Dr. Ancheta and administrator Berry both told the Board that they believed disciplinary actions against Oksanen were appropriate. The Board voted unanimously to request that the medical staff take corrective action against Oksanen. The Board, based on the staff's earlier refusal to take action against Oksanen, warned that if action was not taken against Oksanen, it would be forced to evaluate more thoroughly his hospital privileges during the annual credentialing process.

[10] In response, the medical staff voted to revoke Oksanen's staff privileges. Oksanen then appealed this decision to a joint conference committee comprised of Dr. Ancheta and two members of the Board. This committee heard testimony from sixteen witnesses, including Oksanen. Some witnesses testified to Oksanen's competence, while other witnesses testified to the corrosive impact of Oksanen's behavior on staff morale and relations. For instance, the committee heard testimony that Dr. Oksanen initially rebuffed a suggestion by administrator Berry that they meet to discuss a concern about patient care raised by Oksanen. Then one night around 10:30 p.m. Oksanen called Berry at home demanding that they meet later that night to discuss the concern and stating that he would call back every twenty minutes until a meeting was arranged. Eventually Oksanen agreed to meet with Berry, two nursing supervisors, and the Chief of Staff the next morning at the hospital, but Oksanen failed to appear for the meeting even though he apparently was in the hospital and had been paged. After considering the body of evidence relating to Oksanen, the joint conference committee recommended to the Board that, at a minimum, his privileges be suspended.

[11] The Board then in October of 1983 held a meeting at which Oksanen and his attorney argued against the committee's recommendation. The Board voted 9-2, with Dr. Holsinger abstaining, to suspend Oksanen's privileges for a two-month period, to be followed by a grant of privileges on a one-year probationary basis. The Board also stated that members of the medical and hospital staffs would be expected to cooperate with Oksanen during his probationary period.

[12] Around the time of the suspension, public interest in Oksanen's relationship with the hospital began to increase, stimulated in part by Oksanen's own actions. A few days after the suspension, Oksanen held a news conference at which he appealed for community support in his confrontation with the hospital. During the conference, he also questioned the competence of one surgeon practicing at Page Memorial and expressed his belief that Dr. Holsinger's alleged control over the local nursing home was preventing him (Oksanen) from admitting patients to the home. A group of Oksanen's patients formed the nucleus of a committee that campaigned to elect their representatives to the Hospital's Board of Trustees. Four representatives were elected to the Board, including a replacement for Dr. Holsinger.

[13] Oksanen made some conciliatory gestures toward the medical staff when he began his probationary period in January, 1984. It appears, however, that relations between the medical staff and Oksanen had been irreparably harmed. During the probationary period, Oksanen and the medical staff traded charges that they were not living up to the conditions imposed on them by the Board. The hospital administration continued to receive further complaints relating to Oksanen's disruptive behavior. On May 8, 1984, the Board of Trustees again requested the medical staff to take corrective actions against Oksanen. This set in motion the same administrative process that previously had evaluated Oksanen's conduct. The joint conference committee heard, among other things, testimony expressing concern that Oksanen's delay in providing care threatened the welfare of a mother and her newborn child. Hospital and medical staff members also complained that Oksanen's failures to communicate with them and to fulfill his duties to provide emergency room coverage jeopardized patient care. The medical staff eventually recommended that

Oksanen's privileges be permanently revoked. Before the Board made a final decision, Oksanen resigned from the staff on June 27, 1984.

[14] After his resignation, Oksanen remained on the staff at nearby Shenandoah Memorial Hospital and he continued to practice medicine in Virginia through the end of 1984. In September, 1984 the Virginia Board of Medicine initiated disciplinary proceedings against Oksanen. These proceedings concluded in a consent order reprimanding Oksanen for practicing medicine without a valid license and for negligence in the death of a patient in March, 1984.

[15] In 1988, Oksanen brought suit against Page Memorial and the members of its medical staff. He contended that the revocation of his staff privileges and other activities allegedly engaged in by the defendants violated sections one and two of the Sherman Act, the Virginia Antitrust Act, and other state law provisions. On the section one claim, the district court recognized that as a matter of law the defendants may have lacked the capacity to conspire, but did not base its decision on intracorporate immunity. Instead, the court concluded that Oksanen had failed to prove the existence of a conspiracy. The court then granted summary judgment for the defendants on all counts.

[16] Oksanen appealed from that judgment. The defendants argued that they were legally incapable of conspiring. A panel of this circuit concluded, to the contrary, that defendants had the capacity to engage in an antitrust conspiracy. The panel went on to reverse the grant of summary judgment, ruling that Oksanen had not been given an adequate opportunity for discovery. *Oksanen v. Page Memorial Hosp.*, 912 F.2d 73 (4th Cir. 1990).

[17] The court then voted to rehear the case *en banc*. . . .

[18] To prove a violation of section one of the Sherman Act, 15 U.S.C. § 1, a plaintiff must show the existence of an agreement in the form of a contract, combination, or conspiracy that imposes an unreasonable restraint on trade. Oksanen advances two different but related theories on whether an impermissible contract, combination, or conspiracy existed in this case. He first contends that during the peer review process, the medical staff conspired with the hospital to exclude him from practicing medicine at Page Memorial. Oksanen also argues that the members of the medical staff, during the peer review process and on other occasions, conspired among themselves to exclude him from the market. [. . .]

[19] Section one of the Sherman Act applies only to concerted action; unilateral conduct is excluded from its purview. Proof of concerted action requires evidence of a relationship between at least two legally distinct persons or entities. Oksanen contends that this plurality requirement is met in this case because the medical staff and the hospital are legally discrete entities. We think, to the contrary, that the staff is acting as an agent of Page Memorial Hospital during the peer review process and as such is indistinct from the hospital.

[20] Our view is premised upon the principle of intracorporate immunity announced in *Copperweld Corp. v. Independence Tube Corp.,* 467 U.S. 752 (1984). *Copperweld* established that the unilateral actions of a single enterprise are immune from the coverage of section one despite any corresponding restraint on trade. As an example of unilateral conduct, the Court pointed to agreements among corporate officers. "The officers of a single firm are not separate economic actors pursuing separate economic interests, so agreements among them do not suddenly bring together economic power that was previously pursuing divergent goals." Applying that reasoning, the Court held that agreements between a parent corporation and its wholly owned subsidiary are not concerted actions for purposes of section one. The Court noted that a parent and its subsidiary always have a unity of interest so the law's concern with a sudden joining of independent interests is not present in such a case.

[21] We think a similar unity of interest is present in the relationship between the hospital and its staff, both of which seek to upgrade the quality of patient care. Oksanen contends, however, that intracorporate immunity should not shield the participants in the peer review process for the simple reason that the medical staff and the hospital, unlike a corporation and its officers, are legally separate entities. This argument, however, ignores the functional approach to the question of intracorporate characterization which we believe is mandated by the *Copperweld* decision. *Copperweld* in fact criticized the notion that a corporation can conspire with itself because this "looks to the form of an enterprise's

structure and ignores the reality." Consistent with *Copperweld,* we must examine the substance, rather than the form, of the relationship between the hospital and the medical staff during the peer review process. When we do so, we find ourselves aligned with those circuits recognizing the applicability of intracorporate immunity to peer review proceedings. *Nurse Midwifery Assoc. v. Hibbett,* 918 F.2d 605 (6th Cir. 1990); *Nanavati v. Burdette Tomlin Memorial Hosp.* 857 F.2d 96 (3d Cir. 1988).

[22] Like a corporation delegating authority to its officers, the Board of Trustees at Page Memorial delegated peer review decisionmaking in the first instance to the medical staff. "As such, with regard to these decisions, the medical staff operated as an officer of a corporation would in relation to the corporation." *Weiss v. York Hosp.,* 745 F.2d 786, 817 (3d Cir. 1984). In effect, the medical staff was working as the Board's agent under an "internal 'agreement' to implement a single, unitary firm's policies" of evaluating the conduct and competence of those to whom the hospital extended privileges. *Copperweld*, 467 U.S. at 769.

[23] This type of delegation of authority does not implicate the concerns of section one of the Sherman Act. The decision to conduct the peer review process does not represent the sudden joining of independent economic forces that section one is designed to deter and penalize. "[T]here are no strong antitrust concerns that would warrant a departure from traditional concepts of agency since the hospital and medical staff are not competitors." *Nurse Midwifery,* 918 F.2d at 614. Far from being a competitor with the hospital, the medical staff was in fact a natural component of the hospital's management structure.

[24] Indeed, the Supreme Court has cautioned that adopting a rule that penalized coordinated conduct "simply because a corporation delegated certain responsibilities to autonomous units might well discourage corporations from creating divisions with their presumed benefits." *Copperweld*, 467 U.S. at 771. Penalizing coordinated conduct in the health care context would not only discourage hospitals from investing authority in their medical staffs, but it would also discourage staff members from accepting and exercising delegated authority if to do so involved the omnipresent fear of antitrust treble damage suits. One presumed benefit of authorizing the medical staff to conduct the initial peer review is that it allows physicians with expertise in medical care to make an initial evaluation of whether other physicians have achieved a certain level of professional competence. *See* Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships,* 1984 Duke L.J. 1071, 1130 n.192. This and other benefits achieved by delegating peer review to the medical staff would likely be lost if the participants in the peer review process were potentially subject to antitrust liability any time they made a decision. Such a threat to the peer review process is at odds with Congress' intent to encourage the process by granting immunity to participants. It was this critical element of delegated authority that was absent in one of the principal cases relied on by appellant, *Oltz v. St. Peter's Community Hosp*., 861 F.2d 1440 (9th Cir. 1988). In *Oltz,* a group of anesthesiologists acted on their own initiative in their attempt to coerce a hospital to abandon its contract with a nurse anesthetist and enter into an exclusive contract with them. These actions were taken outside the peer review process and did not involve an entire medical staff. Because the "anesthesiologists were not empowered to act for St. Peter's," we believe the case has little relevance to the determination of whether a hospital can conspire with its medical staff during the peer review process. 861 F.2d at 1450.

[25] In the Health Care Quality Improvement Act of 1986, Congress specifically found that "the threat of . . . treble damage liability under Federal antitrust law unreasonably discourages physicians from participating in effective professional peer review." Congress further noted that "[t]here is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review." 42 U.S.C. § 11101(4) (5). This legislation, however, is not controlling in this litigation which concerns events occurring before the Act's effective date.

[26] As an additional aspect of our functional inquiry into the relationship between the hospital and the medical staff, we must assess the degree of control the hospital exercised over the staff during the peer review process. In *Copperweld,* the parent corporation's ability to exercise control over its subsidiary if the subsidiary failed to act in its best interests influenced the Court's decision that the coordinated activities of the two entities should be treated as that of a single enterprise. 467 U.S. at 771-72. Here, although the Board of Trustees sought advice from the medical staff, the Board could modify the staff's recommendations at any time and it retained ultimate responsibility for all of the

hospital's credentialing decisions. In this regard, the by-laws of Page Memorial Hospital provide that "[n]o assignment, referral, or delegation of authority by the Board of Trustees to . . . the Medical Staff . . . shall preclude the Board of Trustees from exercising the Authority required to meet its responsibility for the conduct of the hospital." The Board's ultimate control over peer review decisions enables it to employ peer review to pursue its interests.

[27] Moreover, a hospital's interests generally would not be furthered by engaging in a conspiracy to restrain competition among doctors. Given that hospitals compete for the admission of patients, they have an incentive to maximize the number of physicians to whom they grant admitting and staff privileges. If a physician is qualified and does not disrupt the hospital's operations, it is in the hospital's interest to include, not exclude, that physician. *See Weiss,* 745 F.2d at 828. These incentives apply with particular force to this case. Page Memorial was suffering a decline in admissions during the 1980s. As a result, its economic incentive was to maintain the admitting privileges of qualified physicians in the area.

[28] Oksanen seems to suggest that Page Memorial's incentives were different because it wanted to exclude him from the staff in retaliation for referring patients to other hospitals. Appellant's argument ignores the realities of the marketplace. If the hospital dismissed him for illegitimate reasons, he could presumably continue to treat at least some of his patients at Shenandoah Memorial Hospital where he remained on staff. Moreover, Page Memorial had to anticipate that Oksanen might obtain admitting privileges at another competitor hospital eager to accord privileges to a physician with his self-proclaimed large patient base. In sum, a hospital "makes its decisions to serve its own interests, not those of the staff, and thus should not be seen as a possible co-conspirator with them." P. Areeda and H. Hovenkamp, *Antitrust Law,* ¶ 1471b (1990 Supp.).

[29] Oksanen argues that even if the hospital and the medical staff are part of the same enterprise, intraenterprise immunity is inapplicable because individual doctors on the medical staff had personal stakes in the outcome of the peer review process. According to Oksanen, the physicians' personal stakes are their medical practices that would benefit if he were eliminated as a competitor. This circuit has observed that an exception to the general rule that a corporation cannot conspire with its officers or agents "may be justified when the officer has an independent personal stake in achieving the corporation's illegal objective." *Greenville Pub. Co. v. Daily Reflector, Inc.,* 496 F.2d 391, 399 (4th Cir. 1974). Since *Greenville* was decided, however, this exception has expanded and in the process has been criticized for, among other things, becoming an exception that threatens to swallow the rule. *See Nurse Midwifery,* 918 F.2d at 615; P. Areeda, *Antitrust Law,* ¶ 1471 (1986).

[30] Given the force of these criticisms, we decline to extend the personal stake exception beyond the rationale underlying the *Greenville* decision. There it was held that the president of the defendant company could conspire with it where he had a financial interest in another firm that competed with the plaintiff and would directly benefit if the plaintiff was eliminated as a competitor. 496 F.2d at 400. Here, only one member of the medical staff, Dr. Dale, could be said to have been in competition with Oksanen when any of the disputed peer review decisions occurred. Dr. Dale's areas of practice apparently overlapped somewhat with Oksanen's, but Dale did not begin practice at Page Memorial until August, 1983—well after much of the basis for disciplining Oksanen was established—and he did not take part in the proceedings leading to Oksanen's suspension. Dr. Holsinger was a family practitioner, like Oksanen, but he was not accepting new patients after 1982. Drs. Horng and Ancheta did not compete with Oksanen, but were surgeons who looked to the general practitioners for referrals. Thus, it is unclear whether any decision to eliminate Oksanen from the market would directly benefit the members of the medical staff. Drs. Holsinger, Horng, and Ancheta could conceivably have attained some benefits in the longrun if their critic, Oksanen, was no longer practicing at Page Memorial. We doubt, however, that these indirect economic interests justify a personal stake exception.

[31] In any event, the more important aspect of *Greenville* for the purposes of peer review is the degree of control the officer or agent with the independent interest exercised over the defendant firm's decisionmaking process. If the officer cannot cause a restraint to be imposed and his firm would have taken the action anyway, then any independent interest is largely irrelevant to antitrust analysis. *See* P. Areeda, *Antitrust Law,* ¶ 1471d g (1986). In *Greenville,* the individual who

had an interest in another firm was also the defendant company's president, director, and shareholder. Consequently, he could control the defendant company's decisions.

[32] Here, by contrast, the medical staff had no such control. . . . The Board of Trustees at Page Memorial requested and encouraged the medical staff to take corrective action against Oksanen. The Board in the end retained authority over staff privilege decisions at Page Memorial. Because the challenged decision was subject to review by the hospital and because decisionmaking authority in Dr. Oksanen's case was dispersed among a number of individuals, the personal stake exception is inapplicable.

[33] We thus conclude that under the principle of intracorporate immunity, Page Memorial and its medical staff lacked the capacity to conspire during the peer review process.

[34] The question remains whether the medical staff has the capacity to conspire among itself either during peer review or at other times. We recognize that a medical staff can be comprised of physicians with independent and at times competing economic interests. As a result, when these actors join together to take action among themselves, they are unlike a single entity and therefore they have the capacity to conspire as a matter of law. *See Nurse Midwifery,* 918 F.2d at 614. To conclude that members of the medical staff have the capacity to conspire among themselves does not mean, however, that every action taken by the staff satisfies the contract, combination, or conspiracy requirement of section one. *See Cooper v. Forsyth County Hosp. Auth.,* 789 F.2d 278, 281 n.12 (4th Cir. 1986); *Bolt,* 891 F.2d at 819. The Supreme Court in *Monsanto Co. v. Spray-Rite Service Corp.* established the governing standard for what constitutes sufficient evidence to permit the inference of an antitrust conspiracy:

> [T]here must be evidence that tends to exclude the possibility of independent action. . . . That is, there must be direct or circumstantial evidence that reasonably tends to prove . . . a conscious commitment to a common scheme designed to achieve an unlawful objective. . . .

[35] Oksanen seems to suggest that the fact that the medical staff met and took action against him through the peer review process proves the existence of a conspiracy. Of course, "mere contacts and communications, or the mere opportunity to conspire . . . is insufficient evidence from which to infer an antitrust conspiracy in the context of the denial of hospital . . . privileges." *Cooper,* 789 F.2d at 281. Simply making a peer review recommendation does not prove the existence of a conspiracy; there must be something more such as a conscious commitment by the medical staff to coerce the hospital into accepting its recommendation. To speak of a conspiracy among a medical staff during the peer review process is not very meaningful in antitrust terms if the staff lacks the final authority to implement any agreement that it does reach. In this case, there is no evidence that the staff attempted to usurp the Board's power to make the final decision on Oksanen's status. Nor is there any evidence that the staff illicitly agreed to exclude Oksanen from the market or engaged in anticompetitive activity outside the official meeting and hearing process.

[36] "That the challenged conduct . . . is consistent with legitimate activities also weighs against inferring a conspiracy." *Cooper,* 789 F.2d at 282 n.14. Here, the conduct of a peer review proceeding, a proceeding mandated by state law and by accrediting agencies, is certainly a legitimate activity designed to enhance the quality of care and to provide a harmonious working environment for all the hospital's staff. That the medical staff's actions during the peer review process were legitimate is further evidenced by the fairness of the procedures used to discipline Oksanen. The defendants made many attempts to resolve the complaints against Oksanen short of taking formal disciplinary actions. When disciplinary action finally was taken, it was incremental: Oksanen was initially placed on probation and only later were his privileges permanently revoked after additional complaints were received about his conduct. Additionally, before Oksanen's privileges were suspended for the first time, a hearing was held at which he was represented by counsel and had the opportunity to call witnesses.

[37] We are not suggesting that the antitrust laws are designed to achieve fairness or due process, but when due process is accorded a disgruntled physician it only enhances the legitimacy of a hospital and medical staff's actions. *See* Havighurst, *Doctors and Hospitals,* 1984 Duke L.J. at 1132–33; *see also* 42 U.S.C. § 11112 (according immunity from antitrust litigation to peer reviewers when certain procedural safeguards are observed). The litany of complaints from

a variety of sources concerning Dr. Oksanen provides ample evidence that the doctors on the staff were justified in disciplining a fellow physician who was perceived to be both unprofessional and uncooperative. Where, as here, the peer review process has been operating in accordance with proper procedures, under the aegis of the hospital, and with a substantial basis in the evidence, the likelihood of an antitrust conspiracy is also substantially diminished. [. . .]

III.

[38] Oksanen also bears the burden of proving under section one of the Sherman Act that any concerted action that did take place caused an "antitrust injury" by imposing an unreasonable restraint on trade. The focus of the antitrust laws is on promoting competition. *National Collegiate Athletic Assn. v. Board of Regents,* 468 U.S. 85, 103 (1984). As a result, a plaintiff cannot demonstrate the unreasonableness of a restraint merely by showing that it caused him an economic injury. For example, the fact that a hospital's decision caused a disappointed physician to practice medicine elsewhere does not of itself constitute an antitrust injury. *Jefferson Parish Hosp. Dist. No. 2 v. Hyde,* 466 U.S. 2, 31 (1984). If the law were otherwise, many a physician's workplace grievance with a hospital would be elevated to the status of an antitrust action. To keep the antitrust laws from becoming so trivialized, the reasonableness of a restraint is evaluated based on its impact on competition as a whole within the relevant market. *See Atlantic Richfield Co. v. USA Petroleum Co.,* 495 U.S. 328 (1990).

[39] To assess the reasonableness of a restraint on trade, courts have taken one of two approaches. "In the first category are agreements whose nature and necessary effect are so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality—they are 'illegal *per se.*'" *National Soc. of Prof. Engineers v. United States,* 435 U.S. 679, 692 (1978). Certain forms of agreements, such as varieties of group boycotts, have been classified as *per se* violations. *See FTC v. Superior Ct. Trial Lawyers Ass'n.,* 493 U.S. 411 (1990). Oksanen seems to contend that the combined actions of the hospital and the medical staff amounted to a group boycott and should be classified as *per se* violations of the Act. The Court has cautioned, however, that the category of restraints classed as group boycotts should not be expanded indiscriminately, particularly where, as here, the economic effects of the restraint are far from clear. *FTC v. Indiana Fed. of Dentists,* 476 U.S. 447, 458–59 (1986).

[40] We believe that the second approach to analyzing restraints, the rule of reason, is applicable to this case. Under the rule of reason, Oksanen bears the burden of proving that the actions of the defendants have unreasonably restrained trade. *See, e.g., Hyde,* 466 U.S. at 29. To meet this burden, Oksanen must prove what market he contends was restrained and that the defendants played a significant role in the relevant market. Absent this market power, any restraint on trade created by the defendants' actions is unlikely to implicate section one.

[41] Oksanen asserts, with little proof, that Page County is the relevant market and that Page Memorial and its medical staff exert complete control over the market. Although Page Memorial may be where Oksanen prefers to practice, this preference alone does not justify excluding other hospitals and other doctors from the relevant market definition. Oksanen's narrow market definition violates a fundamental tenet of antitrust law that the relevant market definition must encompass the realities of competition. *See United States v. Grinnell Corp.,* 384 U.S. 563, 572–73 (1966). The defendants note that they compete with hospitals and doctors in surrounding counties. For example, four hospitals, aside from Page Memorial, are situated within twenty-five miles of Page County. Based on statistics derived from a 1979 study, Page Memorial's share of the market served by these five hospitals is 5.2%. Moreover, 53.8% of Page County's residents went to hospitals other than Page Memorial, including Rockingham Memorial which attracted 30% of all Page County residents in 1979. Under these circumstances, we doubt whether the defendants possess the market power necessary to significantly restrain trade.

[42] Of course, a detailed inquiry into a firm's market power is not essential when the anticompetitive effects of its practices are obvious. *Federal Trade Commission v. Superior Court Trial Lawyers Ass'n.,* 493 U.S. 411. If any anticompetitive effects exist in this case, however, they are far from clear. For instance, Oksanen has neither demonstrated a rise in the price of medical services above a competitive level nor a decrease in the supply of doctors in the relevant market. In fact, from August 1983 to 1987 seven additional doctors began practicing at Page Memorial. The aphorism that

"the antitrust laws were enacted for 'the protection of *competition,* not *competitors*'" rings true in this case. *Atlantic Richfield,* 110 S.Ct. at 1891 (quoting *Brown Shoe Co. v. United States* (1962)). This case is not one in which a representative of a class of competitors is being excluded from the market. *Cf. Oltz* (attempt to exclude nurse anesthetist); *Cooper* (attempt to exclude podiatrists); *Weiss* (attempt to exclude osteopath). Oksanen, as an individual competitor, may have been hurt by the hospital's decision to revoke his privileges, but there is no evidence that competition as a whole in the relevant market has been harmed.

[43] Moreover, the peer review process, by policing the competence and conduct of doctors, can enhance competition. "By restricting staff privileges to doctors who have achieved a predetermined level of medical competence, a hospital will enhance its reputation and the quality of care that it delivers." *Weiss,* 745 F.2d at 821 n.60. Similarly, the friction created between a hospital and a doctor with a legacy of trouble in interpersonal relationships can decrease efficiency, discourage other qualified doctors from joining the staff, and detract from a hospital's ability to provide quality patient service. *Id.*

[44] In sum, the anticompetitive effects are by no means so clear and one-sided as Oksanen would have them, and the revocation of Oksanen's staff privileges, while undoubtedly impacting adversely on his practice, has not been shown to have had any adverse impact on competition in the relevant market. Consequently, his section one claim fails. [. . .]

VI.

[45] This case illustrates well the dilemma that hospitals face when they consider disciplining a physician by altering his admitting privileges. On the one hand, if the hospital failed to discipline a physician against whom documented complaints were legion, the efficiency of the entire institution could be affected and the hospital could even be exposing itself to malpractice liability. Yet, if the hospital takes corrective action, it and its medical staff face the prospect of a disgruntled physician bringing an antitrust suit against them.

[46] In our view, the antitrust laws were not intended to inhibit hospitals from promoting quality patient care through peer review nor were the laws intended as a vehicle for converting business tort claims into antitrust causes of action. While we cannot say that no peer review decision would ever implicate the Sherman Act's concern for competition, this assuredly is not such a case. Page Memorial simply took measured steps to discipline an imperious physician. In taking these actions, Page Memorial and its medical staff have violated neither federal nor state law. The judgment of the district court is therefore

AFFIRMED

* * *

Oksanen is just one of many examples of litigation filed by disgruntled physicians who claimed disciplinary actions taken against them as a result of peer review violated the antitrust laws. These physicians have claimed that peer review decisions that impaired their hospital privileges constituted a conspiracy in restraint of trade under Section 1 of the Sherman Act, an act of monopolization (or attempted monopolization) under Section 2, or (as Dr. Oksanen argued) both. Many of these cases were filed in the 1980s and 1990s (and some continued to be filed, albeit at a slower pace, into the new century).[122] Over the years plaintiffs have lost the vast majority of these cases on many grounds, including lack of conspiracy (in Section 1 cases) and failure to show anticompetitive effect (in both Section 1 and 2 cases).[123] But early in this litigation parade, one disgruntled physician who had lost his hospital privileges in Astoria, Oregon, a small town near the mouth of the Columbia River, won his antitrust lawsuit big time. Dr. Timothy Patrick sued 11 physicians who sat on the hospital's peer review committee, accusing them of conspiring to deprive him of hospital privileges so as to eliminate him as a competitor in the community. The claim made a trip to the Supreme Court (where the Court

[122] Peter J. Hammer, *How Doctors Became Distributors*, 14 Loy. Consumer L. Rev. 411, 421 (2002) ("one-third of all health care antitrust cases between 1985 and 1999 consisted of staff-privilege disputes").

[123] *Id.* (plaintiffs won only 9% of staff privilege cases between 1985 and 1999).

held that the state action doctrine did not protect the defendants[124]) and ultimately resulted in a jury verdict of $2.2 million against the physicians.[125] After that, according to an article that appeared on the front page of the Sunday New York Times, all but two of the doctors left Astoria, "embittered and financially crippled by the years of litigation."[126] Congress was aware of the *Patrick* case as it dragged through the courts and responded[127] by enacting the Health Care Quality Improvement Act of 1986—a statute sponsored by then-Rep. Ron Wyden of Oregon.[128]

Congress found (in the preamble to the statute) that it is important to improve quality of care in the U.S.—and that one way to improve quality is to encourage peer review to weed out incompetent physicians. But, the findings recognized, physicians would be reluctant to participate in peer review (or perhaps would refuse to participate altogether) if they were exposed to the threat of treble damage actions which could—as it did in Astoria—ruin them financially. So, Congress enacted the HCQIA to encourage peer review by immunizing physicians who participate in effective peer review activities.

Congress did not provide absolute immunity to physicians participating in peer review. Instead, Congress protected physicians who participated in peer review so long as they could show any disciplinary action imposed was the result of (i) a reasonable belief the action was in furtherance of quality health care, (ii) taken after a reasonable effort to obtain the facts of the matter, (iii) after adequate notice and hearing procedures to the physician involved, and (iv) taken in the reasonable belief that the action was warranted by the facts.[129] Although it may seem dauting to physicians who have been sued in a peer review case to establish "the four reasonables," as these requirements have come to be known, in practice courts have been sympathetic to physicians participating in peer review and in many cases where the HCQIA is raised, physicians either have won summary judgment under the HCQIA or have won after trial.[130]

Physicians can be excluded from a hospital's medical staff in various ways—losing hospital privileges as a result of a peer review action is just one way. But a hospital can enter into an exclusive provider of certain services (anesthesia, pathology, radiology, and emergency services are common examples), it can "close" a department and take no further applicants, or it can impose residency qualifications such as requiring that physicians live or practice within a certain distance of the hospital to qualify for the active medical staff. The opinion below, written by a future Supreme Court justice, shows how courts often deal with exclusion claims that don't involve peer review activities.

Four Corner Nephrology Associates v. Mercy Medical Center of Durango

582 F.3d 1216 (10th Cir. 2009)

Judge Gorsuch.

[1] To provide Durango, Colorado, residents and Southern Ute Indian tribe members with greater access to kidney dialysis and other nephrology services, Mercy Medical Center, a non-profit hospital, together with the tribe, sought to entice Dr. Mark Bevan to join the hospital's active staff. When Dr. Bevan declined, the hospital hired somebody else. To convince that physician and others to settle in Durango, and aware that starting a nephrology practice was likely to prove unprofitable for the foreseeable future, the hospital and tribe agreed to underwrite up to $2.5 million in losses

[124] Oregon law mandated peer review at hospitals, but state authorities did not review individual peer review actions. The Supreme Court held that this statutory scheme did "not establish a state program of active supervision over peer review decisions" and so such decisions were not immunized as state action. Patrick v. Burget, 486 U.S. 94, 102 (1988).

[125] After trebling and adding plaintiff's legal fees, the judgment would amount to about $20 million in 2024 dollars.

[126] Kenneth Noble, *How Doctors Judge Peers Is Challenged*, N.Y. Times, p. 1 (March 13, 1988) https://www.nytimes.com/1988/03/13/us/how-doctors-judge-peers-is-challenged.html.

[127] *See* Charity Scott, *Medical Peer Review and Antitrust*, 50 Maryland L. Rev. 316, 328 (1991) ("During congressional consideration of HCQIA, the most often invoked example of peer-review litigation run amok-and of the chilling effect such litigation was said to have on legitimate peer review activities—was the federal district court's damage award in *Patrick v. Burget*.").

[128] Codified at 42 U.S.C. § 11101 *et seq*.

[129] 42 U.S.C. § 11102. The statute sets out a safe harbor for what constitutes adequate notice and hearing procedures.

[130] *See, e.g.*, Rare Physician Win in Peer Review Lawsuit, Faegre Baker Daniels (March 14, 2017), https://www.jdsupra.com/legalnews/rare-physician-win-in-peer-review-65575/.

they expected the practice to incur. To protect its investment, Mercy made its new practice the exclusive provider of nephrology services at the hospital.

[2] In response, Dr. Bevan sued. He contended that Mercy's refusal to deal with other nephrologists, including himself, amounted to the monopolization, or attempted monopolization, of the market for physician nephrology services in the Durango area. The district court granted summary judgment to the hospital, and we affirm for two reasons. First, the hospital has no antitrust duty to share its facilities with Dr. Bevan at the expense of its own nephrology practice. Second, in demanding access to Mercy's facilities, Dr. Bevan seeks to share-not to undo-the hospital's putative monopoly. That, of course, is not what the antitrust laws are about: they seek to advance competition, not advantage competitors.

[3] Viewing the facts in the light most favorable to Dr. Bevan as the summary judgment non-movant, they reveal that Dr. Bevan and his associates at Four Corners Nephrology Associates, P.C., enjoy a thriving practice based in Farmington, New Mexico. For years, patients throughout the Four Corners area (where Colorado, Utah, New Mexico, and Arizona meet) have traveled to Dr. Bevan's office to receive kidney dialysis and other outpatient nephrology services. These include patients from Durango, Colorado, and its nearby Southern Ute Indian reservation, many of whom require dialysis three times per week. Each round-trip drive between Durango and Farmington can take these patients an hour-and-a-half or more.

[4] In part because of the distance to Farmington and the prevalence of kidney disease in the Durango area, most acutely among members of the Southern Ute tribe, the tribe, Mercy hospital, and the Durango Rotary Club all sought for many years to convince Dr. Bevan to provide kidney dialysis and other nephrology services in Durango. Dr. Bevan consistently declined these invitations. While Dr. Bevan held consulting medical privileges at Mercy, and occasionally took inquiries by phone from doctors there, the last time he entered the Durango hospital to treat patients was in 1995.

[5] Unable to lure Dr. Bevan to town, Mercy and the tribe decided to undertake a joint effort to recruit another nephrologist. After extensive interviews, the tribe selected Dr. Mark Saddler, who agreed to come to Durango in 2005-but on a condition. Concerned that patient numbers in Durango would not provide him with the income he previously enjoyed, Dr. Saddler insisted that the hospital employ him on a salaried basis. The hospital agreed. Anticipating that its new nephrology practice would lose money for many years, the hospital also agreed to underwrite losses of up to $500,000 over seven years, while the tribe agreed to backstop certain additional losses, depositing $2 million into a trust fund for that purpose. In addition, Dr. Saddler was permitted to serve as the director of a new, independently owned outpatient dialysis center in Durango.

[6] Under Mercy's preexisting bylaws, the employment of Dr. Saddler as a full-time active nephrologist automatically terminated Dr. Bevan's consulting privileges. The point of consulting staff members, the bylaws make clear, is limited to filling gaps in the expertise of the hospital's active staff: "Consulting Staff consist of providers who offer services required or desired but not otherwise provided by an Active Medical Staff member." Mercy Medical Staff Bylaws, J.A. at 419. While no longer eligible to serve as a consulting staff member, Dr. Bevan was able, consistent with the hospital's bylaws, to remain a member of its courtesy staff, a position that allowed him to consult and write orders with the permission of an attending physician.

[7] Unsatisfied with these developments, Dr. Bevan, along with one of his associates at Four Corners Nephrology, filed an application to become a member of the hospital's active staff, on par with Dr. Saddler and competing with the hospital's nephrology practice. Mercy's bylaws did not forbid the hospital from having two active staff members with the same expertise, but they did present at least one significant hurdle for Dr. Bevan. Unlike members of the consulting staff, members of the hospital's active staff were obliged by the bylaws to reside within 30 minutes of the hospital in order to be available to provide emergency care. To meet this mandate, Dr. Bevan, who continued to live in Farmington, first suggested that he resided in Durango office space. When that gambit failed to persuade hospital authorities, he told Mercy he had leased a residence near Durango, which, on investigation, turned out to be a plot of vacant land.

[8] As these events unfolded, Mercy decided to preempt any future application from Dr. Bevan and his colleagues by designating its nephrology practice—now including Dr. Saddler and a partner—as the sole provider of nephrology services to the hospital. Mercy cited several factors contributing to its decision. First, hospital administrators expressed concern that granting active staff membership to Dr. Bevan and other Four Corners Nephrology doctors would reduce the volume of patients for Dr. Saddler and his partner to the point where they would lose technical proficiency or leave for better jobs. Second, while Mercy and the tribe anticipated that the hospital's new nephrology practice would operate at a loss, they feared that granting staff privileges to other nephrologists would exacerbate those losses, causing the hospital to draw down the Southern Ute and hospital subsidies more rapidly. Ultimately, the hospital feared that money would run out before its practice could become self-sustaining. Finally, Mercy administrators expressed concern that Dr. Bevan would offer a repeat performance of his actions in Page, Arizona. According to them (though disputed by Dr. Bevan), when a competing group of nephrologists opened a dialysis center in Page, about four hours west of Farmington, Dr. Bevan responded by opening his own dialysis center in Page. The town apparently couldn't support two competing clinics, however, and the competitor clinic soon closed. Shortly after that, Dr. Bevan closed his clinic in Page, leaving the town with no nephrology practice and many of its kidney dialysis patients once again with a four-hour trek to Farmington. In light of its understanding of this episode, the hospital worried that Dr. Bevan's true intentions were to destroy Durango's nephrology practice, rather than to increase the quality and quantity of nephrology services in Durango.

[9] In response to the hospital's decision, Dr. Bevan filed this lawsuit. While his complaint outlined various causes of action, for purposes of this appeal Dr. Bevan pursues only his claims that Mercy's decision to exclude him and other nephrologists from admitting patients amounted to the unlawful monopolization, or attempted monopolization, of the market for "nephrology physician services" in the "Durango area," in violation of Section 2 of the Sherman Act, 15 U.S.C. § 2, and the Colorado Antitrust Act of 1992, C.R.S. §§ 6-4-101 et seq. He now stands ready, he says, to reside in Durango and practice nephrology there, but cannot do so without some assurance he might be considered for active staff privileges at Mercy. In due course, Mercy moved for summary judgment. With respect to the antitrust claims remaining in play before us, Mercy raised many arguments. [. . .]

[10] We review the question whether to grant summary judgment de novo, and will affirm a district court's decision to do so only if, viewing the facts in the light most favorable to the non-movant, we discern no genuine issue as to any material fact and conclude that movant is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c). Undertaking this analysis, we first examine the rationale the district court offered for its grant of summary judgment to Mercy, before then turning to consider two alternative bases the hospital has proffered for affirmance. [. . .]

[11] Mercy argues that its refusal to deal with Dr. Bevan does not constitute anticompetitive conduct within the meaning of Section 2 of the Sherman Act or its state law analog. We agree. The Supreme Court has recently emphasized the general rule that a business, even a putative monopolist, has "no antitrust duty to deal with its rivals at all." *Pac. Bell Tel. Co. v. Linkline Commc'ns, Inc.*, 555 U.S. 438 (2009) ("As a general rule, businesses are free to choose the parties with whom they will deal, as well as the prices, terms, and conditions of that dealing."); *Verizon Commc'ns Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 407 (2004) ("[A]s a general matter, the Sherman Act 'does not restrict the long recognized right of [a] trader or manufacturer engaged in an entirely private business, freely to exercise his own independent discretion as to parties with whom he will deal.' " (quoting *United States v. Colgate & Co.*, 250 U.S. 300, 307 (1919)) (second alteration in original)).

[12] This presumption should hardly surprise. Allowing a business to reap the fruits of its investments "is an important element of the free-market system": it is what "induces risk taking that produces innovation and economic growth." *Id.*; *see also Christy Sports, LLC v. Deer Valley Resort Co., Ltd.*, 555 F.3d 1188, 1194 (10th Cir. 2009) ("The Supreme Court has recognized the economic value of allowing businesses to decide with whom they will deal."). Without some confidence that they can control access to their own property, real or intellectual, how many firms would be deterred from undertaking the risks associated with, say, a significant new endeavor or facility? In *Trinko*, for example, the plaintiff sought access to Verizon's local telephone network in order to sell its own, competing services. Finding that

Verizon had no antitrust duty to share its network infrastructure, the Supreme Court explained that forcing firms "to share the source of their advantage is in some tension with the underlying purpose of antitrust law, since it may lessen the incentive . to invest in those economically beneficial facilities." *Trinko*, 540 U.S. at 407–08 ("The opportunity to charge monopoly prices-at least for a short period-is what attracts 'business acumen' in the first place."). Put another way, it is the investor's potential pay-off that breeds risk-taking investment. To deny the payoff is to deter the investment.

[. . .]

[13] . . . The substance of Dr. Bevan's claim, of course, is that Mercy, after having entered the inpatient nephrology business by hiring Dr. Saddler and investing considerable sums to ensure the success of its practice, engaged in anticompetitive conduct by refusing to share its facilities with a potential rival for inpatient nephrology services. As Dr. Bevan himself puts it, "Mercy barred [him] from providing nephrology physician services on an inpatient basis in the Durango area by denying him medical staff privileges," and "having inpatient nephrology privileges is essential for a nephrologist to compete successfully [for outpatient dialysis patients]," . . . .

[14] In this, the substance of Dr. Bevan's claim, our case is analytically parallel to *Trinko* and *Christy Sports*. In both of those cases, the plaintiff argued that a putative monopolist engaged in anticompetitive conduct by failing to provide a rival access to certain of its facilities. In both of those cases, the claim was dismissed as a matter of law. In *Trinko*, the Supreme Court affirmed Verizon's refusal to deal with its rival because "possession of monopoly power [is] unlawful [only where] accompanied by an element of anticompetitive conduct," and Verizon's decision to deny a rival access to its own facilities in order to maximize its own "short-term profits" reflected "competitive zeal," not "anticompetitive malice," . . . . In the Court's view, Verizon's evident interest in pursuing short-term profits tended to belie Section 2 liability, not to suggest it. In *Christy Sports*, a ski rental company complained that the Deer Valley resort refused to extend the company's lease at the resort. Holding that Deer Valley's conduct did not offend the antitrust laws, we explained that, "[h]aving invested time and money in developing a premier ski resort, [Deer Valley] could recoup its investment in a number of ways," including "delv[ing] more deeply into the rental ski market" within the resort by declining to accommodate competitor ski rental companies on its property and keeping that opportunity for itself. *Christy Sports*, 555 F.3d at 1194–95.

[15] Much the same might be said here. Having made a substantial investment in developing its own nephrology practice-indeed, having even tried to secure Dr. Bevan's services for that practice-Mercy is entitled to recoup its investment without sharing its facilities with a competitor. And doing so may well help consumers. Prior to the hospital's arrangement with Dr. Saddler, there were no full-time nephrologists in Durango. Now there are two, Dr. Saddler and his partner. As a result, the consumers—the people of Durango and members of the Southern Ute tribe—have greater access to nephrology services: they still may travel to Farmington and Dr. Bevan's practice, but they now also enjoy other, more convenient options. . . .

[16] At the same time, the record reveals that the hospital correctly anticipated that a nephrology practice in Durango would operate at a loss for many years and would require the hospital and tribe to underwrite those losses. In reaching its decision to deny Dr. Bevan privileges at the hospital, Mercy worried that a contrary course would cause the premature exhaustion of its loss reserves and leave the town without a nephrologist. The record before us thus suggests that to force Mercy to deal with Dr. Bevan well might deter future investments of the sort the hospital and tribe made in this case-and thus to undermine, rather than promote, investment, innovation, and consumer choice, as the Supreme Court feared in *Trinko*. 540 U.S. at 407–08; *cf. Balaklaw v. Lovell*, 14 F.3d 793, 799 n. 13 (2d Cir. 1994) (finding a "pro-competitive justification" for an exclusive contract between a doctor and a hospital where the hospital judged that the doctor was most responsive to the hospital's needs).

[17] Having noted the general rule that the antitrust laws don't compel competitors to share, the rationales for that rule, and the applicability of both to the case before us, we must also recognize an exception. As the Supreme Court has explained, "[t]he high value that we have placed on the right to refuse to deal with other firms does not mean that

the right is unqualified." *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 601 (1985). In *Aspen Skiing*, the leading case delineating when a single firm's unilateral refusal to cooperate with a rival might run afoul of the antitrust laws, the defendant Ski Co., which owned and managed three Aspen ski mountains, joined with Highlands Corp., the owner of a fourth, to offer a joint ski pass. This arrangement continued for years. Eventually, however, Ski Co. decided to end the arrangement and sell passes for its three areas alone. It even refused to sell lift tickets to Highlands Corp. at the retail rates available to consumers. Ultimately, the Supreme Court held that Ski Co.'s conduct could be found to violate Section 2 because Ski Co. had disclaimed "short-run benefits and consumer goodwill in exchange for a perceived long-run [monopoly]" achieved by driving Highlands Corp. from the market.

[18] More recently, however, first in *Trinko* and then again in *Pacific Bell*, the Court has instructed us that *Aspen Skiing* lies "at or near the outer boundaries of § 2 liability," and that *Aspen Skiing* controls only where the monopolist's "unilateral termination of a voluntary (and thus presumably profitable) course of dealing suggest[s] a willingness to forsake short-term profits to achieve an anticompetitive end." *Trinko*, 540 U.S. at 409. We are told that courts should impose a duty to deal under Section 2 only "very cautious[ly], . because of the uncertain virtue of forced sharing and the difficulty of identifying and remedying anticompetitive conduct by a single firm." . . .

[19] That key fact is not present here. As was true in *Trinko* and *Christy Sports*, in the case before us "[t]here is no allegation that [Mercy] was motivated by anything other than a desire to make more money for itself." *Christy Sports*, 555 F.3d at 1197. In *Aspen Skiing*, the monopolist was willing to jettison a profitable short-term business relationship and deny to a rival the retail prices available to all other consumers. By contrast, the evidence here suggests that Mercy refused to deal with Dr. Bevan to avoid an unprofitable relationship, and that the hospital pursued the course it did to protect and maximize its chances of profitability in the short-term. Dr. Bevan himself comes close to admitting as much, accusing Mercy of harboring the "goal" of "mak[ing] its nephrology physician practice profitable,"—an accusation that does more to undercut than to underscore Section 2 liability. . . . In fact, the record before us reveals that Mercy, a non-profit entity, acted as it did merely to keep its practice from becoming so unprofitable that it would exhaust more rapidly than anticipated the reserves the hospital and tribe had set aside and leave the town and tribe without the benefit of a local nephrologist. *Aspen Skiing* does not require more economic justification than this to avoid Section 2 liability.

[20] Equally and independently problematic for Dr. Bevan is the question of antitrust injury. To succeed in a claim for monopolization or its attempt, Dr. Bevan must show not only that he was harmed by Mercy's conduct, but that the injury he suffered involved harm to competition. *See Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 489 (1977) ("[A]ntitrust injury . . . should reflect the anticompetitive effect either of the violation or of anticompetitive acts made possible by the violation."); *Elliott Indus. Ltd. P'ship v. BP Am. Prod. Co.*, 407 F.3d 1091, 1125 (10th Cir. 2005) (finding no "antitrust injury because [the defendant's conduct] has no adverse effect on competition or consumers"). After all, it is the "protection of competition or prevention of monopoly[ ] which is plainly the concern of the Sherman Act," not the vindication of general "notions of fair dealing," which are the subject of many other laws at both the federal and state level. . . .

[21] The antitrust violation Dr. Bevan alleges is Mercy's refusal to grant him active medical staff privileges, and by way of remedy he asks us, in addition to damages and other things, to order Mercy to grant him those privileges. In doing so, he does not ask us to prevent a monopoly or break one apart. Instead, what he seeks is the chance to share in Mercy's putative monopoly. The difficulty is that "[w]hen the monopolist is forced to sell [to a competitor], it sets the monopoly price and overall competitiveness is not affected at all; we simply have two firms sharing the monopoly rather than one." Areeda & Hovenkamp, *supra*, ¶ 773, at 239. That is, even if we were to force Mercy to accommodate Dr. Bevan's demand, the hospital could simply impose costs and conditions on Dr. Bevan's activities that would prevent him from undercutting the hospital's own nephrology practice. Dr. Bevan very well might be better off with such a shared monopoly, but there's no guarantee consumers would be. Whatever injury he may have suffered, then, it is not one the antitrust laws protect because "a producer's loss is no concern of the antitrust laws, which protect

consumers from suppliers rather than suppliers from each other." *Stamatakis Indus., Inc. v. King*, 965 F.2d 469, 471 (7th Cir. 1992).

[22] Dr. Bevan might reply that we could order Mercy not merely to share its facilities with him, but also dictate the terms of such an arrangement in a manner likely to help consumers. The difficulty with this tack is that the Supreme Court has recently and repeatedly reminded us that "[c]ourts are ill suited 'to act as central planners, identifying the proper price, quantity, and other terms of dealing.' " *Pac. Bell Tel. Co.*, 129 S.Ct. at 1121 (quoting *Trinko*, 540 U.S. at 408); *see also Town of Concord v. Boston Edison Co.*, 915 F.2d 17, 25 (1st Cir. 1990) (Breyer, C.J.) (listing many difficult questions that "show why antitrust courts normally avoid direct price administration, relying [instead] on rules and remedies . . . that are easier to administer"). The federal judiciary is not a price control agency. As Professor Areeda has argued, and the Supreme Court has affirmed, "[n]o court should impose a duty to deal that it cannot . . . adequately and reasonably supervise." *Trinko*, 540 U.S. at 415 (quoting Areeda, Essential Facilities, *supra*, at 853).

[. . .]

[23] Dr. Bevan's monopolization and attempted monopolization claims fail as a matter of law for at least two independent reasons: Mercy's failure to share its facilities is evidence of competitive—not anticompetitive—conduct, and whatever injury Dr. Bevan may have suffered from his exclusion from the hospital's staff, it is not one that the antitrust laws were designed to remedy. The district court's judgment is therefore

[24] Affirmed.

* * *

G. When Government Displaces Health Care Competition: Certificates of Need (CONs) and Certificates of Public Advantage (COPAs)

For decades some states have pursued policies explicitly designed to displace competition based on the view that, at least in certain situations, health care markets cannot function effectively. One approach requires a health care provider that wishes to furnish certain new or expanded services in a market first to obtain a "certificate-of-need" (CON) from a state agency based on a showing that the need for such services is not being met by existing providers. This approach is premised on the belief that *too much* competition may lead to more costly care in certain situations, and therefore government-erected barriers to entry will ensure that existing providers can survive, and additional capacity is allowed only when needed as determined by government review.

The second approach provides an antitrust exemption for conduct pursued under a "certificate of public advantage" (COPA) that meets state action requirements as delineated in *MidCal* and its progeny.[131] The premise underlying most COPAs is that in certain markets there may be insufficient demand to support meaningful competition or that whatever competition does exist will not achieve certain goals that may be beyond the reach of the antitrust laws, such as assuring access by the uninsured to needed health services, such as preventive care, addiction and mental health services or ensuring the survival of certain entities that employ local workers.

Not surprisingly, the FTC has a long history of bipartisan opposition to both CONs and COPAs.

[131] The state action doctrine is discussed in Ch. IX (Immunities and Exemptions).

1. Certificate-of-Need Laws

As former FTC Commissioner Maureen Olhausen describes below, CON laws can be traced back to the 1960s, when hospitals were reimbursed largely on a "cost-plus" basis, which incentivized them to over-invest in facilities because even the high cost of under-utilized facilities was largely paid for by the federal government. Policymakers believed, given this environment, that hospitals would engage in wasteful spending that amounted to "medical arms races," and that the best solution was to limit new entry or expansion to those entities that could prove there was a need for the new services.

Maureen K. Ohlhausen, Certificate of Need: A Prescription for Higher Costs

30 Antitrust Magazine 50 (Fall 2015)

[. . .]

History and Original Intent

[1] CON laws typically establish requirements for state approval before a new health care provider can enter a market or an existing provider can make certain capital improvements. For example, if a hospital wants to build a new wing and add additional beds, it must seek approval from the state. The state will determine whether there is sufficient public "need" for the capital improvement and either grant or deny the provider's application.

[2] Normally, states are not directly involved in the market entry or capital improvement decisions of private firms. If a business wants to build a new factory, the state may require the business to conform to local zoning laws and other generally applicable regulations, but the state does not second guess management's decisions about the business need for the new facility. Instead, the free market mediates those decisions. If a company makes unwise capital investments, it will lose business to its more skillful rivals. Market forces will naturally push firms to optimize their capital expenditures without any need for state intervention.

[3] So why did states start regulating decisions that they would normally leave to the private sector? It turns out that there is a long history here that commentators often ignore or sweep under the rug in the current debates over CON laws. Yet that history is critical to understanding not only how we got to where we are today on this contentious issue, but also whether these laws should continue to remain in force.

[4] The story of CON laws stretches all the way back to the mid-1960s. At that time, there was a view that high health care costs were driven largely by wasteful, over-investment in duplicative health care facilities. A brief hypothetical best explains the concern that legislatures originally sought to address through CON laws.

[5] Imagine that Metropolis is a city with four major hospitals of roughly equal size. Hospital A decides that it needs to buy a new, expensive MRI machine. Patients in Metropolis now have access to a brand-new diagnostic tool they did not have before. So far, so good, at least for Hospital A. Things are not quite as rosy over at the other hospitals. Hospitals B, C, and D are now suddenly at a disadvantage because their competitor, Hospital A, has important new capabilities they lack. Fearful that they will lose patients and prestige to Hospital A, the other three hospitals each decide to buy an MRI machine of their own. Unfortunately, Metropolis does not have enough people to utilize all four MRI machines fully. In fact, just one machine might adequately serve all the MRI needs of Metropolis. Thanks to the "me too" purchases by the rival hospitals, all four of these very expensive machines are now frequently idle.

[6] Governments passed CON laws so that they could step in and effectively mandate that Metropolis only have one, fully utilized MRI machine. Once Hospital A had an MRI, there would be no public "need" for the additional machines and so the state would reject each remaining hospital's application to buy one for competitive reasons.

[7] Importantly, at the time states enacted these CON laws private health care expenditures tended to be reimbursed on a "cost plus" basis, and many thought that there was little incentive for providers to control costs and avoid

excessive, unnecessary spending. Proponents viewed state intervention as a necessary check on a perceived market failure created by the existing reimbursement structure.

[8] New York State adopted a CON law restricting new hospital construction back in 1964. As the idea gained favor, the American Hospital Association began to lobby for other states to adopt CON regimes. Eventually, the federal government got involved. In 1974, Congress passed a mandate for all states to establish a CON program as part of the National Health Planning and Resources Development Act. By 1980, every state except Louisiana had a CON law on the books.

Original Cost-Saving Rationale Fails to Deliver

[9] Ever since states enacted these laws, economists and policy makers have been studying how well they work. The majority of studies fail to establish any definitive link between CON laws and lower unit costs. Although a small number of studies identify some very modest benefits from CON laws, these studies suffer from significant methodological problems.

[10] The lack of success in controlling costs is understandable. CON laws are simply output restrictions mandated by the government. Normally, if you want the price of something to decline, creating an artificial shortage of it is not the way to achieve that. There is no clear reason to expect that the basic laws of supply and demand would not apply, either when the states enacted the CON laws or today. Even worse, although the states originally enacted these laws to address a perceived problem with the "cost plus" reimbursement system, health care is generally no longer reimbursed that way. Instead, the federal government establishes universal reimbursement rates for Medicare and Medicaid, and private insurers negotiate payments procedure by procedure rather than by provider cost. In this environment, providers have little incentive to make unnecessary capital improvements. In effect, the purported market failure that CON laws were designed to fix no longer exists. Thus, we should not be terribly surprised that it has proven difficult to demonstrate the benefits of a legislative scheme designed to fix an issue overtaken by subsequent events.

[11] Finally, CON laws reflect an expectation that governmental central planning is more efficient than the actions of private actors who have a direct interest in the outcome. Although the MRI hypothetical discussed in the previous section may sound simple, things in the real world are far more complex. Government actors respond to political pressure, often exerted by special interests that seek to place their own, narrow interests ahead of the general public welfare. History amply demonstrates that central economic planning is inefficient and deeply harmful to the societies that practice it. In short, there are some very good reasons why the government typically stays out of this kind of private economic activity in other parts of the economy. None of those general concerns disappears simply because we are talking about health care.

CON Laws Inhibit Socially Beneficial Competition

[12] Although establishing actual benefits from CON laws has proven elusive, the downsides of these laws are much easier for economists and antitrust lawyers to understand. By restricting expansion and new entry, CON laws help to insulate incumbent providers from competition.

[13] To understand just how these laws inhibit competition, consider how they might work in another industry. If Burger King wants to build a new restaurant just down the street from an existing McDonalds, it does not have to go before a state board and demonstrate a "need" for another restaurant. It does not have to fight for the right to open in a lengthy, expensive, and contested proceeding where McDonalds can successfully object to its entry on the ground that it is already providing all the hamburgers the area requires. Yet this is exactly how states administer CON laws, with the incumbent provider weighing in on whether there is a need for it to face competition. As one might imagine, there are powerful reasons for incumbent firms to oppose such an application that have nothing to do with the public welfare. In effect, a market intervention originally designed to remedy a perceived market failure actually renders markets for health care services less competitive.

[14] Normally, we want firms to face additional competition, so that customers can play firms against one another and obtain lower prices and better service. Competition also pressures firms to innovate, and beneficial innovation further improves our collective standard of living. In fact, ensuring that markets remain competitive so they can continue to provide these benefits to the public is so critical that both the Federal Trade Commission and Department of Justice devote considerable resources to identifying anticompetitive agreements and conduct. For example, we look at every merger of a certain size and challenge the ones that create excessive concentration precisely because free market competition is such a powerful force in benefitting the public.

[15] By contrast, CON laws actively restrict new entry and expansion. They displace free market competition with regulation and tend to help incumbent firms amass or defend dominant market positions. If government is going to displace the well-proven and socially beneficial forces of free market competition in favor of economic regulation, those regulations should provide some clear public benefit that outweighs the consumer harm they create. Placed against that yardstick, CON laws do not measure up.

[16] Fortunately, many policymakers eventually figured this out. At the federal level, the failed experiment in trying to control health care costs by regulating capital expenditures ended in 1986, when Congress repealed the National Health Planning and Resources Development Act. In the wake of the federal repeal, a number of states followed suit and repealed their own CON laws. Unsurprisingly, subsequent studies did not show a massive explosion in health care costs in the states without CON laws.

* * *

While CON laws have been disfavored in recent years, they still exist in a number of states where entrenched providers have been able to defeat legislative efforts to repeal the laws. The FTC (occasionally with the DOJ) continues to submit comments to state legislatures urging their repeal, pointing out that such laws impede competition and have failed to achieve their intended goals.[132]

2. Certificates of Public Advantage

COPAs also have been around for several decades, but unlike CONs they seem to be growing in popularity in recent years. COPAs are based on the now well-established state action principles enunciated in *MidCal:* (1) the state legislature must clearly articulate its intention to displace competition: and (2) the private parties that seek exemption from antitrust scrutiny must be subject to active and ongoing state supervision.[133]

COPAs have been adopted by state legislatures that have been convinced that, in certain circumstances, they can achieve better policy outcomes than would result from competition. The classic rationale for COPAs is that some rural health care markets lack the population base to support robust hospital competition. Such markets may include several struggling hospitals, typically serving predominantly underinsured or uninsured patients, and which lack the scale or resources to provide cost-effective, quality care, particularly to those most in need. Allowing competition to play itself out may take years before one or more of the struggling hospitals fail and, in the end, would result in the surviving facility being dominant and facing little competition in the relevant market. Proponents of COPAs argue it would be preferable to allow consolidation to proceed sooner and in a more orderly fashion, and that a COPA would allow for state supervision of the combined entity. They assert that a COPA could require the merged entity to address public policy goals that are unlikely to be achieved through competition, such as public health initiatives, expanded access to care, and continued employment of local workers.

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[132] *See, e.g.*, Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice to the Virginia Certificate of Public Need Work Group, F.T.C. (Oct. 26, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-virginia-certificate-public-need-work-group/151026ftc-dojstmtva_copn-1.pdf; *see also* Federal Trade Commission and Department of Justice, Letter to Senator David Wilson (Mar. 11, 2019), https://www.justice.gov/atr/page/file/1146346/dl.

[133] California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980). *See supra* § XI.C. (state action defense).

The FTC has long signaled its opposition to COPAs.[134] In 2022, FTC staff issued a "Policy Paper" summarizing the basis for its opposition.[135] Among other things, the policy paper argued, (1) competition is more reliable and effective than are COPAs in controlling health care costs and assuring quality; (2) often hospitals seeking COPAs have adequate financial resources to continue to operate independently; (3) hospitals can achieve the goals they seek under a COPA without consolidation; (4) hospitals often are unable under a COPA to meet the expansive goals they have promised; (5) regulatory oversight under a COPA is difficult, expensive, and often ineffective, and (6) it is difficult to unwind an unsuccessful COPA and recover the competition that has been lost. The policy paper includes references to several studies that showed disappointing results from several past COPAs.

For many years, FTC staff limited their advocacy to opposing COPA legislation. More recently the FTC has weighed in where a state already has passed COPA legislation and has actively participated in the COPA approval process. So, for example, when the only two health systems in southwestern Virginia and northwest Tennessee sought COPA approval for their merger, the FTC testified in favor of stringent criteria for granting and a COPA and supervising the parties if a COPA were granted and the agency presented evidence from its own investigation of the merger to support its view that the parties had not demonstrated they met the state's criteria.[136]

This is not the only way that the FTC is continuing to aggressively oppose COPAs. In 2017, the FTC announced a long-term study of the impact of COPAs,[137] and followed that with a public workshop on the subject.[138] And in 2019, the agency announced that it had issued orders to 5 health plans and two health systems to provide detailed information to facilitate the study.[139] These studies necessarily will take many years to complete; preliminary results have not been released as of early 2025.

In addition, in 2023 the FTC sought to enjoin a merger that had been approved under a Louisiana COPA on the grounds that the parties had failed to comply with the premerger notification requirements of the Hart-Scott-Rodino ("HSR") Act. The district court, in a decision the FTC chose not to appeal, rejected the FTC's argument that even if

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[134] The first indication the FTC was concerned about a COPA law may have come in a 1996 letter the then-Assistant Director at the FTC division charged with supervising hospital mergers sent to counsel for two merging hospitals in Great Falls, Montana, advising that the agency was closing an investigation into the merger because the state had passed a COPA law and the hospitals had obtained a COPA for the transaction. The letter stated FTC staff had not made "a determination that the regulatory scheme devised by Montana is in any way more appropriate than the national policy favoring competition that is articulated in the antitrust laws" but felt bound, under the state action doctrine, to close the investigation, nonetheless. Letter from Robert F. Leibenluft to Joe Sims re: Columbus Hospital/Montana Deaconess Medical Center, F.T.C. (June 28, 1996), https://www.ftc.gov/sites/default/files/documents/closing_letters/columbus-hospital/montana-deaconess-medical-center/960628columbushospitalletter.pdf.

[135] FTC POLICY PERSPECTIVES ON CERTIFICATES OF PUBLIC ADVANTAGE, Federal Trade Commission Staff Policy Paper (Aug. 15, 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf.

[136] *See* STAFF SUBMISSION TO THE TENNESSEE DEPARTMENT OF HEALTH REGARDING THE CERTIFICATE OF PUBLIC ADVANTAGE APPLICATION OF MOUNTAIN STATES HEALTH ALLIANCE AND WELLMONT HEALTH SYSTEM, F.T.C., (Nov. 21, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-submission-tennessee-department-health-regarding-certificate-public-advantage-application/161122wellmontcommenttenn.pdf; *See also* STAFF SUBMISSION TO THE TENNESSEE DEPARTMENT OF HEALTH REGARDING THE CERTIFICATE OF PUBLIC ADVANTAGE APPLICATION OF MOUNTAIN STATES HEALTH ALLIANCE AND WELLMONT HEALTH SYSTEM, F.T.C. (Jan. 5, 2017),https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-supplemental- submission-tennessee-department-health-regarding-certificate-public-advantage/170105mshatennesseesuppcmt.pdf; and STAFF'S THIRD SUBMISSION TO THE TENNESSEE DEPARTMENT OF HEALTH REGARDING THE CERTIFICATE OF PUBLIC ADVANTAGE APPLICATION OF MOUNTAIN STATES HEALTH ALLIANCE AND WELLMONT HEALTH SYSTEM, F.T.C. (July 18, 2017), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staffs-third-submission-tennessee-department-health-regarding-certificate-public-advantage/ftc_-_third_comment_to_tennessee_-_final_public_version.pdf.

[137] *FTC Staff Notice of COPA Assessment: Request for Empirical Research and Public Comments* , F.T.C. (Nov. 1, 2017), https://www.ftc.gov/system/files/attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/copa_assessment_public_notice_11-1-17_revised_3-27-19.pdf.

[138] *A Health Check on COPAs: Assessing the Impact of Certificates of Public Advantage in Healthcare Markets,* F.T.C. (June 18, 2019), https://www.ftc.gov/news-events/events/2019/06/health-check-copas-assessing-impact-certificates-public-advantage-healthcare-markets.

[139] *FTC to Study the Impact of COPAs*, F.T.C. (Oct. 21, 2019), https://www.ftc.gov/news-events/news/press-releases/2019/10/ftc-study-impact-copas.

the merger was immune under the state action doctrine, the parties still were obligated to provide *notice* of the transaction to the federal antitrust agencies.[140] Parties contemplating COPAs view this as an important victory. They feared that if they were required to file their transactions under the HSR Act, they may have faced extensive delays and costs in complying with an agency investigation despite the fact that the underlying deal was immune from antitrust challenge. The FTC, on the other hand, is concerned that it has lost an important tool for learning about and investigating transactions, making it more difficult to timely oppose those that it believes are not immune from federal antitrust law challenge on the basis of a state's COPA law.

[140] Louisiana Children's Medical Center (LCMC) v. Attorney General of the United States, No. CV 23-1305, 2023 WL 6293887 (E.D. La. Sept. 27, 2023).