ANTITRUST & HEALTH CARE: PRINCIPLES AND PRACTICE

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AHLA/ABA Antitrust in Health Care
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• Antonin Scalia at his confirmation hearing:
  – “In law school, I never understood [antitrust law]. I later found out, in reading the writings of those who . . . do understand it, that I should not have understood it because it did not make any sense . . . .”
Agenda

1. History: Healthcare Antitrust Enforcement
2. Purpose of the Antitrust Laws
3. Antitrust Enforcers
4. Key Antitrust Statutes
5. Sherman Act § 1
6. Sherman Act § 2
7. Clayton Act § 7 and § 7A
8. Antitrust Exemptions
Government Health Care Antitrust Guidance

• All available on the FTC web site, www.ftc.gov
  – Antitrust Guidelines for Collaborations Among Competitors (2000)
  – Enforcement Policy Statement Regarding ACOs Participating in the Medicare Shared Savings Program (2011)
A Great One-Volume Source

Health Care Antitrust History

• Very few cases before late 1970s, even though the Sherman Act was enacted in 1890
• Why?
  – Insufficient effect on interstate commerce? Exploded in Rex Hospital, 425 U.S. 738 (1976)
• 1976 formation of FTC Health Care Division
• Early cases: Mostly simple doc staff-privilege antitrust cases
• Issues have become more complex over the years—mergers, JVs, MFNS, ACOs, pharma reverse payments
The Primary Foci Now

• Provider mergers, e.g.,
  – Hospitals
  – Physicians
  – Health plans
  – Pharmaceutical

• Health-plan mergers

• Pharmaceutical “reverse payment” agreements
Purpose of the Antitrust Laws

• Protect and promote competition as U.S. method for allocating resources
  – By protecting buyers and sellers from the effects of seller or buyer “market power” unless obtained by competition on the merits

• Conclusive presumption: Lower prices, higher output, higher quality, greater choice, better access, greater efficiency, greater innovation

• Antitrust is a “consumer welfare prescription”

• Protect competition, not competitors per se
The Antitrust Enforcers

• **DOJ Antitrust Division**
  – Civil and criminal prosecutions

• **Federal Trade Commission**
  – Civil enforcement only

• **State Attorneys General**—Don’t forget!
  – Can enforce both state and federal antitrust laws
  – Wide differences in antitrust activity

• **Private Plaintiffs**: Treble damages and attorneys fees
The FTC/DOJ Tacit Market-Allocation Agreement

• FTC has primary responsibility for provider antitrust issues

• The Antitrust Division has responsibility for health-plan antitrust issues
Primary Antitrust Statutes

- **Sherman Act § 1**—Prohibits agreements that unreasonably restrain competition
- **Sherman Act § 2**—Prohibits (1) monopolization, (2) attempted monopolization, and (3) conspiracies to monopolize
- **Clayton Act § 7**—Prohibits acquisitions that may substantially lessen competition
- **FTC Act § 5**—Prohibits “unfair methods of competition”
Antitrust = Collusion, Exclusion, or Both

• Almost every antitrust issue involves collusion, exclusion, or both
  – Collusion: Joint action usually directed at consumers (e.g., horizontal price-fixing)
  – Exclusion: Unilateral (or joint) action to harm competitors directly to ultimately harm consumers (e.g., single-firm predatory pricing)

• Start your analysis by determining the potential competitive concern
Section 1 of the Sherman Act
15 U.S.C. § 1
(Collusion)
Section 1 Elements

• **Agreement**
  – Unilateral action is never a violation
  – Two issues:
    • **Capacity to conspire**: The *Copperweld* single-entity doctrine. See *American Needle*
    • **Fact of conspiracy** and “conscious parallelism”

• **Unreasonable restraint on competition**
  – **Per se rule**
  – “Full blown” rule of reason
  – “Quick-look” rule of reason
Capacity to Conspire

• Are the parties “Copperwelded”?  
  – Parents and subs: Yes  
  – Hospitals and medical staffs: Depends  
  – Principals and agents: Depends  
  – Mergers: Yes  
  – Virtual mergers and JOAs: Depends  
    • Med. Ctr. at Eliz. Place v. Atrium Health (6th Cir. 2016)  
  – Joint ventures: No  
  – IPAs: No  
  – ACOs: No
Fact of Agreement

• Requires a “contract,” “combination,” “conspiracy,” “agreement,” “understanding,” “joint action,” or a “meeting of the minds”

• Proof by direct or circumstantial evidence

• “Conscious parallelism” not sufficient
  – Must be “plus factors” tending to exclude the possibility of independent action
Section 1—Per Se Rule

• Agreement **conclusively** presumed unlawful

• Limited applicability
  – Applies only to types of conduct that always or almost always have obvious and substantial anticompetitive effects
  – Applies to agreements among competitors (1) fixing prices, (2) allocating markets, or (3) rigging bids
  – But agreement must be “**naked**” rather than “**ancillary**”
Section 1—Per Se Rule

• Naked v. ancillary agreements:
  – **Naked**—Little or no economic integration among the parties; sole effect is anticompetitive
  – **Ancillary**—Two requirements:
    • Must be substantial integration likely to generate significant efficiencies, and
    • Agreement must be “reasonably necessary” for achievement of the efficiencies
    • Examples: Collective price negotiations by financially or clinically integrated IPAs and ACOs; JV agreements not to compete
Section 1—Per Se Rule

• If the agreement is per se unlawful:
  – Plaintiff need not prove relevant market
  – Plaintiff need not prove defendants have market power
  – Plaintiff need not prove any actual anticompetitive effects
  – Defendants not permitted to proffer any defenses or arguments other than “no agreement” or “agreement’s not the type that’s per se illegal”
  – “Trump card of antitrust” – Just count the damages
Section 1—Rule of Reason

• Bottom line—Agreement unlawful only if anticompetitive effects significantly outweigh procompetitive effects

• Burden-shifting analysis:
  – **Plaintiff**—Initial burden to show anticompetitive effects from market power from conduct
    • Proof by **direct evidence**, e.g., supracompetitive prices
    • Proof by **circumstantial evidence**: (1) definition of relevant market, (2) substantial market share, (3) entry and expansion barriers
      – At least 35% share
Section 1—Rule of Reason

– Burden of **going forward** shifts to defendants
  • To produce evidence of conduct’s procompetitive effects
– If defendants do, burden of going forward and ultimate burden of persuasion shift back to plaintiff to show:
  • Defendants’ justifications are pretextual
  • Same benefits could be accomplished by a less restrictive alternative, and/or
  • Anticompetitive effects significantly outweigh procompetitive effects
Section 1—Procompetitive and Anticompetitive Effects

• Anticompetitive effects
  – Supracompetitive prices
  – Sub-competitive output, quality, choice, innovation
  – Anything harming consumers from market power

• Procompetitive effects
  – Greater efficiency
  – Lower prices
  – Higher quality
  – Anything benefitting consumers
Section 1—Balancing Effects

• Bad news: No practical way to objectively or empirically balance procompetitive and anticompetitive effects—just a subjective evaluation or “hunch”

• Reasonable minds can differ

• Good news: Very rarely necessary to balance effects in litigation; vast majority of cases settle or are dismissed pursuant to Rule 12(b)(6) or Rule 56
Section 1—“Quick-Look” Rule of Reason

• Applies to “inherently suspect” conduct but that appears to have significant plausible procompetitive justifications or effects
• Conclusive presumption of anticompetitive effects without actual proof, but
• Defendants can adduce evidence of plausible justifications or procompetitive effects
• If so, more in-depth analysis of effects is required—maybe full-blown RoR analysis
A Digression on Relevant Market Definition

• The product and geographic area in which competition is affected by the conduct

• Not an end in itself but merely one tool to help determine or predict conduct’s effect on competition

• May not be necessary if effect can be proven directly, e.g., actual supracompetitive prices from the conduct
Relevant Market Definition

• **Relevant product market**—Product affected by the conduct
  – In general, products that are *reasonably interchangeable* in the eyes of consumers with significant *price cross-elasticity of demand*
  – But the agencies and, more and more the courts, apply the “**hypothetical monopolist**”/smallest *market*” test
    • Could a “**hypothetical monopolist**” of the product *profitably* raise its price? If not, add next-best substitute
Relevant Market Definition

• Relevant geographic market
  – Geographic, rather than product, substitutes if firms in question attempt to raise price
  – In general, the area in which the sellers operate and to which their customers can practicably turn for alternative sources of supply if sellers attempt to raise prices. *Tampa Electric v. Nashville Coal*, 365 U.S. 320 (1961)
  – But—agencies apply hypothetical monopolist/smallest market principle here, too, resulting in smaller geographic markets than in the past
Section 1—Problematic Agreements

- Horizontal v. vertical agreements
- Inter- v. intrabrand restraints
- Horizontal agreements
  - Primary concern of § 1
    - Price fixing
    - Market allocation
    - Bid rigging
    - Any type of agreement not to compete
    - Exchanges of price information
    - Group boycott
Section 1—Problematic Agreements

• **Vertical Agreements**
• Always analyzed using the rule of reason
  – Vertical price-fixing agreements
  – Tying agreements
  – Exclusive dealing (many types)
Section 1—Problematic Agreements—Health Care

• **Horizontal price fixing**—An IPA negotiates reimbursement levels on behalf of its physician members—*Maricopa*, 457 U.S. 332
  – There is a price-fixing agreement
  – Is it naked or ancillary? **Statement 8**
    • Clinically or financially integrated?
    • Why the need to negotiate jointly?
  – Does the IPA have market power?
    • Participation percentages?
    • Exclusivity?
    • See FTC Staff Advisory Opinions
Section 1—Problematic Agreements—Health Care

• Market allocation—Competing hospitals A and B agree that A will offer open-heart surgery, B will offer sophisticated cancer services, and they won’t compete in those services.
  – Naked or ancillary agreement?
  – Market power? Efficiencies?
  – See Statement 3

Agreements to exchange competitively sensitive information—The HR personnel of Hospitals A and B, which compete for RNs, meet and exchange information about the salaries paid or to be paid their RNs.

– Somewhat complicated rule-of-reason analysis. See Todd v. Exxon Corp., 275 F.3d 191 (2d Cir. 2001); Fleischman v. Albany Med. Ctr., 728 F. Supp. 2d 130 (N.D.N.Y. 2010); Statement 6

– What if the hospitals had agreed on wages?
Section 1—Problematic Agreements—Health Care

• Group boycotts—Competing hospitals, upset about competition from physician-owned specialty hospitals, agree not to contract with any health plan that contracts with a local physician-owned cardiac hospital
Section 1—Problematic Agreements—Health Care

- **Tying Agreements**—Hospital A refuses to contract with health plans for hospital services unless plans also contract with the hospital’s employed physicians for services
  - Are there two services?
  - Does the hospital have market power in hospital services?
  - Is there coercion?
  - Does the arrangement foreclose other physicians from significant business?
Section 1—Problematic Agreements—Health Care

- **Exclusive dealing agreements**—Hospital A contracts with Acme Anesthesiologists for services at the hospital, agreeing not to grant privileges to any other anesthesiologists
  - Percentage of all market business foreclosed to other anesthesiologists by the contract?
  - Duration of the contract?
  - Acme’s market share and market power?
  - Efficiencies from the contract?
  - Tying agreement, too? *Jefferson Parish*, 466 U.S. 2
Section 2 of the Sherman Act
15 U.S.C. § 2 (Exclusion)
Section 2 of the Sherman Act

- Prohibits (1) monopolization, (2) attempted monopolization, and (3) conspiracies to monopolize
  - And probably “monopsonization,” too
  - First two are single-firm violations—no concerted action necessary
- First two are single-firm violations—no concerted action necessary
- Third is basically redundant to § 1
Section 2 of the Sherman Act
Monopolization

• Requires proof of (1) monopoly power (2) obtained or maintained by “predatory” or “unreasonably exclusionary” conduct

• A monopoly is not, by itself, unlawful

• Monopoly power—Definition:
  – A substantial degree of market power
  – Ability to raise prices or exclude competitors from the market
  – Power must be durable
Section 2 of the Sherman Act
Monopolization

• Proving monopoly power
  – Direct evidence—Supracompetitive prices, sub-competitive output or quality
  – Circumstantial evidence—May be inferred from:
    • Correct definition of the relevant market,
    • Dominant market share—typically, at least 60% or more, and
    • Evidence of significant entry and expansion barriers
Section 2 of the Sherman Act
Monopolization

• “Predatory” or “unreasonably exclusionary” conduct
  – Impossible to define precisely; no universal standard for identifying
  – Always conduct that has an exclusionary effect on competitors, harming their ability to compete, to obtain or maintain monopoly power
  – Best generic definition: Conduct with significant exclusionary effects but no beneficial consumer or procompetitive effects or justifications
  – Recent decisions require balancing the effects
Section 2 of the Sherman Act
Monopolization

• Examples of potentially predatory conduct:
  – Charging a monopoly or supracompetitive price is **not** predatory conduct
  – Some **refusals to deal** with competitors
  – Single product **predatory pricing**
  – **Bundled discounts**, i.e., multi-product predatory pricing
  – **Exclusive dealing arrangements**
  – **Tying arrangements**
  – **Sham litigation**
Section 2 of the Sherman Act

Attempted Monopolization

• Applies where defendant lacks monopoly power but likely would obtain it if predatory conduct continued

• Elements:
  – Specific intent to monopolize
  – Predatory conduct (same as for monopolization)
  – “Dangerous probability of actual monopolization”
    • 45% or more share of correctly defined relevant market
    • Few other competitors
    • Share likely to increase to monopoly level
Section 2 of the Sherman Act
Health Care Examples

• Hospital A, with an 80% share, enters into contract with Health Plan whereby health plan contracts only with Hospital A and not its competitors—an exclusive dealing agreement
  – Rule of reason applies
  – Degree of foreclosure? Function of Health Plan’s share
  – Effect on A’s market share? Maintain power?
  – Any procompetitive justification?
  – U.S. v. United Reg’l, 2011-2 Trade Cas. ¶77,619
Section 2 of the Sherman Act
Health Care Examples

• Hospital A charges health plans $100 if they purchase only inpatient services from it, but $80 if they purchase both inpatient and outpatient services from it. ASC 1 provides only outpatient services (the “competitive product”).

• Example of a “bundled discount”; bundled discount results where firm sells two products but price for products purchased together is less than price when purchased separately
Section 2 of the Sherman Act
Health Care Examples

• Outpatient services are the “competitive product”
• ASC 1 may be just as efficient (or more efficient) a producer of the competitive product as Hospital A and yet not able to sell it because of the bundled discount
• Some courts view the discount as predatory.
• Cascade Health Solutions, 515 F.3d 883 (9th Cir. 2008)
Section 2 of the Sherman Act
Health Care Examples

• Health Plan A has an 70% share and enters agreements with hospitals requiring that they not grant other health plans a lower price than that given A—a most-favored-nations (MFN) provision

• Can deter new entry or growth of other plans

• But may be efficiencies, too

Section 7 of the Clayton Act
15 U.S.C. § 18
(Collusion)
Section 7 of the Clayton Act

• Prohibits all types of acquisitions whose effect may be to substantially lessen competition
• 99% of cases by FTC and DOJ
• Relief: Preliminary injunctions or divestiture
• Very active health Care enforcement area
  – Hospital mergers; ProMedica Health (6th Cir. 2014)
  – Health plan mergers: Two UnitedHealth cases
A Digression—Importance of Sufficient Integration

• Single entity or separate entities capable of conspiring?

• Hospital “virtual mergers”—JOAs, etc.

• Physician mergers—“clinics without walls”
Section 7 of the Clayton Act Analysis

• Rule of reason/burden-shifting type analysis

• Proof of actual or likely effects
  – Actual effects on price from consummated mergers
  – Inferences drawn from:
    • Post-merger share and concentration
    • Competitive “closeness” of merging parties
    • Party and consultant “intent” and “effect” documents
    • Testimony, particularly from customers
    • Econometric studies estimating price effects
Section 7 of the Clayton Act

• Most important single source—FTC and DOJ 2010 **Horizontal Merger Guidelines**
  – Not “the law”
  – But they explain how DOJ and FTC analyze mergers and when a challenge is likely
  – Increasingly influential on the courts
  – Understanding and application are crucial
  – No guidelines for vertical mergers, only horizontal
Section 7 of the Clayton Act
“Traditional” “Linear” Analysis

• Define the relevant market
• Identify “market participants.” Guidelines §5.1
• Calculate:
  – Post-merger market share and increase
  – Post-merger market concentration and increase
• Identify potential competitive concern
• Determine if rebuttable presumption applies
• Consider primary rebuttal factors: Entry, efficiencies, party financial condition
Section 7 of the Clayton Act
Product Market Definition

• Apply “hypothetical monopolist/smallest-market” analysis discussed before

• Healthcare relevant product markets
  – Hospitals
    • “Cluster market” concept
      – Usually inpatient general acute-care inpatient services
  – Physicians
    • Typically, medical specialties
  – Health plans
    • May break out different insurance products
Section 7 of the Clayton Act
Geographic Market Definition

• Apply hypothetical monopolist/smallest market analysis discussed before

• Hospital mergers—RGMs have shrunk
  – Evanston Nw.—Triangle between hospitals
  – ProMedica—A county
  – OSF—Area within 30 minutes of hospitals

• Physician acquisitions—Depends on specialty

• Health plans—Local markets because of networks and patient unwillingness to travel
Market Definition

Buyer v. Seller Market Power

• Above applies to the more usual seller market power concern
• But buyer market power can also be of concern, e.g., health-plan mergers
• Seller market power: Market definition focuses on product and geographic alternatives for purchasers
• Buyer market power: “Mirror image” analysis—Market definition focuses on alternatives for sellers
Section 7 of the Clayton Act

Potential Concerns

• **Concern 1: Unilateral effects**: Price increases by merged firm itself. [Merger Guidelines § 6](#)
  – Most important variables:
    • The competitive “closeness” of the merging firms as shown by the “diversion ratio” when the product is heterogeneous or “differentiated”
    • To a lesser extent, post-merger market share
      – Rebuttable presumption at levels above 30 or 35%?
    • HHI or level of concentration doesn’t tell you much
Section 7 of the Clayton Act
Potential Concerns

• **Concern 2: Coordinated effects:** Price increases by multiple or all firms in the market resulting from explicit or tacit collusion; increased oligopolistic interdependent conduct; conscious parallelism
  – Merger Guidelines § 7
  – Most important variables:
    • Level of post-merger market concentration
    • Increase in post-merger market concentration from merger
    • Susceptibility of market to tacit collusion
Section 7 of the Clayton Act
Market Concentration

• A measure of the number and relative sizes of firms in the market
• Assumption: Higher the concentration, greater the likelihood of collusion
• Measured by Herfindahl-Hirschman Index (HHI)
  – Add shares of merging firms
  – Square and sum market participant shares
  – HHI Increase: Multiply product of merging shares by two
Section 7 of the Clayton Act
Market Concentration

• **Merger Guidelines** concentration benchmarks:
  – *Unconcentrated Market*: HHI less than 1,500 (safe harbor) (6 to 7 equal-size firms)
  – *Moderately Concentrated Market*: HHI between 1,500 and 2,500
    • No problem if increase less than 100 (e.g., 10% and 5%)
  – *Highly Concentrated Market*: HHI above 2,500 (4 equal-size firms)
    • Rebuttable presumption if greater than 200
    • A “prima facie” case
Shares and HHIs in Recent Mergers

- FTC litigated cases:
  - Inova/Prince William (hospitals) (northern Virginia)
    - Share: 74%
    - HHI: 5,562; increase: 974
  - Rockford Mem’l/St. Anthony’s (hospitals) (Rockford, Ill.)
    - Share: 59%
    - HHI: 5,177; increase 1,764
Shares and HHIs in Recent Mergers

– ProMedica/St. Luke’s (hospitals) (Toledo, Ohio)
  • Share: 58%
  • HHI: 4,392; increase: 1,078

– Reading Health/Surgical Institute (hospitals) (Reading, Pa.)
  • Share: 67%
  • HHI: 4,585; increase 2,050

– St. Luke’s/ Saltzer Medical Group (physicians) (Nampa, Idaho)
  • Share: 80%
  • HHI: 6,219; increase: 1,607
Shares and HHIs in Recent Mergers

• Consent orders:
  – Renown Health (cardiologists) (Reno, Nev.)
    • Share: 88%
    • HHI: 7,185; increase 3,108
  – Keystone Orthopaedic/Orthopedic Associates (orthopods) (Reading, Pa.)
    • Share: 76%
    • HHI: Not provided
Shares and HHIs in Recent Mergers

• Outstanding FTC Challenges (as of Mar. 31)
  – Cabell Huntington/St. Mary’s (hospitals) (Huntington, W. Va.)
    • Share: 75%
    • HHI: 5,824; increase: 2,825
  – Pinnacle/Hershey (hospitals) (Harrisburg, Pa.)
    • Share: 64%
    • HHI: 4,500; increase: 2,000
  – Advocate/North Shore (hospitals) (north Chicago)
    • Share: 55%
    • HHI: 3,517; increase: 1,423
Section 7 of the Clayton Act

Rebuttal Factors

- **Entry and expansion**—Must be “timely,” “likely,” and “sufficient”
- “Timely”—In general, within 2 to 3 years
- “Likely”—Profitable at pre-merger prices
- “Sufficient”—Scale sufficient to replace acquired firm
- Healthcare market entry generally difficult
- A non-starter, especially in CON states
Section 7 of the Clayton Act
Rebuttal Factors

• **Efficiencies**
  – Merger specific
  – Quantifiable and provable
  – Net
  – Can’t reduce output
  – Incredibly detailed expert report necessary
  – Extreme agency skepticism
  – Start the analysis early
  – FTC says efficiencies have never rescued a prima facie case
Section 7 of the Clayton Act
Acquired Firm Financial Status

• **Failing firm doctrine**—Absolute defense
  – Proof burden for a “failing firm” very strict
  – Need to have “shopped” the firm to others
  – See *Cal. v. Sutter Health*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001); Merger Guidelines § 11

• **Weakened competitor doctrine**—One factor to consider
  – Requirements unclear
  – *FTC v. ProMedica*, 749 F.3d 559 (6th Cir. 2014) (weakest factor; “Hail Mary” defense)
Section 7A of the Clayton Act
Pre-Merger Notification

• Most large acquisitions must be reported to FTC and DOJ prior to consummation
  – Depends on transaction structure, size of the transaction, and size of the parties

• Wait 30 days after filing notice

• Second-Request Letter? Yes? Wait another 30 days after production compliance

• Agency must clear, challenge, or ask for more time with “timing agreement”
“Gun Jumping”

• Can be a problem under Clayton § 7A and Sherman § 1

• Clayton § 7A
  – If firms fail to report or acquiring firm begins to obtain control over or beneficial ownership of acquired firm before HSR clearance
  – Substantial civil penalties for non-compliance
**“Gun Jumping”**

- **Sherman § 1**
  - Parties are competitors til closing and must act as such
  - Actions reducing competition between them before closing can be problematic
  - Problem can arise during due diligence through sharing competitively sensitive information, e.g., prices or reimbursement from health plans
  - Law firms have boilerplate guidance documents
  - See Omnicare v. UnitedHealth, 629 F.3d 697 (7th Cir. 2011)
Antitrust Exemptions
Most Important Antitrust Exemptions

• **State-action exemption**
  – State COPA and exemption statutes

• **Solicitation of governmental action—”Noerr-Pennington” exemption**

• **Health Care Quality Improvement Act**
  – *St. John’s Med. Ctr.*, 693 F.3d 1269 (10th Cir. 2012)
THE END