Vertical Integration: Does it Matter that it’s Healthcare?

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Introduction

The antitrust rules applied to vertical integration are well-established. Although vertical combinations can, in some circumstances, raise competitive issues, the integration of two firms at different levels of the production chain frequently brings significant efficiencies and benefits for consumers. As a result, the antitrust enforcement agencies tend to give more attention to horizontal mergers and acquisitions than they do to vertical combinations. This not to say, of course, that all vertical integrations are per se lawful. For example, a vertical combination involving a dominant firm at the upstream or downstream level could potentially lead to foreclosure concerns that would be an issue under the antitrust laws. Antitrust enforcers might also consider whether a combination could facilitate collusion. But in general, vertical integrations are recognized as carrying the potential to achieve significant procompetitive efficiencies.¹

In healthcare, vertical integrations involving payers and providers are an increasingly common phenomenon. As in other industries – perhaps even moreso – many of these combinations have the potential to benefit consumers. Given the increasing frequency of such transactions, and some recent high-profile antitrust investigations involving payer/provider integration, a reasonable question to ask is whether healthcare presents unique issues when compared to other industries. In other words, when analyzing a payer/provider combination, does it matter that the firms are in the healthcare space? Do different rules apply, or can we confidently apply longstanding antitrust doctrine to the healthcare environment?

Traditional Antitrust Analysis of Vertical Integration

Vertical integration can sometimes take the form of a firm unilaterally expanding vertically. In the healthcare context, one example might be a health system beginning to offer a provider-sponsored health plan. Antitrust typically will have little to say about such “unilateral” vertical integration through organic growth, as it does not involve an acquisition, and represents a new product offering in the marketplace.

¹ The Federal Trade Commission has acknowledged, for example, that “[v]ertical mergers can generate significant cost savings and improve coordination of manufacturing or distribution.” https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/mergers/competitive-effects.
In other situations, vertical integration can take place through merger, acquisition or other form of affiliation. In such cases traditional antitrust doctrine frequently considers whether a vertical combination will include a firm with a dominant position in a market. If so, there is a risk that post-merger the dominant firm would be able to exercise its market power to disadvantage its rivals in the competitive segment of the market upstream or downstream. For example, in a combination of a dominant input supplier with one of its downstream customers, the combined firm might have the incentive and opportunity to disadvantage the downstream firm’s rivals, raising the cost of the input provided by the dominant upstream firm, or denying it altogether. Similarly, in a merger of a dominant downstream firm with one of its upstream suppliers, the combined firm might deny the upstream firm’s competitors of a market for their inputs. A classic, early example of the issue is stated by Justice Warren in the Brown Shoe decision:

Economic arrangements between companies standing in a supplier-customer relationship are characterized as “vertical.” The primary vice of a vertical merger or other arrangement tying a customer to a supplier is that, by foreclosing the competitors of either party from a segment of the market otherwise open to them, the arrangement may act as a “clog on competition,” which “deprive[s] . . . rivals of a fair opportunity to compete.”

The FTC has succinctly articulated the issue more recently: “[S]ome vertical mergers present competitive problems. For instance, a vertical merger can make it difficult for competitors to gain access to an important component product or to an important channel of distribution. This problem occurs when the merged firm gains the ability and incentive to limit its rivals’ access to key inputs or outlets.” Although other competitive issues can flow from a vertical combination, such as the improper flow of competitively sensitive information, or the facilitation of collusion, the analysis frequently begins with this consideration of whether the combination includes a dominant firm.

Cases raising vertical issues arise in a variety of industries. Recently, for example, federal antitrust enforcers have brought vertical cases in industries as diverse as defense, General Electric’s acquisition of Avio, a component manufacturer for jet aircraft engines, “would provide GE with both the ability and the incentive to disrupt the design and certification of the Avio-supplied [component] for the Pratt & Whitney PW1100G engine.”

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4 In the Matter of General Electric Company, Analysis to Aid Public Comment (FTC 2013), https://www.ftc.gov/sites/default/files/documents/cases/2013/07/130719generalelectricanalysis.pdf (General Electric’s acquisition of Avio, a component manufacturer for jet aircraft engines, “would provide GE with both the ability and the incentive to disrupt the design and certification of the Avio-supplied [component] for the Pratt & Whitney PW1100G engine.”).
television broadcasting\(^5\), and software\(^6\). In each case, the enforcement agencies alleged a similar scenario involving the upstream firm disadvantaged its downstream rivals, or the downstream firm disadvantaged its upstream rivals. The familiar issues manifest themselves in a variety of ways in each case, but they are still the familiar issues. But what of healthcare?

**Is Healthcare Different?**

As in other industries, vertical integration is a common phenomenon in healthcare. Payers and providers, especially, are exploring ways to integrate in an effort to control costs and improve patient care. The “Kaiser” model is a familiar one, where a payer employs its network physicians, providing maximum care coordination and control. But other structures are flourishing as well, as payers and providers look for ways to integrate more closely. Provider-sponsored health plans are increasingly common, and more and more payers are managing provider groups and forming Accountable Care Organizations.

In healthcare, as elsewhere, where a firm chooses to expand vertically through organic growth, offering a new product to the marketplace, there should be few, if any, antitrust impediments to such expansion. Where two existing firms choose to come together through a transaction, however, in healthcare as in other industries, antitrust might play more of a role. A recent example is the affiliation between Highmark, the Blue Cross affiliate in Western Pennsylvania, and West Penn Allegheny Health System (WPAHS), a large hospital system in the same geography. The combination drew an inquiry from the DOJ Antitrust Division, which allowed the transaction to proceed without challenge. In its closing statement, DOJ addressed vertical issues presented by the deal that are very similar to the vertical issues presented in other contexts. Characterizing Highmark as “the region’s dominant health insurance company” and WPAHS as the “second-largest hospital network” in the “highly concentrated” Pittsburgh region hospital market,\(^7\) the Division acknowledged that “[v]ertical agreements, such as the affiliation agreement, can reduce competition by limiting entry or expansion by third parties.”\(^8\) Nonetheless, the Division allowed the affiliation to proceed, in part because the region’s highly concentrated market structure would not provide the parties with the incentive to

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\(^5\) *United States v. Comcast Corp., et al.*, Competitive Impact Statement (DOJ 2011), https://www.justice.gov/atr/case-document/competitive-impact-statement-72 (“Comcast will have a strong incentive to disadvantage its competitors by denying them access to valuable programming or raising their licensing fees above what a stand-alone NBCU would have found it profitable to charge.”).

\(^6\) *United States v. Google, Inc., et al.*, Competitive Impact Statement (DOJ 2011), https://www.justice.gov/atr/case-document/competitive-impact-statement-115 (“Google intends to launch a new service after completing the transaction that will compete directly with other OTIs by providing flight search results. Because so many OTIs rely on ITA as an input to their services, Google will have the ability and incentive to either shut off access to ITA to those competitors, or degrade the quality of QPX that is available to those competitors.”).


\(^8\) Id.
disadvantage rivals. Also important to the Division’s analysis were recent developments in the market that suggested an increasing level of competition, at both the upstream and downstream levels. The Division noted that UPMC, the largest hospital in Pittsburgh, had recently signed agreements with other significant payers, increasing competition at the payer level. The Division also cited Highmark’s investment in WPAHC as carrying the potential to improve competition between WPAHC and UPMC at the provider level.

A related doctrinal question impacting healthcare is what happens after a firm is vertically integrated? Whether vertical integration comes about through organic growth or acquisition, once a firm is vertically integrated the challenge becomes organizing its conduct in a way that is consistent with the antitrust laws. Here, as with acquisitions, cases have generally applied traditional antitrust principles to healthcare in a familiar way. Take, for example, the question of whether a dominant firm – whether payer or provider – has an affirmative duty to deal with another firm. Well-established antitrust doctrine holds that “in the absence of any purpose to create or maintain a monopoly, 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.” This right is not unlimited, however. The Supreme Court has found that cessation of a voluntary, presumably profitable, financial relationship by a dominant firm can sometimes form the basis of a Section 2 claim where the dominant firm’s conduct forgoes short-term profits, and only makes economic sense given its tendency to harm a rival. This same principle also has been applied in the healthcare setting. For example, in Steward Health System, et al. v. Blue Cross & Blue Shield of Rhode Island, the court denied the defendants’ motion to dismiss, finding that plaintiffs had sufficiently pled a refusal to deal with a hospital by a dominant health plan.

Interesting prior the Highmark/WPAHS affiliation, WPAHS sued Highmark and University of Pittsburgh Medical Center (UPMC), the “dominant” hospital system in Pittsburgh, alleging a vertical conspiracy pursuant to which each would use its respective market power to protect the dominant position of the other. The allegations echo the concerns commonly raised in connection with vertical combinations. “The complaint alleges that UPMC agreed to use its power in the provider market to prevent Highmark competitors from gaining a foothold in the Allegheny County market for health insurance, and in exchange Highmark agreed to take steps to strengthen UPMC and to weaken West Penn.” West Penn Allegheny Health System v. UPMC, et al., 627 F.3d 85, 93 (3d Cir. 2010).

The Closing Statement also considered other antitrust issues commonly associated with vertical collaborations, such as the likelihood of either party sponsoring new entry, the possibility of anticompetitive information exchange, and the possibility of increasing the likelihood of horizontal collusion. United States v. Colgate Co., 250 U.S. 300, 307 (1919).


Blue Cross would have the Court believe that Steward’s refusal to deal claim fails as a matter of law because Blue Cross has the right to deal, or refuse to deal, with whomever it likes. . . . [T]he right of those engaged in private business to choose with whom they will deal is subject to the qualification that the right exists only in the absence of any purpose to create or maintain a monopoly. . . .
From a doctrinal perspective, then, healthcare looks very much like other industries. So how might healthcare be different? The answer lies not so much in legal doctrine, as in the context in which the industry finds itself. The healthcare industry is in the midst of an increasing focus on reducing costs and improving patient care. These goals are being driven, in part, by incentives in the Affordable Care Act. They are also reflected in antitrust enforcement statements from the FTC and DOJ. For example, the FTC/DOJ Accountable Care Organization guidelines provide for rule-of-reason treatment for ACOs that promote, among other benefits, enhanced reporting on quality and cost measures, and promotion of care coordination. This transition includes much-discussed revolutions such as the increasing use of clinical integration, and the formation of multi-specialty ACOs to promote care coordination and population health management. But it also includes a shift from “fee for service” to “pay for value.” Under the pay-for-value model, providers’ compensation is tied more to the health outcomes of their patients than to the particular procedures or services they perform. With incentives to coordinate care, manage conditions, and intervene early, pay-for-value is one tool to help patients, providers and payers prevent a major health problem before it arises, improving the result for the patient and avoiding the costs associated with a significant health event. Ideally, this increased sharing of risk will be a tool to better manage care, align incentives, and promote investment.

This unique context is important because it provides a helpful backdrop for vertical integration in healthcare. Whether it is a transaction or a conduct matter, it is important for a vertically integrated firm to be able to articulate a positive vision for how its transaction or its conduct will be beneficial to consumers, whether that includes a reduction of costs, the introduction of new products, or a more effective competitive position. In the healthcare context, the drive to reduce costs and improve patient care – and the concomitant transition from fee-for-service to pay-for-value – can provide a compelling story for firms who are committed to achieving these goals. By demonstrating a commitment to aligning incentives to improve care and lower costs, participants in a payer/provider integration can help assuage concerns that their integration might lead to anticompetitive foreclosure. Certainly, good intentions will not save a transaction or conduct that is manifestly anticompetitive, in healthcare or anywhere else. But the revolution taking place in healthcare does make it different, and can have a significant impact on how a vertical integration is viewed.

Conclusion

So does it matter that it’s healthcare? While there may not be doctrinal differences for payer/provider integrations, the unique shift taking place in healthcare, and the benefits that

Complaint alleges sufficient facts to suggest that Blue Cross’ conduct falls within the scope previously found by courts to be violative of the antitrust laws.”)
such transactions promise, do make them different than similar combinations in other industries. Viewing healthcare as “just another industry” would be a mistake, and would miss some important developments driving healthcare that can materially impact the analysis of a payer/provider combination.