

Market Power: Advanced Antitrust Issues for Payors and Providers

Arthur N. Lerner

Crowell & Moring LLP

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(more)

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“You’re Special....., But No Contract for You” (more)

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MARKET POWER:
ADVANCED ANTITRUST ISSUES FOR PAYORS AND PROVIDERS

Arthur Lerner
Crowell & Moring
Washington, D.C.

American Health Lawyers Association
Payors, Plans and Managed Care Institute
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I. INTRODUCTION

While antitrust enforcement and litigation seem at times to cover the “same old” issues, there are fresh twists and new challenges. We focus on a few cases today involving – the latest twists and turns in health plan and hospital merger enforcement, tie-ins and bundling in health care provider contracting, “clinical integration” as a potential pathway for joint provider contract negotiations, and alleged conspiracies to exclude new entrant hospitals from managed care networks.

II. HOSPITAL MERGER ENFORCEMENT: THEY'RE BA-ACK

After years of losses and then quiet on the hospital merger federal antitrust enforcement front, the FTC has been pressing forward with innovative hospital merger enforcement measures. Since this is an “advanced” session, we do not review the prior track record of defeats for the

agencies¹ or the separate initiatives by state attorneys general that were in some instances more successful during that same time period.

A. Evanston Northwestern:

In 2004, the FTC challenged Evanston Northwestern Healthcare Corporation's ("ENH") acquisition, four years previously, of Highland Park Hospital ("Highland Park").² The case arose following an FTC staff retrospective study of the effects of mergers that had already been consummated. Ironically, although the Commission eventually ruled the merger unlawful, it did not order divestiture due to the "high costs and potential disruptions to patient care" that could result from separating the hospitals after seven years.³ The Commission ordered the merged hospitals to set up independent contracting teams, one for ENH and one for Highland Park, that are to "compete" with each other in managed care contracting.⁴

Since there was no attempt to block the merger before it occurred, the Commission used its own administrative law judge trial process and avoided the federal district courts that had in prior years been inhospitable to federal government hospital merger enforcement actions. This time, the first trip to

¹ See *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 (8th Cir. 1999); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1300-1301 (W.D. Mich. 1996); *United States v. Long Island Jewish Med. Center*, 983 F. Supp. 121 (E.D.N.Y. 1997); *FTC v. Freeman Hosp.*, 69 F.3d 260 (8th Cir. 1995); *United States v. Mercy Health Servs.*, 902 F. Supp. 968 (N.D. Iowa 1995); *FTC v. Hosp. Bd. of Lee County*, 38 F.3d 1184, 1187 (11th Cir. 1994).

² *In re Evanston Nw. Healthcare Corp.*, 2007-2 Trade Cas. (CCH) ¶ 75,814 (F.T.C. Aug. 6, 2007), slip op. avail. at <http://www.ftc.gov/os/adjpro/d9315/070806opinion.pdf>.

³ *Id.* at 89.

federal court is the hospitals' now pending appeal from the Commission's final decision. Since the trial was held years after the merger, it created interesting opportunities for proving market definition and anticompetitive effects, while making effective relief uncertain.

1. Market Definition and Effects

The Commission disapproved reliance on so-called Elzinga-Hogarty patient flow analysis for determination of hospital geographic markets. Heavy reliance on patient flow data has been criticized from both sides. On the one hand, it is "static" in nature, not necessarily shedding light on what would occur in response to a price or increase or other change in market dynamics. On the other, it may place undue emphasis on the choices open to individual patients, and not on the managed care contracting dynamics affecting hospital pricing. Instead, the key locus of hospital price competition is the negotiation of contracts with third-party payors, the Commission indicated.

While some individual patients might be willing to travel considerable distances for hospital care, outside a hypothesized geographic market, a payor might have to include hospitals within that area in its panel of participating hospitals in order to have a marketable health benefits product. Such a hospital might therefore be able to exercise market power in its price

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⁴ *Id.*

negotiations with payors, even if there are a substantial number of patients who leave the area for health care services. The Elzinga-Hogarty test was also faulted for assuming that because some patients are willing to travel to distant hospitals, other patients in large numbers could and would switch to other hospitals in response to increased prices. If the proportion of patients who are “in play” or “contestable” is not great, this is a factor supporting definition of a narrower geographic market.

In *Evanston*, the Commission relied on post-merger pricing to help define the relevant geographic market. The hospitals’ post-merger price increases had not induced sufficient numbers of customers to switch to other hospitals whose prices did not rise as rapidly, the Commission noted. In a way, the evidence permitted a backwards market definition analysis. Since the price increase stuck, there must be market power, and if there is market power, there must be a narrower geographic market than that alleged by the hospitals, the Commission in effect reasoned, rejecting claims by the hospitals that other factors explained the increase in prices, apart from market power. The Commission noted that “market definition is not an end in itself but rather an indirect means to assist in determining the presence or the likelihood of the exercise of market power.”⁵

⁵ *Evanston*, slip. op. at 86-87.

2. Implications for Future Challenges

Divestiture is the remedy of choice in merger enforcement. The Evanston remedy – telling two components of the same parent business entity to “compete” with each other – is, at best, not ideal. For this and other reasons, it is not likely that we will see a major continuing emphasis on post-hospital merger antitrust enforcement where the agencies could rely on years of post-merger pricing behavior as evidence. The bulk of future enforcement activity will be focused on newly proposed mergers.

B. Inova Health System – Prince William Health System Merger

In May 2008, the FTC issued an administrative complaint challenging Inova Health System Foundation’s proposed acquisition of Prince William Health System, Inc.⁶ The FTC with the Virginia Attorney General also requested the federal district court in Northern Virginia to issue a preliminary injunction blocking the merger. While both proceedings were pending, Inova and Prince William announced they were abandoning the merger because of the challenge and what they said were “unusual process

⁶ *Inova Health System Foundation*, Dkt. 9326 (May 8, 2008).
<http://www.ftc.gov/os/adjpro/d9326/080509admincomplaint.pdf>

changes by the Federal Trade Commission [that] threatened to prolong completion of the merger by as much as two years.⁷

Inova already operated five hospitals in Northern Virginia and had grown significantly through acquisitions. Prince William owns a 180 bed hospital in Manassas, Virginia. The Complaint alleged the merger would give Inova control over 73 percent of the licensed beds in Northern Virginia and eliminate a key “head to head” competitor, with only four independent hospitals left in Northern Virginia.

The Commission took some innovative steps. First, apart from the federal court preliminary injunction action, the Commission assigned one of its own commissioners to preside over the administrative proceeding on its complaint. The FTC staff moved the parallel administrative complaint on a fast track, resisting efforts by the hospitals to stay discovery in the administrative proceeding. The Commission staff also pressed an argument in the federal district court that the preliminary injunction proceeding should not be the virtual equivalent of a full-blown hearing on the merits. They urged the district court to move quickly, to limit depositions and not to require live testimony in the injunctive action, instead offering to produce affidavits and documentary evidence to support the showing required for

⁷ Statement from Inova Health System and Prince William Health System about the Proposed Merger. June 6, 2008
http://newsroom.inova.org/article_display.cfm?article_id=5135&archiveYear=2008

interim relief. The court, in Northern Virginia’s “rocket docket” agreed with the FTC staff’s proposed handling for the hearing, and the hospitals abandoned the merger without even waiting to see how the court would rule on the injunction, issuing a press release complaining about the “unusual” process changes by the Commission and its staff. The Commission then dismissed its Complaint.⁸ While the procedural maneuvering is “inside baseball,” it is important to recognize that the Commission’s successful litigation strategy will, at the margins, give the Commission confidence for future challenges.

On the merits, the Commission again focused on the impact of the merger on competition for participation in health plan provider networks, alleging up front in paragraph 1 of the Complaint that “health plans are the direct customers” of the hospitals. (emphasis added). This would appear to be an overstatement, and was seemingly qualified by other allegations in the complaint about competition on the basis of quality, customer service and other factors, but it nonetheless shines a light on the FTC’s core analytical premise.

The Complaint also returned to use of patient flow data as one factor in support of the alleged geographic market. The Complaint states at ¶ 22:

⁸ Order Dismissing Complaint, Dkt. 9326 (June 17, 2008).
<http://www.ftc.gov/os/adjpro/d9326/080617orderdismisscpt.pdf>

Few patients who live within the relevant geographic market travel outside its borders to seek these general, acute care inpatient services in, for example, Maryland or Washington, D.C. hospitals. In 2006, for the hospitals located in Northern Virginia, approximately 90 percent of their patients came from Northern Virginia. Of the patients who reside in Northern Virginia, approximately 90 percent go to hospitals in Northern Virginia.

The quote is a striking echo of the Elzinga-Hogarty test.

Two themes on the merits are also notable. Both concern market power. First, even if a hospital system is a “must have” for managed care network marketability, it may be argued that if patients could travel outside the putative geographic market for care, an attempt to force price increases on managed care payors could be defeated by payors steering patients to other hospitals, either inside or outside the network. This argument is weakened, though, if the hospital system has sufficient power to secure above market prices in its managed care contract, and it also has sufficient power to include contract language or otherwise prevent steering large numbers of patients to other hospitals. The government apparently had affidavits from numerous payor witnesses to address this and related issues.

Second, there was relatively little emphasis in the *Inova* case on allegations that Prince Williams’ competition helped constrain the larger Inova system’s prices. Instead, the Complaint highlighted that two of the larger system’s hospitals were the key competitive alternatives to the smaller Prince Williams hospital. The loss of that competition appears to have been the key focus of the complaint.

III. HEALTH PLAN MERGERS -- UNITEDHEALTH GROUP – SIERRA HEALTH SERVICES

Mergers of health insurers that create market power either in the sale of health benefits products or in the purchase of health care providers' services are subject to challenge by federal and state antitrust enforcers and by state insurance departments. The UnitedHealth Group acquisition of Sierra Health Services illustrates some of the issues and proceedings involved.⁹

UnitedHealth Group announced its agreement to acquire Sierra Health Services in March 2007. Sierra and United were leading players in the sale of health insurance products in the Las Vegas, Nevada area. Quickly, concerns were raised by some provider and consumer advocacy organizations that the transaction would lessen competition. Subsequently, reviews of the merger's competitive impact were conducted by the Nevada Insurance Commissioner, the Nevada Attorney General, and the Antitrust Division of the Department of Justice.

The Insurance Commissioner acted first. She approved the merger after extensive hearings, finding insufficient grounds to conclude that the merger would lessen competition either in the sale of health insurance to

⁹ The presenter represented Sierra Health Services in this matter and the combined entity in the Tunney Act proceedings.

small employer groups, or in the purchase of health care provider services.¹⁰ She also found that HMOs were not in a separate product market from PPOs, and at least with regard to larger employers, insured products were in the same market with self-insured product offerings. She deferred to the Department of Justice with regard to Medicare product offerings.¹¹

On February 25, 2008, just before the acquisition closed, the parties reached settlements with DOJ and the Nevada Attorney General. Both filed complaints alleging that the merger would lessen competition in a market “no larger than” the sale of Medicare Advantage (MA) plans to individuals. The settlements call for United to divest all assets dedicated to the administration and selling of its individual Medicare Advantage plans in the Las Vegas metropolitan area, including its MA HMO that was marketed as “Secure Horizons” and later as “Medicare Complete” with the endorsement of the AARP. The divestiture sought to remedy substantially increased concentration in the already concentrated alleged market for Medicare Advantage plans sold to senior citizens in the Las Vegas area.

This alleged market, of which United and Sierra together controlled 94 percent, was defined in the complaints as separate from the Medicare fee-for-service program, including the new Medicare Part D drug benefit, because,

¹⁰ See Findings of Fact, Conclusions of Law and Order, *In re: Acquisition of Health Plan of Nevada*, Cause No. 07.188 (State of Nevada Division of Insurance, Aug. 27, 2007) at ¶¶ 67 - 74, 80 - 92, 108.

¹¹ *Id.* at ¶¶ 109 - 111 and p. 45.

the complaints alleged, an insufficient number of MA plan enrollees would switch to fee-for-service plans in response to small but significant price increases by United post-merger. Implicitly, both enforcers rejected the notion that Department of Health and Human Services review, negotiation and approval of Medicare Advantage bids, benefit packages and premiums would prevent the exercise of market power.

In a “fix it first”-type remedy, the settlement called for United to sell its MA assets (with the first attempted sale to Humana) and to provide the acquiring party with transitional support for operational aspects of the plan, assistance negotiating with providers to ensure few changes for enrollees. On May 1, 2008, with the approval of DOJ and the Nevada Attorney General, United divested its individual Las Vegas Medicare Advantage business to Humana, the nation’s second largest Medicare Advantage company.

The Nevada Attorney General consent judgment has some additional requirements, including limitations on use of exclusive provider contracts and “all products” and “most favored customers” clauses, creation of a physicians council, and contributions to charity.

The DOJ consent judgment was published for public comment pursuant to the Tunney Act. Commenters, including the American Medical Association and the Service Employees International Union, objected that the complaint and order did not address the merger’s purported creation of undue market power in the purchase of health care provider services and also failed

to alleviate alleged harm to competition in the sale of health insurance products to small employer groups. They also alleged, with somewhat less vigor, that the DOJ order did not adequately remedy harm to the Medicare Advantage market because it did not require divestiture of commercial lines of business to help the acquirer get a firmer foothold, did not restrict for a longer period United's use of certain trademarks, and did not tackle provider contracting concerns that that the Nevada Attorney General did address.

Last month, the federal district court rejected the commenters' request for further hearings and for an opportunity to present additional evidence. She noted that their "chief argument is that the potential harm is broader than that alleged in the complaint, which only addresses the Medicare Advantage market. . . . [but that] the Court's review is limited to the scope of the complaint, so the Court cannot consider any additional information about other markets." She also found that the government established that its proposed remedies sufficiently address the potential harm to the Medicare Advantage market.¹² She entered the final judgment.¹³ The Nevada federal district judge followed suit last week, entering the parallel final

¹² See *United States v. UnitedHealth Group Incorporated*, Case 1:08-cv-00322-ESH Document 19 (D.D.C. Sept. 24, 2008).

¹³ *Id.*, Document 18 (D.D.C. Sept. 24, 2008).

judgment resolving the complaint issued by the Nevada Attorney General.
bringing finality to the enforcement actions concerning the merger.¹⁴

Take aways:

1). Market shares in the sale of various health benefit products do not translate automatically into the same market shares in the purchase of health care provider services. The commenters on the DOJ consent judgment objected that, whereas DOJ has pursued monopsony allegations in prior health plan merger enforcement actions,¹⁵ it may have erred in its United-Sierra analysis by including government source Medicare and Medicaid program revenues in the calculus used to determine whether a private insurer would have “monopsony” power in the purchase of health care provider services.¹⁶ They claimed that providers cannot economically depend

¹⁴ *State of Nevada v. UnitedHealth Group Incorporated*, Case No. 2:08-cv-00233-JCM-(RJJ) (Document 16), Stipulated Final Judgment (D.Nev. Oct. 8, 2008).

¹⁵ *United States v. Aetna Inc.*, Case No. 3:99CV1398-H (N.D. Tex. June 21, 1999) (complaint), available at www.usdoj.gov/atr/cases/f2500/2501.pdf; *United States v. UnitedHealth Group Inc.*, Case No. 1:05CV02436 (D.D.C. Dec. 20, 2005), available at <http://www.usdoj.gov/atr/cases/f213800/213815.htm>.

¹⁶ A federal district court judge has noted the possible separateness of government program markets from commercial health insurance products as an issue for resolution after discovery. See *Powderly v. Blue Cross Blue Shield of North Carolina*, Dkt. No. 3:08-cv-00109-W (W.D.N.C. Sept. 4, 2008) (order denying motion to reconsider denial of motion to dismiss). The court found that, for purposes of a motion to dismiss, the plaintiffs claim that the defendant had over 60% of the market for commercial health insurance was, in context, a sufficient factual basis to support its claims in the nature of monopsony, since market power as a seller could be an indication of market power as a buyer. It ruled that the proper treatment of Medicare and Medicaid patients in this assessment could be considered at a later stage of the proceedings. An issue not yet addressed in the case is what conduct is required to prove unlawful “monopsonization”. It would presumably not be enough to prove

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on Medicare or Medicaid program revenues as an alternative to reduced prices from a commercial payor, because the government programs already pay at a lower level. This contention has not been validated.

2) Because of the perceived inability of small employers to self-insure, there may be a tendency for merger reviewers to focus separately on an alleged small employer market or sub-market, as the Nevada Insurance Commissioner did in the United-Sierra matter.

3) The financial support given to the Medicare Advantage program by Congress in recent years has helped permit plans to offer “zero premium” plans that, for those interested in Medicare Advantage products, may offer a clear cost advantage over traditional Medicare paired with a Medicare Supplement product and/or a Medicare Part D product. If Congress sharply cuts back on funding for Medicare Advantage products, it could undermine whatever legitimacy there may be for claims that Medicare Advantage products are in a separate product market from the traditional Medicare program.

4) The remedies included in the Nevada Attorney General consent judgment include a potpourri of provisions, including contributions to charity

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that the alleged monopsonist has market power and that it is using that power in a manner that harms competitors in, or competition in, a provider services market. Rather, it would seem necessary for the plaintiff to prove that the alleged monopsonist has taken unreasonably exclusionary or predatory action that would tend to create or preserve its own monopsony power.

and support for the development of better dispute resolution systems in coordination with the Governor’s Office of Consumer Advocacy. The Attorney General’s inquiry was undertaken even though state law authority over the merger appears to have been vested with the Commissioner of Insurance.

IV. “IT’S AN ALL OR NOTHING DEAL”: THE “BUNDLING” CONUNDRUM IN HEALTH SYSTEM CONTRACTING

Bundling, or selling products together at a discount from their prices when purchased separately, is common in the health care sector. While it is generally beneficial or innocuous, bundling may sometimes raise serious antitrust concerns. The principal concern is that market power in one arena will be used to harm competition in an adjacent or separate market or product. Depending on the circumstances, bundling may implicate predatory pricing or other monopolization benchmarks, tie-in analysis, or exclusive dealing standards.

A. Bundling Bubbling Up in Monopolization Law

In *Cascade Health Solutions v. PeaceHealth*, an appeal from a plaintiff’s jury verdict in a hospital v. hospital dispute regarding pricing deals with managed care plans, the Ninth Circuit took the unusual step of asking for amicus briefs on the appropriate treatment of bundled contract pricing

under Section 2.¹⁷ Its detailed ruling rejected both a pro-plaintiff standard and a more defense oriented standard, deciding that the full impact of bundled price cuts can be allocated to a product line where competition is affected to see if net pricing is below cost and unlawfully predatory.¹⁸

In *PeaceHealth*, the McKenzie Hospital, a 114 bed hospital that provided primary and secondary but no tertiary hospital care, and PeaceHealth, which included the larger 432 bed Sacred Heart Hospital and two smaller hospitals, and which provided primary, secondary, and tertiary care, were the only two providers of hospital care in Lane County, Oregon.¹⁹

McKenzie sued PeaceHealth on antitrust tying, exclusive dealing, monopolization, attempted monopolization, conspiracy to monopolize, and state law grounds, claiming that PeaceHealth had restrained competition by acquiring smaller “feeder” hospitals, acquiring medical practices, and anticompetitive pricing/bundling in contracts with the Regence health plans and other insurers.²⁰ McKenzie alleged that PeaceHealth, in its nonexclusive insurance arrangements, priced services in which it competed with McKenzie

¹⁷ See 515 F.3d 883, 899 n.9 (9th Cir. 2008).

¹⁸ See *id.* The Ninth Circuit initially decided this matter in a September 4, 2007 opinion, 502 F.3d 895 (9th Cir. 2007), which had, inter alia, vacated the jury’s verdict in favor of McKenzie-Willamette Hospital on an Oregon state law price discrimination claim. On February 1, 2008, however, the court superseded and amended the initial opinion, certified a question regarding the price discrimination claim to the Oregon Supreme Court, and stayed further proceedings pending resolution of the certified question.

¹⁹ 515 F.3d at 891.

below cost, recouping revenues by linking these low prices to supracompetitive prices for services for which PeaceHealth had no effective competition.²¹ McKenzie also alleged that PeaceHealth formed a preferred provider agreement with the Regence plan under which Regence agreed to exclude McKenzie from preferred provider status in exchange for PeaceHealth providing Regence with large discounts.

At trial, the judge instructed the jury as follows:²²

Bundled pricing occurs when price discounts are offered for purchasing an entire line of services from one supplier. [This] may be anticompetitive if [the discounts] are offered by a monopolist and substantially foreclose . . . a competitor who does not provide an equally diverse group of services

The jury ruled for the defense on the exclusive dealing claim, but found for the plaintiff on the attempt to monopolize claim based principally on a bundling theory.²³ On appeal, the defendant insisted that bundling of services cannot be unlawful if the discounted prices offered on the “bundled” services are not priced below the hospital’s cost.²⁴ PeaceHealth relied on Supreme Court precedent from more traditional single product predatory

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²⁰ *Id.* at 890-92.

²¹ *See id.* at 892-93.

²² *See id.* at 898

²³ *Id.* at 893.

²⁴ *Id.* at 898-99.

pricing contexts reflecting hostility to finding price reductions unlawful since they are almost always beneficial to competition and consumers.

The Ninth Circuit took an unusual step. It asked the public for amicus briefs. It got a bunch. They fell loosely into three categories.

- **Position 1** argued that bundling is only potentially unlawful if pricing for the entire package is below the appropriate cost threshold for predatory pricing.
- **Position 2**, bundling is unlawful if:
 - (a) after allocating all discounts and rebates attributable to the entire bundle of products to the competitive product, the defendant sold the competitive product below its incremental cost for the competitive product;
 - (b) there is a likelihood that the defendant will recoup the short term losses caused by the bundling discount, such as through predatory pricing after competitors have been excluded by the bundling; *and*
 - (c) the bundling practice will have an exclusionary impact on competitors
- **Position 3** -- bundling may be an exclusionary practice supporting an antitrust claim where, on balance, it has an anticompetitive impact that outweighs procompetitive aspects, even in the absence of evidence that sales were below the hospital's cost.

The Ninth Circuit adopted a variation of Position 2. It applied the first criterion of the three-part test without modification, but found the next two criteria unnecessary since they are largely subsumed within the other elements of a plaintiff's proving a claim of monopolization or attempted monopolization.²⁵

²⁵ 515 F.3d at 903-10

B. Tie-in Analysis as an Alternative to the Predatory Pricing Monopolization Rubric

This discussion has analyzed bundling through the lens of monopolization benchmarks, but bundling can be looked at in other ways as well. If the impact of bundling is to use the seller's market power in Product 1 to effectively force acceptance of the bundle, and thus purchase of Product 2,²⁶ then the conduct may be separately analyzed under tie-in and/or exclusive contract standards without regard for a "predatory pricing" test. Proper treatment of tie-in and exclusive dealing contracts is itself an evolving antitrust issue.²⁷

Tie-in analysis can apply even if the products are seemingly available separately, if the seller imposes a price differential so severe as to effectively

²⁶ In *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984), the Court stated: "It is far too late in the history of our antitrust jurisprudence to question the proposition that certain tying arrangements pose an unacceptable risk of stifling competition and therefore are unreasonable "per se." See also *Northern Pacific R. Co. v. United States*, 356 U.S. 1, 11 (1958). Notwithstanding this precedent, it is unclear whether the Supreme Court will, when the issue is next presented, uphold the long-standing doctrine that imposition of a tie in another product line by a firm with market power in the tying product is per se illegal when a substantial amount of interstate commerce is affected. In light of the court's recent rejection of the long-standing precedent applying the per se rule to resale price maintenance agreements (*Leegin Creative Leather Products, Inc. v. PSKS, Inc.*, No. 06-480 (June 28, 2007)), the continued vitality of the per se rule for any tie-ins is uncertain.

²⁷ The Department of Justice, for example, has called for "rule of reason" treatment of tie-ins, even when used by dominant firms, rather than the "per se" rule, to bring their treatment more in line with recent judicial trends, in contrast to their treatment historically. See *Competition and Monopoly: Single-Firm Conduct under Section 2 of the Sherman Act*, Department of Justice (Sept. 2008) at p. 89. www.usdoj.gov/atr/public/reports/236681.pdf

leave customers no choice, thereby imposing a de facto tie.²⁸ The Ninth Circuit recognized this possibility when it reversed the district court’s grant of summary judgment in PeaceHealth’s favor on the tie-in claims – a decision the district court reached simply because alleged tying and tied products were, technically, offered separately by the defendant.²⁹ In this scenario, the bundling may not be viewed as a form of discounting, but rather as a form of coercion. Thus, ironically, the offense could be framed as forcing purchase of bundled goods at above market prices, as opposed to predatorily low prices.

In the managed care contracting context, these arrangements may be reinforced by additional restrictive contracting terms that: (1) prohibit health plans from giving incentives to providers to use less expensive providers; (2) restrict health plan use of benefit designs that give consumers financial incentives to use less expensive providers; (3) restrict plans from educating providers or enrollees on the relative costs of various health care providers in the network; and (4) impose restrictions on plans’ ability to implement “center of excellence” programs for selected health care services.

The Department of Justice has proposed that where competing firms are able to offer “bundle to bundle” competition, a safe harbor should apply to product bundling so long as the pricing for the entire package is not

²⁸ Even where the seller lacks market power in the tying market, a tie may be unlawful under the rule of reason if it can be shown to have anticompetitive effects in a relevant market. *See Med Alert Ambulance, Inc. v. Atlantic Health Sys, Inc.*, Civ. A. No. 04-1615 (JAG) (D. N.J. Aug. 6, 2007) (denying defendant’s motion for summary judgment)

predatory. If bundle to bundle competition is not practicable, a safe harbor would be available if conditions for allocation of the discount similar to the *Peace Health* standard are met. It also provided suggestions for analysis of situations outside both its proposed safe harbors.³⁰ The FTC did not join in the new proposed safe harbor guidance.

V. “I’M INTEGRATED, CLINICALLY”: EVOLVING PROVIDER NETWORK CONTRACTING ISSUES

Antitrust issues associated with the “messenger model” and joint negotiation of managed contracts by health care providers who are sharing “risk” and thereby “financially integrated” are long-standing staples of antitrust guidance and enforcement. In this session, we will comment briefly on some salient issues that arise in connection with joint managed care contracting negotiation by providers who are, or purport to be, “clinically integrated.”

Joint price setting is not subject to outright condemnation as *per se* price fixing, but rather benefits from rule-of-reason analysis, *if* it is ancillary or incidental to a broader productive joint venture activity. Examples include

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²⁹ 515 F.3d at 892.

³⁰ Competition and Monopoly: Single-Firm Conduct under Section 2 of the Sherman Act, Department of Justice Antitrust Division (Sept. 2008) at 101-02. www.usdoj.gov/atr/public/reports/236681.pdf

risk-sharing to encourage joint efficiency-enhancing efforts in the delivery of health care services or price-setting cooperation needed to make possible valuable clinical integration. Joint price-setting that is purportedly premised on its nexus to clinical integration activities, but that cannot be justified on that basis, will be vulnerable to antitrust enforcement action.

The clinical integration approach is exemplified in the favorable FTC staff advisory opinion issued to the Medsouth multispecialty physician IPA in Colorado.³¹ The advisory opinion emphasized that apart from demonstrating that the collaboration would produce productive efficiencies, the physician network was able to identify plausible grounds on which its joint contracting activities were reasonably necessary for the efficiency enhancing cooperation. They claimed that it was key to assure widespread participation by providers in the time-consuming and expensive development of treatment protocols and that re-allocation of relative values in commonly used fee schedules would give appropriate recognition and emphasis to the primary care services that were central to the network's functioning effectively. Some observers have seized upon the "clinical integration" model as a new "preferred" pathway for joint contract negotiation by providers.

Three key cautions are in order. First, if the collaboration will create or enhance market power, then even if the activity produces efficiencies it

³¹ Feb. 19, 2002, avail. at <http://www.ftc.gov/bc/adops/medsouth.htm>.

would still likely pose serious antitrust risk. Therefore, if the intention of the parties is to stick together and use market power to generate price levels higher than the competitive norm for services of comparable value, antitrust risk will be high, regardless of the robustness of the clinical integration.

Second, if there is activity to promote clinical improvement but there is “integration” or interdependence among the participating providers, then a precondition is not established. For example, a group of competing providers could form an association with each provider agreeing to hire a consultant to give advice to that physician practice on possible clinical improvements the practice might undertake. This would not appear to involve any material clinical “integration” even if there might be major clinical improvements that result.

Third, the requirement of nexus between prospective efficiencies from integration and the joint contracting or pricing activity is a serious one, not always easy to meet. The Fifth Circuit Court of Appeals recently ruled for the FTC in a key case, *North Texas Specialty Physicians v. FTC*,³² the first appellate decision to address “messenger model” contentions are other key issues involved in provider network contracting. The ruling addressed a series of contentions that the appellant’s conduct did not constitute or reflect any agreement to restrain competition. While “agreement” issues drew much

³² *N. Tex. Specialty Physicians v. FTC.*, 528 F.3d 346, 352 (5th Cir. 2008).

of the court’s attention, the decision also focused critically on the defendant’s claims that its joint managed care contracting activities could be justified by the quality enhancements fostered by the organization’s activities. The Court stated pointedly that “closer examination of the underpinnings of the justification reveals significant gaps in logic.” The Court noted favorably the FTC’s observation that the defendant “does not address how [its] nebulous ‘teamwork’ efficiencies are dependent on its price-fixing activities” and that appellant did not explain 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” its joint activities restraining price competition.³³ The medical group did not cogently articulate how the quality of the professional service that its members provide is enhanced by the price restraint. This condemned the group’s rule of reason defense.

VI. “YOU’RE SPECIAL, BUT NO CONTRACT FOR YOU” – ALLEGED CONSPIRACIES AGAINST PHYSICIAN OWNED SPECIALTY HOSPITALS OR AMBULATORY SURGERY CENTERS

New entrants frequently claim that entrenched competitors seek unfairly to exclude them from the marketplace. In health care, these claims may take the form of allegations that full service hospitals have conspired with managed care organizations (“MCOs”) to deny new specialty hospitals or

³³ *Id.* at 369.

ambulatory surgery centers, not affiliated with full-service hospitals, from network participation. We cannot give full treatment here to the issues that can arise in this arena. It is key to appreciate, though, that whereas unilateral business activity is only rarely of antitrust moment, evidence of agreement can seriously aggravate antitrust risk. One recent federal district court opinion highlights how a court found that a combination of weak direct evidence, a plausible economic motive for conspiracy and permissible inferences from circumstantial evidence warranted denial of defendants' motion of summary judgment.³⁴

The plaintiff specialty hospital alleged a conspiracy of area hospitals and managed care companies to boycott the plaintiff. The court sifted through the evidence to assess whether there was sufficient evidence of conspiracy to deny summary judgment for the defendants, considering the evidence defendant by defendant. Evidence the court noted included network configuration clauses that triggered higher rates, notice to the hospital or a requirement for permission from the contracted hospital, if a health plan added a specialty hospital to its panel.

The court also quoted from statements by one defendant hospital official to a payor:

³⁴ See *Heartland Surgical Specialty Hospital, LLC v. Midwest Division, Inc.*, Civ. Action No. 05-2164-MLB (D.Kan. Oct. 1, 2007).

Thanks for confirming what I thought was the case re [plaintiff]. I think they're desperate, hoping that they can convince an MCO that they're being added to everybody else's networks so that MCO will feel the pressure to also add. All he probably thinks he needs is one deer-in-the-headlight MCO to cave and then rest will fall like dominos.³⁵

A former staff member for one health plan also testified to an “understanding, unwritten but understood,” among MCOs not to extend managed care contracts to specialty hospitals. Hospital and managed care officials also attended dinner together where a hospital official said it was his hospital's preference that MCOs not contract with physician-owned specialty hospitals and MCO representatives acknowledged that they had not offered contracts to new specialty hospitals.³⁶

The court considered this evidence, along with other plaintiff and defense evidence, including denials of concerted activity and evidence purporting to show that the defendants' actions were fully explained as unilateral behavior in pursuit of their own legitimate business objective. Various defendants also sought to deny admissibility against them of hearsay statements by representatives of other alleged conspirators. Ultimately, in a 126 page opinion, the court denied summary judgment on the core antitrust claims.

³⁵ *Id.* at 48.

³⁶ *Id.* at 55.