CURRENT ANTITRUST ISSUES RELATING TO PHYSICIAN MERGERS, ACQUISITIONS AND COMBINATIONS

David A. Ettinger
Honigman Miller Schwartz and Cohn LLP
Detroit, Michigan

I. INTRODUCTION

With the onset of accountable care organizations and the rapidly increasing pace of mergers and acquisitions involving physician practices, the antitrust concerns relating to physician transactions are becoming much more significant. Important events in the last year have included at least three antitrust challenges to physician mergers or acquisitions, and the release of the Antitrust Enforcement Policy Regarding Accountable Care Organizations ("ACO Antitrust Enforcement Statement"). Antitrust concerns will become increasingly important in dealing with physician transactions, whether undertaken by physicians or by hospitals, and whether involving merger acquisition or an ACO or other network.

II. RECENT CASES

There have been several recent antitrust actions relating to acquisitions of physician practices. On September 1, 2011, the State of Pennsylvania entered into a consent order with a Harrisburg urology practice that was formed as a result of the merger of five smaller practices. *Commonwealth of Pennsylvania v. Urology of Central Pennsylvania, Inc., Urology Associates of Central Pennsylvania, P.C., Mid-Penn Urology, Inc. and Harrisburg Uro-Care Group* (M.D. Pa. Case No. 11-01625).[1] The complaint alleged that the merged urology practice represented the only urology group in the Harrisburg metropolitan area and more than half the urologists in the

[1] Mr. Ettinger litigated the *Urology of Central Pennsylvania* case.

alleged relevant market. The order resulted from an investigation commencing two years after the merger occurred in 2005.[2]

Another recent action involved the proposed acquisition of two cardiology practices by Providence Health Care in Spokane, Washington. An analysis of public sources suggests that these transactions would have given Providence control over approximately 60% or more of the cardiologists in the area. The transaction was abandoned in the midst of an FTC investigation. Providence later acquired one of the cardiology groups, without government intervention.

State of Maine v. MaineHealth, Maine Medical Center, Maine Cardiology Associates, P.A. and Cardiovascular consultants of Maine, P.A. (Maine Sup. Ct. 2011), involved the acquisition of the two major cardiology practices in the Portland, Maine area by Mercy Hospital. The parties entered into a consent decree.

The combination of physician practices has in the past rarely been the subject of antitrust review, in part because such transactions are usually too small to come to the federal government's attention under the Hart-Scott-Rodino pre-merger notification process. However, *Urology of Central Pennsylvania* illustrates that actions can be brought based on post-merger conduct, if that conduct generates complaints to enforcement authorities. None of these transactions required Hart-Scott-Rodino filings.

The ACO Antitrust Enforcement Statement may have an even greater impact. Compliance with the Enforcement Statement is not mandatory in order to qualify for CMS approval of an ACO, but antitrust agencies will be receiving information directly from CMS on

[2] While only the State of Pennsylvania ultimately pursued the consent order in the *Urology of Central Pennsylvania* case, the earlier investigation also involved the Federal Trade Commission.

ACO applications, and will be in a position to directly monitor each such application. As a result, those combinations will likely receive a more careful antitrust review in the future.[3]

III. RELEVANT PRODUCT MARKET

The first step in evaluating any merger involves defining a relevant product market and geographic market. This is required because the ultimate question in deciding whether a merger is legal (whether it is likely to have anti-competitive effects) must be assessed with reference to a particular market. The proper definition of the relevant market is a "necessary predicate" to assessment of whether an acquisition may lessen competition substantially in violation of Clayton Act § 7 and Sherman Act § 1.[4] The party challenging a merger bears "the burden of describing a well-defined relevant market, both geographically and by product."[5]

That same context is necessary to assess many of the questions that are important to an analysis of market power and market share. For example, market share cannot be determined without a definition of the market within which the share is to be calculated.

Courts have defined the relevant product market as consisting of all firms that:

- produce or sell the same products or services as the merging firms;
- produce or sell close substitutes for those products; or

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[3] For many years, federal antitrust agencies have frequently challenged physician hospital organizations and physician networks, especially where these organizations were not sufficiently integrated.

[4] *United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586, 593 (1956); *United States v. General Dynamics Corp.*, 415 U.S. 486, 510 (1974); *United States v. Columbia Steel Co.*, 334 U.S. 495, 527 (1948).

[5] *H.J., Inc. v. International Tel. & Tel. Corp.*, 867 F.2d 1531, 1537 (8th Cir. 1989); *Morgenstern v. Wilson*, 29 F.3d 1291 (8th Cir. 1995); *Flegel v. Christian Hosp., Northeast-Northwest*, 4 F.3d 682 (8th Cir. 1993).

- could produce or sell those products or substitutes with relatively little effort.[6]

Typically, government enforcers will look at a traditional physician specialty area as a product market, while treating primary care as one such market. The ACO Antitrust Enforcement Statement suggests that the traditional specialty classifications are at least the starting points for an antitrust market.[7]

There can be room to argue in particular cases that the relevant product market is broader than a single specialty, because other physicians may provide competition for some or all of a specialty's services. *See e.g. Pulmonary Assocs., Ltd.,* DOJ Business Review Letter (Oct. 31, 1994) (pulmonology not a market because of competition with general surgeons, cardiac surgeons and primary care physicians) and *CVT Surgical Center*, DOJ Business Review Letter (April 16, 1997) (in evaluating a merger of cardiovascular and peripheral vascular surgeons, market could include "cardiologists and other specialists").

The scope of a "primary care" market can also be debatable. In *HTI Health Services, Inc. v. Quorum Health Group, Inc.*, 960 F. Supp. 1104, 1116 (S.D. Miss. 1997), the court held that pediatricians constituted a separate submarket, separate from other primary care physicians. The court accepted expert testimony that while "pediatricians provide primary care to children, they cannot substitute for internists or general practitioners in the formation of a manage care panel." *Id.* Additionally, the court declined to include obstetrician/gynecologists in the primary care market, stating that the "record does not identify any specific ob/gyn in the Vicksburg area who is generally capable of providing primary care services to the population as a whole and who

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[6] *United States v. E.I. du Pont e Nemours & Co.*, 351 U.S. 377, 195 (1956); *Twin City Sportservices, Inc, v. Charles O. Finley & Co.*, 512 F.2d 1264, 1271-72 (9th Cir. 1975), cert. denied, 459 U.S. 1009 (1982).

[7] ACO Antitrust Enforcement Statement at pp. 7, 9 ("useful as a screening device").

would therefore be an acceptable substitute for general practitioners, family practitioners or internists." *Id.* These factual conclusions may vary among geographic areas.

Managed care's view of its competitive alternatives will also be relevant to the product market determination. *See e.g. Gastroenterology Associates, Ltd.*, DOJ Business Review Letter (July 7, 1997) (gastroenterologists a relevant product market even though others performed some of same procedures because managed care plans need gastroenterologists in their panels). Such evidence will in each case depend on the practices in each area. But see *Quorum Health*, where the court refused to define a submarket consisting of physician services purchased by managed care. 960 F. Supp. at 1120.

It is also possible that an analysis by traditional product markets may not fully capture the competitive effects of physician acquisitions across specialties. One critical antitrust question is under what circumstances physician groups can credibly demand higher prices because managed care networks need their presence in order to offer an attractive panel to employers and subscribers. *See e.g. In the Matter of Evanston Northwestern Healthcare* Corporation, 2007 WL 2286195 at *18-24. That threat may be much more credible if made by an entity with a high share in multiple physician specialties than by a group that is strong in a single specialty. An employer may or may not be persuaded to reject a managed care panel if 30% of its subscribers will lose "their" primary care physicians if the plan with that panel is chosen. It is more likely to be swayed if those 30% are joined by another 30% who will also lose their orthopedic surgeon or their cardiologist. However, this issue of power across specialties has not yet been litigated or addressed by the antitrust agencies.

IV. GEOGRAPHIC MARKET

The relevant geographic market is perhaps the most important issue in health care merger cases. Almost every litigated hospital merger case to date has turned on the issue of geographic market.

The plaintiff bears a substantial burden in defining the relevant market. Because the definition of the market will often be determinative of the outcome, "[t]he geographic demarcation should not be too tightly drawn, unless clear evidence exists that potential competitors outside the region are hindered from entering," as a "[a] market drawn too tightly, creates the illusion of market power when none may exist."[8] Some courts have insisted that "hard evidence" on market definition be presented.[9]

The U.S. Supreme Court has indicated that the relevant geographic market should include the area in which sellers compete and "to which the purchaser can practicably turn for supplies."[10] Other courts have explained that the "geographic market encompasses the area in which the defendant effectively competes with other individuals or businesses for the distribution of the relevant product."[11]

The determination of the relevant market is a question of fact that necessarily depends upon the unique situation in each case.[12] For example, the distance that patients will travel for health care services in a rural area may be much greater than the distance that patients will be

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[8] *Consul. Ltd. v. Transco Energy Co.*, 805 F.2d 490, 495 (4th Cir. 1986), *cert. denied*, 481 U.S. 1050 (1987).

[9] *H.J. Inc. International Tel. & Tel. Corp.*, 867 F.2d 1531, 1540 (8th Cir. 1989) (quoting *Morton Bldgs. of Neg., Inc. v. Morton Bldgs, Inc*., 531 F.2d 910, 919 (8th Cir. 1976)).

[10] *Tampa Elec. Co. v. National Coal Co.*, 365 U.S. 320, 327 (1961).

[11] *E.G. Morton Bldgs. of Neg., Inc. v. Morton Bldgs., Inc.*, 531 F.2d 910, 918 (8th Cir. 1976).

[12] *E. I. du Pont de Nemours & Co.*, 353 U.S. at 593.

willing to travel in a city. Similarly, the fact that competition within a particular market can change quickly limits the extent to which a market can be defined in reliance on prior decisions, and requires each court to engage in a factual analysis of the market.[13]

While the ACO Antitrust Enforcement Statement defines markets by reference to a 75% "primary service area" for the provider, this is described as only a "screening device." Antitrust markets are not defined by service areas, but by patients' and managed care's alternatives. *See, e.g., Morgenstern v. Wilson*, 29 F.3d 1291, 1296 (8th Cir. 1994) (holding that a physician market "focused upon where …. residents actually went, as opposed to where they could practicably go" for healthcare services was impermissibly narrow); *FTC v. Freeman Hosp.*, 69 F.3d 260, 271 (8th Cir. 1995) (in rejecting the FTC's proposed geographic market, the court stated that "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."); *U.S. v. Mercy Health Services*, 902 F. Supp. 968, 978 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997) ("The analysis must focus . . . on where patients . . . could practicably go should [defendants] become anticompetitive.").

"The geographic market should determine not only the firms that constrain competitors' actions by currently selling to the same customers, but also those that would be a constraint because of their ability to sell to those customers should price or quality in the area change." *In the Matter of Hospital Corporation of America*, ("HCA") 106 FTC 361 (1985).

The *Evanston Hospital* decision criticized the use of patient origin data as a method of defining geographic markets and, instead, focused on other factors, including prices and

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[13] *FTC v. R.R. Donnelly & Son Co.*, 1990-2 Trade Cas. (CCH) ¶ 69,239 n.63 (D.D.C. 1990) (position in merger case that "might have had considerable validity ten or even five years ago" was not valid because of changes in product).

contemporaneous documents. 2007 WL 2286195, *57-58; 75-76 (F.T.C.). The FTC concluded that it "view[ed] patient flow data with a high degree of caution…." *Id.* at 77-78.

The scope of the geographic market will vary depending on the physician specialty involved. The antitrust case law with respect to at least some specialty physicians supports broad geographic markets. *See e.g.*, *Morganstern v. Wilson*, 29 F.3d 1291, 1296-97 (8th Cir. 1994) (at least a 60 mile radius for cardiac surgery); *Patel v. Verde Valley Medical Center,* No. CV-05-1129-PHX-MHM, 25 (D. Ariz. March 31, 2009) (120 miles for cardiology); *Gardner v. Lewistown Hospital*, 423 F.3d 184. 212-13 (3rd Cir. 2005) (Rejecting two county Central Pennsylvania market for cataract surgery).

By contrast, geographic markets involving primary care physicians are often viewed as relatively local. *See, e.g.*, *CVT Surgical* ("It has been our experience that, in general, and especially in urban and semi-urban areas, health care geographic markets are localized. . . . [T]his is somewhat less the case of health care specialist markets than it is for primary care markets."). In *Quorum Health*, however, the federal district court defined the geographic market for primary care physicians as one county and five surrounding zip codes. This was an area that extended at least 36 miles west and 17 miles east of Vicksburg.

In a business review letter involving the merger of cardiovascular-thoracic surgeons and peripheral vascular surgeons, the DOJ analyzed the effects of the merger "under a range of assumptions about the relevant market size," including a market defined as "within a one and one-half hour drive of Baton Rouge," and a much smaller market defined as the city of Baton Rouge.[14]

[14] *CVT Surgical Center*, DOJ Business Review Letter (Apr. 16, 1997).

There will often be evidence to address whether the geographic market applicable to a particular physician specialty area is broader than the physicians' primary or even secondary service area. The likely source of such evidence will be behavior in other physician specialties, where there has been an effort to exercise market power by refusing to participate in an insurer's panel. If such efforts have resulted in patients traveling farther for care, that can be evidence of a broader market potentially applicable to many specialties. Other useful examples that may apply across specialties can involve evidence of referral patterns over greater distances because of quality preferences.

V. MARKET SHARE AND STRUCTURE

A. Market Share Levels

A critical antitrust question is whether a transaction will result in market power, defined by the U.S. Supreme Court as "the ability to raise prices above those that would be charged in a competitive market."[15] An initial assessment of whether a merged entity will have market power begins by examining the market shares of the merging firms and assessing "concentration" in the relevant market before and after the merger.

High market shares in and of themselves, are not unlawful, and do not establish the existence of market power. If two merging firms have very low market shares, it is clear that they could not possess market power, because there is sufficient additional competition in the market to defeat any attempt to raise prices over competitive levels. Thus, a number of courts have dismissed merger cases because the firm involved had a market share of under 30 percent.[16]

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[15] *NCAA v. Board of Regents of Univ. of Okla.*, 468 U.S. 85, 109 & n.38 (1984).

[16] *See e.g.*, *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984).

However, the converse is not true. Firms with high market shares may not have market power because of the possibility of entry, changes in the characteristics of the market over time, or other factors.

There is some reason to believe that physician mergers and acquisitions will raise concerns only at relatively high market shares. The original proposed ACO Antitrust Enforcement Statement imposed a 50% threshold, but the final statement only talks about a "high share." The ACO Antitrust Enforcement Statement also provides for a "safety zone" market share of 30%, below which a government challenge is extremely unlikely.

In *CVT Surgical Center*, DOJ Business Review Letter (Apr. 16, 1997), the DOJ stated that it had no intention to challenge that physician merger with as high as a 50 percent market share, noted that "our investigation has confirmed that payers in Baton Rouge are generally confident that the merged group is not likely to acquire market power."

However, lower shares have been a concern, particularly with primary care physicians. In another settlement, which involved the Massachusetts Attorney General's Office and the merger of Partners Health Care Systems and North Shore Medical Center, the parties agreed in March 1996 that the merged entity would not employ, have a controlling interest in, or have an exclusive risk contract with, more than 40 percent of the available primary care physicians, pediatricians, and obstetricians in an area comprising 26 North Shore communities. *In re Partners Health Care Sys.*, No. 96-1713B (Mass. Super. Ct.). Massachusetts Attorney General Scott Harshbarger stated that similar restrictions would be imposed in the future on other emerging health car networks in the state. *See Physician Cap Resolves State's Concerns over Merger of Massachusetts Hospitals*, 5 BNA's Health L. Rep. 854 (June 6, 1996).

The FTC/DOJ Horizontal Merger Guidelines do not contain a market share threshold as such, but do include as a criterion the post-acquisition level of, and change in, the Herfindahl Hirschman Index ("HHI"), which represents the sum of the squares of the market shares of the merging parties and other market participants. A merger or acquisition that results in a HHI in excess of 2500, with an increase of 100 or more, is "presumed" to create market power. Mergers or acquisitions resulting in a market share for the post-merger entity of 45-50% or more will generally meet this standard.

However, the HHI figures are usually only a starting point for merger analysis. Other issues, such as entry and competitive effects, will be critical to any decision.

B. Factors Affecting Relevant Share Levels

A number of factors may affect the market share level that creates antitrust concern. One such factor is the "vulnerability" of that market to coordination or collusion. Horizontal Merger Guidelines at 25.

The argument can be made that physician markets will often be vulnerable to coordination or collusion. The number of independent practice associations and physician hospital organizations who have entered into consent decrees relating to allegedly lawful negotiation with managed care may arguably provide evidence of such vulnerability.

Coordination is viewed as difficult if price terms are complex, so that agreement on price terms is difficult. This difficulty may or may not be present in particular physician markets. In some cases, each procedure code has a separate price, so that any effort at coordination might have to involve 30-50 or more different prices. On the other hand, in some markets the negotiation centers around one or few conversion factors, applied to relative value scales set by Medicare. An agreement on those conversion factors would not appear to be difficult.

The Horizontal Merger Guidelines also provide that transactions resulting in an HHI of between 1500 – 2500, with an increase of 100 or more, are "likely" to be challenged if the market shows "signs of vulnerability to coordinated conduct" and there is a "credible basis" to believe that the "merger may enhance that vulnerability." Horizontal Merger Guidelines at 25. This numerical standard will often be met by a merger resulting in a physician group with a share of 40% or more.

If a key indicium of market power is a merged physician group's ability to successfully demand higher prices because managed care panels cannot be successful without its participation, then the question arises as to what market share is sufficient to create that ability. Of course, that number could vary depending upon the specialty as well as the reputation of the physicians in question.

For example, the Department of Justice, in its Competitive Impact Statement in *U.S. V. Idaho Orthopedic Society* (D. Id. 2010), found that Blue Cross of Idaho rescinded a proposed price reduction after 31 of 67 orthopedic surgeons in the area announced that they would refuse to deal with Blue Cross if the price reduction took effect. This suggests that in that case, a 40% share was sufficient to exercise market power.

On the other hand, in many non-routine specialties, there may be very little patient loyalty to, or interest in, particular physician groups, because subscribers may rarely use that specialty, and therefore may not be very concerned about which physicians in that specialty are in their panel. In that event, a very narrow network may be acceptable to employers, and an extremely high share of the available physicians might be necessary before a group might have any power over price. Similarly, subscribers may be more willing to travel for non-routine care, expanding the geographic market.

The market position of the remaining independent competitors may also be relevant. The FTC has recently challenged a hospital merger in Rockford, Illinois, both because of effects on the hospital market, and because of effects in the primary care physician market. In the latter case, the FTC alleges that the merging hospitals will possess 37% of the primary care physicians, leaving only one hospital owned physician group that will be independent, with the remainder of the market "fragmented." *In The Matter of OFD Healthcare System, et al.,* Dkt. No. 9349 (F.T.C. November 17, 2011) (complaint).

High shares of specialties including few physicians in the market in total are unlikely to raise concerns. For example, in *Quorum*, the court noted that one entire relevant market consisted of two urologists. After the physician merger, both would be practicing with the merged entity. The court stated that "[c]onsidering the specific character of this two-person market that exists within a relatively small medical community, this Court finds it inconceivable that Congress intended the Clayton Act to prohibit two urologists in Vicksburg, Mississippi from practicing together under the same roof. The practical effect of such an impractical statutory interpretation could be to deprive two physicians from taking alternate weekends off or an occasional family vacation. With the real life implications of this alleged antitrust violation in mind, it appears to this Court that, if there is any arguable monopoly here at all, it is a 'natural monopoly."' 960 F. Supp. at 1128. *See also Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406, 1412 (7th Cir. 1995) (clinic employing all twelve physicians in a county might be considered a "natural monopolist" – a firm that has no competitors simply because the market is too small to support more than a single firm).

C. Methods of Calculating Share

The easiest way to measure physician market share is by "head count"; what percentage of physicians in a specialty will be in the merged entity? But this can be oversimplified for

several reasons. First, many physicians, especially primary care physicians, may be supplemented by "mid-level" nurse practitioners and physicians' assistants, who may provide substantial output in the market. Second, physicians may vary widely in their productivity. A calculation based on cases or revenues may differ significantly from a calculation based on headcount.[17]

Under the doctrine established in *United States v. General Dynamics*,[18] the key test under the antitrust laws is the effect the merger will have on competition in the future. Therefore, evidence of current competitive strength, measured by market share, may be outweighed by evidence concerning future competitive conditions.

VI. RELEVANCE OF ENTRY

Where entry is sufficiently easy, no antitrust problem is present at any market share. *See, e.g., FTC v. Occidental Petroleum*, 1986-1 Trade Cas. (CCH) ¶ 67,071 at 62,518 ("If entry barriers are low, then an acquisition will be unlikely to lessen competition, regardless of the market shares of the existing firms or the degree of concentration in the relevant market"). *See also United States v. Calmar, Inc.*, 612 F. Supp. 1298 (D.N.J. 1985) (merger held lawful, despite post-merger market shares of 83 percent and 79 percent in two markets, because entry barriers were low); *United States v. Baker Hughes Inc.*, 908 F.2d 981, 983 (D.C. Cir. 1990) (merger of firms with combined market share exceeding 60% upheld because of ease of entry); *Ball Mem'l Hosp., Inc. v. Mut. Hosp. Ins., Inc.*, 784 F.2d 1325, 1336-37 (7th Cir. 1986) (80% market share insufficient to establish market power where no barriers to entry).

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[17] Head count roughly corresponds to capacity, but the Horizontal Merger Guidelines provide that revenue is usually a better measure of share, except in the cases of commodity products. Horizontal Merger Guidelines at 17.

[18] *United States v. General Dynamics Corp.*, 415 U.S. 486 (1974).

Ease of entry is potentially a much more substantial issue with regard to physician activities than for many other entities. A physician can physically enter and begin practicing in a new geographic area with few or no regulatory restrictions or capital requirements. Physician practices, in many respects, are thus comparable to the kind of simple product assembly[19] or waste hauling[20] activities that courts have concluded involve such easy entry that even very high market shares were of no antitrust significance.

As a result, the easy entry argument has been recognized as significant in several cases. *See e.g. Hassan v. Independent Practice Associates, P.C.*, 698 F. Supp. 679 (E.D. Mich. 1988). ("Even if the plaintiffs were to leave the tri-county market, there is no reason to believe that they would not be easily replaced so that the market would be served by enough allergists."); *Quorum*, 960 F. Supp. at 1134 ("[T]his court would be hard-pressed to conclude that significant barriers to entry into the primary care market exist in the light of ... recent and successful recruitment of ... new primary care physicians"). In *Quorum*, as a result, physician shares as high as 70% were found insufficient to create an antitrust violation.

See also CVT Surgical Center, DOJ Business Review Letter (Apr. 16, 1997) (DOJ approves merger of cardiovascular-thoracic and peripheral vascular surgeons with as much as 50% market share, stating that "given that payers require few vascular specialists on a panel, it appears that sponsored entry or expansion by an incumbent group would likely defeat an attempt by current providers to raise price.").

However, the antitrust agencies have been cautious in applying the entry argument to physician transactions. A business review letter, in which the DOJ approved a plan to form a

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[19] *Echlin Mfg. Co.*, 105 F.T.C. 410 (1985).

[20] *United States v. Waste Mgmt., Inc.*, 743 F.2d 976, 983 (2d Cir. 1984).

statewide chiropractic contracting organization was based on part on the possibility of entry.[21] But DOJ specifically distinguished entry by chiropractors from entry by physicians. It stated that "[o]ur investigations in this and other matters involving chiropractors indicate that chiropractors, unlike many physicians, do not depend on other chiropractors to provide or accept referrals, or for access to hospital staff privileges or other hospital perquisites."

In *Gastroenterology Associates, Ltd.*,[22] DOJ found that the likelihood of new entry of gastroenterologists into the Allentown, PA area in response to a small but significant price increase was not great. DOJ noted that there was already "an oversupply of gastroenterologists in the Allentown area." DOJ also stated that payors believed that two hospitals dominated the Lehigh Valley market, and that both had powerful physician-hospital organization networks, "with which no entering gastroenterologist could successfully compete." Additionally, one of the gastroenterologists proposing to merge was also the head of the gastroenterology department at Allentown Sacred Heart Hospital, and therefore would "hold approval authority over any new entrant as well as the ability to schedule procedure times and use of space in the hospital." This was considered to be another barrier to entry for new gastroenterologists into Allentown.

The entry issue may well turn on the facts in a particular market. For example, in a market with an abundance of primary care physicians and a stable population with strong loyalties to primary care physicians, successful entry by new primary care physicians could be difficult because of the challenge in attracting patients. And in a market in which almost all physicians practice in large clinics and achieve economic advantages from doing so, entry through the establishment of a small new practice might be economically impractical. New

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[21] *International Chiropractor's Assn'n of Cal.*, DOJ Business Review Letter (Oct. 27, 1994).

[22] DOJ Business Review Letter (July 7, 1997).

single physician practices, and recruitment of new physicians into markets by small physician practices, are increasingly rare in many markets.

VII. COMPETITIVE EFFECTS

A. Horizontal Effects

Competitive effects from a physician merger may arise from the concern that too much power in a physician specialty market will lend to higher prices. Thus, in one physician network case, DOJ alleged that the physician group's ("FCSSI") "joint negotiations and other collusive activities left MCPs with a 'Hobson's choice': inflated contract rates for FCSSI surgeons or an unmarketable network without FCSSI surgeons." *United States v. Federation of Certified Surgeons and Specialists*, D.O.J. Case No. 99-167-CIV-T-17F (January 26, 1999) (complaint).

"[A] network that included most or all of the surgeons in a relevant geographic market could create market power in the market for surgical services and thereby permit the surgeons to increase price." Statement of Department of Justice and Federal Trade Commission Enforcement Policy on Multiprovider Networks (http://www.ftc.gov/bc/healthcare/industryguide/policy/statement9.htm).

Post-merger behavior can provide more direct evidence of such anticompetitive effects, i.e. price increases resulting from the merger. For example, in *Evanston*, the FTC cited party documents stating the following: "The larger market share created by adding Highland Park Hospital has translated to better managed care contracts." "Some $24 million of revenue enhancements have been achieved – mostly via managed care negotiations…. None of this could have been achieved by either Evanston or Highland Park alone. The 'fighting unit' of our three hospitals and 1600 physicians was instrumental in achieving these ends." *Evanston* at 2007 WL 2286195 at *13.

In physician transactions, however, it may not be enough to isolate the effects of the merger. That is because there is another major causal factor to be addressed that is related directly to the merger, but is not an anticompetitive effect. A merger can cause prices to increase because the merging parties gain market power. But it can also have that effect if the merging physician groups gain (for the first time) some modicum of sophistication in dealing with managed care.

When a physician practice merger results in a significantly larger group, one critical change may be that the merged group gains the scale to be able to employ professional staff and (often) sophisticated consultants. The physicians can then go from signing whatever is put before them by healthcare plans to negotiating rates, in the same way that larger physician groups and most hospitals have done all along. This does not mean that they have market power, any more than every hospital that negotiates rates has market power. It simply means that they may not accept the managed care plan's first (and perhaps "lowball") offer. Effectively, if rates increase, that may mean that they have gone from subcompetitive to competitive, not from competitive to supracompetitive.

B. Vertical Effects

Another concern may arise from the vertical effects of physician mergers on hospital markets. "[V]ertical mergers can result in competitive foreclosure through the control of necessary upstream inputs, by either making it impossible for competitors to obtain these inputs or by raising their costs in doing so. This result could … occur in a hospital's acquisition of physician practices, particularly if the hospital thereby acquired a large percentage of primary care physicians who could in turn control most referrals to specialists." Varney, Christine, "*Efficiency Justifications In Hospital Mergers and Vertical Integration Concerns*" (1995) (http://www.ftc.gov/speeches/varney/varht.shtm).

"[A] hospital might use a multiprovider network to block or impede other hospitals from entering a market or from offering competing services." Statement of Department of Justice and Federal Trade Commission Enforcement Policy on Multiprovider Networks (http://www.ftc.gov/bc/healthcare/industryguide/policy/statement9.htm).

No court decision has yet addressed these vertical effects. But they have been raised in a number of litigated cases, and can raise concerns, especially when dominant hospitals acquire physician practices, divert admissions, and thereby increase their dominance.

VIII. EFFICIENCIES

Merger cases have rarely turned on the presence of efficiencies, but physician practice acquisitions may present new opportunities for an efficiencies defense. The efficiencies from a merger of small physician practices into a larger practice may be obvious and compelling. The movement to sufficient scale to permit a centralized office and professional staff can mean the difference between amateurish and businesslike operations. It can also free up physicians to spend more time practicing medicine, reflected in objective measures of improved output such as patient visits per physician. Moreover, centralized accounting, billing, collection, purchasing, human resources, scheduling, and information technology could well generate substantial savings. Elimination of duplicative diagnostic equipment might also yield significant efficiencies.[23]

IX. PROCESS ISSUES

Mergers or acquisitions involving physician groups are generally unlikely to meet the threshold required for a premerger filing under the Hart-Scot-Rodino Act. The initial threshold

[23] *See e.g. CVT Surgical Center*, DOJ Business Review Letter (July 7, 1997).

for such a filing at this time is that the transaction involve consideration or fair market value in excess of $66 million, with additional requirements also applicable.

However, even if a filing is not necessary, transactions can and do come to the attention of the antitrust authorities through the health care press and through complaints, which can come from either competitors or payors.

Competitor complaints will certainly be considered by the antitrust agencies, but must address harm to competition, not merely to the competitor's interests. "The antitrust laws … were enacted for the protection of competition, not competitors." *Brunswick Corp. v. Peublo Bowl-O-Mat, Inc.*, 429 U.S. 477, 489 (1977) (internal citations and quotations omitted). "[A] competitor has no incentive to vindicate the legitimate interests of a rival's [customers] and will [ordinarily] be injured and motivated to sue only when the arrangement has a procompetitive impact on the market." *Atlantic Richfield Co. v. USA Petroleum*, 495 U.S. 328, 329 (1990).

Complaints by payors may have the most impact. However, the courts have also been skeptical of payor complaints. "We question the district court's reliance on the testimony of managed care payers. . . ." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999). Courts have rejected proposed market definitions based on views of MCOs. *United States v. Mercy Health Services*, 902 F. Supp. 968, 977 (N.D. Iowa 1995). The FTC has found that managed care testimony provided only "modest" support for conclusions. *Evanston*, 2007 WL 2286195 at 67 (F.T.C.)

Antitrust issues can arise either before or after consummation of a physician transaction. The *Urology* matter arose as a result of an investigation that began two years after the merger in question, and resulted in a settlement approximately five years after the merger.

The structure of the merger or acquisition can be affected by antitrust concerns. Some transactions are sufficiently loose that they are viewed by the antitrust agencies as *per se* illegal vehicles for price-fixing or market allocation, rather than legitimate mergers. For example, physician transactions that do not change the name or location of individual offices or the flow of funds among the practices have faced more stringent antitrust reviews.

X. REMEDIES

The FTC has had a longstanding policy that favors structural over conduct remedies under most circumstances. Therefore, the likely federal remedy relating to a physician practice merger or acquisition will involve (1) an injunction against the subject acquisition and any future acquisitions, and/or (2) required divestiture after the acquisition has been consummated.

On the other hand, many physician transactions have been challenged by state antitrust officials. The states often are interested in regulatory remedies. The prime element of such a remedy is often some form of rate regulation, whether through an arbitration procedure or a court order setting rate ceilings. A form of rate regulation was present in both the *Urology* and *Maine* matters, though the scope and degree of intrusiveness of the regulation varied significantly. Both also involved other limitations on managed care contracting and on referrals for ancillary services. The *Maine* consent order also involved certain requirements relating to quality and medical education.

XI. ACOs AND OTHER PHYSICIAN NETWORKS

A. Joint Negotiation And *Per Se* vs. Rule Of Reason

An agreement between competitors (i.e., independent hospitals and/or physicians) to set or negotiate prices without more is a *per se* violation of Section 1 of the Sherman Act, 15 U.S.C. § 1. *United States v. Trenton Potteries Co.*, 273 U.S. 392 (1927). The *per se* nature of the action means that once an agreement is proven, a violation of the law is present, no matter what

justifications are offered. The Federal Trade Commission has been especially active in attacking "sham" IPAs and PHOs, which jointly negotiate price or reimbursement without sufficient integration.

Many PHOs and IPAs operate under the belief that they fall within the "messenger model" doctrine, and are therefore not engaged in illegal price-fixing. However, the vast majority of federal enforcement actions involve PHOs and IPAs who claimed to be operating under a messenger model or a "modified messenger model," but instead were found to have fixed prices.

The messenger under a proper messenger model must do little more than simply convey pricing offers. The messenger cannot negotiate, and competing physicians cannot reach any agreement regarding price. For example, physicians could not agree that they will accept any prices above a certain level, with offers below that level transmitted to individual physicians for approval. Nor may the messenger facilitate agreements among the physicians. *See e.g. United States v. Woman's Hosp. Found.*, 1996-2 Trade Cas. (CCH) ¶ 71,561 (M.D. La. Sept. 11, 1996) (Consent Order) ("The messenger does not negotiate collectively for participating physicians, disseminate to any physician the messenger's or any other physician's views or intentions as to an offer, or otherwise serve to facilitate any agreement among competing physicians on prices or other terms and conditions;").

Risk-sharing is one method by which an IPA or PHO may operate in an integrated manner and thereby avoid the *per se* prohibition against price-fixing. For example, the sharing of risk through a 12% withhold was held sufficient to avoid per se treatment in *Hassan, supra*.

An IPA or PHO may also avoid *per se* condemnation through the provision of significant clinical integration, if joint negotiation is viewed as "reasonably necessary" for the integration to occur.

> 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.

U.S. Dep't of Justice and Fed. Trade Comm'n, Statements of Antitrust Enforcement Policy in Health Care (1996). Alternatively, the new ACO Antitrust Enforcement Statements provide that satisfaction of CMS's requirements for clinical integration for approval of an ACO will also meet the antitrust test.

Efforts at clinical integration that do not add to the payor's requirements, do not involve true physician collaboration, or that are not enforced, will likely not be sufficient. Some examples where clinical integration was found insufficient under these circumstances are as follows:

- IPA did "not: engage in case management; provide feedback to physicians concerning patient care; require adherence to its clinical guidelines and protocols; operate or refer patients to any disease management programs or patient registries; or engage in meaningful education."[24]

- IPA did "not monitor practice patterns and quality of care, or enforce utilization standards regarding services provided by its PPO network." Its physicians were "required to abide by the utilization management

[24] *N. Tx. Specialty Physicians*, Dkt. No. 9312 (FTC Nov. 16, 2004) (initial decision).

guidelines established by payors, not by the guidelines in [the PIA's] risk-sharing contracts."[25]

- Network provided "practice management programs (including two quality improvement projects, clinic inspections, and quarterly quality council meetings)" but "[t]hese activities . . . [did] not involve collaboration to monitor and modify clinical practice patterns to control costs and ensure quality or otherwise integrate their delivery of care to patients.[26]

There is no "cookbook" explanation of what clinical integration must entail. There are many potential elements, including, e.g.:

- Care maps, guidelines, and/or toolkits for disease management.
- Patient and physician education programs and materials.
- Utilization review (e.g., ER utilization, increase generic drug use).
- Review of medical records.
- Review of office procedures.
- Electronic medical records system and/or electronic or other patient registries.
- Data analysis and physician feedback/monitoring.
- Pharmacy usage review.
- Preventive health management.
- Electronic prescribing.
- Surgical infection prevention.
- Surgery process improvements.
- Sharing of physician and hospital savings from re-engineering.

[25] *Cal. Pac. Med. Group*, 137 F.T.C. 411 (2004) (consent order).

[26] *Minn. Rural Health Coop.*, Dkt. No. 0510199 (FTC Dec. 28, 2010) (consent order).

B. Rule Of Reason Analysis

Networks that are clinically integrated are governed by the rule of reason. A rule of reason analysis considers overall market effects in a manner that is similar to a merger analysis. The primary difference in the network or ACO context is that one of the key factors is whether the network is or is not exclusive. Mergers always create exclusive relationships. Arguably, non-exclusive networks do not have market power, whatever their share of providers, since other networks can also utilize those same providers.

Hassan, supra, illustrates the significance of exclusivity. In that case, more than 75% of the physicians in the relevant market were affiliated with the defendant IPA. The plaintiff argued that this meant that the IPA had market power. In rejecting the plaintiff's argument, the court noted that the IPA existed only to deal with one payor, an HMO, and that HMO had only a 20% share of the market. Therefore, the court reasoned, the IPA had no power, since it did not restrict the physicians from dealing with other payors outside of the IPA.

The ACO Antitrust Enforcement Statement also expresses concerns about exclusivity if networks have "high" market shares. The ACO statement addresses contractual provisions that "prevent or *discourage*" providers from contracting with other ACOs. Other agency statements have provided that exclusivity can be "implicit or explicit," formal or informal," or based on a "written or *de facto* agreement."

The FTC has enumerated five criteria that affect whether "a network is truly non-exclusive":

a. that viable competing networks or managed care plans with adequate provider participation currently exist in the market;

b. that providers in the network actually individually participate in or contract with, other networks or managed care plans, or there is other evidence of their willingness and incentive to do so;

c. that providers in the network earn substantial revenue from other networks or through individual contracts with managed care plans;

d. the absence of any indications of substantial departicipation from other networks in the market; and

e. the absence of any indications of coordination among the providers in the network regarding price or other competitively significant terms of participation in other networks or managed care plans.

U.S. Dep't of Justice's Fed. Trade Comm'n, Statements of Antitrust Enforcement Policy in Health Care (1996).

The ACO Antitrust Enforcement Statement lists three other kinds of conduct that may be of concern for ACO networks with "high" market shares. They include preventing or discouraging payors from steering patients; tying the ACO's services to other provider services; and restricting a private payor's ability to make cost, quality efficiency or performance information available to health plan enrollees.