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Kathleen Snow Sutton

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**Wait Then Reassess: Antitrust Risks of Vertical Integration in Healthcare Remain an Open Question**

# WAIT THEN REASSESS: ANTITRUST RISKS OF VERTICAL INTEGRATION IN HEALTHCARE REMAIN AN OPEN QUESTION

KATHLEEN SNOW SUTTON<sup>†</sup>

## ABSTRACT

In the November 2018 elections, healthcare was a top priority for voters, who are frustrated with increasingly unaffordable health insurance and healthcare. The United States has struggled for decades with how to pay for healthcare. Healthcare reform created pressure for healthcare entities to consolidate, a trend that manifested first as horizontal integration, and now, increasingly manifests as vertical integration. Despite the pressures to consolidate, federal antitrust authorities have continued to scrutinize healthcare mergers. Horizontal mergers have faced an uphill antitrust battle, but vertical integration—such as deals between insurance companies and pharmacies or physician groups—has encountered fewer headwinds until recently. Typically, antitrust disputes have involved anticompetitive behavior or concentration among providers or among payors, with little overlap between the two players. Recently, the line has begun to blur between providers and payors.

A case that is pending in the District of New Mexico, *New Mexico Oncology & Hematology Consultants, Ltd. v. Presbyterian Healthcare Services*, presents a novel conflict between two integrated entities, in which the plaintiff alleges that a vertically integrated healthcare entity possesses monopoly and monopsony power. This case is one to watch. The outcome may provide either a green light or a cautionary tale for healthcare businesses who see an opportunity to grow through consolidation and integration while tackling high costs and fragmented care.

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<sup>†</sup> Kathleen Snow Sutton is a healthcare attorney with Polsinelli in the Denver office. Kathleen's practice focuses on healthcare transactional and regulatory matters, including provider reimbursement, alignment and organizations, and compliance with healthcare licensing and fraud and abuse laws. The viewpoints and opinions expressed in this Article do not necessarily reflect those of Polsinelli or its clients. Kathleen would like to thank Bridget DuPey, Zachary Lass, Chelsea Marx, Natalie Spiess, and the entire *Denver Law Review* team for their hard work and thoughtful edits.

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## INTRODUCTION

Americans are frustrated with the U.S. healthcare system, to the point that healthcare issues were a top priority for voters in the November 2018 elections.<sup>1</sup> Affordability is the main source of consumers' anxiety about healthcare.<sup>2</sup> Changes to healthcare insurance, payment models, and delivery all aim to decrease the costs of healthcare while preserving and improving the quality of healthcare and population health.<sup>3</sup> These changes, however, have also caused rapid consolidation in the industry among insurers and providers, several of which have been scrutinized or blocked by federal antitrust enforcement agencies.<sup>4</sup>

In addition to high-profile mergers, newer healthcare payment models and vertical integration present fresh antitrust questions.<sup>5</sup> Courts are currently reviewing antitrust cases involving vertical mergers and allegations that an entity possesses both monopoly and monopsony power. The outcome of these cases may provide important guidance for healthcare organizations seeking to grow through vertical integration. This Article begins with a brief history of the development of managed care in Part I. Section II.A contains a brief overview of antitrust law, before analyzing recent managed care case law in the Tenth Circuit in Section II.B. Part III discusses the regulatory pressures for healthcare companies to integrate and introduces the nuanced antitrust issues presented by integrated entities. The Article concludes that, while organizations may benefit from the guidance provided by courts to avoid antitrust pitfalls, consoli-

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1. Abigail Geiger, *A Look at Voters' Views Ahead of the 2018 Midterms*, PEW RES. CTR. (Nov. 1, 2018), <http://www.pewresearch.org/fact-tank/2018/11/01/a-look-at-voters-views-ahead-of-the-2018-midterms>; Robert Pearl, *Healthcare Is the No. 1 Issue for Voters; A New Poll Reveals Which Healthcare Issue Matters Most*, FORBES (Aug. 13, 2018, 7:53 AM), <https://www.forbes.com/sites/robertpearl/2018/08/13/midterms>.

2. Pearl, *supra* note 1.

3. See Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 760 (2008), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.27.3.759>; *Value Based Programs*, CMS.GOV, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html> (last updated July 25, 2018, 3:16 PM).

4. Aaron Smith & Jackie Wattles, *Aetna-Humana & Anthem-Cigna: Two Mergers Die in One Day*, CNNMONEY (Feb. 14, 2017, 5:31 PM), <https://money.cnn.com/2017/02/14/investing/aetna-humana>; Edith Ramirez, Chairwoman, Fed. Trade Comm'n, Keynote Address at the Antitrust in Healthcare Conference in Arlington, Virginia (May 12, 2016) ("In 2015, the number of hospital mergers increased 18% over the prior year and were 70% higher than in 2010. And the rate may even be accelerating. The number of deals rose significantly in the second half of last year.").

5. ANTHONY W. SWISHER, VERTICAL INTEGRATION: DOES IT MATTER THAT IT'S HEALTHCARE? 1, 5 (May 12-13, 2016), <https://pdfs.semanticscholar.org/14dc/2895ee6ba6e872e31c8a836159daa497f51a.pdf>.

dition and integration are likely to continue in healthcare, spurred by the pressure and movement to improve care and control costs.

### I. BRIEF HISTORY OF MANAGED CARE

The U.S. healthcare delivery system is currently comprised of independent, fragmented parties.<sup>6</sup> The largest players include third-party payors (i.e., insurance companies), professional providers (i.e., physicians), and facilities (i.e., hospitals, skilled nursing facilities, etc.).<sup>7</sup> While patients are the beneficiaries of the care, they are typically only indirectly involved in the payment and flow of money for the care that they receive (with the exception of cost-sharing obligations under their insurance plans).<sup>8</sup> Instead, third-party payors are responsible for the majority of the payments to providers and facilities.<sup>9</sup> A variety of suppliers in the market also provide technology, durable medical equipment, drugs, and other tangible items to providers and patients as a part of their care.<sup>10</sup> Additionally, employers have a stake in the healthcare system because they provide insurance as an employee benefit.<sup>11</sup> This complicated and fragmented structure developed in reaction to historical and regulatory pressures, rather than through a cohesive plan for providing and paying for healthcare.<sup>12</sup>

Third-party payors did not exist in the United States until the late 1920s and 1930s with the formation of the Blue Cross and Blue Shield Plans.<sup>13</sup> After some experimentation in the 1910s, the Blue Cross Plans were established in 1929 to provide prepaid hospital care to enrollees.<sup>14</sup> Enrollment in these prepaid hospital plans grew from 1,300 to 3 million

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6. See William M. Sage, *Assembled Products: The Key to More Effective Competition and Antitrust Oversight in Health Care*, 101 CORNELL L. REV. 609, 625 (2016).

7. *Id.* at 623, 625, 630.

8. See Philip Betbeze, *Big Ideas: Healthcare Price Transparency: Patients and Payers Versus Providers?*, HEALTHLEADERS (Jan. 4, 2016), <https://www.healthleadersmedia.com/strategy/big-ideas-healthcare-price-transparency-patients-and-payers-versus-providers> (describing the complexity and opacity of medical prices, and noting that patients are taking more of an interest in price transparency now that they must manage high deductibles and out-of-pocket maximums).

9. See Sage, *supra* note 6, at 630.

10. See, e.g., *Drug Establishments Current Registration Site*, U.S. FOOD & DRUG ADMIN., <https://www.accessdata.fda.gov/scripts/cder/drls/default.cfm> (last updated Oct. 12, 2018) (including a searchable database of parties involved in the development and distribution of drugs); *Establishment Registration & Device Listing*, U.S. FOOD & DRUG ADMIN., <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfRL/rl.cfm> (last updated Oct. 22, 2018) (including a searchable database of parties involved in the development and distribution of medical devices).

11. See PWC, *MEDICAL COST TREND: BEHIND THE NUMBERS 2019*, at 1 (2018), <https://www.pwc.com/us/en/health-industries/health-research-institute/assets/pdf/hri-behind-the-numbers-2019.pdf> (analyzing medical cost trends in the employer-sponsored insurance market and efforts by employers to manage costs).

12. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 4 (1982).

13. *Id.* at 295–96.

14. *Health Insurance from Invention to Innovation: A History of the Blue Cross and Blue Shield Companies*, BLUE CROSS BLUE SHIELD (Nov. 11, 2012), <https://www.bcbs.com/the-health-of-america/articles/health-insurance-invention-innovation-history-blue-cross-and-blue>.

enrollees in just ten years.<sup>15</sup> Around the same time, the Blue Shield Plans emerged to allow employers to pay physicians a monthly fee to provide healthcare to their employees.<sup>16</sup> World War II ushered in the U.S. dependence on employer-based health insurance.<sup>17</sup> The combination of a worker shortage with strict price and wage controls left employers unable to attract workers with higher wages.<sup>18</sup> Instead, employers began offering healthcare benefits to attract workers.<sup>19</sup> Employees grew to expect this benefit, and employers continued to use healthcare coverage as a tool to attract and retain employees.<sup>20</sup> This structure is so ingrained in the United States that large employers are now required to offer healthcare coverage to their employees or pay a “shared responsibility payment” to the federal government.<sup>21</sup>

Led by the Blue Cross and Blue Shield Plans, most health insurance coverage originally operated under a traditional indemnity model.<sup>22</sup> Under this model, an employee would submit proof of a medical expense (a claim) to the insurance carrier, which would then indemnify the employee by paying or reimbursing the healthcare provider the amount owed.<sup>23</sup> Insurers reimbursed providers and facilities for each service they provided (fee-for-service payments).<sup>24</sup> Over time, managed care models developed alongside the traditional indemnity plans, beginning in the 1940s, but gaining traction in the 1970s.<sup>25</sup>

In 1973, Congress passed the Health Maintenance Organization Assistance Act (HMO Act), which exempted “federally qualified” health maintenance organizations (HMOs) from state insurance laws to encourage the development of organized healthcare delivery systems.<sup>26</sup> The HMO Act, combined with rising healthcare costs, encouraged the development of alternative prepaid models, under which employers would pay a fixed monthly amount per covered employee in exchange for a full range of medical benefits.<sup>27</sup> Throughout the 1970s and 1980s, healthcare

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15. *Id.*

16. *See* STARR, *supra* note 12, at 301–02, 311.

17. *Id.*

18. *See id.*

19. *Id.*

20. *See, e.g.,* Brigitte C. Madrian, *Employment-Based Health Insurance and Job Mobility: Is there Evidence of Job-Lock?*, 109 Q. J. ECON. 27, 27 (1994) (estimating that “job-lock reduces the voluntary turnover rate of those with employer-provided health insurance by 25 percent, from 16 percent to 12 percent per year”).

21. 48 U.S.C. § 4980H (2018).

22. *See* STARR, *supra* note 12, at 331.

23. *Id.* at 291.

24. *Id.*

25. *See id.* at 320, 439.

26. *See* Health Maintenance Organization Act of 1973, Pub L. No. 93-222, 87 Stat. 914 (codified as amended at 42 U.S.C. §§ 300e to 300e-17 (2018)).

27. Deborah Farringer, *Everything Old Is New Again: Will Narrow Networks Succeed Where HMOs Failed?*, 34 QUINNIPIAC L. REV. 299, 305 (2016).

costs—as a proportion of gross domestic product—nearly doubled,<sup>28</sup> prompting a dramatic shift to managed care in an effort to control costs.<sup>29</sup> Enrollment in HMOs and Preferred Provider Organizations (PPOs) skyrocketed as employers and insurers sought ways to contain costs.<sup>30</sup> Managed care in the 1980s and 1990s used a variety of tools to manage care and contain costs, including contracting with a limited network of providers and either requiring patients to use contracted providers for their care or requiring patients to pay significantly higher copayments or coinsurance for using out-of-network providers.<sup>31</sup> HMOs also imposed checks on utilization, such as requiring referrals from primary care “gatekeepers” for patients to access more expensive specialty care or obtaining preauthorization before beginning certain types of treatment.<sup>32</sup>

The restrictions imposed on coverage—along with concerns that provider organizations were unable to absorb the risks associated with accepting capitated payments—resulted in a backlash against managed care.<sup>33</sup> States intervened, enacting legislation to counteract these restrictions and to stabilize insurance markets.<sup>34</sup> These laws include: “any willing provider” laws, which require insurance carriers to contract with providers who meet certain criteria; benefit mandates, such as the requirement that emergency care be included as a covered benefit regardless of the provider used; and provider-protection laws, such as prompt-pay requirements, which require insurers to pay providers within a specified time frame.<sup>35</sup> While these laws addressed patient protections and payments to providers, they undermined the managed care cost-containment methods, prompting healthcare costs to return to the earlier trend of rising at an increased rate.<sup>36</sup>

Today, most healthcare coverage retains some aspects of managed care, such as a network of preferred providers which patients can access

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28. STARR, *supra* note 12, at 385. Experts dispute the exact reasons for the rapid rise in healthcare costs. Some suggest that increased federal funding without corresponding cost regulation permitted providers to run wild with the types and costs of services provided. *Id.* at 384–85. Others argue that the industry is over-regulated, which has created inflationary pressures on the industry by creating a fragmented system. Sage, *supra* note 6, at 628. Some say that overutilization of healthcare services is the underlying cause, while others acknowledge that underuse of appropriate services also leads to higher costs. See *Right Care*, LANCET (Jan. 8, 2017), <https://www.thelancet.com/series/right-care>.

29. See AARON C. CATLIN & CATHY A. COWAN, HISTORY OF HEALTH SPENDING IN THE UNITED STATES, 1960–2013, at 7–8 (2015), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/HistoricalNHPEpaper.pdf>.

30. Farringer, *supra* note 27, at 305–07.

31. THOMAS BODENHEIMER & KEVIN GRUMBACH, UNDERSTANDING HEALTH POLICY: A CLINICAL APPROACH 66–67 (7th ed. 2016).

32. *Id.*

33. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 651 (7th ed. 2013).

34. *Id.*

35. *Id.* at 651–53.

36. CATLIN & COWAN, *supra* note 29, at 18–20.

at a lower cost, but the restrictions imposed in the 1990s have largely been abandoned.<sup>37</sup> Insurance companies often contract with all of the hospitals and nearly all of the physicians in an area so that patients may elect to use almost any provider in a community, with minimal or no referral requirements or increased costs.<sup>38</sup> Unlike managed care of the 1990s, which shifted the risk of loss to providers, recent attempts at reigning in healthcare costs also attempt to shift the burden to patients through the use of high-deductible health plans and health savings accounts.<sup>39</sup> These plans purport to improve patient engagement and to encourage patients to research and use the lowest cost provider for their care.<sup>40</sup> However, recent survey data suggest that, rather than engaging in their care, patients simply delay or avoid receiving treatment, even if doing so poses a risk to their health.<sup>41</sup> Delaying or avoiding care can lead to more severe illness or poorly managed conditions, which increases both the physical risks to patients and the eventual cost of required care.<sup>42</sup>

Changes to federal healthcare law continue to encourage integration of healthcare delivery and the management of healthcare costs through payment reforms and care management. The Patient Protection and Affordable Care Act (ACA) was primarily focused on expanding access to insurance coverage but also permitted the creation of Accountable Care Organizations to provide care to certain Medicare beneficiaries and to permit provider participants to receive a bonus for minimizing costs while maintaining quality, as measured by certain benchmarks.<sup>43</sup> More recently, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), in part, to change the way Medicare reimburses physicians, focusing on paying for the value of the services and care provided, rather than the volume of services provided, through two potential

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37. David C. Szostak, *Vertical Integration in Health Care: The Regulatory Landscape*, 17 DEPAUL J. HEALTH CARE L. 65, 93–95 (2015).

38. Sage, *supra* note 6, at 644 (explaining this phenomenon and quoting a California health insurer who welcomes providers to a “carefully selected panel of more than 300 hospitals and 21,000 physicians” (quoting Robert A. Berenson, *Beyond Competition*, 16 HEALTH AFF. 172, 175 (1997))).

39. See 2017 Employer Health Benefits Survey, HENRY J. KAISER FAM. FOUND. (Sept. 19, 2017), <https://www.kff.org/report-section/ehbs-2017-summary-of-findings>; *Pulling It Together: What Do We Want Health Insurance to Be?*, HENRY J. KAISER FAM. FOUND. (Sept. 26, 2008), <https://www.kff.org/health-costs/perspective/pulling-it-together-what-do-we-want>.

40. See Karen Davis, *Consumer-Directed Health Care: Will It Improve Health System Performance?*, 39 HEALTH SERV. RES. 1219, 1219 (2004).

41. Sara Heath, *64% of Patients Avoid Care Due to High Patient Healthcare Costs*, PATIENTENGAGEMENTHIT (Feb. 15, 2018) (citing *New CarePayment Research Shows Americans Can't Afford Their Medical Bills*, BUS. WIRE (Feb. 14, 2018, 12:06 PM), <https://www.businesswire.com/news/home/20180214006069/en/New-CarePayment-Research-Shows-Americans-Can%E2%80%99t-Afford>), <https://patientengagementhit.com/news/64-of-patients-avoid-care-due-to-of-high-patient-healthcare-costs>).

42. Neeraj Sood, *Are High-Deductible Plans a Healthy Option for Patients?*, USC SCHAEFFER (July 17, 2018), <https://healthpolicy.usc.edu/research/are-high-deductible-plans-a-healthy-option-for-patients>.

43. Patient Protection and Affordable Care Act, Pub. L. 111-148, § 3022, 124 Stat. 119, 395–99 (2010) (codified as amended at 42 U.S.C. § 1395jjj (2018)).



payment programs: the Merit Based Incentive Payments System or Alternative Payment Models.<sup>44</sup>

## II. HEALTHCARE CONSOLIDATION AND ANTITRUST LAW

The ACA initiated a movement towards coordinated care and value-based payments, which require increased scale and expensive medical-record technology to survive the price pressures, which encouraged a surge in consolidation.<sup>45</sup> Merger activity in the healthcare industry has skyrocketed, and remained active, since the passage and implementation of the ACA, with fifteen straight quarters of 200 or more health-services mergers and acquisitions.<sup>46</sup> Hospital and health-system transactions reached a record 115 deals in 2017,<sup>47</sup> and other providers are actively engaged in consolidation activities as well, especially in the areas of long-term care, physician medical groups, and managed care.<sup>48</sup> Whether this consolidation is beneficial or harmful is debatable. Proponents argue that consolidation is necessary to achieve the efficiencies required to truly affect necessary changes to the healthcare system to contain and lower costs, while critics argue that a lack of competition inevitably results in higher prices for consumers.<sup>49</sup> Insurance companies have also made headlines with proposed two proposed mega-mergers, first between Aetna and Humana and second between Anthem and Cigna. Both mergers were challenged and later blocked because the mergers were likely to have a substantial effect on competition in an already concentrated market.<sup>50</sup>

### A. Brief Overview of Antitrust Law in Healthcare

Despite the market and regulatory pressures driving consolidation in the healthcare industry, the ACA explicitly states that nothing in the act should “be construed to modify, impair, or supersede the operation of

44. Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, 129 Stat. 87 (2015) (codified as amended in scattered sections of 42 U.S.C.).

45. Paul B. Ginsburg, *Health Care Market Consolidations: Impacts on Costs, Quality and Access*, BROOKINGS (Mar. 16, 2016), <https://www.brookings.edu/testimonies/health-care-market-consolidations-impacts-on-costs-quality-and-access>.

46. THAD KRESHO, PWC, PWC DEALS: US HEALTH SERVICES DEALS INSIGHTS Q2 2018, at 1 (2018), <https://www.pwc.com/us/en/health-industries/publications/assets/us-health-services-deals-insights-q2-2018.pdf>.

47. KAUFMAN, HALL & ASSOCS., LLC, 2017 IN REVIEW: THE YEAR M&A SHOOK THE HEALTHCARE LANDSCAPE 1 (2018), [https://www.kaufmanhall.com/sites/default/files/kh\\_report-ma-year-in-review\\_d4-rebrand.pdf](https://www.kaufmanhall.com/sites/default/files/kh_report-ma-year-in-review_d4-rebrand.pdf).

48. KRESHO, *supra* note 46, at 3.

49. See Susan Adler Channick, *The ACA, Provider Mergers and Hospital Pricing: Experimenting with Smart, Lower-Cost Health Insurance Options*, 6 WM. & MARY POL’Y REV. 1, 2–4 (2014); see also MARTIN GAYNOR & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., THE IMPACT OF HOSPITAL CONSOLIDATION—UPDATE 1 (June 2012), [https://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf73261](https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261).

50. See *United States v. Anthem, Inc.*, 236 F. Supp. 3d 171, 179, 259 (D.D.C. 2017); *United States v. Aetna, Inc.*, 240 F. Supp. 3d 1, 93 (D.D.C. 2017).

any of the antitrust laws.”<sup>51</sup> This Section provides a brief overview of antitrust laws and their application in the healthcare industry.

Section 1 of the Sherman Act states: “Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.”<sup>52</sup> Courts have interpreted this broad prohibition to bar only arrangements that unreasonably restrain trade.<sup>53</sup> For example, in 1918, the Supreme Court acknowledged that “[e]very agreement concerning trade, every regulation of trade, restrains” competition, but tempered the potentially sweeping prohibition on restraints of trade, holding that the “true test of legality is whether the restraint imposed . . . merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition.”<sup>54</sup>

To determine whether an arrangement violates the Sherman Act, courts rely on tests with varying levels of scrutiny.<sup>55</sup> On one end, conduct may be considered per se illegal, regardless of any procompetitive benefits (such as horizontal price-fixing or agreements to divide a market).<sup>56</sup> On the other end of the spectrum, “rule of reason” analysis requires a complex (and expensive) inquiry into the industry, market, and particular arrangement to balance the procompetitive benefits and anticompetitive effects to determine whether an arrangement is anticompetitive.<sup>57</sup> “Quick look” or “truncated rule of reason” analysis offers a middle ground between determining that conduct is per se illegal and a full rule of reason review.<sup>58</sup> Quick look analysis is appropriate “‘when the great likelihood of anticompetitive effects can easily be ascertained,’ and ‘after assessing and rejecting [the] logic of proffered procompetitive justifications.’”<sup>59</sup>

Antitrust law also specifically addresses the creation of monopoly power. The Sherman Act states: “Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony.”<sup>60</sup> Courts have interpreted this provision not to prohibit a monopoly per se but rather to prohibit monopolization through the use of predatory

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51. 42 U.S.C. § 18118(a) (2018).

52. Sherman Antitrust Act, 15 U.S.C. § 1 (2018).

53. See, e.g., *Bd. of Trade of Chi. v. United States*, 246 U.S. 231, 238 (1918).

54. *Id.*

55. *Teladoc, Inc. v. Tex. Med. Bd.*, 112 F. Supp. 3d 529, 536 (W.D. Tex. 2015) (citing *N. Tex. Specialty Physicians v. FTC*, 528 F.3d 346, 362 (5th Cir. 2008)).

56. *N. Tex. Specialty Physicians*, 528 F.3d at 362; *Teladoc, Inc.*, 112 F. Supp. 3d at 536.

57. See, e.g., *Standard Oil Co. of N.J. v. United States*, 221 U.S. 1, 60 (1911) (employing a rule of reason analysis); *Teladoc, Inc.*, 112 F. Supp. 3d at 536.

58. *Teladoc, Inc.*, 112 F. Supp. 3d at 536.

59. *Id.* (quoting *N. Tex. Specialty Physicians*, 528 F.3d at 362).

60. 15 U.S.C. § 2 (2018).

or exclusionary conduct, such as using tying arrangements,<sup>61</sup> exclusive dealing,<sup>62</sup> or anticompetitive leveraging.<sup>63</sup>

Additionally, Section 7 of the Clayton Act prohibits specific conduct that was not directly addressed by the Sherman Act. Section 7 prohibits entities “engaged in commerce or in any activity affecting commerce” from acquiring the stock or assets of another entity “where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or tend to create a monopoly.”<sup>64</sup> The Robinson-Patman Act of 1936 amended the Clayton Act, banning certain discriminatory pricing and allowances in dealings between merchants.<sup>65</sup> The Hart-Scott-Rodino Antitrust Improvements Act of 1976 (HSR) also amended the Clayton Act. The HSR aims to limit concentration of market power in too few entities by requiring certain large organizations to both give regulators advance notice of mergers and acquisitions and wait to consummate the transaction until after the expiration of a waiting period to give the agencies the opportunity review, comment, or enjoin the merger if necessary.<sup>66</sup>

The final major antitrust law is the Federal Trade Commission Act (FTC Act), which also prohibits unfair methods of competition.<sup>67</sup> But the FTC Act’s main contribution to antitrust law is the creation of the Federal Trade Commission (FTC) and the authorization for the FTC to enforce the FTC Act. The FTC may pursue cease and desist orders in response to alleged violations of antitrust laws.<sup>68</sup> The Department of Justice Antitrust Division also enforces the antitrust laws.<sup>69</sup> State attorneys general also play a role in antitrust enforcement under state law, and private parties may seek damages for injuries that result from conduct that violates the antitrust laws.<sup>70</sup>

Because managed care implicates the business of insurance, federal and state laws may be at odds.<sup>71</sup> The McCarran-Ferguson Act of 1945 specifically permits states to regulate the business of insurance without interference from federal law (unless the federal law specifically states

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61. See, e.g., *Jefferson Par. Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 12 (1984), *abrogated on other grounds by* *Ill. Tool Works Inc. v. Indep. Ink, Inc.*, 547 U.S. 28, 42–43 (2006).

62. See, e.g., *United States v. Dentsply Int’l, Inc.*, 399 F.3d 181, 187 (3d Cir. 2005).

63. See, e.g., *White & White, Inc. v. Am. Hosp. Supply Corp.*, 723 F.2d 495, 506 (6th Cir. 1983).

64. Clayton Act, 15 U.S.C. § 18.

65. *Id.* § 13.

66. *Id.* § 18(a).

67. *Id.* §§ 41–58.

68. *Id.* §§ 41, 46, 49, 57b-1.

69. *The Enforcers*, FED. TRADE COMM’N, <https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/enforcers> (last visited Dec. 22, 2018).

70. *Id.*

71. See 15 U.S.C. §§ 1011–15 (exempting the business of insurance from federal law, except when the federal law specifically states that it includes the business of insurance).

its intent to regulate insurance).<sup>72</sup> Therefore, insurance companies and contracts, including managed care arrangements, are typically exempt from federal antitrust laws under the McCarran-Ferguson Act.<sup>73</sup>

### *B. Healthcare Antitrust Cases in the Tenth Circuit*

Antitrust battles in the healthcare industry have often turned on problematic arrangements with providers on one side and insurance companies or managed care organizations on the other.<sup>74</sup> For example, numerous cases have involved challenges to arrangements under which providers join together to collectively negotiate higher reimbursement rates from insurers.<sup>75</sup> Providers who have been excluded from a network have also brought cases alleging anticompetitive behavior by insurers or managed care organizations.<sup>76</sup>

One recent case, *Bristow Endeavor Healthcare v. Blue Cross & Blue Shield Ass'n*,<sup>77</sup> provides a typical example of an antitrust dispute arising from a provider's in-network or out-of-network status.<sup>78</sup> In *Bristow*, Bristow Endeavor Healthcare, LLC (Bristow), a system that operates three facilities in Oklahoma, alleged that Health Care Service Corporation (HCSC) and Blue Cross Blue Shield Association (BCBSA) engaged in anticompetitive behavior.<sup>79</sup> Two of Bristow's facilities were covered by a provider agreement with HCSC and BCBSA.<sup>80</sup> In 2015, Bristow attempted to add its third facility to the provider agreement, but HCSC refused to consent to the addition.<sup>81</sup> The parties attempted to enter into a separate agreement for the third facility but could not come to an agreement.<sup>82</sup> Bristow alleged that HCSC conspired with another healthcare system, Ardent Health Services (Ardent), to protect Ardent's

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72. *Id.*

73. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) (quoting *Grp. Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 220 (1979)) (acknowledging that one of the primary goals of the McCarran-Ferguson Act was to exempt insurance from antitrust laws).

74. *See, e.g., Arizona v. Maricopa Cty. Med. Soc'y*, 457 U.S. 332, 348–49 (1982) (holding that physicians committed a per se violation of the Sherman Act by agreeing to fix the maximum prices for their services); *Abraham v. Intermountain Health Care Inc.*, 461 F.3d 1249, 1265–67 (10th Cir. 2006) (finding no competitive injury in a case between optometrists and an insurance company).

75. *See Maricopa Cty. Med. Soc'y*, 457 U.S. at 356–57; *United States v. Alston*, 974 F.2d 1206, 1210 (9th Cir. 1992); *In re N. Tex. Specialty Physicians*, 140 F.T.C. 715, 726–27 (2005), *order rescinded in part by In re N. Tex. Specialty Physicians*, No. 9312, 2008 WL 4235322 (F.T.C. Sept. 12, 2006); *see also* HEALTH CARE DIV., BUREAU OF COMPETITION, FED. TRADE COMM'N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS 8, 27 (August 2018), [https://www.ftc.gov/system/files/attachments/competition-policy-guidance/overview\\_health\\_care\\_august\\_2018.pdf](https://www.ftc.gov/system/files/attachments/competition-policy-guidance/overview_health_care_august_2018.pdf).

76. *See, e.g., Bristow Endeavor Healthcare, LLC v. Blue Cross & Blue Shield Ass'n*, 691 F. App'x 515, 517–18 (10th Cir. 2017).

77. *Id.*

78. *Id.*

79. *Id.* at 517.

80. *Id.*

81. *Id.*

82. *Id.*

control of the market in northeast Oklahoma.<sup>83</sup> Bristow pointed to several meetings and communications suggesting that HCSC and BCBSA met with Ardent to discuss how to keep the Bristow facility out of the northeast market and to ensure that BCBSA would “protect” Bristow if another system attempted to open a facility in an area where Bristow facilities predominated.<sup>84</sup> The district court granted HCSC and BCBSA’s motions to dismiss and Bristow appealed.<sup>85</sup> The Tenth Circuit noted that a “naked assertion of conspiracy in a § 1 complaint . . . gets the complaint close to stating a claim, but without some further factual enhancement it stops short of the line between possibility and plausibility.”<sup>86</sup> The Tenth Circuit concluded that, although it was a “reasonably close question,” Bristow had failed to demonstrate that HCSC and BSBCA had a rational economic motive to conspire with Ardent, and therefore, there was insufficient evidence of a conspiracy.<sup>87</sup>

Other Tenth Circuit cases also reflect the common theme of disputes between providers and insurance companies or between providers as competitors. For example, *Arapahoe Surgery Center, LLC v. Cigna Healthcare, Inc.*<sup>88</sup> pitted a surgery center against insurance companies in a dispute over out-of-network ambulatory surgery centers’ practice of limiting patient charges to the amounts that patients would have had to pay for in-network providers.<sup>89</sup> Similarly, in *Heartland Surgical Specialty Hospital, LLC v. Midwest Division, Inc.*,<sup>90</sup> the District of Kansas found that a specialty physician-owned hospital had presented sufficient evidence to survive a motion for summary judgment alleging that defendant hospitals and insurance companies had conspired to exclude Heartland, had engaged in a boycott, and had engaged in other unfair competition.<sup>91</sup>

One pending case in New Mexico falls outside of the normal disputes between providers and insurance companies or between providers as competitors.<sup>92</sup> *New Mexico Oncology & Hematology Consultants, Ltd. v. Presbyterian Healthcare Services*<sup>93</sup> involves a clash between two integrated providers.<sup>94</sup> The plaintiff claims that Presbyterian Health Services (Presbyterian) has engaged in unfair competitive practices and possesses both monopoly and monopsony<sup>95</sup> power.<sup>96</sup> The claim survived a motion

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83. *Id.*

84. *Id.* at 518.

85. *Id.*

86. *Id.* at 519 (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 557 (2007)).

87. *Id.*

88. No. 13-cv-3422-WJM-CBS (D. Colo. 2016).

89. *See id.*

90. 527 F. Supp. 2d 1257 (D. Kan. 2007).

91. *Id.* at 1309, 1313.

92. *See N.M. Oncology & Hematology Consultants, Ltd. v. Presbyterian Healthcare Servs.*, 54 F. Supp. 3d 1189, 1197 (D.N.M. 2014).

93. *Id.*

94. *Id.* at 1197.

95. A monopsony exists when a firm exercises complete control over the buyer’s side of the market, in contrast to a monopoly, which exists when a firm exercises control over the supply side of

to dismiss.<sup>97</sup> Through a network of subsidiaries, Presbyterian not only operates a hospital but also controls an insurance company that operates multiple HMO and PPO plans.<sup>98</sup> In 2014, the District of New Mexico found that, if true, the allegations that Presbyterian (1) obstructed referrals to the plaintiff's cancer center by requiring patients to use Presbyterian's pharmacy and (2) lowered the rates paid to the cancer center were sufficient to support a claim that a violation of antitrust laws had occurred.<sup>99</sup> This case has been contentious and is ongoing,<sup>100</sup> but the final outcome may serve as an important guide to navigating antitrust laws for vertically integrated actors in the healthcare market.

### III. HEALTHCARE INDUSTRY CHANGES AND ANTITRUST SCRUTINY

The healthcare industry is slowly evolving from the traditional fee-for-service payment structure to new "value based purchasing" or "pay for performance" payment models.<sup>101</sup> Led by the Centers for Medicare and Medicaid Services (CMS), third-party payors are beginning to pay providers based on quality metrics, such as reductions in hospital-acquired conditions<sup>102</sup> or hospital readmission rates.<sup>103</sup> CMS is also experimenting with bundled payments in which providers receive a set reimbursement amount for an episode of care, such as a joint replacement or a coronary artery bypass graft surgery.<sup>104</sup> In 2015, Congress passed MACRA, which requires CMS to implement a quality payment program to accelerate the transition to payments based on quality measures.<sup>105</sup> These programs aim to align the costs of healthcare with the quality of

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the market. *N.M. Oncology*, 54 F. Supp. 3d at 1205 ("Just as consumers can be injured by a monopolist-seller's practices, so too can a seller suffer antitrust injury by a monopsonist-buyer's power in a particular market."); see generally Roger D. Blair & Jeffrey L. Harrison, *Antitrust Policy and Monopsony*, 76 CORNELL L. REV. 297 (1991) (discussing the treatment of monopsonies in antitrust law, including comparisons to the treatment and concerns related to monopolies).

96. *N.M. Oncology*, 54 F. Supp. 3d at 1198.

97. *Id.* at 1211, 1236.

98. *See id.* at 1197.

99. *Id.* at 1221–22.

100. *See, e.g., N.M. Oncology & Hematology Consultants, Ltd. v. Presbyterian Healthcare Servs.*, Civ. No. 12-526 MV/GBW, 2018 WL 5792320, at \*1 (D.N.M. Nov. 5, 2018) (ordering the defendants to pay the plaintiff \$499,335.99 for costs associated with the plaintiff's Motion for Sanctions).

101. *See* Julia James, *Health PolicyBrief: Pay for Performance*, HEALTH AFF., Oct. 11, 2012, at 1, 5, <https://www.healthaffairs.org/doi/10.1377/hpb20121011.90233/full>.

102. *See Hospital-Acquired Condition (HAC) Reduction Program*, CMS.GOV, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HAC/Hospital-Acquired-Conditions.html> (last modified July 30, 2018, 5:06 PM).

103. *Hospital Readmissions Reduction Program (HRRP)*, CMS.GOV, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program.html> (last modified Dec. 4, 2018, 5:03 PM).

104. *Bundled Payments for Care Improvement (BPCI) Initiative: General Information*, CMS.GOV, <https://innovation.cms.gov/initiatives/bundled-payments> (last updated Dec. 11, 2018).

105. *See Quality Payment Program*, CMS.GOV, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html> (last modified Dec. 21, 2018, 9:57 AM).

care that is provided to patients<sup>106</sup> and standardize costs across regions and providers.<sup>107</sup>

These payment reforms are intended in part to encourage coordination between providers and have already led to dramatic consolidation among providers in the healthcare industry.<sup>108</sup> New payment programs encourage risk sharing among providers and payors, which encourages vertical integration and horizontal consolidation to allow providers and payors to coordinate their actions and incentives more effectively to manage costs and risks.<sup>109</sup> On one hand, hospitals are beginning to operate health insurance plans,<sup>110</sup> such as Presbyterian's operation of the insurance plan and hospital system at issue in *New Mexico Oncology*. On the other hand, health insurance companies are buying physician groups and employing physicians.<sup>111</sup> Optum, an affiliate of the insurance giant UnitedHealthcare, is poised to become one of the largest employers of physicians in the country.<sup>112</sup> The integration and alignment of the financing and provision of care may create significant benefits for consumers by developing a rational, coordinated, and cost-effective healthcare system.<sup>113</sup>

Despite these potential benefits, however, legal barriers may obstruct this progress. Antitrust enforcement agencies have stated that they do not see a conflict between enforcement of antitrust laws and efforts to coordinate and integrate care and have clearly indicated that antitrust

106. See Rabah Kamal & Cynthia Cox, *How Do Healthcare Prices and Use in the U.S. Compare to Other Countries?*, PETERSON-KAISER HEALTH SYS. TRACKER (May 8, 2018), <https://www.healthsystemtracker.org/chart-collection/how-do-healthcare-prices-and-use-in-the-u-s-compare-to-other-countries>; Bradley Sawyer & Selena Gonzales, *How Does the Quality of the U.S. Healthcare System Compare to Other Countries?*, PETERSON-KAISER HEALTH SYS. TRACKER (May 22, 2017), <https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries>.

107. See Zack Cooper et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured* 37–38 (May 7, 2018) (unpublished manuscript), [https://healthcarepricingproject.org/sites/default/files/20180507\\_variationmanuscript\\_0.pdf](https://healthcarepricingproject.org/sites/default/files/20180507_variationmanuscript_0.pdf) (discussing the substantial variation of healthcare prices from region to region).

108. See Robert Kocher & Nikhil R. Sahni, *Hospitals' Race to Employ Physicians—The Logic Behind a Money-Losing Proposition*, 364 NEW ENG. J. MED. 1790, 1790, 1791 fig.2 (2011).

109. See Szostak, *supra* note 37, at 72.

110. N.M. Oncology & Hematology Consultants, Ltd. v. Presbyterian Healthcare Servs., 54 F. Supp. 3d 1189, 1197 (D.N.M. 2014); Szostak, *supra* note 37, at 72–73.

111. See Szostak, *supra* note 37, at 110; Jon Stone, *UnitedHealth Group Soon to Be Largest Employer of Doctors in the US; Clinical Laboratory Outreach More Critical than Ever Before*, DARK DAILY (June 29, 2018), <https://www.darkdaily.com/unitedhealth-group-soon-to-be-largest-employer-of-doctors-in-the-us-clinical-laboratory-outreach-more-critical-than-ever-before-629> (noting that after acquiring DaVita Medical Group, UnitedHealth Group will be the “largest individual employer of physicians in the [United States]”).

112. Morgan Haefner, *With 8k More Physicians than Kaiser, Optum Is 'Scaring the Crap out of Hospitals'*, BECKER'S HOSP. REV. (April 9, 2018), <https://www.beckershospitalreview.com/payer-issues/with-8k-more-physicians-than-kaiser-optum-is-scaring-the-crap-out-of-hospitals.html>.

113. Sage, *supra* note 6, at 633–37; Szostak, *supra* note 37, at 70–76, 114.

enforcement in the healthcare industry remains a top priority.<sup>114</sup> However, enforcement actions and litigation have typically focused on competition between providers or battles to gain in-network status with payors.<sup>115</sup> The integration of the financing and delivery of healthcare through consolidation is a newer movement that is currently being litigated and reviewed.<sup>116</sup>

For example, cases that involve both monopoly and monopsony power typically involve allegations that buyers and sellers conspired to reduce competition.<sup>117</sup> Historically, the buyers and sellers have been separate parties (e.g., a health system and an insurance provider like BCBS).<sup>118</sup> In *New Mexico Oncology*, the plaintiff alleges that defendants engaged in a conspiracy, but unlike other cases involving conspiracy allegations involving a monopsony, the plaintiffs allege that a single party—Presbyterian—controls both the buyer and seller markets.<sup>119</sup> This is a nuanced change for antitrust cases in healthcare. Only recently have healthcare providers and insurers been sufficiently integrated and strong enough to threaten to dominate both the buyers' and sellers' markets. As such, this specific antitrust threat is still being tested in the courts.<sup>120</sup> The outcome in *New Mexico Oncology* may signal a greater openness to vertical integration in healthcare (as opposed to the roadblocks faced with horizontal integration), or it may serve as a canary in the coal mine for other organizations hoping to find efficiencies through consolidation and integration.

#### CONCLUSION

If allowed to develop, fully integrated healthcare models may upend the traditional notions of healthcare products and markets,<sup>121</sup> redefining the notion of consumers, producers, and competition in the healthcare

114. See Michael W. King, *Health Care Efficiencies: Consolidation and Alternative Models vs. Health Care and Antitrust Regulation—Irreconcilable Differences?*, 43 AM. J. L. & MED. 426, 448 (2017).

115. See *supra* Part II; see also *United States v. Anthem, Inc.*, 855 F.3d 345, 349–50 (D.C. Cir. 2017) (affirming the enjoinder of the merger between the second and third largest national health insurance carriers—Anthem and Cigna); *United States v. Aetna Inc.*, 240 F. Supp. 3d 1, 8, 99 (D.D.C. 2017) (blocking a merger between two large insurance companies—Aetna and Humana).

116. *N.M. Oncology & Hematology Consultants, Ltd. v. Presbyterian Healthcare Servs.*, 54 F. Supp. 3d 1189, 1197–98 (D.N.M. 2014); Emily Baumgaertner, *Judge Seeks Monitoring of CVS and Aetna During Antitrust Review*, N.Y. TIMES (Dec. 18, 2018), <https://www.nytimes.com/2018/12/18/health/cvs-aetna-merger-antitrust.html>; Morgan Haefner, *FTC Asks for More Information on Optum's Takeover of DaVita*, BECKER'S HOSP. REV. (Mar. 22, 2018), <https://www.beckershospitalreview.com/hospital-transactions-and-valuation/ftc-asks-for-more-information-on-optum-s-takeover-of-davita.html>.

117. See *W. Penn Allegheny Health Sys., Inc. v. UPMC*, 627 F.3d 85, 103–05 (3d Cir. 2010) (involving an allegation that a hospital system and insurance provider conspired to restrict trade, including exercising monopsony power); *St. Bernard Gen. Hosp., Inc. v. Hosp. Serv. Ass'n of New Orleans, Inc.*, 712 F.2d 978, 983–85 (5th Cir. 1983) (same).

118. See, e.g., *W. Penn Allegheny Health Sys., Inc.*, 627 F.3d at 91–92.

119. *N.M. Oncology*, 54 F. Supp. 3d at 1198.

120. See *id.* at 1197–98; see also Baumgaertner, *supra* note 116.

121. See Sage, *supra* note 6, at 652, 655–57, 681, 699–700.



industry. Whether these new models will be allowed to proceed or will be blocked by antitrust laws remains an open question that will likely be driven by case-by-case, fact-specific analysis. Nevertheless, when it comes to the future of the healthcare industry, trends toward integration and consolidation are likely to continue, driven by the need to coordinate care for chronically ill and aging patients and reigning in costs. Payment reforms will continue to shift traditional roles in the healthcare industry as industry players follow the age-old rule: follow the money.

